MINUTES OF THE DRUG UTILIZATION REVIEW (DUR)
BOARD MEETING
Wednesday, September 2, 2015
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
Robert Breslow, RPh
Michael Brown, PharmD
Daniel Erickson, MD
Hannah Delong, MSN, PMHNP-BC
Michael Ochowski, RPh
Lora Wiggins, MD
Jake Olson, PharmD
Absent:
Ward Brown, MD
Paul Cesarz, RPh

HP Staff
Present:
Jenny Nelson, CPhT
Tom Olson, PharmD
Jacque Nash, PharmD
Lynn Maskel, MD
Randy Cullen, MD

DHS Staff
Present:
Kimberly Smithers
Kelsey Gmeinder
Rachel Currans-Henry
Tiffany Reilly
Lynn Radmer, RPh
Lisa Reese

Welcome and Introductions
Kimberly Smithers called the meeting to order at 1:07 p.m., and began with a welcome and thanks to the Board members for their attendance at the meeting. The members were reminded of the meeting materials in their respective binders for reference and review. Kimberly informed the Board that Rachel Currans-Henry would be joining the group later in the meeting. A quorum of members attended the meeting.

Review of the Agenda and Board Materials and Approval of June 3, 2015 Meeting Minutes
Kimberly Smithers 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. Kimberly briefly reviewed highlights of the minutes from the last meeting. The June minutes were then approved with an initial motion from **Michael Ochowski** and a second from **Lora Wiggins**. The motion passed unanimously.

Three-Month Supply Update
Lynn Radmer, RPh, began the conversation by providing a history of the Three-Month Supply policy changes discussed with the Board in 2013 and 2014. Prior to 2013, the NS alert functioned in three ways:

- **Drug Authorization and Policy Override (DAPO) alert,** which required a three-month supply be dispensed unless an override was granted by DAPO.
- **Prospective DUR alert,** which required the pharmacy to override the alert in order to dispense less than a three-month supply.
- **Permissive alert,** which informed the pharmacy that a three month supply could be dispensed, but did not require any further response before processing.

In 2013, the Board recommended modifying the Three Month Supply policy to include only DAPO and permissive NS alerts. Post implementation data presented to the Board in 2014 demonstrated a high volume of claims included both the permissive NS alert and another Prospective DUR alert; and it was discovered that pharmacies could override all Prospective DUR alerts on a claim by responding to the permissive NS alert only. In 2014, the Board recommended modifying the functionality so pharmacies could no longer override all Prospective DUR alerts by responding to a permissive NS alert. The modification was implemented in August 2015. The Board discussed the benefits of the three month supply policy which include: member pays one-copay instead of three, the program pays one dispensing fee, and the pharmacy could provide a Medication Therapy Management (MTM) service when the pharmacy works with the prescriber to convert a script from a one-month to a three-month supply.

Analysis will be presented in a future meeting to show the impact of separating the NS alert from the other Prospective DUR alerts.

Stimulant DUR Newsletter

The second agenda item, led by Lynn Radmer, RPh, was a discussion about the "Stimulant Drug Use in Children and Adolescents" DUR Newsletter. The Board received a draft version of the newsletter for review/comment in July 2015. At the time of the meeting, the newsletter had not yet been published, but it is expected to be mailed following Labor Day. The Board members were supplied with the final version of the newsletter. Dr. Cullen highlighted one important myth that was uncovered during the intervention process, the idea that rapid metabolism occurs with methylphenidate compounds as well as the amphetamines. This misinformation may have accounted for errors outside of the norm, as Dr. Cullen advised that there is no data confirming rapid metabolizer populations for methylphenidate and stated that this was a very important take-away for some providers involved in the stimulant intervention. Michael Ochowski noted that guanfacine ER was added to the PDL (and brand name Intuniv moved to BMN), and Jake Olson expressed a concern regarding PDL changes from brand name products to generic formulations. Dr. Cullen advised that guanfacine should not be used as an alternative agent to stimulants, but rather as an adjunct therapy due to the calming effect it provides without an effect on attentiveness. Hannah Delong asked about the PDL status of Strattera and Lynn Radmer indicated that it is a preferred agent on the PDL. This is the first newsletter that contains an e-mail address specifically for provider feedback. The hope is that the e-mail address will spur a higher volume of responses. The next step will be to continue monitoring dosing data and conduct provider outreach as needed.

CMS Annual Report

Tiffany Reilly provided a summary of the State's annual DUR report. The report was submitted on June 30, 2015, as required and covered federal fiscal year 2014 (October 2013 through September 2014). There were no significant changes noted for this year's report, but Tiffany did highlight the State's responses for the following areas: Prescription Drug Monitoring Program (PDMP), quantity limits, morphine equivalents, buprenorphine limit, and the use of antipsychotics in children. Wisconsin does have a PDMP but the program is managed by another state agency, which hinders collaborative efforts, especially regarding the Lock-In program. The State currently does not monitor morphine equivalents, but opioid quantity limits were on the agenda and Tiffany noted that they would be discussed in detail in today's meeting. Lastly, antipsychotic use in children seven years of age and under is continuously monitored through a prior authorization review process conducted by psychiatrists. The CMS website where the annual report is published was provided to the Board members, and Kimberly encouraged the Board to take a look and compare Wisconsin to other states to gain a better understanding of the report as well as the State's performance.

