



Drug Utilization Review (DUR) Meeting

May 14, 2014

Members Present

Matthew Beatty, PA-C, James MacNutt, D.O., Pierre Rioux, M.D, Amy Sapola, Pharm.D., Allyson Schlichte, Pharm.D., MBA, and Abigail Stoddard, Pharm.D., MBA

DHS Staff Present

Mary Beth Reinke, Pharm.D., Sara Drake, RPh, Pat Nygaard, Children's Mental Health Division.

Other attendants

Larry Dent, Pharm.D.

Public Comments: None

Approval of Minutes: Yes

Introduction of new DUR Board Member: James MacNutt, D.O. was welcomed as a new physician member.

Old Business

Psychiatric Consultation Service Updates

Pat Nygaard from the Children's Mental Health Division provided an update on psychiatric consultation service. There were no responders to the Request for Proposal (RFP) to provide psychiatric consultation services beyond June 1, 2014. The Children's Mental Health Division is planning to hire a new staff member to assist in implementing provisions under MS 245.4862 Mental Health Urgent Care and Psychiatric Consultation and MS 256B.0625 Subd.13j. One of the issues with the current model was the lack of a central coordination and accountability. Four different health systems staffed the psychiatric consultation service with each system providing their own child and adolescent psychiatrists (CAPS) and social workers to handle calls and mandatory consultations.

Mandatory consultations: Nearly all mandatory consultations resulted in approval of prescribed medications. While ninety-eight percent of all calls were generated because of the mandatory high dose per age for second generation antipsychotics and drugs to treat ADHD, the current CAP consultants advised discontinuing the mandatory consultations. They particularly did not believe it was a worthwhile use of their time to do consultation with prescriber's who were also CAPS.

Weekend training: Education efforts using the REACH Training Institute were helpful to build relationships with prescribers and CAPs. However, the cost outweighed the benefits as only 134 providers participated in training over the 2 year period. Further, REACH trainings did not incorporate the mental health treatment protocols developed by the DHS Children’s Protocols Workgroups, especially with regard to trauma-informed care.

Database and outcomes: The database for the project was not fully developed until well into the second year of the project, which made it difficult to track ongoing activities and outcomes. A separate excel format was maintained throughout the project. DHS will work to sort the data and outcomes into a meaningful report over the next few months.

DHS Board agreed to change prior authorization – psychiatric consultation for the high dose per age for atypical antipsychotic drugs and drugs to treat attention deficit disorder to an informational only edit at the pharmacy point-of-service.

Question to DUR Board – should there be a minimum young age at which these drugs aren’t covered? Per FDA labeling, risperidone is the second generation antipsychotic (SGA) approved at the age of five, other SGAs are approved starting at the age of six.

Recent FFS utilization information was provided in Table 1.

Table 1. FFS Utilization - Approximately 1st Quarter 2014

| SGA Drugs | 1 yr | 2 yr | 3 yr | 4 yr | 5 yr | 6 yr | Total |
|--|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|--------------|
| ARIPIPRAZOLE | | | | 2 | 4 | 16 | 22 |
| OLANZAPINE | | | | | | 1 | 1 |
| QUETIAPINE FUMARATE | | | | 1 | | 13 | 14 |
| RISPERIDONE | | | 5 | 16 | 23 | 52 | 96 |
| ZIPRASIDONE HCL | | | | | | 2 | 2 |
| Subtotal | | | 5 | 19 | 27 | 84 | 135 |
| ADHD Drugs | | | | | | | |
| ATOMOXETINE HCL | | | | 1 | 7 | 29 | 37 |
| CLONIDINE HCL | 2 | 4 | 16 | 51 | 77 | 107 | 257 |
| GUANFACINE HCL | | | 8 | 44 | 84 | 166 | 302 |
| Subtotal | 2 | 4 | 24 | 96 | 168 | 302 | 596 |
| ADHD Drugs - Stimulants | | | | | | | |
| DEXMETHYLPHENIDATE HCL | | | | 2 | 7 | 20 | 29 |
| DEXTROAMPHETAMINE SULFATE | | | | 4 | 7 | 6 | 17 |
| DEXTROAMPHETAMINE SULF-SACCHARATE/AMPHETAMINE SULF-ASPARTATE | | | 5 | 31 | 57 | 166 | 259 |
| LISDEXAMFETAMINE DIMESYLATE | | | | 4 | 17 | 50 | 71 |
| METHYLPHENIDATE | | | | 1 | 5 | 13 | 19 |
| METHYLPHENIDATE HCL | | | 3 | 28 | 96 | 233 | 360 |

