Idaho DUR Committee Meeting Record

Date: January 19, 2012 **Time:** 9:00 a.m. – 12:15 p.m. **Location:** Idaho Medicaid, 3232 Elder Street, Conference Room D-West

Moderator: Mark Turner, MD

Committee Members Present: Perry Brown, MD, Wayne Baures, RPh, Paul Cady, Pharm.D, and Mark Turner, M.D.

Others Present: Tami Eide, Pharm.D., Jane Gennrich, Pharm.D., Elise Heil, RPh, Mark England, Pharm.D., and William Milne, RPh

Committee Members Absent: Erich Garland, MD, Janet Mayo, Pharm.D., Suzette Cooper, Pharm.D., Myrna Olson-Fisher, NP

AGENDA ITEMS	PRESENTER	OUTCOME/ACTIONS
Committee Business		
➢ Call to order	Mark Turner, MD	
➢ Approval of Minutes from October 20, 2011	Mark Turner, MD	Minutes approved as presented.
➢ **Follow-up Studies – updates**		
o Analysis of Auto Refill Practices- Discussion	Mark England, Pharm.D.	As of 1/16/2012 – 78 surveys (318 were sent to pharmacies on 7/08/2011) have been returned (25% response). At the October 2011 DUR Board meeting, the members suggested a rule change to not allow auto refill for Medicaid prescriptions due to concerns over drug stockpiling, duplicate therapy, increased drug cost, and disposal of unwanted medications. Dr. Eide reported that Paul Leary suggested that a temporary rule be put into place for a year and that it be presented to the legislature in 2013. There was further discussion about whether Auto Refill practices should be discussed with other insurance companies such as Blue Cross and Regence Blue Shield. Magellan also provided information that when a physician has his license revoked, it can take a long time before this information is updated in the national physician database file. Similarly, when a physician has died, the Idaho Board of Pharmacy allows refills to be dispensed by a pharmacy for up to 90 days after the pharmacy is aware of the physician's death.
o *Hepatitis C DUR*	Mark England, PharmD	

		Multiple ribavirin products are available at a large variance in the drug costs. Dr. England reviewed a detailed slide covering the cost differences. As the patients reviewed in the DUR project were all being treated for chronic Hepatitis C (the FDA approved indication), the DUR Board recommended at the October 2011 meeting that prior authorization is not needed at this time. In October 2011, the DUR Board recommended requiring prior authorization with therapeutic criteria for the new and very expensive class of drugs used to treat chronic Hepatitis C – Protease Inhibitors (Incivek and Victrelis). The P&T committee reviewed this class of drugs in November 2011 and recommended NOT instituting prior authorization with therapeutic criteria at this time as the only requests for these drugs so far had been for appropriate patients and were being prescribed by specialists. The P&T Committee did recommend that a DUR project be done in approximately six months to evaluate whether or not the drug was being prescribed and used appropriately. Due to the development of drug resistance, once therapy has started, patients should only receive one course of therapy of either Incivek or Victrelis. If the therapy is started and then stopped for any reason (e.g. side effects from the medication, non-compliance), the patient should not restart therapy in the future with any Protease Inhibitor. The DUR Board discussed the new P&T Committee recommendations and agreed with them.
○ Transdermal Testosterone DUR	Mark England, Pharm.D.	This DUR project was presented at the October 2011 meeting, including the rationale from the P&T committee, patient selection, appropriate diagnoses, and symptoms of androgen deficiency. It was noted that approximately 50% of the patients reviewed did not have an appropriate diagnosis. It was also noted that a large percentage of patients only fill their topical testosterone prescriptions one time. DUR Board recommendations: Initiate therapeutic criteria for transdermal testosterone as listed on the presentation slides. Complete an intervention of current users by contacting prescribers of current patients (within the most recent 60 days) receiving transdermal testosterone to inform them of the new criteria and request documentation of the diagnosis, symptoms and laboratory results. Grandfathering was discussed but the final recommendation was to handle on a case-by-case basis.
○ Oral Terbutaline Utilization DUR	Mark England , Pharm.D.	On Feb 27, 2011, the FDA released a Safety Announcement warning against the use of terbutaline to treat preterm labor. A review of Idaho Medicaid recipients showed that 28 female patients between the ages of 10-55 years had at least one paid claim for oral terbutaline between 5/1/2011 and 7/31/2011. 23/28 of these patients had a pregnancy diagnosis in their electronic profile.

