Drug Utilization Review (DUR) Meeting

December 9, 2015

Input from Members
Chaitanya Anand, MD, Pierre Rioux, MD., Amy Sapola, PharmD., Allyson Schlichte, PharmD., and Abigail Stoddard, PharmD.

DHS Staff Present
Mary Beth Reinke, PharmD., Sara Drake, RPh, and Liz Schiller.

Other attendants
Larry Dent, PharmD., Xerox

Public Comments: None

Approval of Minutes: Moved to the next meeting.

Old Business: None.

New Business:
Dr. Reinke announced there is a new five-year contract RetroDUR contact with Xerox. There were three major changes in this contact. Ten to fourteen percent of mailed packets are returned as undeliverable. On an ongoing basis, the Xerox Service center will correct these in their database prior to the next scheduled RetroDUR mailing. The return rate will be monitored for improvement.

Second, DHS will provide PPHP (managed care) claims to allow for more complete recipient histories and therefore, more accurate identification of DUR issues. Comparisons of the rate of DUR issues across specific PPHP plans and with the FFS population will be possible.

Third, the mandatory FFS psychiatric consultation for children contract was not renewed (April 2014). The new contract provides for voluntary consultations. The point-of-service (POS) hard edit was therefore lifted for high dose second generation antipsychotics and drugs to treat ADHD in children. To continue to address the issue, the new Retrospective DUR contract provides for two additional mailings per contract year which will target children with psychotropic drug issues. A number of periodic reporting requirements were also added to the new contract which will provide recipient specific information on children < 18 years of age and their respective psychotropic drug utilization. Specific Minnesota indicators are ≥ 4 multiple concurrent psychotropic drugs for at least 53/60 days, high dose per age per drug for SGA and drugs used to treat ADHD, and proper metabolic monitoring for SGA drugs. These reports will be shared with the Children’s Mental Health Division for which their intent is to do targeted outreach using their psychiatric consultation service contract.
The Opioid Dose Outcome assessment was discussed in detail showing multiple slides depicting opioid utilization prior to and after the January 1, 2015 implementation of the POS hard edit which rejects claims that exceed a max opioid quantity of 120mg Morphine Equivalent Doses. On November 6, 2014, a RetroDUR mailing was sent to prescribers whose recipients had opioid claims during September 2014 which would exceed the new quantity limit. Prescribers were sent an opioid drug profile on each of their affected recipients alerting the prescriber of the upcoming change. This RetroDUR mailing was in addition to provider updates and other announcements.

Because of the uniqueness of this mailing, it does not follow the typical ‘educational only” retrospective DUR format and outcomes analysis. Whether the recipient’s therapy changed or not, is attributable to the QL edit, rather than the RetroDUR intervention. There was a lengthy discussion regarding the best way to measure the effect of implementing the opioid QL edit. Approximately, 30% of recipients in the targeted group had their daily line item dose lowered to 120mg MED or less. However, since the QL edit is based at the line level and not a sum of the total mg MED dose from all prescriptions, recipients who are obtaining multiple opioid formulations concurrently may be over 120mg MED but not identified by the POS QL edit.

When this mailing was created, it was discussed whether to create an second indicator that would be “over 120mg MED based on adding together the MED contributions from multiple concurrent opioids, without a line level exceeding 120mg MED”. It was decided not to add this indicator to the November 2014 mailing because it may confuse the main message of the new QL hard edit.

From a pharmacy program financial outcome perspective, measuring the “total opioid expenditures” for the one month, September 2014, before any communication about the QL occurred compared to the last month in a six month post period, June 2015, where the effect of the QL edit is stabilized would provide summary financial changes because all target drugs, in this case opioids, are considered. Compared costs will be the sum of paid opioid prescriptions based on the pharmacy date of service in the pre month (September 2014) compared to the sum opioid paid prescriptions in the post month (June 2015).

Xerox also provided the number of recipients pre and post in terms of “patient days exceeding 120mg MED from multiple opioids without line level 120mg MED”. The magnitude of rise in this indicator in the post period was less than the magnitude of decline of the QL, high dose mg MED indicator indicating a favorable clinical outcome.

