

DUR UTILIZATION AND REVIEW (DUR) BOARD MEETING
June 1, 2005 MINUTES

Wednesday, June 1, 2005
1:00 P.M. – 4:00 P.M.
10 East Doty Street, Suite 210
Madison, WI 53703

DUR Board Members Present:

Mark Buhler, R.Ph.
Robert M. Breslow, R., Ph.
Daniel Erickson, M.D.
Pamela Ploetz, R. Ph.
Nancy Ness, M.D.
Nancy Ranum, M.S., RN

APS Healthcare:

Mike Mergener, R. Ph. Ph.D.
Allan Mailloux, Pharm. D.
Karen Paulson (Scribe)
Bruce Christiansen, Ph.D.
Margaret Asquith, Pharm.D.

DHCF:

Richard Carr, M.D. -DHCF
Rita Hallett R.N.– DHCF
Marilyn Howe R.N. - DHCF
Pam Appleby - DHCF
Ted Collins, R.Ph. – DHCF
Scott Hawley - EDS

GUESTS:

Greg Aronin –Johnson & Johnson
Jagdish J. Shastri - Lilly
Dan D. Anderson – Purdue Pharma
Kathy Bovid – BMS
Heather Swartz – Pharmacy Student, APS

Minutes

Dr. Richard Carr called the meeting to order at 1:00 P.M.

I. Approval of Agenda

Agenda was approved as published.

II. Approval of Minutes – March 9, 2005 Meeting

Correction: Robert Breslow was not present at the March 9, 2005 DUR board meeting.

Minutes were approved as amended.

III. Retrospective DUR

Use of anti-epileptic drugs.

- Mike discussed the analysis of the newer anti-epileptic drugs. This was done to develop potential targets for a letter intervention.
- This analysis was recommended by the Board in lieu of a gabapentin only intervention.

Methods

- ✚ Anti-epileptic drugs that have more recently been introduced to the market were included in the analysis. Claims for these drugs were extracted from April 2004 through May 2005.
 - Drugs included in the analysis are gabapentin, lamotrigine, felbamate, tiagabine, oxcarbazapine, topiramate and levetiracetam.
 - Prescribers associated with the claims were merged with the type and specialty we had on file for the prescriber.
 - Any patients with one diagnosis for post-herpetic neuralgia, diabetic neuropathy or for any seizure disorder since 2003 were eliminated from the analysis.
 - Data were re-aggregated with the type and specialty information.

Preliminary Results

- ✚ Summary of the findings.
 - Medicaid paid almost \$40 million for these drugs in the last 12 months.
 - 1/3 of payment – \$13 million was for gabapentin even though this drug is now generic and dropped to less than half the cost. Almost 80% of the gabapentin utilization had no approved diagnosis in the data.
 - Overall, no approved diagnosis was found for 60% of prescriptions.
 - Levetiracetam (Keppra), felbamate (Felbatol), and tiagabine (Gabitril) were used primarily for approved indications and do not appear, at this point, to be problematic drugs.
 - Less than 10% of the top 500 prescribers accounted for 60% of the total expenditures. 50% of the prescriptions were written by psychiatrists.
 - We are going to exempt neurologists at this time, assuming that neurologists would be using the drugs more appropriately.

Recommendations

We propose to move forward with this intervention to include inappropriate prescribing of the newer anti-epileptic drugs that do not have an approved indication on file.

The proposed intervention includes:

- Sending educational interventions to prescribers, other than neurologists, informing them of the Medicaid expenditures for antiepileptic drugs and asking them to review their use of these drugs.
 - Materials will include:
 - cover letter
 - summary of the appropriate use of antiepileptic drugs
 - list of patients attributed to the prescriber,
 - response form
 - a return envelope

Discussion

- ✚ The information for approved indications is taken from the USPDI and Facts and Comparisons. These references are updated regularly.
- ✚ Targeting is based on the whole class, not just gabapentin.
- ✚ Excluded diabetic neuropathy, post-herpetic neuropathy, and any seizure disorder.
- ✚ What should go out:
 - A refined provider letter.
 - Prescribing guidelines for the newer antiepileptic drugs.
 - A summary of the expenditures and percentages of claims without an approved indication.
 - A response form.
 - A list of patients, particularly to the prescriber. Even if the prescriber filled in for a colleague, if the prescription is attributed to him/her, he/she will get an intervention.

