Executive Office of Health and Human Services

RI Department of Human Services

Drug Utilization Review (DUR) Board Meeting Minutes

Date – Tuesday, August 27, 2013

Time – 10:30 AM

DUR Board Members Present:	Michelle Booth, RPh Stephen Kogut, PhD, RPh, MBA Linda Rowe Varone, RPh Richard Wagner, MD
DUR Board Members Absent:	Ellen Mauro, RN, MPH
Others Present:	Ann Bennett (HP Enterprise Services) Jerry Fingerut, MD (Rhode Island Medicaid) Deidre Gifford, 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 June 4, 2013 meeting were approved with no changes.

Several topics discussed at the P&T Committee meeting held earlier this morning were referred to the DUR Board for further evaluation. These issues were reviewed before the agenda items were discussed.

The DUR Board was asked to evaluate adherence and length of therapy for treatment of hepatitis C. The Board recommended that managed care (MCO) data be evaluated as well, if possible. HP indicated that it may be possible to utilize the data warehouse to evaluate MCO data. HID will evaluate Medicaid claims data.

The P&T also requested that the DUR Board evaluate the utilization of Intuniv® and, if possible, reach out to prescribers of this non-preferred agent in an effort to shift utilization to preferred agents if clinically indicated. It was noted that some claims for guanfacine (Intuniv®) may be those which are partially paid for by Medicaid as part of the coordination of benefits with other insurers. The Board also recommended that patients on both guanfacine (Intuniv®) and clonidine be identified since this represents an interaction that could result in hypotension. HID will work with HP to review data and develop an intervention letter.

The P&T Committee also recommended that prior authorization criteria be developed for armodafinil (Nuvigil®) and modafinil (Provigil®), and that their use be approved only for FDA-labeled indications such as obstructive sleep apnea, narcolepsy, and shift work disorder. HID was asked to evaluate the utilization of these agents and determine if diagnosis data was available for review of patients with claims for these medications.

HID summarized the current state of the lock-in screening program. Currently, HID reviews patients each month who are found to be utilizing short-acting opioids at higher doses continuously for more than 3 months, have received excessive quantities (based on days supply) of any controlled substance over the past 3 months. or have claims for buprenorphine (Subutex®) or buprenorphine/naloxone (Suboxone®) concurrently with other opioids. In the past, patients who where utilizing multiple pharmacies to obtain the same opioid could be restricted to a single pharmacy if the behavior did not change after two DUR letters were mailed to their prescribers. No new patients have been restricted to a single pharmacy in this manner for quite some time. However, there are currently approximately 60 patients restricted to a single pharmacy by the Connect Care Choice Program due to excessive use of emergency room facilities and other criteria. It was recommended that HID report to the Connect Care Choice Program any patients they find who continue to utilize multiple pharmacies to obtain opioids, despite the fact that DUR intervention letters were mailed to their prescribers. It was noted that the Neighborhood MCO had a lock-in program (pharmacy home program), and it was recommended that their screening criteria be shared with HP and HID if possible.

Board members asked if the prospective DUR alert for buprenorphine/naloxone (Suboxone®) use with another opioid would deny at point of service. These claims would flag a therapeutic duplication edit that could be overridden by the dispensing pharmacy. There was some discussion of possibly considering prior authorization for buprenorphine/naloxone (Suboxone®) in the future.

There was some discussion of the statewide Prescription Drug Monitoring Program (PDMP). However, Medicaid does not have access to the PDMP.

Board members noted that both the FDA and CMS were taking a much closer look at issues related to use and potential misuse of both opioids and benzodiazepines. The Board asked if Rhode Island Medicaid could be compared to other states with respect to the prevalence of opioid use in the fee-for-service population. The Board also recommended that HID identify patients with ongoing chronic utilization of both opioids and benzodiazepines and those individual patients with multiple prescribers of buprenorphine/naloxone (Suboxone®).

Utilization of methadone was also discussed. In the past, a review of data from methadone treatment centers was compared to data from the fee-for-service Medicaid program. Due to privacy concerns, this review may not be possible. It was recommended that a review of patients on methadone in the fee-for-service program be evaluated and patient diagnosis data be reviewed if available to determine if any patients have a diagnosis of drug dependency.

