

**North Carolina DUR Board Meeting
October 28, 2010
Minutes**

Introductions and Public Comments

The meeting was called to order at 1:00 PM. Public comment was offered, but there was none.

Minutes

Minutes from the July 2010 DUR Board meeting were reviewed. No changes or corrections were noted. A motion was made and seconded to approve the minutes. The Board unanimously approved the minutes.

Prospective DUR

Pro-DUR Status-May 2010

The August 2010 Pro-DUR Status report was reviewed with the Board and areas of interest were highlighted. There were no major changes with the drug-disease Pro-DUR alerts. Drug-drug interactions were also discussed and no major changes existed.

Medications with high overutilization Pro-DUR alerts were discussed. It was noted that albuterol HFA inhalers and omeprazole 20mg topped the list. In August 2010 there were approximately 81,000 overutilization alerts and of those almost 6,000 were overridden at the point-of-sale. The Board was informed that pharmacies are required to enter a reason for override at the point-of-sale.

High dose by age was discussed and it was noted that Omnicef/cefдинir was removed from the high dose alert. The Board was informed that buprenorphine-naloxone and escitalopram were new to the high dose by age report. In August 2010 there were approximately 67,000 alerts for high dose by age and of those approximately 37,000 were overridden at the point-of-sale.

Low dose by age was discussed and azithromycin 600 mg and 1 g packets were new to the report. It was noted that First DataBank (FDB) is used to determine high dose and low dose. Therefore if FDB makes any systematic changes it will impact the North Carolina Medicaid data. Additionally, an inaccurate day supply entered at the point-of-sale could also impact this alert.

The therapeutic duplication alert by GSN was discussed and narcotics attributed to a majority of alerts. Therapeutic duplication by GC3 was also reported and narcotics and antipsychotics represented a bulk of alerts. Overall, no major changes existed compared to the last review.

Overall it was noted that the Pro-DUR alert percentage decreased from approximately 12 percent to 9.85 percent. The Board was reminded that the goal for Pro-DUR alerts is less than 10 percent.

Pro-DUR Alert Update

A peer-reviewed report was provided to the Board that grouped medication alerts by disease states. The purpose of the report was to inform the Board of current Pro-DUR point-of-sale alerts and provide recommended changes, additions, or removals. The high dose Pro-DUR alerts were discussed and the Board accepted the recommended changes. However, the Board also recommended adding high dose alerts to Orap and haloperidol. The therapeutic duplication Pro-DUR alerts were also peer reviewed and recommendations were provided to the Board. The Board

approved all recommendations and also approved the addition of classes H2M, H7P, H7R, H7S, H7U, and H7W. No changes in low dose Pro-DUR alerts were recommended.

Top 15 by Amount Paid

Abilify 5mg tablets were the highest amount paid for August 2010 followed by Abilify 10 mg, Singulair 10 mg, and Singulair 5 mg. Suboxone 8 mg-2mg appeared on the list for the first time but it was noted that utilization may decrease once the PDL takes affect. No other significant changes were noted.

Top 15 by Drug Name

Expenditures for Abilify were the highest paid amount by drug name followed by Seroquel, Singulair, and Concerta. Oxycontin and Intuniv appeared on the list for the first time.

Suggested Action Item

1. *The Board requests a comparative report on stimulant utilization over the past two years.*

Top 15 by Number of RXs

The Board was informed that no major changes occurred since the last report. The Board was informed that oxycodone-APAP 10-325mg and omeprazole 40mg appeared in the list for the first time. The Board noted that many of the medications appearing in the report are generic and provide cost savings which is a Board objective.

Suggested Action Item

1. *The Board requests a quarterly snapshot of the utilization of the generic drugs that appeared in the top 15 by number of prescriptions over the last year.*

Top 15 by GC3

No major changes occurred since the last report. The H0E drug class appeared for the first time and it was noted that Copaxone was the highest contributor in this GC3 class.

Retrospective DUR

Old Business

The Board was informed that prescribers with patients taking benzodiazepines at 150 percent of the maximum daily dose were sent a Provider Profile letter. At this time approximately 15 percent of prescribers have responded to their letter and of those respondents most have stated they would reassess their patients' therapy. The Board was informed that the Division of Medical Assistance (DMA) has acknowledged a lower than expected response rate and are currently developing a process to educate prescribers on the importance of feedback through newsletters and CCNC outreach. The Board asked if there was a process for prescribers to provide feedback electronically. However, the Board stated this increases prescribers' risk of HIPAA violations.

