

*Idaho Drug Utilization Review Program*

**DUR BOARD MEETING MINUTES**

July 10, 2008

9:00 am

Idaho Medicaid Offices 3232 Elder Street  
Boise, ID

**Board Members:** P. Brown, J. Mayo, M. Olson-Fisher, J. Steiner, M. Turner

**DUR Staff:** J. Adams, V. Culbertson, K. Eroschenko, R. Force, C. Lee, B. Pugmire,  
C. Owens

**Medicaid Representatives:** E. Heil

**Guests:** R. Meyers (Eli Lilly), Paul Voss (Allergan), Aaron Huwe (Gilead),  
E. Bergstrom (PharmD Student)

**APPROVAL OF MINUTES (April 2008)**

*The minutes of the April 2008 meeting were approved.*

**DUR for Continuing Education Program**

1. **An overview of presentation given in Spring CE Program –C. Owens**

- a. *A presentation summarizing the Idaho Drug Utilization Review Program was given to pharmacists that attended the Idaho State University Continuing Education Program. The program displayed the pharmacist's role in the DUR program, and explained how Idaho's DUR Program differs from other states. Comments were displayed from all three Continuing Education Programs. The presentation was well received from the attendees.*
- b. *The board suggested trying to present this to the physicians in Idaho. The DUR staff stated that we did have a booth at IMA one year, but it is difficult to get time for a formal presentation. Dr. Brown suggested that the DUR staff present this overview to the Family Medicine residents in Boise and Pocatello. This would be feasible because they have noon conferences daily and the residents would be able to take the information that they learned to their practices. This would hopefully have a downstream effect to make Idaho Physicians aware of their role in the Idaho DUR Program.*

## CURRENT INTERVENTION/OUTCOMES REPORTS

### 1. Treatment of Fibromyalgia- C. Owens

- a. *Intervention was presented and discussed. The study concluded that the incidence of Fibromyalgia (FM) has increased in adults and children since 1994. The most commonly used agents to treat FM were opioids, NSAIDS, and cyclobenzaprine which are not considered preferred first line agents for this condition in newly diagnosed FM patients within 3 months of their diagnosis. Approximately 20% of newly diagnosed patients had no FM-related drug therapy on file. About 1/3 of patients had 3 or more FM-related drugs.*
- b. *It was found that FM patients often have many comorbid conditions. Less than 3% of patients had no additional FM related coded diagnoses. Lyrica utilization has been increasing since June of 2007. Approximately ½ of Medicaid spending on Lyrica in 2007(\$70,000) was associated with FM patients.*
- c. *Most physicians and pharmacists who responded to our survey agree or strongly agree that FM is a legitimate medical condition. There is less agreement about the value of DTC advertising for facilitating provider-patient conversations. Most respondents indicated that exercise is an important part of FM treatment recommendations.*
- d. *The ICD-9 code used was 729.1 is named fibromyositis not fibromyalgia. There was a comment saying that this would be very problematic for coding. Medicaid responded that if you look in the index of the ICD-9 codes under fibromyalgia it will direct you to code 729.1.*
- e. *Medicaid also mentioned that the 729 code wasn't approved by Medicaid for coding until Lyrica was FDA approved. The 729 code wasn't used until October of 2007. Most patients that were using Lyrica prior to March 2007 were receiving it under neuropathy and radiculopathy diagnoses.*
- f. *The diagnosis of FM 729.1 has also increased in the <18 year old category. Dr. Brown (pediatrician) suggested that this may be due to wrongful coding for muscular dystrophy or chronic fatigue syndrome. There are very few patients that he has seen that fall into the FM category. Differentiating between symptoms of fibromyalgia and chronic fatigue can often be difficult.*
- g. *There was discussion on the effect of direct to consumer advertising with the recent FM commercials. It was stated that when commercials first started advertising in the early 90's, there was a significant effect on sales, but has since died off with multiple companies advertising their products.*
- h. *Due to the prevalence of FM in the Idaho Medicaid population, future studies and educational interventions may be warranted.*

