Idaho Drug Utilization Review Program

DUR BOARD MEETING MINUTES

October 16, 2003, 9:00am
Len B Jordan Bldg, Room 302
Boise, Idaho

Board Members Attending: K. Clifford, K. Jensen, N. Mann, D. Smith, J. Steiner, R. Ting and G. Wilburn
DUR Staff: P. Cady, V. Culbertson, R. Force, C. Owens, and N. Murdock
Medicaid Representatives: T. Edie, T. Young, S. Kittridge
Excused: M. Olson-Fisher
Guest:

	Subject	Discussion	Action/Follow up
1.	**Approval of meeting minutes** - R. Ting		Minutes approved Seconded by K. Clifford
2.	**Quarterly report** - V. Culbertson		No action taken
3.	**Follow-up 2nd Qtr Studies**	**Acetaminophen Overdose** – N. Murdock The APAP overdose intervention performed last quarter identified patients receiving an average of ≥5 grams of APAP over a 90-day period. Patients with documented liver dysfunction or alcoholism were identified if they exceed a 2-gram limit. Letters were sent to physicians and pharmacies. A retrospective query evaluated the success of this intervention. Since the conclusion of the intervention, the following changes in patient therapy have been observed: Of the 147 patient letters involved in the original intervention for whom replies were received (representing 84 individuals), 78 patients appear to have undergone a change in therapy and in the last 3 months have not exceeded the 5 gram (or 2 gram) limit of APAP. **Statin Compliance** –R. Force	The board discussed possibility of a computer flagging system for patients who exceed recommended APAP doses. Implementation likely problematic. Due to response rate and reminder importance, will re-run intervention again next year. The board recommended tabulating data on ALL original intervention subjects to check for changes in therapy, instead of on just patients for whom responses were received. Appears this intervention was

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		This intervention identified patients who were started on statin therapy, but who failed to get a refill for 3 consecutive months without a documented physician visit in the interim, indicating a patient-initiated discontinuation of therapy. Since the conclusion of this intervention, the following changes have been observed: Of the 82 patients involved in the original intervention for whom replies were received, 54 patients appear to have undergone a change in therapy and records indicate a fill of their statin drug in the last 3 months.	successful in that the majority of patients filled their statin since conclusion of intervention
		<u>Inappropriate Prescribing of Antibiotics for Sinusitis</u> –R. Force This intervention identified physicians who frequently prescribe antibiotics for sinusitis. The database was queried for patients with a prescription for an antibiotic filled within two days of a diagnosis of sinusitis. Physicians identified as prescribers of ≥7 prescriptions of these antibiotics in the past year were sent a letter and questionnaire regarding diagnosis criteria and prescribing habits. Since the conclusion of the intervention, the following changes have been made: Of the 38 physicians involved in the original intervention for whom replies were received, 38 continue to have similar prescribing habits.	Follow-up on educational materials for patients for physicians who requested additional information
4.	**Intervention responses**	**<u>Metformin Safety</u>** –C. Owens	The board was impressed by the number of physicians who reported a

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		Despite the proven benefits and overall tolerability and safety of metformin in the treatment of Type II DM, important contraindications and monitoring parameters must be considered to ensure patient safety, maximize benefit, and ensure that metformin remains available in the marketplace. Some evidence suggests that metformin's contraindications and monitoring recommendations are not being followed in routine medical practice. This intervention identified patients receiving metformin who may be at risk for the development of complications due to a concurrent diagnosis of congestive heart failure, advanced age (>80 years), or infrequent laboratory monitoring of renal function. Primary care providers of these patients received a letter and educational materials regarding current monitoring recommendations, methods for calculating creatinine clearance, and a description of lactic acidosis. **Physician Responses:** Physician letters: 95 Physicians responding: 29 (31%) See results in 'Metformin Safety' packet	serum creatinine level. Recommended database check on patients who have reported serum creatinine level and date to assess completeness of database information and comparison with Heritage information Follow up on patients in whom SrCr is above safe limit for D/C of drug TZD safety intervention to be run in the future
		<u>Statin Therapy in High-Risk Patients</u> –N. Murdock Several clinical trials have demonstrated the benefits of statin and other lipid-lowering therapy in patients at high risk for cardiovascular or cerebrovascular events. Such patients include those with a documented history of CAD, PAD, ischemic stroke, TIA, or diabetes mellitus. Despite existing evidence, studies have shown that a large percentage of high-risk individuals who qualify for lipid-lowering therapy do not receive it. This intervention identified high-risk patients who had no record of statin or other lipotropic therapy and provided educational information regarding Adult Treatment Panel III guidelines for hyperlipidemia, lipid lowering effects of different drug classes, potential adverse effects of lipid-lowering agents, and data from clinical trials. **Physician Responses** Physician letters: 93 Physicians responding: 35 (38%) See results in 'Statins in High-Risk Patients' packet	Results are concerning in that a large population of at-risk patients are not receiving statin therapy, however, our results (25%) appear to be consistent with averages in Utah Several responses indicate that physicians are providing patients with lipid lowering drug samples – possible question to ask in next intervention Several responses indicated that patients in nursing homes and of advanced age were included in this intervention, will likely exclude patients >80 years in next run Check lipid panels in this population Assess compliance issues with lipid panel testing (often patients do not

