MINUTES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD MEETING
Wednesday, September 12, 2018
1:00 p.m. to 4:00 p.m.
1 W. Wilson Street, Room 751
Madison, WI 53701

DUR Board Members
Present:
Robert Factor, MD
Paul Cesarz, RPh
Jake Olson, PharmD
Michael Brown, PharmD
Michael Ochowski, RPh
Robert Breslow, RPh
Ward Brown, MD
Daniel Erickson, MD
Michelle Bensen, MD
Absent:
Hannah Delong, MSN, PMHNP-B
Lora Wiggins, MD

DXC Staff
Present:
Chally Clegg
Tom Olson, PharmD
Jacque Nash, PharmD
Katie Counts, PharmD
Kristie Chapman
Eric Matyas
Randy Cullen, MD
Scott Donald, PharmD

DHS Staff
Present:
Kimberly Smithers
Lynn Radmer, RPh
Tiffany Reilly
Julie Sager, MD
Steve Tyska, MD
Rachel Currans-Henry
Susan Seibert
Sean Gartley

Welcome and Introductions
Rachel Currans-Henry called the meeting to order at 1:07 p.m. and began with a welcome and thanks to the Board members for their attendance at the meeting. A personnel change was announced. Jacque Nash, the Health Information Design pharmacist, will be replaced by Katie Counts. A special thank you was noted for all of Jacque's hard work. Additionally, Dr. Steve Tyska was introduced as a new part time Medical Director. All Board members and staff present introduced themselves. A quorum of members attended the meeting.

Review of the Agenda and Board Materials and Approval of June 2018 Meeting Minutes
The members were reminded of the meeting materials in their respective binders for reference and review. Rachel walked through the agenda as printed. Prior to this meeting, Board members received the agenda, 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 **Michael Ochowski** and a second from **Ward Brown**. The motion passed unanimously.

Quarterly DUR Reports
Lynn began the reporting discussion by reminding the Board that a yearly CMS DUR Annual report is due each June and was submitted on time. It was noted that the content of next year's annual report will be changing significantly. There will be an in-depth review and discussion of these changes at the September 2019 meeting.

The quarterly reports were reviewed with the Board beginning with discussion of the multiple drug classes report. Lynn reminded the Board that this report identifies members who have claims for all five drug classes that are tracked for use (opioids, stimulants, benzos, sedative hypnotics, and opioid dependence medications). Members that are receiving drugs from all five classes are reviewed for possible inclusion in the Lock-In program or sending physician alert letters. The information from first quarter 2018 was not available for the June meeting, but has been included in the report with the current quarter information. In addition, the deduplicated claims reports have been expanded to include a graph that further illustrates claims that have single versus multiple prospective DUR alerts. This new report will be discussed in more detail during the upcoming Multiple Alerts agenda topic. Lastly, the ongoing interventions that are being tracked were reviewed. The use of codeine, tramadol, and hydrocodone in pediatric members was revisited in July with intervention letters being sent in August. Lynn noted the small number of members under the age of 12 receiving these medications. Also noted was that the small percentage of claims for cough suppressants may be a result of the time of year. The dental and benzodiazepine/opioid intervention results will be discussed later in the

meeting.

Multiple Alerts Discussion
Lynn provided an overview of prospective DUR alerts and the claims functionality. DUR alerts are triggered when the claims processing system identifies a potential drug therapy problem. Up to 10 alerts may be triggered on a single claim. The alerts are posted according to a hierarchy. The hierarchy in place today is: patient age (pending implementation) drug-drug, reported disease, therapeutic duplication, pregnancy, early refill, and late refill. Currently, a pharmacy is only required to respond to one alert which allows the provider to override all alerts. There is concern that clinically important alerts are being overlooked or missed because of this approach. Based on a survey of six states, Wisconsin is only one of two states that allow an override of all alerts when only one alert is addressed. Claims analysis of a single month indicated that approximately 8% of all claims had two or more alerts; and only 2.5% of those had 3 or more alerts. The State recognizes that changes to the override process will have an impact on pharmacies and is seeking Board input on how best to manage multiple alerts.