Three previously approved Retro-DUR interventions, \geq four EpiPens per prescription, \geq 13 EpiPens per 12 months, and tramadol utilization above the maximum daily dose, were brought to the Board for Provider Profile lettering consideration. The interventions were previously approved as Patient Medical Profile lettering. However, due to the large number of prescribers and pharmacies requiring a letter DMA would like the Board to consider performing these interventions via Provider Profile lettering. Provider Profile lettering allows the Board to maximize education on high risk patients

while minimizing the number of letters being sent to prescribers and pharmacies. The Board motioned, seconded, and approved the three interventions being sent via Provider Profile lettering rather than Patient Medical Profile lettering.

Suggested Action Items

- 1. The Board requests research is performed on the possibility of prescribers and pharmacies providing DUR letter feedback electronically.*
- 2. The Board requests that prescribers and/or pharmacies be lettered using the Provider Profiling method for the following interventions: \geq four EpiPens per prescription, \geq 13 EpiPens per 12 months, and tramadol utilization above the maximum daily dose.*

Antipsychotic Polypharmacy Utilization in Children

During the July 2010 DUR meeting the Board asked DMA to research the antipsychotic prescription data that was provided in the DUR packets. The Board suggested the data provided be used to determine which prescribers may benefit from a peer-to-peer consultation. As a follow up, the Board was provided a list of 76 pediatric patients, ages less than one to 18 years old, who appear to be concurrently taking three or more antipsychotic medications which could serve as a starting point for peer-to-peer interventions. The Board was informed that patients who appear to be tapering from one medication to another were excluded from the report if tapering caused them to fall below the minimum requirements. The Board questioned the possibility of patients inadvertently being dropped from the list due to limiting the time frame to three months and/or data interpretation. The Board asked for DMA to provide the large report that included these patients along with prescriber specialty, if possible.

Suggested Action Item

- 1. The Board requests DMA to provide the Board the entire report that these 76 patients were identified from and to include prescriber specialty, if possible.*

High Dose Benzodiazepine with Antipsychotic Prescriptions on File

During the July 2010 DUR Board meeting the Board requested information pertaining to patients using high dose benzodiazepines who were also taking an antipsychotic medication. As a follow up, information was provided to the Board indicating between December 2009 and February 2010 268 patients were taking high dose benzodiazepines and also had an antipsychotic prescription. The Board discussed the utilization of medications but did not take any action as a result of the information provided.

Utilization of Tretinoin Products \geq 30 Years Old without a Diagnosis of Acne or Actinic Keratoses

The Utilization of Tretinoin Products \geq 30 Years Old without a Diagnosis of Acne or Actinic Keratoses materials in the Board packets were reviewed. The Board was informed that 198 patients met this criteria and could be potentially taking tretinoin off-label or for cosmetic purposes. The Board was reminded of DMA's policy concerning medications used for cosmetic purposes and that they are not covered as a benefit to Medicaid recipients. The Board was also provided information regarding the number of prescriptions and average cost per prescription by prescriber specialty. It was noted that the average cost per prescription for Dermatologists were slightly higher than General Practitioners'. The Board questioned whether P&T should address this issue and place clinical criteria on these medications. However, it was noted that the cost of a clinical PA may outweigh the potential savings associated with this medication and diagnosis requirement. The Board was also informed a point-of-sale edit could be placed on the medication requiring pharmacies to submit a diagnosis code in order to collect payment. The process would require prescribers to write the

appropriate ICD-9 code or provide additional wording on the face of the prescription indicating the reason for use. The Board was also offered the recommendation of producing a DUR letter in combination with providing prescriber education in the next DMA bulletin. The Board asked that more information be gathered from Dermatologists regarding appropriate conditions for which tretinoin could be used and the information be provided at the next DUR Board meeting.

Suggested Action Item

1. *The Board requests that DMA provide a list of approved diagnoses in which tretinoin should be covered after consulting with Dermatologists.*

Skeletal Muscle Relaxants: Duplication of Therapy and High Dose

The Duplication of Therapy and High Dose Skeletal Muscle Relaxant Utilization materials in the Board packets were reviewed. It was noted that patients with the diagnoses listed in the packet were excluded from the intervention and that time frame was expanded to include three months of data, as requested by the Board. There were 130 patients who met the duplication of therapy intervention and 376 patients who met the high dose intervention. The Board discussed whether there was a need to letter prescribers when they were the only prescriber of the skeletal muscle relaxant prescriptions. However, the Board discussed the possibility of drug diversion occurring within the medication class and that prescriber awareness may be warranted. A motion was made, seconded, and approved to letter all prescribers who have patients taking more than one skeletal muscle relaxant or who have patients taking dosages above the FDA approved maximum daily dose.

