ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Drug Utilization Review Board
Meeting Summary

Wednesday, April 17, 2013

The Drug Utilization Review (DUR) Board met on Wednesday, April 17, 2013, at 8:00 a.m., in the Pharmacy Practice Residents 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: Mark Davis, Vertex; Tom Erikson, BMS; Chris Gillette, Pfizer; Mary Kaneaster, Eli Lilly; Jim McNamara, ViiV Healthcare; Rachel Scif, Otsuka; Sunhder Singh, Otsuka; Sam Smothers, MedImmue; Bob White, Forest Pharmaceuticals; Lisa Willshaw, MedImmune.

*Attendance via teleconference

Call to Order.
The meeting was moved to a larger conference room next to the Drug Information Conference Room to accommodate more meeting attendees. Rachel Caskey, MD, called the meeting to order April 17, 2013 at 8:00 am.

Agenda and Minutes review.
No changes were suggested to the agenda or meeting summary. John Tulley, MD made a motion to approve the summary of the January 16, 2013 meeting. Lori Wilken, PharmD, seconded the motion and the summary was unanimously approved. Dr. Caskey reminded DUR Board members to recuse themselves from discussion if they have a conflict of interest and to provide staff with an updated Conflict of Interest form when conflicts arise. C. Petrykiw, PharmD, noted that all members have received their DUR Board appointment letters.

Report from the Department of Healthcare and Family Services (HFS) Bureau of Pharmacy Services.

Mark Huston, HFS BPS provided an update regarding new initiatives from the HFS Bureau of Pharmacy Services. As a result of the Save Medicaid Access and Resources Together (SMART) Act, solid oral dosage forms will be approved for a 14-day supply for long-term care facilities in an effort to improve efficiencies and decrease waste effective May 1, 2013. The change has been discussed with long-term care providers. This mirrors current Medicare policies, although the list of medications impacted is smaller than the Medicare list. A new Long-Term Care Pharmacy Web page is available at http://www.hfs.illinois.gov/pharmacy/ltc.html. The link for the medication list is http://www.hfs.illinois.gov/assets/ltc_14daylist.pdf.

Also effective May 1, 2013, the use of automatic refills by a pharmacy will no longer be allowed for HFS clients. Automatic refilling of prescriptions increases the risk of a medication being dispensed after the prescriber had intended the medication to be discontinued. Pharmacy claims for refills auto-refilled will not be paid in an effort to

decrease potential for polypharmacy, drug/drug interactions, adverse medication events, and confusion for patients and prescribers. The notice is available at http://www.hfs.illinois.gov/assets/042413n2.pdf. Anitha Nagelli, PharmD, asked how HFS identifies prescriptions that were auto-filled. Claim audits provide information about claims processed via automatic refill.

Effective February 5, 2013, a change was made to the percent that triggers a refill-too-soon (RTS) hard edit. Anitha Nagelli, PharmD, asked for clarification about the triggers for the RTS edit. Mark Huston, HFS BPS and Patty Steward BSPharm explained that the percent of product that has been used since the dispense date of the prescription triggers the RTS edit. For most medications, 85% of the medication that is taken on a scheduled basis must be used up before a refill may be obtained. Previously 75% was the percent of fill that triggered the edit. The percent of fill that must be used up for patients in long-term care facilities remains at 75%.

The DUR Board members asked how providers are informed about the new initiatives. Mary Lynn Moody, BSPharm, noted that education is placed on HFS provider and long-term care Web pages.

Mark Huston, HFS BPS provided an update regarding the Four Prescription Policy Program. The number of prescriptions able to be filled in a rolling 30 day period without a prior authorizationwas decreased to 4 as of April 1, 2013. Prescription Policy prior authorization requests are entered by operators in Springfield within 2-3 hours of receipt. The requests are then adjudicated within 1.5 hours after entry by the operators. Rachel Caskey, MD, mentioned that pediatric providers are asking if and when prescriptions for children will be added to the Prescription Policy program. Mark Huston, HFS BPS stated that the addition of pediatric prescriptions is anticipated in early summer. Providers will be notified prior to implementation. Dr. Caskey asked whether implementation will follow a phase-in process as was done with the Four Prescription Policy program in adults or whether it will trigger after four prescriptions have been filled. Mark Huston, HFS BPS asked DUR Board members for input regarding use of a phased-in process for the prescription policy in children. A phase-in process was used in adults because it was a new process for providers and HFS. The population of children covered by HFS is smaller than adults and in general fewer medications are used in children. If a phased in process is used, implementation to four prescriptions will be over a shorter time period than was done for adults.

