Report on Pharmacy Liaison Committee and Drug Utilization Review Board

Virginia Department of Medical Assistance Services
December 2006

AUTHORITY FOR REPORT

Item 302 (I) of the 2006 Appropriation Act directs the Department of Medical Assistance Services (DMAS) to implement continued enhancements to the prospective drug utilization review (proDUR) program. DMAS is directed to continue the proDUR Committee and the Pharmacy Liaison Committee in order to promote the implementation of cost effective initiatives within the Medicaid pharmacy program. The Appropriation Act further requires DMAS to report on the activities of these Committees to the Board of Medical Assistance Services, the Department of Planning and Budget, and the Chairmen of the House Appropriations and Senate Finance Committees by December 15 each year.

KEY DRUG UTILIZATION REVIEW BOARD ACTIVITIES

The proDUR Committee, known as the Drug Utilization Review Board, hereafter, ("the Board") is composed of physicians, pharmacists and nurse practitioners appointed by the DMAS Director and serves as an expert panel empowered to define the parameters of appropriate medication use within the federal and state guidelines. The Board meets to review, revise and approve new criteria for use of prescription drugs. The Board develops drug utilization review criteria by addressing situations in which potential medication problems may exist, such as high doses, drug-drug interactions, drug-diagnosis interactions, adverse drug reactions and therapeutic duplication. These new or revised criteria are integrated into two components of the DUR program: prospective DUR (proDUR) and retrospective DUR (retroDUR), which are explained in more detail below.

The Board met three times during 2006 (March 23, August 17, and November 9) and completed its evaluation of new drug products released in 2006. Specifically, the Board reviewed and approved criteria for 10 new drugs:

- *Ranexa* (heart drug),
- *Amitiza* (laxative),
- *Emsam* (antidepressant),
- *Azilect* (Parkinson's drug),
- *Chantix* (smoking cessation drug),
- *Exubera* (inhaled insulin formulation),
- *Prezista* (HIV drug),
- *Noxafil* (antifungal drug),
- *Fentora* (narcotic analgesic), and
- *Opana* (narcotic analgesic).

They also reviewed and updated existing criteria for antidepressants, antihypertensives, antipsychotics, antiviral agents, narcotic analgesics, oral hypoglycemic agents (diabetes drugs), lipotropics (cholesterol drugs), antiarrhythmics (heart drugs), diuretics (heart/blood pressure drugs), and quinolones (antibiotics).

ProDUR

ProDUR is an interactive on-line, real time process in which pharmacy claims are evaluated for potential problems related to the established appropriate use criteria during the claims submission process. Immediate alert messages are sent to the pharmacist on the most serious potential concerns due to for the short turn-around time of 30 seconds or less per transaction with point-of-sale processing. The Board has established a hierarchy of risks and continually reviews the criteria to enhance and improve the program.

The Board reviewed appropriate use criteria for the top twenty-five drugs ranked two ways: claim count and payment amount. The Board specifically focused on cost and utilization analyses for each drug type, the proDUR cost savings report, and a summary of proDUR alerts. Based on these informational tools, the Board's review found the following examples to be the most relevant:

- The Board reviewed Gabapentin (anticonvulsant) utilization for the service date of April 1, 2006 to June 30, 2006. There was an extensive discussion on the potentially inappropriate use of Gabapentin in patients with bipolar disorder and its ineffectiveness at any dose. The Board suggested this as a topic for a future retroDUR review.

- The Board reviewed the utilization of *Exubera*, a newly released inhaled form of insulin, at the November 2006 meeting. Since only three recipients were found to have claims for this product for the service dates of July 1, 2006 through October 31, 2006, the Board saw no need to establish restrictions on this drug at this time. The Board agreed to continue to monitor and review *Exubera's* use periodically, to determine if interventions are needed in the future.

