MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, September 10, 2025
1:00 p.m. to 4:00 p.m.
Virtual meeting via Zoom

DUR Board Members Present:	Gainwell Staff Present:	DHS Staff Present:
Jake Olson, PharmD	Tom Olson, PharmD	Kim Wohler
Paul Cesarz, RPh	Ashley Beaderstadt	Lynn Radmer, RPh
Jeff Huebner, MD	Chally Clegg	Tiffany Reilly
Robert Factor, MD	Willie Wilberg, PharmD	Darla Stachowiak
Travis Copeland, MD	Katie Counts, PharmD	Pamela Appleby
Michael Ochowski, RPh	LaToya Lang	Susan Seibert
Brook Passolt, MD	Josh Wampler, PharmD	Nicole Schneider, PhD

Absent:
Ward Brown, MD

Welcome and Introductions
Kim Wohler called the meeting to order at 1:04 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, Kim provided technical instruction on how the meeting would proceed. A quorum of members attended the meeting. Kim also noted that Jordan Wulz had resigned his position as a Board member due to exciting opportunities that will make him unable to commit to serving on the Board after the June 2025 meeting. We appreciate his service and wish him all the best. Kim introduced Travis Copeland, who is newly appointed to the Board and thanked him for his willingness to serve on this important Board.

Review of the Agenda and Board Materials and Approval of June 2025 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 June minutes were briefly reviewed and approved with an initial motion from **Mike Ochowski** and a second from **Paul Cesarz**. The motion passed unanimously.

Quarterly DUR Reports
Lynn began by reviewing member enrollment. The enrolled member count does continue to be higher than in the past but continues to decrease due to the end of the public health emergency. Overall decrease of about 380,000 members since Q1 2023, our highest enrollment point. Board discussion in regard to enrollment included inquiries as to whether the Department has insight into why members are not re-enrolling and what happened to those members as far as transitioning to another medical coverage. She continued by pointing out that claim volume continues to trend downward. Lynn then reviewed the quarterly reports with the Board beginning with 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. There were two members identified in the last quarter. One of those members received an alert letter, and one was suppressed from a previous lock-in letter.

Lynn then presented graphs for the percentage of adults and children on stimulant medications. The percentage of children on stimulant medications remains cyclical due to the school year in this age group, but that trend has become less obvious in the data over time. The percentage of children has been down since COVID-19 public health emergency but now seems to be increasing and is close to the pre-public health emergency percentage. The percentage of children taking stimulants in the total Medicaid population is above the percent of adults now. There has been a sustained increase in use since 2020 in adults. The next slide is a comparison graph of children and adults within the total Medicaid population shows that the greatest increase of members receiving stimulants has been within the adult population. However, there has been a continued decrease beginning in 2023 of the adult population which is likely due to changes in enrollment status. Additional DUR alert trend graphs were presented. Lynn noted that most of the alerts are stable or decreasing, although the early refill alert has been trending upwards. A trend graph for high cumulative dose was also

presented. Lynn 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 because of this change. Lynn noted that the percentage of overrides has remained stable.

Next, an overview of claim volume was presented to the Board and the percentage of claims with a DUR alert per quarter has continued to remain stable overall and approximately 50% of paid claims are paid with no DUR alerts. She also noted that less than 1% of paid claims have multiple DUR alerts. Slides were presented to review claim count changes. Claim volume continues to decrease. The claim volume from Q2 2024 to Q2 2025 has decreased by about 170,000 claims. Lynn noted that the changing member population and policy changes could be a component of the decreasing claims volume. Trend graphs for average morphine milligram equivalents (MMEs) per member per day and members utilizing buprenorphine from 2022 - 2025 were also included. The average MME has hovered around 41MME for about a year and continues to remain stable. Upon presenting the members on buprenorphine graph it was noted that historically, as the overall average MME has decreased, the overall use of buprenorphine has increased. However, there has been a slight decrease in the number of members on buprenorphine over the last four quarters. While this may be a result of enrollment changes, the trend was further investigated to reveal that when looking at the percentage of members on buprenorphine, there is still an increase in use over time.

