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Drug Utilization Review Board
Meeting Summary
Wednesday, February 18, 2015

The Drug Utilization Review (DUR) Board met on Wednesday, February 18, 2015, at 8:30 a.m. in Conference Room B-16, University of Illinois at Chicago College of Pharmacy, 833 S. Wood Street, Chicago, Illinois.

DUR Board members in attendance: Rachel Caskey, MD, Chairperson; Anitha Nagelli, PharmD, M.Ed, Vice-chairperson; Lori Wilken, PharmD, AE-C.

Illinois Department of Healthcare and Family Services (HFS) Representatives: Donna Clay BSPharm, Prior Authorization, University of Illinois at Chicago (UIC); Arvind K. Goyal*, MD, Medical Director, Medical Programs, HFS; Mary Lynn Moody, BSPharm, UIC; Christina Petrykiw, PharmD, CDE, UIC.

Interested parties: Mark Davis, Vertex; Lisa Dunn, Amgen; Tom Erikson, Bristol Myers Squibb; Chris Gillette, Pfizer; Judy King, MD; Mike Krug, Sunovion; Randi Lewandowski, Teva; Mai Masri, Amgen; Cherie McCormick, Astellas; Terry McCurren, Otsuka; Scott Mills, Allergan; Ashley Polce, Abbvie; Shane Scott, Astellas; Rachel Self, Otsuka; David Skibicki, Pfizer; Gary Thurnauer, Pfizer.

*Attendance via teleconference

Call to Order. Rachel Caskey, MD, called the meeting to order on February 18, 2015 at 8:42 am.

Agenda, conflict of interest review, and approval of October 22, 2014 meeting minutes. Illinois DUR Board members had no changes to the February 18, 2015 meeting agenda. A spelling correction was requested in the October 22, 2014 minutes, page 2, for Dr. Wilken's name. Rachel Caskey, MD, called for a vote. Anitha Nagelli, PharmD, made a motion, seconded by Lori Wilken, PharmD, and the DUR Board unanimously approved the October 22, 2014 minutes with the corrected name. Rachel Caskey, MD, requested DUR Board members to recuse themselves from discussion if a conflict of interest exists and to update their Conflict of Interest form when conflicts arise.

Department of Healthcare and Family Services, Bureau of Professional and Ancillary Health Services report. Mary Lynn Moody, BSPharm, notified members that Governor Rauner's budget will be released later today. In July, it is anticipated that the new Point-of-Service software for pharmacy claims adjudication will be live.

Prospective Drug Utilization Review

Role of medication adherence. Mary Lynn Moody, BSPharm, addressed the need to partner with providers regarding medication adherence, which is not optimal in HFS clients. Provider outreach is planned to identify barriers to adherence in HFS clients. Currently pharmacists who are adjudicating Four Prescription Policy and Prior Authorization requests address medication adherence that is identified. Sharing information regarding medication adherence with the provider helps stem unnecessary therapy escalation or changes. Pilot program will address outcomes related to adherence within the fee-for-service population based on accessible data. Members of the DUR Board asked why outreach is to the medical provider rather than the pharmacist. Mary Lynn Moody, BSPharm, explained that the medical provider writes the prescription and can then make adjustments or changes immediately upon learning about the patient's adherence to the prescribed regimen. Donna Clay, BSPharm, noted that the one-on-one provider interaction has been successful in decreasing dose increases or therapy additions. The medical provider's assumption may be that the therapy was not working, thus a dose increase or change in therapy is warranted. In reality the client has not filled the prescription ever or is not filling it monthly. A quarterly update to the provider regarding the patient's medication adherence with chronic therapy that should be filled monthly is proposed. Auto-refill is no longer reimbursed by HFS, thus it is easier to identify medication non-adherence and act to improve care.