Prospective Drug Utilization Review

Prospective DUR criteria recently implemented.
Christina Petrykiw, PharmD, summarized select claims processing drug utilization control edits that were implemented since the January DUR Board meeting. Edits include duplicate therapy edits for multiple sclerosis medications, inhaled glucocorticoids, and cholesterol-lowering agents – HMG-CoA inhibitors (statins); edits to prevent inappropriate use of narcotic antagonists (Suboxone®/buprenorphine), tramadol and tramadol combination products, as well as topical antibiotic and benzoyl peroxide formulations for the treatment of acne; an edit to prevent drug-drug interactions between the cholesterol-lowering agents simvastatin and gemfibrozil, and an edit to help manage the current drug shortage of the tetracycline antibiotic doxycycline. The table of edits is available at http://www.hfs.illinois.gov/assets/duredits.pdf. Dr. Tulley asked for clarification of the tramadol hard edit. Patients had been filling multiple tramadol-containing products concurrently in addition to other products that contained short-acting narcotics. The maximum monthly quantity of narcotics that may be filled without requiring prior authorization is 186. This has been in place for other narcotics for some time. Tramadol is now subject to the same quantity limit alone, or in combination with other short-acting narcotics. A month is considered 31 days. DUR Board members asked whether an edit was in place for the drug-drug interaction of simvastatin and calcium channel blockers. Mary Lynn Moody, BSPharm, noted that the gemfibrozil-simvastatin interaction is at a level of contraindication, while the calcium channel blocker interaction is a major interaction that generates a warning, but not a contraindication. Staff will evaluate clinical information and usage regarding a potential edit for calcium channel blockers and simvastatin. DUR Board members requested clarification about the edit for tetracycline antibiotics. Prior authorization is required to obtain doxycycline. Minocycline is the suggested alternative when a tetracycline antibiotic is requested. Rachel Caskey, MD and John Tulley, MD expressed concern that treatment for sexually-transmitted diseases or other conditions that requires doxycycline not be delayed. A note on the Website regarding the shortage would be helpful for practitioners. Staff will evaluate the Illinois Healthy Women Preferred Drug List for sexually transmitted diseases to determine where notation regarding the doxycycline shortage is needed. DUR Board members asked whether an edit was in place for combination angiotensin receptor blockers

and ACE-Inhibitors. The work on this edit is in the queue. DUR Board members were reminded to provide suggestions for edits as they notice issues with patients.

Update regarding Prospective Drug Utilization Review Criteria implemented July 2012.
Mary Lynn Moody, BSPharm, provided an update regarding utilization for the prospective drug utilization review criteria implemented July 2012 for erythropoietic support agents, hepatitis C treatments, chemotherapy agents, and gamma immune globulin. A 6-month comparison pre- and post-edit implementation demonstrates greater decreases in paid claims for erythropoietic support agents and hepatitis C treatments and limited decreases in claims for chemotherapy agents and gamma immune globulin. Pharmacist review is improving appropriate drug utilization based on evidence-based practice and ensuring patients adhere to treatments.

Mary Lynn Moody, BSPharm, reviewed data regarding duplicate therapy edits implemented since July 2012 for ace inhibitors, angiotensin receptor blockers, insulins, oral and injectable contraceptives, anxiolytics, inhaled combination corticosteroid and long-acting beta agonist inhalers, asthma spacers, blood glucose monitors, and medications for multiple sclerosis. The intent of the duplicate therapy edit is to prevent a second same type drug being dispensed in the same month. Duplicate therapy can be caused by discontinuation of a drug product that the patient continues to fill, different physicians prescribing drugs in the same category for the patient, changes to drug therapy during and after hospitalization, and/or automatic refill practices by pharmacies. Duplicate therapy can result in patient confusion, adverse events, and increased costs. Medical justification and prior authorization are required in the limited circumstances where duplicate therapy may be necessary. DUR Board members questioned whether Plan B is addressed by the oral contraceptives edit. The number of times per year Plan B is utilized may signal need for patient education by the provider. New legislation for Plan B that will lower the age at which it may be used may increase usage.

A change was made to the refill-too-soon edit on February 5, 2013. This led to a 42% increase in prescriptions rejected for being refilled too early. The edit incorporates carryover days from the previous medication refill before it blocks an early refill. John Tulley, MD inquired what may happen if a patient needs to fill medications earlier because they will be traveling. The edit may be overridden in those cases. Anitha Nagelli, PharmD noted that patients who may not be able to fill a prescription because prior authorization is not available on weekends may miss a few days of medication. Mary Lynn Moody, BSPharm requested notifying HFS staff of such cases. As indicated in the Pharmacy Provider Handbook, in an emergency situation when department staff are not available to process prior authorization requests (during non-business hours), the pharmacy can dispense and HFS will pay for a 72-hour emergency supply after the pharmacy follows up with a prior authorization request for the emergency supply. (Section P208.34 72-hour Grace Period, available at http://www.hfs.illinois.gov/assets/p200.pdf). This has been in place for years, but providers may need to be reminded.

