Idaho DUR Committee Meeting Record

Date: August 23, 2012 **Time:** 9:00 a.m. – 3:00 p.m. **Location:** Idaho Medicaid, 3232 Elder Street, Boise, Idaho, Conference Room D-W

Moderator: Tami Eide, Pharm.D.

Committee Members Present: Paul Cady, Pharm.D, Myrna Olson-Fisher, NP

Others Present: Tami Eide, Pharm.D., Chris Johnson, Pharm.D., Jane Gennrich, Pharm.D., Mark England, Pharm.D., William Milne, RPh

Committee Members Absent: Mark Turner, MD, Erich Garland, MD, Perry Brown, MD, Wayne Baures, RPh, Suzette Cooper, Pharm.D.,

AGENDA ITEMS	PRESENTER	OUTCOME/ACTIONS
Committee Business		
➢ **Call to order**	Tami Eide, Pharm.D.	
➢ **Review of Minutes from April 19, 2012**	Tami Eide, Pharm.D.	Approval will be requested from the Board by email.
➢ **Follow-up Studies – updates**		
o Citalopram High Dose	Mark England, Pharm.D.	On March 28, 2012 the FDA issued a revised Drug Safety Communication with updated recommendations: The maximum recommended dose of citalopram is 40 mg per day for patients under 60 years and 20mg per day for patients over 60 years. Citalopram is recommended to be discontinued in patients who are found to have persistent QTc measurements greater than 500ms. Magellan surveyed data from 1/1/2012 to 3/31/2012 and there were 77 recipients over 60 years receiving 40mg of citalopram daily. The follow up review of the current prescribing trend for recipients over 60 years of age shows 10 new patients in June 2012 and 51 claims for the same patients from first quarter 2012 with a paid claim for citalopram 40mg daily for patients 60 years and older. The board recommended that Idaho Medicaid add an edit to deny claims at point of sale for citalopram doses greater than 20mg daily for patients 60 years and older.

➢ **Current Interventions/Outcomes studies**		
○ Narcotic Patterns of Use in Chronic Non-Malignant Pain	Tami Eide, Pharm.D. Chris Johnson, Pharm.D.	Background: At the January 19, 2012 DUR Board meeting the Idaho P&T Committee recommendations for narcotic analgesic DUR activities were discussed. The resulting DUR activity included generation of profiles for the top 150 recipients by total narcotic claim count between May 1, 2011 through December 31, 2011, for the recipients who had at least one paid narcotic claim in each of the 24 months for the period ending December 2011. The 150 profiles were hand reviewed by Idaho Medicaid pharmacists. Six of the recipients had cancer diagnoses and were therefore excluded from analysis. The following data is from the 144 profiles of recipients who were receiving narcotics for chronic non-malignant pain. Dr. Eide and Dr. Johnson reviewed the following data. • Average length of time for continuous opioid use = 8.2 years. • Average number of different opioids = 2.9 • Average daily morphine equivalents = 256 mg equivalents • Average number of prescribers per participant = 2 • Other concurrent potentially addictive drugs being used – the majority of patients were on concurrent potentially addictive drugs, most commonly benzodiazepines and/or muscle relaxants and/or sedative hypnotics. (see slide for detail)* • Diagnosis and indications – most patients had multiple diagnoses with the most common diagnoses being lumbago/back pain and chronic pain syndrome. • Average days prior to refill = 27 • Number of Medicaid pharmacy lock-in patients – included 4 patients currently enrolled in the lock-in program. • Non-Medicaid opioid prescription fills – using the Idaho Board of Pharmacy reports – 43 of the 144 patients (30%) had opioid prescriptions paid for outside of Medicaid pharmacy benefits (most commonly the additional opioids were paid for in cash). • Concurrent drug abuse diagnosis in patient's electronic profile = 56 patients (39%).

		P&T Recommendations from their May 2012 meeting included:
		• Long-Acting Narcotic Analgesics
		  ○ Tighten up definition of "failure of a preferred agent" beyond just a prior fill of preferred agent. Recommended evaluating morphine equivalent dosing when requests received to switch opioids.
		  ○ Tighten up criteria for fentanyl transdermal patches – currently only requires failure of one oral preferred long acting opioid.

○ PROP – Physicians for Responsible Opioid Prescribing	Jane Gennrich, Pharm.D.	Dr. Gennrich presented an overview of PROP – Physicians for Responsible Opioid Prescribing Their mission statement is: Our mission is to reduce morbidity and mortality resulting from prescribing of opioids and to promote cautious, safe and responsible opioid prescribing practices. They have submitted a petition to the FDA to request changes toopioid analgesic labels:
		1. Strike the term "moderate" from the indication for non-cancer pain.
		2. Add a maximum daily dose, equivalent to 100 milligrams of morphine for non-cancer pain.
		3. Add a maximum duration of 90 days for continuous (daily) use for non-cancer pain.
		