Retrospective Drug Utilization Review

Concomitant therapy with extended-release and short-acting serotonin norepinephrine reuptake inhibitors (SNRIs) and selective serotonin reuptake inhibitors (SSRIs). Christina Petrykiw, PharmD, noted that Four Prescription Policy claims adjudication revealed frequent use of extended-release venlafaxine with short-acting SSRI therapy. Guidelines and clinical literature for the management of depression and anxiety support use of an agent from either drug class, but not combination therapy. A retrospective review was conducted to determine the extent of combination therapy used. Approximately 154,000 clients filled prescriptions for these drug classes in calendar year 2014. At least 120 and 150 clients filled combinations of these agents in calendar years 2013 and 2014, respectively. More than one prescriber in some cases filled the combinations for a patient, which may be reflective of uncoordinated care by multiple providers or multiple providers in the same practice setting providing cross-coverage. The long-acting SNRIs in combination therapy were extended-release venlafaxine (73%), extended-release duloxetine (25%), and extended-release desvenlafaxine (2%). Doses were in the starting to middle range. The short acting agents used in the combinations were citalopram, fluoxetine, and sertraline (20% each), paroxetine, low-dose venlafaxine, or escitalopram (up to 11% each), and fluvoxamine (up to 3% of clients). Doses of short-acting agents used with extended-release venlafaxine or duloxetine ranged from low to maximal doses. In many cases, doses of both agents used were low, thus lack of efficacy at maximal doses was not the reason to add a second agent. Duration of combination therapy was 3 continuous months in 64% of cases, 6 continuous months in 12% of cases, 9 continuous months in 7% of cases, and 12 continuous months in 1% of cases. At least 16% of clients received therapy for more than 3 months, with breaks between periods of therapy. Overall, less than 1% of all SNRI or SSRI users were using combination therapy. Dr. Rachel Caskey and Anitha Nagelli, PharmD, noted that it was not uncommon to see these combinations used by psychiatrists for refractory depression, despite lack of clinical evidence support in the literature. At this time the DUR Board members felt that a hard edit was not warranted for combination SNRI-SSRI therapy. During the adjudication process, pharmacists can continue to discuss therapy with providers to eliminate inappropriate combination therapy. It was suggested that HFS discuss combination use with psychiatrists to determine what changes in practice may be occurring that may not yet be reflected in published clinical literature or guidelines. This insight may assist in adjudication. Dr. Caskey noted that regardless of whether combination therapy was intended, non-adherence as evidenced by breaks in therapy and multiple restarts is not usually desired. Anitha Nagelli, PharmD, offered to reach out to providers in her setting that are prescribing combination therapy.

Asthma. Christina Petrykiw, PharmD, provided an overview of results from provider outreach for the retrospective asthma Drug Utilization Review. The pediatric clients in the pilot group had more than one Emergency Room (ER) and medical visit for asthma, filled 8 or more rescue inhalers,and 0-2 controller steroid inhalers in fiscal year 2013. Questions posed by DUR Board members during the last meeting were addressed:
1) Was increased inhaler use noted in relationship to ER visits and hospitalizations as had been seen around times of infections or the allergy season? Increased rescue inhaler use was evident in about 27% of clients prior to the ER visit. No rescue inhaler use was seen for 2 months prior to the ER visit in the clients who were hospitalized. In clients who were using medications, increased usage of rescue medications as inhalers or nebulizations was seen in the two months prior and after the ER visit. Steroid inhaler usage increased a bit in the month before the ER visit, a lot in the month of the visit, and within 1-2 months after the visit returned to baseline. Oral steroid use increased 1-2 months prior to the ER visit and the month of the visit, then decreased subsequently as expected if acute management is completed. 2) Are patients receiving short-acting beta-agonist (SABA) inhalers from one or multiple physicians? The majority of the clients were prescribed SABA inhalers (2-13 fills) from one to two physicians. In many cases of multiple physicians, the additional physician was an ER medical provider or worked out of the same clinic, for example clinics staffed by residents. 3) Was the provider of the last refill, the primary provider responsible for the patient's asthma care? Provider outreach was intended to address medication adherence with the physician of the last refill. In 30% of the cases this was the ER provider, which is not responsible for chronic care of the client. The calendar 2014 fill history was used to identify the primary asthma care provider by majority of fills from the same physician. The primary provider was a pediatrician (37% of clients), Family Medicine physician (27% of clients), Internal Medicine physician (10% of clients), pulmonary specialist (3% of clients), or a Nurse Practitioner specializing in Pulmonology (3%), Pediatrics (7%), or general practice (7%). In 6% of clients, each prescription was from a different provider. In 60% of cases, the provider primarily responsible for the asthma care was the provider of the last refill. Provider outreach revealed that 73% of the providers used the Asthma Control Test (ACT) or an electronic medical record (EMR)-based survey to identify symptoms and assess asthma control since the last visit. For

