



**MEDI-CAL DRUG USE REVIEW BOARD
MEETING MINUTES
Tuesday, November 25, 2014
9:30 a.m. – 12 p.m.**

**Location: Xerox State Healthcare, LLC
840 Stillwater Road
Monterey Room
West Sacramento, CA 95605**

Topic	Discussion
1) WELCOME/ INTRODUCTION	<ul style="list-style-type: none"> • The meeting was called to order by the Chair of the Board, Dr. Andrew Wong • Board members present: Drs. Marilyn Stebbins, Timothy Albertson, Janeen McBride, Patrick Finley, Randall Stafford, and Andrew Wong • Board members absent: Dr. Robert Mowers • Pauline Chan, RPh and Michael McQuiddy, PharmD were present from DHCS Pharmacy Benefits Division. • Ivana Thompson, PharmD (Xerox) announced that the DUR Board meeting is being recorded and reminded everyone to sign in.
2) CALL TO ORDER/ REVIEW AND APPROVAL OF SEPTEMBER, 2014 MINUTES	<p>The Medi-Cal Drug Use Review Board (the "Board") reviewed the September 16, 2014 minutes. Dr. Wong and Dr. Stafford noted minor typographical errors and motioned that the minutes be approved with these changes. There was no discussion. The Board voted unanimously to approve the minutes with this change.</p> <p>ACTION ITEM: Incorporate Dr. Wong and Dr. Stafford's edit into the minutes and post to the DUR website.</p>
3) OLD BUSINESS	<p>a. Review of Action Items from Previous Board Meeting:</p> <ol style="list-style-type: none"> i. Section 20 DUR Manual edits: Dr. Thompson reported these edits were submitted and the edits are reflected in the current version of the DUR manual, which is available on the Medi-Cal website. ii. DUR Annual Report: Ms. Chan stated the DUR Annual Report for FFY 2013 had been submitted to the Centers for Medicare & Medicaid Services (CMS) on September 26, 2014, and she had received an email from CMS confirming receipt. The deadline for submission was September 30, 2014. iii. Morphine milligram equivalency document revisions: <ul style="list-style-type: none"> • At the last meeting, the Board requested that the DUR Workgroup reach out to other state agencies for their input on morphine milligram equivalent daily dose (MEDD). Ms. Chan contacted the Medical Board of California (MBC), as they were updating their policy on pain management. • Since feedback from MBC was not received in time for inclusion at the November meeting, a separate email was sent to the Board with the MBC policy. Ms. Chan asked if the Board wanted to comment on this now or if this topic should be added to the next meeting agenda. Dr. Wong suggested this item be added to the meeting agenda in February. • Dr. Thompson stated that because there is no DHCS policy regarding MEDD, the DUR Workgroup had discussed possibly drafting a DUR educational bulletin that could include a review of the literature on MEDD and how other states and agencies use MEDD. • Dr. Stafford suggested we seek input from the California Division of Worker's Compensation (DWC) since they also have draft guidelines regarding MEDD. Dr. Stafford sees the need for better coordination between agencies. Dr. Thompson stated that she will be working with State resources to establish a contact and will

