Minnesota Department of **Human Services**

Drug Utilization Review (DUR) Meeting August 10, 2016

Members Present
Matthew Beatty, PA-C, Amy Sapola, Pharm.D., and Abigail Stoddard, Pharm.D.

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

Other attendants
Larry Dent, Pharm.D., Xerox and Andrew Riehle, Pharm.D.-4 Student

Public Comments: None

Approval of Minutes: Not discussed

Pre-Meeting Comments:
Dr. Reinke noted that three DUR Board members' positions have expired or will within three days. Per protocol, these have been posted for a twenty-one day period. Applications are coming in.

Old Business
None

New Business
Minnesota Program Assessment 2015
Xerox performs an annual FFS assessment for RetroDUR to analyze the business and clinical aspects of the program. The business analysis showed only slight changes in prescription claims, dollars spent, and recipients. From October 2014 through September, 2015, there were 2.9M prescriptions, $261M paid to pharmacies, and an average number of recipients per month was 222,597.

The top six therapeutic classes in rank order of dollars paid were psychotropic drugs - $60M, CNS drugs - $24M, antivirals - $22M, antiasthmatics - $18M, and gastrointestinal agents - $11M. Even though psychotropics ranked #1 in drug expenditures, the PUPM (per user per month) was lower at $103 than antivirals which ranked #3 but had a PUPM of $724. The top drug was Abilify® at $19.6M or 7.5% of total drug paid. Generic formulations of Adderall® (2nd highest drug) and Ritalin® (3rd highest) combined were another $14M or 5.4%.

Based on the current program assessment, annual recommendations for RetroDUR population-based mailings made by Xerox were psychotropic drugs which was mailed this March, diabetes

management which mailed June 2016, and lastly infectious disease. The most recent diabetes intervention reached 2,700 providers and impacted over 6,000 patients.

Dr. Dent mentioned multiple sclerosis as a possible intervention that another state, Texas, used in 2012-2013. A pharmacy staff comment was made concerning potential underutilization of MS treatment when recipients do not meet criteria for oral MS agents, then choose to not utilize traditional therapy either, for example, Copaxone®.

The price of H.P. Acthar® has skyrocketed in recent months as a result of there being only one manufacturer, so one suggestion was a criterion around its appropriate use referencing its place in therapy. Since there is already prior authorization criteria in place, DHS will not need to explore as RetroDUR criteria.

On the Xerox's program assessment slide about drugs with the largest growth, oseltamivir (Tamiflu®) had the second highest growth rate. There were 4,458 recipients and an amount paid of $558,188. The question was raised by a DUR Board member as to the benefit of prescribing at all since it only shortens duration of the flu by one day. DHS pharmacy staff noted that this drug recently became available as a generic.

Potential criteria under appropriate antibiotic medication could include the black box warning regarding quinolones and tendon rupture risk. The FDA recently sent out a safety communication to prescribers warning not to use quinolones for prophylactic use. Dr. Dent commented on the concomitant use of fluoroquinolone with prednisone. This could be explored further.

Apart from the areas presented, other possible DUR interventions suggested by the DUR Board were as follows:

- If non-adherence to oral contraceptive therapy, then consider recommending the use of long-acting reversible contraception (LARCs) to lower the likelihood of unplanned pregnancy.
- Botox® migraine treatment requested without attempting traditional treatment options first.
- Prescriber mailing suggesting smoking cessation treatment for those recipients with smoking diagnosis without a history of smoking cessation therapy. This could be a standalone intervention as well as an emphasis within the asthma mailing.
  The background for this stems from Sara Drake stating that Minnesota is one of the nine states participating in the CHCS Center for Health Care Strategies, Inc. "State Medicaid & Public Health Collaboration to Advance the CDC's 6/18 Initiative." The link regarding this project is added to the minutes. http://www.chcs.org/project/state-medicaid-public-health-collaboration-to-advance-the-cdcs-618-initiative/

RetroDUR – population based interventions

The DUR Board chose asthma and polypharmacy before today's meeting to focus on for upcoming interventions.

