Executive Office of Health and Human Services

RI Department of Human Services

Drug Utilization Review (DUR) Board Meeting Minutes

Date – Tuesday, April 8, 2014

Time – 10:30 AM

DUR Board Members Present:	Stephen Kogut, PhD, RPh, MBA Ellen Mauro, RN, MPH Linda Rowe Varone, PharmD, BCPP Richard Wagner, MD
DUR Board Members Absent:	Michelle Booth, PharmD
Others Present:	Ann Bennett (HP Enterprise Services) Jerry Fingerut, MD (Rhode Island Medicaid) Karen Mariano, RPh (HP Enterprise Services) Ralph Racca (Rhode Island Medicaid) Joe Paradis, PharmD (Health Information Designs – HID)

Minutes from the December 3, 2013 meeting were approved with minor changes.

The lock-in program and monitoring of the use of opioids were discussed. Connect Care Choice evaluates patients to recommend them for lock-in to a single pharmacy if they are utilization multiple prescribers and have frequent emergency room visits. Currently, 92 patients are enrolled in the Connect Care Choice lock-in program.

HID reviews patients to determine if intervention letters should be mailed to prescribers if patients are found to be utilizing short acting opioids for greater than 90 days or are taking buprenorphine concurrently with other opioids. Patients are also reviewed if they have a total day supply of greater than 120 days of any controlled substance dispensed in the most recent 90 days.

HID reviewed lock-in screening and opioid overuse criteria utilized by other state Medicaid programs. One state has restricted all buprenorphine patients to a single pharmacy of their choosing to prevent the use of other opioids in these patients. Another state Medicaid program uses specific criteria to automatically restrict patients to a single pharmacy. The criteria used are 6 or more controlled substances from 3 or more prescribers and 4 or more pharmacies. This state also utilizes a committee made up of DUR Board members to review individual patients for lock-in. The Board and other attendees were in favor of adopting similar criteria to automatically restrict patients to a single pharmacy. The criteria recommended for automatic lock-in are, patients receiving 6 or more claims for controlled substances from 3 or more pharmacies and 2 or more prescribers in the most recent 30 days. HID was asked to present at the June DUR Board meeting the number of patients who meet these criteria. Any patients who meet the proposed automatic lock-in program will be verified to determine of they are hospice patients since these patients would normally only have a single prescriber.

There was further discussion regarding the merits of a lock-in program and other issues related to opioid use. Board members noted that emergency room prescribers are reluctant to prescribe opioids to patients and this could lead to patients seeking drugs at the street level. More restrictive programs implemented by insurance companies, pharmacies and the Drug Enforcement Administration (DEA) with respect to limiting patients access to opioids could all have serious unintended consequences. Board members also noted that the Connect Care Choice patients who are restricted to a single pharmacy do have multiple medical and social issues but are closely monitored. The use of limiting the availability of long term use of short acting opioids was suggested as an alternative to restricting patients to a single pharmacy. However, it was noted that using a lock-in program helps promote the pharmacist has a key member of the healthcare team.

The Prescription Drug Monitoring Program (PDMP) was also discussed. The program has limitations since it is voluntary and claims data are loaded into the system by pharmacies on a monthly basis. There has been discussion regarding making weekly data updates mandatory to improve the usefulness of the program. The Board recommended adding language to DUR intervention letters that the PDMP program was available to monitor patient utilization in an effort to increase participation in the program.

There was also discussion of the use of naloxone in an emergency situation to treat opioid overdose. Naloxone has been available on all emergency EMT and police vehicles and an agreement has been reached with Walgreens pharmacy to allow anyone to obtain naloxone at any Walgreens pharmacy in Rhode Island without a prescription. It was suggested that top prescribers of opiods and prescribers of opioids for lock-in patients be contacted and made aware of the availability of naloxone at Walgreens so that they could inform their patients and caregivers. The drug is both available in injectable form and can be given by nasal spray and a new auto injector device was recently approved by FDA.

HID reviewed a summary of DUR intervention letters directed at prescribers for patients who are receiving opioids at a dose that is greater than 100mg morphine and those receiving concurrent therapy with oipoids and benzodiazepines. HID also reviewed a summary of diagnosis data found for the patients receiving greater than 100mg equivalents of morphine. Of the 43 patients who met the criteria, 6 had a cancer diagnosis, 5 had a diagnosis of chronic pain and 26 other patients had a diagnosis that indicated the patient had a chronic condition that would require opioid use. Some examples include; arthritis, myalgia, spinal stenosis, joint pain and sickle cell. A total of 11 patients had no recent diagnosis data to review.

