

MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING

Wednesday, June 3, 2026

1:00 p.m. to 4:00 p.m.

Virtual meeting via Zoom

DUR Board Members Present:

Paul Cesarz, RPh
Jeff Huebner, MD
Robert Factor, MD
Travis Copeland, MD
Michael Ochowski, RPh

Gainwell Staff Present:

Tom Olson, PharmD
Chally Clegg
Willie Wilberg, PharmD
Katie Counts, PharmD
LaToya Lang

DHS Staff Present:

Kim Wohler
Tiffany Reilly
Darla Stachowiak
Pamela Appleby
Susan Seibert
Ben Minch, PharmD
Nicole Schneider
Jennifer Snow, RPh

Absent:

Brooke Passolt, MD

Welcome and Introductions

Kim Wohler called the meeting to order at 1:04 p.m. and began with a welcome and thank you to the Board members for their attendance at the meeting. As the meeting was held virtually, Kim provided technical instruction on how the meeting would proceed. A quorum of members attended the meeting. Kim also noted that Dr. Brooke Passolt and Paul Cesarz have resigned from their positions on the Board after today's meeting. She thanked them for their years of service.

Review of the Agenda and Board Materials and Approval of March 2026 Meeting Minutes

The members were reminded of the meeting materials sent via email for reference and review. Prior to this meeting, Board members received the agenda, minutes, and RDUR Quarterly Report via email and had the opportunity to review each document. The March minutes were briefly reviewed and approved with an initial motion from **Paul Cesarz** and a second from **Mike Ochowski**. The motion passed unanimously.

ADURS Update

Dr. Copeland began the meeting by providing an update to the Board regarding initiatives that were discussed at the ADURS meeting he attended in February. Several initiatives were discussed by the States in attendance, including monitoring the use of antipsychotics in adults in all care settings as is now required by Federal mandate. He noted that due to data limitations identifying care settings, all States are monitoring the full population like Wisconsin has chosen to do. He also noted that some states are engaging in outreach to hospitals in addition to the retrospective DUR interventions. Retrospective interventions include those that focus on safety/metabolic screening, polypharmacy with multiple antipsychotics, and polypharmacy between antipsychotics and other drug classes. Other initiatives that were of interest to Dr. Copeland included outreach to specific diabetes populations regarding medication coverage and another that focused on stimulant polypharmacy.

Quarterly DUR Reports

Tom began by reviewing member enrollment. The enrolled member count continues to minimally decrease due to the end of the public health emergency. The highest enrollment point was Q1 2023, and enrollment has returned to pre-public health emergency levels and has been stable for the last six months. He continued by pointing out that claim volume continues to trend downward, mirroring enrollment, though there was a slight increase in claims for the most recent quarter. Tom then reviewed the quarterly reports with the Board beginning with the multiple drug classes report. He reminded the Board that this report identifies members who have claims for all five drug classes (opioids, stimulants, benzodiazepines, sedative hypnotics, and opioid dependence medications) that are tracked for use. Members that are receiving drugs from all five classes are reviewed by a pharmacist for possible inclusion in the Lock-In program or sending physician alert letters. There were eight members identified in the last quarter. Five of those members received an alert letter, and three were suppressed due to previous recent action. Additional DUR alert trend graphs were presented. Tom noted that most of the ProDUR alerts are stable or decreasing. The early and late refill alerts continue to be the highest volume alerts.

Next, an overview of claim volume was presented to the Board and the percentage of claims with a DUR alert per quarter

has continued to remain stable overall and approximately 45% of paid claims are paid with no DUR alerts. He also noted that less than 2% of paid claims have multiple DUR alerts. Slides were presented to review claim count changes. Claim volume continues to decrease, though a slight increase was noted this quarter. The claim volume from Q1 2025 to Q1 2026 has decreased by about 274,000 claims. Tom noted that the changing member population and policy changes could be a component of the decreasing claims volume. Trend graphs for average morphine milligram equivalents (MMEs) per member per day and members utilizing buprenorphine from 2023 - 2026 were also included. The average MME has hovered around 41-42MME for about two years and continues to remain stable. Upon presenting the members on buprenorphine graph it was noted that historically, as the overall average MME has decreased, the overall use of buprenorphine has increased. However, there has been a slight decrease in the number of members on buprenorphine over the last four quarters. While this may be a result of enrollment changes, the trend was further investigated to reveal that when looking at the percentage of members on buprenorphine, there is still an increase in use over time.