The DUR Board's initial recommendation was a minimum age edit of five years of age for both SGA and ADHD treatment drugs. Since current thresholds for medication to treat ADHD for mandatory psychiatric consultation are age three and younger, their recommendation was modified to a minimum age of three years for these medications. The age three minimum will not be applied to clonidine formulations approved in 1974 which are classified as central α -agonist antihypertensives by the American Hospital Formulary Service.

Suboxone and overlapping opiate and/or benzodiazepine therapy analysis.

Results of the DHS internal analysis were presented. Fee-for-service (Dec 2013-Jan 2014) and managed care organization (MCO) (Nov 2013-Dec 2013) data were both presented when available. The average number per month buprenorphine recipients were similar with n=255 (0.13%) for FFS and n=936 (0.16%) for MCO. Approximately thirty percent of buprenorphine recipients in both FFS and MCO populations received one or more of the target drugs prescription concurrently based on overlapping "days supply" of the prescription claims.

Study drugs include:

- Index drug: buprenorphine products
 - exclude buprenorphine patch (Butrans) which is indicated for pain
- Target Drug Therapies:
 - Group A- adherence to treatment for addiction
 - Opioids
 - Tramadol
 - Group B- FDA warning regarding concurrent benzos
 - Benzodiazepines
 - Zolpidem

Table 2 shows the MCO recipients results for those with overlapping therapy. Additionally, the persistence of overlapping therapy in both study-months was determined and found to occur, for the most part, in each month indicating that use is ongoing rather than short term.

Lastly, a distribution of the number of days overlapping out of the study month was prepared. For opioids, the largest number of recipients was in the ≤ 5 days of overlapping therapy followed by those with 16-30 days of overlapping therapy. For benzodiazepines, the overwhelming majority of recipients were in the 16-30 days of overlapping therapy per month group. In determining overlapping therapy as a function of the number of prescribers, there was more overlapping therapy as the number of prescribers increased.

The DUR Board recommendation was to allow for a small amount of opioid per month, for instance, ≤ 5 days accumulated per month, due to weekend filling of prescriptions for acute pain. However, for Group B drugs, the recommendation was that the recipient

should not receive any benzodiazepines during buprenorphine treatment for opioid addiction.

Table 2. MCO Results N=93 with One Target Therapy

| Target Therapy | Percent |
|-----------------|---------|
| Group A | |
| Opiates | 19% |
| Tramadol | 3% |
| Group B | |
| Benzodiazepines | 63% |
| Zolpidem | 14% |

Opioid Abuse in Minnesota and the Universal Opioid Formulary Policy Workgroup

The goal for 2015 is implementation of similar policies across managed care and FFS to limit plan shopping to get the medication desired. Their current discussion continues around the development of the exact survey questions to their workgroup.

New Business

RetroDUR- clinical criteria

No new criteria were presented at this meeting.

RetroDUR – population based interventions

Hypertension Proposal

To begin with, Dr. Dent presented the differences and changes in the 2014 Evidence-based Guidelines for the Management of High Blood Pressure Joint in Adults from the 8th Report of the Nation Committee (JNC-8) and the Clinical Practice Guidelines for the Management of Hypertension in the Community as stated by the American Society of Hypertension and the International Society of Hypertension (ASH/ISH) compared to JNC-7. The proposed intervention was comprised of the following fifteen performance indicators. DUR Board accepted criteria as presented except for #4, #10, #11, and #12.

