

**Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
Drug Management Review Advisory Board Meeting
May 13, 2010**

Meeting Minutes

Voting Members in attendance:

Kim Croley, PharmD, CGP, FASCP, FAPhA, Patricia Freeman, Kathy Hager, DNP, APRN, FNP-BC, CDE, Gerald Payne, B.S., B.H.S., PA-C, Clay Rhodes, PharmD, MBA, BCPS, Kathryn Schat, MD, Sarah Smith, PharmD, Glenn Stark, RPh, Carmel Wallace, MD,

Non-Voting Members in attendance:

Thomas Badgett, MD, Chief Medical Officer

Steve Davis, MD

Laura Hieronymus, MEd, RN, BC-ADM, CDE

Non-members present from First Health Services:

Alan Daniels, RPh, Account Manager, Tina Hawkins, PharmD, Clinical Program Manager, Kasie Purvis, Provider Services Manager

Non-members present from Department for Medicaid Services:

Lee Barnard, Assistant Director, Division of Medical Mgmt, Trista Chapman, Contract Monitor

- I. **Introduction and Welcome of Committee Members**
- II. **Establishment of Quorum (Cabinet for Health and Family Services)**
 - A quorum was present.
- III. **New Business (Slide Presentation is embedded for reference)**



DMRAB Slides
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A. DUR 101 (slides 3-10)

- On slide 4, it was noted that appropriate compendia consists of peer reviewed literature; however, package inserts published by pharmaceutical manufacturers are not included in this list.
- On slide 5, it was noted that the OBRA '90 requirement for counseling and maintenance of patient records only applies to Medicaid prescriptions; however, the Kentucky Board of Pharmacy, along with many other state boards, expanded this requirement to all prescriptions.
- On slide 7, it was noted that today's point-of-sale (POS) systems are much more advanced than they were in 1993 when OBRA '90 took affect. This has resulted in RetroDUR taking on a new face. No longer are we performing activities such as drug-to-drug interactions or maximum/minimum dose, as these types of checks can be done

- On slide 9, the Board was reminded that the Kentucky RetroDUR activities have traditionally been conducted via the lettering process rather than face-to-face or telephonically due to the large Medicaid population.
- It was noted that medical claims data, such as office visits, diagnosis codes, and ED visits, from the MMIS vendor (HP) are loaded into the system that produces the RetroDUR profiles. Therefore, the clinical reviewer does have that data available at the time of profile review.
- The Board was reminded that these medical claims data are not as current as pharmacy claims data due to the lag time associated with medical claims billing.
- The Board was also reminded that we would not have access to Passport (KY's MCO) claims data. When we report data, we are only reporting on fee-for-service Medicaid recipients.

B. Population Statistics (slides 12-14)

- On slide 12
 - It was noted that the population reported here may vary slightly from other reports due to the methodology used. Some members may have only been on the rolls a few days of the quarter, so this data will never be exact.
 - The Board was informed that Kentucky Medicaid has divided its population into children and adults based on age. A member is considered a child until their 19th birthday. At 19 years and 1 day, they are considered an adult.
 - These numbers do include the KCHIP population.
- On slide 13, it was noted that the average paid amount per claim has gone down 1Q2010 versus 1Q2009, likely due to some block buster drugs going generic such as topiramate and adopting new guidelines published by the American Academy of Pediatrics for the appropriate utilization of Synagis®.

C. Utilization Data

- Total Population (slides 16-19)
 - On slide 16
 - It was noted that data was compared 1Q2010 to 1Q2009 so that seasonal variances in drug utilization can be taken into account.
 - SSRI utilization increased from this time last year resulting in it ranking 10th. Aspirin utilization decreased compared to this time last year resulting in it ranking 11th.
 - On slide 17
 - It was noted that Atypical Antipsychotics cost Medicaid the most. This is probably unique to Medicaid when compared to commercial payers; however, this is the top class for all Medicaid programs across the country.
 - It was pointed out that PPI cost is still on the rise, and