RetroDUR

The DMAS retroDUR program examines the history of medication utlization to identify certain patterns. After a systems 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 pharmacies and prescribers, depending on the specifics of each case. RetroDUR profile reviews were performed on the following topics from October 2005 through December 2006:

- Acetaminophen (analgesic) overutilization,
- Long-Acting Beta Agonists (LABAs) (respiratory drugs) utilization,
- Antibiotics used in Upper Respiratory Infections (URIs),
- Rosiglitazone (diabetic drug) FDA Warning,
- ACE Inhibitors (heart drugs) use not recommended during pregnancy,
- Telithromycin (antibiotic) FDA Public Advisory,
- HIV Medication Non-compliance,
- Beta-blocker (heart drugs) non-compliance,

- Beer's List Criteria (defined below),
- Polypharmacy (defined below), and
- New drugs approved by the Board at the November 2005 and August 2006 meetings

After the initial review of patient profiles is complete and letters have been sent to providers, re-reviews are conducted after seven months to verify that recommendations are being accepted. RetroDUR recommendations continue to produce changes in therapy resulting in increased compliance to accepted treatment guidelines. For the period from October 2005 through June 2006, there have been 1,341 letters with 216 prescriber responses which equals a 16 percent retroDUR response rate overall.

A response is a formal acknowledgement that a presciber has received and reviewed the patient profile letter. The response rate is the percentage returned compared to the total number of patient profile letters sent. Some potential responses are:

- Aware of situation and no adjustment to current therapy is necessary at this time,
- Plan to discontinue medication(s),
- Information clinically useful and plan to alter treatment regimen for specified patient,
- Information clinically useful and plan to monitor or counsel specific patient,
- Plan to change dose,
- Information regarding patient or provider appears to be incorrect, or
- Other (additional comments may be added by prescriber)

The 2003 session of the Virginia General Assembly passed legislation requiring DMAS 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. With the implementation of Medicare Part D, pharmacy coverage plan, Medicaid no longer covers the majority of the medications on the "Beers List" for dual eligibles (Medicaid enrollees who are also Medicare eligible). However, two major classes of drugs, which are excluded by Medicare, are still covered by Medicaid. These are the benzodiazepines and barbiturates (sedatives). The focus of the retroDUR review in August 2006 was on the Beers criteria for these types of medications. Of particular interest in this review was that 50.7 percent of the inappropriate use criteria interventions involved the use of benzodiazepines in doses that exceed the recommended maximum for older adults; 31.3 percent involved the use of benzodiazepines or barbiturates that are inappropriate to use in older adults at any dosage; and 18 percent of the interventions involved the use of benzodiazepines that are not recommended in patients with certain medical conditions. Overall, the inappropriate use of these medications can lead to prolonged sedation and an increased incidence of falls and fractures in the older adult patient. There were a total of 175 letters sent in September 2006 to prescribers whose patients were receiving these medications; results will be reported in the 2007 annual report.

Polypharmacy is defined as patients who are receiving multiple prescriptions, are seen by multiple prescribers and have their prescriptions filled at multiple pharmacies. These patients are at increased risk of medication related adverse events. Also, they may lack a primary care physician and a single pharmacy to coordinate and optimize their medication regimen. Polypharmacy is seen predominately in the older adult population because these are the patients

with the greatest number of co-morbid diseases that require multiple prescribers and medications.

A polypharmacy review was incorporated into the existing retroDUR program in August 2005. The focus of this review was to evaluate patients who received greater than nine unique prescriptions in a 34-day period, whose prescriptions were written by 3 or more different prescribers, and filled at 3 or more different pharmacies. Approximately 4,000 patient medication profiles have been reviewed for polypharmacy and a total of 527 intervention letters have been sent to prescribers. With the establishment of Medicare Part D (which is focused on older adults), we are seeing a decline in polypharmacy criteria violations. However, the issue of polypharmacy still exists in the remaining population and the prescribers are receptive to the information that is provided. For the polypharmacy retroDUR program the overall prescriber response rate is 21 percent; of those responding, 57 percent indicate that they find the information useful and plan to monitor, alter or discontinue the treatment regimen.