Naloxone Use Updates

Two graphs were presented to the Board looking at naloxone member trends from 2022-2025. Naloxone usage has continued to be steady. Further analysis of the trend graph was done based on opioid use and MME levels. This analysis continues to reveal 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). A third graph with data on the use of naloxone in non-opioid use members revealed that the percentage of members on buprenorphine continues to change and is now at 36%, down from 52% a year ago. Lynn presented a slide which was introduced at the December 2022 meeting, tracking naloxone fills for members at 90 MME or greater. From Q3 2022 to Q2 2025, we saw a reduction in members with 90 MME as well as a reduction in naloxone dispensed. The average percentage of members with 90 MME or greater and receiving a naloxone fill in Q2 2025 was 10%, with the average fill rate over time being 12%. Additionally, a second slide was presented tracking naloxone fills for members receiving buprenorphine for opioid use disorder (OUD). For about a year we have seen a decrease in members with OUD as well as in naloxone dispensed. The average percentage of members with OUD and receiving a naloxone fill in Q2 2025 was 7%, with the average fill rate being 9%. It was noted that the slight drop in members and naloxone fills may be a result of the enrollment changes. A graph with the percentage of members taking opioids or opioid dependency agents and also getting buprenorphine since 2018 was shared. The graph indicated an increased dispensing until about Q3 2023, but a recent upward trend continues.

Opioid Script Limit

Lynn began by presenting the average MME by override graph. There was a decrease in the average MME by override over the last three quarters that brought the average back down to where it had been for the last year. There is a process in place to review high MME outlier claims. The top five claims are reviewed each quarter for possible intervention. There were no members referred to Acentra for possible lock-in for this quarter. The percentage of override trend was also presented, and overrides are consistently issued for less than 0.5% of the total opioid claims. While the opioid script limit policy impacts a very small number of claims, trends indicated it is an effective policy.

Multiple CNS Depressants

Lynn began by reminding the Board that this is a quarterly intervention. The current methodology for inclusion has been in place since Q1 2022. The 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, and are receiving 45 or more actual days' supply of each of the four medications during the quarter. The members must have a claim for each drug class in the last month of the quarter. The selected members are reviewed, and a letter is sent to prescribers regarding the risks of the noted polypharmacy. Letters are sent quarterly to providers of newly identified members and annually to prescribers of previously identified members. A full refresh of all identified members is done in the second quarter each year. For Q2 2025, there were 146 members on all four drugs, 59 members with 45 or more total days' supply, and all 59 members were selected for intervention because Q2 2025 was a reset quarter. Lynn reminded the Board that all of these numbers can be located and will be updated quarterly on the continuing intervention spreadsheet.

Continuing Interventions

Lynn closed out the Updates and Quarterly Reports with a review of the Continuing Intervention spreadsheet. She reminded the Board that the retrospective high MME intervention was changed in October 2024 to identify members on 120 MME or more per day. This was a decrease from 150 MME per day. The volume of members identified continues to be larger, as expected. She also reminded the Board that the Opioid/Benzodiazepine intervention is an ongoing quarterly intervention. There are two phases to this intervention. The phase one letters are focused on members who have chronic opioid (non-medication-assisted treatment), and benzodiazepine use and who exceed 50 MMEs per day. Chronic use is defined as 90 days each of opioids and benzodiazepines in 90 days. The phase two letters involve members who have chronic opioid (non-medication-assisted treatment), and benzodiazepine use and who exceeded 50MMEs per day, but phase two specifically identifies the top prescribers with members meeting the criteria and who previously received the phase one letter. Phase one letters were sent to all prescribers in August 2025 as part of a yearly reset. Lynn went on to discuss the two types of monthly Sickle Cell disease interventions. These interventions identify members with underutilization of disease modifiers and overutilization of opioids with concurrent underutilization of disease modifiers. She noted that, as expected, the volume of letters is small. Lastly, Lynn discussed the polypharmacy of sedating medications in children. She reminded the Board that this intervention identifies pediatric members that have claims for three or more drug groups for at least 80% of the time in an 180-day period. Letters are sent every six months, with the next set being mailed in September 2025. The data for all these interventions is available on the Continuing Interventions spreadsheet.

Department Guidelines and Bylaws

Tiffany began the discussion by reminding the Board that the proposed updates being reviewed were sent to them in the meeting materials packet. Prior to reviewing the proposed updates, she indicated that the last time these guidelines and bylaws were updated was in 2017. The rationale for the current update is to bring Wisconsin's Board guidelines into alignment with Federal guidelines. Proposed updates were presented for the following sections: Composition and Membership (Section B), Replacement of Members (Section D), Duties and Responsibilities (Section F), Meetings (Section G), and Confidentiality and Immunity (Section H). Board members were asked to share any comments or concerns with the updates. No issues were brought forth by the Board. Kim Wohler asked for a motion to approve the recommendations. An initial motion was made by **Dr. Travis Copeland** and a second by **Mike Ochowski**. The motion passed unanimously.