## 2. Treatment of GERD in Adults –K. Eroschenko

- a. *Intervention was presented and discussed. It was determined that in patients who received an H2 antagonist initially, 12% were stepped up to a PPI. In patients that received a PPI initially, 43% were stepped down to a H2 antagonist. The survey sent to physicians also showed similar statistics when asked whether they preferred to initiate step up or step down therapy. The majority of patients were adequately controlled on an H2 antagonist.*
- b. *Of those patients newly diagnosed with GERD 92% did not have a claim for a medication within 90 days. This may be partly due to samples. There are also many patients that are less than 18 years old in the Idaho Medicaid population that have been diagnosed with GERD.*
- c. *Medicaid mentioned that the therapeutic criterion for PPI's was removed on April 15, 2008. This enabled patients to receive a preferred agent for once daily dosing with out a prior authorization. It was also mentioned that the cost tables in the educational leaflet did not accurately reflect Medicaid's net savings on PPIs. The DUR staff responded saying that the cost tables were reflecting the drug costs associated with filling a PPI had the patient not been covered by Medicaid. Medicaid is also not authorized to disclaim the amount of savings that they receive for medications.*
- d. *The DUR board may want to conduct a follow up intervention.*

## 3. Judicious use of Benzodiazepines –C. Lee

- a. *Study presented and discussed. The study revealed that approximately 5% of BZDs users in 2007 received multiple BZDs chronically. This may be due to multiple prescribers. The study also showed that 47% of anxiety patients regularly taking a BZD were not taking another anti-anxiety medication. There were also 13% of patients using a BZD once daily that had an insomnia diagnosis. The majority of patients receiving a non-clonazepam BZD long term in 2007 did not have a diagnosis of anxiety or insomnia.*
- b. *Many prescribers surveyed state that chronic BZD use may be appropriate in patients who have failed/cannot tolerate the recommended alternatives; and for intermittent, as needed use. The majority of surveyed pharmacists encounter 1-4 patients per week that are prescribed BZDs from multiple prescribers. All surveyed prescribers responded that they expect a pharmacist to contact them if a patient is receiving a BZD from another provider.*
- c. *The DUR Board may want to investigate the frequency of BZD prescribing from multiple prescribers, identify the chronic users of BZDs without a diagnosis of anxiety or insomnia, prevalence of BZD withdrawal and/or overdose, and the presence of other CNS depressant drugs in BZD users.*

#### 4. Synagis Outcomes–B. Pugmire

- a. *Study presented and discussed. Approximately 80% of Idaho Medicaid patients with requests for palivizumab (Synagis) were approved for treatment in the past three RSV seasons.*
- b. *There were 10% of approved patients that did not receive one administration. On average, patients received 3-4 palivizumab (Synagis) treatments per season; most received less than the five recommended doses.*
- c. *Patients denied palivizumab(Synagis) did not have higher rates of RSV, healthcare utilization, or costs compared to patients approved for treatment.*
- d. *The Board may wish to make additional comparisons. The DUR staff suggested that they further research patient groups that are listed below:*
  1. *Patients that were approved for and received treatment compared to approved for but did not receive treatment.*
  2. *Patients that were approved for but did not receive treatment compared to denied treatment*
  3. *Patients denied treatment compared to controls that did not request treatment.*
  4. *Patients that were approved for and received treatment compared to candidates that did not request treatment.*
- e. *Dr. Brown mentioned that many physicians are now testing for RSV and in the past have not always tested for RSV. The treatment would be the same, but the coding would be different.*
- f. *Medicaid explained the large number of claims of Synagis as the pharmacy billing as well as the physician for the drug. Only one claim would be paid. The physician's office may charge an administration fee of and the administration fee only would be paid by Medicaid. It was also mentioned that another aspect that cannot be captured in this study is how the child is cared for at home. Some parents will continue to smoke and take children in public places because they have received a Synagis shot. This type of care would have a negative effect on the child's health.*
- g. *Medicaid stated that they have not seen any extremely hazardous outcomes from patients that were denied Synagis treatment.*

