



**Center for Operations and Pharmacy Management
Drug Utilization Review (DUR) Board Meeting Minutes
Wednesday December 2, 2009
Hewlett Packard Conference Room
171 Service Avenue
Warwick, Rhode Island**

DUR Board Members Present: Tara Higgins, RPh, CGP, CDOE
Stephen Kogut, PhD, RPh, MBA
Ellen Mauro, RN, MPH
Richard Wagner, MD

Others Present: Paula Avarista, RPh, MBA (RI Medical Assistance Program)
Ann Bennett (Hewlett Packard)
Karen Mariano (Hewlett Packard)
Joe Paradis, PharmD (Health Information Designs)

There were no changes made to the minutes from the September 16, 2009 meeting.

Paula Avarista discussed some of the changes made to the Preferred Drug List at the Pharmacy and Therapeutics (P&T) Committee meeting held on December 1, 2009. Changes were made to the anticonvulsant drug class and a new class of fibromyalgia agents was developed. The P&T Committee asked that the DUR Board review the use of fibromyalgia agents going forward to determine if placing restrictions on the use of these agents may result in an increased use of narcotics. The DUR Board also was interested in reviewing data on anticonvulsant use and obtaining information on what other State Medicaid Programs were doing with regard to brand restrictions for anticonvulsants. HID will report back on what other State Medicaid Programs have in place regarding brand anticonvulsant use. In the future additional dose optimization edits may be discussed and implemented.

New legislation will require the reimbursement for smoking cessation products in the year 2013. The Connect Care Choice Program is developing a proposed budget for a smoking cessation program. The proposed budget and estimated impact of the program will help determine if this effort will eventually improve patient outcomes and save money. It was noted that many smokers have a short life expectancy and do not utilize expensive long-term care services. It was also noted that many hospitals, including Veterans Administration (VA) facilities are smoke free. The Board asked if HID could report back on what other states cover with regard to smoking cessation drugs and programs if possible.

The DUR Board asked if continuous use of antidepressants could be evaluated. There was some concern that PDL changes may be disrupting therapy.

Paula Avarista asked HID to provide her with a list of patients with a diagnosis of hepatitis C who did not have recent claims for drugs used to treat hepatitis C. The Board wanted to determine if there was any way to determine if patients had been offered treatment and refused.

There was some discussion regarding the Blue Chip Optima Medicare Advantage plan that will no longer be servicing the state of Rhode Island. There was concern that many of these patients may have not chosen a new health plan.

Problems associated with non-adherence were discussed. HID is planning to supply the Department with a list of patients names and identification numbers who have been identified as non-adherence to lipid lowering and antihypertensive therapy. Intervention letters are being sent to prescribers on an ongoing basis. A list of patient identifiers will also be made available to the Nurse Case Managers who are directly responsible for monitoring patients in an effort to improve adherence. The Department is also trying to identify patients with diabetes who may be non-adherent to testing their blood glucose levels. Since one of the goals of the Connect Care Choice program is to reduce ER visits and hospitalizations, they also tracks patients who are non-adherent to lipid lowering, beta blocker and antidepressant therapy. Ellen Mauro will coordinate efforts with HID to determine how best to identify and intervene with these patients.

Paula Avarista discussed the Community Medication Assistance Program (CMAP). CMAP covers mental health drugs and has a formulary but has not formal mechanism to review, add or remove drugs from the formulary. CMAP has asked the department to have the DUR Board recommend formulary coverage of two newer agents in particular, desvenlafaxine (Prestiq[®]) and paliperidone extended release injectable suspension (Invega[®] Sustenna[™]). The Board recommended that CMAP follow the recommendations set forth in the PDL for any drug reviewed as part of the PDL process. If new drugs are added to the PDL then they should be added to coverage under CMAP as well. Injectables are not part of the PDL review process. Therefore, the Board recommended that CMAP include coverage of paliperidone extended release injectable suspension (Invega[®] Sustenna[™]). However, since desvenlafaxine (Prestiq[®]) was made non-preferred, the recommendation was for CMAP not to include coverage of the drug. The Board also recommended that if possible the CMAP reimbursement system be modified to allow for step edits or prior authorizations similar to the PDL.

The ongoing use of a long acting injectable antipsychotic agent with oral therapy was discussed. The Board noted that there are some cases where ongoing oral and long acting therapy could be clinically indicated despite the high costs associated with duplicate therapy. It was also noted that avoidance of hospitalizations is a key factor in determining if patients should remain on duplicate therapy. HID will send a list of patients identified to the Department for further review.

The use of buprenorphine/naloxone (Suboxone[®]) and other opioids was discussed. Each month approximately 10% of buprenorphine/naloxone (Suboxone[®]) patients also have a claim for another opioid. This data includes both Medicaid and CMAP patients. The Board asked if the data could be broken out by Medicaid and CMAP patients in the future and that CMAP be notified of the results as well. DUR letters have not been sent at this time per previous recommendations from the DUR Board. HID will continue to monitor this on a monthly basis.

The under utilization of lipid lowering therapy in patients with diabetes as well as the use of atypical antipsychotics in the diabetic population was discussed. HID will send the Department lists of patient identifiers for further follow-up.

The use of atypical antipsychotic agents in patients under age 18 was discussed. Some of the atypical agents are indicated for children as young as 6 years of age, but some are not indicated for patients under

age 18. HID will send a list of patient identifiers of younger children (those under the approved age noted in the product labeling) who are receiving atypical antipsychotic agents to the Department for further follow-up.

A list of the top classes based on total claims and dollars was reviewed. The Board requested if at all possible could the list of top drug classes be broken down by those patients with single versus duplicate drug therapy within the top drug classes. Paula Avarista noted that parts of the new MMIS system will allow for the addition of prospective edits to check for duplicate therapy and additional quantity limits could be included.

The next meeting is scheduled for Wednesday April 7, 2010 at 8:00am.