MINUTES OF THE DRUG UTILIZATION REVIEW
(DUR) BOARD MEETING
Wednesday, September 13, 2017
1:00 p.m. to 4:00 p.m.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members	DXC Staff	DHS Staff
Present:	**Present:**	**Present:**
Robert Factor, MD	Chally Clegg	Kimberly Smithers
Paul Cesarz, RPh	Tom Olson, PharmD	Lynn Radmer, RPh
Jake Olson, PharmD	Jacque Nash, PharmD	Tiffany Reilly
Daniel Erickson, MD	Kristie Chapman	Lisa Reese
Michael Ochowski, RPh	Corinne Eckert	Rachel Currans-Henry
Robert Breslow, RPh	Randy Cullen, MD	Susan Seibert
Ward Brown, MD		
Hannah Delong, MSN, PMHNP-B		
Absent:		
Michael Brown, PharmD		
Lora Wiggins, MD		

Welcome and Introductions
Rachel Currans-Henry called the meeting to order at 1:12 p.m. and began with a welcome and thanks to the Board members for their attendance at the meeting. Rachel introduced Susan Seibert, the new Associate Director of Operations for the Bureau of Benefits Management at DHS. All members, staff, and guests present introduced themselves. The members were reminded of the meeting materials in their respective binders for reference and review. A quorum of members attended the meeting.

Review of the Agenda and Board Materials and Approval of June 2017 Meeting Minutes
Rachel 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. The June minutes were then briefly reviewed and approved with an initial motion from **Daniel Erickson** and a second from **Ward Brown**. The motion passed unanimously.

Quarterly DUR Reports Update
Lynn reviewed the quarterly reports with the Board. Lynn reminded the Board that the Quarterly Overview report identifies members who have claims for all five drug classes used for selected lock-in review and discussion of that data would occur later in the meeting; she also acknowledged an overall decreasing trend in opioid use among the Medicaid population. The second quarterly report reviewed prospective DUR alerts both individually and collectively. It was noted that the quarterly claim activity reflects recently implemented prospective DUR alerts changes related to the nursing home setting.

The second half of the discussion focused on a more in-depth data presentation for the individual prospective DUR alerts in an effort to determine the level of detail and type of information necessary to assess the effectiveness of the Board's policy changes throughout the last few years. The first two alerts presented at this meeting are late refill and therapeutic duplication alerts. This was the initial attempt to find an appropriate data set that would enable the Board to monitor the effectiveness of the revised alert. The reports summarize the criteria required for an alert and the top 10 drugs currently alerting. Anticonvulsants topped the late refill alert list; however, Lynn also noted that the top individual drug in this class was gabapentin, which is most commonly used for non-epileptic indications. Gabapentin accounts for roughly 8% of the total 23% for anticonvulsants, leaving 16% for other drugs in the class, which causes some concern. Paul Cesarz provided feedback from his dispensing experience, stating that multiple issues arise due to new start titration schematics and associated refills. Hannah Delong provided a well-accepted recommendation to solve some of

those issues by inhibiting the alert until at least 90 days of drug claims history were available, thereby prohibiting any unnecessary alerts during the titration and trial and error phases of therapy.

Therapeutic duplication was the second alert presented. Narcotics topped the drug list at 22.21%, with morphine and oxycodone being the top two combinations, either taken together or alone in different strengths. Robert Breslow suggested providing a percentage per total claims to add additional value to the report. Narcotics resulted in 22.21% of all therapeutic duplication alerts for one quarter but only represented 12,501 claims, which is a small percentage when compared to total claims for the same quarter.

The last report reviewed was the newly created report for the ongoing benzodiazepine/buprenorphine intervention. This report tracks both phase I and phase II of the intervention, detailing timelines, how many members were identified in each cycle, when the letters were sent to the prescriber and how long the members are suppressed. There is an overall downward trend in total volume of member interventions as the cycles continue. As a reminder, each member is being suppressed for two years to avoid prescriber burnout with letters.

CMS Annual Report

Tiffany summarized the 2016 CMS Annual Report. The report was submitted on time with the due date of June 30, 2017. There were no changes from the previous year's requirements. Changes are anticipated for next year's submission due to the Managed Care rule mandating all MCOs implement active DUR committees. The requirements have not been published yet. Wisconsin is in a unique position since MCOs do not provide pharmacy benefits for our members. The State is anticipating more comprehensive and inclusive annual reports from others across the country, which will be beneficial for learning opportunities.