Asthma Proposal

The purpose is to educate prescribers on opportunities for improving the safety and efficacy of drug therapy for all FFS recipients with a history of asthma in the past 2 years.

The purposed intervention was comprised of the following 8 performance indicators:

Performance Indicator #1: Overutilization of Short-Acting Beta$_2$-Agonist Inhalers
N=685 with N=309 < 18 years.
Criteria:

- Patients who have received a SABA during the last 60 days AND who have received ≥ 4 SABA inhalers in the last 120 days.

The DUR Board discussion was that some children FFS recipients have a need for additional inhalers due to family status and the current proposal may be too stringent. The DUR Board recommendation was to change the number of SABA inhalers from ≥ 4 to > 4 in the last 120 days.

Performance Indicator #2: Overutilization of Short-Acting Beta$_2$-Agonist Nebulizers N=1,656.
There are two groupings of candidates.

1) Those who may be candidates for MDI as they do not have conditions that would indicate that they could not use a SABA MDI instead of SABA nebulizer.
2) Those who have reasons for nebulizer use, but are utilizing doses that may suggest inadequate asthma control.

It was recommended, to avoid confusion, for performance indicator #2 to be separated into two distinct indicators.

1) Potential inappropriate use of SABA nebulized solution
2) Overutilization of SABA nebulizers

Performance Indicator #2a: Potential Inappropriate Use of SABA Nebulized Solution
N= 1,490 with N= 1,066 < 18 years.
These recipients could likely change from a nebulizing solution dose form delivery to a metered dose inhaler (MDI). Studies show that SABA MDI is as effective as nebulizing solution and is a more cost-effective drug delivery method.
Criteria:

- Patients receiving SABA nebulizer solutions without or without previous MDI use.
  Message 6651 and 6652 were proposed.
- Patients > 12 years without history of any of the following conditions in the last 2 years:
  - Degenerative joint disease
  - Alzheimer's disease
  - Dementia
  - Paralysis/paraplegia/quadriplegia
  - Parkinson's disease
  - Ventilator dependence

DUR Board recommendation was to change the age from > 12 years to > 8 years. The DUR Board discussion was that younger children down to the age of 8 years may be capable of using an MDI drug delivery form.

The two existing messages were confusing. Post meeting discussions with Xerox resulting in using the following message (#7740) instead of the two proposed at the meeting.

Nebulized Beta2 Agonist with Opportunity to Change to MDI – According to submitted pharmacy and medical claims, your patient is currently receiving therapy with a nebulized short-acting beta2 agonist and does not appear to have a contraindication to using a metered dose inhaler (MDI). In clinical trials, MDIs with holding chambers have been shown to be as effective as nebulizers in the treatment of mild or moderate asthma exacerbations. Please review your patient's current therapy and consider switching to a MDI formulation.

Performance Indicator #2b: Overutilization of SABA Nebulizers

N=128 with N=64 < 18 years. Patients will be identified, who have reasons for nebulizer use, but are utilizing high doses that may suggest inadequate asthma control.

Criteria:

Exclusions: Patients with COPD, < 12 years of age, or with cystic fibrosis.

Inclusions:

Patients ≥ 12 years with a history of any of the following conditions in the last 2 years

- Degenerative joint disease
- Alzheimer's disease
- Dementia
- Paralysis/paraplegia/quadriplegia
- Parkinson's disease
- Ventilator dependence

AND

Who are receiving ≥ 2 SABA nebulizer claims with the following quantities in the past 60 days.

i. Albuterol 0.5% solution for nebulization – 200 mL (~ 6 nebulizer treatments/day)
ii. Albuterol 0.021%, 0.042%, Albuterol 0.083% solution for nebulization – 1080 ml (6 nebulizer treatments/day)
iii. Levalbuterol 0.31mg/3ml, 0.63mg/3ml, 1.25mg/3ml - 1080 ml (6 nebulizer treatments/day)

The DUR Board approved the criteria. The DUR Board recommended to assess clinical benefits of the different concentrations of albuterol nebs, and if it is confirmed in literature, add sentence to message 6650 on excessive beta2 agonist nebulizers: "The most cost-effective dose of albuterol solution is 0.083%."

