ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Drug Utilization Review Board Meeting Summary

Wednesday, January 16, 2013

The Drug Utilization Review (DUR) Board met on Wednesday, January 16, 2013, at 8:00 a.m., in the Drug Information Center Conference Room, University of Illinois at Chicago College of Pharmacy, 833 S. Wood Street in Chicago.

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

Illinois Department of Healthcare and Family Services (HFS) Representatives: Lisa Arndt*, Bureau Chief, HFS Bureau of Pharmacy Services (BPS); Donna Clay BSPharm, Prior Authorization, University of Illinois at Chicago (UIC); Sheri Dolan*, BSPharm, HFS BPS; Arvind K. Goyal, MD, Medical Director, HFS; Mark Huston*, HFS BPS; Mary Lynn Moody, BSPharm, UIC; Christina Petrykiw, PharmD, CDE, UIC; Linda Schuh*, BSPharm, HFS BPS; and Patricia Steward*, BSPharm, HFS BPS.

Interested parties: Tom Erikson, BMS; Judy King, M.D.; Terry McCurren, Otsuka America; Libby Brunsvold, MedImmune; Dennis Manshio, private practice; Sam Smothers, MedImmune; Jim Carey, MedImmune.

*Attendance via teleconference

Call to Order. Rachel Caskey, MD, called the meeting to order January 16, 2013 at 8:06 am.

Agenda and Minutes review.
No changes were suggested to the agenda or meeting summaries. John Tulley, MD, made motions to approve the summaries of the September 26, 2012 and October 24, 2012 meetings. Lori Wilken, PharmD, seconded both motions and the summaries were unanimously approved.

Report from the Department of Healthcare and Family Services (HFS) Bureau of Pharmacy Services.
Lisa Arndt, Bureau Chief, provided an overview of ongoing cost savings from the SMART initiatives, including ensuring that third party payors pay prescription claims first, with the balance of claims paid by Medicaid. The Pharmacy Services budget for fiscal year 2013 was cut to 1 billion. If current trends continue, Pharmacy Services will be within the budgeted allotment for FY13. Mark Huston provided an update on the implementation of the Four Prescription Policy. He noted that the Four Prescription Policy will be moving from seven to five prescriptions per month covered before prior approval will be required in February 2013. In addition, prescriptions from Long-Term Care facilities will be added to the Four Prescription Policy at the same time. Facilities that are Community-Integrated Living Arrangements (CILA) and Supportive Living Facilities (SLF) will continue to be exempt from the Four Prescription Policy as part of the phase-in, and will be added at a later date. The HFS Hotline is currently entering all Four Prescription Policy requests within 45 to 60 minutes of receipt. Pharmacists are adjudicating the requests within 2 hours of request entry. Daily between 1,200-1,500 requests are being adjudicated for the Four Prescription Policy. John Tulley, MD, requested a brief overview of the Four Prescription Policy process. Mary Lynn Moody, BSPharm, explained that exempt medications will not count toward the limit (Oncolytics, Anti-Retroviral Agents, Contraceptives, Immunosuppressives, Antibiotics, Over-the-Counter Drugs/Products, blood glucose monitors and test strips). Examples of medication classes that may count toward the prescription limit, but currently will always adjudicate, include insulin, antihypertensives, and high-cholesterol

agents. When the patient fills medications above the set limit, a patient medication review and completion of a Four Prescription Policy request for approval are required. Completed requests are adjudicated (approved or denied) by pharmacists.

DUR Board.

Appointment letters and training. Christina Petrykiw, PharmD, confirmed that everyone except John Tulley, MD, has received their appointment letter for the DUR Board. She asked Dr. Tulley to notify staff after he receives his letter. The DUR Board members were thanked for completing all required training and submitting training verification and conflict of interest forms.

DUR Board schedule for 2013. The DUR Board schedule for 2013 was reviewed and members were notified that the schedule is now posted on the new HFS DUR Board Website. Screen shots of the new Website at www2.illinois.gov/hfs/PublicInvolvement/BoardsandCommisions/DUR/Pages/default.aspx were provided.

DUR Board procedures. Christina Petrykiw, PharmD, reviewed updates to the procedures that had been incorporated based on discussion at the last meeting, in particular sections on public viewing and taping and interested parties speaking at the meetings. Anitha Nagelli, PharmD, moved to approve the procedures and after John Tulley, MD, seconded the motion, the DUR Board procedures were approved unanimously.

Prospective Drug Utilization Review criteria.