- Synagis[®] was ranked 6th last year and has dropped to 12th this year.
 - On slide 18
 - It was noted that most of the drugs were generics. Singular[®] is the only drug that Kentucky Medicaid (KYM) truly considers a brand.
 - Prilosec OTC[®] is considered a generic because the cost of that drug is actually less expensive than the generic products net of CMS and supplemental rebates. The generic will deny at POS for prior authorization and the pharmacy will receive a supplemental message informing the dispensing pharmacist that brand is preferred.
 - On slide 19
 - Synagis[®] was the top most expensive drug 1Q2009; however, this year it has dropped to 5th. The Board was reminded that the American Academy of Pediatrics published new guidelines which narrowed the population targeted for RSV prophylaxis and the RSV season was a month shorter this year. By following these guidelines, we have been able to save quite a bit of money without an increase in hospitalization for RSV.
 - It was also noted that all drugs on this slide are branded products.
 - Prior approval criteria were placed on Suboxone[®] in February of 2010, and the utilization of this drug keeps rising. This time last year Suboxone[®] was the 19th most expensive drug, this year it is 9th.
 - It was noted that the PA criteria for Suboxone[®] does not allow for use for pain, and the prescriber must have a Drug Addiction Treatment Act waiver and must agree to query KASPER monthly.
 - The Board asked if the hospitalization costs have decreased since more patients are utilizing Suboxone[®] on an outpatient basis compared to utilization of methadone on an inpatient basis. First Health will try to work with DMS to get that data.
 - The possibility of adding quantity limits will be investigated as well as limiting the length of the prior approval and placing a therapeutic duplication prior approval if Suboxone[®] is being taken with another opiate.
 - It was noted that Crestor[®] is a preferred product, because the P&T committee felt that either Crestor[®] or Lipitor[®] should be preferred since studies have shown that these drugs lower LDL cholesterol more than simvastatin. There is not an edit in place to require patients to try simvastatin before Crestor[®]. The

- It was also noted that Adderall XR[®] is less costly to the Commonwealth net of all rebates than its generic equivalent. Once competition in the market place drives the cost of the generic down, we will switch and prefer the generic over the brand.
- Adult Population (age 19 and above) [slides 21-24]
 - On slide 22, Skeletal Muscle Relaxants dropped from the 9th most costly drug to the 18th most costly drug this year compared to last.
 - On slide 23, clonazepam is the 3rd most prescribed medication to adults. Could it be due to the fact that there are duration edits on other commonly prescribed benzodiazepines resulting in movement toward clonazepam to avoid the prior approval? It was noted that clonazepam is an adjunct therapy for anxiety with a shorter duration of action, and it is less likely to be addictive. This could be the reason for its high utilization.
 - On slide 24
 - It was noted that prior authorization criteria was placed on Lyrica[®] and Lidoderm[®] so they are not used first line for neuropathic type pain.
 - The Board was informed that the cost on all of these slides do NOT take CMS or supplemental rebates into account.
 - It was noted that all CMS and supplemental rebates are kept by the Commonwealth; First Health does not keep any portion of those rebates.
 - The only edits around the Atypical Antipsychotics are the need for appropriate diagnosis (via an ICD-9 override) and prior authorization required for multi-source branded products. It was noted that the increased utilization of Abilify[®] is likely due to the wide range of FDA-approved indications such as Major Depressive Disorder (MDD). A good activity that could be done in the future is to ensure that Abilify is being used as adjunct therapy for the treatment of MDD. Dose restrictions and therapeutic duplication edits may also help control utilization of Atypical Antipsychotics.
 - It was noted that First Health has the ability to do some ad-hoc type reporting. The Board is welcome to help us develop some queries to identify potential miss/over utilization.
- Child Population (ages 0 through 18) [slides 26-29]
 - On slide 27
 - First Health was asked to look at the utilization of Atypical Antipsychotics and drugs for ADHD in the following ages: <4, 4-8, 9-12 and 13-19 years of age.
 - It is very difficult to limit drugs to certain prescriber specialties due to the accuracy of the prescriber files. Additionally, many of the behavioral health drugs are prescribed by practitioners at Community Mental