IV. Prospective DUR

ER and TD interventions summary.

We haven't run the data yet to see if the percentage of overrides is decreasing.

- ✚ Ran query – (Pharmacies primarily serving nursing homes are not included in the analysis).
- ✚ The first intervention analyzed only the early refill (ER) alert. The second intervention looked at all alerts.
- ✚ Based on some feedback – we decided to look at the ER and TD alerts.
- ✚ We aggregated those, looked at those, ranked them, and eliminated those that had primarily nursing home clientele because they are exempt from real time prospective DUR.
- ✚ There are quite a few providers to nursing homes and long term care facilities that really want to use the prospective system. If they do that, then I am not going to exempt them because they made a conscious choice to use the system. I give them the feedback based on their use.
- ✚ There were 131 pharmacies that were included in the intervention, which is roughly about 10% of the total pharmacies. Out of the 131 pharmacies, there were 98 (75%) responses to date.
- ✚ Fifty pharmacies were for the ER alert only.
- ✚ Sixty four pharmacies were for TD alert only.
- ✚ Seventeen of those pharmacies that were in the top 10% for both therapeutic duplication and early refill.
- ✚ Received phone calls from 15 to 20 pharmacists.
 - Went back and constructed a query and sent the pharmacists the particular list of drugs causing alerts to set for that particular month. The ER was fairly easy. The other one was more complicated. We had to construct two files and merge them because one drug was duplicating with another drug.

Feedback and Preliminary Results:

Some of the reasons for the high percentages of overrides expressed by pharmacists as being problematic:

- Very few pharmacies have issues with the ER alert.
- Greatest issue: the patient lives 25 miles out of town, they come in and what to get their prescription filled early.
- One pharmacist response: 1 LR + 1 ER = 0.
- Another response that comes back quite often: Patient mix; for CBRF, mental illness and patients with chronic pain.

- Proprietary software systems that run prior to the point of sale that points to problems prior to entering the claim into the Wisconsin point of sales system. Therefore, many are resolved before they hit Medicaid's system so there is a higher percentage of problematic claims.

We are going to monitor these pharmacies for two consecutive months and look at their percentages of overrides and pre-interventions.

Patterns that included a high number of TD alerts:

- Opioids – (long/short acting) system built so that this will come up as a duplicate therapy. Appropriate action is to override.
- Loop diuretic duplicating with another diuretic, but more frequently with metolazone.
- Effexor 75 and Effexor 37.5: in order to get the appropriate dose, have to take two doses of the same drug.

We need to work on fixing the noise.

DISCUSSION AND COMMENTS

- Suggestion – After this is all over, we should respond back to the 131 pharmacies.
- It was a very positive interaction with the pharmacists. They want to cooperate.
- Based on feedback from the pharmacist, the early refill alert is serving a purpose. The pharmacists agree that they could do a better job.
- There is a 25% leeway. A lot of states now, instead of using 25%, are cutting it back to 10%. And on narcotics, 5% before they don't allow an alert to hit. You have to be careful with the accuracy of to what the pharmacist is putting in a day's supply of medication.
- We agree that monitoring ER is a legitimate course to take as it has some obvious problems.

TD Interventions

We could create therapeutic classes within the opioids, creating 2 separate TD classes. A long acting would duplicate along with another long acting and the short acting would duplicate against the short acting.

- Would prevent long acting from duplicating against the short acting and take away some noise.
- Duplicate therapy is a problem.

Could separate the diuretics out so that thiazide does not hit against metazolone, for example.

We could suppress the alert if the drug is being dispensed in the same pharmacy.

We do not like doing it if it is the same prescriber at different pharmacies.

We do not dup on all therapeutic categories.

