June 2013 DUR Board Meeting Minutes
Thursday, June 13, 2013 at 6:30 PM
Connecticut Pharmacists Association Office
Rocky Hill, CT

ATTENDEES

Board Members Present: Kenneth Fisher, R.Ph. (Chair), Keith Lyke R.Ph., Dennis Chapron, M.S., Bhupesh Mangla, M.D., Ram Illindala, M.D., Richard Gannon, Pharm.D., Carol Drufva R.Ph., Angela Moemeka, M.D.

Ex-Officio Non-Voting Member Present: Heather Kissinger, Pharm. D. (HID), James Zakszewski, R.Ph. (DSS), Mark Synol, R.Ph. (HP), Jason Young, Pharm.D. (HP)

Guests: Lisa Libera (Teva), Robert Gallagher (Amgen), Paul DiNunzio (GlaxoSmithKline), Ronald Poppel (Sunovion), Mark VanWoert (Supernus), Thomas Garrison (Purdue), Karla White (CSL Behring), Robert Palma (Purdue)

INTRODUCTORY BUSINESS

- Ken Fisher called the meeting to order at 6:41 p.m.
- Ken stated that we would begin the meeting by reviewing the CMS report first and then move on to the remainder of the DUR Board packet.

A. CMS Report

- The Board began reviewing the FFY 2012 CMS report and summary found in section 5.
- Heather stated that the CMS report is comprised of 3 tables and 9 attachments and its purpose is to provide prospective and retrospective DUR data to CMS on an annual basis.
- Heather stated the Executive Summary could be found on pages 3-7 and the CMS Survey could be found on page 8-16.
- The executive summary summarizes the key points made throughout the report, lists the number of DUR meetings during the year, lists prospective and retrospective reviews, and highlights the cost savings. The CMS survey is a high level survey regarding each attachment/table with the CMS report.
- Keith Lyke questioned the answer to 4.C on page 10 of the CMS survey and asked if both the pharmacist and prescriber obtain authorization for early refill for non-controlled drugs.
- Mark Synol responded yes and stated we would change the answer for 4.C to either.
- Rich Gannon asked if the Generic Utilization Rate (GUR) for years prior to FFY 2012 was available in the report.
- Heather stated this information was not in the report but could be found in the previous year’s reports.
- Dennis Chapron asked how Connecticut’s GUR compared to other states and if we had access to GUR data for Medicare Part D programs.
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- Heather stated that since FFY 2011 CMS has required states to report the GUR using a universal method. Since then most states have comparable GURs. CMS makes archived copies of all States CMS reports on line and individual GURs can be found there.
- Jim Zakszewski stated we do not have Medicare Part D GUR information available.
- The Board members reviewed ProDUR Table 1 and 1a on pages 17-22.
- Heather stated there are 12 ProDUR criteria, 8 requiring an override, and 4 that are informational in nature. The 8 requiring an override are; Early Refill, Therapeutic Duplication, Drug-Drug Interaction, High Dose, Pregnancy, Drug-Age Pediatric & Geriatric combined, Ingredient Duplication, and Drug Disease. The 4 alerts that are informational in nature are; Low Dose, Late Refill, Minimum Duration and Maximum Duration.
- Heather reported that table 2 of the CMS report could be found on pages 23-25 and included Retrospective DUR criteria approved by the DUR Board during FFY 2012.
- The Board reviewed Table 2 and had no questions, changes, or comments.
- Heather stated that Attachment 1 of the CMS report could be found on pages 25-60. Attachment 1 is the year end summary report on prospective DUR screening using the on-line POS system.
- Each of the 8 ProDUR alerts that require an override has a 3 page section that includes a table and a bar graph to illustrate the top 20 therapeutic categories by HIC3 class that made each alert hit. The alerts that require an override also have an additional page displaying a bar graph of the % overrides versus the % cancelled and no response. The 4 ProDUR alerts that do not require an override have a 2 page section that includes a table and a bar graph to illustrate the top 20 therapeutic categories by HIC3 class that made each alert hit.
- Angela Moemeka pointed out a typo on page 25 found under number three. “Suing” should be changed to “using.”
