MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, March 2, 2022
1:00 p.m. to 3:45 p.m.
Virtual meeting via Zoom

DUR Board Members	Gainwell Staff	DHS Staff
Present:	**Present:**	**Present:**
Jordan Wulz, PharmD	Tom Olson, PharmD	Kim Wohler
Jake Olson, PharmD	Katie Counts, PharmD	Lynn Radmer, RPh
Michael Ochowski, RPh	Justin Soniat	Tiffany Reilly
Brooke Passolt, MD	Ashley Beaderstadt	Russ Dunkel, DDS
Paul Cesarz, RPh	Willie Wilberg, PharmD	Susan Seibert
	Chally Clegg	Pamela Appleby
Absent:	Burton Copeland, MD	Darla Stachowiak
Robert Factor, MD	Emily Gentry, PharmD	
Ward Brown, MD	Ben Minch, PharmD	

Welcome and Introductions
Susan Seibert called the meeting to order at 1:02 p.m. and began with a welcome and thanks to the Board members for their attendance at the meeting. As the meeting was held virtually, Susan provided technical instruction on how the meeting would proceed. A quorum of members attended the meeting. Additionally, Susan welcomed new Pharmacy Section Chief, Kim Wohler, who replaces Kelsey Brundage. She also shared the new Deputy Medicaid Director is Ruth Sullivan, and reminded the Board that Lisa Olson is now the Medicaid Director.

Review of the Agenda and Board Materials and Approval of December 2021 Meeting Minutes
The members were reminded of the meeting materials sent via email for reference and review. Prior to this meeting, Board members received the agenda, minutes, and RDUR Quarterly Report via email and had the opportunity to review each document. The December minutes were briefly reviewed and approved with an initial motion from **Paul Cesarz** and a second from **Michael Ochowski**. The motion passed unanimously.

Updates
Quarterly DUR Reports
Lynn reviewed the quarterly reports with the Board beginning with discussion of the multiple drug classes report. Lynn reminded the Board that this report identifies members who have claims for all five drug classes (opioids, stimulants, benzodiazepines, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members that are receiving drugs from all five classes are reviewed by a pharmacist for possible inclusion in the Lock-In program or sending physician alert letters. Overall, the downward trends for these medications continue. Lynn noted that enrollment has continued to increase over the last several quarters. This increase is still attributed to the COVID-19 pandemic. In addition, trend graphs for average morphine milligram equivalents (MMEs) per member per day and members utilizing buprenorphine from 2018 - 2021 were included. As seen with last quarter, as the average MME has decreased, and the use of buprenorphine has increased. A trend graph for Vivitrol® was presented to the Board. The number of members has increased and has returned to pre-pandemic levels. Of note, the diagnoses on the claims have shifted slightly to increasing use for alcohol dependence vs. opioid dependence. Lynn noted that this will be the last meeting in which this trend graph will be shared with the Board. The Department will still monitor use and will notify the Board of any significant changes. The last trend graph presented was for naloxone. Lynn noted that because of new interventions required by CMS as part of the SUPPORT Act, the number of claims in the last two quarters have increased significantly. Further analysis of the trend graph was done based on opioid use and MME levels. That analysis revealed that most members with a claim for naloxone either had no opioid claims or claims for low MME values (less than or equal to 50 MME per day).

DUR alert trends and quarterly deduplicated claims information were also included for Board review and were discussed in more depth. Changes to alerts in response to the COVID-19 pandemic were noted to have impacted the volume of both the alerts and claims. Total claims volume has been noted to be increasing, possibly due to increasing enrollment numbers. Also, notable changes to DUR alerts for the past two years include an increase in the Early Refill alert and a decrease in the Late Refill alert. These changes are attributed to system modifications to some alerts and expanding the number of medications that are eligible to be dispensed for a three-month supply. Lynn reminded the Board that on November 1, 2021, new and updated groupings and drug list updates for the Therapeutic Duplication and Late Refill alerts were implemented Due to these changes the Late Refill alert increased and Therapeutic Duplication decreased. She shared the new drug grouping again and reiterated that these recent changes have impacted alert volumes and will continue to be monitored by the Department. Lynn also discussed the High Cumulative Dose alert and the changes associated to the October 2021 implementation of a soft alert in place of the informational alert. Pharmacists are required to respond to the soft alert and alert trends have shifted as a result of this change. The increase in overrides and pre-overrides was not unexpected and will continue to be monitored by the Department.

