

MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING

Wednesday, March 6, 2013

1:00 pm to 4:00 pm

1 W. Wilson Street, Room 751

Madison, WI 53701

DUR Board Members

Present:

Maria Brenny-Fitzpatrick RN, MSN FNP-C, GNP-C

Ward Brown, MD

Paul Cesarz, RPh

Daniel Erickson, MD

Robert Factor, MD

Michael Ochowski, RPh

Jake Olson, PharmD

Lora Wiggins, MD

Absent:

Robert Breslow, RPh

Michael Brown, PharmD

HP Staff

Teai Czajka

Tom Olson, PharmD

Lu Anne Green

Monica Yeazel, RPh

DHS Staff

Rachel Currans-Henry

Marilyn Howe, RN

Lynn Radmer, RPh

Lisa Reese

Kay Reniero

Kimberly Smithers

Welcome and Introductions:

Rachel Currans-Henry called the meeting to order at 1:03 pm, with thanks to the Board. Introductions were made.

Review of the Agenda and Board Materials and Approval of Minutes-December 5, 2012 meeting:

Rachel Currans-Henry walked through the agenda as printed and the Board packets. Members had received minutes, Lock-In Activity Report, Lock-In Overview and RDUR Quarterly Report via email and had the opportunity to review prior to this meeting. With a quorum present, Rachel asked for a motion on the minutes.

Motion to approve minutes as printed made by Michael Ochowski and seconded by Paul Cesarz. Motion passed unanimously.

Prospective DUR: Update on Previously Reviewed Alerts:

Lynn Radmer reviewed the status of Prospective DUR alerts changes to date and gave an overview of the Alert Activity in Fourth Quarter 2012.

- The method of tracking alerts has changed over time, so we are not comparing actual numbers of alerts in old data vs. new data. Note that a claim can have more than one alert.
- Overall, about 15% of claims get a Prospective DUR alert according to Fourth Quarter data, but AT-Additive Toxicity has been turned off since then.
- We can say we see a slight decrease in DD-Drug-Drug and PG-Pregnancy alerts, and a slight increase in TD-Therapeutic Duplication alerts. HD-High Dose is a very low volume alert.
- While it is true that the percent of claims alerted was higher previously, we can't say exactly by how much due to changes in tracking methods.
- Board members gave feedback that the amount of alert "noise" has reduced.

Detailed Alert Statistics from Fourth Quarter 2012: Lynn Radmer provided a walkthrough of slides and data packet.

1. Drug-Drug:

- Data provided to the Board shows most common drug combination that alerts is cyclobenzaprine and tramadol, and >80% of those alerts are overridden. Putting the DD alert in perspective, in Q4 2012, there were about 6,000 DD alerts involving tramadol as one of the drugs, but there were about 45,000 tramadol claims.
- Overall, about 80% of DD alerts are overridden. Discussion about if this is appropriate or if we need to take steps at a later date to modify this alert (change dissipation factor, only alert on FDB major, etc.) Information provided may still be causing pharmacists to take action. 80% override still means 20% of claims were stopped, which was deemed significant.

2. Therapeutic Duplication:

- Analgesics/narcotics is largest class of alerts.

- Overall, see a 77% override rate, but without narcotic analgesic alerts included, the override rate is <70%.
- Data provided gives perspective on claims alerted. 36,000 narcotic analgesics claims got an alert in Q4 2012, but almost 300,000 analgesic narcotic claims in same time period.
- Board discussion indicates that moving to grouping by FDB therapeutic class groupings has cut down on alert “noise” and the alerts are more useful and easier to be maintained.

3. Pregnancy-Drug:

- Updated ICD9 codes for determining pregnancy status, and pregnancy profile is created.
- About 50% of pregnancy profiles are created by a pharmacy claim for a prenatal vitamin (PNV), which are only covered for pregnant or lactating women. Some profiles may be created based on incorrect billing of PNV.
- Profile is active for 260 days time span, unless claim comes in with a diagnosis indicating woman is no longer pregnant.
- FDB must consider the drug dispensed to be contraindicated in pregnancy for alert to set.
- Ibuprofen is most common drug that alerts, at 24%.
- Override rate is about 80% for all alerts regardless of whether the pregnancy profile was created from a pharmacy claim or other claim type.
- Looked at whether same vs. different pharmacy creating profile and filling drug affects override. It does not.
- Discussion: Should we continue to monitor PG alert for pregnancy profiles created by PNV claims? If we retain the alert, should we stop alerts where the pharmacy that created the profile and dispensing the offending drug are the same?
 - Redundant systems are good in this case. Not aware of pharmacy software that uses PNV as proxy marker for pregnancy, therefore rely on Medicaid to do that.
 - This may be easily missed in pharmacist’s review of patient profile, and pharmacists appreciate being alerted.
- **Motion** to recommend the State not make any changes to the pregnancy drug alert at this time made by Michael Ochowski and seconded by Jake Olson. Motion carried unanimously.

HD-High Dose Alert: Lynn Radmer provided a walkthrough.

