Idaho DUR Committee Meeting Record

Date: October 18, 2012 **Time:** 9:00 a.m. – 4:00 p.m. **Location:** Idaho Medicaid, 3232 Elder Street, Boise, Idaho, Conference Room D-W

Moderator: Mark Turner, M.D.

Committee Members Present: Perry Brown, M.D., Wayne Baures, RPH, Paul Cady, Pharm.D, Mark Turner, M.D., Suzette Cooper, 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:

AGENDA ITEMS	PRESENTER	OUTCOME/ACTIONS
Committee Business		
➢ **Call to order**	Mark Turner, M.D.	
➢ **Review of Minutes from August 23, 2012**	Mark Turner, M.D.	Approved
➢ **Follow-up Studies – updates**		
o 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 August 2012 DUR slides for more details on types of infections. Dr. Gennrich reviewed the current age parameters in Idaho Medicaid's drug database for ciprofloxacin (0-999 years) and levofloxacin (16-999 years) She compared the package insert information for both drugs; as well as the American Academy of Pediatrics and World Health Organization guidelines. The majority of levofloxacin age override requests that the department receives are for CF patients, oncology patients, or patients with documented infections resistant to most other antibiotics.

		The board recommended that Idaho Medicaid change the age limits on levofloxacin to match ciprofloxacin which is set at age 0. They also recommended that the Board review again in 2 to 3 years to ensure use has been appropriate.
○ Synagis DUR	Jane Gennrich, Pharm.D.	Review of the 2011-2012 RSV season: • Medical claims = $274,881 & Pharmacy claims = $1,362,627 Idaho Medicaid's prior authorization criteria are 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. Dr. Gennrich discussed the review of potential billing errors from medical claims data including billing errors and dosing inconsistencies as recommended by the DUR Board at the August 23, 2012 meeting. The Board recommended that prior authorization review would continue to be done by the IDHW Pharmacy staff for both pharmacy claims and medical claims in order to insure consistency.
○ 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 growth hormones to determine if savings could be accomplished if patients were switched from a non-preferred to a preferred agent (currently patients are grandfathered on their current growth hormone when a particular product is switched from preferred to non-preferred status). Genotropin, which is now a non-preferred agent, is still being used by 16 patients (14 prescribers) 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. Dr. Turner offered to make those contacts. In general, the consensus was that it would be okay to eliminate the current grandfathering of agents, pending the outcome of prescriber discussion.
➢ **Current Interventions/Outcomes studies** ○ Narcotic Patterns of Use in Chronic Non-Malignant Pain	Tami Eide, 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 reviewed by Idaho Medicaid pharmacists. Six of the recipients had cancer diagnoses and were therefore excluded from analysis. The August DUR Board Meeting suggested that the pharmacy department look at other state current narcotic management strategies. Dr. Eide presented a comprehensive review of narcotic management in Idaho in comparison with other states. Strategies used by other states include: • Dispensing restrictions that include limits on the number of prescriptions allowed per patient per month or per year. • Restrictions on therapeutic duplication including restriction on long-acting agents and short-acting agents or the combination of the two. • Noted: Most states exclude cancer, hospice and long-term care patients from their restrictions. • Additional state management strategies include: ▪ Case management program (Montana) ▪ Commissioned evidence-based review on treatment of specific categories, such as treatment of low back pain. (Oregon) ▪ Implementation of a second opinion reviewer for high dose/duplicate opioid therapy requests. (Alaska) ▪ The Washington State legislature directed 5 governing boards and commissions to adopt rules concerning management of chronic non-cancer pain. The practitioner boards included: Physicians, Physician Assistants, Osteopathic Physicians (and assistants), Advanced Registered Nurse Practitioners, Dentists, and Podiatrists The Pharmacy Department is in the process of implementing the P&T Recommendations from their May 2012 meeting which 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. • In addition, the department is implementing new criteria for the Butrans patch – including: ○ Manual review ○ No history of opioid abuse or addiction ○ ICD-9 diagnosis of moderate or severe chronic pain ○ History of long-acting opioid within last 60 days at a dose less than 30 morphine equivalents. ○ Inability to take oral medications. In summary – the DUR Board and pharmacy staff agree that the project of narcotic management review and strategies will be a long term DUR project.
○ Psychotropic Medications in Foster Children	Tami Eide, Pharm.D.	Dr. Eide reviewed data on psychotropic medication use in foster children who are enrolled in Idaho Medicaid. (Please see the August 2012 DUR Board Minutes for additional background information on this project.) • Comparison of Idaho Medicaid statistics to five states in the GAO (General Accounting Office) 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 from 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. This quarter the pharmacy department reviewed the profiles of foster children prescribed two (2) or more concomitant antidepressants. Study Parameters and Results: • Children in Foster Care ages 0–17 years • Time Period 3/1/2012 through 8/31/2012 • Two or more antidepressants ○ 75 children met the criteria