High MME Intervention

Lynn began the review of the high MME intervention by reminding the Board that the SUPPORT Act requires states to monitor the use of high dose opioids by members and prescribers. The High MME intervention identifies members taking 250 or greater MME per day and letters are sent to the opioid prescriber. This intervention was started in December 2019. Additionally, some prescribers are selected for an outreach call based on no change to the MME or an increase in the MME after receipt of an intervention letter. These outreach calls were started in August 2020.

Lynn shared current letter volume with the Board and noted that the current process is to send a letter to a prescriber only one time. Additional letters are only sent if the member is identified again and has a new prescriber. She reminded the Board that at the last meeting it was noted that it may be beneficial to formulate an approach to try to redefine what is considered a high MME and decreasing the upper limit used for this intervention. After further research, the Department feels that redefining a high MME to mean 180 MME per day or greater is appropriate and still encompasses the top 1% of members receiving opioids. Additionally, letters will now be sent at least yearly to prescribers. The volume of letters is expected to triple initially. This change will go into effect in March 2022. This intervention will continue to be monitored and be brought back to Board later to provide an update on the new process.

Multiple CNS Depressants in Adults Intervention Impact Analysis

Lynn reminded the Board of the quarterly intervention approved at the September 2020 meeting that targets members who are on multiple CNS depressants. The current intervention methodology identifies members who are concurrently receiving at least one medication from each of the following drug classes: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants. The intervention focuses on those members considered high risk due to chronic concurrent use. Members are considered high risk when they are receiving 90 days of each of the four medications in during the quarter. The selected members are reviewed, and a letter is sent to prescribers regarding the risks of the noted polypharmacy. Letters are sent to a prescriber only one time per member.

Impact analysis was performed for this intervention. The analysis included those members that were identified for letters in Q3 2020 (the original run for this intervention). Analysis of member claims for providers receiving a letter indicated approximately a 70% success rate. Thirty-seven of the original forty members were included in the analysis. The remaining three members had a change in their eligibility status. The intervention was counted as successful if the member was still an active Medicaid member and had fallen below the threshold of four drugs for 90 days each. Lynn noted that while the success rate appeared to be high, a control group was used in the analysis and the control group had a similar success rate. There is a possibility that the letters prompted prescribers to make changes in medication regimens for more members in their practice than the member identified in the letter.

Lynn followed the impact analysis by noting that at previous meetings there was Board discussion around changing the parameters for inclusion into this intervention so that more members are identified for a letter. Additional discussion centered around the frequency of the letters to providers. After further research, the Department feels adjusting the methodology used to identify members for the intervention is appropriate. Members will be identified by having a claim for all four medications in the last month of the quarter, in addition to receiving all four drugs for at least 45 days in the last quarter. Letters will be sent to prescribers at least yearly. This change will go into effect with members identified in

Q1 2022 data.

Polypharmacy Sedating Medications in Children

Lynn reminded the Board members of the recent interventions surrounding CNS depressants in adults. She noted the ongoing Multiple CNS Depressant intervention, a duplicate sedative intervention, and a multiple benzodiazepine intervention. Children were rarely found in the populations identified for these interventions. Discussion from the December 2021 meeting prompted research into creating an intervention targeted specifically for the pediatric population. Lynn then introduced Dr. Copeland to discuss the process the DUR work group used to develop a pediatric intervention for sedating medications and possible future interventions.

Dr. Copeland started by reiterating that very few pediatric patients were identified in the previous interventions. However, this did not necessarily mean that sedating agents were not being utilized in the pediatric population. It was noted that many of the medications that are used for sedation in the pediatric population are not those that are traditionally used in adults. He shared that benzodiazepines and traditional sedative hypnotics are rarely used in children. More commonly, prescribers utilize alpha agonists, antihistamines, antidepressants, antipsychotics, and melatonin. Dr. Copeland noted that utilization of the different drugs within these classes varies between different age groups.

During the discovery process, the goal was to identify members for possible outreach. The methodology for identifying members included screening for multiple sedating medications in children 18 years of age and younger. The child must be on medication from three or more of the identified drug groups for 90 days or more during the last quarter. This methodology identified 55 children, ranging from two to 18 years old. The majority of the children were 10-17 years old (41). The top five drugs for all children were discussed and then the medications were broken out by age group. Top medications included: trazodone, quetiapine, hydroxyzine, mirtazapine, and clonazepam. Dr. Copeland shared that there is limited literature for pharmacology related to sleep in pediatric patients. Many prescribers utilize sedating medications to treat other conditions that result in sleep improvement. Improved sleep is associated with better outcomes in those other conditions. Additionally, he noted that polypharmacy is common in treatment resistant mood and anxiety disorders; and, in fact, polypharmacy can be considered standard of care in complex cases. Dr. Copeland went on to discuss the case reviews that were identified for intervention via peer-to-peer outreach calls. Opportunities for productive interventions were identified by including children with polypharmacy from multiple sources. These cases tended to be complicated and involved multiple specialists. The six cases included children ages two to 17 years old. Lastly, he noted that possible next steps in expanding this intervention may include dose-based screening, age-based screening, polypharmacy-based screening, and expansion of the list of sedating medications included for review.

