Executive Office of Health and Human Services

RI Department of Human Services

DRAFT Drug Utilization Review (DUR) Board Meeting Minutes

Date - Tuesday, August 28, 2012

Meeting - 10:30 AM

DUR Board Members Present:	Michelle Booth, RPh Stephen Kogut, PhD, RPh, MBA Richard Wagner, MD
DUR Board Members Absent:	Ray Maxim, MD Ellen Mauro, RN, MPH Linda Rowe Varone RPh
Others Present:	Ann Bennett (HP Enterprise Services) Karen Mariano RPh (HP Enterprise Services) Joe Paradis, PharmD (Health Information Designs - HID) Ralph Racca (Rhode Island Medicaid)

Minutes from the June 5, 2012 meeting were approved with minor changes.

HID reviewed the process in which patients are screened for overuse of controlled substances and then may be restricted to a single pharmacy (locked-in) if overuse is not affected by sending intervention letters to prescribers. Three (3) to six (6) months after intervention letters are mailed to prescribers; patient drug history profiles are again reviewed. A decision is then made by the HID lock-in review committee to recommend a patient for lock-in. The HID lock-in committee consists of a group of clinical pharmacists and a social worker. In the past, the committee recommendations for lock-in were sent to the Rhode Island Medicaid Pharmacist. Since that position is currently vacant, lock-in recommendations from HID have been forwarded to HP. For the first and second quarter of 2012, a total of nineteen patients have received warning letters that they may be locked-in and five (5) of those patients have been recommended for lock-in by HID.

The recommendations was made that the DUR Board review blinded drug and diagnosis histories of those patients recommended for lock-in and make a final recommendation to the State. Board members noted that this would be a new responsibility of the DUR Board and asked what other states were doing. HID described the process used in Maryland where the DUR Board does review blinded patient drug utilization information and does recommend patients to be locked-in. In addition, specific criteria has been established by the Maryland DUR Board that if met would automatically result in the lock-in process being initiated without review by the Board. Arkansas and Connecticut do not have the DUR Board review patient information and the final decision is made by the State Medicaid Pharmacist.

The Board recommended that those patients recommended for lock-in should be reviewed by the Medicaid Medical Director. Board members suggested that they could perform an initial review of lock-in recommendations, which

would not involve a complete case review, but a review of the number of claims for controlled drugs for each patient, number of pharmacies utilized and number of prescribers utilized.

According to representatives from the Medicaid Program, the Medicaid Medical Director would be required to review each case recommended for lock-in since patients would have the right to appeal the process. However, it was estimated that few patients would likely apply for an appeal.

HID presented information on patients taking Suboxone® and other opioids and those utilizing short acting opioids for greater than 90 days. Intervention letters were sent to prescribers for these patients. The Board recommended that the prescribers of these patients should be identified and referred to the Medicaid Medical Director for follow-up. The Board suggested that specific criteria could be established for prescribers that would trigger a review of their prescribing by the Medical Director. Providers who demonstrate prescribing that differs by more than two (2) standard deviations from the average prescriber, as it relates to long term use of short acting opioids and duplicate use of long acting opioids, could be identified. There was concern over what action should be taken if prescribers do not initially respond to letters or phone calls from the Medical Director. HID will identify these prescribers and this issue will be discussed again at the December meeting.

HP noted that there is a prospective DUR edit for duplicate opioids that can be overridden by the dispensing pharmacists. However, a representative from the Neighborhood plan indicated that a similar edit for their patients cannot be overridden and requires prior authorization. Methadone is considered a long acting opioid for purposes of these edits.

The Board indicated that it was important to evaluate appropriate prescribing of opioids due to increases in deaths associated with opioid use over the past few years. The Board suggested that focusing efforts on prescriber education may be more beneficial than simply restricting patients to one pharmacy. If the Medical Director were to contact prescribers directly, changes in prescribing patterns for those prescribers could be measured in the future.

The Board also was concerned that pharmacists would not be aware of duplicate therapy of opioids or overuse at the time of dispensing. Within a particular chain pharmacy would pharmacists be able to see claims for prescriptions filled at another store within the chain? HP indicated that therapeutic duplication edits for claims filled under the Medicaid Program would alert the pharmacist regardless of where the prescription was filled.

HID sent targeted letters to the top 10 non-responders to DUR letters and found that six (6) of the ten (10) prescribers did respond to the targeted letter. Prescribers had the opportunity to complete a short survey of four (4) questions and check each response that applied. There were a total of eight (8) responses. Four (4) of the responses indicated that the letters were not useful. Three (3) responses indicated the prescriber did not have time to respond. One (1) response indicated the response form was too cumbersome. No one responded that they had not received the letters. The overall respond rate for all DUR letters for the past six (6) months has been 31%, with 76% of responders indicating that they felt the letters were useful.