Naloxone Use Updates

Two graphs were presented to the Board looking at naloxone member trends from 2023-2026. Naloxone usage has continued to be steady, with a slight increase in the most recent quarter. Further analysis of the trend graph was done based on opioid use and MME levels. This analysis continues to reveal that most members with a claim for naloxone either had no opioid claims or claims for low MME values (less than or equal to 50 MME per day). Tom then presented a slide which was introduced at the December 2022 meeting, tracking naloxone fills for members at 90 MME or greater. From Q2 2023 to Q1 2026, we saw a reduction in members with 90 MME. The member fill count for the current quarter has increased. The average percentage of members with 90 MME or greater and receiving a naloxone fill in Q1 2026 was 13%, with the average fill rate over time being 12%. Additionally, a second slide was presented tracking naloxone fills for members receiving buprenorphine for opioid use disorder (OUD). For about a year we have seen a decrease in members with OUD as well as in naloxone dispensed, but the most recent quarter showed a slight increase. The average percentage of members with OUD and receiving a naloxone fill in Q1 2026 was 8%, with the average fill rate being 8%. A graph with the count of members getting naloxone since 2019 was shared. The graph indicated an increased dispensing until about Q3 2023, but a recent upward trend continues.

Opioid Script Limit

Tom began by presenting the percentage of override trend, and overrides are consistently issued for less than 0.3% of the total opioid claims. While the opioid script limit policy impacts a very small number of claims, trends indicated it is an effective policy. Additionally, Tom reminded the Board that there is a process in place to review high MME outlier claims. The top five claims are reviewed each quarter for possible intervention. There were no members referred to Acentra for possible lock-in for this quarter.

Multiple CNS Depressants

Tom began by reminding the Board that this is a quarterly intervention. He also indicated an update to this intervention has been made that breaks the members into two age groups. The adult group is ages 18 to 64 years and the older adult group is those 65 years and older. The new older adult age group intervention was implemented for the February 2026 cycle. The older adult alert message was shared with the Board. The current methodology for inclusion has been in place since Q1 2022 and will continue to be utilized but will be modified to include older adults who are receiving three of the four drug classes while the adult group will continue to require use of all four drug groups. The methodology identifies members who are concurrently receiving medications from the following drug classes: benzodiazepines, opioids (non-MAT), sedative hypnotics, and skeletal muscle relaxants, and are receiving 45 or more actual days' supply of the medications during the quarter. The members must have a claim for the drug class in the last month of the quarter. The selected members are reviewed, and a letter is sent to prescribers regarding the risks of the noted polypharmacy. Letters are sent quarterly to providers of newly identified members and annually to prescribers of previously identified members. A full send of letters for all identified older adults was done for the first cycle of the intervention. Going forward, a full refresh of all identified members will be done in the second quarter each year. For Q1 2026, there were 63 adult members on all four medications and 27 new members selected for intervention. There were 62 older adult members on at least three medications, and 30 new members were selected for intervention.

Stimulant Utilization Discussion

As an introduction to this discussion, Tom presented the usual graphs for the percentage of adults and children on stimulant medications. The first slide is a comparison graph of children and adults within the total Medicaid population that shows that the greatest increase of members receiving stimulants has been within the adult population. However,

there has been a continued decrease beginning in 2023 of the adult population which is likely due to changes in enrollment status. The next slide is the percentage of children on stimulant medications remains cyclical due to the school year in this age group, but that trend has become less obvious in the data over time. The percentage of children has been down since COVID-19 public health emergency but now seems to be increasing and is close to the pre-public health emergency percentage. The percentage of children taking stimulants in the total Medicaid population is above the percent of adults now. There has been a sustained increase in use since 2020 in adults.

Dr. Copeland continued this discussion by reminding the Board that stimulant utilization trends have been reviewed at several meetings, but they have looked at high-level data and primarily in children, though some adult review has been done. He also reminded the Board that there are existing stimulant initiatives in children that may result in case review, but with there is only claim count data for adults. He noted that there has been an increased interest in DUR for psychotropic prescribing in adults, thus it was decided to do a more granular analysis of stimulant use in children and adults. He reviewed high level utilization trends prior to moving to more in-depth trends involving dosing and diagnosis data. Stimulant utilization was noted to have increased in both pediatric and adult populations during the COVID-19 public health emergency (PHE). Since that time, utilization in children has fallen to pre-PHE levels, while adult use has stayed higher than pre-PHE levels. Overall claim counts and member counts by medication have shifted from heavy use of amphetamine salts to highest volume of use being lisdexamfetamine and methylphenidate. When stratified by age, pediatric use is dominated by lisdexamfetamine and methylphenidate, while adult use is dominated by lisdexamfetamine. Some of this use is driven by PDL changes over time. There is less seasonal variation noted in claims for adult members than noted for pediatric members. Dr. Copeland also discussed high-level trends for wakefulness promoting agents which are not indicated for ADHD but are used for sleep disorders and somnolence. It was noted that member counts for these medications are significantly lower than for traditional stimulants in both adults and children. Utilization trends for these medications changed significantly with changes to prior authorization requirements in 2019. Modafinil is the main driver of utilization in this drug class.

