North Carolina DUR Board Meeting
October 22, 2009
Minutes

Introductions and Public Comments

The meeting was called to order. Participants introduced themselves. Public comment was offered, but there was none.

Minutes

Minutes from the July 2009 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-August 2009

The August 2009 Pro-DUR Status report was reviewed and areas of interest were highlighted. The drug-drug interactions were reviewed which included severity 1 alerts. The appearance of the interaction between naltrexone and narcotics was noted. This interaction did not appear in the May report and may be an area that warrants monitoring.

Drug overutilization data was discussed and there was a question of whether the overutilization could be contributed to overrides for lost/stolen prescriptions and vacation overrides. North Carolina Medicaid has begun monitoring the lost/stolen frequencies but could also monitor vacation overrides. It was suggested that the Board consider placing limitations on these overrides, if necessary.

The high dose alerts were reviewed and there was concern regarding flagging these alerts too frequently causing the retail pharmacist to override them arbitrarily. The Board was informed the alert thresholds are configured by First DataBank using FDA recommendations but could be altered with additional programming, if needed. However, there were concerns with altering the alerts since there could be benefits to the higher alert frequency.

Low-dose alerts were discussed and it was noted they could be due to an inaccurate day supply being entered at the pharmacy.

The therapeutic duplication report indicated narcotic alerts and overrides were the most frequent. The combination of short-acting and long-acting narcotics could contribute to the high alert and override rates.

Top 200 by Amount Paid

The total cost has not changed significantly although Atripla has had a high increase in amount paid and may be worth monitoring. The Board discussed the helpfulness of having data pertaining to the prevalence of disease states for the Medicaid population in order to determine whether an increase/decrease of medication utilization was logical. The Board was reminded that pharmacy claims do not require a diagnosis therefore determining the patient's diagnosis for the medication is not a simple process.

Top 200 by GC3

The Anti-Psychotic medication class was the top paid class for August 2009. There was a discussion on whether all prescriptions were appropriately indicated and the helpfulness of associating disease states with medications. The Board was informed that the mental health committee has been looking at anti-psychotic medication utilization and trending. The Board was also informed that the amount paid for anti-convulsant therapy has decreased with the implementation of MAC pricing for this group. Conversely, Tamiflu spending and utilization has increased since the last review. It was requested that patient demographics were obtained (i.e. disease burden of population). The Division of Public Health may have this information.

Suggested Action item:
1. Lost/Stolen prescriptions and vacation overrides will be monitored and a report of the findings will be provided at January's DUR meeting.
2. Specifics regarding the monitoring of disease states and medication utilization rates will be developed.

Retrospective DUR

Metoclopramide & EpiPen Patient Medical Profile Update

The Board was updated regarding the Patient Medical Profiles and having their dissemination approved with the North Carolina Attorney General's Office since it contains mental health information. There is also a question out to the Attorney General's Office about including medications that treat substance abuse such as Suboxone. Once the Patient Medical Profiles have been approved by the Attorney General's Office, First Health Services has approximately 80 hours of programming hours before letter production can begin.

Chantix Utilization

The Chantix background and intervention methodology data provided in the DUR packet were reviewed. It was noted that there were 253 patients identified as using Chantix over the FDA recommendation duration of therapy of 6 months within the last year. It was asked if Community Care of North Carolina (CCNC) was assessing and intervening on patients and smoking cessation. CCNC does assess smoking cessation when case managing patients. A question was asked whether the DUR Board should be concerned with patients taking Chantix who are also on mental health medications due to Chantix's black box warning. The Board agreed all physicians who have patients receiving Chantix greater than 6 months receive a letter.

Suggested Action item:

1. *Draft letter will be generated and sent to the Board for comments/suggestions.*
2. *Letters will be sent on patients with parameters indicated above.*

Tamoxifen and SSRI (Paroxetine, Sertraline, Fluoxetine)

The Tamoxifen/SSRI background and reports included in the DUR packet were reviewed. The reports indicated 52 patients who appeared to be concurrently taking the Tamoxifen and SSRI combination since January 1, 2009. It was determined that both, the Tamoxifen prescribing physician and the SSRI prescribing physician, receive DUR letters and be asked to coordinate their patients care. The letters can be created to meet this request and will include both physicians' names in order to expedite the letter process. The Board agreed all physicians whose patients have been receiving Tamoxifen and Fluoxetine, Sertraline, or Paroxetine receive a letter.

Suggested Action item:

1. *Letter will have collaboration and salutation language added.*

2. *Letters will be sent on patients with parameters indicated above.*

Short-Acting Beta Agonist (SABA)

The SABA background, data, and graphs included in the DUR packets were reviewed. There was interest in whether ER/hospitalization data was linked to pharmacy claims but the Board was informed that the adhoc reporting system did not have that particular capability. The Board also asked whether patients with exercise induced bronchospasm would have been included in the report. The Board was informed that anyone with a SABA filled within this time frame would have been included. However, the Board was reminded that the reported patients were receiving 13 or more SABAs throughout the year and most likely patients with an exercise induced bronchospasm diagnosis only would have been filtered out. It was recommended that the data reflect 14 or more fills annually in order to eliminate patients who may have picked up one refill too early. The Board questioned the 206 patients not on an inhaled corticosteroid (ICS) with greater than 12 SABA fills, what was the age breakdown and how were they filling their SABA prescriptions since this may be a group needing intervention. Other suggestions from the Board were to look at the 714 patients and the 315 patients with > 12 SABA fills and an ICS on file to determine the ICS fill frequency, look at adherence rates of the ICS/alternative long-term therapy medications to identify patients with compliance rates less than 80%, and look at adherence data from other First Health states to see what precipitated their intervention and what outcomes resulted. It was suggested that many of these issues could be brought to the attention of CCNC for patient outreach and education. Since the data only reflected whether a patient filled an ICS during the year, it was asked if the patients were actually following the guidelines for treatment and had a previous trial/failure of an ICS which may explain use of alternative long-term therapy medication.

