Executive Office of Health and Human Services

Drug Utilization Review (DUR) Board Meeting Minutes
Date - Tuesday, June 5, 2012
Meeting - 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:	Ray Maxim, MD Ellen Mauro, RN, MPH
Others Present:	Ann Bennett (HP Enterprise Services) Karen Mariano RPh (HP Enterprise Services) Joe Paradis, PharmD (Health Information Designs) Ralph Racca (Rhode Island Medicaid)

At the P&T Committee meeting held just prior to the DUR Board meeting, the P&T Committee requested that the DUR Board evaluate the following topics listed below. These items will be discussed later during the meeting.

- Consider an electronic prior authorization for the non-preferred antipsychotic agent lurasidone (Latuda®)
- Evaluate the utilization of inhalers for COPD
- Evaluate utilization of triazolam
- Continue ongoing evaluation of opioid utilization

Minutes from the April 3, 2012 meeting were approved with a change to page 3. The first sentence of the second paragraph was updated to read as follows: "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."

The number of patients identified by specific criteria used to screen for the Lock-in program were reviewed. In the previous quarter, three (3) patients were identified that were taking buprenorphine/naloxone (Suboxone®) or buprenorphine (Subutex®) and other opioids. Intervention letters were sent to the prescribers of buprenorphine. None of the patients have current claims for opioids since the letters were mailed. One (1) patient continues on buprenorphine (Subutex®) without the naloxone component. Board members questioned why this patient may be on buprenorphine alone. It is possible that this patient is a "spend down" recipient since generic buprenorphine is now available and is much less expensive than buprenorphine/naloxone (Suboxone®). Board members indicated that buprenorphine alone should normally only be used on a long term basis in pregnant patients. The Board asked that a discussion of patients who are identified by these criteria be reviewed at each DUR Board meeting.

The number of patients who received Lock-in warning letters, based on their utilization of controlled substances, was also reviewed. Patients and prescribers are sent Lock-in warning letters if over-utilization of controlled substances does not improve after prescribers are sent DUR intervention letters. A total of fourteen (14) patients were sent

warning letters in calendar year 2012 to date. It appears that five (5) of these patients continue to over utilize controlled substances. The Board asked that these five (5) patients continue to be followed and discussed at the August DUR Board meeting. The Board also recommended that all patients who have received warning letters in the previous quarter be reviewed at each DUR Board meeting.

Board members noted that pharmacists should have access to the Rhode Island State wide Prescription Drug Monitoring Program (PDMP) to help identify those patients who may be receiving excessive quantities of opioids. The Board asked if HID could report back what other states have in place with respect to PDMP. It was noted that Rhode Island Medicaid does have in place a high dose alert for opioids, but it can be overridden by the dispensing pharmacist. The Board asked if the Rhode Island Managed Care Organizations (MCOs) that service Medicaid patients had quantity limits or high dose edits in place for opioids. If quantity limit edits are in place for opioids could each MCO report the number of edits and number of approvals for overrides requested? It was reported that the Neighborhood Health Plan has high dose alerts and quantity limits in place and was able to reduce the use of sustained release oxycodone (OxyContin®) by utilizing these edits. Utilization was shifted to other long acting opioids such as generic sustained release morphine.

Patients who appear to be utilizing short acting narcotics for greater than 90 days with no long acting opioid are identified as part of the Lock-in screening process. Intervention letters were mailed to prescribers of opioids for the patients identified. The Board recommended that these patients continue to be followed and if the use of short acting agents continues without a long acting agent being added, a second DUR intervention letter should be mailed to prescribers. Prescribers should be queried as to why short acting agents are being used chronically and those who do not respond should be referred to the Medicaid Medical Director. The Board recommended that these patients be reviewed at each Board meeting.

The utilization of buprenorphine/naloxone (Suboxone®) was reviewed. A small number of patients appeared to be taking doses in excess of 24mg per day. The Board recommended that doses of greater than 24mg require prior authorization. In addition, a small number of patients were taking buprenorphine, without the naloxone component, chronically. The Board requested that these patients be reviewed to determine why they were taking buprenorphine and not the combination product.

There was further discussion of the PDMP. In the State of Rhode Island the prescribers, pharmacists and law enforcement would have access to the data. However, the Medicaid Program would not have access to PDMP data. The Board asked if HID could report back to them as to how many of other State PDMPs give Medicaid access to the data.

Responses to DUR interventional letters were discussed. An overall response rate of 31% was noted for letters mailed between September 2011 and February 2012. A letter was drafted to be sent to the top 10 prescribers who have not responded to any DUR intervention letters. The Board recommended that these prescribers be asked why they have not responded, that they may be contacted by the Medical Director and that the Medicaid Program can provide additional copies of the letters if needed.

