MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, June 5, 2013
1:00 pm to 4:00 pm
1 W. Wilson Street, Room 630
Madison, WI 53701

DUR Board Members
Present:
Maria Brenny-Fitzpatrick RN, MSN FNP-C, GNP-C
Robert Breslow, RPh
Michael Brown, PharmD
Ward Brown, MD
Paul Cesarz, RPh
Daniel Erickson, MD
Robert Factor, MD
Jake Olson, PharmD
Absent:
Michael Ochowski, RPh
Lora Wiggins, MD

HP Staff
Teai Czajka
Tom Olson, PharmD
Monica Yeazel, RPh

DHS Staff
Rachel Currans-Henry
Lynn Radmer, RPh
Lisa Reese
Kay Reniero
Kimberly Smithers

Welcome and Introductions:
Rachel Currans-Henry called the meeting to order at 1:05 pm, with thanks to the Board. Introductions were made.
Review of the Agenda and Board Materials and Approval of Minutes-March 6, 2013 meeting:
Rachel Currans-Henry walked through the agenda as printed and the Board packets. Members had received minutes and RDUR Quarterly Report via email and had the opportunity to review prior to this meeting. Rachel added a Budget Update to the Agenda. With a quorum present, Rachel asked for a motion on the minutes.
Motion to approve minutes as printed made by Paul Cesarz and seconded by Michael Brown. Motion passed unanimously.
Prospective DUR: Update on Previously Reviewed Alerts:
Lynn Radmer reviewed the status of Prospective DUR alerts changes to date. Specifically High Dose alert plan was explained. Alert had small number of drugs and doses. Plan is to turn off alert, and use FDB drugs and doses running in informational mode for a trial period. This has not been accomplished due to complexity of interrelated systems, but is still the plan.
Three Month Supply Policy Review and Discussion:
Lynn began a walkthrough of the Three Month Supply (TMS) Policy, explaining it encompasses multiple parts:

- Insufficient Supply (NS Prospective Alert), TMS/100 day supply, DAPO Hard Alert
    - Prospective DUR (NS) Alert- soft alert to pharmacy, if drugs on list not dispensed in 3 month supply, stops claim, alert says can be dispensed in TMS, pharmacy can override at point of sale (POS).
    - Permissive drug list-no alert to pharmacy, up to 100 days supply goes through.
    - DAPO Hard Alert- claims for drugs on list stopped at POS if not dispensed in TMS, to dispense in less than TMS pharmacy must call Drug Authorization and Policy Override (DAPO) call center to get override.
- Goal is to simplify and make more manageable the TMS Policy and maintain the drug list.
- Further explanation of three policies
    - Permissive TMS: Pharmacy gets no alert, but can dispense a TMS. There is no published list of what drugs are allowed. The drugs included were born of Admin code 107, which allows a TMS supply for certain drugs.
    - Prospective DUR (NS): Pharmacy will get alert on claims that can be dispensed in TMS if the days supply is less than 84 days. Drug has to be on list which was determined by state staff several years ago. The list has not been maintained.

- DAPO hard alert: DAPO is the pharmacy call center that pharmacies can call to request an override when they get a hard stop. Member must be considered to be stable on the drug, determined by at least 90 days supply of the drug in the past 120 days. Pharmacy will get a hard alert if the days supply on the current claim is <84 days. Drug list is generally low cost, generic, maintenance meds for chronic conditions; originally intended as cost savings measure by reducing the number of prescription dispensing fees.