Cost Savings Related Drug Utilization Review programs

- ProDUR cost savings for the period from October 2005 through September 2006, was estimated to be $44 million. The proDUR cost savings for the Virginia Medicaid prescription drug program are calculated from the cost of claims receiving proDUR alerts which are denied coverage and are not overridden by the pharmacist. The pharmacist, based on clinical judgment, may override the proDUR alert by providing additional information to allow the claim to be paid.
- RetroDUR cost savings were calculated based on changes in the prescription drug costs for those patients whose profiles were identified through the retroDUR program. Cost savings are tracked over a 12-month period. Changes in prescription drug costs are totaled to yield overall cost savings for the review period. RetroDUR cost savings for the period from June 2005 through July 2006 were estimated to be nearly $100,000.
- Polypharmacy cost savings is calculated separately using the same logic described above for RetroDUR. Polypharmacy cost savings for the period from August 2005 through July 2006 were estimated to be $83,000.

THE PHARMACY LIAISON COMMITTEE ACTIVITIES

The Pharmacy Liaison Committee (PLC) includes representatives from: long-term care pharmacies; the Pharmaceutical Research and Manufacturers Association (PhRMA); the Virginia Association of Chain Drug Stores (VACDS); and the Virginia Pharmacists Association (VPhA).

The PLC met on October 5, 2006 and heard a DMAS staff presentation on National Provider Identification (NPI) implementation, the new *Healthy Returns* disease management program, and an update on the Comprehensive NeuroScience (CNS) Behavioral Management Pharmacy Program. The focus of this meeting, however, was the implementation of a Specialty Pharmacy Drug Program in Virginia Medicaid. There was discussion about the drug classes and conditions that should be addressed through care management services, the pros and cons for each of the program models, and models that have worked well in other states and/or commercially which could possibly be replicated at Medicaid. The Committee is scheduled to meet again on

December 19, 2006 for a review of requested data relating to the Specialty Pharmacy Drug Program.

For further information on the Specialty Drug Program, please refer to DMAS' November 2006 annual report to the Virginia General Assembly on the Specialty Drug Program.

OTHER MEDICAID PHARMACY INITIATIVES

Behavioral Pharmacy Management System

In April 2005, the Department, in partnership with the Department of Mental Health, Mental Retardation, and Substance Abuse Services, implemented a new pharmacy quality initiative, the Behavioral Pharmacy Management System (BPMS) program. This program has the support of the Psychiatric Society of Virginia. The program is administered by Comprehensive NeuroScience (CNS) and supported by Eli Lilly and Company. This system provides a retrospective review of behavioral pharmacy claims and delivers interventions to Medicaid providers whose prescribing practice patterns fall outside best practice guidelines. The program has been implemented in more than 25 states since 2003.

As directed by Appropriation Act language, the DMAS Preferred Drug List excludes atypical antipsychotic drugs, antidepressants, and antianxiety medications. These exclusions increase the need for the review of behavioral health medications through the BPMS program. There is evidence that for the targeted patients, i.e., those patients whose physician received an intervention from CNS, the total pharmacy costs of behavioral drugs for this population is decreasing. DMAS continued this program in 2006 with some significant enhancements. The enhancements are largely in response to the changing Medicaid fee-for-service population as a result of the implementation of Medicare Part D. For 2006, the average response rate was 12 percent per month on the prescriber mailings. For the next phase of the program, DMAS is working closely with the Psychiatric Society of Virginia and community psychiatrists to develop a team of peer reviewers for consultations with prescribers based on "best practice" guidelines.

Other Pharmacy Initiatives

For information on other pharmacy initiatives, the Preferred Drug List and Maximum Allowable Cost programs, please refer to DMAS' annual reports to the Virginia General Assembly dated November 2006 and January 2007, respectively.

ACKNOWLEDGEMENTS

DMAS wishes to acknowledge the many health care professionals and industry groups who have participated in the development and implementation of pharmacy program initiatives over the past year.