Several pharmacists on the Board shared examples of the pharmacy workflow so that non-pharmacist members had a better understanding of how prospective DUR alerts are currently handled at the pharmacy. It was noted that in most cases the claims are processing through two DUR systems, the pharmacy's internal system and the Medicaid claims processing system. Both systems could be considered a barrier as the pharmacy has to provide an answer to a potential problem prior to completing the fill/refill and discussing any problems with the member. However, in order to keep workflow moving the pharmacy may go ahead and override the alerts. This can impact the usefulness of any data collected because it may or may not be reflective of the pharmacist/patient interaction that actually takes place. Despite issues with the pharmacy workflow, board members agreed that a change needs to happen to ensure that important alerts are not missed, but further discussion is needed to determine the best solution. This topic will be discussed again at the December 2018 meeting.

Dental Opioids Intervention
Lynn provided a recap of the opioid intervention involving dentists. Dentists who had two or more members under the age of 18 receiving more than 10 units were identified. A letter was mailed to these providers with recommendations to avoid using opioids unless necessary; and when it is necessary, to prescribe small amounts. The initial intervention cycle identified 128 dentists, which accounted for 1,001 members, between April – September 2017. Letters were mailed to these providers in December 2017. A second intervention cycle identified 98 dentists, which accounted for 544 members, between January – June 2018. Letters were mailed to the 30 new dentists in September 2018. When evaluated, 46% of the 68 prescribers that were identified in both cycles showed a decrease in their prescribing. The State is working with the DHS dental consultants to further evaluate and address the dentists that had an increase in their prescribing in the second cycle. Additionally, the State is collaborating with the policy analyst that works with the Wisconsin Dental Association to determine if further action on this intervention is needed.

Opioid/Benzodiazepine Intervention
Lynn provided a recap of the opioid/benzodiazepine intervention. The intervention targets members receiving at least 90 days of a benzodiazepine in combination with at least 90 days of 50 morphine milligram equivalents (MME) or more of any non-medication-assisted therapy opioid. The initial cycle letters were mailed in February 2018 to 902 providers, which accounted for 781 members. A second cycle of letters will be mailed in September 2018 to 745 providers, which accounts for 639 members. There were 351 members identified in both cycles, as well as 288 new members in the second cycle. Lynn noted that in the second cycle most of the repeat members had new prescribers. Based on "prescriber churn", letters were sent to all providers identified in the second cycle. In June, feedback data as of February 2018 was presented and included a 30% response rate with at least a third of those respondents indicating that either one drug had been titrated down or discontinued or the member had an appointment to discuss modifying therapy. Upon evaluation of feedback data as of August 2018, 165 total comments were noted and 54 indicated a positive action had either already taken place or was planned. A random selection of comments reviewed for measures taken confirmed that providers are, in fact, implementing the changes they indicated in their responses.

Continued discussion on this intervention focused on opportunities to further evaluate and address the "prescriber churn". It was suggested some of the providers might be in the same office or health plan and would not necessarily indicate a true change in physician or doctor "shopping". Doctor shopping was noted to be an ongoing issue. It was suggested that there is a need to provide help and support to these providers. A potential source of help may include

letters that provide information on how to refer a patient to the Lock-In program and also encourage use of the Prescription Drug Monitoring Program. It was suggested that a different letter be sent to providers of members who were identified in both cycles but with a different provider in the second cycle. The purpose of this letter would be to notify the new provider that the patient had been previously identified under another provider and may potentially be doctor shopping.

Benzodiazepine Intervention Discussion

Lynn introduced a new potential intervention to address chronic benzodiazepine use. In past discussions, chronic benzodiazepine use without an opioid has been noted to be problematic. This initial intervention proposed to address chronic diazepam use due to the long half-life of diazepam. Internal data was reviewed at multiple doses (>10mg/day, >20mg/day, >30mg/day) and multiple durations (3 months, 6 months, 1 year) to determine an appropriate dose/duration target. Members with a diagnosis of seizures were excluded from the data. The results suggest that letters should be considered for those members that have been on an average daily dose of 20mg/day or more for six months or longer. Dr. Randy Cullen joined the discussion to provide some real-world insight into obstacles that providers are facing with respect to de-prescribing benzodiazepines. There are multiple ways in which prescribers, especially family practice/primary care prescribers, are vulnerable and are perpetuating the chronic use of benzodiazepines, including threats from patients and the rationale that a specialist was the initial prescriber. These prescribers often find it difficult to instigate de-prescribing. Dr. Cullen indicated that these prescribers need help with starting the conversation to de-prescribe. Education on adjunct treatment options has been noted to be beneficial to providing the prescribers with a first step to initiate the de-prescribing process.