- Currently there are seven drugs in HD Prospective alert. This is a low volume alert.
- Drugs and dosage limits monitored determined by DUR Board previously.
- Four drugs are monitored for all ages, three are monitored only for elderly.
- Doses being monitored for all ages are only one dose, not age specific.
- For perspective, compare to Retrospective DUR HD monitoring of over 300 drugs with about 450 criteria.
- RDUR HD criteria are based on published literature. Various criteria take into account age, sex, liver and/or kidney function. Some drugs have multiple HD criteria, based on patient parameters.
- Prospective alert is based on units per day, not age specific dose. If patient takes drug on inconsistent basis, units/day calculation may be incorrect.
- Alert uses FDB system for age identification. Elderly is defined by FDB as age 60 and older.
- Data shows acetaminophen has the most alerts. The max dose is 4 grams, but that would not be appropriate for a small child. We see concerns within this alert. The alert is overridden almost 90% of the time.
- Alert is difficult to maintain and may not include, for example, all drugs that contain acetaminophen. Updates must be done manually currently, as not linked to FDB.
- Dosage max limits we currently have are incomplete compared to what FDB would have for various ages.
- Discussion: Should we continue to monitor HD through Prospective DUR? If the alert is retained, what drug(s) should be monitored? The State strongly encourages adopting FDB parameters to support this alert.
 - Need to add drugs like simvastatin, toradol.
 - Now have quantity limits in place on some drugs which may address some HD issues.
 - Selecting on a drug-by-drug basis would be very complicated.
 - Could “model” on FDB information, by turning alert off and running it in informational mode, which would not require a response from the pharmacy. We could gather data over time.
- **Motion** to turn off HD alert as it is now and use FDB in informational mode only to bring back data at a future meeting made by Jake Olson and seconded by Paul Cesarz. Amendment to motion made to run for at least 3 months and have preliminary data back to Board at future Board meeting when available. Motion passed unanimously.

Pharmacy Services Lock-In: Monica Yeazel reviewed the Program and presented the Annual Report. Lynn Radmer provided an update on the HMO referral process progress.

- Board received and reviewed the overview of the process.
- Board also received and reviewed Annual Activity Report.
- Monica specifically called attention to the Provider Letter Volume. Prescriber alert letters are the majority, followed by warnings, then lock-ins. Emphasis of the program is to get information to the clinician so they can make best decisions.
- Medications Monitored list is available on the Portal.
- HMOs now have the ability and responsibility to assign and change lock-in prescribers. Different HMOs may have differing standards for what they allow as sufficient reason.
- Additionally, the Provider Response Indications and Provider Written Comments were reviewed. Many members involved in the Program appear to not have ongoing stable relationships with one provider. Providers in many cases are using the information in the letters to make changes in member care.
- Board discussed the PDMP that is new in WI. More information will be available from the Department of Safety and Professional Services at <http://dsps.wi.gov/PDMP>. Board members suggested including information about the PDMP in lock-in letters.
- Lynn outlined the HMO process to identify other drug use behavior regarding lock-in that does not come through pharmacy claims. HMOs can refer members to go directly into lock-in without interventions.
- Currently working on forms, policies and procedures to give to HMOs. The HMO is responsible to defend any appeal.
- This is a compromise reached through the contract process; being responsive to HMOs as we manage Rx on MA FFS side. Should be operationalized in next couple of months.

ADURS Update: Lynn Radmer shared information.

- Lynn and Monica attended the annual meeting of the American Drug Utilization Review Society in February.
- Learned PDMP programs generally exclude Medicaid access.
- Common themes heard from many states: opioid restrictions- limits based on morphine equivalents, problem of antipsychotics in kids, limits on amount of stimulants, limits on suboxone.
- States vary significantly in their MA populations and resources, and what they can accomplish, and their approach to similar problems can be quite different.
- Lynn asked about other states doing additive toxicity. No one is doing anything like it, nor did anyone have suggestions. Suggestion that the decision Board made to turn off AT Alert was correct, and further pursuit of any AT alert may not be productive.

Targeted Intervention Update: Tom Olson shared information.

- Past intervention involved four specific topics: exceeding recommended dosages of citalopram and simvastatin in select populations.
- Letters were sent in late November, >800 letters sent, about 250 responses received. Response rate about 30% which is in line with rates seen in RDUR and Lock In. Providers are giving a favorable response to the information received.
- This was a well received and relatively uncomplicated intervention. Will wait to re-measure after a 6 month washout. Will look at those specific members who were intervened on.
- Considering next targeted intervention focus to be stimulant dosing in kids \leq 14 years old.
- Are working with child and adolescent psychiatrists to determine what doses constitute "high dose" as there is lack of clinical consensus.
- Consultant psychiatrists have, through outreach, heard that prescribers may not consider high doses as a problem. Need to have buy-in from DUR Board and Mental Health Drug Advisors Group as to how to form dosage limits and how to consider what is inappropriate use.
- Suggestion and discussion of reviewing FDB information for HD parameters for stimulants.
- From ADURS, some states use long acting agents, or prefer certain agents that may be less misused.
- Stimulants are the number one drug spend class for Medicaid.
- Board suggested phase two could be adult high dose stimulants, as that is a concern also. Also consider quantity limits for certain stimulant drugs.

- Suggestions for other targeted interventions are: high dose Strattera, guanfacine, clonidine, multiple benzodiazepines used concurrently.
- Rachel Currans-Henry made a call to the Board for input into any areas for us to think about for future meetings. Email Monica with suggestions.
- Will need to complete Prospective alerts first, then move on to new ideas.

Adjournment:

Motion to adjourn made by Paul Cesarz and seconded by Maria Brenny-Fitzpatrick . Motion carried unanimously. Meeting adjourned at 4:05 pm. Next meeting June 5, 2013.

Guests: Michael Healy (Gilead), Dawn Bina (NNI), Julie Brown (Amgen), Nick Boyer (Otsuka), Mark Davis (Vertex)