Center for Operations and Pharmacy Management
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday October 6, 2010

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

There were no changes made to the minutes from the June 2, 2010 meeting. The Board recommended that in the minutes any discussions and general comments made during meetings should not be identified by the specific Board member making the comments. However, minutes should indicate by name those Board members who voted in favor or against motions that were voted upon at the meeting.

Since the P&T Committee meeting was held in September, there was some time to address issues that were raised by the P&T Committee and to discuss them at this meeting. Normally the two meetings are held on consecutive days for ease of scheduling for those attendees serving on both committees.

The P&T Committee recommended that the DUR Board evaluate the use of low dose (< 200mg per day) of quetiapine. Over a recent four month time period, it was found that 46% of patients taking quetiapine received doses less than 200mg per day based on a calculation of quantity dispensed and days supply submitted on pharmacy claims. Similar utilization was noted with two other State Medicaid Programs. The Board asked if the cost of the low dose quetiapine claims could be determined along with the cost of all quetiapine claims and all antipsychotics over the same time period. They also recommended the use of low dose quetiapine be evaluated in the Rhode Island Pharmacy Assistance Program for the Elderly (RIPAE) and the Community Medical Assistance Program (CMAP). In the past when the CMAP program was limited to a small number of pharmacies, prescribers had to provide a justification for use of low dose quetiapine and use of the low doses were more closely monitored. The CMAP program is now available to most pharmacies throughout the State and prescribers are no longer required to give justification before claims for low dose quetiapine are filled.

Board members indicated that a New Drug Application (NDA) for quetiapine in the treatment of anxiety and insomnia had been filed with the FDA and it was possible that the anxiety application may be approved in the future. Low doses of quetiapine are often used as sedatives, although other less costly agents are available. The Board recommended that the prescribers of low dose quetiapine be identified. An educational intervention letter may be useful in alerting prescribers of low dose quetiapine that other less costly sedative agents are available. It was also recommended that prescribers be asked to provide an indication for using low dose quetiapine in their patients.

Board members also cautioned that healthcare should be looked at as an integrated approach and not to focus solely on pharmacy costs. An evaluation of medical data should also be done in conjunction with an evaluation of pharmacy claims data. It is difficult to determine how the use of a specific medication for a non-indicated diagnosis has an impact on the overall healthcare of a particular patient. For example, many of the patients on low dose quetiapine may also be on other antipsychotics and other mental health agents. The impact of prescribing low dose quetiapine in these patients, with respect to their overall care, would be difficult to measure.

The P&T Committee raised concerns that tacrolimus (Protopic®) and pimecrolimus (Elidel®) may be inappropriately used without a prior trial of a corticosteroid as required by the prior authorization criteria in place. Data were evaluted over the previous four months and it was found that only seven patients had claims for pimecrolimus (Elidel®) and fourteen had claims for tacrolimus (Protopic®). All patients taking tacrolimus (Protopic®) and four of the seven patients taking pimecrolimus (Elidel®) had prior or concurrent claims for corticosteroids. Due to the low utilization of these drugs, there was no further action recommended by the DUR Board.

The P&T Committee also recommended that the utilization of rosiglitazone (Avandia®) be evaluated due to the recent FDA action significantly limiting its use. It was found that only ten patients had clams for the drug over the most recent four months. The DUR Board recommended that the Medicaid Program consider contacting prescribers of the drug. However, since the use of the drug is very limited and the drug will have restricted access as a result of the FDA action, alerting prescribers may not be necessary.

An evaluation of the Connect Care Choice population was conducted to determine the use of beta blockers in patients who had a history of myocardial infarction (post MI) or ischemic heart disease and the use of antidepressants in patients with a diagnosis of depression. The use of beta blockers in patient that were post MI was found to be 68% which was noted to be lower than national statistics. Possible explanations to this were discussed and included the fact that patients with diagnoses that are contraindication to beta blocker use were not excluded. Also there is a continued misunderstanding that beta blockers are contraindicated in patient with diabetes. The Medicaid Program will follow up with nurse case managers to attempt to improve the use of beta blockers. The Board also recommended that the Medicaid Program consider alerting those prescribers who are not utilizing beta blockers in their post MI patients. The Board also recommended that the Medicaid Program evaluate the use of aspirin in the post MI population. This evaluation of beta blocker use will be repeated annually. The Board also recommended that nitrates could be used as a drug marker for ischemic heart disease in future evaluations.

In the Connect Care Choice population 71% of patients with a diagnosis of depression were found to have current claims for an antidepressant. It was noted that many primary care providers may still be reluctant to code for a diagnosis of depression since in the past many health plans would not reimburse providers based on a depression diagnosis. This evaluation of antidepressant use will also be repeated annually.

A general overview of the Connect Care Choice Program was also discussed. Currently there are approximately 2,500 patients enrolled. Patients with the following chronic conditions are eligible for the Program, diabetes, COPD, sickle cell, asthma, psychiatric disorders and coronary artery disease. Approximately 60% of patients have two chronic conditions in addition to a psychiatric disorder. Patients risk of adverse outcomes is evaluated and high risk patients are assigned a nurse care manager. Each nurse is responsible for anywhere from 150 to 200 patients.

The utilization of triazolam was discussed. It was found that 113 patients had at least one claim for the drug over the previous four months and 60% of those patients had received the drug for more than 90 days. It was noted that there are alternatives to triazolam and that the drug should be avoided in the elderly since it causes retrograde amnesia. The Board recommended that the data be evaluated to determine how many patients taking the drug were Medicaid patients or Medicare Part D patients. It was also recommended to alert prescribers of triazolam that safer alternatives are available. The long term use of other benzodiazepine sedatives and the use of zaleplon and zolpidem were also discussed.

The use of Proton Pump Inhibitors (PPIs) in the elderly (55 and over) population was discussed due to the risk of potential fractures in this population. It was noted by Board members that fractures are usually not seen until after approximately two years of maintenance therapy with a PPI. The Board did not recommend the Medicaid Program take any action with regard to limiting the use of PPIs in the elderly since there was concern that any intervention my reduce the use of these drugs which are used to prevent serious gastrointestinal bleeding in many patients.

The interaction of omeprazole and clopidogrel was discussed. The Board recommended that prescribers for patients on these two drugs be alerted to the potential interaction. It was also recommended that if possible recommendations for alternate PPI therapy be included in the letter.

The use of long acting beta agonist therapy without the use of another asthma medication was discussed. A small number of patients were found to have claims for single agent long acting beta agonist products. All of these patients also had recent claims for other asthma medications such as short acting beta agonists, inhaled or oral corticosteroids or montelukast. No further action was recommended by the Board.

HID will send DUR Board members a listing of retrospective criteria which are utilized by other State Medicaid Programs prior to the December meeting to see if any of these criteria may be beneficial to the Rhode Island Program.

It was acknowledged that one new pharmacist and one new physician members are being recruited to serve on the DUR Board. The next meeting is scheduled for December, date to be determined.