		The following topics were reviewed as part of the PROP program:
		
		• Review of FDA REMS Recommendations for extended release and long acting opioids – July 9, 2012 which includes:
		• Training for Prescribers
		• Updated medication guides for consumers
		• Assessment/Auditing of prescriber education
		  ○ Guidelines for companies on what to include in prescriber education
		  ○ Assessment of prescriber's understanding of risk information
		  ○ Assessment whether the REMS is adversely affecting patient access to necessary pain medication.
		
		The department is hoping to send a department representative to the National Summit on Opioid Safety which will be held in Seattle on Oct 31 – Nov 1, 2012.
		
		Proposed Idaho pharmacy department activities regarding long-acting opioid criteria: Ask for chart notes on all patients currently receiving more than 500mg morphine equivalents daily for review by pharmacist/medical director. Send a copy of Board of Pharmacy report on patients paying cash for additional doses to the prescriber.

○ Aliskiren DUR	Mark England, Pharm.D.	The FDA published a safety announcement on April 20, 2012 warning of the possible risks when using aliskiren containing products with ACEIs or ARBs in patients with diabetes or kidney impairment. A report was run to identify patients who had received an aliskiren containing product within the last 90 days. These profiles were then reviewed by Idaho Medicaid pharmacists to determine if these patients were concurrently on an ACEI or an ARB. • Letters were sent to 17 prescribers concerning 13 patients (in several cases, the ACEI/ARB was prescribed by a different prescriber than the aliskerin) on 4/30/2012. • Four (4) responses have been received as of 8/10/2012 (24% response rate).
○ Lupron DUR	Jane Gennrich, Pharm.D.	Reason for the DUR project – Received prior authorization request for Lupron for a 14 year old genetically male patient who is requesting a gender change to female. The request was denied as not medically necessary. Previously Lupron claims would pay with prior authorization not needed. Idaho Medicaid has now instituted prior authorization requirements for Lupron. • Profiles were reviewed for patients with paid claims for Lupron between 9/1/2011 and 3/31/3012 (n=25), 15 patients were children with sexual precocity and 10 patients were women with endometriosis. Prior authorization approvals were entered for all current patients who are still receiving Lupron therapy. • The department will institute an auto-PA rule so that claims for children with precocious puberty and women with endometriosis will pay at point of sale if the applicable diagnosis is in the patient's electronic profile. • Therapeutic criteria for payment for Lupron include the following diagnoses: sexual precocity in children, endometriosis, breast/ovarian/prostate cancer.
○ Ciprofloxacin DUR	Jane Gennrich, Pharm.D.	The Pharmacy Unit was requested to analyze why (e.g. what type of infection) ciprofloxacin is prescribed for pediatric Idaho Medicaid patients. Ciprofloxacin is FDA approved for pediatric patients 1-17 years of age with complicated urinary tract infections and pyelonephritis due to E coli and for pediatric patients (age not specified) with inhalational anthrax. • Retrospective DUR was done on patients under 16 years of age with one or more paid claims between 2/1/12 and 4/30/12. 77 patients were identified with a mean age of 10.3. Please refer to the slides for a breakdown of infection type. The DUR board deferred making a recommendation until a pediatrician could evaluate the data.

○ Synagis DUR	Jane Gennrich, Pharm.D.	Review of the 2011-2012 season: • Medical claims = $274,881 & Pharmacy claims = $1,362,627 Idaho Medicaid's prior authorization criteria is the same as the current AAP (American Academy of Pediatrics) recommendations. All patients with paid medical claims for Synagis did have prior authorization approval through the Pharmacy Unit. More than half of these patients did not have their prior authorization request forms marked correctly to indicate that the drug was going to be billed as a medical claim rather than as a pharmacy claim. Several potential billing inaccuracies were identified such as (1) patients being billed for up to 7 doses when the medical claims and the pharmacy claims were combined for a single patient and (2) inconsistent dosages billed (e.g. would expect doses to increase with age and increasing weight and not decrease over time). The DUR committee recommended requesting chart notes and administration records to evaluate for billing errors. In July 2012 the AAP Red Book updated their Synagis Prophylaxis recommendations: (1) multiple births younger than 1 year of age do not qualify as fulfilling the young siblings risk factor for infants with gestational age between 32 weeks, 0 days and 34 weeks, 6 days and (2) section added on infants with congenital abnormalities of the airway or neuromuscular disease.
○ Growth Hormone DUR	Mark England, Pharm.D.	Background: Idaho Medicaid's Pharmacy & Therapeutics Committee requested that the DUR Board look at the utilization numbers for the Growth Hormone class to determine if savings could be accomplished if patients were switched from a non-preferred to a preferred agent. Genotropin, which is a non-preferred agent, is still being used by 16 patients who have been grandfathered. The DUR board recommended that several endocrinologists be contacted by Idaho Medicaid to discuss the issues with switching these patients over to a preferred agent.
○ Psychotropic Medications in Foster Children	Tami Eide, Pharm.D.	Dr. Eide discussed data on psychotropic medication use in foster children who are enrolled in Idaho Medicaid. • Comparison of Idaho Medicaid statistics to five states in the GAO Study. ○ Percentage of children prescribed psychotropics by state ▪ Foster children percentage ▪ Non-foster children percentage ▪ Ratio of foster to non-foster children