Dr. Copeland went on to discuss the number of members on traditional stimulants and dosing distributions based on age for the top four utilized drugs during Q4 2025 that include methylphenidate, dexamethylphenidate, lisdexamfetamine, and mixed amphetamine salts. Methylphenidate and dexamethylphenidate use are significantly higher in children versus adults. The number of members exceeding the State identified dose threshold of 110mg is very low in both populations at less than 0.4%. The use of lisdexamfetamine is noted to be very similar across both the adult and pediatric population. The number of members exceeding the State identified dose threshold of 140mg is minimal in both populations at less than 0.07%. The use of mixed amphetamine salts is significantly higher in adults versus children. The number of members exceeding the state identified dose threshold of 60mg is higher in both populations, but much higher in the adult population (1.6% in children and 9% in adults). For all drugs in the pediatric population, low to moderate doses are most common with a steep drop off at higher doses. For the adult population, the dose distribution mirrors the pediatric population except for the amphetamine salts which trend toward moderate to higher doses being more common.

Lastly, Dr. Copeland discussed the diagnostic data associated with stimulant claims during Q4 2025. He noted that stimulants have diagnosis data included on most claims. The main limitation of this diagnosis data is that multiple diagnosis codes may be entered, some of which may not be relevant to the stimulant utilization. The majority of stimulant claims include an attention disorder diagnosis. A much smaller volume includes a diagnosis of a sleep disorder or an eating disorder. When reviewing high dose stimulant claims, the dominant diagnosis codes were those for attention disorders. Of note, none of the high dose claims had a diagnosis of an eating disorder. The majority of high dose stimulant claims involve an amphetamine-based product. He finished the discussion by reviewing options for future DUR stimulant interventions including possible distribution informational materials, interventions addressing stimulant polypharmacy with other high-risk medications, and possible high dose case reviews.

Polypharmacy of Sedating Medications in Children

Dr. Copeland began by reminding the Board that this topic has been reviewed several times and has had several iterations. The most recent changes were made in 2024, with no changes made in 2025 or 2026. This intervention identifies children (0-18 years) who have a claim for medications from at least three of the sedating medication drug groups in the last month of the quarter and have been on those drugs at least 80% of the time in a 180-day period. The sedating medication drug groups include sedative hypnotics, benzodiazepines, antipsychotics, melatonin, antidepressants, antihistamines, and clonidine (immediate release). He went on to review the history of the intervention parameters, including changes to the drug groups and days' supply used for member identification. He also shared the

letter volume for multiple rounds of the intervention stratified by member count, prescriber count, and member/prescriber combination count. Member counts were further stratified by age and date period to illustrate changes to letter volume. Dr. Copeland went on to discuss member counts by age and drug group based on the 2025 mailings. He discussed the changes to the drug groups as members become older, indicating that changes to the medications utilized in older drug groups can be a result of different behaviors and conditions being treated in the older age groups.

Dr. Copeland finished the discussion with a review of the high-risk members from 2024 to 2026. He indicated that the cases identified for intervention are considered high-risk due to the highest number of ongoing sedating medications and also those with multiple providers. He noted that in some cases the member may not have been on all of medication simultaneously for the entire period. Most members identified as high-risk typically were older and had complex medical diagnoses. Anticonvulsants were involved in many of the polypharmacy regimens, as well as the use of multiple antipsychotics. Board discussion included possibly updating the drug groups again and the types of diagnoses seen in children on multiple antipsychotics.

Diabetes Guidelines Discussion

Katie began the discussion by providing the Board with background information that prompted the creation of an intervention to identify concurrent therapy with DPP-4 inhibitors and GLP-1 receptor agonists. She noted that an email was sent in a large contact group of State Medicaid Drug Utilization Review programs inquiring how programs were addressing the updated 2025 treatment guidelines from the American Diabetes Association (ADA) that specifically indicates concurrent use of DPP-4 inhibitors with a GLP-1 RA or dual GIP/GLP-1 RA is not recommended. The rationale for the recommendation is that both classes of medication act on the same incretin pathway and that there is evidence of a lack of additional glucose-lowering benefit beyond what is achieved with GLP-1 RA alone. She went on to remind the Board that the concurrent use intervention was implemented for the June 2025 cycle and reviewed the criteria parameters and alert message sent to prescribers.

