Annual Report of the Drug Utilization Review (DUR) Board and Pharmacy Liaison Committee

Department of Medical Assistance Services

December 2004

AUTHORITY FOR REPORT

Item 326 (I) of the 2004 Appropriations Act directs that the Department of Medical Assistance Services (DMAS) shall implement continued enhancements to the prospective drug utilization review (pro-DUR) program. The Department shall continue (i) the implementation of a disease state management program including physicians, pharmacists, and others deemed appropriate by the Department and (ii) the Pharmacy Liaison Committee. The Department shall continue to work with the Pharmacy Liaison Committee to implement the disease management program and such other initiatives for the promotion of cost-effective services delivery as may be appropriate. The Department shall report on the Pharmacy Liaison Committee's activities to the Board of Medical Assistance Services and to the Chairmen of the House Appropriations and Senate Finance Committees and the Department of Planning and Budget no later that December 15 each year of the biennium. This report responds to the requirements of the Appropriations Act.

ACTIVITIES OF THE DRUG UTILIZATION REVIEW (DUR) BOARD

The DUR Board ("the Board") met four times during 2004 (March 18, May 6, August 12 and November 4) and completed its evaluation of all new drug products. The Board composed of physicians, pharmacists and nurse practitioners appointed by the Director of DMAS, is an expert panel empowered to define the parameters of safe medication use according to federal and state guidelines. The new or revised criteria were integrated into the criteria base used in DMAS' pharmacy program. The criteria are used in the two components of the DUR program: (i) Retrospective DUR (RetroDUR); and (ii) Prospective DUR (ProDUR).

The DMAS "RetroDUR" program examines a history of medication used to identify certain patterns of use. After a computer analysis of claims data, an expert panel of reviewers evaluates a sampling of records and requests the generation of educational intervention letters in appropriate circumstances. Educational letters are customized to each identified case and mailed by the program contractor. Letters may be sent to both patients and prescribers, depending on the specifics of each case.

"ProDUR" is an interactive on-line, real time process in which pharmacy claims are evaluated during the submission process. Potential problems related to the established criteria generate an immediate alert message to the pharmacist. Due to the short turn-around time of 30 seconds or less per transaction, the most serious concerns are the focus of this endeavor. The Board has established a hierarchy of risks and continually reviews the criteria to enhance and improve the program.

KEY DRUG UTILIZATION REVIEW BOARD ACTIVITIES

During 2004, the Virginia DUR Board reviewed ProDUR and RetroDUR criteria for six new drugs and approved two of the drugs. They also reviewed and updated existing criteria for benzodiazepines, typical and atypical antipsychotic agents. The DUR Board requested and reviewed several reports of criteria. First, the Board reviewed Narcotic Therapeutic Duplication Criteria, Beer's List Criteria, and ProDUR Early Refill Criteria.

Beers List Criteria

The 2003 Appropriations Act required the Department of Medical Assistance Services to review its elderly long-term care enrollees for any inappropriate use of medications as defined by Dr. Mark Beers. Dr. Beers has published several articles describing the inappropriate use of various medications in older adults. The Beers criteria were presented to the Virginia Medicaid DUR Board for review and approval. The Board approved the criteria and agreed that this review would be performed every 6 months as a retrospective review of 1000 enrollee medication profiles. Additionally, the Board recommended that the review should include all Virginia Medicaid enrollees 65 years and older, not just those in long-term care facilities.

April 2004 drug claims were reviewed for the Beers criteria. One thousand medication profiles were generated for all enrollees 65 years and older who excepted to any of the Beers criteria. Letters were sent to prescribers for 466 Medicaid enrollees. There were 731 criteria interventions in a total of 533 letters sent to prescribers whose patients are receiving medications or dosages that are potentially inappropriate for them. Many of the letters contained more than one criteria intervention. Furthermore, many of the enrollees had letters sent to more than one prescriber.

No one single notable trend was detected in the review of these profiles. However, the large number of interventions reflects the widespread use of these medications in older adults.

Therapeutic Duplication for Narcotics

The Board requested a report of therapeutic duplication (TD) for Narcotics. This report showed the total number of denied and paid claims for narcotic medications that hit the TD edit. The report listed in detail the drugs that denied and the intervention codes used to override the alert and dispense the medication. Thirty-eight percent of the denied claims were overridden. It was a lengthy report, but it clearly revealed the types of interventions made by the dispensing pharmacists. While a few of the overrides appeared to be questionable, the majority were appropriate.

