MINUTES OF THE DRUG UTILIZATION REVIEW
(DUR) BOARD MEETING
Wednesday, March 1, 2017
1:00 p.m. to 4:00 p.m.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members	HPE Staff	DHS Staff
Present:	**Present:**	**Present:**
Robert Factor, MD	Paul Jones	Kimberly Smithers
Paul Cesarz, RPh	Tom Olson, PharmD	Rachel Currans-Henry
Michael Brown, PharmD	Jacque Nash, PharmD	Tiffany Reilly
Daniel Erickson, MD	Kristie Chapman	Lynn Radmer, RPh
Michael Ochowski, RPh	Jamie Jones	Dan Kierman
Robert Breslow, RPh		Chris McKinney
Lora Wiggins, MD		Kenya Bright
Ward Brown, MD		Julie Sager, MD
Jake Olson, PharmD		
Hannah Delong, MSN, PMHNP-B		

Welcome and Introductions
Rachel Currans-Henry called the meeting to order at 1:03 p.m. and began with a welcome and thanks to the Board members for their attendance at the meeting. All board members and staff present introduced themselves. The members were reminded of the meeting materials in their respective binders for reference and review. A quorum of members attended the meeting.

Review of the Agenda and Board Materials and Approval of December 7, 2016 Meeting Minutes
Rachel walked through the agenda as printed. Prior to this meeting, Board members received the minutes, RDUR Quarterly Report and two Drug Effectiveness Review Project (DERP) reports regarding the treatment of attention deficit hyper activity disorder via e-mail and had the opportunity to review each document. The December minutes were then reviewed and approved with an initial motion from **Ward Brown** and a second from **Paul Cesarz**. The motion passed unanimously. Prior to moving on to official business, Rachel asked for any input from the opioid roundtable discussion that had taken place earlier in the day. Dr. Wiggins noted that the main focus was on three research projects currently underway investigating alternative methods of pain management and explained that the biggest roadblock to success has been gaining access to alternative treatment methods. Jake Olson also paraphrased a speaker's comment that he found very substantial, stating that it is harder to get access to mental health medications than to opioids. Dr. Factor inquired if the State considered sending out a survey to determine different levels of accessibility throughout the state. Mike Ochowski asked if Medicaid currently covered alternative treatments, such as yoga and acupuncture. Rachel confirmed these methods are not covered, but chiropractic services are covered. Rachel confirmed that recommendations have been submitted to the Governor's Opioid Task Force.

Update: Quarterly DUR Reports
Lynn reviewed the four quarterly reports with the Board. The DUR Alert Trends report was discussed in more detail. A reference line notating the date of alert changes has been added to the report as requested by Robert Breslow at the December meeting. Most of the DUR alert changes occurred prior to this data date set, so a reference point is not noted on some of the alert graphs. The last alert change waiting to be implemented is the early refill alert in the long-term care setting. Robert Breslow asked if any unexpected negative consequences had been uncovered after the implementations; both Lynn and Kimberly confirmed that most feedback from both providers and call center personnel has been positive.

The final quarterly report reviewed was the quarterly overview report. A chart illustrating the number of members who are on more than one drug class and up to five drug classes has been added to this report as requested by Robert Breslow at the December board meeting. A significant statistic is the existence of 19 members who are on all five drug classes. To further address these potentially problematic cases, Health Information Designs will perform selected lock-in reviews on all of these member profiles. Paul Cesarz asked if there was any specific trend in the overall decrease of opioid use, such as lower total daily doses or switching from long- to short-acting formulations. Dr. Wiggins advised that this information will be much easier to obtain once the new PDMP is in place, as it will also contain daily morphine equivalents to track dosing trends. Mike Ochowski would like to know which combinations of classes are more prominent, but this data has not been analyzed. This will be taken into consideration and brought back at a future board meeting for discussion.

Lock-In Annual Report

Jacque began the annual Lock-In Report with an overview of the program's functionality and objective, which is to identify and reduce drug-seeking behavior and inappropriate prescribing patterns. The program currently reviews five criteria that look for excessive use of controlled medications, combinations of methadone and buprenorphine with opioid agonists, and the newly-added criterion identifying excessive use of controlled substances with a history of drug poisoning. Jacque reviewed the program modifications that were adopted by the board in March 2016, which included the addition of the drug poisoning criterion, the removal of HIV and antiretrovirals from the negating criteria, extending the profile history from 12 months to 18 months, and increasing the days' supply threshold from 120 days to 240 days on the main lock-in criterion.