A summary of DUR intervention letters mailed was reviewed. Many of the intervention letters address non-adherence to maintenance therapy and potential therapeutic duplication. One of the alerts was for duplicate antidepressants. The Board clarified that these were duplicate antidepressant agents from the same drug class, such as duplicate SSRIs. With respect to duplicate antipsychotic agents, it was noted by HP that there is a prospective DUR edit in place to alert for duplicate antipsychotics. However, the duplicate therapy alert can be overridden by the dispensing pharmacist. The Board was not in favor of recommending a prior authorization requirement for the use of duplicate antipsychotic agents, since that could have unintended consequences of limiting access to these agents.

The use of low dose quetiapine was discussed. The Board noted that the FDA did not approve an application for the drug to be used in low doses for the treatment of anxiety. It was noted that the Neighborhood Health Plan requires prior authorization for the 25mg and 50mg tablets. However, the Board was not in favor of requiring prior authorization for low dose quetiapine since it could have the unintended consequence of increasing benzodiazepine use. The Board asked HID to evaluate quetiapine use to determine the percentage of patients on low doses (< 200mg per day) and report back at the August meeting.

Therapeutic duplication of benzodiazepines was discussed. The majority of DUR intervention letters sent, with respect to duplicate benzodiazepine therapy, involve the use of a benzodiazepine during the day and a different sedative benzodiazepine at night for sleep or the use of clonazepam with another benzodiazepine. It is possible that there may not be a prospective DUR alert in place for the use of clonazepam with another benzodiazepine since clonazepam is categorized by the American Hospital Formulary Service (AHFS) as an anticonvulsant. The Board asked HP to verify if there was a prospective DUR alert in place that would flag the use of clonazepam with another benzodiazepine. The intervention letter for the current HID retrospective DUR criteria for use of clonazepam with another benzodiazepine simply states that duplicate therapy may be occurring. The Board recommended that HID develop a new criteria to alert for the use of clonazepam with another benzodiazepine noting that this combination should normally only be used if clonazepam was being used as an anticonvulsant.

HID reviewed a summary of the use of ezetimibe (Zetia®) with and without statin therapy as requested by the P&T Committee at the April meeting. No further action on this issue was recommended by the Board.

There was discussion regarding the non-preferred antipsychotic agent lurasidone (Latuda®). The drug has pregnancy B status. Other antipsychotic agents have pregnancy C status. The P&T committee recommended that an electronic prior authorization be developed by the DUR Board so that pregnant woman could access the drug without the need for prior authorization. The Board recommended that prior authorization criteria be developed for the use of lurasidone (Latuda®) that includes a diagnosis of pregnancy or the concurrent use of prenatal vitamins in women less than 45 years of age. The Board requested a review of the use of lurasidone (Latuda®) be presented at the August meeting.

HID will evaluate the use of triazolam. In the past there were only one or two prescribers of the drug. The Board recommended that the Medicaid Medical Director contact prescribers of triazolam in an effort to limit its use due to potential severe adverse effect.

HID will evaluate the use of inhalers for patients with COPD as requested by the P&T Committee and DUR Board.

The quarterly drug utilization reports were reviewed which list top drugs and drug classes by dollars (total reimbursed amount). The Board requested that a disclaimer be added to the dollar value indicating that this value does not reflect the true cost to the Medicaid Program and does not include any federal or other rebates. The Board also asked for data to be reported by top drug by claims, cost per claim in addition to total dollars. The Board also requested that quarterly utilization reports be presented with reports from previous years for the same time period for comparison. In addition the Board requested if utilization reports could be evaluated based on data from a time period prior to the implementation of the PDL compared against data after the PDL had been implemented.

There was discussion regarding the Community Medication Assistance Program (CMAP) and how their list of covered drugs compares to the Medicaid PDL. CMAP covers mental health drugs and many other adjunct drug therapies. Many patients are eligible for CMAP at different times and may be eligible for Medicaid and tend to be covered by one or the other program at various times. Since patients go in and out of CMAP and Medicaid, the Board proposed

that CMAP be contacted and questioned if it would be possible for them to adopt the PDL or parts of the PDL as their covered drug list. If so, would CMAP be entitled to receive supplemental rebates for preferred drugs. HP will follow up with CMAP.

DUR Board members were invited to attend P&T Committee meetings and P&T members will be invited to attend DUR Board meetings.

The next meeting will be August 28, 2012 after the P&T Committee meeting.