Idaho Drug Utilization Review Program

DUR BOARD MEETING MINUTES

July 12, 2007
9:00 am
Idaho Medicaid Offices 3232 Elder Street
Boise, ID

Board Members: W. Baures, S. Cooper, G. Kadlec, J. Mayo, M. Olson-Fisher, J. Steiner
DUR Staff: J. Adams, P. Cady, R. Force, R. Holt, C. Lee, C. Owens, B. Pugmire
Medicaid Representatives: T. Eide, S. Gearhardt
Guest: S. Sparks (Sciele-Pharma Inc.), Eric Byres, Greg Bakke (Alcon Laboratory), 2 representatives from Eli-Lilly

APPROVAL OF MINUTES (July 2006, March 2007 Meetings)

The minutes of the July 2006 and March 2007 meetings were approved.

DUR OVERVIEW

1. Brief Overview of the DUR Program –C. Owens

    a. *Overview provided to orient new board members and pharmacy residents. DUR history and activities were highlighted.*

MEDICAID UPDATE –T. Eide

- **Deficit Reduction Act**

    a. *The final rules were published on July 1, 2007.*

    b. *Manufacturers will be reporting the Average Manufacturing price (AMP) to CMS monthly.*

    c. *AMP is used by CMS to calculate rebates and was previously confidential. It will now be published and used to calculate the Federal Upper Limit. The quarterly AMP will be used to calculate rebates. The FUL will be calculated on the AMP reported price at 250% of the lowest AMP for the drug. The lowest generic price will be the starting point. There is also an outlier rule. The rule is that if the lowest price is greater than 40% below the next lowest price they will go with the next lowest one. They will make sure that every pharmacy will have at least two generic products that they can choose from that will be under the cost of the FUL. There has also been a change in the way FUL is calculated. Previously, they were calculating it by WAC or AWP with 150% mark-up with at least 3 generics required, but now there will only need to be 2 generics.*

d. *They have also asked states to look at dispensing fees. Some states were only assigning dispensing fees to generic drugs, but CMS will now deny a state plan that differentiates a different dispensing fee for generic and brand name drugs. The reasoning behind this is CMS would like a true dispensing fee. This fee should not be different in brand name drugs.*

e. *Starting October 2007 physician administered drugs will have to have an NDC put on the claim when it is sent in.*

f. *By October 2007, all Medicaid prescriptions will have to be written on tamper resistant prescription pads. Currently there are no requirements, but the government has promised a guidance document that will give further instructions.*

- **Other updates**

a. *There have been two companies that have presented their material for the updating of the module system reprocurement. A pharmacist has been sent to see how the systems are working in other states. One change in the new system will be that Medicaid will work directly with the vendor.*

b. *Cost savings: Provider synergies negotiates supplemental rebates. Idaho Medicaid began with the TOPS program starting Q3 2006. In 2006 the following number of drugs classes on PDL and cost savings were: Q1 11 classes and $271,000, Q2 16 classes and $420,000, Q3 38 classes and $1.5 million, Q4 51 classes and $2.3 million. Idaho Medicaid drug spending currently is approximately $101 million. The classes of drugs with the most savings include stimulants, PPIs, SSRIs, Sedative Hypnotics, and Anticonvulsants. Through working with the DUR program Idaho Medicaid has been able to save money and improve patient care.*

FOLLOW-UP REPORT

1. **Proton-Pump Inhibitor Outcomes Study** –B. Pugmire

b. *Report presented and discussed. It was concluded that after removing gastritis from adverse GI events, Idaho Medicaid patients denied PPI therapy still had significantly more GI events than matched controls. It was also concluded that the location of denial had no apparent effect on GI event rates and that only 20% of denied patients were elderly. DUR board may wish to discuss presentation of this data to the P&T committee to consider revising or removing therapeutic PA criteria for PPIs.*

c. *It was commented that some of the patients denied PPI therapy may have received samples. It was also pointed out that patients denied PPI therapy*

that had an adverse GI event may have had the event even if they had received PPI therapy; this is difficult to determine.

d. *It was recommended that the 46 patients that had an ulcer or GI bleed complication be explored further, specifically, age breakdown, presence of other drugs with risk of GI hemorrhage (SSRIs, Plavix), and costs for adverse GI events and hospitalizations. It was also recommended that Medicaid request the medical charts (outpatient and inpatient) for these 46 patients to enable the DUR staff to review the charts and discover any other causes for the GI events.*

CURRENT INTERVENTION REPORTS

2. **Ophthalmic Antibiotics** –B.Pugmire

a. *Intervention presented and discussed. It was concluded that Idaho Medicaid total claims and costs for ophthalmic fluoroquinolones are increasing and are currently the most prescribed ophthalmic antibiotics for acute conjunctivitis. Many prescribers prefer these agents for severe infections, treatment failures, or to improve compliance. Prescribers may be receiving misinformation regarding Idaho Medicaid costs of 4th generation fluoroquinolones.*

b. *The cost table to be included in the DUR newsletter will include relative Medicaid costs so providers can see the cost ratios.*

c. *Letters received from prescribers were read and given to Medicaid representatives to write or request DUR staff to draft response letters.*

d. *It was also suggested that further research be conducted on school district policies, possibly to include surveys to School District Health Officials about regarding individual policies for various infectious diseases. Comment was made that it is difficult to obtain information regarding such policies in daycares. It was suggested that it may be beneficial to provide the school districts with educational material regarding appropriate treatment of conjunctivitis and other infectious diseases.*

