DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, June 4, 2008
1:00 P.M. to 4:00 P.M.
1 W. Wilson Street, Room 751
Madison, WI

DUR Board Members Present:	Robert Breslow, RPh Ward Brown, MD Patrick Cory, PharmD Daniel Erickson, MD Robert Factor, MD Franklin La Dien, RPh Michael Ochowski, RPh Nancy Ranum, MS, RN, CS-ANP, APNP
DHCAA:	Rita Hallett, MA, RN Lynn Radmer, RPh James Vavra
APS Healthcare, Inc.:	Debbie Matitz (squire) Michael Mergener, RPh, PhD
Guests:	Dareen Bleibel – UW School of Pharmacy John Bullard – Amgen Dean Groth – Pfizer Cheryl Holliday – Gunderson Lutheran Hisham Ismai – Amgen Lydia Leung – UW School of Pharmacy Susan Schmitz – GSK Casie Walsh – UW School of Pharmacy

Minutes

James Vavra called the meeting to order at 1:10 p.m.

I. Approval of Agenda

II. Approval of Minutes – March 5, 2008 Meeting

Dr. Factor requested his November 2007 minutes revisions be resent to him; delete any references to Dr. Breslow in the March 5, 2008 minutes.

III. Introduction of New Board Members

Six new members have been appointed to the DUR Board, two of which are in attendance today - Patrick Cory with Unity Health Plans and Michael Ochowski with Group Health Cooperative of SC Wisconsin.

IV. Overview of DUR Board Responsibilities, New Bylaws and Conflict of Interest (Attachment 1)

Rita Hallett distributed copies of the current DUR Board Bylaws.

Rita presented "BadgerCare Plus Medicaid and SeniorCare Pharmacy," a general overview of pharmacy coverage, and the functions and responsibilities of outside boards, including the DUR Board.

Coverage. Under Federal law, Medicaid (MA) has to cover any drug that is FDA approved where the manufacturer has signed a rebate agreement with the Centers for Medicare and Medicaid Services (CMS) and reported RPU information with certain exceptions. The drug rebate agreement requires that all manufacturers pay a rebate of at least 15.1% for brand name drugs and 11% for generics off of the average manufacturer's price as reported to CMS. Should a manufacturer raise a drug price above CPI, it must also be rebated. If brand name drugs have been on the market a long time, we may get 25-30% of the cost of the drug rebated to us which is a base all state MA programs follow. We are allowed certain restrictions (e.g., require Prior Authorization (PA), diagnosis restriction, quantity limits). Unlike other insurance plans, MA cannot have a formulary per se – we can require PA, but if a drug is medically necessary and it meets the required criteria, then MA must cover it. The Pharmacy PA Committee recommends drugs for the Preferred Drug List (PDA) and Provider Synergies assists with that by providing the Committee with clinical research of the various drug classes being reviewed. They also work with manufacturers about supplemental rebate offers. The PA Committee (statutorily mandated), is comprised of physicians, pharmacists and advocates from around the state, meets twice a year and currently reviews over 60 classes of drugs (30+ at each meeting). There is also a Mental Health Advisory Committee (not statutorily mandated) that weighs in on the recommendations of the Pharmacy PA Committee about mental health drugs that were reviewed. Meeting structure consists of public testimony in the morning, followed by closed session for discussion of proprietary rebate information. Open session then occurs for discussion of the drugs and a vote on recommendations which go to the Department Secretary for final decision. The next meeting is August 6, 2008 with July 7, 2008 as the starting date for public testimony sign-up.

Drug Utilization Review (DUR). Federal law requires that every state MA program have both a DUR Program and DUR Board. DUR activities have to include retrospective and prospective DUR as well as educational interventions. The purpose is to improve the quality of pharmaceutical care by insuring prescriptions are appropriate, medically necessary and not likely to result in adverse medical results. Cost effectiveness is not a component per se, but often occurs with appropriate use of medications. The responsibilities of the DUR Board include reviewing and making recommendations about predetermined standards for retrospective and prospective DUR, and evaluating the use of predetermined standards concerning any modification or elimination of existing standards or adding new ones.

