Executive Office of Health and Human Services

RI Department of Human Services

Drug Utilization Review (DUR) Board Meeting Minutes

Date - Tuesday, April 3, 2012

Meeting - 10:30 AM

DUR Board Members Present:	Michelle Booth, RPh Stephen Kogut, PhD, RPh, MBA Richard Wagner, MD
DUR Board Members Absent:	Ray Maxim, MD Ellen Mauro, RN, MPH Linda Rowe Varone RPh
Others Present:	Ann Bennett (HP Enterprise Services) Karen Mariano RPh (HP Enterprise Services) Joe Paradis, PharmD (Health Information Designs)

Minutes from the December 13, 2011 meeting had been approved prior to this meeting via e-mail communications with Board members.

Board members asked if recent published reports discussing concerns regarding the efficacy of antidepressants had been discussed at the P&T meeting held earlier. Recent published data in the Journal of the American Medical Association discussed a meta-analysis which reviewed several clinical trials studying the efficacy of antidepressant. The publication raised concern that medications may not be as effective in treating mild to moderate depression compared to treating severe depression. Board members noted that other meta-analysis studies have shown lack of efficacy in children and adolescence. However, some of these trials were not adequately designed to show a difference of drug vs. placebo. Some studies show an increase risk in suicide ideation after treatment in adolescents and young adults but no correlation between suicide ideation and actual suicide was made. Board members also noted that efficacy of antidepressants is very variable and related to many factors such as age, gender, race and duration of treatment. In addition, studies have shown that placebo patients appear to relapse quicker than treated patients. The P&T Committee did discuss these reports and also the possibility of evaluating efficacy of specific drug classes in the future. The idea of evaluating non-drug treatments for depression was also mentioned at the P&T meeting. It was also noted that 90% of antidepressants are prescribed by general practitioners who are not psychiatrists.

The risk of QTC prolongation related to higher doses of citalopram was discussed. Board members noted that the drug should not be used in doses of greater than 40mg along with drug that also may cause QTC prolongation. However, there is no data that correlates citalopram blood levels with QTC prolongation. Board members asked if prescribers have been alerted to this issue. HID noted that a criteria had been developed and DUR letters were mailed to prescribers with a 43% response rate. It was noted that escitalopram is now available generically and

perhaps the P&T Committee should consider making citalopram non-preferred for safety reasons. Medicare Part D plans are mandated to cover either citalopram or escitalopram by federal regulations.

The Lock-in program was reviewed. No patients are currently restricted to a single pharmacy due to abuse of controlled substances. The patients who are restricted to a single pharmacy are those who reside in group homes or facilities outside of the state of Rhode Island and one local pharmacy has been identified to process their prescriptions. The intention of the Lock-in program is to enlist the help of one pharmacy to assist patients with more comprehensive pain management by reviewing all of their medications. Normally the pharmacy most frequented by the patient would be selected as the restricted pharmacy. However, the pharmacy and pharmacists working at the store must agree to take on the role of coordinating prescription services for that patient.

Based on discussion from the last DUR Board meeting, HID identified patients taking Suboxone® or Subutex® and another opioid and those taking short acting opioids for greater than 90 days with no long acting agent. There was considerable discussion regarding the cost of Suboxone® and lack of a generic agent where as Subutex® is available as a generic. Subutex® only contains buprenorphine and Suboxone® also contains naloxone as a deterrent for patients to abuse the drug by dissolving tables and injecting them. Despite the higher cost of Suboxone®, Board members noted that the only time that Subutex® should be used as an ongoing treatment was for patients allergic to naloxone or in pregnant females.

HID noted that there were only three (3) patients taking Suboxone® along with another opioid being started after Suboxone® therapy had been initiated. Board members requested that HID send a DUR intervention letter to the Suboxone® prescriber for these three (3) patients. If no response is noted and patients continue on opioid therapy along with Suboxone® a second letter should be sent from the Medicaid Medical Director. If possible, the second letter should inform the Suboxone® prescriber of the name of the opioid prescriber. Prescribers of patients found to be taking short acting opioids for greater than 90 days should also be sent a DUR intervention letter. If no change in prescribing is noted, a second letter should be sent indicating that the patient will be restricted to a single pharmacy. The Board requested that these patients be reviewed again at the next meeting.

