Drug Utilization Review (DUR) Board Meeting
Wednesday, December 3, 2008
1:00 P.M. to 4:30 P.M.
1 W. Wilson Street, Room 630
Madison, WI 53701

DUR Board Members Present:	Phillip Bedrossian, MD Lon Blaser, DO, CPE Robert Breslow, RPh Patrick Cory, PharmD Robert Factor, MD Michael Ochowski, RPh Eva Vivian, PharmD Franklin La Dien, RPh
DHCAA:	Rita Hallett, MA, RN Jonathan Moody Lynn Radmer, RPh James Vavra
APS Healthcare, Inc.:	Debbie Matitz (squire) Michael Mergener, RPh, PhD Tom Olson, PharmD
Guests:	Kathy Bovid – BMS Fallon Colby – UW-School of Pharmacy Kay Cram – University of Wisconsin Ron Diamond, MD – University of Wisconsin Matt Glaser – UW-School of Pharmacy Lisa Goetz – P & G Brian Groeschel, PharmD – EDS Jen Helmers – UW-School of Pharmacy Matt Hustad – UW-School of Pharmacy Hugh Johnston – BMS Mike Kapocius –Takeda George Kaetsch – AstraZeneca Yushi Li – UW-School of Pharmacy Ardy Maninfalah – Walgreens Rotation Student Amanda Maynard – UW-School of Pharmacy James Rollins – GSK Alex Shlansky – UW-School of Pharmacy Michelle Solomon – UW-School of Pharmacy Lauren Walker – UW-School of Pharmacy Maria Wopat – UW-School of Pharmacy

James Vavra called the meeting to order at 1:15 p.m. Introductions were made.

I. Approval of Agenda

Agenda approved as published.

II. Minutes

Minutes approved as published.

III. Results of Migraine Intervention (Attachment 1)

Tom Olson presented the results of the migraine intervention which looked at Medicaid recipients receiving triptan therapy for migraines without any prophylactic therapy in the medication profiles. We had modified the criteria to increase the number of alerts hitting. The Board had asked how prescribers have responded to the new criteria. The results reported are based on the responses to 42 prescriber alerts sent out between March and June 2008. Of 42 alerts, 13 providers (30%) responded. 12 providers included an evaluation code; on a scale of 1 to 5 (5 being the most useful), the letter was rated at a 4. All 13 included an outcome code indicating common outcomes from alerts, with the most common "patient is being monitored". Seven included written responses – overall providers found the alerts helpful but minimal action was taken by them as a result of the alert. Dr. Mergener explained we provide a response sheet with a check box that we converted to an outcome code to enter into the computer. We see patients on a significant number of repeat prescriptions for triptans within a short period of time with no evidence of prophylactic medication. Letters are not sent to infrequent users. Within that group, the same product was used. Providers were also concerned about narcotic use in addition to anti-migraine drugs.

IV. Follow-Up on Atypical Antipsychotic Intervention (Attachment 2)

Dr. Mergener presented follow-up items on low dose monotherapy with atypical antipsychotic drugs.

- Pre and post prescriber analysis – due to the transition from DEA to NPI, the data was incomplete for a comparison. Once the data warehouse becomes available, Dr. Mergener will attempt doing another crosswalk with DEA to NPI.
- What was the prescribers' specialty? Of 86 prescribers, 61 were psychiatrists and 9 were pediatricians, with a limited number of other practices.
- What are the age components of the patients? Age categories were: under 5, 6 to 14, 15 to 20, and over 21. Upper limit is most likely 65 due to the majority of seniors being dually eligible with Medicare. Slightly more than half of the patients were less than 15 years old.
- With decreasing use of atypicals, any changes in other medications? Only drugs with a substantial change pre to post were included. There was primarily an increased use of ADHD drugs.
- What are the patients' diagnoses? 10% of patients had to have at least 1 diagnosis in order to appear on the list. The majority of patients being treated with low-dose atypicals have Attention Deficit Disorder or some type of conduct issue.

It appears the 1st tier patients had different outcomes than the 2nd tier. The last time, the 2nd tier appeared to be sicker, one reason being they could have been newer patients, resulting in more visits. Dr. Mergener will send the Board the "do no harm report" which looks at pre and post psych visits.