Prospective DUR is aimed toward the pharmacist because it alerts the pharmacist at the time of dispensing, while retrospective DUR is aimed at the prescribers because it is done

after drugs are dispensed. Paid claims are run through the retrospective DUR cycle on a monthly basis. Claims also run through the Decision Support (DSS) tool which identifies potential fraud and abuse by identifying potential abusers of the system, multiple narcotics, and multiple prescribers of narcotics. All information is then reviewed by APS pharmacists to determine any follow-up to be done and to identify potential lock-in candidates. A scoring system in the DSS tool scores a person based on an accumulation of factors and floats the highest number of scores to the top providing preliminary recommendations. The pharmacist then reviews all cases and makes recommendations to the State for final sign-off. There are approximately 150 members currently in the lock-in program, resulting in a large volume of letters going out. The criteria for these letters are recommended by the DUR Board.

The DUR Board also recommends educational interventions to improve prescribing and dispensing practices. The most recent example of this is the atypical antipsychotic intervention.

Action Item: The DUR Board focus on 2 to 3 targeted interventions per year.

V. Break

VI. Annual DUR Report – CMS; Internal (Attachment 2)

Mike Mergener presented on the Annual DUR report to CMS. The Executive Summary incapsulates the report and basically states we are in compliance with federal regulations. We estimate cost savings by using the algorithm provided by HID (our retrospective DUR vendor) which looks at pre-post analysis of drug costs for cases we've alerted on and then takes a randomly chosen comparison group with the same number of cases looking at those pre and post costs. To estimate prospective DUR cost savings, an example is with early refill (ER) alerts -- we look forward one month and if there is an ER alert that was not overridden by the pharmacist, we look to see whether or not the same drug was filled. Savings are not counted unless it was not filled for 30 days plus the grace period. If it wasn't filled, it is then considered an ER and savings are calculated. With other clinical interventions, we look forward 7 days. The system does not currently look at whether a different drug was dispensed as a result of an alert.

The next set of handouts in attachment 2 summarizes the scope and volume of reviews. The first chart displays the number of retrospective DUR profile reviews the pharmacy staff performed in calendar year 2007 (approximately 500 reviews per month). The process for profile reviews is: 1) HID gets a claims extract of all claims, including diagnoses from medical claims, and those are entered into the HID engine and run against the Board-approved criteria. 2) The system also assigns points to a variety of claims characteristics. The point accumulation filters to the top and selects various levels of severity – typically, the high severity cases are reviewed. We get a 13-month drug history of the patient with profiles and history diagnosis going back 14 years, exception being the SeniorCare population due to lack of diagnosis data because we only process pharmacy claims. 3) The pharmacy staff does the reviews and determines for every case whether or not an intervention letter should be sent to the prescriber. The next chart displays approximately how many letters were sent out in calendar year 2007.

The next 4 pages are the interventions that were performed broken down by yield – meaning whenever we reviewed an alert, what the percentage of time was that a letter was actually sent out. The key to the unlabeled column with ER, DD, etc, is on the 3rd page (please note: add "ER – overutilization" to that key) which shows how often we alert on a case and ranks them by number of reviews that have been done. After printing, letters are reviewed again to determine if the letter should be sent (e.g. could be a bad address). Once a letter is sent, a prescriber is exempted from getting another letter for 6 months for the identical problem. If in 6 months the same problem is occurring, another letter may be sent dependent on the severity of the problem or response received. A response form is sent with each letter – we've historically received a 60-65% response rate. Responses are coded into the system so when we do a profile review and there's been a response, that response is reviewed by the pharmacist. Because responses are self-report, the true way to look at those is by doing a pre and post claims analysis.