○ Thiazolidinediones (TZD's) DUR	Mark England, Pharm.D.	As of November 8, 2011, GSK withdrew all rosiglitazone products from the current supply chain and they are only available through the Avandia-Rosiglitazone Medicines Access Program. On 3/22/2011, letters were sent to 65 prescribers about 63 patients informing them of this upcoming change. Usage of rosiglitazone containing products (Avandia, Avandamet, Avandaryl) has steadily decreased: 131 paid claims in December 2009, 66 paid claims in December 2010, and no paid claims in December 2011. Rosiglitazone containing products now require prior authorization; there have been no requests for these drugs as of November 2011.
➢ **Current Interventions/Outcomes studies**		
○ Citalopram High Dose DUR	Mark England, Pharm.D.	On August 24, 2011, the FDA released a Drug Safety Announcement changing the maximum daily dose from 60mg to 40mg due to abnormal heart rhythms associated with high doses of citalopram (Celexa). Letters regarding 235 patients who had recent paid claims for greater than 40mg citalopram daily were sent on 10/6/2011 to 186 prescribers with a list of their patients along with the FDA Safety announcement and Survey Response Form. As of 1/3/2012, 59 responses have been received (32% response rate). The response detail comments were review and discussed. Several patients receiving liquid citalopram were discovered to be on less than 40mg daily according to the prescriber even though the pharmacy was billing for 30ml (60mg) daily – e.g. 240ml/8 day supply when the daily dose was really 10ml daily DUR Board Recommendations: Decrease the maximum daily dose from 60mg to 40mg. Require prior authorization for doses over 40mg. Do not grandfather current patients.
○ Oral Terbutaline Intervention	Mark England, Pharm.D.	Letters were sent to prescribers on 12/7/2011 for the 24 patients identified with at least one paid claim for oral terbutaline between 7/1/11 and 9/30/2011. The letters included the FDA Safety Announcement and specifically tailored prescriber response form for oral terbutaline. As of 1/3/2012, only 3 responses have been received with minimal information on the response forms. DUR Board Recommendations: Do not institute prior authorization criteria for oral terbutaline at this time. Review utilization data for oral terbutaline in approximately six months to see if the utilization is decreasing.
➢ Study Proposals for Next		

Quarter		
○ Injectable Atypical Antipsychotics	Tami Eide, Pharm.D.	The responsibilities of Magellan, the Idaho Medicaid Pharmacy Unit and the Idaho Medicaid Program Integrity Unit were reviewed for the DUR project evaluating the use of injectable Risperdal Consta and Invega Sustenna. The medical records received to date are very incomplete. Examples include documentation of intramuscular injection of MS Contin (rather than a long acting antipsychotic) and no documentation of who or where the dose was administered. Proposals include having clinics buy and administer the drug rather than having the drug delivered to the clinic by an outpatient pharmacy as an outpatient prescription for a specific patient who then may or may not show up for his appointment.
○ P&T Committee Narcotic Analgesic Studies	Mark England, Pharm.D.	The P&T recommendations for DUR of Narcotic Analgesics included: A comprehensive DUR review of short and long-acting narcotics. Patient profiling analysis as listed on the DUR power point slides. Using several data sources outside of Medicaid including reports from the Board of Pharmacy's prescription drug monitoring program, legal/arrest databases and hospital discharge medication records. Possible policy changes suggested for consideration from P&T include: Restriction of prescriptions to prescribers and pharmacies within Idaho state borders Stricter refill policies (90% versus current 75% threshold) Expansion of lock-in program
○ Synagis 2010-2011 Season	Elise Heil, R.Ph.	Reviewed the 2010-2011 Synagis season and the impact of using the 2009 revised AAP recommendations for infants with gestational age between 32-35 weeks. Need to insert data from Elise's slides here (I don't have a copy). .
○ Leukotrienes vs inhaled corticosteroids in children with asthma	Mark England, Pharm.D.	The number of recipients <18 years of age with a paid claim for leukotrienes from 7/1/2011 – 9/30/2011 = 3,369. The number of recipients <18 years of age with a paid claim for inhaled corticosteroids during the same period = 1,595. This study has to be put on hold until diagnosis data is available.
○ Use of psychotropic medications in foster children	Mark England, Pharm.D.	The U.S. Government Accountability Office released the results from a study that was performed to examine the rates of psychotropic medication for foster and non-foster Medicaid children in 2008 in Florida, Massachusetts, Michigan, Oregon, and Texas. Data was presented for Idaho Medicaid children in 2008 and in 2011. Idaho has a high percentage of psychotropic drug use in both foster children and non-foster care children and the percentages are consistent from 2008 to the present.