ProDUR Early Refill Criteria

The early refill (ER) edit denies a prescription claim at point-of-sale (POS) if less than 75% of the original medication has been used based on the date of service. In the past, this edit allowed the pharmacy provider to override the denial. In June 2004, DMAS enhanced the existing early refill edit to no longer allowed the provider level override. Long-term care pharmacies were excluded from this program enhancement. Pharmacies were required to call First Health to obtain an override for the claim. Prior to this, the pharmacy providers were overriding the early refill edit approximately 20% of the time. After the enhancement, the override rate dropped to approximately 3%.

At the request of the DUR Board, we performed an analysis of the types of claims and recipients that received the early refill denial to determine if patients were being denied access to important medications. We identified and monitored the claims of 20 recipients taking furosemide, pantoprazole hydrocodone or oxycodone. The Board concluded that patients were receiving their medications at the appropriate time.

RetroDUR

RetroDUR profile reviews were performed on the following therapeutic classes – lipotropics, acetaminophen overutilization, sedative hypnotic benzodiazepines, atypical antipsychotic therapeutic duplication, nsaids and cox-2 inhibitors, anticonvulsants, and anticoagulants. Letters were sent to pharmacy providers and prescribers to notify them of dispensing and prescribing concerns when appropriate. The Board also requested a RetroDUR review be conducted on the use of estrogen replacement in women with cardiovascular disease. Recent trials have suggested that estrogen replacement therapy does not confer cardiac protection and may actually increase the risk of coronary heart disease and stroke. Letters were sent to 31 prescribers for patients receiving estrogens who also had a diagnosis of cardiovascular disease to alert them to the potential risk for their patients.

ACTIVITIES OF THE PHARMACY LIAISON COMMITTEE

The Pharmacy Liaison Committee (PLC) met three times during 2004 (March 16, August 17, and November 16). The PLC includes representatives from: the Community Pharmacy Coalition; Long-Term Care Pharmacists; the Pharmaceutical Research and Manufacturers Association (PhRMA); the Virginia Association of Chain Drug Stores (VACDS); and the Virginia Pharmacists Association (VPhA).

Members of the Pharmacy Liaison Committee have provided important feedback on the pharmacy program initiatives including the Preferred Drug List, Prior Authorization Programs, Threshold/Polypharmacy Program, and Mandatory Generic Program.

MEDICAID PHARMACY INITIATIVES

Preferred Drug List (PDL) and Prior Authorization (PA) Programs

The PDL is effective for the Medicaid, MEDALLION, and FAMIS-Plus (formerly known as Medicaid for children) fee-for-service populations. The PDL does not apply to enrollees being served by the Managed Care Organizations, or to FAMIS enrollees. The Department of Medical Assistance Services (DMAS) is implementing this program to provide clinically effective and safe drugs to its clients at the best available price.

The PDL provides a selection of therapeutically effective products for which the Medicaid program will allow payment without restriction. It is a listing of preferred drugs by therapeutic class. Specific drug products within these classes have been designated by the Pharmacy and Therapeutics (P&T) Committee as "preferred". In the designated classes, drug products that do not appear on the PDL will be subject to prior authorization (PA). The PDL does not restrict access to a drug class. In an effort to ensure appropriate drug therapy with the least risk to the recipient and that is cost effective, other drugs, as recommended by the Pharmacy and Therapeutics Committee, may be subject to prior authorization. No patient will be left without appropriate drug therapy under this initiative.

The P&T Committee meetings have been open to the public and comments have been received from patients, providers, manufacturers, and constituency groups. Certain categories of drug products for fragile populations are not affected by the PDL, such as antipsychotics and drugs for cancer or HIV. Please refer to Attachment A for further information on the Preferred Drug List program.

Threshold/Polypharmacy Program

The Threshold/Polypharmacy program, which began in October 2004 is a two-step program (Coordination of Care initiative, then retrospective review of all patient profiles with greater than 9 prescriptions in 30 days). The Coordination of Care initiative has identified patients who use multiple medical and pharmacy providers and take a high number of drugs. A letter was sent to these patients' prescribers to educate and promote coordination of care to optimize drug therapy for these identified patients. The Threshold program identifies those patients with greater than 9 prescriptions in 30 days, and allows FHSC clinical pharmacist to review the entire profile for possible drug conflicts. This will help identify and correct inappropriate drug regimens, improve quality of care and reduce costs.

