DRUG UTILIZATION REVIEW (DUR) BOARD MEETING MINUTES

Wednesday, September 7, 2005
1:00 P.M. to 4:00 P.M.
1 W. Wilson Street, Room 751
Madison, WI 53701

I. Approval of the agenda
Agenda was approved as published

II. Approval of Minutes – June 1, 2005 Meeting
Minutes were approved as distributed

III. Retrospective DUR
Anti-epileptic intervention progress report

Included in your packet was an update of the analysis for the anti-epileptic drug intervention. The first section contains summaries as we presented the last time, updated with new data.

The first spreadsheet contains all the claims in the past year from when we refreshed this report after the last meeting. The dollar amounts and the percent of the total amount are on the bottom. The next spreadsheet contains patients for whom we could not find an excluding diagnosis in the past two years of medical claims. Excluding diagnoses were any seizure disorder, post-herpetic neuralgia or diabetic neuropathy. 57.8 percent of the claims had no excluding diagnosis. Of the total of $39 million worth of anti-epileptic drug claims paid, we could find no diagnosis for $22 million of the claims.

Dually eligible recipients were not excluded from this analysis, which may have inflated the number of recipients with no excluding diagnosis. When a person is on both Medicare and Medicaid, their medical claims are paid for by Medicare so Medicaid does not receive these diagnoses. For gabapentin use, we found no diagnosis almost 80 percent of the time.

There are some newer FDA-approved diagnoses for some of these agents and there continue to be some new diagnoses that are being investigated but were not included in this retrospective review. We do know that there is use in other neuropathies and there appears to be anecdotal case study evidence that there's some success in their treatment

The letter intervention was sent to the top 500 prescribers ranked by dollar amount paid. Of the top 500, the psychiatrists accounted for almost 7 million dollars of amount paid. The top 500 prescribers account for over 50 percent of the total expenditures

Topiramate relatively recently received FDA-approval for a new indication of migraine. Because we're looking back in the data, most of the time it was available in the past was before the indication was approved, so we did not include it in this analysis.

We have 158 responses as of September 6. The response form asks, among other things, how useful do you think this intervention was. There are more positive responses than negative responses, so, it was generally well received.

Forty percent of respondents did not modify the therapy. Thirty-one percent reported that they did review the treatment regimens.

In addition, included is a summary of the comments sent with the responses. A couple of themes come out of the responses.

- There are a number of prescribers that prescribe these drugs to patients as a result of a consult with a psychiatrist or with a neurologist, and are basically managing the patient and refilling the prescription. The patient goes back once a year for their psychiatric consult, but the family practitioner maintains the patient on that therapy.

- These are difficult patients; there are few alternatives and I've explored a lot of them and the reason they're on the drugs that they're on is that I have done all the things that you've asked me to do and my prescribing is appropriate,

There were a couple of comments that were of concern. Examples are:

- "I'm prescribing an atypical anti-psychotic to this patient. The patient is gaining weight. I used Topamax to help them lose weight." That's an awful expensive drug to be using for weight loss.
- The use of gabapentin for generalized anxiety disorder or some other kind of anxiety disorder. "And gabapentin is not a controlled substance so I don't have to worry about that when treating pain. I can give them as much gabapentin as I want and nobody's on my case for over-prescribing narcotics for pain or benzodiazepines for anxiety disorders."

We only provided the prescribers with patients who had one of the anti-epileptic drugs with no excluding diagnosis drugs within the last three months of the intervention. We included the name of the patient, the patient's birthday and ID number so that they could identify them if they needed too, the drug that was prescribed and the amount paid by Medicaid.

To evaluate the success or non-success of the intervention, we will take the same patients and compare their drug costs in the pre-period and in the post-intervention period to see if there's any change.

By merging the drug data with the medical data, we did the best job that we could using the combination of the data we had to try to eliminate as many false positives as we could.

The Board identified a radiologist, a cardiologist, and a pathologist prescribing these drugs and expressed concerns. It was felt that these three prescribers should be contacted separately about their use of these drugs.

IV. Prospective DUR
ER and TD intervention

The information was updated since the last meeting and is the final report for the intervention. The table shows the pharmacist's responses, so for example, 93 percent of the responders said they will share the information with pharmacy staff. We ran the data of extracted ER and TD override percentages 2 months post and 3 months post intervention.

This is the third time we've done an intervention on the early refill alert. Each time there is a period of time after the intervention where the pharmacist override percentage seems to improve and it persists for at least three months out from the intervention. So, at 3 months, it still is at 8.6 percent lower than baseline. The TD alert percentages do not change much compared to baseline.

It appears from the study that the ER intervention run on a periodic basis might yield something for us. The other alerts are more clinical in nature so the problem that is pointed out to the pharmacist, the intervention is not necessarily not to fill the drug, but it is a clinical intervention.

The Board discussed whether we need to continue to be proactive in educating pharmacists about the intended purpose and outcomes of prospective DUR. There was also some discussion about using the results of the alert hits to define areas that may need an educational intervention, for example, the most common drug/drug interactions detected.

The feedback from the intervention did provide us with some valuable feedback from pharmacists with respect to alerts hitting on therapeutic duplication that pharmacists perceived as "noise in the system. There may be some value in doing these interventions as a way for us to evaluate the program and get feedback so that we can be responsive.