		The DUR Board discussed this subject at length and agreed that the same scrutiny should be used for all children regarding the use of psychotropic drugs.
○ Ophthalmic antibiotic/steroid combinations	Mark England, Pharm.D.	The P&T Committee requested a DUR review to evaluate whether the prescribing physicians were specialists (ophthalmologists), primary care, or Emergency Room prescribers. They also wanted to determine in the review the age of the recipients.
○ Atopic Dermatitis	Mark England, Pharm.D.	The P&T Committee requested a DUR review on the Atopic Dermatitis drug class to include patterns of use, presence or absence of step therapy from steroids, specialty of prescribers and geographic regional differences of prescribing patterns. This DUR should include an educational piece on risks of these agents compared to risks from steroids because many practitioners seem to be using these agents to spare patients from any steroid exposure.
➢ ProDUR Quarterly Report	Mark England, Pharm.D.	The quarterly Prospective DUR Report was presented to the board. No specific ProDUR messaging was presented or reviewed for 4th quarter 2011.
➢ DUR Newsletter	Mark England, Pharm.D.	The Fall 2011 DUR Newsletter was distributed in the DUR Board packets and is available on line. Topics for the Winter 2012 newsletter were discussed, including: The Synagis review from this meeting. Foster Kids and use of psychotropic medications Prescription coverage for people who are incarcerated. Transdermal testosterone products will now require prior authorization
➢ Medicaid Update	Tami Eide, Pharm.D.	Tami Eide, Pharm.D., and Elise Heil, R.Ph. spent a majority of their time during the 4th quarter 2011 preparing for and participating in the CMS Certification Survey that occurred December 5 – 9, 2011. They presented the pharmacy system to the CMS survey team to review and understand in order to certify the Magellan system for Idaho. Certification of the system by CMS is a contractual condition and affects the percentage of federal matching funds for prescription drugs back to Magellan go-live in Idaho on February 1, 2010. The Idaho MMIS system was presented to CMS as one comprehensive system that includes three vendors, but each vendor will be certified individually. The reaction from the CMS team regarding the pharmacy system was very positive. The ongoing topic of the electronic unavailability of medical claims information in the Magellan DUR database for the pharmacy unit to utilize in DUR activities was discussed several times during this meeting. Dr. Eide assured the DUR Board that the

➢ *Adjourn, 12:15 p.m.*		State Medicaid management is well aware of the need to have the information available in order to effectively accomplish retroDUR projects. Dr. Eide discussed the updated PDL from the P&T meeting regarding inhaled albuterol products, which will be a preference change for the pharmacy providers. The Board discussed the ramifications as it pertains to various pharmacy settings. This PDL change has not been implemented yet. Next DUR Board Meeting: April 19, 2012 at 9:00 AM