Default Provider Identification Numbers

The use of default provider identification numbers has been significantly curtained. In the past, pharmacists have been allowed to submit one of four default numbers on DMAS claims rather than the actual prescriber identification number. While this has been a convenience for pharmacists, it completely eliminates DMAS' opportunity to implement programs designed to improve patient safety and quality of care. DMAS reduced the utilization of these default numbers from 32% to 17% in 2004. DMAS is also currently considering a change to use the DEA number, which is more readily available to the providers and currently used with most all commercial plans. Additional steps will most likely be taken in the future when a "National Identification number" is implemented nationwide. This will ensure that DMAS will be able to accurately indentify the prescribing physician for each pharmacy claim.

ProDUR

Prospective drug utilization review helps ensure appropriate drug use by identifying drug interactions, unusual dosing, and drug to disease contraindications. In February 2004, DMAS enhanced three DUR edits from Message to provider level override (DD-drug-drug, MC drug-disease, PG-pregnancy). In June the early refill edit was upgraded from provider level override to phone call for PA. Providers have accepted these changes and the program appears to be working well.

Mandatory Generic

The mandatory generic program was enhanced in September 2004, it helps ensure that pharmacists are utilizing brand name and generic drugs appropriately. In the Commonwealth of Virginia, unless the Prescriber writes on the face of the prescription "Brand Necessary" the pharmacist should substitute the less costly generic equivalent. DMAS has placed a hard edits on multi-source brand name claims, which do not have a DAW of 1 (Brand Necessary mandated by the prescriber), to ensure appropriate generic utilization. This will reduce brand name dispensing when generic dispensing is warranted.

Maximum Allowable Cost (MAC)

DMAS has implemented a new Maximum Allowable Costs (MAC) program for multi-source generic drugs on December 1st of 2004. The MAC program will set a maximum price for individual multi-source generic drugs to ensure proper payment to providers. The generic marketplace is very dynamic and pricing and availability changes occur frequently. DMAS has contracted with a vendor to monitor these changes and develop a list of MAC drugs in accordance with the Appropriations Language. The vendor is also responsible for interfacing with the Medicaid Management Information System (MMIS); to ensure the MAC prices are applied appropriately. The MAC list is posted to the Web and updated on a monthly basis. DMAS has worked with select providers to pro-actively resolve any issues that may be associated with the MAC list, for wider provider acceptance upon implementation. The MAC program will ensure that providers prudently select multi-source generic products in terms of quality and price.

Cox-II-Step Therapy

This ensures that effective cost savings alternatives were tried first before beginning Cox-II therapy. The edit is specific to those patients <60 years old and requires the failure of two traditional NSAIDs (non-steroidal-anti-inflammatory drugs) i.e.- Ibuprofen, Naproxen. This edit was implemented with appropriate clinical considerations given (grand fathering) to those patients currently using Cox-IIs in the drug regimen. Thus the potential to save money lies with new patients who need to start anti-inflamatory therapy.

Over-The-Counter Drugs (OTC)

DMAS covers OTC drugs if the OTC is a designated drug prescribed by a licensed prescriber through a prescription (oral or written) and is to be used as a less expensive alternative to the covered legend drug. In August of 2004, DMAS revised the OTC list. The revisions, education, and communication were posted to the DMAS website.

DMAS will report on the results of the implementation of these new pharmacy initiatives in its report to be filed by December 15, 2005.

ACKNOWLEDGEMENTS

DMAS wishes to acknowledge the many representatives of the pharmacy community who have assisted the Department in developing and implementing the cost savings initiatives listed above, as well as the advice and expertise they have shared with the agency during 2004. The cooperative efforts of the provider community have been essential to the success of these pharmacy program initiatives.

Attachment A:

November 8, 2004 Memorandum Regarding the Status Report on the Medicaid Preferred Drug List Program and Other Pharmacy Initiatives

(See seven page document immediately following this attachment)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 8, 2004

MEMORANDUM

TO: The Honorable Vincent F. Callahan, Jr.
Chairman, House Appropriations Committee

The Honorable John H. Chichester
Chairman, Senate Finance Committee

The Honorable Harvey B. Morgan
Chairman, Joint Commission on Health Care

FROM: Patrick W. Finnerty

SUBJECT: Status Report on the Medicaid Preferred Drug List Program and Other Pharmacy Initiatives

As required by the 2003 Appropriations Act, the Department of Medical Assistance Services (DMAS) submitted a report on the Preferred Drug List (PDL) program to the Senate Finance Committee, the House Appropriations Committees, and the Joint Commission on Health Care in April 2003. While not required by the Appropriations Act, subsequent reports were submitted on June 16, 2003, September 1, 2003, and February 12, 2004. This memorandum summarizes the PDL activities and accomplishments that have occurred since the last status report, and provides information on several other pharmacy-related activities ongoing within the Department.

