Drug Utilization Review (DUR) Board Meeting
Wednesday, June 3, 2009
1:00 P.M. to 4:00 P.M.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members Present: Lon Blaser, DO, CPE
Robert Breslow, RPh
Patrick Cory, PharmD
Daniel Erickson, MD
Michael Ochowski, RPh
Dennis Olig, RPh
Nancy Ranum, MS, RN, CS-ANP, APNP

James Vavra called the meeting to order at 1:05 p.m. Introductions were made.

I. Approval of Agenda
Agenda approved as published.

II. Approval of Minutes – March 4, 2009 Meeting
Minutes approved as published.

III. Retrospective Drug Utilization Review (DUR) (Attachment 1)

Dr. Mergener presented Retrospective DUR. Attachment 1 is RDUR Criteria Review for August-October 2008 and is ranked in order by number of cases reviewed; RPh Yield is percent of cases reviewed and responses sent out; MD Yield is percent of responses received.
Dr. Mergener would like the Board to review this list and provide feedback for additions/deletions.
Mr. Breslow expressed his concern that most pharmacists have access to drug interaction systems but always miss the drug disease issue, and he feels it's redundant unless we proactively identify people and help them correct their behavior. In the prospective world, the State has all pharmacy claims and is able to identify the other pharmacy that is filling the prescriptions. With fee-for-service, they have medical history prospectively but there is a problem of timing with encounter data. The HMOs submit encounter data on a monthly basis and there is no ability to do this real time.
Pat Cory suggested another way is of looking at RDUR is looking at trends to see if impacts occur over time.

IV. Prospective DUR (Attachment 2)

Dr. Mergener presented Prospective DUR. The first alert in attachment 2 is FDB Severity Level 1 Geriatric Alerts. The Board previously approved turning on all severity level 1 age alerts, both pediatric and geriatric. In the new system, the geriatric alert is available and ready to turn on. The majority of the severity level one alerts in the FDB module are the BEERS list drugs. The motion was made and seconded to utilize the list of severity level 1 geriatric age alerts. The list was approved.

The second alert is high dose. When retrospective DUR was initiated, high dose was discussed but at the time, it was decided to not activate it. The table again was driven from First Databank with 3 high dose alerts per drug (geriatric over 65, 18 to 65, and pediatric). The pediatric high dose could be further divided based on pediatric age. The second page of the attachment lists high dose alerts available in the retrospective system that we currently send alerts on and a comparison of the information in the FDB module. These doses are not tied to specific diseases so the high dose is the maximum dose used. We propose to do testing on the drugs we currently have turned on in the retrospective system. After testing, we can review thresholds and then work on expanding and fine tuning the list. The motion was made and seconded to do testing with the limits as listed in the retrospective column but use the dose of 30 mg for escitalopram. After activation, a report back to the Board on the number of hits and overrides should be prepared.

The motion was made, seconded, and approved to activate for RDUR high dose alerts the RDUR Threshold as listed but change to greater than 30mg/day

Action Items:

- The motion was made and accepted to amend the list for severity level 1 and become operational for geriatric age.
- The motion was made and accepted to do testing and report back to the Board on the number of hits and overrides.
- The motion was made and approved to activate for RDUR high dose alerts the RDUR Threshold as listed but change to greater than 30mg/day for escitalopram.

V. Break

VI. Drug Spend Discussion (Attachment 3)

Dr. Mergener presented on the drug spend. Attachment 3 is our attempt at a dashboard for Jason Helgerson and demonstrates what is happening with the drug budget on a quarterly basis. There are currently 5 drug benefit plans the State provides payment for: Benchmark (generic drug plan); the Core plan being utilized for GAMP and the childless adult population; SeniorCare; WCDP (Wisconsin Chronic Disease Program); and Wisconsin Medicaid. The aggregate rebates collected and aggregate rebate of drug spend are included. We are currently holding at about a 65% generic drug utilization rate. Jim Vavra commented due to rebates, some older drugs lose patent and because of the rebate the State gets, the cost initially can be far less than for a generic prescription. We could be higher than 65% but choose to prefer the brand name over the generic in some drug classes because of the large Federal rebate..