Mary Lynn Moody, BSPharm, and Rachel Caskey, MD, reviewed select drug utilization control edits for claims processing implemented July through December 2012 that are posted on the Website. Prospective DUR is an item that is included in annual DUR reports to the federal agency. More criteria have been implemented in the past quarter as a result of increased scrutiny of medication profiles by the new Medication Review/Academic Detailing (MRAD) pharmacists. They have identified patterns of utilization that can be addressed through the prospective criteria edit process. These edits were reviewed with clinicians and the UIC Drug Information Group prior to implementation. Edits address duplicate therapy, inappropriate therapy, and unnecessary therapy. The edits may be overridden. The DUR Board discussed mitigating duplicate therapy edits that result from dose increases or changes of drugs within the same drug class. John Tulley, MD, noted that in the community setting, physicians traditionally do not write a prescription to discontinue therapy when a dose increase or change to a new therapy for a condition occurs. Current electronic prescribing systems do not facilitate the therapy discontinuation process either. Rachel Caskey, MD, mentioned that a comment about drug discontinuation needs to be put in notes or special instructions. This is an extra step that is not traditionally associated with writing a prescription and hasn't been a prescriber priority. Anitha Nagelli, PharmD, mentioned that pharmacies can respond to and override a hard edit in some pharmacy adjudication systems. Current Medicaid system functionality related to overrides was discussed. Lisa Arndt, Bureau Chief, noted that HFS is in the process of obtaining a new claims system, which should incorporate the desired functionality. Arvind Goyal, MD, inquired how providers will be notified regarding new drug utilization control edits. He suggested a provider notice to decrease need for calls to the agency or call outs to physicians. Lisa Arndt, Bureau Chief, noted that utilization edits that address various issues, including quantity or duration limits are created regularly as part of routine operations. Provider notices are published for more complicated edits. In the future, a pharmacy bulletin may be a vehicle for communicating such information. Rachel Caskey, MD, mentioned that education of providers is an issue and options such as Grand Rounds exist.

Retrospective Drug Utilization Review (DUR).

Angiotensin Converting Enzyme Inhibitors (ACEI)/Angiotensin receptor blocker (ARB) concomitant therapy drug utilization review (ACEI-ARB DUR). Mary Lynn Moody, BSPharm, provided an overview of ACEI-ARB use. Over 164 million prescriptions for ACEIs (ranked 5th) and 86 million ARB prescriptions (ranked 16th) are dispensed in the United States. Illinois Medicaid had over 535,000 prescription claims paid for these agents in Fiscal year 2011. Utilization review yielded over 13,000 patients in 1 quarter receiving either two dosage strengths of the same agent or multiple agents in the same therapeutic class. A duplicate therapy edit was applied for ACEI-ACEI and ARB-ARB duplicate therapy. Use of combination therapy has increased since the medications were introduced. In select patients with advanced heart failure and proteinuric nephropathy combination therapy may be warranted. Combination therapy doubles the risk of hyperkalemia and renal failure compared with

monotherapy. From December 2012 to January 2013 MRAD pharmacists reviewed claims of patients who had received an ACEI and an ARB together. Physician call-outs were conducted to determine indications and appropriateness of therapy. In completed interventions, physicians chose to discontinue one of the medications in 79 cases and to continue the combination in 17 cases. In multiple cases, providers were not aware the patient was taking the combination, medications were prescribed by more than one physician, and therapy was changed, but the patient continued the old and new therapies. HFS recommended implementing a hard edit for ACEI-ARB combination therapy and requiring prior authorization for combination therapy. Prior authorization would facilitate appropriate therapy and physician education about current standards of therapy, as well as help ensure patient safety. Educational materials developed related to combination therapy will incorporate reminding physicians to review with patients what they should be taking. The DUR Board agreed that prior authorization and provider education were good solutions for combination ACEI-ARB therapy. Lori Wilken, PharmD, asked whether limiting to dispensing from one pharmacy was an option in helping control duplicate therapies. Lisa Arndt, Bureau Chief, noted that under Medicaid laws and regulations, patients are entitled to freedom of choice of providers; however, restricting a patient to one pharmacy can occur in limited situations, but it is typically as a result of fraud, abuse, or safety concerns, and must follow specific processes. John Tulley, MD, noted that sheer number of patient encounters would make it unmanageable to limit to one pharmacy. Anitha Nagalli, PharmD, stated that the concept of a pharmacy home, like a medical home, would help collaborative practice. The majority of patients frequent one pharmacy now. Community pharmacists should be reminded to be proactive in identifying opportunities for interventions.