Other issues

- There are quite a few pharmacies that have 0% overrides.
- About 30% of the ER alerts are overridden.
- Have not looked at the demographics of 0% overrides.
 - **Board requested that we bring back some stats pharmacies with no overrides at the next DUR board meeting.**
- The intervention opens up more of an opportunity to communicate about the system with pharmacists.

Summarization

We are still going to do early refills.

We are going look at modifying some of the therapeutic duplication alerts.

We will prepare some data on pharmacies that have no overrides for ER.

V. Update of Prospective DUR Criteria

Prospective DUR Alerts Review handout – A lot of background information to get you back up to speed.

- The prospective DUR system has been operational for 3 years.
- Feedback from the pharmacists has given us some things that we can evaluate.
- We should review, assess and update the current DUR alerts.
- Review our recommendations to determine whether or not changes to the prospective DUR can be implemented.

Previous issues we have discussed

- Additive toxicity alert – If we have drugs that cause loss of menses – we send out an alert even though it is a male patient.
 - We should be able to tweak in the system so that a gender appropriate message is sent. In the example above, if gender is a male patient, do not send.
 - We should examine TD alerts that are hitting where therapy may be appropriate and attempt to fix them.
 - Need for a review of drugs used to set alerts.
 - For example, we have ACE inhibitors hitting against ACE inhibitors.
 - Add ARBs against ARB to therapeutic dup?

Late Refill Alert

We only select a sub-set of drugs for late refill.

- Looked for maintenance drugs – If patient wasn't getting their drug on a consistent basis, we ought at least alert the pharmacist.

Potential additions discussed.

- Thyroid medications.
- All Oral hypoglycemics - Mike will check to see if drugs other than sulfonylureas are included.
- Osteoporosis and steroid drugs.
- Inhaled steroids for asthma. This is difficult to measure – how many puffs, smaller size versus larger size, and so on.

Therapeutic Duplications

- Antilipemics – Do we need to do a category split with this? It is statin duplicating statin only. It was a narrow category.
- Diuretics – We should separate the classes out.
- SSRIs/other new antidepressants – check on how categories are listed for duplication.
- Benzodiazepines – do not have a therapeutic duplication with anxiolytics. They are slightly different. There is some overlap in these categories. It is only a benzodiazepine with a benzodiazepine.
- Sedative hypnotics – are hitting with the sleeping aids. This is based on what normal use is.
- H-2 antagonists – **Mike is going to check to see where it reads the therapeutic class from.** When they were originally built, it was an H-2 versus an H-2. We try to keep those dup categories separate.
- NSAIDs – one NSAID is duping against any other NSAIDs.

- Antitypical psychotics – We do not have a duplicate alert for these. Not necessarily duping anti-psychotics against anti-psychotics. **It has been agreed to go forward with this therapeutic class to create and add to the system.**

Dr. Carr suggested that we could send the sheet for early refill alert and for the TD alert and send it to the DUR board for review.

Early and Late Refill days supply: Is at 25%. Some states go lower than that. There are some flaws in it. Days supply is entered by the pharmacist. and the issue of take one or two every four to six hours is really difficult for Mike to resolve. We could change the percent for setting the alert.

Additional alerts not addressed: We did not do drug allergies but, the pharmacist still needs to screen the prescription for allergies.

- Potential alerts to look at in the future: High dose, ingredient duplication, low dose, insufficient duration, excessive duration, excessive quantity and drug/gender conflict.
- High dose - This is only for drugs where there are a narrow number of indications and where the dosage range is fairly established. There are guidelines established which set what a high dose is.
- Ingredient duplication: Close to therapeutic duplication but, it is a little bit different.
- Low Dose: **It was unanimous to not include this alert.**
- Insufficient duration/excessive duration: It is used for prescribing guidelines for sedative agents. Can use this to look at the continuation of a prescription that is for several months that is only supposed to be short term. Do not see a lot of excessive duration on antibiotics unless it is indicated.
- Excessive quantity: Ties in with excessive duration.
- Drug/gender conflict. – One example is that men can't get contraceptives.

Final Summary.

We will send the letter on the use of Epileptic Drugs and the alert info to the Board for review.

Meeting adjourned at: 4:00.