Increased Risk of Adverse Events:

1. Increased Risk of Adverse Event (ADE): Hypertension and no antihypertensive therapy, with presence of condition that can precipitate high blood pressure. N=77.
Criteria:
Recipients with a diagnosis of hypertension in the past 2 years, who do not have a history of an antihypertensive agent in the past 90 days. AND
Recipients with a medical claim in the past 2 years for sleep apnea, chronic kidney disease, primary aldosteronism, renovascular disease, Cushing’s Syndrome, pheochromocytoma, coarctation of the aorta, or thyroid/parathyroid disease.

DUR Board approved as presented.

2. Increased Risk of ADE: Hypertension and no antihypertensive therapy, with concomitant oral corticosteroids. N=79.
Criteria:
Recipients with a diagnosis of hypertension in the past 2 years, who do not have a history of an antihypertensive agent in the past 90 days. AND
Recipients receiving prednisone >7.5mg/day or recipients receiving 90 or more days out of the past 120 days of oral corticosteroids.
DUR Board approved as presented.
3. Increased Risk of ADE: Drug-induced hypertension. N=145.
Criteria:
Recipients with a diagnosis of hypertension in the past 2 years, who do not have a history of an antihypertensive agent in the past 90 days. AND
Recipients with claims history in the past four months for stimulants (amphetamines), oral contraceptives, non-steroidal anti-inflammatory drugs, venlafaxine (>300mg), bromocriptine, erythropoietin, cyclosporine, tacrolimus, cold remedies (pseudoephedrine), and agents to treat migraines (for 90 days with drug-free periods of no more than 10 days) that can worsen hypertension, who have not had a submitted medical or procedural claim, suggesting an office visit, in the past 6 months.
DUR Board approved as presented.
4. Increased Risk of ADE: Angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs), aliskiren, and triamterene in pregnancy. N=3.
Criteria:
Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days, who have a diagnosis in the past 9 months indicating pregnancy (and without a claim indicating delivery or termination). AND
Recipients with a claim in the past 45 days for an angiotensin modulating containing product or a triamterene containing product.
DUR Board expressed concerns with the timeliness of the notification to the prescribers if the mailing doesn't occur until next quarter. Dr. Reinke will explore an alternative means of notification for these three cases.
5. Increased Risk of ADE: Metolazone and impaired hepatic function. N=2.
Criteria:
Recipients with a pharmacy claim for metolazone in the past 45 days. AND
Recipients with a diagnosis in the past year for chronic hepatic disease, cirrhosis, viral hepatitis, or hepatic coma.
DUR Board approved as presented.
6. Increased Risk of ADE: Triamterene and renal or hepatic impairment. N=7.
Criteria:
Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days, who have a diagnosis in the past two years of

moderate to severe renal impairment or hepatic impairment. AND Recipients with a claim in the past 45 days for a triamterene containing product.
DUR Board approved as presented.

7. Increased Risk of ADE: Duplicate therapy with ACE-inhibitors, ARBs and/or combination products. N=11.
DUR Board approved as presented.
8. Increased Risk of ADE: Angiotensin modulating agents, direct renin inhibitors and angioedema history. N=39.
Criteria:
Recipients with a pharmacy claim in the past 45 days for an angiotensin modulating agent or a direct renin inhibitor (aliskiren). AND
Recipients with a history of angioedema in the past 2 years.
DUR Board approved as presented.

Underutilization

9. Underutilization of recommended first line therapies (Thiazide diuretic, Calcium Channel Blocker, ACE-inhibitor, or ARBs). N=1,242.
Criteria:
Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days, who do not have additional comorbidities, and do not have anuria, gout, hyponatremia, are not pregnant, or are not on dialysis. AND
Recipients who do not have a claims history for a thiazide-containing product, CCB, ACE inhibitor, or ARB in the past 2 years.
DUR Board approved as presented.
10. Underutilization of angiotensin modulating agents with the presence of a compelling indication. N=3,173.
Criteria:
Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days. AND
Recipients with a diagnosis of chronic renal disease, diabetes, or stroke in the past 2 years, without a contraindication to angiotensin modulating therapy (i.e. renal artery stenosis, renal dialysis, angioedema, renal failure), who have not been on angiotensin modulating therapy.