		▪ 66 had two concurrent antidepressants ▪ 6 had three concurrent antidepressants ▪ 2 had the same drug with different strengths ▪ 1 had two with only a one week overlap. • Trazodone was the second drug in 63 children – which most likely was being used as a sedative rather than as an anti-depressant. Recommendation: The Board did not see any areas of concern and recommended no further action.
○ Zometa DUR	Jane Gennrich, Pharm.D.	Zometa (zoledronic acid) injection is a bisphosphonate that is FDA approved for: • Hypercalcemia of malignancy and • Multiple myeloma and patients with bone metastases from solid tumors in conjunction with antineoplastic therapy. Medical claims for Zometa were reviewed from 8/01/2011 through 7/31/2012 to determine if the pharmacy unit should prior authorize this medication. Summary: All patients had an FDA approved diagnosis. All patients had appropriate dosages and dosing intervals between repeat doses. Recommendation: Prior authorization is not needed. The DUR board concurred with this recommendation.
○ Asthma DUR	Mark England, Pharm.D.	Background: The Idaho Medicaid focus for management of asthma is the proper use of medications. There are four (4) components of asthma care following accurate diagnosis – which are appropriate for all ages: • Assessment and Monitoring • Education for a partnership in care • Controlling environmental factors and other conditions • Medications which control the disease and reduce impairment reduce risk by preventing exacerbations. The Stepwise Approach (both up and down) gives consideration to both impairment and risk. The focus of this DUR Review was <u>Leukotrienes vs. inhaled corticosteroids in children with asthma.</u> Recipients <18 years of age with a paid claim for an inhaled corticosteroid (individual inhaled glucocorticoid or combination with a long-acting beta-adrenergic agent) were reviewed for the following date ranges- ○ 7/1/2011-9/30/2011 = 1,875 recipients

		○ 1/1/2012-3/31/2012 = 2,143 recipients ○ 7/1/2012-9/30/2012 = 2,012 recipients • The total number of recipients <18 years of age that had a prescription for any medication between 7/1/2012 and 9/30/2012 that had an asthma diagnosis on their profile = 8,582 individuals. • The number of recipients <18 years of age with paid claims for leukotriene receptor antagonists were analyzed for the same date ranges as the inhaled corticosteroid recipients: • ○ 7/1/2011-9/30/2011 = 3,232 ○ 1/1/2012-3/31/2012 = 3,000 ○ 7/1/2012-9/30/2012 = 3,253 After reviewing the data presented and discussing the appropriateness of therapy being used, the Board discussed next steps. They recommended that the 1318 patients with asthma receiving a leukotriene with no history of an inhaled corticosteroid be further reviewed for use of oral steroids, hospitalization and ER visits. The prescribers of these 1318 should receive an educational intervention on preferred asthma treatments and place of inhaled steroids vs leukotrienes in therapy. They also requested further review of the 38 patients receiving individual steroids and combination steroid and beta agonists concurrently.
○ Immune Globulin – intravenous and subcutaneous DUR	Jane Gennrich, Pharm.D.	Currently prior authorization is not needed for either an outpatient prescription (if less than $7500) or a claim on the medical side. Paid claims between 8/01/2011 and 7/31/2012 were evaluated for appropriateness of therapy. <u>Medical Claims</u> 116 individual claims for 24 patients Total expenditure $288,410 DUR letters were sent to the providers of immune globulin for all 24 patients requesting information on diagnosis, dosing regimen, and response to therapy. 13 responses were received as of 9/13/2012. The individual patients were reviewed (see slides for more details). Potential issues identified were: multiple patients who received only a single dose of immune globulin with no follow-up IgG level obtained; discrepancies between dose ordered, dose administered, and dose billed to the department; drug given despite an adequate IgG level prior to administration. <u>Pharmacy Claims</u> 79 individual claims for 14 patients Total expenditure $279,527

