**Center for Operations and Pharmacy Management**
**Drug Utilization Review (DUR) Board Meeting Minutes**
**Wednesday March 2, 2011**

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

A new pharmacist DUR Board member Linda Rowe Varone was introduced.

There were no changes made to the minutes from the December 15, 2010 meeting.

Adherence to stimulants was evaluated from July through December of 2010. Recipients with claims for stimulants in July and claims for any drug in December, as a means to check for current eligibility, were included in the evaluation. Approximately 60% of recipients had at least a 180 day supply dispensed and 82% had a least a 150 day supply dispensed over the 6 month time period evaluated. There was discussion regarding possible diversion of stimulants as a concern even for recipients who appear to be adherent. There was also consideration that some school age recipients may be on a "medication holiday" for part or all of the summer and this could have an impact on an evaluation of adherence data. It was also noted that some children may be off drug on the weekends as well. The Board recommended that the age of recipients be determined to better interpret the data. The Board also recommended that prescribers be notified by means of a DUR intervention letter that their patients were non adherent to stimulants.

A similar evaluation was performed over the same time period to evaluate adherence to Alzheimer's agents. Similar results were found. Approximately 54% of recipients had at least a 180 day supply dispensed and 82% had a least a 150 day supply dispensed over the 6 month time period evaluated. The Board asked if it could be determined how many recipients included in the evaluation were nursing home patients. No nursing home indicator is available in the claims data. However, the pharmacy provider can be evaluated to determine if how many recipients had claims from long term care pharmacy providers, using this as an indicator that the recipient was likely a nursing home patient. It was noted that for those drugs which are being used to slow the progression of Alzheimer's, once the disease has progressed continuing therapy is likely not to be beneficial.

The utilization of combined therapy with an ACE inhibitor and ARBs was evaluated. Over a three month period it was found that approximately 0.5% of recipients with continuous therapy with ACE inhibitors also

had claims for ongoing therapy with an ARB. The Board noted that the combination of these agents is not contraindicated and in some patients could be beneficial. Even though the numbers of patients potentially receiving duplicate therapy was very small, the Board recommended that a new criterion be developed to alert prescribers if patients were taking both agents concurrently, especially if two different prescribers were involved.

The utilization of triazolam was evaluated. There is a relatively small population of recipients receiving the drug (91 patients) and 70% have claims for only benzodiazepine and are assumed to be Part D dual eligible patients. There was discussion about recommending that triazolam be made a non-preferred agent and developing prior authorization criteria for its use due to its potential to cause more severe adverse effects than other sedative agents. The Board recommended that prescribers of triazolam be identified and contacted with an educational intervention letter describing the potential adverse effects of the drug and that preferred sedatives agents be considered as an alternative.

The use of duplicate benzodiazepines, notably clonazepam and another agent, was discussed. Clonazepam is often used as adjunct therapy for the management of bipolar disorders. Pharmacists receive an alert message at the point of service if two benzodiazepines are used concurrently. However, the alert can be overridden by the pharmacist by entering appropriate intervention and outcome codes. Therapeutic duplication and early refill alerts require an override. Alerts for high does, low dose and late refills do not require an override. Board members indicated that they could find no clinical justification for patients receiving multiple benzodiazepine and recommended that education intervention letters be sent to prescribers for patients who were found to be taking two agents concurrently.

The utilization of low dose quetiapine was discussed in general and more specifically its use within those patients enrolled in the Community Medication Assistance Program (CMAP). Educational intervention letters have been sent to prescribers of Medicaid patients found to be taking low dose quetiapine (less than 200mg). It was recommended that patients enrolled in the CMAP program be included in the interventions. The CMAP coordinator will be contacted and if approval is given, a letter will be developed to be used to alert CMAP prescribers of low dose quetiapine. It was noted that quetiapine 50mg was not included on the CMAP formulary but the 25mg and 100mg dosage forms were available.

The utilization of atypical antipsychotic agents in children less than the FDA labeled indicated age was discussed. There was discussion concerning if these agents were being used to treat a known clinical diagnosis or being used simply to treat a specific behavior. The Board recommended that if possible any available diagnosis for these children should be reviewed. There was also discussion as to what kind of follow up should be down routinely for these children to monitor the possible development of metabolic adverse effects associated with these agents. There was also discussion as to who these specific children were. Are these children in foster care, in sate or out of state? The Department will review this information. There was also discussion if the implementation of age related prior authorization criteria for the use of atypicals in children would be appropriate. It was also recommended that the use of atypicals in children enrolled in the CMAP program be evaluated.

There has always been an interest by the Department to find ways in which to improve prescriber response rates to intervention letters. There was discussion as to if there should be a follow-up letter sent to prescribers who routinely do not respond. At this time Rhode Island Medicaid honors valid prescriptions from any prescriber. Those prescribers who are not enrolled as Medicaid providers and out of state

prescribers may be less likely to respond to intervention letters. There was also discussion regarding if only Medicaid enrolled prescribers should be allowed to prescribe to Medicaid patients.

The was some discussion regarding the new FDA ruling, that will not take effect until 2014, that would limit the amount of acetaminophen in opioid combination products to 325mg. HID will evaluate the utilization of acetaminophen combination products for discussion at the June meeting.

The next meeting will be held on June 7, 2011 after the P&T Committee meeting at 11:30am.