- Heather stated she change the word prior to submitting the report.
- Keith questioned how the % overridden value was calculated on page 26.
- Mark stated it used all alerts to calculate the value and the number seemed low because there are no values for low dose, late refill, maximum and minimum duration because those alerts do not require an override by pharmacies.
- The Board had no further questions, changes, or comments regarding Attachment 1.
- Heather reported that Attachment 2 of the CMS report could be found on pages 61-62 and is a report on the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid agency and the State Board of Pharmacy.
- Heather stated Attachment 3 could be found on pages 63-78 and is a yearend summary report on retrospective screening and interventions.
- Heather stated that attachment 3a is the summary of the Therapeutic Class Exceptions (TCEs) submitted by HID and summarizes the total number of patients who hit on a TCE within each AHFS drug class during FFY 2012. Attachment 3b is the summary of the interventions performed during FFY 2012 by HID summarized by AHFS class.
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- Heather stated the Attachment 3c is the summary of the patient profiling performed for DUR and Lock-In during FFY 2012.
- Ram Illindala questioned why the total claims reviewed was low during December 2011 compared to the other months.
- Heather stated the claims were low because January (December data review) is the month that HP processes the reversal claims.
- Angela questioned why the prescriber response rates were in the 20% range and suggested electronic communication may increase the responses.
- Heather reported that Attachment 4 of the CMS report could be found on pages 79-121.
- It was stated that attachment 4 includes the FFY 2012 DUR Board meeting minutes, criteria selections, and quarterly provider newsletters.
- Heather stated that the header date would be changed from “2011” to “2012” on page 103.
- Heather stated that page 113 was updated and handed out the updated page to the members for review.
- The Board reviewed Attachment 4 and had no additional questions, changes, or comments.
- Heather reported that Attachment 5 of the CMS report could be found on page 122 and describes policies in place to encourage the use of therapeutically equivalent generic drugs. Attachment 5 had updates to include information regarding the MAC Tier process and the updated page was handed out to the members for review.
- Heather stated Table 3 of the CMS report could be found on page 123. The Generic Dispensing Rate (GDR) for FFY 2012 was 67.95%.
- Heather reported that attachment 6 of the CMS report could be found on pages 124-140 and is the program evaluations/cost savings estimates prepared by HID and HP.
- RetroDUR and Lock-In cost savings during FFY 2012 reported by HID was $4,042,869.
- Rich pointed out that the return on investment (ROI) for the RDUR program had increased since FFY 2011. The ROI for FFY 2012 was reported at 644%.
- ProDUR cost savings during FFY 2012 was estimated to be a total of $21,881,972 on 2,086,837 prescriptions.
- Heather stated Attachment 7 of the CMS report can be found on pages 141-142. Attachment 7 describes the Prescription Drug Monitoring Program (PMP) in CT. The cost savings generated from the PMP during calendar year 2012 was estimated at $733,000.
- Heather stated Attachment 8 of the CMS report can be found on page 143. Attachment 8 describes innovative practices developed during FFY 2012. The narrative focuses on the monthly pediatric reviews and adult reviews performed during FFY 2012.
- Heather stated Attachment 9 of the CMS report can be found on page 144-145. Attachment 9 describes E-Prescribing in CT.
- Heather handed out an updated copy of Attachment 9 to the members for review.
- The Board approved the CMS report contingent upon Heather Kissinger making the changes that were requested.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.
B. Previous Meeting Minutes
   • Minutes to the March 28, 2013 meeting were approved as written.

