Drug Utilization Review (DUR) Meeting  
March 12, 2014

Members Present
Matthew Beatty, PA-C, Justin Boals, Pierre Rioux, M.D, Amy Sapola, Pharm.D., Allyson Schlichte, Pharm.D., MBA, Abigail Stoddard, Pharm.D., MBA and Ling Xu, Pharm.D.,

DHS Staff Present
Mary Beth Reinke, Pharm.D. and Sara Drake, RPh,

Other attendants
Larry Dent, Pharm.D., Xerox, and two Pharm.D. candidates: Briana Coyne and Brittany Okland.

Public Comments: None

Approval of Minutes: This item was moved to the next meeting to allow members ample time to review.

Introduction of new DUR Board Members: Matthew Beatty, PA-C and Justin Boals, consumer representative.

Old Business
Psychiatric Consultation Service Updates

New Business
Sara Drake and Mary Beth Reinke respectively presented Pharmacy Program 101 and Drug Utilization Review 101.

Medicaid FFS Pharmacy 101 presentation highlights
Title 1927 of the Social Security Act and Minnesota Statue 256B.0625 govern the Medicaid program. The formulary is considered open for all FDA-approved legend drugs with some listed exceptions. The State has an option to cover or exclude OTC products (with the exception of smoking cessation products). Select covered OTCs were listed. Medicaid does not cover medical foods, investigational drugs, or drugs for dual-eligible beneficiaries.
2013 changes included SMAC pricing applied to drugs billed via the medical benefit, implementation of diabetic testing supply POS January 1, 2014, continued generic
introductions, and continued eligibility shift to managed care plans. Program statistics reflected the shift to managed care. Specialty drugs accounted for over twenty-three percent of drug expenditures. Total reimbursement for home infused drugs increased by 35% from last year. Priorities for 2014 include streamlining the PA process, improved oversight of opiate utilization, collaboration with managed care plans through the Uniform Formulary Committee, analysis and policy proposals for the new or updated drug pricing methodology, dependent upon CMS rules, optimize vendor relationships, and improved claims editing for third party liability.

**Drug Utilization Review (DUR) 101 presentation highlights**

DUR is mandated federally under Section 1927 (g) of Social Security Act (OBRA ‘90) and 42 CFR 456.702-724 and by the State of Minnesota under Minnesota 256B.0625: Subd. 13a. An Annual DUR Report is submitted to Center for Medicare and Medicaid (CMS) by June of each year. Predetermined criteria or standards or practice parameters are applied to claims either prospectively at the point-of-service or retrospectively post claims analysis. Edits include therapeutic duplication, drug-disease contraindications, drug-drug interactions, incorrect drug dosage or duration, and clinical abuse or misuse. The refill-too-soon edit rejects claims at less than 75% utilization from last fill. The retrospective quarterly educational mailings are provided by Xerox. The population-based interventions with associated criteria, paragraphs, cover letter, education material, and response forms are presented at DUR Board meetings. At six months post mailing, Xerox completes outcome assessment which is reviewed by the DUR Board and included in the Annual DUR Report to CMS.

**Opioid Abuse in Minnesota and the Universal Opioid Formulary Policy Workgroup**

Biweekly meetings are held with DHS pharmacy and members of each of the managed care plans attending. The goal is to align opioid analgesic polices across plans, reduce overuse and abuse of prescription opioid analgesics, and identify prescriber activity that is inconsistent with sound clinical practice. At the onset, members were surveyed to prioritize focus. Results, in order of importance, were (1) OxyContin: prior authorization policy, quantity limits, and override criteria (2) morphine equivalents: limits and override criteria (3) Suboxone: dose, duration, and place of therapy (4) claim edit mechanics such as refill-too-soon thresholds and override policy and (5) retrospective review/DUR of opiate therapy.

**Buprenorphine or Suboxone treatment and concurrent benzodiazepines, opiate, zolpidem, and/or tramadol**

An internal claims analysis is going to determine the extent of the DUR issue. Preliminary results identified n=479 recipients with one or more buprenorphine prescription from 12-1-2013 through 2-21-2014. Of these, n=98 received benzodiazepines, n=64 had opiate prescriptions, n=40 with zolpidem and n=25 with tramadol prescriptions. Overlapping therapy will be determined by the prescription’s “days’ supply” and date of service.
**Xerox Annual FFS Program Assessment**

The program assessment shows where current drug spend occurs and suggests areas of DUR focus for the upcoming year. Claims analysis time period was October 2012 through September 2013. At twenty-four percent of paid claims, psychotropic drugs remain the top drug class, followed by CNS drugs, antiasthmatics, antivirals, and antihyperglycemics. Within psychotropic drugs, second generation antipsychotics comprise fifty-three percent of expenditures. The greatest growth was seen in Hepatitis C (telaprevir (Incivek®)) followed by HIV antivirals with Stribild®, a four-drug therapy taken once a day, then antineoplastics, and antihemophilic factor viii. The Hepatitis C drug cost trend will likely continue to increase with Sovaldi’s market entry ($84,000 = 12 weeks of therapy). There was discussion of ways to ensure/confirm drug administration.

