Drug Utilization Review (DUR) Meeting

May 13, 2015

Members Present
Chaitanya Anand, M.D., Matthew Beatty, PA-C, 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. and Sara Drake, RPh.

Other attendants
Larry Dent, Pharm.D.

Public Comments: None

Approval of Minutes: Will be available at the next meeting.

Old Business: None.

New Business:

RetroDUR- clinical criteria
No new criteria were presented at this meeting.

RetroDUR – opioid reporting at the prescriber level discussion
Xerox is developing the capability for more advanced reporting through their HealthClarity Solution®. Minnesota Medicaid has an opportunity to ascertain the utility of the HealthClarity Solution’s by selecting an interest specific Minnesota Medicaid. Xerox will then build the associated reporting for Minnesota Medicaid’s use. The topic of opioids was chosen, in particular, comparisons among opioid prescribers across all FFS (fee-for-service) and PPHP (prepaid health plans) plans as well as comparison of utilization within FFS compared to individual PPHP plans.

Potential parameters that could be used for these comparisons were discussed. To set the stage for the discussion, background information regarding current national and state efforts.

National level: Referencing the Center for Disease Control (CDC)’s Prevention’s 2011 publication “Epidemic: Responding to America’s Prescription Drug Abuse Crisis”, suggested multiple intervention points include problem prescribing, general prescribing, emergency departments and hospitals, pharmacies, insurers and pharmacy benefit managers, general patients and the public and people at high risk of overdose.
**State level:** Minnesota State efforts include the Minnesota Prescription Drug Monitoring Program and the newly formed Minnesota State Opioid Oversight Charter which has the intent to coordinate and inform among different stakeholders and groups within Minnesota.

**Department of Human Services (DHS) level:** The Minnesota Department of Human Services FFS and PPHP implemented a maximum per prescription limit of ≤ 120mg MED per day without prior authorization beginning January 5, 2015. Doses greater than 120mg daily morphine equivalence requires close scrutiny because safety is comprised at this level.

Some considerations in the developing these parameters/criteria would include:

- **Acute pain and pain during terminal illness:** opioids have proven efficacy and (relative) safety.
- **Non-cancer chronic pain:** efficacy not proven and more safety issues especially as doses then to increase over time.
  - Treatment ≥ 90 days. Ninety days is often used in definitions of chronic pain after which opioid treatment is more likely to become life-long and patients tend to be more high-risk.
- **High dose considered to be ≥ 120mg MED per day.**
  - Current edits are the line level, consider total mg MED per day from multiple concurrent opioid prescriptions.

Input was sought from the perspective of what prescribers could receive that would help educate them on how their prescribing compared to other prescribers in target opioid areas of concern.

During 2014, there were 12,922 distinct prescribers and 50,386 recipients with ≥ 1 opioid Rx within FFS Medicaid. An internal claim analysis generated a number of potential variables and parameters that were discussed. The chief result was that prescribers would need to be compared with their peers. The problem with this, however, is that DHS does not require the “specialty” field be answered as condition of provider registration. Besides, it being an optional field in registration, what is reported is not checked against any licensing or registration boards.

**Parameter Results**

1. **Prescriber practice name and location**
   - DUR Board stated that it is more important to identify the prescriber’s specialty so that prescriber comparisons are peer-to-peer. The caveat to utilizing the geographic location is for prescribers in rural areas where they may be the only prescriber available and may, subsequently, show more opioid prescribing that would be expected for their specialty.

2. **Exclude opioid prescriptions for recipients with cancer, hospice, or end of life diagnosis based on medical claims within the last 720 days.**
   - In the DHS FFS population, 5% of recipients would have their opioid claims removed (8% of opioid prescriptions) and 27% of prescribers would have a lower
total MED as a result of this criteria. In the case of one prescriber as an example, the total MED ranking dropped from 25 to 2,952.

DUR Board accepted these criteria as presented.

Rankings:
3. Rank prescribers using total MED of opioid prescriptions per time period.
4. Rank prescribers based on number of opioid prescriptions per time period.
5. Rank prescribers based on number of opioid receiving recipients per time period.
6. Rank prescribers based on the number of opioid prescriptions exceeding 120mg MED.