An inquiry was made if it is possible to look at step therapy to ensure 1st line drugs are being tried and in order to do this, we would have to look at drug use and sequence it out. Is the system capable of doing a step therapy going forward to identify 1st and 2nd steps without actually implementing it to see what the impact would be? The system is capable of this and we do have diagnosis in 100% Medicaid patients, but with the managed care group we would have diagnoses through the encounter data. Dr. Mergener suggested letting this intervention rest a while and focus on another targeted intervention.

Regarding future interventions, Mr. Vavra expressed that Jason Helgerson is very interested in the Board's input into those interventions that promote quality and good outcomes and save money, especially using pharmacy data. For past interventions, we have solicited ideas from the Board, as well as externally, and prioritized them with final approval by the Board. At the 3/4/09 meeting, we will present the Division's suggestions for targeted interventions (e.g. participate in quality initiatives with HMOs, have a component devoted to pharmacy with quality improvement efforts), as well as the Board suggestions. Within the next month, Dr. Mergener will send the Board the Division's ideas and ask for feedback. He suggested we also revisit our fee-for-service clientele and do some utilization analysis to compare what our experience was a year ago versus since the pharmacy consolidation. Mr. Vavra supported this effort due to the Division preparing a draft paper on efforts to improve care as Mr. Helgerson does want a big component of that devoted to pharmacy.

Action Items:

- Pre and post by prescriber – once data warehouse is available, Dr. Mergener will attempt doing a crosswalk with DEA to NPI.
- Dr. Mergener will send the "do no harm report" to Board members.
- Run drug use on certain patients to determine if 1st line drugs being tried.
- Future Targeted Interventions – in preparation for the 3/4/09 Board meeting, send the Board DHCAA's ideas as well as solicit ideas from Board members.
- Provide information to the Board on revisiting our fee-for-service clientele.

V. Early Refill Update (Attachment 3)

Dr. Mergener provided an update on early refill. The first sheet of Attachment 3 lists the new classes of drugs the Board approved at the September 2008 meeting. The second page lists drug classes the Board previously approved but new drugs have entered the class. Dr. Mergener redid the list and added drugs in similar classes that were in the previously approved categories. At the September 2008 meeting, there was discussion about having an early refill alert on atypical antipsychotics. Since the alert is already on for the older agents, it was decided all the other atypical antipsychotics be added. Dr. Mergener reported since the early refills have been added, there's been no negative feedback with the pharmacist denying the antipsychotic so these appear to be appropriate alerts. Pharmacists override approximately 30% across all drugs, the exception being controlled substances as pharmacists are more stringent on giving those early refills. Once the new system is available, the number of alerts in the prospective DUR system will be re-evaluated. Mr. LaDien offered piloting some stores to work on that. Mr. Breslow commented it would be helpful to get demographics of the Medicaid population. In response, Mr. Vavra requested Rita Hallett modify the presentation given to the CACHE Committee which gives statistics on expenditures and describes the various

populations. Patrick Cory is interested in seeing the top used drug classes with costs, as well as a list of past interventions that have been done. It was also requested to see Mr. Helgerson's quality statement – this is still in the developmental phase but once finalized, it will be sent to the Board.

Action Items:

- Once finalized, send the Board Mr. Helgerson's quality statement.
- Prepare demographics of Medicaid population and have as an agenda item for 3/4/09 meeting (Rita Hallett).
- Compile a list of the top drugs used with costs and past interventions that have been done (Dr. Mergener).
- When new system is available, evaluate prospective DUR, looking at number and results of alerts (Dr. Mergener).