	<p style="text-align: center;">follow-up with the DWC.</p> <p>ACTION ITEM: The DUR Board recommended to contact the California Division of Worker's Compensation and to present the revised morphine milligram equivalency document at the February DUR Board meeting will be submitted to DHCS.</p> <p>iv. Tramadol educational outreach letter intervention: Dr. Thompson reported the letters were sent to providers at the end of October and thus far all feedback received has been very positive. Dr. Thompson reported that a formal report regarding the outcomes of this intervention will be presented to the DUR Board at the next DUR Board Meeting in February.</p> <p>v. Educational bulletin on appropriate prescribing of antipsychotics to children and adolescents (publication in March 2015): Dr. Shalini Lynch (UCSF) reported that UCSF is beginning to draft this bulletin for publication in 2015. Dr. Stafford asked for more information on what the bulletin will cover so Dr. Lynch suggested reviewing the minutes from the September DUR Board Meeting where the following topics were proposed:</p> <ul style="list-style-type: none"> • An evaluation of the Medi-Cal data using a new HEDIS 2015 measure (technical specifications will be available in November 2014) that assesses the percentage of children and adolescents who are on two or more antipsychotic medications for an extended period of time. • A description of the FDA-approved product labeling for the appropriate use of atypical antipsychotics in patients < 18 years of age, including information about the potential adverse reactions and risks associated with antipsychotic therapy. • A summary of current treatment guidelines, which endorse a trial of antipsychotics as a second-line treatment, after first-line psychosocial treatments, such as parent and child skills training, have been tried. • A statement of the current lack of evidence for using multiple, concurrent antipsychotics, especially among children and adolescents. • Information regarding the new Medi-Cal restriction, effective October 1, 2014, which will require an approved <i>Treatment Authorization Request</i> for any antipsychotic medication prescribed for Medi-Cal beneficiaries <18 years of age. <p>vi. Educational bulletin on folic acid underutilization (publication in December 2014): Ms. Fingado reported the DUR Workgroup discussed splitting this bulletin into one alert focused on folic acid use in women of child-bearing age and one bulletin on concomitant use of folic acid among beneficiaries with paid claims for methotrexate due to rheumatoid arthritis. The alert is scheduled to publish in December and the bulletin will publish in January or February of 2015. Final versions will be presented to the DUR Board at the next DUR Board Meeting in February.</p>
<p>4) NEW BUSINESS</p>	<p>a. Board Activities: Dr. Finley reported his study looking at depression in the perinatal population has been accepted for publication. He said it is slated to be published in the February issue of CNS Spectrums, an international peer-reviewed journal in psychiatry. He will send Amanda the link as soon as it is published online so she can submit a DUR Educational Alert to publications with a link to the study.</p> <p>b. Quarterly Report – 3Q2014 (July – September 2014): Amanda Fingado (UCSF) presented the DUR quarterly report for the 3rd quarter of 2014. She reported that while the eligible fee-for-service beneficiaries increased from both the prior quarter (increased by 5%) and prior-year quarter (increased by 15%), there was not a corresponding increase in overall utilization. When utilization data from 2014 Q3 was compared to the prior quarter, both total utilizing beneficiaries and total paid claims decreased by 2% and a comparison of 2014 Q3 to the prior-year quarter showed a 5% increase in total utilizing beneficiaries and a 1% decrease in total paid claims.</p> <p>c. Review of Physician Administered Drugs (PADs) – 2Q2014 (April – June): Ms. Fingado showed a summary of paid claims for physician-administered drugs for the 2nd quarter of 2014, which includes paid claims with dates of services between April 1, 2014, and June 30, 2014. These data were presented in three tables: 1) the top 20 drugs by total reimbursement paid, 2) the top 20 drugs by utilizing beneficiaries, and 3) the top 20 drugs by reimbursement paid to pharmacies per utilizing beneficiary. HCPCS codes have been</p>

added to all three tables to provide more information. Ms. Fingado reported increases in both total utilizing beneficiaries(14% increase) and total paid claims (16%) from 1Q2014 to 2Q2014 in the category “PHYSICIAN ADMINISTERED DRUG – NDC NOT REQUIRED,” which can be attributed to large increases in vaccine for diphtheria/pertussis/tetanus vaccine during 2Q2014.

d. Prospective DUR presented by Amanda Fingado (UCSF)

i. Review of DUR Alerts for New GCNs in 3Q2014 (July – September 2014)

- At each DUR Board meeting, a list of new GCN additions with prospective DUR alerts turned on other than ER and DD will be provided to the DUR Board for review. For this meeting, the DUR Board reviewed the alert profiles of these six GCNs:
 - GCN #072501: FLUPHENAZINE DECANOATE, Drug-Disease (MC), Additive Toxicity (AT), Therapeutic Duplication (TD), Ingredient Duplication (ID), Underutilization (LR), High Dose (HD), Low Dose (LD)
 - GCN #072587: CANAGLIFLOZIN/METFORMIN HCL, Drug-Disease (MC), Therapeutic Duplication (TD), High Dose (HD), Low Dose (LD)
 - GCN #072589: CANAGLIFLOZIN/METFORMIN HCL, Drug-Disease (MC), Therapeutic Duplication (TD), High Dose (HD), Low Dose (LD)
 - GCN #072677: CANAGLIFLOZIN/METFORMIN HCL, Drug-Disease (MC), Therapeutic Duplication (TD), High Dose (HD), Low Dose (LD)
 - GCN #072678: CANAGLIFLOZIN/METFORMIN HCL, Drug-Disease (MC), Therapeutic Duplication (TD), High Dose (HD), Low Dose (LD)
 - GCN #072501: NALTREXONE HCL/BUPROPION HCL, Drug-Allergy (DA), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), Underutilization (LR), High Dose (HD), Low Dose (LD)
- A motion was made – and seconded – to accept these alert profile recommendations. There was no discussion. The motion was carried.