Katie continued the discussion by providing the intervention data for the June, July, August, and September 2025 cycles, as well as the March 2026 cycle. She reminded the Board that it was decided that this intervention should become a focused intervention to be performed every six months. She also reminded the Board that members from the initial June 2025 cycle were reevaluated to determine an intervention response rate. Those members identified for intervention in June 2025 were reevaluated six months later to see if they were still being identified for concurrent therapy. Katie noted that intervention response rate, after removing members who lost eligibility, is very good at 46%. Further review of the prescriber responses to the intervention letter was conducted. The majority of the responses indicated that the prescriber was making a positive change, while five prescribers stated that no changes would be made. She indicated that intervention letters will continue to be sent to prescribers who have not stopped the concurrent therapy.

Multiple Antipsychotic Use Letter Update

Katie began the discussion by reminding the Board that this topic has been reviewed multiple time and that at the March 2026 meeting Dr. Copeland indicated letters were developed based on patient age and identify children (0-18) that are taking two or more antipsychotics and adults (19 years of age and older) taking three or more antipsychotics for 80% of the time in a 180-day period. She indicated that letters are being sent every six months with one year between letters regarding an individual member and the first round of the intervention was implemented in February of 2026. In this initial cycle of letters, 103 children were identified for intervention and 99 were selected for intervention. Pediatric letters were mailed to 83 prescribers. There were 188 adults identified for intervention and 179 were selected for intervention. Adult letters were mailed to 118 prescribers. Katie went on to discuss rationale for why a member may not have been selected for the intervention. Those reasons included age changes, adherence issues, eligibility changes, and medication changes. She indicated the next round of this intervention will be completed in August 2026.

Lock-In Impact Analysis

Katie began the discussion with an overview of the program's functionality and objectives, which are to identify and reduce drug-seeking behavior and to identify inappropriate prescribing patterns. The Board was reminded that these reviews are performed monthly and that there are multiple steps in the lock-in process. She indicated that once the process is started, letters are sent to prescribers and/or members every six months, and the process takes 12 to 15 months to enroll a member in the program. Once enrolled in the program, members are locked into a single pharmacy and prescriber for a period of two years. She reminded the Board that members are reviewed at the end of the

enrollment period for possible continuation in the program. Members have the right to appeal initial enrollment and reenrollment decisions. Katie closed her portion of the discussion reviewing the criteria utilized for lock-in enrollment which include criteria that look for excessive use of controlled medications (#3147) and combinations of buprenorphine with opioid agonists (#5304). Both criteria utilize days' supply to identify members for review.

Tom continued the discussion by reminding the Board that a similar analysis was presented at the March 2025 meeting. The goal for this analysis was to determine if there were sustained changes to utilization patterns of members after being released from the lock-in program. The average days' supply of controlled substances was utilized as the measure for the analysis. Tom indicated that the milestone time periods used for analysis were adjusted from the previous analysis to capture more members. Twenty-six members whose lock-in ended in 2024 were eligible for analysis. In order to try to standardize the analysis some members were excluded from analysis due to eligibility changes. The analysis compared the member's controlled substance utilization the quarter prior to being locked in with the four quarters after being released from locked in. The analysis of the average days' supply revealed a 28% decrease at the end of lock-in versus the quarter prior to lock-in. Additionally, one year after the end of lock-in, the average days' supply was still 26% less than the quarter prior to lock-in. Further analysis of four members was presented that included a review of days' supply, number of pharmacies used, and number of prescribers used pre- and post- lock-in. The results indicated that the lock-in program does generally have a continued positive impact on utilization patterns for those members included in the program.

PDL Update

Kim provided a brief PDL update from the May 6, 2026, PDL meeting. She indicated that the DHS secretary is currently reviewing the recommendations. A ForwardHealth Update will be available June 19, 2026, and the approved changes will be implemented on July 1, 2026

Adjournment

Travis Copeland motioned to adjourn the meeting. The meeting adjourned at 3:50 p.m. Upcoming meetings are on the following Wednesdays: September 2, 2026, December 2, 2026, March 3, 2027, and June 2, 2027.

Guests: Matt John, Otsuka; David Large, Chiesi Global Rare Disease; Bill Eicholzer, PTC Therapeutics; Todd Kailas, Alkermes; Ryan Miller, Teva; Jenna Doerr, Petauri Health; Erin Nowak and Nancy Nau, Abbvie; Ann Marie O'Toole, Lilly; Scott Mills, Bristol Myers Squibb; Carrie Schaack, Sarepta.