		• Total number of foster children and non-foster children from 2007-2011.
		  ○ Percentage of foster and non-foster children receiving psychotropic medications between 2007-2011. In summary: The trends include increased use of psychotropic medication in foster children in comparison to a stable percentage of use in non-foster children.
		
		She then presented a detailed analysis of the use psychotropic drugs in 2011, including:
		• Percent of foster and non-foster children psychotropic use by drug class for four major classes of drugs – ADHD, Antidepressants, mood stabilizers and Atypical antipsychotics.
		• An analysis of which prescriber types are prescribing these drugs in Idaho as well as regional prescriber variation.
		• Age distribution by percent of prescription volume by age was graphed.
		
		The following red flags for Foster Children and Psychotropic Drugs have been identified:
		• Five or more psychotropic medication prescribed concomitantly.
		• Two or more concomitant antidepressants.
		• Two or more concomitant antipsychotic medications.
		• Two or more concomitant stimulant medications.
		  ○ Long-acting plus short-acting concomitantly is acceptable
		• Three or more concomitant mood stabilizers.
		• Psychotropic polypharmacy (two or more agents) for a given mental disorder being prescribed before trying monotherapy.
		
		Dr. Eide then summarized the steps in the implementation of the Red Flags process to improve drug utilization in these patients. The steps include:
		• Retroactive evaluation
		• Identification of outliers
		• Profile review
		• DUR Board Intervention using targeted education.
		• Re-evaluation of both individuals and the overall population.
		• Further Action: Initiate Point of Service edits both:
		  ○ Informational (soft/pharmacist override) and
		  ○ Hard stop edits.
		
		Dr Eide then presented an analysis of five foster care children with five or more psychotropic medications (the first red flag). The study parameters included:
		
		• Foster children with 5 or more distinct behavioral health drugs
		• The service dates were between 11/1/2011 and 4/30/2012 (6 months)

➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	The Mental Health Drug List included:
		
		• Stimulants – itemized by drug name.
		• Other ADHD Treatments – such as atomoxetine, clonidine, guanfacine, bupropion, imipramine, nortriptyline.
		• Antidepressants – such as SSRIs and SNRIs
		• Mood Stabilizers including carbamazepine, divalproex, lithium and lamotrigine.
		• Second Generation (atypical) Antipsychotics
		• First Generation (typical) Antipsychotics
		
		The five patients were then reviewed by their mental health diagnoses listings and prescription drugs prescribed including the duration of time for use of each drug.
		
		It was recommended that complete medical records be requested from prescribers for further clinical analysis.
		
		The study of drug usage in the foster child population will continued to be reviewed by proposed studies in future quarters.
		
		Proposed Studies for Next Quarter:
		
		• P & T Committee Narcotic Analgesic Studies continued.
		• Leukotrienes vs inhaled corticosteroids in children with asthma.
		• Use of Psychotropic Medications in Foster Children
		  ○ Two or more concomitant antidepressants.
		• Migraine Prevention
		  ○ Prophylaxis Utilization in Chronic Triptan Utilizers
		  ○ Topiramate
		  ○ PA, Medical Claim and Triptan Use Mismatch
		• IVIG – Intravenous Immune Globulin
		  ○ Currently prior authorization is not needed for either an outpatient prescription (under $7500) or a claim on the medical side.
		  ○ The pharmacy staff is in the process of sending out letters to gather medical information including:
		  ▪ Diagnosis
		  ▪ Dosing regimen
		  ▪ Response to therapy
		  ○ The staff will review IVIG information at the October 2012 DUR Meeting.
		  ○ A future question to answer: Should IVIG require prior authorization?

➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	Dr. England reviewed the prospective DUR report for ProDUR messaging for the prior quarter.
➢ **DUR Newsletter**	Mark England, Pharm.D.	The Spring Newsletter was included in the packet. Topics to be included in the summer newsletter include information on Psychotropic Use in Foster Children and Narcotic Analgesics.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	Dr. Eide reviewed the prior quarter activity in the Medicaid pharmacy department. The primary extracurricular activities recently have involved a series of OIG audits for rebates and an upcoming OIG Security Audit.
➢ ***Adjourn, 2:15 PM***		
Next Meeting: ***October 18, 2012 – 9:00 AM***		