Suggested Action item:

1. *Data on patients with a Medication Possession Ratio <80%, previous fill histories to determine compliance with national guidelines, and SABA fill histories of the patients without ICS or other long-term therapies will be obtained. Data will be sent back out to the DUR Board members.*

Dose Optimization Program

The dose optimization materials in the Board packets were reviewed. The Board felt this type of program is an area where they should focus more attention and intervention letters be sent. It was noted that twice daily dosing is seen frequently for particular clinical conditions. The Board was informed that the data provided was based on FDA dosing recommendations and may not represent what is done in actual practice. There were comments that these medications were a good place to start since, for example, a leukotriene drug manufacturer representative stated there was no clinical rationale for twice daily dosing of their product. It was requested that the number of patients this data represents be presented in order to determine the volume of letters. The Board also inquired into what Pro-DUR edits were in place with the medications so they could determine whether Pro-DUR edits needed adjustments. It was recommended that the Board wait until after the prior authorization takes affect on the Leukotriene Modifier and Statin drug classes and re-assess letters at that time.

Suggested Action item:

1. *The volume of patients for Plavix, Toprol XL, Actos, Avandia, and Norvasc who meet the above criteria will be provided to the Board.*
2. *Established Pro-DUR clinical edits for the dose optimization drugs will be gathered and provided to the Board.*

Criteria Exception Report:
The 2009 first and second quarter Trigger Report was reviewed and GC3 classes with large utilization changes were highlighted. It was noted that many of the medications changed due to their seasonality. The Board was also informed that the GC3 class, D6S, had a decrease most likely due to the brief discontinuation of the PEG3350 products. The Board asked the reason for the large decrease in L3A and they were informed it was due to the removal of coverage of a drug called Radiaplex Rx. The Centers for Medicare and Medicaid Services determined Radiaplex Rx does not meet the definition of an outpatient medication and therefore coverage has ceased. The Board also noted there was a large increase in the GC3 class J3A which includes nicotine replacement patches.

Future Topics
The January DUR topics include patients using greater than 4 grams of acetaminophen for 30 or more days, Suboxone utilization/concurrent use of Suboxone and narcotics, and patients on hemophilia drugs. The Board was asked if they had any additional topics and there were no suggestions.

DMA Pharmacy Updates
Medication prior authorizations were discussed as one methodology in meeting budgetary requirements. A list of medications which were recently placed or potentially will soon be placed on the Outpatient Pharmacy Program's list of medications requiring prior authorization were provided. These medications include ACE Inhibitors, Angiotensin Receptor Blockers, Renin Inhibitors, Short-Acting Beta Agonists, Synagis, Leukotriene Modifiers, Statins, Fibrates, Anticonvulsants, Topical Anti-Inflammatories, and Orally Inhaled Corticosteroid Inhalers, Topical Anti-infectives, Long Acting ADHD drugs, and Doryx and Adoxa.

The Board was informed of DMA's decision regarding the discontinuation of coverage for the expectorant and cough suppressant medications which are also excluded by Medicare D. The discontinuation of coverage will begin in December 2009.

The Board was updated regarding the changes in pharmacy reimbursement rates. On October 5, 2009, Medicaid's pharmacy reimbursement changed from AWP minus 10% to WAC plus 7%. Medicaid also increased its SMAC pricing to compensate pharmacies and to promote generic dispensing. The pharmacy dispensing fees have remained unchanged. It was explained that each medication goes through the pricing methodology and the appropriate lowest cost reimbursement is applied to each medication.

On November 15, 2009 blood glucose supplies will be covered by Prodigy only. Medicaid will provide patients with a one time only override between November and February to give them enough time for the change and ensure continuous therapy. The glucose meters will be supplied by Prodigy at no cost to Medicaid, pharmacies, or patients. The testing supplies will be billable through Durable Medical Equipment (DME) at Medicaid and will be eligible for rebates which help DME meet budgetary requirements.

The Board was also informed that Medicaid has focused much of its attention to fraud and abuse of controlled substances as a result of a recent report from the U.S. Government Accountability Office (GAO). The GAO selected North Carolina Medicaid, in addition to other states, due to its high volume of narcotic medications. Medicaid representatives have been meeting frequently to address and work on issues identified in the report.

Other Business
The Board was asked for any additional business and there was none.

A motion was made and seconded to adjourn the meeting. The meeting was adjourned at 2:47 pm.

The next DUR meeting is scheduled for January 28, 2010 from 1:00 PM - 3:00 PM at the Kirby building, room 297.