Asthma discussion. Mary Lynn Moody, BSPharm, noted that asthma was an area identified at the last meeting for discussion. She reviewed statistics related to the burden of asthma in Illinois and noted that improvement in care is warranted given that the mortality rate due to asthma in Illinois is higher than national mortality rates. DUR Board members were asked if a retrospective DUR is warranted and what areas for improvement they view as priorities. Rachel Caskey, MD, mentioned that asthma is a high cost area and cases of duplicate and inefficient therapy occur. Inhaled corticosteroids that are used for long-term control of asthma, use of short-acting beta-agonist (SABA) inhalers, and excessive use of SABA inhalers are areas to target for evaluation. Lori Wilken, PharmD, noted that patients with chronic obstructive pulmonary disease (COPD) may be included in the data because they use SABA inhalers twice daily on a scheduled basis, although prescriptions may state only to use them as needed. Misdiagnosis to COPD, when the patient has asthma, may occur as well, based on history of smoking. Lisa Arndt, Bureau Chief, noted that HFS can view medical claims data and can exclude patients with COPD from data evaluation. Emergency room visits can also be evaluated. Rachel Caskey, MD, stated that it may be useful to use the asthma statistics to identify subpopulations that should be addressed first, for example children less than 3 years of age and adults less than 30 years of age. Education will be incorporated based on DUR results. A question was asked about whether HFS patients are limited to one inhaler over another (for example, Advair versus Symbicort). Preferred inhalers are recommended first for use, followed by the agents that are non-preferred.

Chronic pain discussion. Mary Lynn Moody, BSPharm, notified Board members that at a significant number of HFS clients are using opiates for pain management. Clients that would benefit appropriately from chronic opiate use must be identified. The DUR Board was asked what steps can be implemented to address misuse of narcotics. Arvind Goyal, MD, noted that there is abuse and overuse of opiates. Opiate use should be evaluated because it is a safety issue that can save lives and also may provide cost savings. Issues include numbers of prescribers used by one patient for opiates, use of opiates in combination with other medications to treat pain, patients seeing family practice physicians, pain specialists, emergency rooms, and psychiatrists concurrently and crossing state lines to obtain opiates. In situations of fraud, patients may use different names or aliases to obtain opiates. Dr. Goyal indicated that of prescribers that have had their license disciplined, narcotic prescribing has been implicated in over 50% of cases. Unfortunately there are also cases of physicians selling, using, and carelessly prescribing opiates. An audit does not tell where and why opiate use is occurring. Multiple pharmacies may be frequented to fill a prescription - if the patient can't get product in one location, they will go to a different pharmacy or physician.

Management of chronic pain is a potential DUR target. It is problematic if a physician has been treating the same pain for 20 years with narcotics and has not conducted a recent evaluation of the patient's pain. Anitha Nagalli, PharmD, asked if specific criteria can be developed for medication therapy for chronic pain. Dr. Tulley, MD, noted that use of the same prescriber is helpful and that it would be good to determine appropriate length of treatment for chronic pain. Mary Lynn Moody, BSPharm, explained how the prior approval staff is requiring

additional documentation, for example a letter of medical necessity for patients who are requiring opiates for more than 2 months. The physician must provide a plan for managing chronic pain for the next 3 months. Justification will again be required if additional refills are deemed necessary. If a patient has a narcotic edit, they may be limited to one physician or one pharmacy.

Physicians should be checking the Illinois Prescription Monitoring Program (IPMP) database prior to writing prescriptions and conducting urine screens on patients they are treating with opiates long-term. Arvind Goyal, MD, highlighted this safety issue and recommended education so that opiate therapy is limited to a few months. Items to address in a DUR include chronic refills over 3 months, accessing the IPMP registry, urine testing, concomitant alcohol use, Emergency Room visits, tapering plans from the beginning of therapy, and availability of counseling programs. Prescribers should be alerted to a relatively new Illinois law that intends to prevent prescriber and pharmacy shopping in Illinois. John Tulley, MD, noted that implementing a pain contract with a patient will be a major practice change for many physicians. Mary Lynn Moody, BSPharm, mentioned that physicians and pharmacies contacted regarding opiate use within the Four Prescription Policy have been appreciative of assistance in improving pain management. They are frequently unaware that the patient is obtaining medications from multiple sources. Donna Clay, BSPharm, noted that some physicians now tell patients that they will only write the prescription if HFS approves the prior authorization request. This may indicate a partial transfer of responsibility. Education may be provided in the future via the proposed semi-monthly HFS pharmacy bulletin.

Discussion about use of attention deficit hyperactivity disorder (ADHD) agents in adults. Lisa Arndt, Bureau Chief, and Mary Lynn Moody, BSPharm, reviewed data about the total number of adults who filled prescriptions for stimulants and the numbers of these clients who concurrently filled multiple prescriptions for sedatives, multiple narcotics, abusable drugs, or had diagnoses of alcohol or substance abuse and/or Emergency Room visits for these diagnoses. Lisa Arndt, Bureau Chief, noted that currently prior authorization is required for stimulants in adults. The criteria for prior authorization are being reviewed by the Prior Authorization pharmacists and the UIC Drug Information Group. Once revision is complete, the criteria will be shared with the DUR Board. Donna Clay, BSPharm, noted that none of the agents are preferred in patients over 19 years of age. Most of the approvals of stimulants in adults are for narcolepsy.