Xerox provided the distribution of “the number of days per 30-day month where the 120mg MED was exceeded” using the following increments: 1-5 days, 6-10 days, 11-15 days, 16-20 days, 21-25 days, and 25-30 days. By far, the largest number of ‘patient days of therapy’ was in the ‘25-30 days’ group. Second highest was the ‘1-5 day’ group. The “number of days above 120mg MED” was discussed in terms of adding as an additional criteria or qualifying parameter for the QL implementation outcome. In other words, should either or both of the DUR criteria, (1) additive 120mg MED or (2) QL high dose “exceeding mg 120 MED” have a qualifying number of high dose days to be considered positive for the DUR criteria? For example, is the criteria ≥ 1 day in 30 days? The DUR Board members suggested possible scenarios to be 21/30 days; 30/60 days; 30/90 days; or 60/90 days.
A more comprehensive description of the changes in opioid utilization will be a topic for a future meeting. In particular, the shift to the use of multiple of opioids along with reporting the change in total mg MED per day per recipient could better describe the overall picture.

**RetroDUR – population based intervention**

From January 1, 2015 through October 31, 2015, FFS antipsychotics expenditures were over $29M with 17,453 FFS recipients and 118,323 prescriptions. As expected, second generation antipsychotics (SGA) is 98.5% of antipsychotic paid and 95% of prescriptions.

For FFS third quarter 2015, total SGA paid was $59,761,217 for 626,303 prescriptions. SGA ranked 1st in expenditures, 4th in number of prescriptions, and 5th in number of recipients.

- Aripiprazole accounted for 58% of the amount paid and 20% of recipients.
- Quetiapine was 10% of the amount paid and 30% of recipients.
- Brand name lurasidone (Latuda®) was 10% of amount paid but only 4% of recipients.
- Risperidone was 2% of the amount paid with 19% of recipients.

Various interventions regarding Atypical Antipsychotics in Adults intervention have been mailed in the past on 2/28/2011 and 2/28/2014. Tonight’s proposal combines select components of previous interventions forming a new intervention “Atypical Antipsychotics: Optimization of Use”. The following ten indicators were discussed. Also, new this intervention is separating recipients by age into “under 18 years” and “≥ 18 years of age” columns.

### Total Minnesota Medicaid Fee-For-Service Specific Data

<table>
<thead>
<tr>
<th>Atypical Antipsychotic Indicator Summary</th>
<th>Number of Patients with Opportunities*</th>
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<tbody>
<tr>
<td></td>
<td>&lt;18 Years of Age</td>
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<tr>
<td>1. Recommend dose consolidation (use of single daily dose where possible)</td>
<td>371</td>
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<tr>
<td>2. Identify high daily doses (above the manufacturer or literature based recommended daily dose)</td>
<td>75</td>
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<tr>
<td>3. Avoid use of concomitant anticholinergic/Anti-EPS medications</td>
<td>43</td>
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<tr>
<td>4. Identify use of quetiapine (Seroquel®) in very low daily doses</td>
<td>61</td>
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<tr>
<td>5. Avoid use of multiple ( greater than 2) antipsychotics concurrently</td>
<td>116</td>
</tr>
<tr>
<td>6. Identify the use of atypical antipsychotics for unproven indications</td>
<td>365</td>
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<tr>
<td>7. Monitoring Atypical Antipsychotics: Glucose and Lipids</td>
<td>2,362</td>
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<tr>
<td>8. Long-Acting Injection Option for Chronic Nonadherent Patients</td>
<td>NA</td>
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<tr>
<td>9. Use of Oral Antipsychotic Concomitantly with Long-acting Injectable greater than 90 days.</td>
<td>NA</td>
</tr>
<tr>
<td>10. Ziprasidone and Cardiac Concerns</td>
<td>7</td>
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Results of discussions:

- For indicator #1, dose consolidation add a reference to support recommendation for dose simplification.
- Two indicators, #4 low dose quetiapine and #6 unproven indications, were removed.
- There will be two mailings specific to children under the age of 18 years. Therefore, do not use high daily dose for children based on adult FDA dose as there are Minnesota specific criteria for children.
- Revise the wording of the message regarding aripiprazole with anticholinergic/Anti-EPS medication.
- The two indicators, #8 and #9 regarding long-acting injectables would not apply to recipients under 18 years of age.
- Reorder the indicators to put issues of higher concern first. Move ziprasidone and cardiac concerns to the top of the list. Include the two tables from the proposal, “Contraindications and Risk Factors for Ziprasidone” and “Ziprasidone and QTc Prolongation: Potential Drug-Drug Interactions” in the prescriber letter and list before the other included tables for emphasis.
- Confirm cost savings for aripiprazole before listing in the dose simplification table.

2016 meeting dates will be:

- March 9, 2016
- May 11, 2016
- August 10, 2016
- November 2, 2016