Executive Office of Health and Human Services

RI Department of Human Services

Drug Utilization Review (DUR) Board Meeting Minutes

Date – Tuesday, December 3, 2013

Time – 10:30 AM

DUR Board Members Present:	Michelle Booth, PharmD Ellen Mauro, RN, MPH Linda Rowe Varone, PharmD, BCPP Richard Wagner, MD – via telephone
DUR Board Members Absent:	Stephen Kogut, PhD, RPh, MBA
Others Present:	Ann Bennett (HP Enterprise Services) Cathy Cordy, RPh (Rhode Island Medicaid) 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 August 27, 2013 meeting were approved with no changes.

The lock-in program and prescription drug monitoring program (PDMP) were discussed. Connect Care Choice evaluates patients to recommend them for lock-in to a single pharmacy, using utilization of multiple prescribers and frequent emergency room visits as criteria. Currently, approximately 30 patients are enrolled in the Connect Care Choice lock-in program. The issue of how to accommodate patients in need of pain management if the prescriber has lost prescribing authority was raised regarding a particular prescriber. Patients are being referred to other prescribers.

Another issue regarding the practice of some prescribers dispensing controlled substances from their office was raised. It was noted that all controlled drug dispensing should be reported as part of the PDMP. Reporting of dispensing is required; however, utilization of the system by prescribers and pharmacy providers to evaluate individual patient utilization is voluntary. The Board suggested that perhaps some language could be incorporated into the text of DUR letters recommending that providers enroll in the PDMP as a means of monitoring utilization of their patients. HID will draft language and review with HP.

It was noted that comprehensive pain management guidelines have been drafted by the State in an effort similar to what was implemented in the State of Washington in the past few years.

The issue of Medicaid patients paying cash for opioids was discussed. Pharmacies should not accept cash payments for patients known to be covered under Medicaid. However, patients may utilize a pharmacy

that is not aware that the patient is covered under Medicaid. More widespread enrollment of providers in the PDMP may help to identify some of these patients. It was noted that approximately 20% to 30% of providers across the state are enrolled in the PDMP, which is consistent with national statistics for participation in PDMPs.

HID reviewed a summary of interventions made to prescribers for patients who appeared to be inappropriately utilizing opioids. These patients are identified as part of the lock-in program. Patients are identified if they are utilizing short-acting opioids for greater than 90 days without the use of a long-acting agent, utilizing buprenorphine with other opioids, or have pharmacy claims for a 120-day supply of any controlled substance over the most recent 60 days. Several months after DUR letters were mailed to prescribers, approximately 60% of patients no longer met the criteria for inappropriate use. The Board asked if HID could compare these results with results from other state DUR intervention programs.

HID was asked what is done when patients continue to meet the exception criteria for inappropriate use of opioids after intervention letters are mailed to prescribers. If patients have Medicaid as their primary insurance, they can be referred to the Connect Care Choice lock-in program, or they can be locked in as part of the DUR lock-in program. In the past, the Medicaid Pharmacy Director made the decision to lock in patients. HP noted that many patients identified as potentially using opioids inappropriately have Medicaid as a secondary insurance. These patients could not be restricted to a single pharmacy.

The concurrent utilization of benzodiazepines and opioids was discussed. HID activated a criteria that identifies patients taking 90 days of concurrent benzodiazepine and opioid therapy. The Board requested that the days supply limits be reduced from 90 to 60 days. HID will make this change, and patient profiles will be reviewed and intervention letters mailed to prescribers.

There was discussion as to what procedure should be followed for a prescriber who has been identified as demonstrating inappropriate opioid prescribing. HID can refer identified prescribers to HP for further follow-up. There was discussion concerning developing specific criteria that would be used to identify prescribers. The Board recommended that the Health Department be contacted to determine what prescribing criteria they would find useful to be monitored. However, it was noted that if the prescription were a valid prescription, most pharmacies would fill it unless they had some reason to suspect fraud or forgery.

It was noted that the Neighborhood MCO has quantity limits on both short-acting and long-acting CII opioids. They would also consider adding limits on the long-term use of short-acting agents similar to the criteria HID uses to identify patients.

The use of high doses of opioids was discussed. HID has added a criteria that identifies patients taking more than 100mg of morphine equivalent. Patients will be identified and reviewed by HID and intervention letters mailed to prescribers. Draft guidelines have been developed requiring prescribers to refer patients to a pain management specialist if their dose of opioids exceeds 120mg morphine equivalent per day. Prescribers should be following these guidelines.

The use of methadone and other opioids was discussed. Several years ago, Medicaid pharmacy claims data for patients enrolled in methadone treatment centers was evaluated. The evaluation found that some patients were also receiving methadone billed to Medicaid or receiving other opioids. It was noted that methadone patients do use other opioids; however, if patients are enrolled in methadone treatment, this information cannot be disclosed to other prescribers. The methadone treatment centers could, however, be notified if patients were obtaining additional methadone or other opioids from other

prescribers. It was suggested that the Medical Examiner's office be contacted and asked to report the number of deaths in which methadone may have been a contributing factor to the cause of death.

