

North Carolina DUR Board Meeting
January 22, 2009
Abbreviated Minutes

Prospective DUR:

- Questions asked by the DUR Board members at the previous DUR meeting with answers supplied by Vendor.
 1. When a pharmacist responds to a DUR alert, can the response be valid for the life of the prescription? *The system can be changed so the DUR response is valid for the life of the prescription using the provider number, patient name and prescription number. This could also be based on time frame, patient MID and GCN sequence number. This would affect the DUR alerts (Low Dose, High Dose, Therapeutic Duplication, Drug-Drug and Drug-Disease Interactions) with the exception of Overutilization (early refills).*
 2. Can long-acting and short-acting beta-agonists be divided into two separate GC3 groups? *The alerts are based on First Data Bank's GC3 criteria. First Data Bank will probably not be changing the GC3 class. Internal tables could be built and maintained internally. This would require a system change request under the Point of Sale system. DMA would have to authorize and prioritize the system change.*
- Pro-DUR Status report for December 2008 was reviewed. DUR alert changes that were requested at the last DUR meeting will be implemented in February 2009 and reported on at the next DUR meeting. The Board requested a review of clonidine claims to look at the overutilization reason codes.
- The Top 200 Drugs for December 2008 were reviewed. Reports were sorted by GC3 Therapeutic Class, by Drug Name, by Total Amount Paid, and by Total Number of Prescriptions. Top 200 are sorted by the GCN Sequence Number, not the drug name.
- A report was requested to look at the utilization of Tussionex and Cardec DM Syrup specifically looking at children less than two years of age.
- The Board suggested looking at the utilization of Singulair to see if there has been an increase in utilization since the implementation of the Nonsedating Antihistamine Prior Authorization.
- When looking at the cost per unit in the Top 200 reports, the rebates are not reflected. The PAL ranks the products based on actual costs post rebate. It was suggested for the Board to make recommendations based on the costs provided, and then rebate information will be reviewed by the P&T Committee.
- Since post rebate costs are not available publically, recommendations made by the DUR Board should be based off the AWP or MAC price. There was discussion regarding the cost per unit of omeprazole 40 mg (\$6.43) and omeprazole 20 mg (\$0.38). A suggestion was to have an informational rejection sent to the pharmacy when a claim is submitted for omeprazole 40 mg. The rejection could say "*please use two 20 mg capsules.*" The pharmacy could override the alert and continue to fill the prescription with 40 mg. The philosophy of the DMA and P&T Committee is not to restrict generic use because the prices will eventually come down and pharmacies are encouraged to use generics whenever possible. P&T may be interested in looking at what the actual cost is to Medicaid when a generic drug has exclusive rights for the first six months or longer in the case of omeprazole 40 mg. The Board unanimously agreed to look at the top generic drug expenditures post rebate. EDS has access to rebates, therefore may be able to generate this report. Only include drugs that do not have MAC prices.

Retrospective DUR

- **Methadone Related Unintentional Poisonings**

A report was presented looking at North Carolina Medicaid unintentional poisoning (UP) deaths in 2007 that were related to methadone.

- **Methadone Utilization**

The P&T Committee requested that the DUR Board look at the Brand Name CII Prior Authorization criteria that went into effect on August 4, 2008 to see what the impact of the prior authorization had on methadone utilization in Medicaid recipients.

- The following drug utilization charts were reviewed:
 - Methadone utilization data were reviewed for the time period of January 2007 through November 2008.
 - Opana utilization data were reviewed for the time period of January 2008 through November 2008.
 - Morphine utilization data were reviewed for the time period of January 2008 through November 2008.

- **Suboxone/Subutex Utilization**

A detailed report was generated from the time period of November 1, 2007 through October 31, 2008 looking at the utilization of Suboxone and Subutex. Recipients were identified if having six or more claims for Suboxone and/or Subutex in this time period. The Board suggested monitoring Suboxone and Subutex utilization.

- Top 200 Trigger report was reviewed comparing 2008 calendar quarter two (April, May and June) with calendar quarter three (July, August and September). A request was to look at the utilization of antitussives broken down by age. Also look at this with the next trigger report comparing quarter three to quarter four.

Topics for next DUR meeting:

- The Board discussed looking at adverse drug events that result in Emergency Room visits by Medicaid recipients.
- A suggestion was to look at the top five drugs by cost and see if the prescriber is a medical doctor, physician's assistant or nurse practitioner. Concern is that the physician extenders may not be aware of the cost difference of drugs between generics.

DMA Updates

- The State is looking at cost savings with each section within the state to provide their own cost savings initiatives.
- There have been discussions about a PDL and restrictions on antipsychotics.
- DMA will continue to monitor and become more efficient with the State MAC list that originated in 2002, which saved the State \$151 million last year.
- The PPI Prior Authorization, minus rebates and expenses of managing the PA, has saved the State approximately \$15 million. DMA is considering adding about eight more drug classes to prior authorizations. This could save approximately \$24 million.
- N.C. has mandatory generic substitution that can be overridden by the physician if he/she writes brand "medically necessary" on the prescription and the pharmacy enters DAW1 to allow the dispensing of the brand. Last fiscal year, \$8 million of unrealized savings were due to DAW1. Should additional documentation be required in order to authorize DAW1? 21% of the DAWs are overridden as DAW7 for drugs on the narrow therapeutic index list.
- Generic utilization is at 65%. The generic rate is about 2% higher in the FORM population (recipients who are locked into a pharmacy because they have more than 11 prescriptions per month). Adherence measured by a gap in therapy, is also better in this patient population.

The meeting was adjourned at 3:00 pm.

The next DUR meeting is scheduled for April 23, 2009.