



Minnesota Department of **Human Services**

Drug Utilization Review (DUR) Meeting

August 13, 2014

Members Present

Matthew Beatty, PA-C, Pierre Rioux, M.D, Allyson Schlichte, Pharm.D., MBA, Abigail Stoddard, Pharm.D., MBA, and Ling Xu.

DHS Staff Present

Mary Beth Reinke, Pharm.D., Sara Drake, RPh, and Tiffany Chan, PharmD student.

Other attendants

Larry Dent, Pharm.D.

Public Comments: None

Approval of Minutes: Yes

Old Business: None.

New Business:

RetroDUR- clinical criteria

No new criteria were presented at this meeting.

RetroDUR – population based interventions

Opioid Analgesic – 120 Morphine Equivalent Dose (MED) per day Proposal

Background:

The problem of opioid over-prescribing, misuse and diversion is a public health crisis for which many of the causes and solutions lie squarely within the health care sector. High doses of opiates are linked to an increase in morbidity and mortality.

On or before January 1, 2015, the MCO and the state of MN shall adopt the minimum requirements for high risk and controlled substance medications recommend by the Universal Pharmacy Policy Workgroup (UPPW) on or before October 1, 2014.

The UPPW is a group of pharmacy policy experts from MN Department of Human Services, Blue Cross Blue Shield of Minnesota, UCare, Health Partners, IM Care, Medica, PrimeWest, South Country Health Alliance, and Metropolitan Health Plan who meet twice a month to develop Universal Pharmacy Policy (UPP) for high risk and controlled substance medications. Members of the UPPW include state licensed pharmacists and physicians, as well as individuals with significant pharmacy policy expertise. This group has been meeting biweekly since January 2014 and August 8, 2014

reached a final consensus on eight items, one of which was to implement a quantity 120 Morphine Equivalent per day (MED) or less for all opiate analgesics.

The intervention targets prescribers who have recipients receiving prescriptions where 120 MED is exceeded in the last 45 days prior to the November 1, 2014 mailing date. Besides a cover letter explaining the January 1, 2015 change each prescriber receives in their packet a mini-drug profile of opioid analgesics for each recipient identified with one or more prescriptions exceeding 120 MED.

Mailing date recommendation was accepted.

Inclusion Criteria:

- Focus only on exceeding 120 MED as the message and do not include refill-too-soon changes. The 120 MED applies at the line level of each prescription. DHS will use both a prescription quantity limit as well as a “mg/day” edit. DUR Board accepted recommendation.
 - Add coordination of care as additional message if more than one opioid analgesic prescriber and recipient exceeds 120 MED on ≥ 1 prescription in last 45 days. Send letter to all opioid prescribers where their prescription exceeds the 120 MED or not.
DUR Board accepted recommendation but also advised to add the link to the Minnesota Prescription Monitoring Program.
- Accumulation of > 120 MED criteria will be used for a second intervention after this portion has been implemented. This alerts prescribers when a recipient exceeds 120 MED when receiving multiple opioid prescription that may not exceed 120 MED alone but do when combined with other opioid prescription with overlapping days supply. DUR Board accepted the recommendation to not include in the November 1, 2014 mailing but to mail in second quarter 2015.

Exclusion Criteria:

- None. Those with existing prior authorization for Oxy-Contin will need to reduce doses at ≤ 120 MED. There will be no grandfathering of current doses. There is no exclusion for recipients with cancer at the point-of-service so criteria need to be applied to alert the prescriber.

Educational insert for the mailing:

- Should an attachment be included as a list of the top opioid analgesics or only as a list of the top opioid analgesics whose quantity limits (QL) will change on January 1, 2015. DUR Board recommendation is to include both but designate which ones have changes in allowed QL for the Top ~25 drugs based on FFS utilization in recent quarter.

Prescriber response form:

- Recommend not to include as the 120 MED thresholds is a mandatory change.

RetroDUR – population based interventions

Diabetes Proposal

Ten DUR criteria were presented based on 2014 updated Standards of Medical Care in Diabetes published by the American Diabetes Association.

Underutilization:

1. Underutilization of Angiotensin Modulating (ACE Inhibitor or Angiotensin Receptor Blocker [ARB] Therapy). N=230.

Criteria:

Recipients who have hypertension and diabetes OR recipients who have chronic kidney disease (CKD) and diabetes AND are not taking an angiotensin modulating agent without a documented contraindication or relative contraindication.