The prevalence of opioid use among the entire RI Medicaid fee-for-service population was compared to other states. Approximately 7% of RI Medicaid patients had claims for opioids during the first three quarters of 2013, compared with 13 to 14% for other State Medicaid Programs. The Board asked if the prevalence of opioid use within the RI Medicaid MCOs could be determined.

HID continues to track the number of children under the label-indicated age for the antipsychotics. There has been a slight increase in the number of children identified compared to the third quarter of 2012, but the numbers are still very low. HID has criteria to identify children taking antipsychotics with no apparent diagnosis data (although diagnosis data is usually received much later than pharmacy claims data). HID has also sent intervention letters to prescribers of atypical antipsychotics in children to warn against the potential adverse metabolic effects of the drugs. The Board noted that antipsychotic agents would not be considered first line for the treatment of many mental health disorders in children and should only be prescribed by a psychiatrist. The Board recommended that it may be useful to send the current guideline for use of atypical antipsychotics developed by the American Academy of Child and Adolescent Psychiatry (AACAP) to prescribers of these agents in children. It was noted that the Neighborhood MCO has a large portion of foster children, and they are currently reviewing use of all psychotropic agents in this population.

HID reviewed a summary of quetiapine utilization during the month of September 2013, broken down by total dose per day. Approximately 40% of patients have claims for <200mg per day. HID continues to send intervention letters to prescribers of patients with <200mg total daily dose.

HID identified a small number of patients with concurrent warfarin and NSAID therapy and sent intervention letters to prescribers. The Board recommended the incidence of gastrointestinal bleeds be evaluated in patients with claims for anticoagulants several months after the new Preferred Drug List (PDL) takes effect since the PDL will include additional anticoagulant agents. The goal would be to try and compare the incidence of gastrointestinal bleeds in patients with claims for warfarin versus those on the newer agents.

HID presented a summary of DUR letters mailed to prescribers during third quarter 2013. One-third of the letters addressed concerns of overuse or therapeutic duplication (including letters addressing potential overuse of opioids and other therapeutic duplication alerts). Another third addressed non-adherence issues. Response rates continue to be at approximately 36%. Approximately one-third of responses contained additional handwritten comments from prescribers.

HID presented a summary of prescribers who have not responded to DUR letters. In 2012, outreach was made to the top 10 non-responding prescribers at that time. Four of the 10 non-responding prescribers indicated that they felt the letters were not useful, and three indicated that they did not have time to respond. It was recommended that the top non-responders be identified and referred to the Medicaid Medical Director. It was also discussed whether specific criteria should be developed to identify prescribers who should be referred to the Medicaid Medical Director on a regular basis. Clinically-significant criteria could be identified by the DUR Board. Prescribers who are repeatedly alerted of these issues and fail to respond could be referred to the Medicaid Medical Director. In addition, those prescribers who meet a specific threshold of DUR letters sent and fail to respond could also be referred. It was noted that prescribers receive large amounts of correspondence and actually may not have time to address the letters. The Board suggested that academic detailing conducted by the University of Rhode Island College of Pharmacy could also be entertained as an option to reach out to prescribers.

Several topics discussed at the P&T Committee meeting in August were reviewed. Utilization of agents for the treatment of *hepatitis C* was reviewed. Evaluating claims data over the past two years, HID identified only seven patients with claims for *hepatitis C* agents. The Board noted that many patients are waiting for newer treatments that should be available in the next few months. The Board recommended reaching out to prescribers in an effort to improve the scope and duration of treatment as new agents become available for treating *hepatitis C*.

HID presented a summary of utilization of non-stimulant agents for the treatment of ADHD. A small number of patients were found to have concurrent claims for clonidine and guanfacine.

HID was also asked to identify the number of patients with claims for modafinil (Provigil®) and armodafinil (Nuvigil®) since there was concern that these drugs may be used off label. Only 15 patients were found to have claims for the drug and half had diagnosis data which appeared to indicate that the drug was being used appropriately.

HID identified 77 patients with claims for long-acting injectable antipsychotics during the third quarter of 2013. In an effort to determine the length of therapy for patients on injectable agents and the presence of concurrent oral antipsychotic therapy, historical data was evaluated for each patient. Half of all patients had claims data in the system for two years and also had records of ongoing claims for injectable agents during this entire time. Approximately 85% of all patients had ongoing claims for injectable agents in their history from the time they first were found to have claims in the system. It was also found that 60% of patients had recent claims for concurrent oral antipsychotic therapy. Based on the long duration of treatment for many patients, it appears that these patients are likely stable on the injectable agents.

The next meeting will be held April 8, 2014 at the HP facility.