Executive Office of Health and Human Services

RI Department of Human Services

Drug Utilization Review (DUR) Board Meeting Minutes

Date - Tuesday, December 13, 2011

Meeting - 10:30 AM

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

Introductions were made and the minutes from the September meeting were approved with no changes.

There was discussion concerning how best to organize future DUR Board meetings to ensure that all Federal requirements for State Medicaid DUR Boards were being met. Two specific issues were brought up for discussion. The first was the issue of what to do in cases where prescribers do not ever respond to DUR letters. The second was what action should be taken if prescribing patterns are noted which deviate significantly from what is considered best practices.

Board members noted that the entire Medicaid population as a whole should be evaluated to determine if overall prescribing behavior meets best practices of evidenced based medicine. The Board noted that there will likely be those prescribers who fall outside of the normal distribution of best practices. However, DUR interventions are intended to be educational in nature and non punitive. Therefore, the DUR Board did not recommend reporting prescribers who are identified for particular prescribing practices to the State Medical Board. It was noted that clinically significant issues, such as severe drug interactions, high dose alerts, therapeutic duplication and overuse, would be picked up at the time of dispensing by prospective DUR edits currently in place. Retrospective DUR evaluations would not be able to identify significant clinical issues in a timely manner. It was proposed that when prescribers prescribing patterns are significantly outside of best practices and prescribers do not respond to DUR interventions, their prescribing patterns could be reviewed by the DUR Board and if so determined, recommendations for further action be made by the committee.

It was noted that Federal regulations include face to face interventions when necessary. The Board noted that in most cases face to face interventions would not be necessary based on the types of DUR alerts that are being identified by the program.

Currently responses and response rates to DUR letters are tracked. In the future additional data, such as numbers of patients who continue to meet criteria and those who no longer meet criteria that were intervened on, will be

reported to the DUR Board. Board members asked what other states were doing with respect to concerns regarding non-responders. HID will collect this information for the next meeting.

The agenda for DUR Board meetings going forward was discussed. DUR Board members noted that items related to best practices and a review of the lock-in program should be at the top of the agenda for each meeting. In addition, a review of the number of DUR letters sent, outcomes and responses should be reported in the same format at each meeting. The agenda could also include a quarterly review of drug utilization statistics such as highest claim volume, highest cost and highest risk; along with benchmarking compared to data from other states. In addition, any items that need to be discussed and forwarded to Medicaid's Medical Director should also be included on each agenda. These would include discussion of prescribers who fail to ever respond to DUR letters and those prescribers identified with practice patterns that fall significantly outside of best practices.

There was discussion regarding patient adherence as well as ways in which to identify those patients who may be at risk for poor outcomes. HP Enterprise Services noted that the current prospective DUR system includes a comprehensive database of criteria to screen for drug interactions, duplicate therapy, early and late refills and overuse. There was also a suggestion that when e-prescribing becomes more widely used, there may be an opportunity to identify patients who were prescribed a drug but never picked it up at the pharmacy.

Nomenclature of the lock-in program was discussed. Lock-in implies a punitive program. It was suggested that perhaps a term such as "Supervised Pharmacy Home Program" may be a better alternative.

Follow up with items from the last meeting were reviewed. Utilization of the newer agents for the treatment of hepatitis C was reviewed. Currently there are 9 patients being treated with hepatitis C drugs and 6 unique prescribers. Utilization of hepatitis C agents will be monitored on an ongoing basis.

The utilization of triptans for migraines was reviewed. Criteria are in place that identify patients not receiving prophylaxis therapy and DUR letters will be sent after the next cycle. The DUR Board recommended that even those drugs not FDA approved for migraine prophylaxis, such as gabapentin, carbamazepine and verapamil, be included in the criteria since they are widely accepted in practice as being effective.

The utilization of simvasatin 80mg and citalopram 40mg was discussed. Higher doses of these drugs may be associated with adverse effects. In addition, the use of simvastin with other drug which may result in adverse effects was also discussed.