The total spend is going up proportional to enrollment increase. Pat Cory suggested adding an additional line to track ambulatory percent trend over previous years..

Action Items:

Revise the dashboard by adding a line to track a percent trend over the previous years.

VII. Future Targeted Interventions (Attachment 4)

Dr. Mergener presented on future targeted interventions. Based on feedback from the last meeting, he revised the document (e.g., indicated ongoing intervention, added the suggestion of moving the dial and potential for doing so). The intent is to go through this document and rank these – 2 or 3 are possible for doing in any given year. Getting the intervention together until doing the measurement is usually a 9 month window of time.

1. Asthma and Inhaled Steroids - a couple of issues with this – need to get a handle on the use of Advair and issue with seniors. Would need to identify and weed out those providers we think are candidates and then send out asthma guidelines and price information.
2. Singulair with no asthma diagnosis – have examined and looked at previously taken drugs for rhinitis and came down to about 13% of prescriptions written for allergic rhinitis. Eliminating Singulair in those instances would result in about $100,000 in annual savings.
3. Rosiglitazone – marketshare for this has self-adjusted and the FDA is still undecided on whether or not to act on.
4. Diabetics with no metformin – would need a handle on chronic kidney people and another issue is appropriate dose.
5. Erythropoesis Stimulating Agents – how high do we push hemoglobin values but unsure how to get that as we don't have lab values; could check for billings.
6. Femara for induction of ovulation – Medicaid doesn't pay for any fertility treatments so this would be more of a fraud issue. Lon Blaser commented not sure if prescribers would consider that use as fraud; Dr. Mergener could run the data. Pat Cory suggested including Arimiidex.
7. Overuse of sedative/hypnotics – this is one of the high dose alerts that is activated in retrospective DUR.
8. Medication adherence on atypicals – have therapeutic duplication on those drugs which the Board approved to send alerts on but not sure if activated; design a system to detect when prescription should have expired and then take action.
9. Drug review post-MI and post-stent placement – would need to determine intervention period if doing.
10. Prophylaxis therapy for migraine – we have data and could track those people to see if being put on prophylactic therapy.
11. Adherence to HIV meds– vitally important but should be taken by the pharmacist at the time and they make the phone call. Intervention by person at point of sale or have case managers intervene.
12. Use of Insulin without claims for glucometer test strips – less of an issue now – unable to catch test strips for the elderly.
13. Use of meds without appropriate labs – Tom Olson running data on and fine tuning it. Would like to intervene on patients that have had tests and see if being treated appropriately.
14. Edits for allowing more 100 days supply dispensing – getting ready to do this.
15. Appropriate use of antibiotics – in the office problem; potential newsletter topic.

Tom Olson presented on the number of women of childbearing age (15-45) who use ACEs, ARBS, and Statins without contraception analyzed from April 2008 to April 2009. This captures all forms of birth control (tubal ligation, prophylactics and sterilization are not included). This appears to definitely be a quality issue. .

Dr. Mergener addressed 3 graphs for utilization of Oxycodone, All Opioids, and Hydrocodone for the 1st quarter of 2009. Prescribers include pain management specialists and in some cases, the same people are on all 3 graphs. Looked at average

dose by prescriber per patient per drug, eliminating liquid forms of methadone. This is the first cut so we can do some slicing and dicing, and then send out a revised list broken down by average units per prescriber.

Action Items:

- #7 Overuse of sedative – run data on to see if we get many doses above 16 mg for Ramelteon.
- Utilization of Oxycodone, All Opioids, Hydrocodone – Review and send out a revised list broken down by average units per prescriber.

VIII. Adjournment

The meeting adjourned at 4:00 p.m. The next DUR Board Meeting is scheduled for Wednesday, September 2, 2009.