- A new edit is going into place that will require prior authorization for more than 1 short-acting and more than 1 long-acting stimulant at the same time.
- Dr. Badgett discussed the Comprehensive Neurosciences program (CNS) which looked at the utilization of psychiatric drugs. The data are not ready but may be shared at a later date.
- On slide 29
 - It was noted that the payment amount for Synagis[®] went down significantly. This could be due to a less severe RSV season, and we could see those numbers increase next year. This cost does not include any doses given in the hospital.
 - It was noted that the utilization of Singulair is pretty high. It is possible that Singulair[®] is being used for allergies rather than Asthma.

D. Prospective Drug Utilization Review (ProDUR) [slides 31-32]

E. Review of Retrospective Drug Utilization Review (RetroDUR) Activities [slides 34-36]

F. Future DUR Activities (slide 37)

The following topics were chosen

- Polypharmacy defined as 10 or more systemically absorbed unique chemical entities.
 - The Commonwealth would like to do an activity around polypharmacy about every 6 months, which means it should be done this month. The criteria we used in the past were 24 or more medications, 3 or more pharmacies and 3 or more prescribers. The profiles were ranked by severity, and the top 800 profiles were reviewed for potential letters.
 - It was noted that this criteria would never catch anyone in a nursing home since they all get meds filled by the same pharmacy under the same prescriber.
 - KY does have a lock in program to force recipients to use the same pharmacy; however, this program is usually utilized to prevent narcotic abuse and diversion rather than to prevent polypharmacy.
 - If the patient uses Medicaid to pay for all their drugs, the same safety measures will be activated by the POS system as would by the pharmacy's internal software regardless of how many pharmacies the recipient uses for medications.
- Short-acting narcotics for more that 6 weeks with a diagnosis of headache or acute pain
- Benzodiazepine utilization in patients greater than 19 years of age without a diagnosis of seizures, anxiety, stress disorder or insomnia

The following data were requested for the next meeting:

- Group drug utilization/cost by disease state in addition to drug classes.
- Atypical Antipsychotics
 - Break down utilization by age group, <4, 4-8, 9-12, 13-19, adults
 - Give number of patients on 1, 2, 3, 4 or more atypicals as one time.
 - Break down utilization by diagnosis and drug.
- Number of patients on diabetes drugs, atypicals, and diabetes drugs plus an atypical antipsychotic.
- Look at Joint Commission on Accreditation of Healthcare Organizations (JCAHO) core measures and evaluate our prescribers' compliance.
- Break down utilization of drugs for ADHD by age group , <4, 4-8, 9-12, 13-19, adults
- Try to determine if hospitalization rates for addiction have decreased since adding PA criteria to Suboxone[®].

Future activities that may be developed:

- Activity surrounding Suboxone[®] utilization
- Plavix[®] and PPI drug-to-drug interaction
- Duration of Plavix[®] utilization
- Atypical antipsychotics with no metabolic monitoring
- Beta-agonists with no Asthma controller medication
- Ensure that Abilify[®] is being used as adjunct therapy for the treatment of MDD.

IV. Future Meetings Planning

- Members of the Board would like to investigate obtaining continuing education credit for this meeting.
- The Board will need to elect a Chair and Vice-Chair. Nominations should be emailed to Tina Hawkins (KMHawkins@magellanhealth.com), and the Board will vote and elect at the next meeting.
- Meetings will be the 2nd Thursday afternoon of the 2nd month of each quarter (February, May, August, November).
- The Board would like to have this meeting via Web cast in emergency situations only.
- Information about this meeting will be distributed to the Board members via email whenever possible.
- The Board would like to see data (preliminary slides) before meetings.
- A Conflict of Interest Statement was signed by Board members.

V. Future Meetings

- August 12, 2010
- November 4, 2010

VI. Meeting Adjourned

VII. Collection of Travel Vouchers and Financial Document