practices that did not use a survey, a link to the ACT was provided. All providers give clients an Asthma Action Plan to help them know how to manage their asthma and potential exacerbation at home. A link to sample Asthma Action Plans was provided to one practice. Medical claims identify the asthma diagnosis, but not type of asthma and the intended treatment plan. At least 12% of the clients were deemed at the last visit to have intermittent asthma and their fill history was consistent with the treatment plan. In 75% of clients with intermittent asthma, fill-history suggested a need to re-evaluate if asthma was still intermittent or had become persistent. In 25% of these clients asthma control per provider exam was not consistent with results expected based on fill history. In the clients who had exercise-induced asthma, the fill history was not consistent with the treatment plan and re-evaluation of asthma status was recommended. The majority of the clients had been diagnosed with mild-persistent asthma and only about 27% were filling medications consistent with the treatment plan. In 33% of those with mild-persistent asthma, a therapy change was indicated, while in the rest they just needed to improve medication adherence. Approximately a third of the clients had moderate persistent asthma. Similarly to those with mild persistent asthma, only one-third were filling consistent with the treatment plan and the majority just needed adherence improvement. Providers were informed of their patient's overuse of SABA inhalers and underuse of controller steroid inhalers. The majority of providers (78%) were not aware of their patient's medication non-adherence, although some suspected it. In about 20% of the cases the providers wanted HFS to also reach out to the client to help improve medication adherence. Providers felt it was good to obtain the medication adherence information, which would be used to encourage discussion of desired therapy and adherence with the patient. Educational opportunities identified during outreach included informing providers about current preferred asthma medications, increasing awareness of Asthma Control Tests or Action Plans, increasing understanding that frequent exacerbations of exercise-induced bronchospasm may signal uncontrolled asthma that requires a controller steroid inhaler, and inappropriateness of using montelukast for step 2 therapy instead of the first-line controller therapy recommended by guidelines – a steroid inhaler. During the outreach period, approximately 45% of clients transferred to a managed care Medicaid plan. Some providers were not aware of this and did not know if their practice would be contracted by those plans to provide care for these clients. The DUR Board members agreed with the recommendation to target future outreach efforts to fee-for-service clients. The next tier will be pediatric clients who had more than one ER and Medical Visit for asthma, filled 8 or more rescue inhalers and 3-6 controller steroid inhalers. Outreach will again be with telephone call outs and follow-up faxes. Reaching out to the Medicaid Managed Care plans with the asthma DUR results was discussed. Limits of using fill history only and problems with identifying information from medical encounter data that may bundle several medical problems were discussed. Instituting an alert to catch non-adherence earlier was suggested. It was also suggested to involve pharmacies in starting conversations with clients regarding identified medication adherence problems and to provide a sustained medication therapy program targeting asthma at the point of service. This could be done in conjunction with pharmacy associations. Dr. Goyal noted that initiatives such as Pay for Performance and Care Coordination may help going forward. A time-limited pilot that ties in consequences for patients and providers may be useful. Anitha Nagelli, PharmD, noted that there is also confusion among providers regarding formularies for patients who move from Medicaid fee-for-service to Medicaid Managed Care. The confusion mounts when the clinics see patients with different Managed Care plans. Mary Lynn Moody, BSPharm, noted that the Medicaid benchmark plan is HMO-IL BCBS. Managed Care plans must cover drug classes that Fee-For-Service (FFS) covers. It does not have to be the same drug if there are multiple medications in the drug class, but at least one medicine in the drug class covered by FFS must be on the plan's formulary. Other mechanisms to make the formularies more consistent, including need for all being computerized and transparent, were discussed.

Educational initiatives.

Asthma. As noted in the retrospective asthma DUR pilot, the appropriate place in asthma management for the controller medication, montelukast, was identified as an educational need for providers. Christina Petrykiw, PharmD, provided an overview of asthma guidelines from the National Heart Lung, and Blood Institute and the Global Initiative for Asthma as well as a practice parameter for managing acute loss of asthma control. Systematic reviews and meta-analyses published in the last few years have compared the role of inhaled corticosteroids and anti-leukotrienes. Impact of implementing a prior authorization requirement for montelukast in Medicaid clients in Michigan was insightful related to outcomes. Other publications have been individual comparisons of a controller steroid inhaler and montelukast, outcomes, and adherence studies. The DUR Board members felt that an educational item focused on guideline recommendations would be appropriate.