Message 6650: Excessive beta2-agonist neb use

Potential overutilization of short-acting beta-agonist nebulizers: According to submitted pharmacy claims, it appears that your patient may be using short-acting beta-agonist nebulizers excessively. This may indicate loss of effectiveness or worsening asthma. Please review this patient's current therapy, and determine if the addition or an increase in long term control therapy (e.g., inhaled steroid, leukotriene modifiers, or mast cell stabilizers) would be appropriate.

Performance Indicator #3: Underutilization of Inhaled Corticosteroids
N=82 with N=38 < 18 years.
Criteria:

- Patients with a history of asthma in the past 2 years receiving cromolyn, leukotriene modifiers, nedocromil, or sustained release theophylline without an ICS in the past 45 days with:
  i. ≥ 2 emergency department visits or hospitalizations for asthma in the past 365 days of claims history OR
  ii. ≥ 2 SABA claims or ≥ 3 packs of a SABA in the last 120 days

Messages: 8614, 8615
The DUR Board approved as presented.

Performance Indicator #4: Use of Long-Acting $Beta_2$-Agonists as First-Line Control Therapy
N=157 with N=41 < 18 years.
Criteria:

i. Patients with a history of asthma who have received a LABA-containing product in the past 45 days with no history of ICS therapy within the most recent 45 days
OR
ii. Patients with a history of asthma receiving a LABA-containing product in the past 45 days who are taking a LABA/ICS combination inhaler with either no history of a LABA/ICS combination inhaler prior to the most recent 45 days of claims history or no history of other control therapies within the last 45 days.

Messages: 8319, 8320
The DUR Board approved as presented.

Performance Indicator #5: Use of Long-Acting $Beta_2$-Agonist Products without Short-Acting $Beta_2$-Agonist Inhaler Therapy
N=59 with N=15 < 18 years.
Criteria:

- Patients receiving a LABA-containing product in the past 90 days who did not have a claim for an inhaled or nebulized SABA product within the past year.

The DUR Board approved as presented.

Performance Indicator #6: Increased Risk of Adverse Drug Events with Asthma Therapy
N=522
Criteria:

- Patients receiving a theophylline-containing product in the last 90 days with a history of any of the following conditions in the past 2 years (unless otherwise specified):

i. Peptic ulcer disease (past 90 days)
ii. Seizure disorder
iii. Cardiac arrhythmias
iv. Pulmonary edema
v. Congestive heart failure
vi. Cor pulmonale
vii. Liver disease

- Patients with a history of asthma (either by ICD-9 diagnosis code or inferred from drug therapy) in the past 2 years receiving a non-cardioselective beta-blocker in the last 90 days with ≥ 7 days of therapy.

Messages: 2681-2687, 3922, 3923

The DUR Board recommended removing theophylline from the intervention due small use (N=17). The DUR Board approved as beta-blocker criteria.

Performance Indicator #7: Asthma Medication Non-Adherence
N=1,042
Criteria:

- Patients currently receiving chronic asthma therapy with theophylline (or its analog), a leukotriene modifier, or ICS (MDI or neb) with < 60 days of therapy in the past 90 days.

The DUR Board approved as presented.

Performance Indicator #8: Duplicate Therapy with Long-Acting $Beta_2$-Agonist Inhaler Products
N=18 with N=6 < 18 years.
Criteria:

- Patients receiving a LABA or LABA/ICS combination inhaler during the past 60 days with ≥ 35 days of the following overlapping therapy with:
  i. Multiple salmeterol-containing products OR
  ii. Multiple formoterol-containing products OR
  iii. LABA/ICS combination inhaler with an ICS or LABA (monotherapy)
  The list of combination inhalers will be updated with Breo Ellipta® (fluticasone/vilanterol).