C. Follow-Up from Previous Meeting
   • The Board reviewed section 3 titled “Follow-up from the March 2013 DUR Board Meeting.”
     Follow-up 1, the Board requested a specialty intervention be performed to target the following patients:
     ○ Age ≥ 70 years of age, can decrease the age to 65 if initial search does not return enough patients
       to perform a monthly intervention
     ○ Include patients with diagnoses of cognitive impairment, dementia, vertigo, dizziness, falls,
       Alzheimer’s disease
     ○ Include patients receiving only drugs classified with a score of 2 or 3 from the following list
       http://www.indydiscoverynetwork.org/resources/ACB_Scoring_List_040412.pdf
     ○ If patients are receiving different strengths of the same drug, count the drug only once
     ○ Only target those patients with an ACB score of 6 or higher within a 3 month time period
     ○ Send letter to the prescribers of the drugs with an ACB score of 2 or 3 (patient needs to have
       overall score of 6 or higher) alerting the prescriber that their patient’s ACB score is high, they
       have one of the following diagnoses; cognitive impairment, dementia, vertigo, dizziness, falls,
       Alzheimer’s disease, and that drugs affecting cognitive function should be used with caution in
       these patients
   • Heather stated that HID was building the criteria for this specialty intervention and results would be announced
     during the September 2013 DUR meeting.
   • Follow-up 2, The Board requested to review this follow-up question during the June 2013 meeting to have
     Angela’s input:
   • A request was made to know if a diagnosis comes later to explain the kids with ADHD who are receiving
     antipsychotics. (Question stemmed from the review of the Pediatric Criteria Trend Summary 2011, criteria 3235
     Alert Message: The patient is under the age of 18 with a diagnosis of ADHD and is receiving an atypical
     antipsychotic with no evidence, in their diagnostic history, of a FDA approved indication for use. Atypical
     antipsychotics have not been shown to be safe and effective for the treatment of ADHD. These agents have
     significant adverse effects which can be more prevalent and severe in pediatric patients.)
     Heather stated that another review would have to be performed to know if the appropriate diagnosis comes later to
     explain why children with ADHD are receiving antipsychotics, but if this same criteria were run to determine if
these patients are continuing to hit on this criteria it could mean two things if the patient is no longer being flagged by criteria 3235:
1. The patient is no longer receiving the antipsychotic…or
2. The patient does have a valid diagnosis for use of the antipsychotic

Angela stated that antipsychotics are commonly prescribed to the pediatric population to treat ADHD.
Heather stated that HID was no longer sending letters for criteria 3235 and the criteria would be shut off permanently per Angela’s feedback.
Follow-up 3, a request was made to know what specific drugs made the util categories for criteria 65 and 1474. This request was made because the two criteria look similar in description and the Board wanted to view the differences.
Heather directed the Board to review Attachment A of Section 3. Util A for both criteria have the same antidepressants listed but the difference is in the comparison of the Util B categories. Criteria 65 was the original criteria and criteria 1474 was a modified version of criteria 65 requested by another client. Heather explained that when a new client uses HID they are offered the entire criteria list. Most new clients turn on the entire criteria list and delete criteria when they see something they don’t like, rather than reviewing all 3,000 criteria at the start of the contract.
The Board voted to keep both criteria 65 and 1474 active.
Follow-up 4, Rich mentioned B/C and B/S of Mass looked at > 30 days of short-acting opiate prescribed must go through a review board unless prescribed by a pain management specialist. A request was made to review short-acting opiates >= 90 days (negating with a long-acting opioid) with 120 morphine equivalents as a cutoff.
The query was created to flag patients receiving any short acting opiate for >= 90 days during 2012 at or above the following doses, negate patients who are receiving any long acting opiate.
Codeine 800mg per 24hrs
Hydrocodone 120mg per 24hrs
Hydromorphone 30mg per 24hrs
Morphine 120mg per 24hrs
Oxycodone 80mg per 24hrs
Oxymorphone 40mg per 24hrs

The query results were presented at the March 2013 DUR Meeting and the Board requested a new criteria be created for these specific patients.

Heather stated that Criteria 8630 was turned on in May for testing and can be found in section 8 (New Criteria Selections) to be voted on by the members. HID’s RDUR system does not have a morphine conversion calculator so our programmer created something similar for another client by modifying the values going into the existing dose per day calculation in the RDUR system to attempt to “convert” but it is NOT a morphine calculator. Our
programmer was very specific in saying be very carefully about what you send out because this is not a morphine calculator. It may not hit correctly all the time because it is not an exact morphine calculator.