Medicaid Drug Utilization Review (DUR) and DUR Board. Christina Petrykiw, PharmD presented an educational item about DUR and the DUR Board, which are federally required for Medicaid to ensure appropriate medication utilization. Conducting prospective and retrospective DUR and provider education are necessary. Lori Wilken, PharmD, made a motion, seconded by Anitha Nagelli, PharmD, to approve the educational item which should be posted on the HFS DUR Webpage. Dr. Caskey called for a vote and the DUR Board members unanimously agreed.

Pain management. Christina Petrykiw, PharmD, informed members about newly published information from the National Institutes of Health Pathways to Prevention workshop held in September 2014 that addressed the role of opioids in chronic pain. The conclusion from the workshop attendees was that there is no evidence of long-term safety and efficacy for use of opioids in the management of chronic pain. A systematic review and position paper from the workshop were published in the January 13, 2015 issue of Annals of Internal Medicine. The DUR Board members discussed producing an educational summary or just providing links to the items on the DUR Board Website. Mary Lynn Moody, BSPharm, asked Dr. Goyal about addressing opioid dependence at regional physician meetings. Many patients become dependent on medication due to prescribing. Providers may not be aware that a problem has been created, particularly post-operatively or after treating an acute pain episode. Opioid therapy for 3-4 weeks can set up dependence. The DUR Board members positively supported an educational "road show" that may allow a more active role in provider education. Currently the pain management program, which requires a patient-provider contract, helps provide an opportunity for patient and provider education. At this time the DUR Board members decided not have a written educational piece or links posted on the DUR Website regarding the systematic review and position paper.

Provider education about HFS initiatives – MEDI. Mary Lynn Moody, BSPharm, noted that up to 45% of providers now enter prior authorization requests via MEDI. Extensive provider outreach and onsite visits in the Chicagoland area the last few months helped facilitate this. Although the registration process is simple, completion of registration live or with a staff member on the telephone is frequently desired. Prior authorization request submission via MEDI places the request directly into the queue rather than having to wait for manual entry into the system by HFS staff. Requests are completed in the same day as received unless receipt is after regular business hours. Once opened in the queue, the request is immediately adjudicated (approved or denied), unless more information is required from the medical provider. In those cases, the request may not be adjudicated the same day because it is dependent on the provider submitting information. The other benefit of MEDI submission is that request status can be checked at any time, eliminating the need to call in or email for a status update. During MEDI training staff show providers how to check request status.

Public comments

Dr. Judy King noted that it would be nice to see agendas posted earlier than the statutory required time. Dr. King suggested that HFS send an email to the provider listserv that the agenda has been posted and inquired whether the slide presentations could be posted on the DUR Board Webpage. To engage more public members, conducting the DUR Board meeting as a Web conference or teleconference may be helpful. The informative content presented for clinical issues could be provided for Continuing Medical Education credit, which may engage more medical providers. Dr. Judy King asked whether HFS has considered partnering with Illinois Health Connect for provider education. Dr. Judy King also asked what impact the legislative change to exempt antipsychotic medications from the Four Prescription Policy has had and whether legislation is going to exempt antidepressants. Mary Lynn Moody, BSPharm, noted that currently requests for antipsychotics are not seen for adjudication with the Four Prescription Policy. Prior Authorization continues to review requests for non-preferred antipsychotics, as well as antipsychotic use in long-term care and pediatrics. Ongoing problems with inappropriate usage exist, for example low doses of antipsychotics used for sleep in adults. Drug Utilization Review can address these types of issues.

Adjournment. Anitha Nagelli, PharmD made a motion, seconded by Lori Wilken, PharmD, to adjourn the meeting. Rachel Caskey, MD, adjourned the DUR Board meeting at 9:55 am.

Meeting minutes prepared by Christina A. Petrykiw, PharmD, CDE.

Approved May 20, 2015 by the Illinois Drug Utilization Review Board.