Anticholinergic Medication Use Discussion

Lynn began the discussion by reminding the Board members of the history of the intervention. She indicated that recommendations from a required evaluation of the SeniorCare program were received in 2024. The evaluation indicated a possible issue with duplicate anticholinergic use in the SeniorCare population. To address this issue, a focused intervention was created that reviewed duplicate anticholinergic therapy in all members 65 years of age and older. Medications selected for inclusion in the intervention came from multiple sources. The evaluation report provided a list of medications as a foundation, then more medications were selected based on existing anticholinergic criteria, and a literature review identified additional medications of concern. The new criteria was created and implemented for the April 2024 cycle. Katie went on to remind the Board of the criteria alert message and parameters used for selection. She also shared data on the first three cycles of the intervention (April, May, and June 2024), including updates made to the medications included in the intervention for the May 2024 cycle. She finished this portion of the discussion by indicating that an impact analysis for the June 2024 cycle was completed for this criteria.

Lynn continued the discussion by presenting the findings of the impact analysis. She indicated that this particular impact analysis was a joint effort between Acentra and Gainwell due to the fact that the intervention was an Acentra intervention. Acentra was able to provide member data to Gainwell that included members who were identified for the initial intervention and those who continued to be identified for intervention 6 months later. This minimized any discrepancies that can arise when Gainwell tries to replicate Acentra criteria in their system. Lynn noted that of the 115 members identified for the initial intervention, 107 were available for reassessment. She indicated that 57% of those members (61 members) were not identified for intervention 6 months after the initial intervention. She went on to differentiate the reasons why those members were no longer being identified for intervention. She also discussed how this impact analysis varied from the standard impact analysis. She reiterated that it was a collaborative effort, that the analysis time period was shorter at six months versus the standard one year, and that data review was performed by both Gainwell and Acentra. She finished the discussion stating that this intervention will be continued on a quarterly basis, and she shared the data for the intervention since the September 2024 cycle.

Long-term Use of High Dose Benzodiazepines Intervention Discussion
Dr. Copeland began the update discussion by reminding the Board that at the last meeting the criteria parameters for inclusion in this intervention were updated. There were some members being included or excluded from the intervention based on an inaccurate average daily dose. Additionally, the code was not applying the 80% long-term use threshold and was also inadvertently including or excluding members based on which medication was filled during the last month of the period. These errors were corrected. He went on to discuss other changes that included removing the requirement that prescribers only receive letters if they have at least two members exceeding the dose threshold for the identified drugs. This parameter was updated to include prescribers of any member exceeding the dose threshold that have two or more claims for the member in the data period. He reviewed the rest of the parameters for the intervention that remained unchanged and indicated that letters would be mailed to all prescribers meeting the requirements in September 2025 (for a data period of January – June 2025). He also presented data for letter volume with the implemented code corrections. The code corrections and updates did result in a higher volume of members and prescribers being identified for the intervention. The member/prescriber combinations increased from 271 using the previous methodology to 468 using the updated methodology. This increase was expected.

Underutilization Discussion
Katie began the discussion by reminding the Board of the prospective DUR late refill alert presentation at the June 2024 meeting. She noted that based on the top drugs identified via the DUR late refill alert, Acentra performed a focused underutilization intervention in July 2024 for the following medications: citalopram, escitalopram, fluoxetine, sertraline, duloxetine, vilazodone, vortioxetine, and montelukast. An additional subset of antidepressants was identified by the DUR workgroup for intervention in September 2024 (bupropion, paroxetine, venlafaxine, and desvenlafaxine). The Board was reminded that a second review of all previously identified antidepressants and montelukast was completed in January 2025. Those members identified for intervention in January were reevaluated six months later to see if they were still being identified for underutilization patterns. Data presented for all the antidepressants and montelukast included the number of members identified in January, the number of members who were still identified six months later, the number of ineligible members excluded from evaluation, and the intervention response rate. Katie noted that intervention response rate is very high and ranged from 80 – 100% response. She noted that these rates are likely overinflated given the nature of the identification for inclusion in the intervention. It is difficult to accurately identify the absence of use of a medication when the system must identify the presence of use of the medication to include the member for review.