The DUR Board approved criteria as presented.

The DUR Board recommended adding a Performance Indicator regarding smoking. Larry Dent stated there is an existing smoking cessation indicator under COPD that could be used changing the diagnosis from COPD to asthma. Sara Drake proposed this because of Minnesota's participation in the Centers for Disease Control and Prevention's 6 | 18 Initiative where "Reduce Tobacco Use" is one of the six initiatives.

Asthma Letter
Dr. Allyson Schlichte's pre-meeting comments were to add the asthma section of the FFS's preferred drug list (PDL) to the asthma letter. Therefore, the draft asthma letter contained two different versions on how to display PDL information. The one selected mirrored the DHS

webpage display. The site link will also be included. There was discussion around inclusion of the prepaid health plans' (PPHP) preferred drug lists. Since this mailing is about FFS recipients, it was decided it would be confusing to include PPHP information. However, the need for the prescriber and pharmacy communities to a have easy access was noted. Sara Drake stated there are future plans to have links to each PPHP PDL on the DHS Pharmacy webpage.

Dr. Allyson Schliche noted the current CDC recommendation is not to use live attenuated flu vaccines in asthma patients. The DUR Board approved this change in the asthma letter.

There was also a discussion about adding verbiage about spacers and peak flow meters to the letter which was agreed upon to take offline and assess placement/inclusion of the information at a later time.

Polypharmacy Proposal

The purpose of this intervention is to increase prescriber awareness of patients on polypharmacy regimens and to encourage review of the identified therapy. This may result in discontinuation of drug therapy that is no longer necessary. The setting and population are all patients who have had ≥ 10 medications (excluding antibiotics) filled within the most recent 30 days of claims activity.

Dr. Dent remarked that the last outcome reports showed $1.7 million over a one year period with the last Polypharmacy intervention.

The purposed intervention was comprised of the following performance indicator:

Performance Indicator #1: Polypharmacy
N=3,778
Criteria:

- All patients who have had ≥ 10 medications filled within the most recent 30 days of therapy based on claims activity, excluding antibiotics.

The intervention will be broken down into smaller groups, as shown in the table below:

Identified Polypharmacy Regimens	**<18 Years**	**≥18 Years**
20 or More Medications* with:		
• Opiates from 3 or more Prescribers and Pharmacies	0	3
• 3 or more Prescribers and Pharmacies	1	13
• 3 or More Prescribers	3	83
• 2 Prescribers	0	16
• 1 Prescriber	0	9
Total	**4**	**124**
15-19 Medications* with:		
• Opiates from 3 or more Prescribers and Pharmacies	0	5
• 3 or More Prescribers and Pharmacies	3	59
• 3 or More Prescribers	30	349
• 2 Prescribers	3	97

• 1 Prescriber	0	35
Total	**36**	**545**
10-14 Medications* with:		
• Opiates from 3 or more Prescribers and Pharmacies	0	13
• 3 or More Prescribers and Pharmacies	19	140
• 3 or More Prescribers	166	1,192
• 2 Prescribers	25	525
• 1 Prescriber	8	278
Total	**218**	**2,148**
≥ 10 Medications* with a history of cancer, HIV, chronic renal failure, or transplant.	**17**	**686**
Total Patients	**275**	**3,503**
		* Antibiotics are not counted

The DUR Board approved as presented.

Polypharmacy Letter
Dr. Reinke suggested and the DUR Board approved changing the byline on the letter from "RE: Multiple Drug Therapy Regimen Review (Polypharmacy)," to "RE: Multiple Drug Therapy Regimen Review (Polypharmacy) and Care Coordination."

The meeting was adjourned with no additional discussion after the approval of the Polypharmacy intervention.

Remaining 2016 meeting date will be:
- November 2, 2016