- Prospective (NS) was built as a stop gap measure several years ago before the DAPO hard alert. The NS was meant as a transition until the claim system audit of a 90 days supply of a drug in the past 120 days was available. Although the DAPO hard alert was implemented a couple years ago, the Prospective NS alert did not get changed.
- Discussion about members who have private insurance that allows only a 30 day supply and MA requires TMS . Correct action is for pharmacy to call DAPO and get override to allow 30 days and have private insurance pay, and then coordinate payment with MA.
- Statistics for 1st Quarter 2013:
  - NS Soft Alert: 99 drugs set alert, 127k alerts, overridden 77% of the time and changed to TMS 0.5% of the time. It is high in frequency and low in hierarchy.
  - DAPO Hard Alert: 328 drugs (each strength counts as one) set alert, ~47k alerts, DAPO override granted 23% of the time and changed to TMS 52% of the time.
  - Nursing home claims get informational alerts only.
  - Missing percentages are denied claims, pharmacy did not rebill within the same day.
- Pharmacies can get paid for MTM level one interventions service if they contact prescriber to get prescription changed to TMS.
- Maintenance plan: update TMS drug lists, consolidated into 2 lists; either Hard, or Permissive. If we remove the NS alert that stops claim, should we consider an informational message with the paid claim response to alert the pharmacy that TMS is allowed for this drug? Want to update the TMS drug list and simplify the policy. Plan to eliminate soft alert, and publish one list of TMS drugs that identifies required, or permissive. Hard alert would still filter for stable therapy. Different strengths of same drug would all be grouped together, either all permissive or all hard stop. Drug list would be published for providers.
- Permissive list allows for professional judgment and indications to dictate what supply is appropriate. Some drugs on permissive list are ones (e.g. antidepressants, warfarin) where TMS may not always be appropriate.
- Discussion about how DAPO alert displays in pharmacy's software. Pharmacists will look for truncations. Prescribers should be writing for 90 days whenever appropriate to avoid excess calling.

❖ **Staff Recommendation**: Update the three month supply drug lists and consolidate into two lists 1) DAPO Alert, where the TMS is required if member is on stable therapy (90 days in past 120 days) and 2) Permissive TMS, where the permissive list drug claims get an informational claim message regarding "three month supply opportunity" after the claim is paid. Policy does not apply to compound claims. TMS drug lists will be maintained by state staff and will no longer be handled as Prospective DUR.

- **Motion** made to accept staff recommendation made by Ward Brown, seconded by Jake Olson. Unanimous yes vote. Motion carries.

High Dose Stimulant Discussion:

Lynn Radmer explained the Department has two child and adolescent psychiatrists consulting on a range of issues, now focused temporarily on high dose stimulant use in children 14 years of age and younger. The Board had previously been presented some possible high doses for stimulants. Within the workgroup, the dosages of concern for this population were refined and include a margin for overlapping doses, early refills, etc. Data analysis has considered 125% of maximum dose, and looked at a 6 month period and if member is exceeding max doses and fall into the 125% data analysis, those members may be considered for future intervention. The Department is interested in getting Board support for doses that have been established, the overage threshold, and agreeement to make this a future targeted intervention.

- Max daily doses for age 14 and younger as determined by the psychiatrist workgroup are as follows: Adderall=60mg, Concerta=72mg, Daytrana=30mg, Focalin=30mg, methylphenidate=60mg, Vyvanse=70mg.

- For the 6 month period of 4th Quarter 2012 and 1st Quarter 2013, 385 members were identified as having exceeded the 125% dosage threshold. Prescribers were from a variety of specialty groups, the largest of which was pediatricians. Members as young as age 6 were identified as having exceeded these doses.
- Focalin is the leader in high dosing, with 180 members exceeding the 125% threshold in the 6 month analysis.
- Particular concern of potential for diversion of these drugs to parents and caregivers, kids not getting them, thus the dose is "not working" and needs to be escalated.
- Discussion of some 11 to 14 year olds may have body size of adults, but still concern over brain development at that age.
- Dosages were arrived at based on FDA dosing guidelines where available, other published literature, State of Texas published thresholds, and professional experience. Targeted intervention would be educational, but also intend to make this a more emphatic letter that requires some sort of meaningful response or justification from the prescriber.
- Discussion that while government can't mandate dosages, there is obligation to look out for the welfare of children. Would the Board back up the psychiatrist workgroup in the work they've done. The antipsychotic targeted intervention model worked well, and we should repeat now with stimulants.

❖ **Staff Recommendation**: Bring the dose thresholds to the Mental Health Advisors Group meeting on June 18th and work to develop a targeted intervention letter with the child and adolescent psychiatry consultants.