Chronic Pain Management

Pain Management Program.
Mary Lynn Moody, BSPharm reviewed slides and forms related to the pain management program launched in 2013. The drug classes impacted by the chronic pain management program include narcotic analgesics alone or in combination with non-salicylate, non-steroidal anti-inflammatory, salicylate, barbiturate, and xanthine-containing analgesics, and narcotic withdrawal therapy agents used for pain management. Utilization of narcotics for pain management by quarter has been steady in 2011 and through fall of 2012. Decreases in utilization have become evident since the start of the Prescription Limit Policy in September of 2012 and the start of the pain program in 2013. The pain program encompasses a letter of medical necessity for long-term opioid use as well as an opioid treatment agreement between the medical provider and patient. A total of 4158 pain forms were sent medical providers in the first quarter of 2013. At least 1386 letters of medical necessity have been returned (33%). Of these, 70% have been approved and 30% denied, mostly due to lack of necessary clinical information. Once missing information is provided, the request is re-evaluated and may be approved. John Tulley, MD commented that maybe the return rate was low because some physicians may feel this is an increased burden. Arvin Goyal, MD, Medical Director noted it provides a tool for physicians in managing patients' pain and affords protection in case of an Office of the Inspector General (OIG) audit of the medical practice. Dr. Goyal proceeded to explain that if narcotics are not managed, this may lead to addiction and patient deaths. The OIG will check to see if the practitioner has deviated from standard practice, which now includes use of an opioid treatment agreement. Patients who may not

qualify for long-term chronic narcotic use, may obtain a temporary 3-month approval to facilitate change of therapy and tapering off from medication. Dr. Goyal noted that providers must be educated about the program.

Other initiatives related to chronic pain medications.
Tramadol and tramadol combination products have been added to an edit for narcotics that prevents filling of multiple short-acting narcotics in large quantities in the same month.

Prior authorization is required for the narcotic antagonist (Suboxone®/buprenorphine). Patients are allowed 12 months of therapy. Adherence to a complete treatment program is required. Enhanced guidelines also educate providers regarding Division of Alcohol and Substance Abuse (DASA) services. Donna Clay, BSPharm noted that positive feedback has been received from physicians regarding this initiative. Physicians like the tracking being done. More physicians are conducting drug screening and checking the Illinois Prescription Monitoring Program (IPMP) database to determine if the patient is filling prescriptions for narcotics concurrently. They are working to educate the patient more, ensuring they are involved with a complete treatment program, and working to motivate the patient to adhere to the program. Rachel Caskey, MD inquired whether providers could access neighboring states' prescription monitoring databases, given Illinois has several border states. Linda Schuh, BSPharm noted that several neighboring states have programs in place (Indiana, Kentucky, Missouri) and that Illinois has joined Interconnect, a program that facilitates providers' checking databases in 12 states. Most individual state registries require an active state license to be able to access their database. DUR Board members noted that information about Interconnect and IPMP would be valuable to post on the HFS Website for providers. Administrators of IPMP are also thankful for the HFS pain and Suboxone initiatives because they are increasing subscribers to the database.

Retrospective Drug Utilization Review (DUR)

Proton Pump Inhibitor use in Long-term care facilities.
Mary Lynn Moody, BSPharm reviewed the internal prior authorization policy for use of proton pump inhibitors (PPIs). Prolonged use of PPIs may increase infections with *Clostridium difficile* leading to diarrhea, poses a risk for developing hip fractures, and changes food metabolism. Most indications require 8 to 12 weeks of therapy. For patients with non-complicated diagnoses, PPI therapy will be approved for 3 months. If therapy continuation is then requested, the request will be reassessed. John Tulley, MD noted that long-term PPI use may require a dose taper as part of discontinuation to prevent rebound erosive esophagitis. In practice physicians will often restart therapy without requiring more endoscopic procedures. When patients with gastroesophageal reflux disease undergo subsequent endoscopy, approximately 70% are fine and 30% demonstrate erosive esophagitis. There is no question that PPIs are overused and in some cases there may be underutilization also. Addition of a histamine H2 receptor blocker (H2-blocker) that is available over-the-counter may not be an option for our patients because they may not be able to afford to pay for the product. Anitha Nagelli, PharmD voiced concern that patients that might require continued therapy will get lost because the pharmacy will not send a request for a PPI refill or H2-blocker to the physician. It was noted that the pharmacy still has the ability to fill a 72-hour supply that will be paid. Although corporate headquarters may be aware of this policy, dispensing staff may not have been informed that they will get paid for the 72-hour fill. Patients with Barrett's esophagitis will receive approvals for 1 year of therapy. Arvin Goyal, MD noted that these patients will require life-long therapy and questioned whether longer-term approvals are possible. Mary Lynn Moody, BSPharm noted that 1-year at a time approvals are only possible due to computer programming requirements.