Xerox provides two different sorts of their criteria, either by drug therapy problems or by clinical issue per disease state. Recommendations for the coming year are:

- Diabetes (4/29/11 – last intervention date)
- Hypertension (none)
- Hyperlipidemia (8/21/12)
- Potential Medication Abuse (9/28/12)
- Polypharmacy (9/30/11)

**RetroDUR- clinical criteria**

I. Clinical criteria Updates: October-December 2013

A. Increased risk of ADE/Infectious Disease (Hepatic impairment/Hepatic toxicity)

IADE: KETOCONAZOLE

a.) Updated black box warning and indications
b.) New messages to providers include Increased Risk of Adverse Drug Event - Ketoconazole Use with Hepatic Impairment; Increased Risk of Adverse Drug Event - Ketoconazole without Liver Function Test Monitoring; Increased Risk of Adverse Drug Event – Potential First Line Ketoconazole Use; and Increased Risk of Adverse Drug Event - Ketoconazole Use with Unapproved Indication
c.) Overall update is stating that the use of ketoconazole should be reserved for patients with blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis who have failed therapy with itraconazole, amphotericin B, liposomal amphotericin B, posaconazole, voriconazole, terbinafine, or sulfamethoxazole/trimethoprim. If ketoconazole is determined to be appropriate for the patient, liver function tests should be performed.

B. Increased risk of ADE/Heart Failure

IADE: NSAID’s

a.) Heart Failure Intervention Update
b.) Criteria: Identifies patients with a history of heart failure in the last 2 years with a claim for an NSAID in the last 30 days
c.) New Message to Provider: According to submitted pharmacy and medical claims, your patient with heart failure (HF) has recently received NSAID
therapy. Fluid retention caused by NSAIDs may adversely affect cardiovascular hemostasis in patients with HF. NSAIDs may also blunt the effects of diuretics, ACE inhibitors, and beta blockers. Please consider if your patient would be a candidate for an alternative therapy.

d.) Overall update is stating that NSAID use is not recommended and may not be safe for patients with heart failure.

C. Increased risk of ADE/Cancer
IADE: CYCLOPHOSPHAMIDE
a.) Criteria: Identifies patients with claims for cyclophosphamide in the past 30 days and history of urinary tract obstruction within the past 2 years
b.) New Message to Provider: Based on pharmacy and medical claims data it appears your patient has received cyclophosphamide and has a history that indicates history of urinary tract obstruction.
c.) Overall update is stating that as of May 2013 the FDA issued a public Health Advisory that warned of an apparent link between cyclophosphamide and urinary tract obstruction and the emergence of urinary tract and renal toxicities.

D. Drug-drug interaction/Hepatitis C
DDI: TELEPRAVIR
a.) Criteria: Identifies patients with telaprevir therapy in the last 30 days that have >/= 7 days overlap in therapy with any of the following drugs in the last 30 days. After each drug listed is the new message to the provider:
b.) Alfuzosin: Use of this combination is contraindicated since increased plasma concentrations of alfuzosin may result in hypotension or cardiac arrhythmia
c.) Carbamazepine, phenobarbital, phenytoin: Use of this combination is contraindicated since decreased plasma concentrations of telaprevir may result in loss of virologic response
d.) Rifampin: Use of this combination is contraindicated since decreased plasma concentrations of telaprevir may result in loss of virologic response
e.) Dihydroergotamine, ergonovine maleate, ergotamine, methylergonovine: Use of this combination is contraindicated since increased plasma concentrations of the ergot derivative may increase the risk of acute ergot toxicity. Acute ergot toxicity is characterized by peripheral vasospams and ischemia of the extremities and other tissues
f.) Lovastatin-containing product, simvastatin-containing product: Use of this combination is contraindicated since increase plasma concentrations of the statin may result in myopathy, including rhabdomyolysis
g.) Pimozide: Use of this combination is contraindicated due to an increased risk of cardiac arrhythmias
h.) Triazolam, midazolam (oral): Use of this combination is contraindicated since increased plasma concentrations of the benzodiazipine may result in prolonged or increased sedation or respiratory depression
i.) Revatio, adcirca: Use of this combination is contraindicated since increased plasma concentrations of the PDE5 enzyme inhibitor may increase the risk visual abnormalities, hypotension, prolonged erection, and syncope
j.) Overall update is highlighting some important drug-drug interactions to consider when treating a patient with telepravir

E. Drug-drug interaction/Women’s Health-Contraception

DDI: TRANEXAMIC ACID (Level 1)

a) Criteria: Identifies patients with oral tranexamic acid therapy in the last 30 days that have >/= 7 days overlap in therapy with any combined hormonal contraceptive (oral, transdermal, intravaginal) in the last 30 days.

b) New Message to Provider: Combined hormonal contraceptives are known to increase the risk of venous thromboembolism and arterial thromboses such as stroke and myocardial infarction. Because tranexamic acid is an antifibrinolytic, the risk of venous thromboembolism and arterial thromboses increases with concomitant use of tranexamic acid and combined hormonal contraceptives

c) Overall update is stating that the concomitant use of tranexamic acid and combined hormonal contraceptives increases the risk of VTE and arterial thrombosis.

