Drug Utilization and Review (DUR) Board Meeting
March 7, 2007 Minutes

Wednesday, March 7, 2007
1:00 p.m. - 4:00 p.m.
1 West Wilson Street, Room 751
Madison, WI 53703

DUR Board Members Present:	Michael Boushon, RPh Daniel Erickson, MD Robert Factor, MD Franklin La Dien, RPh Nancy Ranum, MS, RN, CS-ANP, APNP
DHCF:	Carrie Gray Rita Hallett, RN Marilyn Howe, RN Lynn Radmer, RPh James Vavra Richard Carr, MD
APS Healthcare, Inc.:	Allan Mailloux, PharmD Michael Mergener, RPh, PhD Mary Jane Mihajlovic, RN, BSN, HN-BC
Guests:	Jim Canes- Schering-Plough Jagdish Shastri-Eli Lilly Ron Diamond, MD-BMHSA

Minutes

James Vavra called the meeting to order at 1:08 p.m.

I. Approval of the Agenda
Agenda approved as written.

II. Approval of the Minutes - December 6, 2006 Meeting
Minutes approved as written.

III. ADURS Annual Meeting Report

A. ADURS Annual Meeting Report

Dr. Mergener presented information from the 2007 American Drug Utilization Review Society (ADURS) annual meeting. Representatives from 40 states were present at the meeting. Mike summarized the projects of many of the states in attendance. Wisconsin shared information on the atypical antipsychotic low dose intervention.

Mike also summarized two presentations from the meeting:

1. CMAP Algorithms: Evidenced Based Pharmacotherapy for Mental Disorders Among Youth by M. Lynn Crismon, PharmD, from the University of Texas, College of Pharmacy and the Texas Department of State Health Services.

2. Diabetes Management - Current Treatment Guidelines and Tools by Om P. Ganda, MD, from Harvard Medical School and the Joslin Diabetes Center in Boston, MA.

B. Other State Initiatives

Dr. Mergener spoke of the summaries as a means to create discussion later on savings initiatives as well as potential 2007 annual DUR Board projects. The Board expressed interest in the following initiatives:

1. *North Dakota* requires a generic be dispensed for OxyContin. The Board posed a question with regard to incentives. Dr. Mergener was not aware of any additional payments to the dispensers.

2. *Mississippi* limits Synagis to a maximum of 5 doses without a prior authorization (PA), enforces the Preferred Drug List (PDL), identifies prescribers who are not compliant with the PDL, and provides in-services to its psychiatric facilities. Dr. Factor pointed out that only 35% of psychiatric medications are prescribed by psychiatrists and questioned what Mississippi was doing about primary care. Dr. Mergener responded that this prescriber education was not a therapeutic discussion, but rather an outreach to mental health facilities.

3. *Iowa* switched people on long acting opiates to methadone which resulted in increasing methadone's market share from 4% to 9%. Dr. Erickson questioned the incentive.

   Action Item: Dr. Mergener offered to come back to the board with more information.

4. *Kansas* claims processors send a 1) fax-back prior authorization form and 2) a list of preferred drugs to prescribers requesting a non-PDL drug. Kansas recognizes the fax-back as a legal prescription if 1) the physician circles the drug and 2) signs the form. In some states, the documentation for a drug requiring a PA needs to be sent by the prescriber to the claims processor. If rejected, the prescriber receives a message that the drug requires a PA. This makes the claims processor the negotiator. Mr. Boushon commented that if there was more burden put on physicians to prescribe PDL products, there would be less incidence of non-PDL prescriptions. Mr. La Dien noted that generally every 4th or 5th prescription is a non-preferred drug.

5. *Idaho* requires prescriber to provide peer reviewed literature for drugs prescribed for an off label use. Diagnosis is part of the approval process and expert panels carry some weight of evidence.

6. *Oklahoma* created antibiotic education for the provider's office such as check-off prescription pads for cough and cold preparations and posters. Pharmacists can also make recommendations and bill for services without the patient going back to the doctor. Dr. Erickson noted that this eliminates an office visit.

7. *Louisiana* developed an uncontrolled hypertension disease management initiative. Dr. Erickson asked how Louisiana identified "uncontrolled" hypertension.

C. Children's Medication Algorithm Project (CMAP)

The University of Texas developed CMAP over a 2 year period. Expert consensus panels reviewed the evidence to produce treatment recommendations. If there are no well controlled randomized clinical studies or epidemiologic cohort studies or retrospective analyses, the treatment algorithm is developed by expert panel consensus which may be more controversial. For the treatment of ADHD, if there are no co-morbid conditions, there is no statistical difference between drug treatment with or without behavioral therapy. When drugs and behavioral therapy are used to treat co-morbid conditions such as oppositional disorder, the combination is more than either alone. Dr. Diamond commented that the algorithm contains idiosyncrasies and recommended it be used as a guideline rather than a hard edit.

IV. Retrospective DUR – Results of Criteria Review and Implementation (Attachment 1)

Dr. Mergener presented a table of recent activated alerts along with how many times the alert was generated based on pharmacy claims data and how many letters were generated and sent. Not all letters generated are sent. For example, if the doctors are working in the same office, letters that are generated may be pulled and not sent. The last column indicates the number of letters sent per case. Multiple letters are sent if there are multiple prescribers. The letters signal a potential issue for the prescriber to review and requests feedback.

Action Item: Dr. Mergener offered to provide information on prescriber feedback on the newly initiated alerts if there is sufficient information available.