Parameters 3-6:
The DUR Board was provided with top 100 side-by-side comparisons ranking the 12,922 with each parameter 3, 4, 5, and 6 separately. Color coding was used to show which prescribers appeared in one, two, three or all four rankings.

DUR Board recommendation that dentists could be removed as they appeared to have a high number of recipients and there were no recipient safety concerns as prescriptions with one time with a small days supply. DUR Board: Emphasis needs to be a peer-to-peer comparison within a prescriber’s practice specialty.

7. The prescriber’s ratio of opioid prescriptions to legend drug prescriptions. DUR Board commented that it may be helpful within primary care prescribers.
8. Prescriber’s actual recipient count, prescription count, and sum drug quantity per FFS and PPHP. DUR Board: not useful information for the prescriber to know.
9. Prescriber’s recipient and prescription count by opioid drug. DUR Board: the majority thought it was not useful. If used, another column was suggested to contain the sum of the quantity per opioid.
10. Average MED per prescription, count prescriptions greater than 120mg MED, count prescriptions ≥ 121-200 MED, and count prescriptions greater than 200 MED. Report the number of distinct recipients per each group. DUR Board recommended as these identify recipients at higher risk of safety issues.

11. Opioids may be broken into three drug categories, short acting combination products which are 56% of opioid prescriptions during the study period, primarily APAP-hydrocodone and APAP-oxycodone; single-ingredient products of which oxycodone was most often prescribed with 34% short-acting formulations and 10% long-acting formulations. This parameter could be viewed as the percent of these three categories within the prescriber’s prescriptions or as the short-acting ratio dividing the number of short-acting single ingredient by the number of short-acting combination. DUR Board recommendation was this set of parameters not as useful.

12. Should buprenorphine formulations used to treat addiction be included or excluded from the criteria. Only methadone prescribed for pain treatment is captured within prescription claims as methadone dispensed at methadone treatment centers is paid through a composite fee structure. One prescriber asked what MED value was applied to methadone prescriptions as some conversion sources show three if short term methadone use and eight if long term methadone use. DHS has been using a conversion value of “3” across the board for methadone.
The DUR Board recommendation was exclude buprenorphine formulations used to treat addiction.

13. Summary recipient opioid utilization was presented. In the study population, 51% of recipients received only one prescription in 2014 within FFS Rx claims. Should the number of opioid prescriptions be to filter out recipients from prescriber comparisons? An example was provider of one prescriber’s 48 FFS recipients showing how their utilization picture changes if both FFS and PPHP data is combined. Recipients showed long term use of opioids instead of short term; the one or two prescriptions were a function of changing between FFS and PPHP. The DUR Board agreed that an ideal is to show a recipient’s combined utilization with the current health plan taking action if necessary.

14. The second aspect of recipient opioid utilization is the sum of “days supply” in conjunction with the number of prescriptions. From the current study, 38% of recipient with 1 prescription also had a “days supply” less than seven. 56% of recipients with \( \leq 2 \) Rxs and \( \sum \) of “days supply” < 14 days. There was no DUR Board recommendation on this aspect.

15. The distribution of opioid prescribers per recipient was presented. Five percent of recipients have \( \geq 5 \) prescribers, 4% has 4 prescribers, and 8% have 3 prescribers. DUR Board concluded that providing the prescriber with a count of their recipients receiving opioids from 3, 4, or \( \geq 5 \) prescribers would be useful. The question was raised as to the Minnesota PDMP criteria for “unsolicited reporting” (\( \geq 5 \) prescribers and \( \geq 4 \) pharmacies).

16. A recipient’s total mg MED per day from multiple formulations of opioid drugs needs to compared against the \( \geq 120\)mg MED/day to better capture those recipients at greater risk of harms. The proposed time frame is 53/60 days. DUR Board approved.

17. Concurrent multiple short acting formulations for 53/60 days was approved.

18. Concurrent multiple long acting formulations for 53/60 was approved.

19. The DUR Board added the criteria of concurrent use of opioid, benzodiazepines, and skeletal muscle relaxants for 53/60 days was approved.
20. The DUR Board recommendation on the suggested reporting time interval if sent to prescribers is not more often than every six months.

2015 meeting dates will be:
- August 12, 2015
- November 4, 2015