

Idaho Drug Utilization Review Program

DUR BOARD MEETING MINUTES

January 17, 2008

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, M. Turner, P. Brown

DUR Staff: Culbertson, Force, Owens, Pugmire, Eroschenko, Lee, Holt, Adams

Medicaid Representatives: T. Eide, S. Gearhardt

Guests: Chuck Scow, Russ Meyers (Eli Lilly), Felicia Fuller (Biogen Idec), Stephanie Davis (Bristol Myers Squibb)

APPROVAL OF MINUTES (October 2007 Meeting)

The minutes of the October 2007 meeting were approved. Dr. Mark Turner was selected as the Chair of the board. Wayne Bauers was selected as the president, he will serve as chair, if the chair is unable to attend the meeting.

DUR OVERVIEW

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

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

CURRENT INTERVENTION/OUTCOMES REPORTS

1. Depression in Pregnancy –R. Holt

- a. *Intervention presented and discussed. It was concluded that antidepressant use in pregnancy has increased significantly over the last 13 years among the Idaho population. It was also concluded that 24% of Idaho Medicaid covered pregnancies in the last year were for women who were active clients prior to pregnancy. The rate of exposure to ADPs was 6 times higher for pregnancies in women with Medicaid enrollment prior to pregnancy compared to those on Medicaid only during pregnancy. It was determined that the majority of the surveys were filled out by family practice physicians and OB/GYN. Most preferred sertraline and fluoxetine during pregnancy but avoid paroxetine during pregnancy. SSRIs are currently the most commonly used ADPs in pregnant women and over half of the pregnancies with ADP use in early pregnancy did not continue therapy in the 2nd and 3rd trimesters.*

- b. *Dr. Brown suggested that the DUR board send the educational leaflets to the resident physicians in Idaho. The intervention was accepted by the board and no further follow up was recommended.*

2. ACEIs, ARBs, and Statins in Childbearing Women –C. Lee

- a. *Intervention presented and discussed. It was discovered that the utilization of ACEIs, ARBs, and statins has increased 3-fold in women of childbearing age over the last decade. The study also discovered that over 80% of ACEI, ARB, and statin claims among women of childbearing age in the last year were not covered by detectable contraception. It was concluded that the majority of the surveyed physicians and pharmacists are concerned about the use of these drugs in women of childbearing age. Despite the clear evidence of harm, fetal exposure to ACEIs, Arbs and statins is occurring and increasing in the Idaho population.*
- b. *It was suggested that in the educational leaflet the fifth key point be changed. In its present state, the key point leads readers to believe that contraception should be avoided. This will be fixed when the DUR Newsletter is sent out. No further follow up was recommended.*

3. Inhaled Corticosteroid Outcomes –K. Eroschenko, C. Owens

- a. *Study presented and discussed. It was concluded that the predictable market share shifts occurred following both changes to the Enhanced Prior Authorization Program for this class. The only significant differences detected among patients thought to be affected by the EPAP were decreases in overall drug costs. No significant increases in non-drug costs were detected in the 3 months following EPAP implementation for any patient group. The analysis revealed no negative clinical or financial consequences related to EPAP implementation for the ICS class in either time frame studied.*
- b. *It was mentioned that the big change which took place created a very significant burden for patients and providers. It was stated that if Medicaid can avoid this in the future the providers would appreciate it.*
- c. *Medicaid explained that there was such a significant cost benefit that it was impossible to avoid the change. Medicaid also stated that they realized that there is a large inconvenience factor for health care providers and that they avoid large changes in policy when at all possible. They also stated that when a major change like this occurs, a list is sent to physician's offices to notify them of patients who will be affected.*

Advair Utilization Outcomes –K. Eroschenko, C. Owens

- a. *Study presented and discussed. The study showed that there were no increases in drug and non-drug costs for patients denied Advair, as a result of PA criteria in the 3 months following their denial. There were likewise no increases in healthcare utilization among patients denied Advair. Several asthma-related diagnoses were found on patient profile review of denied patients. Inclusion of Advair in the EPAP did not appear to have negative consequences, financially or clinically.*
- b. *Medicaid explained that the denied patients may not have fulfilled the therapeutic criteria required prior to obtaining Advair.*