Discussion about use of ADHD agents in children. The Bureau of Pharmacy Services is working in collaboration with Child and Adolescent Psychiatry providers to review and update current criteria for approving stimulants for ADHD in children. Issues HFS is seeing include children receiving multiple strengths of the same medication or multiple medications in the same class. Prior authorization is considering documentation of efficacy before medication doses are increased. The updated criteria will be presented to the DUR Board.

Educational initiatives.

Optimizing Diabetes Management. An educational update for providers. The MRAD pharmacists have identified patients taking multiple oral medications in conjunction with insulin. Physician call outs have identified the need for patient education, lack of awareness of what the patient is taking on the part of prescribers, and need to educate providers on current diabetes treatment guidelines. Educational material developed by the UIC Drug Information Group regarding current treatment guidelines for diabetes was reviewed. DUR Board members voiced approval of the material. It will be posted on the Drug Utilization Review Website.

Migraine prophylaxis considerations. An educational update for providers. Issues identified have included inappropriate migraine prophylaxis and inappropriate narcotic use for treating migraines. Educational material developed by the UIC Drug Information Group that incorporated current clinical guidelines for pharmacologic management of acute migraine attacks and prevention of migraine headaches was reviewed. DUR Board members voiced approval of the material. The document will be posted on the Drug Utilization Review Website.

Appropriate pain management prescribing. The DUR Board felt that Dr. Goyal's article (*Enhancing Safety for Patients and Family Medicine Practices. Due Diligence in Prescribing Narcotics/Opioids and other Controlled Substances. In: Illinois Family Physician, 62 (5); September/October 2011:1, 4-6.*) should be linked on the Drug Utilization Review Web page. A link to the Illinois Prescription Monitoring Program should also be provided.

Other educational initiatives. DUR Board members were asked to identify additional educational opportunities as they consider topics for drug utilization review. Lori Wilken, PharmD, asked how impact of educational initiatives

will be monitored, for example decreases in incidence of inappropriate prescribing. Mary Lynn Moody, BSPharm, mentioned that because multiple things occur simultaneously (hard edits, education, and call-outs), it may be difficult to attribute the decrease to only one activity. Christina Petrykiw, PharmD, asked DUR Board members what time point after implementation of an edit or other initiative is desired for re-evaluation. DUR Board members felt that an initial measure for impact may be reporting the number of times that an educational item posted on the Website is accessed. John Tulley, MD, inquired whether it is possible to obtain provider emails for sending out materials. Mark Huston noted the existence of a provider listserv for this purpose. Highlighting available educational material on prior authorization forms or adjudication messages to the pharmacy, if possible, was suggested. Arvind Goyal, MD, recommended providing free Continuing Medical Education (CME) credit for completing review of educational materials. Anitha Nagalli, PharmD, suggested live or on-demand Webinars with CME credit. John Tulley, MD, noted that Internet-based technology facilitates this.

New business.

Edits to enforce Department of Child and Family Services (DCFS) consent requirement. Currently prescribers are required to obtain DCFS consent prior to prescribing psychotropic medications such as benzodiazepines, stimulants, or agents for bed wetting for individuals that are wards of the state. The Bureau of Pharmacy Services is evaluating options to decrease duplicative work by the Prior Authorization unit if DCFS has already provided consent. The programming changes may streamline the Prior Authorization approval process and also facilitate identification of patients who require DCFS consent for psychiatric medications but have not received consent. Improving the process will provide additional protection for the children.

Comments from interested parties attending the meeting.

Judy King, MD, noted that provision of CME credits is beneficial and will increase interest in information HFS provides. Educational programs must be deemed useful. Dr. King voiced a concern that in addressing chronic pain, recommendations and decisions be based on data, not solely on individual experiences or opinions. She requested that when considering limiting opiate access, studies that have shown that people of color are undertreated for pain be kept in mind.

Terry McCurren, Otsuka America, asked for clarification regarding prior authorization processes for children covered by DCFS. He wanted to know whether meeting DCFS criteria will speed the process for prior authorization. Lisa Arndt, Bureau Chief, noted that incorporating the DCFS consent process will help streamline, but will not eliminate the Prior Authorization process. Putting out a provider notice about the consent process was suggested.

Adjournment. John Tulley, MD, moved to adjourn the DUR Board meeting. Members unanimously agreed and the DUR Board meeting was adjourned at 9:35 am.

Summary prepared by Christina A. Petrykiw, PharmD, CDE.

Approved 4/17/2013 by the Illinois Drug Utilization Review Board.