- **Motion** made to accept staff recommendation made by Bob Factor, seconded by Paul Cesarz. Unanimous yes vote. Motion carries.
- Board will have opportunity to review the Targeted Intervention letter.

RDUR Focused Criteria Selection Discussion:

Monica Yeazel presented the option of focusing RDUR reviews on current issue of stimulants.

- Reminded Board how member profiles are currently chosen for review based on overall risk score of the member (taking into account age, number of prescriptions, prescribers, pharmacies, etc). This method in theory may result in profile reviews of members with the highest potential need for interventions.
- Suggestion of doing a one cycle RDUR review focused solely on criteria related to stimulant use. The criteria would cover all aspects of use, (e.g. drug-drug interactions, therapeutic duplication, drug-disease interactions or contraindications etc.)
- This RDUR review would not be limited to age 14 and younger as in previous discussion. Nor would this review stratify members by any type of risk score.
- Discussion about how a minority (~30-35%) of prescribers respond to RDUR intervention letters may limit its usefulness as a tool to measure behavior. Not all behavior change is measured by responses received and responses may not be used in any way. Letters are at the least educational, and trying to align all forms of DUR (Targeted, Prospective, and Retrospective) reinforces the messaging and synchronizes messages across policy areas.
- Doing the RDUR cycle this way does not change the cost. This is not an added review, just a substitution. This process is easy and quick to do. This can be a stop gap between now and a targeted intervention, which takes longer.

❖ **Staff Recommendation**: Do a one cycle focused RDUR review on stimulant criteria as soon as administratively feasible.

- **Motion** made to accept staff recommendation made by Bob Breslow and seconded by Ward Brown. Unanimous yes vote. Motion carries.

Update on HMO Lock-In Referral Process and CMS Annual Report:

Lynn Radmer filled the Board in on the latest

- Forms and letters are being finalized for HMOs to use to refer members to Pharmacy Services Lock-In.
- HMOs can refer members using criteria based on member activity outside the scope of what the Department can "see" in claims reviews. (e.g. a member who breaks a pain contract with a provider could be referred, and Lock-In would occur without the usual intervention steps.)
- HMOs are required to defend any referrals if the member appeals to an Administrative Law Judge.

- The CMS Annual Report is online again this year, using the same cumbersome system as last year. Kay Reniero has been instrumental in making the process go as smoothly as possible. We expect to file on time, before June 28.

Update on May PDL Meeting:

Rachel Currans-Henry told the Board the May 15th PDL meeting included:

- AIDS/HIV category with Stribild remaining non-preferred for now, consider recommendations from the World Health Organization for this drug class.
- Anticoagulants category with Xarelto and Pradaxa preferred, Eliquis non-preferred.
- Multiple Sclerosis category with lots of public testimony and newer branded oral agents remaining non-preferred and maintaining injectables as preferred.
- Recommendations will be posted soon, and Update will go out in July.
- Two new classes were added: IBS and H2 Antagonists.

Update on State Budget as related to Medicaid:

Rachel gave a brief summation

- Some current MA will transition over to the exchange or "marketplace".
    - Parents and caregivers >100%FPL moving to marketplace
    - Childless adult population covered 0-100%FPL; >100%FPL moving to marketplace
- Simplify program overall
    - Move to maintain one drug benefit, one PDL, the Standard Plan.
    - Eliminate Basic, Core Plan PDL and Benchmark generic-only drug benefit.
    - Badger Rx Gold program will be discontinued.
    - Pregnant women and kids still covered up to <300%FPL.
    - Medicaid purchase plan also changing.
    - Anticipated effective date January 1, 2014.

Adjournment:

Motion to adjourn made by Bob Factor. Motion carried unanimously. Meeting adjourned at 3:35 pm. Next meeting September 4, 2013.

Guests: Todd Kailas (Sunovion), Jiyoung Kim (Skywalk Pharmacy), Amy Brauns (Otsuka), Tom Erickson (BMS), Dean Groth (Pfizer), Susie Moroney (Pfizer), Chris Metcalf (Lifescan).