		DUR letters were sent to the prescribers of the seven patients that were still currently receiving immune globulin requesting chart notes and serum IgG levels. As of 10/11/2012, responses had been received from four prescribers. One patient had chronic variable immunodeficiency; another patient had hypogammaglobulinemia. Two patients were being treated for chronic inflammatory demyelinating polyneuropathy. Please refer to slides for more details. <u>Dosage</u> The majority of patients were dosed on actual body weight while the national standard of practice is to use either ideal body weight or adjusted body weight in obese patients. <u>Recommendation</u> Due to the expense of this therapy and potential inappropriate use and dosage identified in this DUR, the Board recommended that the Pharmacy Unit institute prior authorization for immune globulin (intravenous and subcutaneous) for claims paid both on the medical side and on the outpatient prescription side requiring diagnosis, dosage, and monitoring parameters including follow-up IgG levels if appropriate for the diagnosis. Initial approval for new patients would be for 3-6 months with additional documentation required after that time period to renew the authorization. Implementation will not be until 01/01/2013 to allow time to notify prescribers and pharmacies of current patients.
○ Topirimate DUR	Chris Johnson, Pharm.D.	Dr. Johnson reported that the topiramate DUR was done due to the increase of claims noted from January 2011 through August 2012 (from 800 claims to 950 claims). The current criteria for Topiramate approval is for seizure disorder and migraine prophylaxis. Non-FDA labeled indications for weight loss and as a mood stabilizer for Bipolar symptoms were evaluated to determine if the increase in topiramate prescribing was due to these non-approved indications. Reporting dates from 1/1/2012 thru 6/30/2012 were reviewed with a total of 1,222 patients evaluated. Clients with approved criteria numbered 970 clients with 252 clients without a listed diagnosis meeting criteria in their medical profile. Of these 252 clients, 52 clients had a diagnosis of obesity, 146 clients had a diagnosis of bipolar disease, 31 clients had a diagnosis of obesity and bipolar disease, and 23 clients had no diagnosis noted in medical profile. It was noted that several prescribers have continuously submitted suspected erroneous information on PA forms for a diagnosis not present in their patient to circumvent the prior authorization system to obtain topiramate for non-evidenced based indications. Recommendation : The Board recommended to do further analysis to stratify

		topiramate use by dose because the migraine prophylaxis dose is normally less than 100mg/day and doses for seizure disorder are usually higher than 100mg/day. The data obtained from this recommendation is to be reported at the November 16th P&T committee meeting. It was also recommended that the pharmacy program work with program integrity if necessary to take action on submission of erroneous information on prior authorization forms by prescribers.
➢ **Study Proposals for Next Quarter**	Mark England, Pharm.D.	Proposed Studies for Next Quarter: • P&T Committee Narcotic Analgesic Studies – Next Steps • Use of Psychotropic Medications in Foster Children – Next Step will be to evaluate patients on two or more antipsychotics • Migraine Prevention o Prophylaxis Utilization in Chronic Triptan Utilizers • Multiple Strengths of Atypical Antipsychotics • Antipsychotic Indication Evaluation – Hold for the future • AAP and DVTs – Hold for the future
➢ **2011 Annual DUR Report**	Tami Eide, Pharm.D.	Dr. Eide reviewed the 2011 Annual DUR Report that has been submitted electronically to CMS. Total cost savings resulting from DUR Projects were highlighted - $815,633 from 10-01-2010 through 9-30-2012
➢ **ProDUR Quarterly Report**	Mark England, Pharm.D.	Dr. England reviewed the pro- DUR report for ProDUR messaging for the prior quarter.
➢ **DUR Newsletter**	Mark England, Pharm.D.	The Summer Newsletter was included in the packet. Topics to be included in the Fall Newsletter include additional information on Psychotropic Use in Foster Children Study, Narcotic Analgesics Study and the Immune Globulin study. The Board would also like to see information on Idaho Medicaid medication spend including total expenditures; cost/prescription and percentage of drug spend in relation to total Medicaid expenditures.
➢ **Medicaid Update**	Tami Eide, Pharm.D.	Dr. Eide reviewed the prior quarter activity in the Medicaid pharmacy department. She is spending significant time on six audits including three OIG (Office of the Inspector General) audits on security, rebates, and a practitioner investigation, CMS audit, and multiple Idaho legislative audits.
➢ ***Adjourn, 2:30 PM***		

Next Meeting: ***January 17, 2013 – 9:00 AM***		