

DUR Board Meeting Minutes Draft

Name of Meeting Drug Utilization Review Board

Date of Meeting Thursday, May 20, 2010

Length of Meeting 2:05 PM – 3:47 PM

Location of Meeting DMAS 13th Floor Board Room

Members Present:

Geneva Briggs, PharmD
Bill Rock, PharmD
Jamie Haight, R.Ph
Jane Settle, NP
Jonathan Evans, MD, MPH
Cynthia Fagan, FNP
Avtar Dhillon, MD

Not Present: Jason Lyman, M.D; Renita Driver, PharmD; Randy Ferrance, MD; Michele Thomas, PharmD; Sandra Dawson, R.Ph, MSHA

DMAS Attendees:

Bryan Tomlinson, Health Care Services Division Director
Keith Hayashi, R.Ph.
Rachel Cain, PharmD
Donna Francioni-Proffitt, Pharmacy Program Manager
Tyrone Wall, Compliance Specialist
Scott Cannady, Senior Health Policy Analyst

Contractor: Donna Johnson, PharmD, Magellan; Debbie Moody, R.Ph, Magellan; Nancy Eldin, PharmD, Magellan; Rob Berringer, PharmD, ACS; Mary Roberts, Magellan; Lisa Pernerose, Magellan

DMAS P&T Committee:

Randy Axelrod, MD (by phone)

Visitors:

Jason Richardson, Forest Pharmaceuticals
Paula Pitnam-Kupresek, Taheda
Bruce Song, AZ
Judy Jenkins, BMS
Brenda Evans, VCB
Rick Meidlinger, J&J
Susan Matthews, Med Immune

Call to Order and Introductions

Chair Geneva Briggs called the meeting to order.

Virginia Medicaid RetroDUR Review Reports February 2010 through March 2010

February 2010 – Metabolic Monitoring in Children and Adolescents on Atypical Antipsychotics

Atypical antipsychotic medications are associated with significant adverse effects on weight, lipids and glucose metabolism. This is of particular concern in individuals with psychiatric disorders as they have a higher incidence of weight gain, dyslipidemia and glucose dysregulation compared to the general population. Routine monitoring is recommended to detect emerging problems early and to initiate steps to minimize or reverse metabolic problems to prevent long-term complications. The following monitoring has been recommended for all patients receiving atypical antipsychotic therapy^{1,2,3}:

- Weight, BMI, waist circumference: at baseline and at each visit
- Blood pressure: at baseline, at three months, then at each visit
- Fasting lipids: at baseline, at three months, then every six months
- Fasting glucose: at baseline, at three months, then every six months
- Personal/family risk factors: at baseline, then annually

For the February review, 1000 pediatric patients were identified who were currently receiving atypical antipsychotic therapy. Their profiles, which contain six months of medical and prescription claims, were reviewed for glucose and/or lipid testing. If no evidence of these tests were seen in the profiles, letters were sent to the prescribers of the atypical antipsychotic medication. While these prescribers may not be the ones who would order the lab tests, they should communicate with the patient's other physicians to ensure complete coordination of care. The internal medicine prescribers may not be aware of all the patient's medications or the need for routine monitoring. A total of 517 letters were sent to prescribers to alert them that their patients may need closer evaluation.

There were also 83 re-review profiles this month for the June 2009 review of acetaminophen overutilization. Of these recipients, 22 (27%) continue to remain on their original therapy. No additional letters were sent to prescribers notifying them of the continued existence of the original issue.

¹ Haupt DW, Roesblatt LC, et al. Prevalence and predictors of lipid and glucose monitoring in commercially insured patients treated with second-generation antipsychotic agents. *Am J Psychiatry* 2009;166:345-353.

² Monteleone P, Vassilis M, Maj M. Management of schizophrenia with obesity, metabolic and endocrinological disorders. *Psychiatr Clin N Am* 32 (2009) 775-794.

³ Correll CU. Monitoring and management of antipsychotic-related metabolic and endocrine adverse events in pediatric patients. *International Review of Psychiatry, April 2008; 20(2): 195-201.*

March 2010 - Polypharmacy

Patients who are seen by multiple prescribers and have their prescriptions filled at multiple pharmacies are at increased risk of medication related adverse events. These patients may lack a primary care physician and a single pharmacy to coordinate and optimize their medication regimen. The focus of this review was to evaluate patients who received greater than nine unique prescriptions in a 34-day period and these prescriptions were written by 3 or more different prescribers and filled at 3 or more different pharmacies. The profiles of patients meeting these criteria were reviewed. Care was taken not to letter when the patients had obvious diseases or combination of diseases that would easily require more than nine prescriptions each month and possibly several doctors. Reviewers looked for patients who are chronically at risk for drug interactions, therapeutic duplication, or those who may be doctor or pharmacy shopping. A total of 214 letters were sent to prescribers informing them of their patients' polypharmacy and the potential risks.

Since the polypharmacy review was incorporated into the existing RetroDUR program in August 2005, approximately 16000 patient medication profiles have been reviewed and a total of 1838 (11.5%) intervention letters have been sent to prescribers. The prescriber response rate for the November 2009 review was 25% with 70% of these prescribers responding that they find the information useful and plan to monitor, alter or discontinue the treatment regimen.