As you know, the PDL program was implemented in three phases (January 5, 2004, April 1, 2004, and July 1, 2004). Implementation of all three phases of the PDL program has been very successful. Attachment A provides an overview of the drug classes that were implemented in each of the three phases.

Some of the major accomplishments related to the PDL include:

1) the Department implemented a "Virginia-specific" program design and supplemental rebate process that is unique among other states and is working quite well;
2) there have been very few complaints regarding the program;
3) there is very high compliance rate (92%) in terms of "preferred" drugs being prescribed for Medicaid clients;
4) the prior authorization process and First Health Call Center are working very smoothly as evidenced by an extremely low call abandonment rate and minimal call time (now less than 2 ½ minutes);
5) no Medicaid recipient has been denied access to a drug under the PDL program; and
6) initial estimates of cost savings indicate that the required savings targets will be met.

The following paragraphs provide additional information about the status of the PDL program and other pharmacy program activities at DMAS.

Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics (P&T) Committee, comprised of eight physicians and four pharmacists, directs all phases of the PDL program including: (i) selecting the therapeutic drug classes to review for possible inclusion in the PDL; (ii) deciding which classes should be included in the PDL; (iii) assessing the clinical efficacy of the drugs within each class under review; (iv) selecting the "preferred" drugs in each class; (v) establishing clinical criteria; (vi) developing appropriate prior authorization procedures; and (vii) advising the Department on other pharmacy initiatives.

The P&T Committee held eleven meetings between June 2003 and October 2004. Attachment B provides an outline of the meetings held by the P&T Committee and the decisions made at each meeting. The Committee has reviewed thirty of the top fifty drug classes to date as well as completed an annual review of thirteen of these classes for 2005. A copy of the PDL "Quick List" which identifies the drug classes included in the PDL program and the "preferred" drugs within each class is provided at Attachment C.

During the most recent meeting of the P&T Committee (October 6, 2004), the Committee reviewed, for possible inclusion in the PDL, the antidepressants (including the Selective Serotonin Reuptake Inhibitors -- SSRIs) and antianxiety medications used in the treatment of mental illness. Immediately following that meeting, I sent a memorandum to the members of the Health & Human Resources Subcommittees of the Senate Finance and House Appropriations Committees as well as the members of the Joint Commission on Health Care summarizing the P&T Committee's deliberations and

the next steps that will be taken on this issue. A copy of my October 7, 2004 memorandum on this topic is provided at Attachment D.

PDL Implementation Advisory Group Activities

In an effort to provide a mechanism for stakeholder participation and program support, DMAS established the PDL Implementation Advisory Group (PDLIAG) to provide advice to the Department regarding the implementation of the PDL program. The PDLIAG consists of representatives from pharmaceutical manufacturers, the provider community, and advocacy groups. The PDLIAG held six meetings from September 2003 through November 2, 2004. Several of the major PDL successes were the direct result of advice and support received from the members of the PDLIAG. The group recommended that DMAS: (i) determine how other states developed PDL educational processes; (ii) arrange statewide training sessions and other educational tools for providers; (iii) conduct PDL beta site testing with chain and independent pharmacies; (iv) develop policies and procedures to clarify the appeals process; (v) implement 72-hour dispensing fees for pharmacists; and (vi) enhance the PDL communications strategy. Although the initial charge of the group (implementation of the program) has been completed, the PDLIAG will continue to meet periodically to monitor progress with the PDL and other pharmacy initiatives.

PDL Clinical Edits (COX II Inhibitors and Long Acting Narcotics)

In developing the prior authorization criteria for PDL drug classes, the P&T Committee decided to implement clinical edits for particular classes to ensure that drug therapy is managed appropriately based on various clinical considerations. Currently, COX II Inhibitors (used to treat inflammation) and Long Acting Narcotics classes have specific clinical edits. For the COX II Inhibitor drug class, the P&T Committee decided to implement clinical edits to ensure clinical efficacy and prevent inappropriate use. Effective July 2004, patients under age 60 with a new prescription for any COX II Inhibitor are required to obtain a prior authorization for use of the drug. The criteria for the edit also require patients to have attempted the use of two appropriate, more cost effective medications or have a pre-existing gastrointestinal disease before utilizing a COX II Inhibitor. Patients under age 60 who have been on COX II therapy between January and June 30, 2004, were able to continue their drug treatment until their current prior authorization expires or until June 30, 2005, whichever comes first.