ii. Review of DUR Manual: Section 35

- Ms. Fingado reported that Section 35 of the DUR Manual is in need of major revisions due to the addition of new target drugs and changes in criteria over time. Because of the difficulty of keeping Section 35 current as weekly real-time updates to the electronic system occur, Ms. Fingado proposed revisions to the format of Section 35 to replace existing data with a single table, organized by target drug and alert status. Ms. Fingado stated that the revisions may help any providers performing manual prospective DUR and would allow quick access to the current list of prospective DUR alerts in a more user-friendly format.
- A motion was made – and seconded – to accept these revisions to Section 35. There was no discussion. The motion was carried.

ACTION ITEM: The DUR Board recommendations to revise Section 35 of the DUR Manual will be submitted to publications for DHCS approval.

e. Retrospective DUR presented by Dr. Shalini Lynch (UCSF):

i. Review of Retrospective DUR Criteria: Metformin, ACE Inhibitors/ARBs, Statins, and Concomitant Use of Antipsychotics

- Dr. Lynch reported that antipsychotic medications are an important component in the medical management of many patients with a variety of psychotic disorders and severe behavioral disturbances and since the introduction of atypical antipsychotics, or second-generation antipsychotics, the use of these medications has soared. However, although the atypical antipsychotics have many notable benefits compared with their earlier counterparts, their use has been associated with potentially serious adverse metabolic effects, including weight gain, hyperlipidemia, and glucose intolerance. Studies suggest these antipsychotic-induced metabolic side effects can increase both the 10-year risk of cardiovascular disease and

mortality from cardiovascular disease.

- Dr. Lynch described one study of Medi-Cal beneficiaries with a diagnosis of schizophrenia found the average monthly prevalence of second-generation antipsychotic drug polypharmacy increased from 3.3% in 1999 to 13.7% in 2004 ($p < .001$), resulting in an annualized antipsychotic medication cost per beneficiary increase of 27%, consistent with reports from other Medicaid populations. This same study also found that among those beneficiaries who were continuously enrolled in Medi-Cal for at least one year and who had a paid claim for a second-generation antipsychotic drug, the percentage receiving continuous second-generation polypharmacy increased from 5.1% in 1999 to 14.4% in 2004 ($p < .001$). Additional research in the Medi-Cal population has shown that the increased use of second-generation antipsychotics was not accompanied by improved adherence to medications or reductions in psychiatric admissions.
- During a one-year period, Dr. Lynch reported that in the Medi-Cal fee-for-service population there were 170,612 unique beneficiaries with a paid claim for a statin, angiotensin converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB) drug, or metformin. Among these beneficiaries, there were a total of 16,549 (10%) who had a paid claim for an atypical antipsychotic during the measurement year. Almost one-quarter of beneficiaries with a paid claim for an atypical antipsychotic ($n=3,641$; 22%) had claims for more than one atypical antipsychotic during the measurement year, indicating the possibility of second-generation antipsychotic polypharmacy.
- Ms. Fingado described the analytical limitations of evaluating concomitant use of antipsychotic medication (a carved-out drug) and other non-carved out drugs (like statins), as it is not easy to determine the denominator of beneficiaries with a paid claim for antipsychotic medication that also have full pharmacy claims data available. Ms. Fingado reported that Ms. Chan agreed to have DHCS provide database assistance in order to quickly identify Medi-Cal beneficiaries who were continuously eligible in the Medi-Cal fee-for-service program for at least 11 of the last 12 months and who had at least one paid claim for a second-generation antipsychotic medication during the last 12 months.
- Dr. Lynch proposed the following recommendations as the next steps for this review:
 - Evaluate the prevalence of second-generation antipsychotic monotherapy and polypharmacy in the Medi-Cal fee-for-service population, including all Medi-Cal beneficiaries continuously eligible in the Medi-Cal fee-for-service program (for at least eleven of the last twelve months) who have at least one paid claim for a second-generation antipsychotic medication during the last twelve months
 - Use of the medical claims data, including primary and secondary ICD-9 codes, to evaluate whether the use of second-generation antipsychotic medication in this population is for FDA-approved indications
 - Use of the medical claims data to determine prevalence of co-morbid medical conditions, including diabetes, cardiovascular disease, and others, as recommended by the DUR Board
 - Evaluate concomitant use of other drugs, as recommended by the DUR Board
 - Determine annual metabolic monitoring rates among beneficiaries who have continuous use of second-generation antipsychotic medications
 - Evaluate concomitant use of statins, angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blocker (ARB) drugs, and metformin, stratified by second-generation antipsychotic monopharmacy or polypharmacy
- A motion was made – and seconded – to agree with the recommendations to update the retrospective DUR review on this topic, as outlined by Dr. Lynch. The motion was carried.