A review of the call volume and selected reviews for 2016 revealed similar data to 2015, with the most notable difference being a switch from OIG in 2015 to HMO in 2016 as the primary source for selected reviews. The letter counts in the step one alert category for 2016 increased significantly from 2015, from 465 cases to 824 cases. Warning cases decreased from 121 cases to 107 cases and lock-in cases (both initial and relock) decreased quite significantly from 53 case to 16 cases; however, this was expected as a result of the program modifications. The addition of a new criterion along with the days' supply increase exposed a new member population to lock-in review; thus, the majority of interventions were step one alerts. The provider feedback did indicate valuable information was received. An overall response rate of 39% was an improvement from 21% in 2015, though the distribution of response types was similar.

There were no new recommendations for program modifications in 2017; however, the 2016 modifications were noted to have been effective as intended with an initial increase in alerts and subsequent decrease in total lock-ins. The strategy for 2017 is to advance the alert recipients through the step two and step three lock-in phases as applicable and to begin to pull medium- and low-risk group profiles for review, as these are likely never-seen profiles due to the overwhelming volume of hits prior to the days' supply change.

Stimulants Discussion

Lynn began the stimulant discussion with a reminder of the state's PDL step-through policy on Vyvanse, which requires the use of Vyvanse and one other stimulant prior to receiving an amphetamine. The data on eligible members taking stimulants depicts a flat utilization trend for children with an increasing trend among adults. This data, along with the more abuse-deterrent properties of Vyvanse, are the basis for the PDL policy. Dr. Cullen reviewed Vyvanse's properties for the Board and noted that there is no street value due to its prodrug formulation, which inhibits the immediate dopamine kick that is seen with amphetamines. The data on the total daily dose and quantities prescribed further supports the PDL policy. Vyvanse data indicates most members are only receiving one capsule per day, whereas amphetamine patients are averaging 1.5 to 2 units per day. Based on the presented data, Lynn informed the board that the proposal would be to maintain the PDL policy. Jake Olson asked if the policy is cost-effective, which Rachel confirmed. Hannah Delong also noted the multiple positive attributes to once-daily dosing, as opposed to more complicated regimens. Dr. Cullen advised that the stimulant drug class is the largest Medicaid spend category (for medications) and that multiple daily immediate-release doses should be a red flag to any provider, as once-daily extended-release dosing is most effective and appropriate per clinical literature.

This discussion led to multiple questions regarding the diagnosis of ADHD in adults. Dr. Cullen advised that diagnostic scales may often misidentify and should be used with caution. Based on a summary from the Center of Evidence-Based Policy from Oregon Health and Science University, providers should use scales that consider the following: self-report, direct examination, clinical interview, case notes, and require that all DSM-5 criteria be met (symptoms in childhood, symptoms that impair function and the ruling out of other conditions). These scales do not require special training but are also not readily available. Mike Brown suggested non-pharmacologic therapy as a prerequisite to stimulants; however, Dr. Sager advised that this would not be effective. Non-pharmacologic therapy could help rule-out non-ADHD diagnoses. Hannah Delong also suggested trials of non-stimulants, such as Wellbutrin and/or Strattera. All of these ideas will be taken into consideration, and the topic of non-stimulant policy ideas will be brought back for further discussion at a later date.

Buprenorphine/Benzodiazepine Continuing Intervention

Lynn Radmer reviewed the intervention timeline and summarized the continuing intervention that was implemented in January of 2016. There were a total of 675 profiles were sent to 275 different prescribers, with 457 members identified by profile reviews. Follow-up data analysis revealed that as those members receiving the intervention dropped off, new members began hitting on the criteria, which indicated the need for an ongoing cycle of intervention. The core team proposed to re-run the focused intervention every six months, sending an alert letter to the prescribers regarding new members that hit on the criteria. This motion was modified at the September meeting and approved as an ongoing intervention being conducted every three months. For the month of November, the criteria was re-run for an intervention cycle on all members. A total of 403 members were identified with 204 members being present in both the January and November cycles and 604 letters being sent to 260 prescribers. All 403 members identified in the intervention were suppressed for 12 months, and this intervention will re-run every three months to look for new members who hit the criteria. This entire first set of members from the initial January 2016 and November 2016 runs will be referred to as "Cohort 1" going forward. The first of the subsequent phase one cycles was run in February 2017. Preliminary data shows approximately 150 profiles, but more detailed data will be available for the June board meeting. This set of members will be referred to as "Cohort 2" going forward.