3. **Pediatric Constipation** – C. Owens

a. *Intervention presented and discussed. It was concluded that Miralax is most frequently used by the pediatric population, usually for non-chronic constipation. The majority of physician respondents think Miralax should be covered by Idaho Medicaid and continue to recommend its purchase though no longer covered. Many pharmacists also think Miralax should be covered by Idaho Medicaid. It was also apparent that many patients do not pay out of pocket. Many respondents have also expressed concern regarding increased healthcare utilization costs if pediatric constipation*

goes untreated. Most respondents found the education leaflet useful to their practice.

b. *Medicaid explained that patients can still receive Miralax. They must go through EPSDT. It would be beneficial for the DUR staff to include this in the DUR newsletter. It was also explained that it is Medicaid policy that when a medication is available OTC, Medicaid will no longer cover it. Exceptions (ie Prilosec OTC and OTC loratadine) are allowed but must go to legislation. It is possible that Miralax will be covered by Medicaid in the near future.*

c. *It was suggested the next newsletter include information regarding Idaho Medicaid Miralax coverage through EPSDT.*

d. *Outcomes follow-up was suggested to assess any negative clinical impact in the pediatric population due to lack of Medicaid coverage of Miralax OTC.*

4. **Angiotensin Receptor Blockers** –B. Pugmire

a. *Intervention presented and discussed. It was concluded that Idaho Medicaid claims and costs have been increasing for the past several years. Nearly 60% of ARB users in 2006 were potentially inappropriately prescribed an ARB. Many patients appeared to be candidates for an ACEI. DUR board may wish to recommend P&T committee discussion regarding therapeutic prior authorization criteria for the ARB class.*

b. *The cost table to be included in the DUR newsletter will include relative Medicaid costs so providers can see the cost ratios.*

c. *No further follow-up was recommended.*

5. **Treatment of Acute Otitis Media** –R. Force

a. *Intervention presented and discussed. It was concluded that antibiotic prescription rates for pediatric AOM in the Idaho Medicaid population were comparable to the national average. When antibiotics therapy is initiated, amoxicillin is most commonly prescribed. Potential inappropriate antibiotic use resulted in over 3 million dollars in costs over the 13 year study period. The watch-and-wait approach from guideline recommendations has not seemed to affect trends in antibiotic prescribing; which is also comparable to the national average.*

b. *It was recommended to Idaho Medicaid that they may consider putting prior authorization criteria in place so that when patients go off Medicaid they will be able to afford the medication.*

c. *No further follow-up was recommended.*

5. **Outcomes study: Sedative Hypnotics** –C. Owens

   a. *Study presented and discussed. It was concluded that the use of sedative-hypnotic agents in the Idaho Medicaid population decreased in 2006 likely because of Medicare part D. Zolpidem(Ambien®*) continues to lead in cost and number of claims among these agents, although claims and costs for eszopiclone (Lunesta®) are increasing. *It was also evident that total claims increased by ~125 and costs increased by $70,000. This cost does not reflect cost savings by supplemental rebates. Pediatrics still make up only a small percentage of sedative hypnotic users(<10%) and of these, about 1/3 carry a likely diagnosis of ADHD. Chronic users in the <65 population had decreased from 13% to 9% since the intervention conducted in 2005 and temazepam utilization has increased.*

   b. *There did not appear to be any significant increases in overall drug or healthcare related costs or utilization in the analysis of patients regularly using non-preferred agents pre and post EPAP implementation. Users of Ambien CR or Rozerem continued using those agents even after EPAP in most cases; users of Sonata most frequently discontinued use of any sedative hypnotic agent.*

   c. *The board also discussed that when users of Ambien decreased the cost went up.*

PROPOSED INTERVENTIONS/OUTCOMES STUDIES

1. **Drug Therapy for Depression** –B. Pugmire

   a. *Intervention topic presented and accepted by the Board.*

   b. *The study will characterize antidepressant utilization among adults with depression in the Idaho Medicaid population and provide educational therapeutic and cost information to prescribers.*

   c. *It was suggested that comorbid conditions be characterized.*

   d. *Will be presented at next meeting in October.*

2. **Treatment of Uncomplicated Cystitis** –C. Owens

   a. *Intervention topic presented and accepted by the Board.*

   b. *The study will identify trends in antibiotic prescribing habits in the treatment of acute uncomplicated cystitis and characterize common antibiotic therapy used in the treatment of this condition. The study will also provide educational information to prescribers regarding local E. coli resistance patterns and antibiotic failure rates when treating acute*

uncomplicated cystitis with sulfa antibiotics in the Idaho Medicaid population.

c. *The board suggested separating patients with a culture from those without.*

d. *Will be presented at next meeting in October.*

4. **Outcomes Study: Methadone** –C. Owens

a. *Study topic presented and accepted by the board.*

b. *The study will conduct market share analysis, general screening tests, and prescriber intervention.*

c. *The board recommended researching to see if patient is on another long acting agent because they are more at risk than those using methadone alone. If the patient is on another long acting agent, determining if the same prescriber is prescribing both agents.*

d. *Will be presented at next meeting in October.*

OTHER BUSINESS

May 2006 NEWSLETTER articles

- Appropriate use of Angiotensin Receptor Blockers
- Ophthalmic Antibiotic Utilization
- Medicaid Supplemental Rebates

Discussion:

Article topics evaluated for inclusion in next DUR Discovery newsletter. The cost tables will include relative Medicaid costs so providers can see the cost ratios for both ARBs and ophthalmic antibiotics. Medicaid staff will forward information to include in the article about supplemental rebates. Information regarding Idaho Medicaid coverage of Miralax through EPSDT will be included if deemed appropriate by Medicaid representatives.

FUTURE MEETING DATES

October 18, 2007 and January 17, 2008

ADJOURNMENT

MEETING WAS ADJOURNED AT 3:30 PM