DUR Board recommendation was to change the “patients with diabetes” criteria to “patients with diabetic nephropathy” instead. The JNC-8 and ASH guidelines specify that diabetes should be initiated on first-line drug therapy similar to recommendations for the general public (ACEI, ARB, CCB, thiazide) unless patients have diabetic nephropathy then first-line therapy should include an ACE or ARB.
11. Underutilization of beta-blocking agents with the presence of a compelling indication. N=44.

Rationale: Beta-blockers reduce cardiac output and decrease the release of renin from the kidney and have been shown to be beneficial in patients with history of myocardial infarction and heart failure. Beta-blockers are also indicated and have been proven beneficial when used as preventative agents in patients with migraine. Patients with hypertension and comorbidities such as myocardial infarction, heart failure, and migraine benefit from the use of beta blockers.

Criteria:

Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days. AND

Recipients with a diagnosis in the past 2 years of myocardial infarction, angina, or migraine, a pharmacy claim for a first line antihypertensive therapy and without a contraindication to beta-blocker therapy (i.e. asthma, COPD, depression, 2nd or 3rd degree AV block), who are on more than one antihypertensive agent but not on beta-blocking therapy.

The DUR Board recommended removing migraines as a compelling indication for beta-blocking agents. The DUR Board did not believe that this was a significant enough of a reason to prefer a beta-blocking agent.

12. Underutilization of alpha-blockers with the presence of a compelling indication.

N=77.

Criteria:

Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days. AND

Recipients with a diagnosis in the past 2 years of benign prostatic hyperplasia (BPH), a pharmacy claim for a first line therapy and who are on more than one antihypertensive agent but not alpha-blockers in the past 45 days.

The DUR Board did not recommend this indicator. The antihypertensive alpha-blockers, such as terazosin and doxazosin, are also used to treat BPH but are notorious for causing postural hypotension and they can also exacerbate CHF in susceptible patients. The newer drug to treat BPH, tamsulosin, is now available generically so cost is less of a consideration in drug choice. Dr. Schlichte would rather have prescribers treat HTN and BPH separately rather than trying to treat both conditions with a single agent. For example, treat HTN with a first-line agent and then treat BPH with an appropriate BPH drug, such as tamsulosin.

13. Underutilization of combination products in recipients on single entity agents. N=62.

Criteria:

Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days. AND

Recipients with pharmacy claims history in the past 45 days for two single agent entities available as a combination product.

DUR Board approved as presented though it was noted that it may increase costs if the generic is more costly in combination products compared to single entity agents.

Discontinuation and non-adherence of therapy

14. Discontinuation of antihypertensive drug therapy. N=1,036.

Criteria:

Recipients with a diagnosis of hypertension in the past 2 years who have been on antihypertensive products in the past year. AND

Recipients without claims history for antihypertensives in the most recent 90 days
DUR Board approved as presented.

15. Non-adherence with antihypertensive drug therapy. N=34.

Criteria:

Recipients with a diagnosis of hypertension in the past 2 years and claims history of antihypertensives in the past 90 days. AND

Recipients who have antihypertensive therapy in the most recent 45 days as well as 45 to 90 days ago, but less than 60 days of antihypertensive therapy in the past 90 days.

DUR Board approved as presented.

Hyperlipidemia Proposal was not reviewed given Dr. Allyson Schlichte's statement that Minnesota Community Standards were updated two years ago and will be not be updated again until 2015. Since the Community Standards are linked to pay-for-performance, prescribers will likely to continue to follow the existing Community Standards. Dr. Schlichte additionally noted that the new hyperlipidemia guidelines are a huge paradigm shift in treatment.

2014 meeting dates will be:

- August 13
- November 5