Center for Operations and Pharmacy Management
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday June 7, 2011

DUR Board Members Present:	Michelle Booth, RPh Ray Maxim, MD Ellen Mauro, RN, MPH Linda Rowe Varone RPh Richard Wagner, MD
DUR Board Members Absent:	Stephen Kogut, PhD, RPh, MBA
Others Present:	Paula Avarista, RPh, MBA (RI Medical Assistance Program) Ann Bennett (HP Enterprise Services via teleconference) Karen Mariano (HP Enterprise Services) Kathy Novak RPh (Magellan Health Services) Joe Paradis, PharmD (Health Information Designs)

A few minor typographical errors were corrected from the minutes for the March 2, 2011 meeting.

Topics that had been discussed earlier in the day at the P&T Committee meeting were presented to the DUR Board and further discussed.

The P&T Committee requested that the DUR Board evaluate the use of a long acting beta agonist in the absence of the use of a concurrent inhaled corticosteroid. Health Information Designs (HID) will evaluate the data prior to the September meeting.

The P&T committee recommended that triazolam be made a non-preferred drug and if possible recommended that the drug not be covered under Medicaid. The P&T recommended that current patient be allowed to continue on the drug but the drug should no longer be covered for new patients. It was recommended by the DUR board that prescribers of triazolam be notified of this change in coverage.

It was noted that rizatriptan (Maxalt®) will no longer be preferred, the orally disintegrating tablet rizatriptan (Maxalt-MLT®) is now preferred.

The P&T Committee recommended that prescribers of non-preferred topical NSAIDS and anesthetics be contacted and reminded which agents are preferred in this drug class.

The P&T Committee recommended that carisoprodol be made non-preferred and if possible not be covered under Medicaid. The P&T recommended that current patient be allowed to continue on the drug but the drug should no longer be covered for new patients.

As requested by the P&T Committee and DUR Board at the last meeting a review of adherence to once daily stimulants was evaluated. Data were evaluated for a six month period from July 2010 to December 2010.

Approximately 82% of patients received at least a 150 day supply of their medication during this time period and 60% of patients received at least a 180 day supply of medication. When demographics of the population were studied it was found that 92% of patients were age 20 or younger. It was noted that there is currently no prior authorization in place for use of stimulants in patients under 21 years old but prior authorization is required for use in adults. There was some discussion that since the time period evaluated included summer months some patients may be off therapy at this time. HID will develop a criteria to evaluate adherence to once daily treatment of stimulants and evaluate this on an ongoing basis along with other adherence criteria for maintenance drugs.

As requested by the P&T Committee and DUR Board at the last meeting a review of adherence to Alzheimer's agents was evaluated. Data were evaluated for a six month period from July 2010 to December 2010. A total of 37 patients had ongoing claims for Alzheimer's agents during this time period. Approximately 54% of patients had at least a 180 day supply of mediation dispensed during the time period evaluated. A total of 14 of the 37 patients had claims associated with long term care pharmacy providers and it was assumed that these patients were long term care residents. It was noted that many patients in long term care show a worsening of symptoms over time. The fact that adherence was low may indicate that drug therapy had been discontinued for those patients with more advanced disease.

HID indicated that a new criteria has been developed to monitoring those patients with ongoing utilization of an ACE inhibitor along with concurrent ARB therapy.

The utilization of low dose quetiapine in the Community Medication Assistance Program (CMAP) population was discussed. The CMAP program administrator requested that similar DUR letters that had been sent to Medicaid prescribers of patients taking less than 200mg of quetiapine also be sent to CMAP prescribers. It was found that 364 CMAP patients had at least one claim for quetiapine during the first four months of 2011. Of those, 26% of patients were selected for intervention since they had ongoing claims for quetiapine of less than 200mg. Responses to intervention letters will be collected by HID. It was noted by Board members that the 50mg dose of quetiapine is now included on the CMAP formulary. Board members asked that the CMAP administrator be given feedback with regard to responses and also provided with utilization data for all doses of quetiapine. Board members questioned if patients taking low dose quetiapine also had concurrent therapy with another antipsychotic agent. HID will further evaluate the concurrent antipsychotic utilization for the CMAP patients selected for intervention.

There was further discussion regarding which patients may be appropriate candidates for duplicate antipsychotic therapy or low dose quetiapine. Board members noted that refractory patients taking clozapine may benefit from duplicate therapy with low dose quetiapine. Also those patients with anxiety disorders and contraindications to benzodiazepine use could also benefit from low dose quetiapine.

The topic antipsychotic utilization in children under the FDA labeled indicated age was discussed. A small number of patients were identified and the Medicaid Department requested that drug history profiles for these patients be sent to them for review. It was noted that the current claims processing system has the capability of performing edits for specific drugs if required. There was also a suggestion from Board members to identify prescribers for specific patients and request that they respond to DUR letters with an clinically valid reason as to why they are using the drugs for patients who are younger than FDA indicated ages. The issue of non-adherence in these patients was also discussed and it was noted by Board members that non-adherence would actually be common since dosing in these patients would be different from

commonly prescribed doses. It was noted that the Neighborhood plan has found that majority of prescribers of atypicals in children are child psychiatrists and that risperidone is required as first line therapy in younger children.

HID presented information on the new requirements for submission of the Centers for Medicare and Medicaid Services (CMS) annual DUR report. New reporting requirements include reporting of innovative practices, state wide prescription drug monitoring programs, e-prescribing plans, summary of prospective DUR overrides by pharmacists, efforts to control fraud, waste and abuse and a nationwide standard means of calculating generic utilization rates for all state Medicaid program. The report is due September 30, 2011.

A discussion of e-prescribing followed. It was noted that all pharmacies in Rhode Island can accept electronically prescribed prescriptions. Currently there is discussion between the states and CMS as to which prescribers should be given prescribing privileges for Medicaid patients. The debate centers around if only Medicaid enrolled prescribers should be allowed to prescribe to Medicaid patients or if any prescriber would be able to prescribe to Medicaid patients.

HID presented a summary of DUR letters sent over from April 2010 to April 2011 addressing non-adherence. Approximately 1,500 DUR letters addressing non-adherence were mailed and a 33% response rate was achieved. The 1,500 letter represents about 35% of all DUR letters mailed. The top three responses to the DUR letter were, patient has appointment to discuss therapy, aware of issue and patient being monitored and will reassess and modify therapy.

The utilization of acetaminophen narcotic combination products was discussed. Within three years all acetaminophen combination products will be limited to 325mg acetaminophen content by an FDA ruling which was published in January 2011. The Board recommended that top prescribers of high dose acetaminophen narcotic combination products be alerted to the changes that are forthcoming. It was noted that there are dose optimization limits currently in place that limit the dose of acetaminophen to 4gms per day.

There was a brief discussion of black box warning criteria alerts. Board members will provide further feedback after review of the summary of alerts provided by HID. However, Board members asked that DUR black box warning letters be sent to all prescribers of methadone.

There was some discussion of the availability of generic nicotine patches and lozenges that are covered by Medicaid. Most pharmacies that did not routinely stock the covered generics were willing to order them for patients.

The next meeting will be held on September 6, 2011 at 10:30am immediately after the P&T Committee meeting.