Stimulants Discussion

Lynn explained that this topic was an area that Dr. Sager had been highly involved with and was prepared to present; thus, her absence from the meeting may limit the depth of the presentation and discussion. To gather evidence and support for further direction regarding the use of stimulants in adults, the State commissioned a report from the Medicaid Evidence-Based Decisions (MED) project through Oregon Health Sciences University's Center for Evidence-Based Policy. The report analyzed medical literature with the objective of identifying the safety and efficacy of non-stimulant treatment in adults with ADHD. The most significant data came from a randomized controlled trial comparing Strattera and bupropion to either placebo and/or methylphenidate. No statistically significant differences were found when either was compared to methylphenidate. Two major limitations include the financing of the study by the Strattera manufacturer and the fact that bupropion lacks an FDA indication for ADHD. Clinically, the major problem with either drug is the urgency for symptom relief sought by adult patients. Stimulants provide immediate efficacy; whereas non-stimulant methods take up to 3-4 weeks, which causes further frustration for adults who may have previously taken a stimulant or are experiencing problems with work due to ADHD.

In addition to the report on non-stimulant use, 10 other states were researched for their stimulant edits. All 10 states had either a total daily dosage limit or monthly quantity limit. Lynn advised the Board that, operationally, a prior authorization edit is not feasible, so the focus should be to implement something in the immediate future that can still have an impact on the amount of stimulants any one member is allowed to take. Rachel proposed a quantity limit to the Board, which could then be published in the ForwardHealth Update announcing the January 2018 Preferred Drug List changes. Lynn presented data to support an initial limit of four units per day for all solid dosage forms, which would only affect roughly 750 members, or 3% of all adults and 1% of all children. Dr. Cullen also reminded the Board that some providers felt helpless and did not know how to handle demanding patients who came into the office already on stimulants or previously diagnosed with ADHD. The ability to "blame Medicaid" for having to reduce dosages was a common theme among Dr. Cullen's previous intervention calls and seemed well received by providers looking for an option to push back against patient demands.

Lynn advised the Board that the an intervention letter targeting members receiving high doses of both immediate- and extended-release Adderall is being worked on; however, the current dosage threshold of 75 mg for each formulation per day was set too high to achieve a significant number of profiles for review. The dosage threshold is going to be lowered and rerun in an upcoming RDUR cycle to assess the most appropriate doses that are both above

a clinically necessary amount and result in enough profiles to make the intervention more impactful on the Medicaid population. Robert Breslow suggested the letter may be more beneficial if an alternative recommendation is added in the text. Dr. Cullen added that such a recommendation might include switching to methylphenidate in cases of fast metabolizers, since this was also a potential limitation discussed. Hannah Delong mentioned adding a stimulant conversion chart to enable amphetamine and methylphenidate conversions at equivalent dosing. **Daniel Erickson** motioned to pursue a quantity limit along with a prescriber letter incorporating the Board's comments. **Mike Ochowski** seconded this motion.

Opioid Use in Children

Jacque opened the agenda item with a review of the codeine intervention criteria and the data from the initial intervention run in June. New information was presented, including provider feedback from the initial intervention run. Most providers noted a one-time use for an acute need, either due to a dental procedure or fracture; however, there were still a few cases indicating an unawareness of the FDA's warning and contraindication in children and adolescents. The intervention was rerun in August 2017, which resulted in 201 new profiles hitting the criteria. The distribution between analgesia and cough suppressants changed significantly from the first cycle to the second cycle, with analgesia use rising from 63% to 88% in the second cycle. This same type of intervention will be run on tramadol beginning in October when the letter is finalized.

The topic of codeine and tramadol use in children led to a proposal from Dr. Erickson to stop paying for codeine altogether in children under the age of 12 years. **Robert Breslow** motioned to add a hard-stop age restriction of less than 12 years of age on all codeine products. **Daniel Erickson** seconded the motioned and all agreed.

Robert Breslow also proposed to add an age restriction to tramadol, since it carries the same FDA warning. **Daniel Erickson** motioned to add the age restriction for all children under 12 years of age. **Mike Ochowski** seconded the motion. **Jake Olson** opposed the motion.

Dr. Sager wants to implement a provider letter specifically for dental opioid prescribing based on data that indicates that 84% of opioid prescriptions written by dentists are for greater than 10 units. The proposed letter will recommend avoiding opioids where possible, leveraging the Prescription Drug Monitoring Program (PDMP) before prescribing, limiting opioids to 10 units/3-days' supply for severe pain, and using caution with tramadol and codeine in adolescents. The Board accepted this proposal with the added revision to note the non-coverage of tramadol and codeine in patients under 12 years of age.

Focused Interventions

- **Trinity**
- **Overutilization of Albuterol**
- **Multiple Drug Classes**

The focused intervention discussion was postponed due to time constraints. This agenda item will be brought back at the December 2017 Board meeting.

Adjournment

Robert Breslow motioned to adjourn. The meeting adjourned at 4:00 p.m. Upcoming meetings are on the following Wednesdays: December 6, 2017; March 7, 2018; June 6, 2018; and September 12, 2018.

Guests: Craig Haubach, Merck; Gia McLean, Celgene; Kevin Gallagher, Melinta.