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			come fasting to appts, etc) Article on this topic to be included in December Newsletter (include NNT) Board recommended separating high risk patients into categories: DM patients, CAD patients, TIA, patients, etc. Possible patient education intervention—Know Your Cholesterol Will f/u on this intervention as it is large in scope and has significant impact. Also intervention involves adding a medication, instead of taking meds away
		ACE Inhibitor Dosing in CHF –C. Owens Large clinical trials have demonstrated the benefits of ACE inhibitor therapy in patients with CHF. When prescribing these medications, clinicians often use lower doses in an attempt to minimize complications; however, existing evidence including the ATLAS trial indicates that higher doses of ACE inhibitors are more effective in reducing rates of complications (hospitalizations). As a result, higher doses than are used for the treatment of hypertension are recommended. Although tolerability, adverse effects, and other patient-specific parameters must be taken into account, doses equivalent to those used in clinical trials are needed for maximum benefit in CHF patients. This intervention identified patients with CHF currently being treated with an ACE inhibitor who would potentially benefit from a dose increase. Educational materials were also provided to physicians and pharmacists regarding the role of ACE inhibitors, dosing strategies to optimize therapy, and cost information. **Physician Responses:**	Some concern regarding pharmacists documenting on rx that ACEI dose may be inappropriate without speaking with prescriber Board members wondered if pharmacists are really contacting prescribers to discuss therapy and make recommendations

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		Physician letters: 75 Physicians responding: 32 (43%) **Pharmacist Responses:** Pharmacist letters: 64 Pharmacists responding: 30 (47%) See results in 'ACEI in CHF' packet	
5.	**Future interventions with therapeutic category assessment**	**Migraine Prophylaxis** –C.Owens Although several abortive agents for the treatment of migraine headache are available (most notably the 5-HT agonists or 'triptan' class), overuse of these medications by individuals with frequent and/or refractory headaches is associated with increased morbidity, rebound headaches, and significant economic concerns. In frequent headache sufferers, prophylactic therapy is warranted and recommended by several national organizations. Agents including beta-blockers, tricyclic antidepressants, and some anti-seizure medications have demonstrated utility in the prevention of migraine headaches and represent a great potential in savings to patients in terms of quality of life and costs, both social and economic. This intervention will identify individuals who, based on refill records, appear to be experiencing >3 migraine headaches per month and who are not being prescribed a prophylactic agent. Physicians and pharmacists will receive a letter and educational material describing the role of preventative agents for migraine, with specific information regarding agents with higher levels of demonstrated benefit. Cost information will also be provided. For more information, see 'Migraine Prophylaxis' proposal	Concern voiced over potential for excessive negative feedback as this topic can be a volatile one. The board recommends this intervention not be patient specific, but rather of an educational nature and to ascertain the prescribing practices of physicians treating migraine and other headaches; three-fold: triptan use (instead of MH diagnosis code), prophylactic drug nonuse, and opioid use Discussed whether this type of 'intervention' would count toward 12 interventions required per year. T. Eide responded in the affirmative. Suggested inclusion of preferred agent, cost information, and effective dose, contraindications in education