Lock-In Annual Report

Katie began the annual Lock-In Report with an overview of the program's functionality and objectives, which are to identify and reduce drug-seeking behavior and to identify inappropriate prescribing patterns. The program currently reviews three criteria that look for excessive use of controlled medications (#3147), combinations of buprenorphine with opioid agonists (#5304), and the use of controlled substances with a history of drug poisoning (#9995). The Board was reminded of member rights, negating criteria used during reviews, and the types of letters sent to providers. A list of drugs that are included and excluded from the program was provided. There were no new criteria in 2021, however it was noted that the review volume was increased from 400 to a maximum of 1080 in July 2021.

A review of case counts for 2021 revealed an increase in the number of cases identified for alert consistent with the increase in the number of profiles being reviews. The trend in the number of cases identified for warnings and lock-ins remained similar to previous years. Katie noted that, due to the time between review for an alert and review for a warning or lock-in, changes in case counts will likely be seen in the 2022 report. It was noted that letters are sent on average every six months to allow the reviewer to better see changes to utilization patterns. Other trends noted for 2021 include a continued decrease in prescriber responses. However, December data for responses was not available at the time this report was created. Despite the lower percentage of overall responses, the percentage of responses with comments remained stable. The overall response rate was 17% with a comment rate of 56%. Most comments were positive and indicated positive actions are being taken, however as expected, there were comments that indicate the program can be a source of frustration for providers. Katie noted that prescriber frustrations may be related to a lack of prescriber understanding of the review process.

During the review of the program, Katie noted that criteria #3147 was set up to identify high risk members on multiple restricted medications with likely early refills. This provides a high volume of effective hits but, due to the expanded review volume, the Department feels an adjustment to the criteria may allow for additional hits for lower risk members that are also worthy of review. Board discussion supported changes to the criteria set up to look for members on 210 days of restricted medications in the last 90 days. A motion to accept the changes was made by **Mike Ochowski** with a second by **Paul Cesarz**. The Board voted unanimously to adopt the changes.

Retrospective DUR Cost Savings Analysis Estimate
In the interest of time, this topic was tabled until the June 2022 meeting.

Board Survey
Susan started the discussion by reminding the Board members of the survey they completed for the DUR work group. As part of the feedback received from the Board, a form was created to allow Board members to submit DUR topic recommendations or questions at any time during the year. Tiffany discussed how to complete and submit the form for topic review. Forms will be available in the June 2022 meeting packet and in each meeting packet thereafter. Additionally, Susan noted that an annual DUR work plan will be provided to the Board to provide insight into topics for meetings and to help cultivate topics for discussion. Lastly, feedback from the Board survey indicated an interest in having speakers from other DHS divisions present at DUR Board meetings. As a result, opportunities for speakers from other divisions are being explored.

Adjournment
Mike Ochowski motioned to adjourn. The meeting adjourned at 3:37 p.m. Upcoming meetings are on the following Wednesdays: June 8, 2022, September 14, 2022, December 7, 2022, and March 1, 2023.

Guests: Gary Behrens, Sanofi Genzyme; Doug Johnson, Sobi; Robert Robey, Indivior, Inc.; Kelly Ruhland, Lilly USA; Kelly Hamilton, Takeda; Matthew Wright, Artia Solutions; Erica Wolf, AbbVie; Jomy Joseph, Sanofi Genzyme; Kelly Petrowski, AbbVie; Lisa Tracz, Global Blood Therapeutics; Joe Payne, Horizon Therapeutics; David Large, Biohaven Pharmaceuticals; Danelle Caldwell, Dexcom; Bradley Kalkwarf, Regeneron; Richelle Andrae, Wisconsin Primary Health Care Association; Caroline Faber, Johnson & Johnson; Chris VanWynen, Sarepta Therapeutics; Kim Witte, Audentes Therapeutics; Karen Finn, Vifor Pharma; Michele Balint, Iovance Biotherapeutics; Stacey Repotski, Sanofi; Kaj Thompson, Johnson & Johnson; Jeff Knappen, Spark Therapeutics; Jeff Hayes, Insulet