F. Underutilization/Heart Failure (Rule 4110)

Underutilized Drug Class: ACE Inhibitors and ARB’s

a.) Heart Failure Intervention Update

b.) Criteria: Identifies patients >/= 18 years of age with a documented diagnosis of systolic or a combination of systolic/diastolic HF in the past 2 years without a history of angiotensin modulating therapy (i.e., ACE inhibitor, ARB) in the past year. Patients with a history of the following are excluded:

- angioedema, renal failure or bilateral renal stenosis in the past 2 years
- currently pregnant
- current therapy with isosorbide dinitrate and hydralazine

Patients taking subtarget doses of ACE inhibitors are not identified.

c.) Message to Providers: Currently the American Heart Association and the American College of Cardiology recommends that all patients with HF due to left ventricular systolic dysfunction with a reduced left ventricular ejection fraction receive an ACEI unless contraindicated. ACEI have been shown in clinical trials to decrease both morbidity and mortality in HF patients with mild to severe to severe symptoms. If ACEI therapy is contraindicated or not tolerated by the patient, an ARB should be prescribed

d.) Overall update is reinforcing the clinical benefit of adding angiotensin modulating therapy to the medication regimen for patients with heart failure due to reduced left ventricular ejection fraction

G. Underutilization/Heart Failure (Rule 4112)

Underutilized Drug Class: Beta Blockers

a.) Heart Failure Intervention Update

b.) Criteria: Identifies patients >/= 18 years of age with a documented diagnosis of systolic or a combination of systolic/diastolic HF in the past 2 years without bisoprolol, carvedilol, or metoprolol therapy in the last year. Patients with history of the following are excluded:

- Asthma in the last 2 years
- Conduction disorder without a pacemaker in the last 2 years
• history of fluid overload or volume depletion in the last 90 days
• Treatment with intravenous positive inotropic agent in the last 90 days
c.) Message to Providers: Use of HF-specific beta blocker therapy in conjunction with an angiotensin modulating agent (e.g., ACE inhibitor or ARB) substantially decreases morbidity and mortality in patients with HF. Current practice guidelines recommend the use of HF-specific beta blockers in all patients with stable HF due to left ventricular dysfunction, unless the use of these medications is contraindicated. Contraindications include reactive airway disease, unstable fluid status, and symptomatic bradycardia, advanced heart block without a pacemaker.
d.) Overall update is reinforcing the clinical benefit of using specific beta blockers for patients with heart failure due to left ventricular dysfunction, provided no contraindications are present.

H. No Apparent Indication/Biologic Immunomodulators
New Approved Indication: CERTOLIZUMAB for treatment of ankylosing spondylitis
a.) Criteria: Added ankylosing spondylitis to the disease states that certolizumab pegol (Cimzia) is approved to treat.
b.) New Message to Provider: Certolizumab is indicated for the treatment of adults with Crohn’s disease, rheumatoid arthritis, and psoriatic arthritis, and ankylosing spondylitis
c.) Overall update is stating that certolizumab is now an approved medication for the treatment of ankylosing spondylitis

I. Duplicate Therapy/Heart Failure
Duplicate Therapy: ACE Inhibitors and ARB’s
a.) Heart Failure Intervention Update
b.) Criteria: Identifies patients with a history of heart failure in the last 2 years receiving > 35 days of therapy in the last 60 days of any of the following combinations:
• Duplicate ACE inhibitor therapy
• Duplicate ARB therapy
• Duplicate ACE inhibitor-containing therapy (1 or more prescribers)
c.) New Message to Providers: Using more than one ACE inhibitor [more than one ARB, more than one ACE inhibitor-containing product] may increase the risk of adverse drug events and may decrease overall adherence with prescribed medication regimens. There are two distinct messages for duplicate therapy with ACE Inhibitor containing therapy (one for single prescriber and one for more than one prescriber).
d.) Overall update states that concurrent use of more than one ACE Inhibitor or ARB therapy may increase the risk of adverse events in patients with heart failure

J. Medication Compliance/Heart Failure
Medication Compliance: Adherence to Cardiovascular Medication Therapy inpatients with heart failure
a.) Heart Failure Intervention Update
b.) Criteria: Identifies patients with a history of heart failure in the last 2 years with less than 60 days of therapy with antihypertensive medication in the most recent 90-day period

c.) New Message to Providers: According to submitted pharmacy and medical claims, it appears your patient with heart failure may be non-adherent with their cardiovascular drug therapy. Prescription data suggests your patient received less than 60 days of their maintenance cardiovascular therapy in a 90-day period

d.) Overall update states the importance of adherence to cardiovascular medications for patients with heart failure.

2014 meeting dates will be:
- May 14
- August 13
- November 5

*Note: starting meeting time is changed to 5:30 pm instead of 6 pm because the front doors are now locked at 6pm.*