DUR Board revised/limited the candidates to include only diabetics who have hypertension and CKD. Revise provider message accordingly.

2. Underutilization of Antilipemic Therapy. N=949.

Criteria:

Recipients 20-80 years of age with diabetes without antilipemic therapy who do not have contraindications (hepatic impairment, myopathy, rhabdomyolysis, or pregnancy).

DUR Board revised/limited the candidates to recipients with diabetes 40-75 years of age or those who have evidence of CVD. Revise provider message accordingly.

Drug-Drug Interaction (DDI) and Increased Risk of Adverse Events N=597

3. Potential Drug-Drug Interactions Involving Diabetes Medications.

Criteria:

First Data Bank (FDB) severity level one. Recipients receiving alpha glucosidase inhibitors with one of the following drugs: acarbose/miglitol & digestive enzymes; acarbose & digoxin; and repaglinide & gemfibrozil.

DUR Board approved as presented.

Increased Risk of Adverse Events

4. Increased Risk of ADE With Oral Diabetes Medications.

Criteria:

Recipients receiving diabetes medications who are at increased risk for adverse drug events due to predisposing medical conditions.

- Acarbose: GI disease, cirrhosis
- Glitazones: active liver disease, heart failure, macular edema
- Rosiglitazone & myocardial ischemia
- Metformin & renal dysfunction
- Metformin combination formulations & heart failure, and/or metabolic acidosis and/or hepatic impairment

DUR Board approved as presented.

Compliance

5. Compliance with Maintenance Diabetes, Antihypertensive, and Antilipemic Medications. N=1,119.

Criteria:

Recipients with diabetes receiving antidiabetic, antihypertensive, and antilipemic medications who have received less than a 60 day supply of medication during a 90 day period.

DUR Board approved as presented.

Increased Risk of Adverse Events (IAE) N=1,998

6. IAE: Routine Monitoring of Laboratory Values.

Criteria:

Recipients with diabetes and lack the documentation for routine laboratory monitoring within the frequency listed below.

- Glycemic control: biannually hemoglobin A1C labs if controlled diabetes and quarterly if uncontrolled diabetes.
- Annual: fasting lipid panel, serum creatinine, and microalbuminuria screen.

DUR Board expressed concerns regarding the ability to identify accurately occurrence from claims data. This could be due to bundling of services or inaccurate coding.

7. IAE: Preventable Measures - Annual Dilated Eye Exams

Criteria:

Recipients with diabetes and lack the documentation for annual dilated eye examinations.

DUR Board expressed concerns regarding the ability to obtain lab values from claims data in order to identify Recipients. Accurate identification of these recipients is required for this intervention.

Underutilization

8. Underutilization of Metformin. N=330.

Criteria:

Recipients with type 2 diabetes who do not have a contraindication to metformin AND

Recipients who have 1) not received metformin in the past year, 2) discontinued metformin in the past 90 days, or 3) received a dose <1700g/day on the most recent prescription.

DUR Board recommended to remove 2) discontinued metformin in the past 90 days if it is already included in the adherence indicator and to remove 3) received a dose <1700g/day on the most recent prescription unless these recipients can be accurately identified and the message is revised to reflect why the provider is getting a letter.

9. Underutilization of Influenza Vaccine. N=2,546.

Criteria:

Recipients with diabetes who are 6 months of age or older who have not received an influenza vaccine in the past year.

DUR Board decided to remove this intervention since claims data may not accurately reflect recipients who have received a vaccination and that vaccinations are being adequately administered in the community.

10. Underutilization of Antiplatelet Therapy. N=1,136.

Criteria:

Recipients ≥ 30 years of age with diabetes who are candidates for either primary or secondary prevention with antiplatelet therapy who are not receiving antiplatelet therapy in the past 45 days (aspirin or an alternative if contraindications to aspirin exist).

DUR Board revised candidates to: identified recipients for primary prevention at age ≥ 50 years instead of ≥ 30 years of age and for only secondary prevention identified using ICD-9/10 codes for CVD.

Hyperlipidemia Proposal

Underutilization

1. Underutilization of lipid lowering therapy. N=1,043.

Criteria:

Recipients ≥ 21 years of age with diagnoses or procedures indicative of clinical ASCVD in their medical history: acute coronary syndrome, myocardial infarction, angina, coronary artery bypass grafting (CABG), percutaneous transluminal coronary angioplasty (PTCA), stent placement, atherectomy, cerebral ischemia and peripheral artery disease.