Dr. Cullen transitioned to providing rationale to support using diazepam as the target for this intervention. As there is no standard dosing conversion between benzodiazepines, Dr. Cullen indicated that choosing a single drug for this intervention would be the most appropriate. Diazepam should be considered due to the long half-life which lends itself to ease the de-prescribing process. Dr. Cullen consulted with multiple sources including Steven Wright, MD, a physician involved in a national movement to change the prescribing of benzodiazepines, for direction as to what aspect of benzodiazepine prescribing should be targeted first. Based on his consultations, Dr. Cullen suggested that duration of use be the first issue targeted in this intervention. There is a considerable amount of support for targeting duration, including benzodiazepine prescribing guidelines and clinical data to confirm the risks of long-term use (i.e. addiction, adverse effects in the elderly, etc.). Additionally, minimizing withdrawal while tapering becomes more difficult once long-term use is established. It was emphasized that the letter must include educational and clinical information on how to actually de-prescribe. There is not a consensus on the best process, so further consideration will need to be given to the information included for the prescribers. Discussion topics with the board included: should the letter include guidance for prescribers on use of overlapping medications during the taper, will the letter consider the use of multiple benzodiazepines, will the letter be diagnosis specific, could a check list be incorporated that can assist, should information be sent to the prescriber that could be distributed to the patient or the family, and should anecdotal evidence be provide to the prescribers. Rachel confirmed that there is interest in going forward with this intervention, and invited the Board to contribute to the drafting of the letter. It was noted that a critical part of the intervention will be to provide prescriber education and support.

Morphine Milligram Equivalents Discussion

Lynn reminded the Board that at the last meeting there was discussion around tracking opioid doses; and that the tracking would be done using the morphine milligram equivalent (MME) calculation. There are several common methods used to calculate MMEs. The CDC methodology is being utilized by the State during the data analysis. An example calculation was provided by Lynn. There can be differences in MME calculations as a result of differing medications lists, conversion factors or the days' supply used in the calculation. Caution must be used when utilizing days' supply from the claim in the calculation due the arbitrary nature of that value. There is a potential for inappropriately elevated results when calculating the MMEs on claims that are for short term use. The State wishes to avoid sending letters in these situations. Therefore, the DUR methodology for retrospective letters which uses the average MME per day calculated over the duration of the study period will be used. However, further MME analysis and discussion with the Division of Public Health is planned. The State will report back to the Board any new information.

Pharmacy Program Statistics

Rachel reminded the board that it is important to look at a broad overview of the pharmacy program and how the program is doing. She introduced Sean Gartley, who reviewed part of an internal report that provides fiscal and claims

utilization information for both Medicaid and SeniorCare. The three-year monthly trend for total expenditures (not including rebates) show a steady increase, while the three-year monthly trend for claims volume remains fairly steady. The outpatient pharmacy benefit continues to account for the majority of the total expenditures. A steady increase in expenditures was also noted for the outpatient pharmacy benefit. These results did not include rebates. When the total paid amounts are compared over time with the net paid amounts (rebates included), the net paid amounts remain relatively steady. Additionally, the per member per month net paid amount, has slightly decreased from 2009 to 2016. It was noted that while these are very basic figures, it is exciting to see that program costs, despite rising drug costs, have remained stable over time.

Adjournment

Jake Olson motioned to adjourn. The meeting adjourned at 4:03 p.m. Upcoming meetings are on the following Wednesdays: December 5, 2018, March 6, 2019, June 5, 2019, and September 11, 2019.

Guests: Lisa Dunn, Amgen; Heather Coufal, Abbvie; Sean Byrne, Gilead; Nick Boyer, Otsuka; Joseph Cirrincione, Otsuka; K.Casey Johnson, ViiV; Michael Pratscher, Osiris; Kelly Ruhland, Lilly