Other issues discussed included:

- DUR issues may not always result in direct cost savings.
- Not all outcomes from an intervention are easily evaluated, e.g., the avoidance of a potential dug/drug interaction.
- Some items that the commercial world calls DUR relate more closely to formulary adherence issues
- Should the total number of RXs filled also be used in the evaluation of the override percentage in addition to the percentage of the specific alerts being overridden

At the last meeting, the Board requested a data extract on those pharmacies that seldom overrode the ER alert. A spreadsheet reporting the pharmacies with low override percentages was presented. It was noted that a considerable number of Walgreen's stores

were on the list. The Board requested that we bring back the addresses of these stores to see if there was a geographic pattern.

V. DUR criteria

Potential modifications to TD

Based on pharmacists' feedback to the Prospective DUR intervention, the Board recommended we implement the following changes:

- Separate the long acting and the short acting opiates. Long acting drug should be extended release morphine and oxycodone, fentanyl transdermal, and methadone.
- Modify diuretics duplication. Change so thiazides do not duplicate with metolazone or loop diuretics but only with other thiazides

Dr. Mergener brought up the issue of providing some feedback to the pharmacists who responded to the ER/TD intervention to thank them for their input and to let them know that as a result of their feedback, we are working on modifications. The Board approved the concept and a letter will be prepared for the Board to review.

Potential additions After discussion of potential suggestions, the Board recommended the following for potential additions to prospective DUR.

- Atypical antipsychotics

VI. Recipient lock-in

Allan provided a summary of 2004 lock-in activities.
We reviewed 1,288 recipient profiles. The results of the reviews were:

- 183 lock-in recommendations
- 243 cases where letters were sent to prescribers
- 163 cases where warning letters were sent to recipients
- 546 cases with no further action

The rest of the cases were re-reviews, routine reviews for individuals going off lock-in, and HMO referrals.

The decision support tool is now a significant source of lock-ins and letter recommendations. Since the implementation of the DST and prospective DUR the patterns of misuse have changed. A significant portion of the no further action results are from re-reviews. Consequently, we are doing less re-review and relying more on the DST. Since the implementation of prospective DUR, we are receiving more referrals from pharmacists.

There were 25 cases for which an appeal was filed. This is up slightly over the previous 2 years.

Allan described the new potential expansion of recipient lock-in for emergency room overutilization. The first steps are being undertaken now. The first one is an educational

letter to the recipient. The goal for this is to go out some time in October. We've identified recipients in both emergency service and managed care with six or more ER visits in a 12 month span of time. Those ID's have been reviewed to see if they have a predominant primary care provider or if they've been a target of case management. Although they may have a legitimate medical need people who are misusing the emergency room are not using appropriate resources for their care. Part of the education may also be directed to case management to inform providers that the people they are responsible for are going to the emergency room frequently. The intervention will include sending a letter to the recipient and cc-ing the providers. Letter types are being drafted now being reviewed this week and next week to try to get everything in the final order to get things going out in late October.

A second line part of this is to provide additional information to the ER staff using the existing infrastructure. This would be a web-based interface for emergency room staff to query when they have a recipient presenting to them in the ER and they have a need to know some information about that recipient. They would enter the ID into a secure database that is an extract of the current data warehouse. Some standard reports would include the claims history for pharmacy, the claims history for hospitalization, emergency room, some of the diagnostic information. We would need to provide outreach and training for ER staff.

The third piece of the expansion of lock-in is to apply a specific restriction to a hospital or ER. We know that other Medicaid states are doing this. Finally, we can send a referral to case management for people who don't voluntarily comply. About 30 percent of the people, who had six or more ER visits, didn't have any kind of PCP or consistent relationship with the provider or case manager.

VII. Referrals from the Prior Authorization Committee

Sedative/Hypnotics

The original recommendation to the PA Committee was to institute quantity limits on sedative/hypnotics. The committee did not approve that recommendation but referred the item to the DUR Board for further analysis.

Claims information for the most recent 6 months of pharmacy claims was extracted. The drugs included were Sonata, Ambien, Lunesta, flurazepam, and temazepam.

The information extracted was the number of prescriptions, the amount paid, and the number of recipients receiving those prescriptions. A number of calculations were performed, including the calculation of the number of doses per prescription. Basically the average number of doses per prescription of a sedative-hypnotic is 30 so the patient is getting one per day for the full month currently. The average cost for a flurazepam prescription is $6; for temazepam, it is $14. The other drugs are in the range of $80-90 per prescription.

The study also included the number of prescription per person per year. The patients were getting almost 5 prescriptions per year indicating that these drugs are taken chronically. The data for Lunesta is even higher.

The use of prescriptions for longer than 7 days and chronically is done despite what has been taught to prescribers and pharmacists that this should not be done. The Board would like to see the Oregon report on sedative hypnotics.
After considerable discussion, the Board made no recommendation for quantity limits at this time.

Leukotriene Modifiers
The concern expressed by the PA Committee is whether we have prescribers using leukotriene modifiers for the treatment of nasal-rhinitis when other less expensive products are available. Margaret Asquith ran the data on this particular question.

The data included all recipients who received at least one prescription for a leukotriene modifier. That yielded 10,712 recipients, and subtracting anyone currently taking a drug for the treatment of asthma or for whom we could find a diagnosis of asthma. This left 1183 recipients. Of this group of patients, we found 285 who had previously tried a nasal steroid, 433 who had tried a non-sedating antihistamine, and 217 who had tried both. This left us with 558 patients whom we could not identify as asthmatics, and who only used a leukotriene modifier, apparently as first line therapy.

The Board discussed whether a targeted intervention should be designed. A final decision was not reached. The Board requested some additional information on the number of prescribers affected and some prescriber demographics.

The next meeting is scheduled for December 7th. This may present conflicts for some members. Dr. Mergener will look for an alternate date but it will remain on December 7th unless Board members are notified within a few weeks.

The meeting was adjourned at 4:00 PM.