MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, March 7, 2018
1:00 p.m. to 4:00 p.m.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members
Present:
Robert Factor, MD
Paul Cesarz, RPh
Jake Olson, PharmD
Hannah Delong, MSN, PMHNP-B
Michael Ochowski, RPh
Robert Breslow, RPh
Lora Wiggins, MD
Ward Brown, MD
Daniel Erickson, MD
Michelle Bensen, MD
Absent:
Michael Brown, PharmD

DXC Staff
Present:
Chally Clegg
Tom Olson, PharmD
Jacque Nash, PharmD
Corinne Eckert
Kristie Chapman

DHS Staff
Present:
Kimberly Smithers
Lynn Radmer, RPh
Tiffany Reilly
Julie Sager, MD
Rachel Currans-Henry

Welcome and Introductions
Kimberly Smithers called the meeting to order at 1:05 p.m. and began with a welcome and thanks to the Board members for their attendance at the meeting. Kimberly then introduced the newest Board member, Dr. Michelle Bensen. Dr. Bensen currently practices full-time in addiction medicine with prior experience in pain management. All members, staff, and guests present introduced themselves adding their respective roles with the DUR Board, as well as area of practice to illustrate the variety of specialties around the room and scope of the Board for its newest member. A quorum of members attended the meeting.

Review of the Agenda and Board Materials and Approval of December 2017 Meeting Minutes
The members were reminded of the meeting materials in their respective binders for reference and review. Kimberly walked through the agenda as printed. Prior to this meeting, Board members received the minutes and RDUR Quarterly Report via e-mail and had the opportunity to review each document. The December minutes were then briefly reviewed and approved with an initial motion from **Mike Ochowski** and a second from **Ward Brown**. The motion passed unanimously.

Quarterly DUR Reports
Lynn reviewed the quarterly reports with the Board. Lynn reminded the Board that the Quarterly Overview report identifies members who have claims for all five drug classes used for selected lock-in review and that an ongoing monitoring report has been created; she also acknowledged a continued overall decreasing trend in opioid use among the Medicaid population. The second quarterly report reviews prospective DUR alerts both individually and collectively. Lynn provided a brief explanation of the prospective DUR alerts and the Board's recent history of refining the alerts. This meeting will likely be the last time the ongoing prospective DUR alert reports will be reviewed and discussed with the Board.

The detailed individual DUR report presentations continued with a focus on reported disease and early refill.

The reported disease alert uses diagnosis codes from medical claims to build member profiles with First DataBank codes and categorizing the codes on an acute, chronic, or lifetime timeline, which determines how long each profile remains active for the member. The member's profile(s) are used against pharmacy claims to alert for drug/reported disease interactions. The alert is not a hard stop and only applies to major drug/disease interactions, as defined by First DataBank. A snapshot of the top ten drugs which triggered the alert in fourth quarter 2017 was presented.

Robert Breslow questioned if monitoring only five diagnosis codes was sufficient. Kimberly responded that the system monitors five diagnosis codes per claim, so the total could be hundreds of diagnosis codes for a single member. Dr. Erickson expressed concern regarding data validity due to the discrepancy in the number of angina versus coronary artery disease occurrences. Further review was recommended.

Early refill reporting data was presented. This alert is divided into a hard stop edit known as the DAPO early refill, as well as a prospective DUR early refill alert that can be overridden at point of sale. The DAPO alert monitors mostly controlled substances and any other drugs added to the list chosen by the State, while the prospective DUR alert monitors all other drugs, with the exception of drugs subject to a quantity limit. The alert threshold varies based on days' supply, with no alert on five days' or less and 65%, 80%, and 85% thresholds for 6-9, 10-34, and 35-100 days' supplies respectively. For the fourth quarter of 2017, 7% of all early refill claims were represented by DAPO alerts. Robert Breslow asked if there are any conclusions to be drawn from the data. Lynn stated no, other than the reassurance of a low overall prevalence. Dr. Erickson also advised that the prospective DUR alerts are likely comprised of dosage adjustments based on the drugs triggering the alert.

Lock In Annual Report

Jacque presented the annual Lock-In Report for calendar year 2017 beginning with a general program overview of objectives, member rights, and current active criteria. The most significant change in 2017 was the addition of the monitored drug class selected reviews. The quarterly profiles selected by the State which monitor members taking all five drug classes led to a 50% increase in selected review volume. The intervention rate rounds to 100% on the State selected reviews as well, which indicates a highly effective approach to identifying high risk candidates.

The total caseload doubled, from 954 in 2016 to 1,837 in 2017. The largest impact was the addition of criteria #9995 (a history of poisoning and use of multiple controlled substances). The new criteria identified a large population of members at risk that had previously gone unrecognized due to the Lock-In volume. The most positive aspect of 2017 is the statistic that even with a high alert case count, the warning and lock-in cases were minimal, which signifies a reaction to the initial alert letter. Some of those actions are verifiably positive and noted as the members subsequently hit the buprenorphine criteria because they began addiction treatment.