### **PROPOSED INTERVENTIONS/OUTCOMES STUDIES**

#### 1. Synagis Outcomes Part 2 –B. Pugmire

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

- b. To further obtain information regarding the clinical and financial outcomes resulting from the prior authorization of palivizumab (Synagis) in the years following the initial decision.*
- c. The board suggested that the DUR staff review the patients that qualified for Synagis but did not receive any treatments. It was mentioned that looking at only children under 32 weeks (non-gestational age) be reviewed.*
- d. The board mentioned tracking Synagis results prospectively. It was mentioned that St. Alphonsus and St. Luke's hospital track infants in the NICU and send letters to physicians suggesting Synagis treatments for select patients. This would be a large process, but would not have the limitations of a traditional retrospective intervention.*

## **2. Treatment of Restless Legs Syndrome –C. Owens**

- a. Intervention topic presented and accepted by the Board.*
- b. To describe the incidence and prevalence of RLS (based on ICD-9 coding) in the Idaho Medicaid population over the past 14 years. Claims data will also be evaluated to determine the therapeutic agents that are currently being used to manage the symptoms of RLS. This intervention will also provide education to physicians and pharmacists regarding the most current evidence for the appropriate management of the condition, including the pharmacological and non-pharmacological options. A questionnaire to assess physicians' and pharmacists' experience and attitudes relating to the treatment of RLS will also be included.*
- c. The board thought this study would be very beneficial to the health care providers in Idaho due to the disease not being well known.*

## **3. Use of Atypical Antipsychotics in Children-K. Eroschenko**

- a. Study topic presented and accepted by the board.*
- b. The study will characterize the use of atypical antipsychotics in the pediatric population (<18 years of age). Also to examine the utilization and costs of atypical antipsychotics in children with bipolar disorder, and evaluate Idaho Medicaid trends in diagnosis of bipolar disorder in children. In addition, to provide education to providers and pharmacists regarding current use and trends of atypical antipsychotics in children as well as important clinical considerations for use of these drugs in the pediatric population.*
- c. The board mentioned that physicians may be using this drug due to its side effects. These include mood stabilization, weight gain, and sleep.*

#### 4. **Benzodiazepine Use and Patient Safety** –C. Lee

- a. *The study will assess the frequency of BZD prescribing from multiple providers, to identify the prevalence of BZD overdose and withdrawal, and to evaluate use of concomitant CNS depressants. Also to educate providers and pharmacists regarding BZD patient safety issues and to make them aware of patients seeking BZD scripts elsewhere.*
- b. *It was stated that the Board of Pharmacy has a website where a healthcare provider can look up to see if a patient is receiving multiple prescriptions from different providers. It was suggested that the Board of Pharmacy be contacted about sending a letter when this is occurring.*
- c. *The board also suggested viewing the overdose hospitalization rate of BZD.*

#### 5. **Annual Report Summary-** V. Culbertson

- a. *A summary of the DUR annual report was given. The DUR staff is required to provide an annual report that includes all of the activities that were conducted that year.*
- b. *A chart displayed that Medicaid prescriptions have tripled since 1993. Drug costs have also increased almost 300%. ADHD drugs have increased for the past 4 years statistically, while Medicaid spending on narcotic analgesics has decreased due to the cost of the drug decreasing.*
- c. *Medicaid spent approximately 54 million dollars (this does not include supplemental rebates) on 25 drugs last year. It was highlighted that the DUR board may want to focus on these drugs to help control drug costs.*

### **OTHER BUSINESS**

August 2008 NEWSLETTER articles:

- ❖ Treatment of Fibromyalgia
- ❖ Judicious use of Benzodiazepines
- ❖ ADHD and Vyvanse
- ❖ Acute Uncomplicated Cystitis Resistance and Failure in the State

### **FUTURE MEETING DATES**

October 16, 2008; January 15, 2009; April 16, 2009

### **ADJOURNMENT**

MEETING WAS ADJOURNED AT 3:15 PM