The use of citalopram at higher doses was discussed. DUR Board members noted that patients receiving doses of 40mg or more should be considered for an EKG. It was noted that the Neighborhood Health Plan of RI requires prior authorization for >40mg of citalopram. Another concern that was noted is the use of citalopram and other drugs that may cause QTC prolongations such as methadone, ziprasidone and antihistamines. The DUR board recommended that intervention letters be sent to prescribers for these specific interactions. The DUR Board noted that DUR letters such as these and those alerting for drug interactions should not necessarily require a response from the prescriber. These types of letters should serve to simply notify the prescriber of the potential interaction.

The lock-in program was reviewed. At this time only patients living out of state in group homes or other facilities are locked into a single pharmacy. This is done to allow for a selected local out of state pharmacy to process prescriptions for Rhode Island Medicaid. No patients are currently locked in for overuse of controlled substances.

The lock-in screening process was discussed. Currently all patients receiving more than 120 days supply of controlled substances over the previous 60 days are reviewed. New criteria were proposed. They include patients taking short

acting narcotic agents for an extended period of time, use of methadone with another opioid, use of Suboxone® with a another opioid and review of patients utilizing 3 or more pharmacies in the previous month to obtain controlled drugs. In the discussion of the proposed criteria it was noted that the Neighborhood Health Plan of RI has strict quantity limits for narcotics and uses a system for lock-in screening referred to as 7-3-3. Patients with 7 claims for controlled drugs from 3 pharmacies and 3 different prescribers are screened for lock-in. The DUR Board did not recommend that the number of pharmacies be considered for the lock-in screening process. However, they did recommend that all patients taking either methadone or Suboxone® and another opioid be considered for lock-in since this was not consistent with best practices. In addition, patients taking short acting narcotic agents for long periods of time should also be considered for lock-in. These new criteria will be implemented going forward to screen for lock-in patients. The DUR Board recommended that the top 100 prescribers of controlled drugs be notified of the lock-in program and the criteria that will be used to screen patients. HP Enterprise Services will also review the actual procedure for locking-in a patient.

It was noted that other State Medicaid programs are considering locking in all Suboxone® patients. DUR Board members were not in favor of recommending this action.

HID presented some examples the impact of DUR letters. It was noted that:

- Approximately half of patients identified as taking low dose quetiapine, who had intervention letters sent to their prescribers, were no longer on lower doses of the drug six months after letters were mailed. Board members recommended that perhaps a prior authorization for the use of low dose quetiapine should be considered.
- It was also noted that 66% of patients found to be non-adherent to lipid lowering therapy were found to be adherent to therapy 6 months after DUR letters were mailed to their prescribers.
- One third of patients found to be taking a proton pump inhibitor and clopidogrel where no longer on this combination of therapy after DUR letters were mailed.

A brief review of the number of DUR letters generated and mailed during FFY 2010 was reviewed. Letters addressing non-adherence represented 55% of all letters mailed. An average response rate of 32% was achieved.

The issue of which DUR letters should be considered strictly informational in nature and which of them should be followed up for a response from the prescriber if possible was further discussed. The DUR Board recommended that letters that address black box warnings, drug interactions and non-adherence should be considered informational in nature and no response would be expected from prescribers. Those DUR letters that addressed duplicate therapy, overuse of narcotics and lock-in screening should be followed up if at all possible. The DUR Board recommended that retrospective DUR interventions be performed to alert prescribers of duplicate antipsychotic therapy.

The Board reiterated that each DUR Board meeting should include a review of high cost high volume drugs for the previous quarter, as well as a review of high risk drugs if possible.

Proposed projects were discussed regarding those items which should be brought to the attention of the Department and the Medicaid Medical Director. The first proposed review would be to evaluate the top prescribers of benzodiazepines. The DUR Board recommended that this review be performed.

The DUR Board also recommended that specific issues, such as a review of the lock-in program, be posted on the Department's website under a section of "Provider Updates."

The next meeting will be held on April 3, 2012 at 10:30am immediately following the P&T Committee meeting.