Dr Diamond asked what the letter might say when an atypical antipsychotic was prescribed for an elderly patient. According to Dr. Mergener, the letter alerts the prescriber that "there is a warning for the elderly with dementia using this drug…Please review this case."

V. Break

VI. Selected 2007 DUR Board Annual Project -- Anticholinergic Burden (Attachment 2)

Goal: To determine the Anticholinergic Burden that certain drugs place on recipients.

What to do next?

The first page of Attachment 2 indicates those recipients who received an anticholinergic drug(s) in the month of January. The information represents an unduplicated count of recipients with at least one anticholinergic drug. The drugs are not unduplicated.

The second page of Attachment 2 is from multiple sources, including First DataBank and the DHFS Nursing Home Project. The drugs are grouped together based on side effects such as dry mouth, dry eyes. The APS pharmacists gathered to make the determination of the drugs included on this list.

Dr. Erickson asked if ophthalmic drugs were included in the drug extract. Dr Mergener responded that only oral agents were included. Topical products, even though they may have systemic effects, were not included in this analysis.

> **Action Item**: Dr. Mergener will confirm that topical products were excluded from this list.

The third page of Attachment 2: Specifically counted (not unduplicated drugs).

Dr Mergener also extracted recipients taking an Alzheimer agent and an anticholinergic agent. He determined that in Medicaid: 50 recipients were identified as taking an Alzheimer's agent and 72% were also taking an anticholinergic agent. In SeniorCare, 2,570 participants were identified as taking an Alzheimer's agent and 40% of these are also on at least one anticholinergic agent.

What are some suggestions for proceeding with intervention?

- Mr. Boushon: Do we dig deeper or do we do a quick intervention for prescribers? Do we want to determine total load as indicated in the article provided to Dr. Mergener or do we also need to deal with age issues, other drugs, and specific diagnoses.
- Mr. Vavra: What you are saying is to focus on drugs with highest level and then look at age?
- Mr. La Dien: SeniorCare is the biggest bang for the buck. The Board can use this as a starting point. Alzheimer's drug comparison seems to be a good approach.
- Dr. Erickson: What if recipient or participant is on more than two really anticholinergic drugs?
- Dr. Diamond: Those recipients with Alzheimer's are more susceptible to the effects of anticholinergic drugs.
- Dr. Mergener: This data can be aggregated by prescriber and the Board can target those prescribers who are prescribing a specific number of anticholinergic drugs. The targeted intervention can include the letter and profile information for their recipients. The approach is more clinically oriented than cost oriented.
- Ms. Ranum: Are the prescriptions for the multiple anticholinergic drugs coming from multiple prescribers?
- Dr. Mergener: The Board could direct us to identify patients on multiple anticholinergic agents and alert all prescribers. The article Mike Boushon mentioned earlier presented a way to identify anticholinergic burden. The gold standard is an

assay that cannot be done outside of an academic setting. The article provides a practical tool to estimate anticholinergic burden.

- Dr. Carr: 1) Alert prescribers that their patients are on these anticholinergic agents. 2) Examine snticholinergic burden by age.

  Action Item: Dr. Mergener will massage the data based on suggestions. The data will be sorted by anticholinergic drugs with higher weights. Ms. Ranum would also like the number of prescribers.

- Dr. Mergener would like to know by next meeting the type of intervention the Board would like done.
- Dr. Factor would also like some dose minimums associated with the weights of the anticholinergic drugs.
- Dr. Erickson would like to help more patients and not focus the intervention on physicians who are the highest volume prescribers. The Board will get more value from the project by casting a wider net and getting multiple prescribers.

VII. Additional Proposed DUR Projects for 2007 (Attachment 3)

Anticholinergic Burden was the highest ranked project. The remaining projects varied in popularity by the Board.

- Dr. Brown suggested doing some kind of cardiovascular disease management as a means to ensure recipients are getting the appropriate medications to prevent recurring CV events. Dr. Brown has been talking about what Gunderson Clinic is doing and has agreed to do a presentation on Gunderson initiatives for these patients at the next Board meeting. The Board may want to decide if cardiovascular disease management is a project to be pursued after Dr. Brown's presentation. Dr Brown indicated that Gunderson Clinic has almost 100% compliance with their program.
- Dr. Mergener suggested using claims to identify potential targets for cardiovascular disease management as a first cut. Other diagnoses such as hypertension, previous myocardial infarction, diabetes, and hypercholesterolemia as second cut.
- Dr. Erickson indicated that there are ICD-9 codes that can be used to identify potential targets from models that have already been created. If this route is chosen, the Board should keep in mind that SeniorCare does not receive any medical claims, only pharmacy claims.
- Mr. La Dien indicated that NIH has issued a $5 million grant for blood pressure management and the African American population in the Madison and Milwaukee markets. A suggestion was made that this would be an excellent DUR Board Presentation opportunity.

VIII. Miscellaneous

A. Progress report of Cost Savings Initiatives (quantity limits, tablet splitting, dose consolidation and 100-day supply) (Attachment 4)

B. DUR Board Member Presentation Opportunities

Mr. Vavra suggested a round robin approach. Several Board members offered the following:

1. Through Dr. Mergener, Dr. Brown extended an offer to present Gunderson's Cardiovascular Program.
2. Mr. La Dien from Walgreen's offered to present on their $5 million dollar grant to study with African Americans and blood pressure.
3. Dr. Factor proposed his presentation on CNS drugs.

IX. Adjournment

James Vavra adjourned the meeting at 3:30 p.m.