- Heather stated that 191 patients hit on criteria 8630 during the June review and suggested to the Board that Rich first review a few patient profiles prior to voting on the criteria to be activated.
- Rich stated he would review the profiles and provide feedback during the September 2013 DUR meeting.
- Follow-up 5, the Board requested to know the specific diagnoses criteria 989 was built to flag (Alert Message: NSAIDS should be used with caution in patients with pre-existing fluid retention, hypertension or heart failure. These agents may cause or exacerbate these conditions) because there was discussion around modifying this criteria to only target patients diagnosed with heart failure.
- Heather directed the Board to Attachment A of Section 3. Util A contains NSAIDS; Util B contains both idc-9s (fluid over load, heart disease, hypertension, heart failure, and edema) and drugs suggesting cardiovascular problems (e.g. beta blockers, ACEIs, ARBs, CCBs) and Util C contains diuretics. This criteria identifies patients with actual diagnoses of fluid retention, hypertension and heart failure but it also requires the patient to be taking a diuretic.
- The Board voted to remove the following diagnoses from criteria 989:
  - 401 ] [ESSENTIAL HYPERTENSION ]
  - 4010 ] [MALIGNANT ESSENTIAL HYPERTENS]
  - 4011 ] [BENIGN ESSENTIAL HYPERTENSION]
  - 4019 ] [UNSPECIFIED ESSENTIAL HYPERTE]
  - 402 ] [HYPERTENSIVE HEART DISEASE ]
  - 4021 ] [BENIGN HYPERTENSIVE HEART DIS]
  - 40210] [BENIGN HYPERTEN HEART DIS UNS]
  - 4029 ] [UNSPEC HYPERTENSIVE HEART DIS]
  - 40290] [HYPERTENSIVE HEART DIS UNSPEC]
- Follow-up 6, the Board requested to know the extent of Xyrem utilization in the Medicaid population.
- Heather referred the Board to the table included:

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<tr>
<th>NDC Code</th>
<th>Rx Num</th>
<th>Qty Dispensed</th>
<th>Total Remb Amt</th>
<th>Total Claim Cost</th>
<th>Label Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>62161000820</td>
<td>0</td>
<td>0</td>
<td>$.00</td>
<td>$.00</td>
<td>XYREM 500 MG/ML ORAL SOLN</td>
</tr>
<tr>
<td>68727010001</td>
<td>36</td>
<td>16380</td>
<td>$196,197.09</td>
<td>$233,481.60</td>
<td>XYREM 500 MG/ML ORAL</td>
</tr>
</tbody>
</table>
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NDC USAGE for Xyrem from 01/01/13 to 03/31/13

<table>
<thead>
<tr>
<th>NDC Code</th>
<th>Rx Num</th>
<th>Qty Dispensed</th>
<th>Total Remb Amt</th>
<th>Total Claim Cost</th>
<th>Label Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>36</td>
<td>16380</td>
<td>$196,197.09</td>
<td>$233,481.60</td>
<td>SOLUTION</td>
</tr>
</tbody>
</table>

- Jim stated that only one pharmacy in the US dispenses Xyrem.

D. Criteria Trend Summary
- Heather discussed the criteria trend analyses tables included in the DUR Board meeting packet. The tables list the number of criteria exceptions found before and after DUR intervention letters are mailed. Criteria are suppressed for patients who are selected for intervention for 6 months after letters are mailed so that prescribers do not receive the same letter for the same patient month after month. In almost all cases the number of criteria exceptions noted 6 months after DUR letters were mailed was reduced as compared to the number of exceptions prior to letters being mailed.
- Rich suggested intersecting the pediatric reviews for September, October, and November 2012 to determine the number of patients who received letters and continued to hit in all three months.
- Heather stated the information requested would be presented during the September 2013 meeting.

E. Program Summary Review
- The Board reviewed the program summary for 1st quarter 2013.
- Heather stated that during 1st quarter 2013 prescription claims cost was approximately $185 million, the number of prescriptions in the 1st QTR were approximately 2.1 million, the number of unique recipients receiving a prescription was approximately 330,000 and the average paid per prescription was $85.11

F. Intervention Activity Report
- Heather reviewed the Intervention Activity Report included in the DUR Board packet.
- It was stated that the Intervention Activity Report is a monthly summary of the distribution of letters mailed to prescribers and also summarizes the main criteria that were reviewed each month.