AND

Candidates who did not receive atorvastatin 40-80mg or rosuvastatin 20-40mg in the past year and have no contraindications to HMG-CoA reductase inhibitor therapy.

DUR Board revised the exception criteria to recipients who did not receive any statin (not just high-intensity statins).

2. Underutilization of lipid lowering therapy in diabetics. N=2,954.

Criteria:

Recipients with a diagnosis or drugs indicative of diabetes in their medical and pharmacy claims history: age 40-75, diabetes, antidiabetic therapy, and no claims for Welchol in the past year

AND

Recipients who did not receive an HMG-CoA reductase inhibitor in the past year and have no contraindications to HMG-CoA reductase inhibitor therapy.

DUR Board approved as presented.

Increased Risk of Adverse Drug Events

3. Potentially inappropriate lipid lowering therapy in children. N=12.

Rationale: NHLBI guidelines discourage use of lipid-lowering medication in children unless indicated (homozygous hypercholesterolemia, primary hypertriglyceridemia with TG ≥ 500 mg/dL or evident CVD).

Criteria:

Recipients <10 years old lacking a diagnosis of hypercholesterolemia, hypertriglyceridemia, diabetes mellitus (type 1 or 2), chronic kidney disease, Kawasaki disease, or cardiac transplant who received lipid lowering therapy in the past year.

DUR Board approved as presented.

4. Potentially inappropriate lipid lowering therapy with an agent other than an HMG-CoA reductase inhibitor. N=151.

Criteria:

Recipients ≥ 21 years of age lacking a diagnosis of ASCVD or diabetes

AND

Recipients who have a history of a non-statin in the past 45 days without a history of a statin in the past year.

DUR Board revised candidates to: Recipients ≥ 21 years of age lacking a diagnosis of ASCVD or diabetes **or hypertriglyceridemia**.

5. Potential drug-drug interactions involving lipid lowering agents defined as level 1 by First Data Bank. N=140.

Criteria:

Recipients receiving a lipid lowering medication and an interacting drug with ≤ 7 days overlap in the past 45 days.

DUR Board accepted as presented.

6. Potential adverse drug events related to lipid lowering therapy. N=774.

Criteria:

Recipients receiving niacin, an HMG-CoA product, a fibrate or colsevelam in the past 45 days.

AND

Recipients receiving:

- A niacin-containing product with a history of peptic ulcer disease in the past 90 days or hepatic impairment or hepatitis in the past year
- An HMG-CoA product with a history of hepatic dysfunction, renal dysfunction or myopathy in the past year or current pregnancy
- A fibrate with a history of hepatic dysfunction or renal dysfunction in the past year
- Colesevelam with a history of bowel obstruction in the past year

DUR Board accepted as presented.

Non-adherence of Therapy

7. Non-adherence with lipid lowering therapy. N=1,998.

Criteria:

Recipients with a diagnosis of hyperlipidemia in the past 2 years and claims history of lipid lowering therapy in the past 90 days. AND

Recipients who have lipid lowering therapy in the most recent 45 days as well as 90-135 days ago, but less than 60 days of antihypertensive therapy in the past 90 days.

DUR Board accepted as presented.

Alternative Therapy

8. Simvastatin 80mg – consider alternative therapy. N=48.

Criteria:

Recipients with a claim in the past 45 days for a simvastatin 80-mg containing product (simvastatin 80mg or Vytorin 10/80). AND

Recipients with < 9 months of therapy with a simvastatin 90mg-containing product in the last 12 months.

DUR Board approved as presented.

The prescriber letter and the one-page educational material, CHD Management with Lipid Lowering Therapy, were reviewed.

The DUR Board recommendation was to add a warning statement about pregnancy: “Statins are listed as pregnancy category X and should not be used in women of child bearing potential unless using effective contraception and are not nursing”.

The proposed DUR Intervention mailing order is:

Last quarter Xerox 2014: Diabetes Disease Management

1st quarter 2014-2015: November 1, 2014: Exceeding 120 MED opioid analgesics

2nd quarter 2015: Hyperlipidemia Management

3rd quarter 2015: Exceeding 120 MED opioid analgesics II (accumulation edit from multiple opioid prescriptions)

2014 meeting dates will be:

- November 5