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			leaflet Questionnaire should address patients having tried and failed prophylactic agents in the past. Also focus on outcomes in terms of ER visits, other pain med (opioid) use and overuse Question about patients having tried preferred agent and then switched back to non-preferred drug and any adverse outcomes. November P&T committee meeting will decide preferred drug, will go into effect in Jan or Feb 2004
		<u>Appropriate Use of COX-2 Inhibitors</u> –N. Murdock Cyclooxygenase-2 (COX-2) specific non-steroidal anti-inflammatory drugs (NSAIDs) are relatively new analgesic agents with some demonstrated advantages over traditional NSAIDs in terms of GI protection. The analgesic efficacy of these drugs, however, appears to be equivalent to that of traditional NSAIDs. Because of their relative higher cost, the use of COX-2 inhibitors should be restricted to those individuals who will achieve greatest benefit, including patients at moderate to high risk for GI complications. The most appropriate use of these agents would be in patients who meet one or more of the following criteria: history of peptic ulcer disease, history of GI bleed or perforation, patients with long-term exposure to systemic corticosteroids, patients >65 years of age, and patients with chronic inflammatory conditions such as rheumatoid arthritis who will require long-term analgesia. This intervention will identify individuals who do not appear to meet the criteria for appropriate use of COX-2 inhibitors. Educational materials will also be provided describing the role of these agents in relation to older NSAIDS, recommendations for optimal use, and cost information. For more information, see 'COX-2 Inhibitor' proposal	Also an educational intervention that may or may not be patient specific Gather data on prescribing habits with regard to COX-2 inhibitors Inclusion criteria for appropriate use to include any history of GI bleed, pt taking warfarin or anti-platelet agents Look especially at steroid use in this population. Criteria should be >35 days of corticosteroid use in past 90

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		H. Pylori Eradication –N. Murdock Peptic ulcer disease (PUD) is a relatively common condition often treated effectively over the long term with antisecretory therapy such as H2-receptor antagonists (famotidine, ranitidine, cimetidine, others) or proton-pump inhibitors (omeprazole, lansoprazole, rabeprazole, others). Although treatment with these agents is effective in reducing symptoms, elimination of the cause would be most advantageous in terms of patient quality of life and economic savings. *Helicobacter pylori* is a pH-sensitive, gram-negative, microaerophilic bacterium believed to have colonized approximately 50% of the world's population. The majority of duodenal or gastric ulcer patients who are not taking NSAIDs have evidence of *H. pylori* infection. Eradication of *H. pylori* is associated with a significant decrease in the rate of ulcer recurrence and can usually be accomplished with intensive combination therapy (antibiotics and antisecretory drugs) for approximately two weeks. Once the causative agent has been eliminated, most patients can safely discontinue antisecretory drugs resulting in increased patient quality of life and significant economic savings. The purpose of this intervention will be to identify individuals on long-term (>6 months) antisecretory therapy who are not on chronic NSAID therapy and have not been tested or treated or *H. pylori* infection. Physicians and pharmacists will be sent a letter and educational material on the role of *H. pylori* in PUD, treatment strategies, and cost information. For more information, see 'H. pylori Eradication' proposal.	Will NOT run this as patient specific intervention, but questionnaire should ask about reasons for PPI such as GERD, taking with NSAIDs, etc.
6.	**By-laws** - T. Eide	No discussion	No action taken

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7.	**Medicaid Update** -T Eide	Two openings for pharmacists with Idaho Medicaid P&T Committee to decide on preferred COX-2 and PPI; committee will meet monthly for now, then every other month	Discussed role of DUR staff and possibility of placing a member on the P & T committee Will have a DUR staff representative from ISU at meetings V. Culbertson will draft a letter outlining request for DUR staff
8.	**Other business**	TOP 40 Highest cost patients, patients with most prescriptions, and patients seeing the most physicians was presented based on last 3 months of data Smart PA presentation by Heritage Description of how program will work	Larger, more detailed report (including patient profiles) requested for discussion at next meeting Discussion regarding cost and other ways of implementing program
9.	**Meeting Dates**	January 15, 2004 in Pocatello	
10.	**Adjournment**	Meeting adjourned at _2:30 PM	