Future RetroDUR Topics

Dr. Johnson presented the following suggestions for future RetroDUR reviews: non-adherence with warfarin therapy and a polypharmacy review of patients on atypical antipsychotic medications. Dr. Berringer suggested the Board review drugs with abuse potential.

Minutes- March 18, 2010 Meeting

The Board reviewed and with a motion, approved the minutes from the March 18, 2010 meeting.

New Drugs

Dr. Johnson presented criteria for the new drugs: vigabatrin (Sabril®) and dalfampridine (Ampyra®). The Board made the following recommendations:

- Sabril®: At the presentation of Sabril® DUR criteria at the March 2010 meeting, the Board requested additional information about the SHARE prescriber enrollment program. Specifically, the Board wanted to know how the SHARE program addresses age, gender and pregnancy testing. Dr. Johnson contacted SHARE and reported their answers to the Board. Subsequently, the Board had the following additional questions regarding the SHARE Program:
 - Have there been any clinical trials for patients 2 to 17 years old?
 - What is appeals process for the SHARE program?

This information will be presented at the August 2010 meeting. The Board did not approve the DUR criteria for this medication pending further follow up.

- Ampyra[®]: The criteria were approved as presented with a motion by the Board. Dr. Johnson mentioned that there is a product currently marketed, 4-aminopyridine powder used in compounding that is chemically similar to Ampyra[®] and if the product is coded as a therapeutic duplication edit – the claim will not deny. However, if 4-aminopyridine is coded as a drug-drug interaction with a severity code=1, the claim will deny at POS.

Atypical Antipsychotic Review

Dr. Briggs presented the following recommendations from DMAS' P&T Committee regarding the use of atypical antipsychotics in children:

- Implement a pharmacy edit that requires all new prescriptions for atypical antipsychotics in children under 6 to be written by a psychiatrist
- Require a six month review of all recipients currently on atypical antipsychotics under 6 by a psychiatrist
- P&T Committee members should attend the May 20th DUR Board Meeting
- Review proposed edit criteria with the Virginia chapter of American Academy of Pediatrics (AAP)
- Potential review with a child psychiatrist
- Continue to evaluate data to identify patterns and issues

In addition, Dr. Briggs shared with DUR Board Secretary Hazel's comments which stressed the need for a coordination of care program that includes a Behavioral Specialist and training for the parents.

Dr. Dhillon recommended that Pediatric Neurologist be included as a specialty permitted to prescribe atypical antipsychotics in children under 6.

The DUR Board discussed both the P&T Committee's and previously presented DUR recommendations. Both the DUR Board's and P&T Committee's members agree there is no justification for the use of these medications in children less than 3 years of age. Dr. Johnson then presented the quarterly update and commented that utilization has decreased 54% in the children less than 6 years old.

Next, Dr. Briggs presented the following outline for implementing a service authorization program for the use of atypical antipsychotic medications in children less than 6 years old:

1. Distribute a Medicaid Memo notifying all providers of the new SA requirement.
2. Implement soft messaging on claims for atypical antipsychotics in children less than 6 years old for a specified period of time (e.g. 3 months to allow prescribers sufficient time to modify therapy)

3. Grandfather all enrollees less than 6 years old currently taking atypical antipsychotics for a period of 6 months.
4. Implement a hard edit that requires each of the following criteria be met in order to approve the claim:
 - a. The prescriber must be a psychiatrist or behavioral health specialist or supply proof of a psychiatric consultation AND
 - b. The recipient must have an appropriate diagnosis (see list of ICD-9 codes below)
5. If the above criteria are met, the SA will be granted for a period of 1 year.
6. If the criteria are not met, the SA request will be referred to the identified resource for review.
7. All calls and requests would go to the First Health call center. If the request did not meet the required criteria, the request would be referred to the FH pediatric psychiatrist for final approval.

Example of Acceptable ICD-9 Codes

| | |
|---------------|---|
| 294 & subsets | Organic Psychiatric Conditions |
| 295 & subsets | Schizophrenic Disorders |
| 296 & subsets | Affective Psychoses (bipolar disorders) |
| 298 & subsets | Psychoses |
| 299 & subsets | Autism Spectrum Disorders |
| 300.14 | Multiple Personality |
| 301 | Personality Disorders |
| 307 | Tourette's |
| 309 | Reactive Adjustment Disorders (includes PTSD) |
| 313.81 | Oppositional Defiance Disorder |

The DUR Board has monitored the utilization of behavioral health drugs and has discussed placing an edit on their use for a number of years. The Board agreed that a clinical service authorization is warranted for the use of atypical antipsychotics in children less than 6 years old and voted to place an edit in the system. The Board discussed potential criteria and how the process should be handled and communicated to the providers. Criteria will be revised and presented to the Board at the August meeting.

Next steps:

- Review proposed criteria and make recommendations
- Finalize the list of “acceptable” diagnoses
- Ask Dr. Dhillon to review the criteria; then ask AAP to review
- Publish a Medicaid Memo that informs and educates prescribers on the changes DMAS plans to implement with the use of atypical antipsychotics in children under age 6
- The DUR Board will review and comment on the above mentioned Medicaid Memo
- The Board needs to finalize the list of acceptable prescribers
- DMAS needs to determine how the service authorization program for atypical antipsychotics in children under the age of 6 will be implemented.

Other Business

Future meeting schedule: August 19, 2010, November 18, 2010, March 17, 2011, and May 19, 2011.

Adjournment: 3:37 P.M.