On September 30, 2004, the Department made changes to the PDL program specific to the COX II Inhibitor drug class as a result of Merck & Co. removing Vioxx from the market. The market withdrawal of this drug affected patients, payers, and providers nationwide. Since Vioxx had been the only "preferred" drug in this class, the Department took immediate action to allow the other two drugs in this drug class (Celebrex and Bextra) to be "preferred" drugs until December 31, 2004. This is an interim step because the P&T Committee decided at its October meeting that effective January 1, 2005, Celebrex will become the sole "preferred" drug and Bextra will revert to

the "non-preferred" status. The Committee will monitor all clinical evidence and studies on COX-IIs to determine whether additional changes are warranted.

For the Long-Acting Narcotics class, clinical criteria were developed to manage these high risk drugs, and ensure that pain management decisions are made in an appropriate and safe manner. Effective January 1, 2005, the clinical criteria will be applied for all long-acting narcotics, and will require the attempt of two short-acting narcotics (average 4 hours) prior to the use of a long acting narcotic (average 8-12 hours). The clinical criteria will not apply to patients stabilized on long-acting narcotics or those that require 24-hour pain therapy for an extended period of time. Special guidelines are also in place for the use of OxyContin and Methadone. In developing these guidelines, the P&T Committee consulted with two national pain management experts.

PDL Program Evaluation Results

DMAS proactively decided to conduct a comprehensive analysis of PDL operations, utilization, and cost savings. DMAS' Policy and Research Division has been conducting ongoing analysis of the program since its inception. The key findings of the most recent analysis are listed below. These findings were presented to the PDLIAG at its meeting on November 2, 2004.

- **Compliance** -- The PDL compliance rate, measured as the percent of patients being prescribed "preferred" drugs, remains high. While the compliance rate varies among the different drug classes, the overall compliance rate across all drug classes is 92%. This rate exceeds the compliance level (85%) needed to achieve the necessary budget savings.

- **Prior Authorization** -- There have been no denials of medications as a result of the PDL prior authorization process. Since the beginning of the program, 76% of all requests for prior authorization have been granted; for the remaining 24%, the prescribing physician voluntarily switched to the preferred drug. There have only been technical denials for retrospective payments to long-term care facilities that have already dispensed the medication but did not comply with the appropriate PDL processes. Therefore, there is no evidence that any patient has been denied access to their medications as a result of this program.

- **Call Center Operations** -- The PDL call center, managed by First Health Services, has been operating efficiently. The Call Center is responsible for receiving and evaluating prior authorizations as well as responding to other program inquiries. As of September 2004, Call Center activity has leveled off with an average of 894 calls per week and an average of 1,755 issues addressed each week. Physicians make the majority of calls and most calls involve requests for prior authorization. The Call Center staff continues to manage these calls

promptly. As of September 2004, calls were being answered within 16 seconds and the average call length was less than two and one-half minutes.

- **Market Shift** -- Market share of PDL drug classes has significantly shifted as a result of the program. In September 2004, preferred drugs accounted for 89% of all claims in PDL drug classes compared to 61% in January 2004 (prior to the PDL Program). This market shift indicates an acceptance among providers of the drugs available as "preferred," and supports the achievement of program savings.

- **Cost Savings** –Evaluation results show the average cost per prescription has decreased below the projected amount since PDL implementation. In addition, the actual pharmacy expenditures are significantly below the Department's official forecast. While the final savings estimates have not been completed, these comparisons of actual versus forecasted expenditures indicate the program is meeting the targeted level of savings required in the Appropriations Act. These savings are driven principally by a supplemental rebate process that has worked very well (overall, manufacturers have provided competitive pricing) and the high PDL compliance rate (92%).

Other Medicaid Pharmacy Initiatives

In addition to the PDL, the Department has implemented several other pharmacy initiatives during 2004 to improve the quality of services provided to its clients. Many of these initiatives also have the added benefit of saving the Commonwealth money.

- **Management of Generic Drug Utilization**

The utilization of less expensive generic drugs can provide significant cost savings in pharmacy claims. DMAS' new Mandatory Generic program helps ensure that, whenever feasible, generics are dispensed instead of more costly brand name products. The Department's state plan requires that prescriptions for multiple source drugs be filled with generic drug products unless the prescribing provider requires that the brand be used. Effective September 1, 2004, pharmacy claims are denied when a brand name drug is inappropriately dispensed rather than a generic. Provisions are in place that ensures claims are paid in those rare situations when the pharmacist must dispense the brand name, because no generics are available.