There was further discussion regarding Subutex® and other buprenorphine products. A transdermal dosage form of buprenorphine is available as the trade name Butrans®. The Board recommended that both of these products require prior authorization. After patients have had their first induction doses with Subutex®, the Board recommended that it should be limited to use in pregnant woman. Automated prior authorization criteria could include the concurrent use of a prenatal vitamin in woman aged 45 and younger. The Board recommended that Butrans® be limited to use patients who have failed two (2) preferred generic long acting generic opioids. This could be accomplished by a review of the patient's claims history in the past 60 days.

The utilization of Suboxone® was further discussed. Board members noted that originally the drug was intended to be used on a short term basis. However, most patients are receiving the drug chronically. Board members suggested that the manufacturer of Suboxone® be contacted in an effort to obtain any national long term safety data for the drug. The Board also recommended that a prospective high dose edit for Suboxone® be considered to limit the dose 24mg daily. The Board asked HID to evaluate the use of Suboxone® by daily dose and determine if patients were receiving daily doses greater than 24mg. After a further evaluation of the utilization of Suboxone® is evaluated, the possibility of placing prior authorization restrictions on the concurrent use of Suboxone® with another opioid may be considered. At the next meeting, and subsequent meetings, a summary of each of the criteria used to screen for patients for potential overuse of controlled substances will be reviewed and summary of the types of prescriber responses to DUR intervention letters will be reviewed.

The Board was asked what types of retrospective DUR intervention alert letter are they most concerned with respect to making an effort to obtain higher response rates from prescribers. Based on a review of responses rates from other State Medicaid Programs, Rhode Island has an average or above average response rate to DUR intervention letters. The Board noted that at this time they are prioritizing their efforts to review those patients identified as receiving short acting narcotics for greater than 90 days and those Suboxone® patients taking other concomitant opioids. The Board would also like to be sure that prescribers of patients on doses of citalopram greater than 40mg are alerted to the issue of possible QTC elevations.

The Board noted that response to DUR letters is not a mandatory requirement for prescribers and letters serve as a means of providing educational outreach to providers. It was also noted that the purpose of the DUR program was not to increase the number of letters mailed to prescribers but to focus on areas that are outside of best practices and make interventions that could improve clinical outcomes. The Board recommended that those prescribers who received the most number of DUR letters be evaluated to determine the individual response rate for each prescriber. Then identify the top ten (10) non-responders to DUR letters and referred them to the Medicaid Medical Director for follow-up to determine why they do not respond and how they feel the program could be improved to better facilitate responses.

HID presented a summary of patients with claims for concurrent therapy with duplicate antipsychotics. A total of 266 patients met the criteria, 134 of them were found to be taking the same drug at different dosage strengths. A total of 52 patients were found to be taking quetiapine and another agent and 31 patients were found to be taking two different agents. It was noted that low doses of quetiapine may be prescribed as an alternative to benzodiazepines. The Board recommended that the prescribers for these two groups of patients be identified. Once the prescribers are identified it was recommended that they be referred to the Medicaid Medical Director for follow-up. It is possible that with direct communication from the Medicaid Medical Director the incidence of duplicate therapy could be reduced.

The utilization of clonazepam with another benzodiazepine was discussed. The Board felt that this combination was not clinically justified. It is likely that this combination is not alerted as duplicate therapy with current prospective DUR criteria since clonazepam is classified as an anticonvulsant. The Board noted that clonazepam can be used effectively as an anticonvulsant in patients with schizophrenia. The Board was asked if the combination of clonazepam and another benzodiazepine should require prior authorization. The Board was not in favor of this action since many patients who have been on this combination have been taking both drugs chronically and it would be very difficult of not impossible to taper patients off either of these drugs. The Board recommended that prescribers be identified and referred to the Medicaid Medical Director.

As requested by the P&T Committee, HID will evaluate the use of Zetia® with and without concurrent Statin therapy. Board members noted that the antipsychotics will be discussed at the next P&T Committee meeting scheduled for June 5, 2012. The recommendation was made to review other Rhode Island healthcare plan formularies prior to the meeting to determine what antipsychotic agents are included. It was noted that other private healthcare and Part D plans have different incentives for rebates and drug coverage based on if they are pharmacy only plan or also include coverage of medical care.

The next meeting will be June 5, 2012 after the P&T Committee meeting.