ACTION ITEM: The DUR Board recommendations for revisions to the retrospective DUR review on the use of metformin, ACE inhibitors/ARBs, and/or statins among beneficiaries with at least one paid claim for a second-generation antipsychotic medication will be submitted to DHCS.

- ii. Review of Retrospective DUR Criteria: Benztropine Mesylate and Concomitant Use of Antipsychotics
- Dr. Lynch reported that anticholinergic agents including benztropine and trihexyphenidyl are often prescribed to prevent or treat antipsychotic-induced extrapyramidal symptoms (EPS), including tremor, rigidity, bradykinesia, and acute dystonia. However, the need for continued therapy with anticholinergics is frequently not reassessed and many patients remain on them for several years, and even decades. Prescribers may be reluctant to discontinue anticholinergics, even when patients are prescribed second- or third-generation antipsychotics, which are less likely than first-generation antipsychotics to induce EPS.
 - Dr. Lynch stated that paid claims for benztropine and trihexyphenidyl with dates of service between July 1, 2013, and June 30, 2014, were reviewed for Medi-Cal beneficiaries. Across all age groups there were 34,813 unique beneficiaries identified with a paid claim for benztropine and/or trihexyphenidyl during this one-year period. The majority of these beneficiaries (n=32,087; 92%) had a paid claim for benztropine and 416 (1%) beneficiaries had at least one paid claim for benztropine and trihexyphenidyl. To determine if anticholinergic use was primarily short-term, the total number of paid claims was calculated for each beneficiary and over half of beneficiaries had six or more paid claims during the same one-year period, suggesting continuous therapy with anticholinergic agents.
 - Dr. Lynch reported that further evaluation was conducted to determine if anticholinergic use was linked to concomitant use of antipsychotics. Pharmacy claims data for all 34,813 beneficiaries was reviewed for concomitant use of antipsychotics. Among those beneficiaries with a paid claim for an anticholinergic medication, a total of 11,679 (34%) beneficiaries also had at least one paid claim for an antipsychotic medication during the same time period (Table 2). Because of the differences in clinical recommendations for anticholinergic use, the claims data were stratified by first-, second-, and third-generation antipsychotics. Of note, the majority of beneficiaries (n=6,489; 56%) had a paid claim for more than one antipsychotic medication.
 - Dr. Albertson stated that it was difficult to determine from the current presentation of the claims data whether or not there was indeed an issue with overuse of anticholinergic agents in this population. He suggested it would be useful to stratify the data by age group and to include the total number of beneficiaries on each of the antipsychotic drugs so efforts could be focused on areas where the percentage of beneficiaries on a potentially inappropriate concomitant anticholinergic drug would be the highest. Drs. Stafford and Dr. Finley agreed there was a need for further analysis on this topic before the decision could be made about the value for further education on this topic, either through an educational alert, bulletin, and/or letter to providers. Ms. Fingado agreed to revise the tables and report additional data elements, per DUR Board suggestions.
 - A motion was made – and seconded – to recommend further analysis of these data. The motion was carried without additional discussion.