4. Proton-Pump Inhibitors Outcomes–B. Pugmire, V. Culbertson

- a. *Study presented and discussed. Further follow-up concluded that Idaho Medicaid patients denied PPI therapy had significantly more GI events than matched controls (6.6% vs. 1.8% $p < 0.001$, RR 2.5, NNH 21). Among patients denied a PPI who later had an adverse GI event, only 28% were elderly, nearly 50% were not taking a high risk drug at the time, and approximately 50% appeared to meet PA criteria at the time of first denial. The DUR staff determined that there were at least two possible explanations as to why patients were denied PPI therapy and had significantly more GI events than matched controls. One reason was that some were eligible for PPI therapy, but denied due to incomplete paperwork or coding. The other explanation that was explored was that PA criteria does not include all patients who may potentially benefit from PPI therapy.*
- b. *It was also stated that it was a possibility that many patients may be receiving sampled medications from physicians because it was easier for the physician to distribute samples, than to have to go through the prior-authorization process. This proposes a problem because patients may not receive their medications all of the time.*
- c. *Medicaid suggested that the problem could be at the pharmacy level. Pharmacy employees may not be running the claim because they know that this medication requires a PA. The other problem that may be occurring is that Medicaid does not allow BID dosing. The patient also had to fail an H2 blocker in 2002 before a PPI would be allowed.*
- d. *Medicaid will review this drug class next month at the P&T Committee meeting, they would like to see the denial codes. This would enable them to see why patients are being denied.*
- e. *Medicaid's new system will allow the pharmacies and physicians office to send the PA online. As soon as Medicaid's new system is running, they will be a lot more efficient in changing drug criteria.*

- f. It was decided to take all of this data to the P & T Committee so they can look at PPI class as a whole, and determine if the PA criteria should be lifted. Medicaid would also like to review the patients who had a diagnosis, but did not receive a PPI.*
- g. The most efficient way for physicians to ensure that patients are receiving prescribed medications is to call Medicaid's help line so by the time the patient gets to the pharmacy their medications will be approved.*
- h. It was also suggested to educate healthcare providers on the Medicaid Prior Authorization process in the DUR Newsletter.*

PROPOSED INTERVENTIONS/OUTCOMES STUDIES

1. Pharmacologic Treatment of GERD –C. Owens

- a. Intervention topic presented and accepted by the Board.*
- b. The study will characterize the initial pharmacologic treatment of patients with newly diagnosed GERD by identifying drug therapy within 30 days of diagnosis and to characterize changes in patients acid suppression therapy. This intervention will also provide education to pharmacists and physicians about the different treatment options and approaches for GERD.*

2. Treatment of Postpartum Depression –R. Holt

- a. Intervention topic presented and accepted by the Board.*
- b. The study will characterize antidepressant utilization among women diagnosed with PPD in the Idaho Medicaid population, including, treatment initiation, duration and most prescribed medications as well as providing educational information to healthcare practitioners involved in the care of these women.*
- c. The board suggested also including information on the treatment of breastfeeding mothers.*
- d. This intervention will be presented at the next DUR meeting in April 2008.*

3. Appropriate Use of LABAs in Asthma- B. Pugmire

- a. Study topic presented and accepted by the board.*
- b. The study will identify patients using LABAs inappropriately and provide educational materials to their providers regarding LABA place in therapy.*

4. **Outcomes Study** –K.Eroschenko

- a. *The board did not have any suggestions for an outcomes study. Medicaid and the DUR staff will discuss this further and present an outcomes study at the April 2008 meeting.*

Tami Eide suggested the DUR Board consider the topic of low-dose off-label use of atypical antipsychotics (particularly quetiapine) for an intervention. Other DUR programs have looked at this topic. There would be an important educational component regarding the misuse and abuse of the drug as well. The intervention was approved by the Board.

MEDICAID UPDATE –T. Eide

1. *The changes in the Deficit Reduction Act were explained. The change to Physician Administered Drugs is:*

- *Single Source Drugs- National Drug Code (NDC) required on all.*
- *Multi-Source Drugs- NDCs required on specified top 20*
- *Non collect NDCs= No Federal Match as of January 1, 2008*

Idaho

- *NDC voluntary 2003*
- *Mandatory 2004*
- *Includes all drugs*

2. *DRA FUL Methodology:*

- *Two or more therapeutically equivalent*
- *FUL= least costly AMP X 250%*
- *Outliers (> 60% below second lowest AMO) not considered*
- *Will be used on all formulations including B-rated drugs*
- *Based on 9 digit NDC not 11 digit.*

3. *Medicaid has applied twice for a transformation grant for the Medication Management Program. Medicaid will be exploring other avenues to make this program a reality.*
4. *The tamper resistant prescription pads that were to be implemented the first part of October, has been extended another six months. These prescription pads must prevent unauthorized copying of a completed prescription form, erasing or modifying of the information written by the prescriber, and prevent the use of counterfeit prescription forms. This will take effect in April of 2008.*
5. *Due to the increasing drug costs, a legislative mandate was passed which required states to research various cost control measures. This mandate resulted in the Enhanced Prior Authorization Program, Supplemental Rebate Process and PDL,*

Clinical Evidence based process, P & T Committee with local providers, DUR Outcomes Studies, and Smart PA Technology.

6. *The Pharmacy and Therapeutics Committee (P&T) focuses on Clinical Decision, Cost Decision. The primary focus is the patient's overall care. If there is an equivalent drug then the cheaper drug will be use for cost effectiveness.*

OTHER BUSINESS

February 2008 NEWSLETTER articles

- ❖ Depression in Pregnancy
- ❖ ACEIs, ARBs, and Statins in Childbearing Age Women
- ❖ Long-Acting Opioids

FUTURE MEETING DATES

April 17, 2008, July 10, 2008, October 16, 2008

ADJOURNMENT

MEETING WAS ADJOURNED AT 3:30 PM