Lynn then discussed phase two of the buprenorphine/benzodiazepine intervention, which entails identifying members who continue to hit the criteria. The prescribers for these members will be sent a phase two letter alerting the provider to a warning for concomitant use of benzodiazepines and opioids as well as references for appropriate alternative treatments for anxiety. The letter warning previously referenced the opioid black box warning but has since been modified, as the black box was omitted from MAT buprenorphine. Robert Breslow and Mike Brown suggested also sending copies of or information on where to locate the related Med Guides and REMS program as additional evidence for the warning.

Buprenorphine/Methadone Discussion

For continued discussion of the buprenorphine and methadone intervention, the core team invited Kenya Bright from the Bureau of Prevention, Treatment & Recovery, Division of Care and Treatment Services to collaborate with the Board and determine the appropriate course of action. Data currently shows a total of 6,700 patients enrolled across 19 methadone clinics, with approximately 4,500 of those being Medicaid members. The primary difference from the buprenorphine intervention is the existence of two prescribers for all methadone cases, as the methadone clinic will not be dispensing any benzodiazepines. According to Kenya, the protocol requires that the methadone provider reach out to the benzodiazepine prescriber. The issue regarding the outreach revolves around legislation prohibiting methadone clinics from disseminating patient information to any outside providers; thus, they cannot directly inform the benzodiazepine prescriber that their mutual patient is on methadone. This legislation has also prompted the question of whether or not an intervention letter would be within legal boundaries. Kenya advised that methadone clinics are not required to check the PDMP. Dr. Erickson inquired as to the amount of regulation Medicaid could require, and Kenya advised that this would not be beneficial as the clinics would turn away Medicaid members if highly regulated. A recommendation was made to develop a risk explanation for methadone clinics to share with patients who could then take to their benzodiazepine prescribers as a way to disseminate the information.

Focused Interventions

- **Trinity**
- **Overutilization of Albuterol**

This agenda item was postponed due to time constraints and will be discussed at the next board meeting.

Opioid Use in Children

The core team has developed an alert message that aligns with both the American Academy of Pediatrics (AAP) and FDA recommendations, which warn against codeine being prescribed in patients under 18 years of age. The alert message was presented to the Board and reviewed. Based on the statistics from the February ICER report for this criteria, with a total of 559 hits, the Board has recommended proceeding with this intervention. Dr. Wiggins presented some relevant national data regarding this subject, noting the most common areas of overuse are for dental procedures and musculoskeletal injuries. The Washington Dental Quality Assurance Commission states there is strong evidence that NSAIDS and acetaminophen are as effective as opioids and should be used as first-line treatment. If opioids are indicated, they should be limited to three days or 10 tablets of 5 mg hydrocodone. Based on a study that monitored 6,220 12th graders through the age of 23, legitimate opioid use before high school graduation is associated with a 33% increase in the risk of future opioid misuse after high school. Of note, this risk was not associated with any history of drug use and was concentrated among individuals who had a strong disapproval of illegal drug use at baseline.

An observation of Wisconsin's data does show both a small level of chronic use and percentage of total population. When use is broken down by provider specialty, physical medicine and rehab and anesthesiology are the top prescribers. Dr. Sager and Dr. Wiggins recommend limiting dental use to three days' supply and possibly three days for any opioid use in children. Lynn proposed sending an educational/alert letter prior to making any formal days' supply limitations. **Mike Ochowski** motioned to approve this proposal, and **Jake Olson** seconded the motion.

Adjournment

Mike Ochowski motioned to adjourn. The meeting adjourned at 4:10 p.m. Upcoming meetings are on the following Wednesdays: June 7, 2017; September 13, 2017; December 6, 2017; and March 7, 2018.

Guests: Chris Stanfield, Supernus; Jeff Samels, Vertex; Nick Boyer, Otuska; Lisa Gronneber, Biogen; A. Elizabeth Plouff, Pfizer; Dean Groth, Pfizer; Cassaundra Johnson, Purdue; Lee R. Marks, Orexo; K. Casey Johnson, Viiv Healthcare; Bob Heinsch, Sunovion; Elizabeth Ariano, Indivior; Will Mullen, Indivior; Anna Depies, CUW.