- **Maximum Allowable Cost (MAC) Pricing for Generics**

Effective December 1, 2004, the reimbursement for multiple source generic drugs will be subject to a new maximum allowable cost (MAC). MAC reimbursement, required by the 2004 Appropriations Act, is used by Medicaid programs in approximately 41 states and by most private insurers throughout the commercial

insurance market to control the cost of generic drugs. By instituting the new MAC reimbursement methodology for multiple source generic drugs, the Department will reimburse pharmacies an amount that more accurately reflects their purchase price, which is considerably less than the current Medicaid reimbursement. The MAC price is a maximum amount a certain drug will be reimbursed, based on the average price of multiple manufacturers' prices of a specific drug. The MAC price may change on a monthly basis due to market conditions; therefore, this pricing mechanism takes advantage of the cost savings of a competitive environment. If a pharmacy provider discovers that the MAC price does not accurately reflect the drug cost, and there are no alternative suppliers, a pricing review may be requested for resolution. The MAC list will be updated monthly and available on the Department's web site.

- **Coordination of Care and Threshold Programs**

The Threshold/Polypharmacy program, required by the 2003 Appropriations Act, is intended to monitor drug profiles for clinically appropriate drug utilization, improve the health and safety of recipients, enhance opportunities to reduce severe adverse drug reactions, retrospectively monitor high drug utilization, enhance continuity and coordination of care, and identify clinical misuse and fraud. This program was implemented in two steps. The first step is a Coordination of Care initiative, which focuses on recipients who may lack a primary care physician and/or a single pharmacy to coordinate and optimize their medication regimens. All physicians of patients identified with coordination of care issues, based on established criteria, received notification on October 1, 2004 of their patients' drug utilization patterns as well as an educational intervention package to consider any necessary changes to promote care coordination and reduce inappropriate drug utilization. The second step, Threshold/Polypharmacy program, expands this focus to all recipients receiving greater than nine unique prescriptions in a 30-day period. Beginning October 15, 2004, all recipients greater than nine unique prescriptions are retrospectively reviewed for appropriate drug utilization; and prescribing physicians of those with potential issues will receive letters requesting review of the information, clarification of issues, and consideration of appropriate changes.

- **Prospective Drug Utilization Review (ProDUR)**

The ProDUR program is a quality improvement program that involves a prospective review of each prescription along with the patient's drug therapy history to determine if there are potential adverse effects including, but not limited to, drug therapy duplications, contraindications, interactions and early refills. Claims with these edits will deny for payment and pharmacists must use their professional judgment in determining when to bypass the edits. Effective February 16, 2004, some ProDUR edits require pharmacists to provide

appropriate intervention and outcome codes to override a payment denial. In addition, effective June 14, 2004, the Early Refill edits (occurs when refill of prescription is presented before 75 percent of the medication is used) that previously required the pharmacist to enter an intervention code to override the denial, now requires a phone call to the First Health Call Center to receive prior authorization based on the approval criteria.

The 2003 Appropriations Act also required the Department to review its elderly long-term care enrollees for any inappropriate use of medications. The Department, with consultation from its Drug Utilization Review Board, approved the Beers criteria, a widely accepted method for pharmacy reviews of older adults, to be conducted every six months as a retrospective review of enrollee medication profiles. The review includes all Medicaid enrollees 65 years and older, not just those in long-term care facilities. In April 2004, one thousand medication profiles were generated for all enrollees 65 years and older who met any of the Beers criteria. Letters were sent to 533 prescribers whose patients are receiving medications or dosages that are potentially inappropriate for them. These letters included information regarding a total of 731 interventions and 466 patients. Many of the letters contained more than one criteria intervention and several recipients had letters sent to more than one prescriber. No notable trend was detected in the review of these profiles; however, the large number of interventions reflects the widespread use of these medications in older adults.

We will continue to submit reports to you in the coming months to keep you abreast of the status of the PDL program and other pharmacy initiatives. More detailed information on the PDL program and other DMAS pharmacy initiatives can be found on the agency's website at www.dmas.virginia.gov. Should you have any questions or wish to discuss any of these issues, please feel free to contact me at (804) 786-8099 or send an email message to PDLInput@dmas.virginia.gov.

Thank you.

/pwf
Enclosures

cc: The Honorable Jane H. Woods
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DMAS PDL Implementation Advisory Group
Susan Massart
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