The next section is background on prospective DUR and volume of alerts sent out. The data reported is for a random week in September 2007 and in that week, there were 149,000 claims processed with the distinct Internal Control Numbers (ICNs) that were alerted on and the percent of all alerts adds up to 100%. The NS alert sets for 3 types of opportunities: dose consolidation, tablet splitting and 100 day supply. The next column shows the total number of actual responses divided by total number of claims to give an idea of pharmacist burden. This is again primary alert first and follows the predetermined hierarchy determined by the Board. For ER, we use 25% as the grace period so if 75% of the drugs should have been expended, the alert will not hit. With a late refill, if they are 125%, the alert sets. One thing we do slightly differently than other plans is with the response that is sent back to the pharmacy. When we send an ER alert, even if they come in on day 23 and the alert hits, we say the patient has 8 more days of therapy left rather than if the patient comes in tomorrow, the alert will not hit. If an alert triggers and the pharmacist overrides it, the next ER alert is triggered from the fill date. We would like the pharmacists to exert their professional judgment because it is their responsibility to be aware of drug-drug interactions or other issues regarding the safe and effective use of drugs. Mr. Breslow suggested an educational opportunity would be to refresh people on some of these issues. Dr. Erickson suggested doing an intervention to notify prescriber/pharmacists going back 6 months and do a history of their drug use.

The next 2 pages summarize what the pharmacist reports he does when he doesn't override. This indicates that 30-35% of ER alerts are overridden by the pharmacist. The first page is what action was taken once the pharmacist got the alert. Since the pharmacist pays a small switch fee for each response, he may not send back a transaction indicating he did not fill the prescription. Michael Ochowski questioned if we've ever looked at a subset of patients (e.g lock-in patients) and Dr. Mergener confirmed we have not. The next page indicates what the pharmacist responded he did as a result of the alert and 86% of the time they are filling it as is.

Action Items:

- Revisit the 75% percentile internally, as well as reviewing people over a specific period of time.
- At the September 2008 meeting, Dr. Mergener will present an evaluation of the atypical antipsychotics intervention.
- Semiannually, the DUR Board review all Board-approved criteria.

- Dr. Mergener provide a comprehensive review of prospective DUR alerts and present to the Board for review.
- At upcoming HID session, Dr. Mergener discuss the possibility of additional scoring parameters.
- With pharmacists' actions in response to prospective DUR alerts, use a subset of patients (e.g., lockin).

VII. Potential Changes to Prospective DUR Alerts

Dr. Mergener explained the State has approached the vendor with ideas for additional endeavors that would provide additional cost savings to the drug budget. EDS is working on the implementation plans for a number of proposals to present to the State. Cost containment ideas being considered include:

- Hard alerts on ERs for certain subsets of drugs with implementation of those over a period of time and as a result, implementing a call center.
- Changing the percentile for ER from 75% to 90%.
- Applying quantity limits on certain medications – currently have limits on triptans, but there may be additional opportunities. In some cases, quantity limits will force dose consolidation and also control doses that do not work correctly.
- Tablet splitting – this will be on a small group of drugs. Other issues to address with this are tablet breakage and early refills.

Details for all of these items are currently being worked on and will be shared with the DUR Board at future meetings.

Action Items:

- Amend the DUR bylaws where we address "clinically appropriate prescribing and clinically appropriate dispensing" by adding "cost effective prescribing".
- Revisit the issue of making 100-day supply mandatory. One thought is for those drugs currently on the list that are not being filled in 100 days, rank pharmacies by the number of prescriptions they have for which they are not compliant and do an intervention with those pharmacies.
- The Board members should consider how to educate prescribers and dispensers about prospective DUR changes and bring their recommendations to the September 3, 2008 DUR Board Meeting.

VIII. Update on Retrospective DUR Criteria for Migraine Prophylaxis

In response to Nancy Ranum's request, Dr. Mergener presented an update on migraine prophylaxis. Even though this produced hits, a gap appeared with prescriptions so it was not enough to determine prophylactic therapy. He cannot comment on the responses received as he did not see them.

Action Item: Dr. Mergener will follow-up on the responses received.

IX. Adjournment

The meeting adjourned at 4:05 p.m. The next meeting is scheduled for September 3, 2008.