Provider feedback for 2017 was lower than 2016 at 23%; however, there was only a 10% "no action" rate. Thirty-seven percent of providers gave a response of having taken action and 50% indicated they no longer had a relationship with the member. Of those 50%, 37% had either referred the member to a specialist or discharged them from the clinic. The idea of patient abandonment was brought to the forefront by Rachel at this point based on a potentially high discharge rate. Dr. Bensen did acknowledge through her practice expertise that abandonment is an ongoing issue and something to keep in mind.

Opioid Use in Children Discussion

Jacque reminded the Board that the dental letter was recently sent in December 2017. The letter targeted 128 dentists who had two or more members under the age of 18 receiving more than 10 units per prescription of any opioid. Feedback from prescribers was available at the time of this meeting but will be presented in June. This intervention will be reevaluated later in the year.

Continuing on this topic, Jacque reviewed the Board's prior decision to implement a prospective DUR alert on all codeine, tramadol, and antitussive hydrocodone products in pediatric members. The inclusion of hydrocodone antitussives is new due to an FDA update published on January 11, 2018. The addition of a prospective DUR alert based on age will be communicated via a Provider Update prior to implementation.

The tramadol intervention was discussed in more detail this month since data was not yet available in December. A total of 88 members hit the criteria and accounted for 75 providers. Thirteen of those providers indicated they had made an appointment to discuss therapy, while another 15 stated the medication was no longer in use or a one-time acute need only. Overall, the prescribing volume decreased among the 75 providers following the mailing. October 2017 there was a total of 176 tramadol prescriptions and by January 2018 that number declined to 31.

Updates to the codeine intervention data from all three cycles, May, August, and October 2017 were presented following the tramadol data. Each cycle saw an overall decreasing trend in the percentage of members under the age of

12; however, new members continue to hit the criteria with each successive cycle as well. The total volume of codeine prescriptions continued to drop as reported, but December saw an increase in all three cycles for total codeine prescribing. Further analysis found the major contributor to this shift was an oral and maxillofacial surgeon who had an increase in procedure volume during the holiday month. This top prescriber accounted for 110 prescriptions in December, all of which were Tylenol #3, and written for a quantity of ten to fifteen tablets lasting one or two days. When this exception is taken into account, the trend is a continued overall decline in codeine prescribing, and those 110 prescriptions were all written for members greater than 12 years of age for acute quantities and non-contraindicated occurrences. Furthermore, an analysis of the January 2018 data reflected a new member population on successive cycles. Only two members hit the criteria twice and both were greater than 12 years of age. Of the 530 providers involved in the total intervention thus far, only 10 have shown up in all three cycles. The letters will be continued in conjunction with the prospective alert with a fourth cycle in March 2018.

Opioid/Benzodiazepine Intervention Discussion
Lynn reviewed the opioid/benzodiazepine intervention. The intervention targets members receiving at least 90 days of a benzodiazepine in combination with at least 90 days of 50 morphine milligram equivalents (MME) or more of any non-medication-assisted therapy (MAT) opioid. The 50 MME benchmark is based on the Wisconsin Medical Examining Board Opioid Prescribing Guidelines released in November 2016 citing this threshold as a higher respiratory depression risk. The letters were mailed in February 2018 to 902 providers, which accounted for 781 members. Of note, the top 10 providers accounted for 119 members. The summary of provider specialties was presented to the Board and Dr. Bensen advised that the top prescriber, which is anesthesiology, would likely not change due to continued practice requirements.

Stimulants Discussion
Lynn advised the Board that the four unit per day quantity limit was effective as of March 1, 2018. The implementation will allow a one-time override in March 2018 while members work with their prescriber to consolidate and/or adjust their stimulant medication(s) and dosages(s); however, any further overrides will only be granted by a drug authorization policy override (DAPO) call for lost/stolen medication, vacation overrides, or dose changes. Notification letters to 462 providers for all affected members were mailed in February. A total of 746 members were reportedly on greater than 4 units per day at the time of the mailing.

Antipsychotics Prior Authorization for Children Update
The prior authorization policy was changed on January 1, 2018 to require a prior authorization (PA) for children eight years of age or younger. The age was updated from seven years of age or younger. A fasting blood glucose or hemoglobin A1C is required when BMI is greater than or equal to the 85th percentile. Lynn presented data regarding PA activity. Since the PA's inception, the use of the more appropriate diagnosis Disruptive Mood Dysregulation Disorder has increased significantly in proportion to the decline in Bipolar Disorder. Over time there has been improvement in prescribers providing the metabolic monitoring information. Overall, the policy is effective and consistent with the State's other insurers. About 60% of the PA requests originate from psychiatrists. PA's are generally not denied as there is peer to peer dialogue generated to discuss the member's clinical picture and determine the best course of treatment.

Adjournment
Paul Cesarz motioned to adjourn. The meeting adjourned at 4:03 p.m. Upcoming meetings are on the following Wednesdays: June 6, 2018; September 12, 2018, and December 5, 2018.

Guests: Lisa Gronneberg, Biogen; Chris Stanfield, Supernus; Todd Miller, Genzyme; David Heisch, Takeda; Patrice Donahoe, Sarepta; Chris VanWynen, Sarepta; Jodi Jensen, Biogen; Dawn Bina, Novo Nordisk; Mary Bonacarsi, UWM.