Dr. Copland continued the discussion by elaborating on clinical challenges that may also contribute to why a member may be identified as being non-compliant with their medication regimen. He noted that it can be difficult to distinguish between non-compliance and discontinuation of a medication. Additionally, he indicated that medication changes may be identified as underutilization, as well as changes in dosing frequency. These types of adjustments can be difficult to identify based only on pharmacy claims data. Lastly, he indicated that literature does support variability in medication utilization in some member populations based on age. Given the inherent difficulty to accurately assess non-compliance with pharmacy claims as the sole source of information, the underutilization of antidepressants and montelukast will not continue as a focused intervention but will remain standard criteria that will be addressed during the normal review process. Additional data and analysis for subgroups based on age may be considered for a future targeted intervention.

CMS Annual Report & PDMP Survey
Lynn began by reminding the Board that CMS requires each Medicaid program to submit an annual report detailing the DUR activity for the federal fiscal year. Each year this report is due June 30th. A link to the CMS website for viewing annual reports was provided. She went on to review the sections contained in the annual report and indicated that the "Fraud, Waste and Abuse" section is the largest and most detailed section of the report. This section addresses many topics Lock-In, Prescription Drug Monitoring Program (PDMP), Opioids, MME requirements, opioid use disorder treatment, outpatient treatment programs, and antipsychotic and stimulant use. Lynn went on to further discuss requirements for the Prescription Drug Monitoring Program (PDMP). Lynn provided background information on this section indicating that the SUPPORT Act of 2018 required all providers to check the PDMP prior to prescribing controlled substance medications for a Medicaid member. Additionally, it is required that the Medicaid programs report compliance with this regulation to CMS as part of the annual report. To fulfill this requirement, DHS contracted with Mercer to administer a survey regarding PDMP use by Wisconsin Medicaid enrolled prescribers. The survey was used to determine the self-reported frequency that prescribers check the PDMP prior to prescribing controlled substances. Provider inclusion parameters were based on controlled substance prescribing data from October 2023 to September 2024. A statistically significant number of

prescribers were selected for inclusion in the survey. Opportunities to complete the survey online or via fax were provided for a four-week period in February 2025. The survey results indicate that prescribers are checking the PDMP prior to writing a prescription for a controlled substance 90% of the time. This is an improvement from 83% reported for last year's report.

Lynn continued the discussion with a more in-depth review of sub-section G in the ""Fraud, Waste and Abuse" section of the report. This sub-section addresses monitoring of psychotropic medications. She indicated there are already requirements to monitor the use of these medications in children, but that there are new requirements to expand antipsychotic monitoring to the adult population, including those members who reside in institutional care settings. She discussed the new questions within the section and shared how those questions were answered by Wisconsin. She did indicate that there are data limitations that impact the ability to monitor adults in institutional settings and that there is little guidance from CMS on how to approach development of these programs. The data issues are not specific to Wisconsin. This is a widespread issue in many State programs. Despite these difficulties, monitoring programs are required to be in place by March of 2026. She indicated that Dr. Copeland will be presenting how Wisconsin plans to address monitoring these medications in the adult population.

Antipsychotic Use in Adults

Following Lynn's review of new CMS requirements for antipsychotic monitoring in adults, Dr. Copland began the discussion by providing an overview of the antipsychotic monitoring that is already in place for children. He reminded the Board that monitoring for children has been in place since 2012 and currently multiple programs are in place including prior authorization for children under the age of nine, clinical reviews for children ages 9 – 18 for multiple antipsychotic use which can include peer to peer outreach, and letters and possible outreach for polypharmacy of sedating medications in children 18 and under. He further reminded the Board that the legislation mandates state Medicaid programs to monitor antipsychotic use in members over the age of 18. The legislation requires monitoring of members in home and community settings, as well as those in institutional settings. Dr. Copeland went on to discuss parameters that should be considered while creating this new intervention and challenges associated with these parameters. He indicated that appropriate prescribing patterns, including polypharmacy and dosing, could be included. Also, diagnostically appropriate prescribing may be considered, but there can be issues with incomplete data due to medical coding issues. The last consideration is identifying members in the appropriate care settings. Data limitations do exist that can preclude accurate identification of the care setting, making it difficult to restrict an intervention based on this parameter. Given the data limitations, the decision was made to focus on polypharmacy of antipsychotics, specifically the use of multiple antipsychotics, and broadly apply this intervention to members of all ages and all care settings.