Quantity Limits for Short-Acting Opioids

Lynn began the quantity limit discussion by reminding the Board that this policy is separate from the monthly opioid script limit and the long-acting opioid quantity limits. Current quantity limits are based on maximum - recommended doses of the non-opioid agent present in the product. Currently, there are four quantity limit groups: 204 (60mg codeine products and butalbital products), 272 (tramadol products), 408 and 544 (both contain combination hydrocodone and oxycodone products). Members may receive up to the quantity limit within each group. The actual number of claims that hit the quantity limit alerts is low, and with the proposed changes, the number of affected claims would increase slightly. Lynn presented the current exceptions to the policy available via DAPO overrides (lost, stolen, vacation, natural disaster, therapy changes).

State staff proposed the following changes to the quantity limits for short-acting opioid policy: grouping all non-liquid, short-acting combination opioid agents (except for tramadol and meperidine products) into a single quantity limit group with a limit of 330 per month and updating the current exception policy to include malignancies, palliative care, and sickle cell patients. Dr. Erickson recommended a limit of 336 to enable maximum medication access, as a 28-day supply would be comprised of 336 units and the script would be refilled on the same day of the week, eliminating the need for refills during a holiday or on a Sunday. The quantity limit proposal was revised to reflect the 336 unit recommendation.

Daniel Erickson motioned to approve the proposal and **Mike Brown** seconded the motion. **Michael Ochowski** opposed and offered that this was not the best way to solve a misuse problem and also acknowledged that he could not propose another solution at this time. State staff will update the Board in a future meeting regarding any impact to the DAPO center and the average number of units per claim.

Benzodiazepines and Opioid Dependency Treatments

Lynn noted that this topic was being brought back to the Board for several reasons: safety issues, lack of provider awareness, member and/or provider misuse, it is congruent with other areas of Board involvement and has potential for a positive impact. Lynn also stated that today's discussion would be limited to buprenorphine agents. Lynn indicated that there may also be a problem with methadone, but that area will be discussed at a future Board meeting. The objective for this discussion was to present the idea to develop an educational, focused provider outreach letter, identify specific providers for further follow-up, and aide in the development of similar data for methadone use.

The Board was then directed to Dr. Maskel and Dr. Cullen, who provided an initial background introduction to the problem of concomitant benzodiazepine and buprenorphine use. Dr. Cullen stated that this is a large public health issue. Dr. Cullen spoke with two leading physicians and noted that they either have a policy of only prescribing one agent. The physicians would like to see a State policy inhibiting concomitant use. The policy would easily enable providers to turn away requests from members who are potentially at risk for misuse. Dr. Cullen noted that these members get started on dual therapies in multiple ways (i.e. comorbid conditions, acute anxiety attacks that never resolve, or abuse) and the problem manifests into chronic use. This becomes an issue for the prescriber as they most often do not have the time or resources to invest in addressing the problem and getting the member off of the benzodiazepine.

The audience for this educational outreach is the prescriber. Members either obtain the benzodiazepine off the street or from a second prescriber who is unaware of the member's buprenorphine use. Hannah Delong proposed including emergency departments (EDs) in this educational outreach. Hannah has experience with a similar policy in Connecticut, which resulted in a no benzodiazepine policy for local EDs, further inhibiting significant concomitant use.

Data was presented for the second quarter of 2015. Of all the members who received both a benzodiazepine and buprenorphine, 68 percent received both for 60 days or longer. The majority of members received both medications from one prescriber.

A question was posed about taking therapeutic agents away from a member who needs them. Dr. Cullen advised that these members need to be treated appropriately for depression and/or anxiety and that there are no guidelines worldwide supporting any chronic benzodiazepine use. Board members proposed the idea of further intervention beyond an educational letter, including quantity limits on benzodiazepines. Rachel asked if any members had emergency department contacts they could reach out to regarding the benzodiazepine policy. Hannah Delong and Dr. Erickson volunteered to communicate with their respective contacts and report back to state staff. An informal consensus was reached among the Board to utilize a combined approach of policy and educational outreach in addressing this Public Health concern. Additional information on this topic will be discussed in the December meeting.

Future DUR Activity Survey Discussion
The agenda item of future DUR activity survey discussion was postponed at this meeting and will be presented at the December Board meeting.

Adjournment
Jake Olson motioned to adjourn. **Mike Brown** seconded the motion. The meeting adjourned at 4:00 p.m. Upcoming meetings are on the following Wednesdays: December 2, 2015 and March 2, 2016.

Guests: Nick Boyer (Otsuka), Jim Bachmann (Alkermes), Patricia Moty, Mike Healy (Gilead), Xia Dian Liu, Jim McNamara (ViiV), Keith Stanek (Baxalta), Merideth Sutton (Allergan), Trista Willis (UW-SOP Intern)