VI. Break

VII. Review of Current Retrospective DUR Criteria (Attachment 4)

Dr. Mergener presented on the retrospective DUR Criteria. No cuts are being done with this list today – the intent is to present and discuss the idea, and revisit this again in the next year for the Board's feedback. Attachment 4 displays the criteria currently active in the retrospective system (this may include some duplication). The target for retrospective versus prospective interventions is different – prospective goes to the pharmacist and retrospective goes to prescribers so they can see drugs their patients are on in a targeted fashion. More filtering is applied to retrospective interventions than prospective because prospective determines that we are going to send something to the pharmacist. With retrospective, the system identifies a condition, drops it for profile review, the pharmacy staff reviews the profiles and decides the alert occurred. However, a letter may not be sent to the prescriber based on the pharmacist's analysis of the case. With every case reviewed, a clinical decision is made and it is determined whether or not to send an intervention letter. Retrospective DUR evaluations are performed every month, but 100% of criteria are not used each time. Health Intervention Designs (HID) provides the engine for this – they get extracts of the pharmacy claims as well as medical claims for loading diagnosis into the system so when reviewing a patient profile, both drug and diagnosis history are reviewed. Diagnosis history includes a list of the diagnoses with the most recent occurrence of that diagnosis on the patient's chart plus the number of times that diagnosis has appeared. Additionally, if the pharmacist has a case previously reviewed, the case is blocked for a period of time. HID has a large criteria list that's been reviewed in the past and the Board has added criteria. Almost all drug-drug interactions have prospective criteria; these alerts are sent to the pharmacies. It's seldom a letter is sent on a drug-drug interaction if it's the same doctor. Lon Blaser questioned if a drug-drug interaction is picked up in the prospective system, the pharmacist resolves it (there is no problem) and the drug is dispensed, is there a way to not send a letter? No as these are stand alone databases and the systems are not linked.

Referring to the columns in Attachment 4, Utility A is the 1st drug and Utility B is the 2nd drug. Utility C is usually a negating factor. HID also assigns their determination of severity levels. In the past, HID has built new criteria based on our suggestions. Newer criteria are incorporating diagnosis and we are doing some disease management by

looking closer at drug and disease interactions, and whether or not there is a drug therapy contraindication because of a condition or whether therapy should be added. Dr. Mergener then presented the list:

- Drug-Drug Markers and/or Diagnosis – for antipsychotics and anticonvulsants, even though criteria is still there, the yield is less as we get more involved with mental health conditions that are using both antipsychotics and anticonvulsants. Less likely to send out letters based on therapy and diagnosis.
- Drug-Drug Interactions – those we currently have on – may want to discuss these in the future.
- Overuse (Early Refill) – a mix of true early refills and more on the overuse/continued use of products. With some sedatives, an alert is sent if someone is using these drugs over a long period of time.
- High Dose Alert – using already established guidelines. SeniorCare included due to running retrospective DUR on that population.
- Drug Disease – Beta-blockers and congestive heart failure – should thought be given to grading measures and building into drug disease interactions? Dr. Mergener will look at.
- Drug Pregnancy Alert – prenatal vitamins are used as a marker.
- Therapeutic Appropriateness – overuse of analgesics – a newer category. We may talk to HID about tweaking antihyperlipidemic therapy.
- Therapeutic Duplication - typical of fairly big drugs. Default to antipsychotics-all because it includes atypicals and typicals and is duplicative of atypicals alone.

Dose consolidation has been turned on in the past and we do alert on those in some cases. A future item for discussion is extracting other data from medical claims. We currently do not do lab claims in the retrospective system, but that is a good idea. Mr. Breslow suggested providing the new Board members with the universe of hits we chose not to include for their feedback. Dr. Mergener will pare the list down to be more specific and send to the Board for review and feedback. He will then incorporate any feedback, redo the list and send it out prior to the 3/4/09 meeting. He will also do a yield (how many alerts that we review do we take action on) for this list and send that out as well. Board members should choose those they want to discuss and bring the list back to the 3/4/09 meeting.

Action Items:

- Drug Disease – beta-blockers and congestive heart failure - should thought be given to grading measures and building into drug disease interactions? Dr. Mergener will look at.
- Provide universe of hits to new Board members for their feedback.
- Dr. Mergener will pare down the list to be more specific and send to the Board for review and feedback. He will then incorporate any feedback, redo the list and send it out, including the yield, prior to 3/4/09 meeting. Board members should choose what they want to discuss and bring the list to the meeting.
- High dose – 15 mg/day elderly is incorrect. Dr. Mergener will look at and make the correction.

VIII. Adjournment

The meeting adjourned at 3:20 p.m. The next meeting is scheduled for March 4, 2009.