Suggested Action Items:

1. *The Board requests letters be sent to prescribers who have patients prescribed daily doses of skeletal muscle relaxants greater than the FDA approved maximum recommended daily dose and who do not have a DUR exclusion diagnosis.*
2. *The Board requests that letters be sent to prescribers who have patients concurrently taking more than one skeletal muscle relaxant and who do not have a DUR exclusion diagnosis.*

Polypharmacy and Drug Safety

The Polypharmacy and Drug Safety materials in the Board's packets were reviewed. The Board noted it may be difficult to letter a prescriber since patients identified for the intervention were seeing multiple prescribers. The Board discussed the possibility of patients billing Medicaid for all prescriptions up to 12 and then paying cash for prescriptions over the 12 prescription per month threshold in order to avoid the FORM program. The Board questioned whether patients identified in the DUR packet materials would be enrolled into the new Lock-In Program. The Board was provided information pertaining to the Lock-In Program's patient enrollment criteria and program design. The Board also discussed whether the patients identified should be referred to Program Integrity. The Controlled Substance Reporting System's content and access procedures were also discussed with the Board. The Board noted that all pharmacies must report prescription utilization to the Controlled Substance Reporting System however only a small percentage of North Carolina prescribers have registered to access the information.

Suggested Action Item

1. *The Board requests a Lock-In Program assessment for the top 50 recipients identified in the Polypharmacy and Drug Safety report to be performed and findings are reported to the Board.*

SSRI and Other Antidepressant Utilization

The SSRI and Other Antidepressant Utilization materials in the Board's packets were reviewed. It was noted that approximately 72 percent of patients were taking a generic prescription. However single-source brand name medications accounted for a disproportionate majority in total payment. The Board was informed that the top two brand name medications by utilization were Cymbalta and Lexapro and it appeared that only one third of these patients previously received a generic or multi-source medication (since 2006). The Board discussed the efficacy of the medications and the impact of direct-to-consumer marketing on physician prescribing. The Board also discussed how no current evidence is available that suggests one medication will be more efficacious for a patient versus a lower cost medication. The Board discussed potential reasons for the decrease in prescription utilization in November 2008 and November 2009. The Board suggested that prescriber education be provided through CCNC and possibly ICARE.

Suggested Action Item

- 1. The Board requests a report of prescribers with high prescribing rates of brand name medications be provided to CCNC for prescriber outreach and education. If CCNC cannot provide prescriber education then the topic will be readdressed by the Board.*

Narcotic (H3A) Utilization Trends: Physicians, Pharmacies, and Patients

The Narcotic (H3A) Utilization intervention was deferred to the January 2011 DUR Board meeting due to time constraints; however a brief review of the materials was provided to the Board.

Trigger Report

The Trigger Report comparing first quarter 2010 to second quarter 2010 was reviewed with the Board and no significant changes were noted. The Board was asked to review the report and provide any feedback regarding utilization trends for further research.

DMA Pharmacy Updates

The Division of Medical Assistance introduced the new Medical Director, Randall Best.

The new Preferred Drug List (PDL) and prior authorization criteria were successfully implemented September 15, 2010. Overall, the implementation went smoothly with only a few time out issues involving prior authorizations. At this time all time out issues have been resolved and DMA is receiving positive feedback regarding the PDL and prior authorization process. The Pharmacy and Therapeutics Committee and Physician Advisory Group (PAG) recently reviewed nine drug classes involving specialty medications and have made PDL recommendations to DMA. The revised PDL should be posted next week for public comment prior to being reviewed by The Panel. The next Panel meeting date has not been determined.

On October 11, 2010, DMA enrolled the first group of patients meeting the Lock-In Program requirements. The second set of patients will be locked-in starting November 1, 2010. Patients meeting Lock-In Program requirements will be locked-in starting the first of every month until all patients meeting the requirements are enrolled. Patients will remain in the Lock-In Program for a minimum period of one year or until they no longer meet the requirements.

A motion was made and seconded to adjourn the meeting. The meeting was adjourned at 3:05 PM.

The next DUR meeting is scheduled for January 27, 2011 from 1:00 PM - 3:00 PM at the Kirby building, room 297.