MISSISSIPPI DIVISION OF MEDICAID
DRUG UTILIZATION REVIEW (DUR) BOARD
MINUTES OF THE FEBRUARY 19, 2013 MEETING

DUR Board Members:	Present	Absent
Allison Bell, Pharm.D.	✓	
Logan Davis, Pharm.D.	✓	
Edgar Donahoe, M.D.		✓
Lee Greer, M.D.		✓
Antoinette M. Hubble, M.D.	✓	
Sarah Ishee, Pharm.D.		✓
Cherise McIntosh, Pharm.D.	✓	
Mark Reed, M.D. **(Chair)**	✓	
Sue Simmons, M.D.	✓	
Dennis Smith, R.Ph.	✓	
Cynthia Undesser, M.D.		✓
Vicky Veazey, R.Ph.	✓	
Total	**8**	**4**

Also Present:

DOM Staff:
Shannon Hardwick, R.Ph., DOM Clinical Pharmacist, DUR Coordinator; Terri Kirby, R.Ph., DOM Clinical Pharmacist

MS-DUR Staff:
Kyle Null, Pharm.D., Ph.D., Clinical Director; Ben Banahan, Ph.D., Project Director

Xerox Staff:
Leslie Leon, Pharm.D.

Visitors:
Darlene Bitel, Shire US, Inc.; Jason Norman, Teva Pharma; Juan Trippe, Reckitt Benckiser; Hope Berry, Forest Labs; Dan Barbera, Lilly; Brian Berhow, Sunovion; Ian Clarke, IPSEN; Callista Goheen, Medimmune

Call to Order: Dr. Mark Reed, Chairman of the Board, called the meeting to order at 1:56 pm. Dr. Reed asked for a motion to accept the minutes from the meeting of November 15, 2012. Dr. Hubble made a motion to accept the minutes with a second from Dr. Simmons. All voted in favor of the motion.

Resource Utilization Review:
Dr. Null noted that no special issues have emerged with respect to the resource utilization during the last three months. He mentioned the typical seasonal decline in utilization during the month of December and noted that the decrease in utilization was more pronounced due to beneficiary movement into the managed Medicaid plans on December 1, 2012.

Pharmacy Program Update:
Ms. Hardwick thanked the Board for being flexible about the change in the meeting date to the American Drug Utilization Review Society (ADURS) meeting in Arizona that she, Dr. Null and Dr. Banahan would be attending on the regularly scheduled meeting date. She noted that Ms. Clark is speaking at a conference and will be present at the next Board meeting. Ms. Hardwick presented the Board the new DOM logo and also provided the Winter Medicaid Pharmacy Newsletter.

Dr. Banahan provided update on Suboxone utilization, noting that many Suboxone beneficiaries shifted into MS-CAN following the legislative action which moved select beneficiaries beginning on December 1, 2012. Dr. Banahan mentioned that many point of sale (POS) claim denials were due to lack of a diagnosis in the medical records. Pharmacists are able to input a diagnosis code at the POS and communicating that information to pharmacists has reduced the number of resubmission attempts. Dr. Banahan noted that the purpose of moving Suboxone users into SmartPA was to reduce the manual prior authorization (PA) burden on DOM's staff in addition to encouraging prescribers to titrate beneficiaries off of therapy.

New Business:
Shift to MS-CAN
Dr. Banahan provided an overview of the analysis conducted for DOM on how increased enrollment in MS-CAN might affect pharmacy services. Dr. Banahan noted that the most recent shift of beneficiaries to MS-CAN would significantly reduce prescription volume for fee-for-service Medicaid and the MS-CAN population was slightly sicker, having more conditions and comorbidities, compared to the FFS population. Mr. Smith inquired about the 2013 MS-CAN projections, specifically about how the data were extrapolated. Dr. Banahan noted that the beneficiaries were projected to move into MS-CAN based on their FFS Medicaid category of eligibility and that the projections did not account for differences in MS-CAN plan offerings, projected utilization changes, preferred drug list or clinical edit differences between the FFS and MS-CAN plans. Dr. Davis asked why the medical costs (Table 3, page 47) were relatively flat for MS-CAN beneficiaries between 2012 and the projected 2013 expenditures, whereas the prescription costs dropped for MS-CAN. Dr. Banahan noted that projection just assigns FFS beneficiaries and their corresponding costs into MS-CAN, so the expenditures are not reflective of operational differences between the two programs. Additionally, Dr. Banahan noted that the changes in prescription expenditures costs would be more responsive to changes in comorbidity mix than medical expenditures, partially because the sicker patients typically utilize more monthly medications that may be more costly, but the average monthly prescriber visits do not necessarily increase.