Dr. Copeland continued the discussion by reviewing data for Wisconsin Medicaid members receiving antipsychotics. The data was stratified by age and the number of antipsychotics. He indicated that most members were on one or two medications. He stated national data indicates that 15-30% of adults are on two antipsychotics and that adult members in Wisconsin Medicaid fall into that range. Additional data was shared that provided the volume of use for all antipsychotic medications based on age, as well as the top medications involved in polypharmacy. Dr. Copeland went on to share that based on data from the first six months of 2025, children are infrequently chronically prescribed two or more antipsychotics, and adults are infrequently prescribed three or more antipsychotics. Based on this data, these thresholds will be used in the development of intervention letters. Letters will be developed based on patient age and will identify children (0-18) that are taking two or more antipsychotics and adults (19 years of age and older) taking three or more antipsychotics for 80% of the time in an 180-day period. Letters will be sent every six months with one year between letters regarding an individual member. Additionally, profile reviews with possible outreach will be performed on adult members who are on four or more antipsychotics. There is very little overlap expected with children identified in other antipsychotic monitoring programs. Board discussion included considering monitoring diagnoses for use and appropriate dosing.

Diabetes Guidelines Discussion

Katie began the discussion by providing the Board with background information that prompted the creation of an intervention to identify concurrent therapy with DPP-4 inhibitors and GLP-1 receptor agonists. She noted that an email was sent in a large contact group of State Medicaid Drug Utilization Review programs inquiring how programs were addressing the updated 2025 treatment guidelines from the American Diabetes Association (ADA) that specifically indicates concurrent use of DPP-4 inhibitors with a GLP-1 RA or dual GIP/GLP-1 RA is not recommended. Katie then provided the Board with a review of the ADA guidelines, including this specific recommendation in section 9

“Pharmacologic Approaches to Glycemic Treatment”. The rationale for the recommendation is that both classes of medication act on the same incretin pathway and that there is evidence of a lack of additional glucose-lowering benefit beyond what is achieved with GLP-1 RA alone. She also noted that this data has been available for many years and provided possible rationale as to why the ADA has waited until now to address this issue specifically. A deep review of several sets of guidelines indicated that this recommendation was either clearly written or implied within the treatment algorithms at one time, but due to new iterations of those algorithms over the years the clear recommendation against concurrent use was lost. Both the American Association of Clinical Endocrinology (AACE) guidelines and the ADA guidelines now clearly indicate that concurrent use of DPP-4 inhibitors with a GLP-1 RA or dual GIP/GLP-1 RA is not recommended.

Katie continued the discussion by informing the Board that other states indicated multiple methods of addressing this issue including prior authorization, prospective DUR edits (ProDUR), and retrospective DUR interventions (RDUR). She noted that a ProDUR edit is not available for use for this duplication of therapy. Thus, an RDUR criteria review for Wisconsin was completed, which showed that a systematic intervention was available but not active, thus the intervention was implemented for the June 2025 cycle. She reviewed the criteria parameters and alert message sent to prescribers. Additionally, data for the June, July, and August 2025 cycles were provided. It was noted that it does not appear this issue of concurrent use is limited to a small set of prescribers. As a result, it was decided that this intervention should become a focused intervention to be performed every six months. Katie also noted that members from the initial June 2025 cycle will be reevaluated and presented at the March 2026 meeting. Board discussion included suggestions for addressing this issue in other ways in addition to the intervention letters. The Board feels that prescriber education to all prescribers, not just those identified by the intervention, is important.

Adjournment
Mike Ochowski motioned to adjourn the meeting. The meeting adjourned at 3:59 p.m. Upcoming meetings are on the following Wednesdays: December 3, 2025, March 4, 2026, June 3, 2026, and September 2, 2026.

Guests: Robyn Bruining and Ciby Chacko, Sanofi; Matt John, Otsuka; Ian Sutker, Otsuka; Marissa Woodward, Abbott; Scott Mills, Bristol Myers Squibb; Jenna Doerr, Artia Solutions; Sherri Werner and Dan Calloway, Intra-Cellular Therapies; David Large, Chiesi Global Rare Disease; Bill Eicholzer, PTC Therapeutics; Todd Kailas, Alkermes; Laura Etheridge, SK Life Science; Gary Parenteau, Dexcom; Sherry Betthauser, Jazz Pharmaceuticals; Mike Donabedian, Sarepta Therapeutics; Brent Fushimi, UCB Pharma; Marc Parker VS Health Group; Max Wattenmaker, Favus Institutional Research.