HID reported the number of children utilizing antipsychotics who were under the labeled indicated FDA approved age for use of the drug. A total of 13 patients were identified during the fourth quarter of 2013 and 14 had been identified in the previous quarter. Board members recommended that HID ensure that each of these patients prescribers be sent an intervention letter stating that the drug was not approved for use in patients of that age and that a summary of the FDA approved indications and approved ages be sent along with the letter. Board members requested that HID review responses to these interventions and report how many prescribers responded that they were aware of the underage use and were monitoring the patient.

HID presented a summary of DUR intervention letters mailed to prescribers of children with concurrent claims for stimulants and antipsychotics. Board members commented that this combination therapy is not normally utilized and may results from prescribers treating psychotic symptoms precipitated by stimulant use. It would be useful to determine how many of these prescribers had made a clinical decision to utilize these agents in combination. However, that information would be difficult to obtain unless the prescriber were directly contacted or specifically noted that in the comments section of the response form attached to the DUR letters.

The utilization of newer agents for the treatment of hepatitis C was discussed as well as the economic impact of their use as a result of the substantial cost of these agents. A task force has formed and is meeting every two weeks to develop prior authorization criteria for the drugs in anticipation that final criteria would be completed by July 1, 2014. The goal is for the Managed Care Organizations (MCOs) and traditional fee-for-service to develop and implement similar criteria for the use of these agents. The MCOs have agreed that if a patient meets the fee-for-service criteria and is started on one of the agents and is then enrolled in an MCO, the MCO will continue therapy and not require additional prior authorization. Board members cautioned that patients should not be initiated on therapy if it appeared that the patient would be non-adherent to the full course of therapy. HID was also asked to provide the Connect Care Choice Program with a list of patients currently receiving hepatitis C treatment.

HID presented a summary of DUR interventions and responses from the fourth quarter 2013. This included a summary of the top 10 non-responder prescribers. These are prescribers who have never responded to a DUR letter. It was recommended that a separate letter be mailed to the top 10 non-responders as was done in 2012 to determine why these prescribers do not respond. HID will draft a letter and forward to HP for final approval. HID was also requested to send the list of the top 10 non-responders to the Connect Care Choice Program to determine if any of the prescribers are associated with the Health Centers throughout the state.

HID indicated that some other State Medicaid programs have addressed the issue of non-adherence to antiretroviral therapy. However, there may be concerns if DUR letters are sent to the incorrect prescribers that patients confidentially may be an issue in disclosing to another prescriber that a patient is on antiretroviral therapy. At times pharmacies do not provide the accurate prescriber identification number when submitting claims. The Board recommended that prescribers of antiretroviral therapy be contacted to determine if they believe a letter indicating that their patient was non-adherent would be useful and if any patients confidentially issues would prevent such a letter from being distributed.

A similar patient confidentially issue was made with regard to DUR interventions letters mailed to prescribers of buprenorphine for their patients who also have claims for other opioids. Would confidentially be an issue if letters were mailed to the incorrect buprenorphine prescriber? Very few alerts are generated for this interaction. However, HID will review all DUR letters for buprenorphine and other opioids and report back at the June meeting if any responses were received indicating that the incorrect prescriber had been contacted. Board members noted that these types of prescriber identification issues will no longer be problems when electronic prescribing is fully adopted as the primary means of transmitting prescriptions.

Several issues were discussed at the P&T Committee meeting which occurred just prior to the DUR Board meeting and were asked to be brought up for review by the DUR Board and are as follows:

1. Review of patients with treatment on alendronate for more than 5 years. Efficacy has not been demonstrated after 5 years and patients should be reassessed for the need for continued treatment with another agent. HID will evaluate use of alendronate and determine length of therapy, demographics of patients and incidence of reported fractures. There may be limitations to the review of diagnosis data since not all diagnosis data may be forwarded to HID.
2. Evaluate patients with claims for non-preferred growth hormone to determine if Medicaid is a secondary payer for these patients. If these patients have Medicaid as the only payer, intervention letters could be drafted in an effort to improve compliance of use of preferred agents.

3. Send intervention letters to prescribers of Victoza indicating that the drug will be non-preferred. However, current patients will be able to continue therapy without prior authorization.
4. Novolin insulin will become non-preferred and patient will be transitioned to Humulin. HID was asked to alert prescribers of Novolin that patients will be required to transition to Humulin or obtain prior authorization if clinically indicated.
5. HID was asked to evaluate patients with claims for SGLT-2 inhibitors to determine if they remain adherent to other medications for the treatment of diabetes.

The DUR Board recommended that any significant PDL changes could be included in the Provider Bulletin.

It was noted that the new sustained release dosage form of hydrocodone (Zyhydro) was made illegal to prescribe or dispense in the State of Massachusetts. The drug is non-preferred for Rhode Island Mediaid until reviewed by the P&T Committee.

The next meeting will be held June 3, 2014 at the HP facility.