The utilization of antipsychotics in children was discussed. Going back to the second quarter of 2012, the number of patients under the labeled age for FDA-approved indications who had claims for antipsychotics has been fairly consistent. There was discussion regarding the metabolic adverse effects of antipsychotic agents and the need to remind prescribers that these events could be more exaggerated in children. There was also discussion of the use of antipsychotics in children with no other apparent diagnosis other than ADHD. This following scenario was described as one that should be avoided: a child on a stimulant becomes irritable due to the stimulant and an antipsychotic is added. HID will develop criteria to alert on the use of antipsychotics in children with no clinically appropriate diagnosis for their use. The lack of access to pediatric psychiatrists and other mental health providers in Rhode Island was also discussed.

The utilization of low dose quetiapine was discussed. HID reported that approximately half of the patients with claims for the drug during the second quarter of 2013 were receiving doses of less than 200mg. It was noted that the Neighborhood plan requires prior authorization for 25mg and 50mg

tablets. The DUR Board requested that HID report the number of quetiapine patients receiving doses of 800mg or more.

The utilization of anticoagulation agents was discussed. The number of diagnoses associated with bleeding was reviewed for patients taking warfarin and those on the newer agents. It is difficult to determine if any differences in bleeding rates can be determined due to the small number of patients with claims for the newer agents (all of the newer agents are non-preferred) and it is very likely that not all diagnosis data for all patients is available for review by HID. Other factors that increased the risk of bleeding could be involved, such as the concurrent use of NSAIDs or aspirin. The Board noted that some of the newer agents may be contraindicated for use in patients with a history of specific bleeding. The Board recommended that HID evaluate the concurrent use of NSAIDs with anticoagulants.

HID reviewed a summary of DUR letters mailed in the previous quarter. Approximately 40% of the letters addressed an issue of non-adherence, 30% addressed a drug-drug or drug-disease interaction, and 20% addressed therapeutic duplication or overuse. Response rates from prescribers who received letters averaged between 30%-40%. The issue of prescriber non-responders was discussed. In the past, non-responders (those who never responded to a DUR letter) were contacted via a separate targeted letter. The previous Medicaid Medical Director intended to contact these top non-responder prescribers who never responded to DUR letters via telephone but never had the opportunity to do so. It was recommended that this outreach process be considered again in an effort to demonstrate that action is still being taken in reference to previous audit findings. HID will provide HP with a list of the top 10 non-responder prescribers. HID will also evaluate non-responders who were previously identified and determine if they have responded to newer, more recent DUR intervention letters. The use of focus groups for prescribers to discuss significant issues was also suggested as a means to engage providers in the DUR process.

HID indicated that a review of the current DUR criteria in place could be undertaken at the December meeting.

The use of long-acting injectable antipsychotic agents was discussed. HID presented a summary of long-acting agent utilization. The Board noted that, at this time, the literature does not support the use of one long-acting agent over another nor does it demonstrate the cost effectiveness of these agents. However, European studies have demonstrated that the long-acting agents do improve adherence. Currently, Invega® Sustenna® and Risperda® Consta® are the preferred agents. The Board requested that HID evaluate all patients with claims for long-acting agents to determine how many also had ongoing claims for oral agents and calculate the interval between injections. If possible, also report the patient's utilization of any antipsychotic agents prior to initiating therapy with an injectable.

HID presented data on the utilization of long-acting opioids to specifically evaluate the use of the non-preferred agent OxyContin®. It was noted that 5 prescribers accounted for 45% of all claims for OxyContin®. The Board recommended that further follow-up with these 5 prescribers be done, if possible, and recommended that HID forward their prescriber identification numbers to HP.

The use of agents to treat *C. difficile* was reviewed. It was noted that 4 patients who were treated with the non-preferred agent vancomycin had no prior metronidazole therapy. The Board questioned whether there was anything unique regarding these 4 patients and asked HID to investigate further, if possible.

The use of zolpidem (Ambien®) was reviewed in light of recent FDA recommendations that lower doses (5mg) should be initiated in women. The majority of recent claims were found to be for the 10mg dose.

The Board noted that use of this drug is often driven by patient requests and many patients would not be satisfied with a lowering of their doses. It was also noted that many patients have very poor sleep habits. However, the Board agreed that DUR intervention letters should be mailed to prescribers in light of the FDA recommendations.

The next meeting will be held December 3, 2013 at the HP facility.