The Board suggested that the Medical Director contact the four (4) non-responders who did not respond to the targeted letter and the prescribers who indicated they did not think the letters were useful in an effort to obtain feedback that may help improve the DUR program. The Board indicated that many prescribers receive so much mail that the letters may very well go unrecognized. They recommended that a bold notation be placed across the top of the front page of the letters indicating that a response was requested in an effort to gain more attention to the letters and improve response rates.

HID reviewed the utilization of low dose quetiapine. For each monthly DUR cycle there continues to be as many as 20% to 30% of patients taking quetiapine who are receiving doses less than 200mg per day. HP noted that dispensing pharmacists receive low dose alerts for quetiapine, but that these are alerts which do not require an override or prior authorization. The Board noted that low dose quetiapine is considered appropriate for use in Post Traumatic Stress Disorder (PTSD) and in patients with anxiety and coexisting substance abuse issues. Metabolic side effects of quetiapine appear to be dose related in adults but not in children. The Board was not in favor of restricting the use of low dose quetiapine since doing this would likely lead to an increase in benzodiazepine use. However, the Board suggested that patients taking quetiapine and medications for diabetes could be identified. Their prescribers could be alerted to the potential metabolic adverse effects of quetiapine and asked to consider an alternate antipsychotic agent if clinically appropriate.

A recent Centers for Medicare and Medicaid Services (CMS) bulletin was discussed. The bulletin discuses the issue of inappropriate use of antipsychotic agents in vulnerable populations, mainly foster care children and long term care patients. States are encouraged to utilize their DUR programs to reduce inappropriate utilization. CMS has a goal of reducing the use of antipsychotics in long term care patients by 15% by the end of 2012. The Board noted that it is not uncommon to see atypical antipsychotics used in patients with only a diagnosis of bipolar disorder since the atypical agents are easier to use than other treatments for bipolar such as divalproex and lithium. Patient adherence with the atypical agents tends to be higher than with the other agents.

The Board recommended that at every DUR Board meeting a summary of the use of antipsychotics in children be reviewed and suggested that a copy of the CMS bulletin could be mailed to all prescribers of antipsychotics in children under the FDA approved age limits. HID noted that several other state Medicaid Programs are now requiring prior authorization for the use of antipsychotics in children who are under the FDA labeled age. The Board also recommended that the use of antipsychotics in long term care patients also be reviewed. Most of these patients will be dual eligible and claims for antipsychotics will be paid by Medicare Part D. The Board also wanted to determine what the policy of the Rhode Island Medicaid Managed Care Organizations was in reference to approving the use of antipsychotics in children.

HID presented findings on two issues that were brought up by the P&T Committee. The P&T requested that the DUR Board evaluate the use of the non-preferred antipsychotic agent lurasidone (Latuda®) and the use of non-preferred agents for COPD. For the first 6 months of 2012, there are only 16 patients with claims for lurasidone (Latuda®) and only 12 claims for non-preferred COPD agents. The Board requested no further follow-up on these issues.

The use of triazolam was discussed. The drug is no longer covered by the Medicaid Program and no claims for the drug have been processed since July 2, 2012. HID was asked to continue to look for claims for triazolam in the future since patients with previous prior authorizations may have refills remaining on their prescriptions.

The issue of alerting prescribers of non-preferred agents was discussed. The Board suggested that there may be several high cost drugs which may be non-preferred. Prescribers could be contacted and asked to consider using a preferred agent. The Board recommended evaluating drugs with the highest cost per claim and determining which of those agents were non-preferred. Then, determine if contacting prescribing with intervention letters may help reduce utilization of these agents in patients where the change to a preferred agent would be clinically appropriate.

Board members noted that hospital formularies differ significantly from the Medicaid PDL. Some patients are discharged on high cost formulary agents that are non-preferred PDL agents. However, continuity of care issues necessitates the utilization of these non-preferred agents. To at least begin a discussion of the use of high cost non-preferred agents, HID will evaluate those drugs with the highest cost per claim, including biologic agents, and this will be discussed again at the December meeting.

At the P&T Committee meeting held just prior to the DUR Board meeting, the P&T asked the DUR Board to evaluate the use of drugs to treat hepatitis C and the potential misuse of androgens in young men. HID will evaluate drug utilization for these two topics.

The next meeting will be December 11, 2012 after the P&T Committee meeting.