In January 2013, 2,876 profiles were reviewed and 2,592 letters were sent.
The main interventions reviewed for the adult population were:
- Migraine Medication Review (597 letters)
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- Lock-in criteria (523 letters)

The main intervention reviewed for the pediatric population was:
- Proton Pump Inhibitor (PPI) Medication Review (556 letters)

In February 2013, 2,858 profiles were reviewed and 2,243 letters were sent.
The main interventions reviewed for the adult population were:
- Zolpidem Medication Review (954 letters)
- Lock-in criteria (343 letters)

The main intervention reviewed for the pediatric population was:
- Overutilization and Dosing Review (447 letters)

In March 2013, 2,775 profiles were reviewed and 2,552 letters were sent.
The main interventions reviewed for the adult population were:
- Anticoagulant Interactions (1124 letters)
- Lock-in criteria (459 letters)

The main intervention reviewed for the pediatric population was:
- Therapeutic Duplication of Antidepressants (153 letters)

G. RetroDUR Criteria New Criteria
- The following criteria as written in the DUR Board packet were approved by the DUR Board
  1. Pioglitazone / Gemfibrozil
  2. Actoplus Met XR & Duetact / Gemfibrozil
  3. Pioglitazone - All / Rifampin
  4. Rosiglitazone - All / Rifampin
  5. Rosiglitazone - All / Gemfibrozil
  6. Alogliptin / Overutilization
  7. Alogliptin / Moderate Renal Impairment Dosing
  8. Alogliptin / Severe Renal Impairment or ESRD Dosing
  9. Alogliptin-All / Pancreatitis
  10. Alogliptin-All / Hepatic Effects
  11. Alogliptin / Insulin & Sulfonylureas
  12. Alogliptin-Pioglitazone / Overutilization
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13. Alogliptin-Pioglitazone / Moderate Renal Impairment Dosing
14. Alogliptin-Metformin / Overutilization
15. Alogliptin-Metformin / Metabolic Acidosis
16. Alogliptin-All / Duplicate Therapy

• Ram asked if a criteria existed for therapeutic duplication of all drugs within the dipeptidyl peptidase-4 (DPP-4) Inhibitor class.
• Heather stated she would look into the request and follow up during the September 2013 meeting.

17. Alogliptin / Nonadherence

• Angela requested to know how the system determines non adherence versus a discontinuation of a medication.
• Heather stated she would look into the request and follow up during the September 2013 meeting.

18. Alogliptin-Pioglitazone / Nonadherence
19. Alogliptin-Metformin / Nonadherence
20. Alogliptin-All / Therapeutic Appropriateness
21. Metformin – All / Hepatic Impairment
22. Haloperidol / Schizophrenia
23. Prazosin / High Dose 0-5 yoa
24. Prazosin / High Dose 6-11 yoa
25. Prazosin / High Dose > 12 yoa

• The following criteria were tabled by the DUR Board
26. Short-Acting Narcotics / Long-Acting Narcotics

H. Newsletter

• The Board approved the June 2013 Newsletter with no changes.

I. HP Provider Bulletin-Proton Pump Inhibitor (PPI) changes in coverage

• Heather reviewed the May 2013 Provider Bulletin with the DUR Board and explained that step therapy for PPIs will go into effect July 1, 2013.
• The PA form was also included as part of the bulletin.
• Keith suggested the list of preferred/non preferred drugs be included on the PA form.
• Mark stated the preferred agents would be included in the updated form.

NEW BUSINESS
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- Physicians need to be enrolled as Medicaid providers in order for their prescription claims to pay. Beginning on September 1, 2013, if the prescriber is not enrolled as a Medicaid provider, prescriptions billed under those NPIs will deny.
- Mark stated that there are approximately 5,000 un-enrolled providers who prescribe maintenance medications to Medicaid clients.
- Jim and Mark both stated that outreach is being performed to enroll providers.
- Keith stated that when he fills prescriptions for Medicaid clients and receives a message back stating the provider is not yet enrolled, he contacts the provider to enroll.
- Jim added as an aside that Charter Oak and ConnPACE programs are ending but with the Affordable Care Act Medicaid Expansion, DSS expects to see a 15-20% increase in covered clients.
- The September DUR meeting was confirmed as Thursday September 12, 2013.
- The meeting was adjourned at 8:37 pm.