Educational initiatives

DUR Board members noted that asthma and pain control/management are desired topics for provider education. Educational modalities suggested for pain included use of Dr. Goyal's article on pain management, education via the Website or Webinars that could be done at a provider's leisure, live regional programming and participation at local/regional conferences regarding pain management. Many organizations have pain-related initiatives. The educational focus should complement the Medicaid pain program to make it more compelling for providers in Illinois. Additional educational topics suggested included the Four Prescription Policy, managing diabetes mellitus, cardiovascular topics such as length of Plavix therapy, asthma management, particularly adherence to therapy, and care management of disease states between physician visits by pharmacists. Arvin Goyal, MD noted that live education may be more effective than online programs. A 1-hour traveling CME program that also addresses

questions and pharmacy initiatives as part of a roving Grand Rounds would be beneficial. Concern about providers being able to take time off for a live program was voiced. Website-based education is complicated due to difficult navigation of the HFS Website. Dr. Goyal noted that HFS staff are frequently invited to speak to different groups and can incorporate a few paragraphs addressing utilization into their presentations. Education should seek to identify providers' educational gaps vs ineffective use of existing prescribed therapies. Methods to reach prescribers regarding patient education gaps were discussed. A pilot survey of provider preferences for obtaining education, a written learning needs assessment, and interactive education were suggested. Lori Wilken, PharmD noted that there is no one model that works for all adult learners. Rachel Caskey, MD, suggested adding a presentation to regularly scheduled local meetings of medical/pharmacy associations, rather than having a HFS-sponsored meeting. DUR Board members chose asthma in pediatric patients for a education pilot that could be held in the fall of 2013. Arvin Goyal, MD suggested exploring incentives for best practices and competency certification for asthma. State-specific data should be incorporated. For adults diabetes and pain management could be topics. Anitha Nagelli, PharmD suggested a focus on how to bridge practice between guidelines and medical practice. An update on other HFS Pharmacy initiatives should be incorporated – general overview and charts with numbers as presented during DUR Board meetings. Rachel Caskey, MD, noted that the education must be meaningful to the practitioner and that practice changes come about with provider education. A buzz must be created amongst practitioners. Linking managed care and pay-for-performance was suggested. John Tulley, MD noted that this was a national, not just a local issue. Mary Lynn Moody, BSPharm noted that if education highlights change in medical practice, then that leads to improvement in patient care.

Comments from interested parties.

Sam Smothers, MedImmune, asked about the role of the DUR Board in light of managed care taking over a portion of patients covered by HFS. Mark Huston, HFS BPS noted that managed care organizations may have medication edits in place, but may not be more restrictive than HFS. The pharmacy benefit was carved in to the three voluntary managed programs effective 4/1/2013. HFS Bureau of Pharmacy Services has reviewed the formularies of the managed care organizations and noted that many of the edits are similar to those HFS has in place.

A question was raised regarding the role of the Medical Review Board in cost avoidance. The Medical Review Board has focused on cost avoidance and hospital-related issues. There is no equivalent to the DUR Board on the medical side. It is often a function for internal hospital staff or a Quality Assurance contractor. Restrictions may cause changes in other areas, such as hospitalizations or emergency room visits, that may end up increasing costs overall. HFS is reviewing data to ensure that cost shifting does not occur. Medical claims are delayed compared to point-of-service pharmacy claims. It is too early in the process to be able to provide data on impact. Lori Wilken, PharmD requested that that data be reported back to the DUR Board once available. Arvin Goyal, MD noted that the Illinois State Medical Society had a HFS Medical Advisory Board that was discontinued. Now departments utilize consultants as needed. The Medical Director is developing an ad hoc group to suggest service improvements.

Adjournment. John Tulley, MD, moved to adjourn the DUR Board meeting. Members unanimously agreed and the DUR Board meeting was adjourned at 9:26 am.

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

Approved 8/21/2013 by the Illinois Drug Utilization Review Board.