Suboptimal Asthma Control
Dr. Null reviewed the suboptimal asthma control analysis. Two quality measures were used in the analysis: "suboptimal asthma control" (SAC) and "absence of controller therapy" (ACT). The criteria for these measures were taken from the measures developed by the Pharmacy Quality Alliance and endorsed by the National Quality Forum. Dr. Null described how the measures have been improving slowly between 2008 and 2013. Dr. Null reported on the North Carolina Medicaid program related to asthma control.

Dr. McIntosh described non-branded educational materials that are available that may be used as a part of education initiatives targeted to providers for patient education. Dr. Reed asked that additional information be brought to the next meeting about the North Carolina edit for consideration by the Board. Dr. Davis asked if anyone knew what MS-CAN programs were doing about clinical edits related to LABAs and rescue inhalers. Dr. Hubble commented that educational materials for patients would be great, noting that the educational materials would help providers meet meaningful use requirements for

electronic health records (EHR) systems. Providers need to give patients materials and need to have URL links in order to incorporate it into their EHR system. Dr. McIntosh pointed out educational materials in a generic template could be modified to be specific to the clinic using the materials. Mr. Smith asked about the need for pharmacy education materials and commented that he did not believe that sending educational materials to pharmacies related to the asthma quality measures may not be the best use of resources. Dr. McIntosh indicated that community pharmacies could play a role in making sure patients are filling and using their controller medicines when needed, but providing education materials sent from Medicaid may not be useful for pharmacists. Mr. Smith pointed out that often there has to be a hard edit that prevents payment in order to be sure pharmacy is involved in helping meet the quality measure. Ms. Kirby discussed issues related to how such an edit could be implemented; including pharmacist overrides by inputting diagnosis codes at the POS for exercise-induced or cough-variant asthma.

Zolpidem Drug Safety Communication
Dr. Null reviewed the FDA drug safety communication for lower recommended doses of zolpidem, noting that most females on the immediate-release are taking the 10mg dose. Because this is a safety communication, a hard edit has already been implemented that will deny a 10mg dose for females at the POS. Dr. Null asked what would be a reasonable criteria for PA when requested. Dr. Simmons noted that most often it will be patient reporting failure on 5mg. Dr. Simmons noted that finding another option may be difficult in that sedation effects of other medications that could be used may be worse. Dr. Smith asked whether there was any information provided by the FDA that would indicate appropriate clinical situations that would warrant a female to be on a higher dose of zolpidem. Dr. Null replied that no information indicating exceptions was provided in the FDA drug safety communication.

Dr. McIntosh pointed out that if it is a safety issue DOM should not approve zolpidem 10mg or equivalent doses for females. Dr. Simmons and Mr. Smith agreed that if the FDA does not recommend an alternative or situations where 10mg would be acceptable, then DOM should recommend a change to another therapy but not have criteria for approving PAs. Dr. Reed summarized the recommendation that DOM not cover the 10mg dose for females. Dr. Null noted that this month's education mailing will be directed at current users of 10mg for females notifying them about hard edit and restriction. Mr. Smith pointed out that rejection message should make it clear that other medication will be needed and not to request a PA. The motion was passed unanimously.

Dextromethorphan and Codeine-Containing Cough Syrup Utilization
Dr. Null reviewed the results from the MS-DUR analysis on dextromethorphan and codeine-containing cough syrup. Dr. Null noted that other states had implemented edits to limit potential misuse and abuse, pointing out that Idaho Medicaid had recently implemented a 2 prescription fill of 120ml per beneficiary in a rolling 6 month period. Dr. Null noted that most use of these medications occurred in patients 18 and under. Dr. Reed pointed out that older kids may need larger quantities, so an quantity edit of 120ml may leave some without medication who legitimately need larger quantities. Dr. Null mentioned that the Idaho Medicaid limits were used as an example in this analysis and that MS-DUR was not recommending those limits be placed. Dr. Reed also noted the need to be able to single out use for cough and also include hydrocodone. Dr. Hubble reported on a recent patient that overdosed on a cough medication. Dr. McIntosh indicated that for adults they dispense 240ml and often give one refill. Dr. Null commented that based on the data, there did not appear to be a real problem and the Board did not believe this needed to be examined further.

Other Business

Exceptions monitoring recommendations were taken as a block and were unanimously approved.

Next Meeting Information:
Dr. Reed announced next meeting date is May 16, 2013 at 2:00p.m. and thanked everyone for making the effort to attend the DUR Board meeting in order to have a quorum. The meeting adjourned at 3:56 pm.

Submitted,
MS Evidence-Based DUR Initiative, MS-DUR