ACTION ITEM: The DUR Board recommendations for revisions to the retrospective DUR review on the use of benztropine mesylate among beneficiaries with at least one paid claim for an antipsychotic medication will be submitted to DHCS.

- iii. Review of Retrospective DUR Criteria: New Additions to the Medi-Cal List of Contract Drugs during FFY 2013
- Dr. Lynch presented utilization data on a total of 19 new prescription medications added to the Medi-Cal List of Contract Drugs during the Federal Fiscal Year 2013 (between 10/1/12 and 9/30/13). Utilization data (total number of paid claims and utilizing beneficiaries with at least one paid claim) were reviewed for each of these 19 drugs during the period between 10/1/11 and 9/30/14 (to allow at least 12 months of utilization data before and after the drug was added to the Medi-Cal Contract Drug List. The following nine new additions did not have graphical representations of the data presented due to low utilization (< 10 utilizing

beneficiaries during all of the months reviewed):

- ado-trastuzumab (added February 25, 2013)
- afatinib (added September 3, 2013)
- alogliptin and alogliptin/metformin (added August 1, 2013)
- bosutinib (added October 1, 2012)
- dabrafenib (added June 11, 2013)
- ponatinib (added January 7, 2013)
- simvastatin/sitagliptin (added October 1, 2012)
- trametinib (added June 17, 2013)
- Of the remaining 10 drugs, six drugs had less than 100 paid claims and utilizing beneficiaries during August 2014 (the most recent month with complete claims data available):
 - linagliptin/metformin (added October 1, 2013)
 - boceprevir (added January 1, 2013)
 - telaprevir (added January 1, 2013)
 - ivermectin (added July 1, 2013)
 - naloxone (added July 1, 2013)
 - rivastigimine (added July 1, 2013)
 - alogliptin/pioglitazone (added August 1, 2013)
 - ticagrelor (added August 1, 2013)
- Dr. Lynch noted that the diphtheria/pertussis/tetanus vaccine was added on August 1, 2013 and has posted increasing utilization during the past year, with over 400 paid claims and utilizing beneficiaries in August 2014 (from less than 100 paid claims and utilizing beneficiaries in August 2013).
- Finally, Dr. Lynch reported utilization for dolutegravir (added August 23, 2013), which has been steadily increasing each month since August 2013 and now has over 1400 utilizing beneficiaries. Due to the high cost of HIV antiretroviral medications drugs it was suggested by Ms. Fingado that we may wish to review pharmacy and medical claims data for the entire class of HIV antiretroviral medications, including utilization, a summary of demographic data of utilizing beneficiaries, and a summary of ICD-9 codes for these beneficiaries. Ms. Chan reported that Medi-Cal managed care plans have also seen an increase in claims across HIV antiretroviral medications and have reached out for collaboration in evaluating use in this class of drugs.
- Dr. McBride asked if it was possible for beneficiaries to receive duplicate claims for these expensive medications and we would not know about some of the claims because they fall under a capitated plan. Dr. McBride clarified her question by providing an example she sees regarding the use of behavioral health medications. It was unclear to the group whether or not Medi-Cal would see paid claims for medications administered by county behavioral health clinics or specialty mental health clinics that are paid a per-member per-month rate. Dr. McBride thought that there are cases where Medi-Cal managed care plans do not have non-capitated drugs paid through the Medi-Cal fee-for-service program.
- A motion was made – and seconded – to investigate DHCS coverage of non-capitated drugs among Medi-Cal managed care plans and whether or not there are paid claims for these drugs that do not appear in the Medi-Cal fee-for-service claims database.

ACTION ITEM: The DUR Board recommendations for a DHCS summary of coverage of non-capitated drugs – specifically, whether or not paid claims for all HIV antiretroviral medications and psychotropic medications are included in the SURS claims database – will be submitted to DHCS.

- In addition a motion was made – and seconded – to write a retrospective DUR review on the entire class of HIV antiretroviral medications. Ms. Chan thought this topic would be a good test for collaboration between the Medi-Cal Managed Care and Fee-for-Service programs. The review would include all medical and pharmacy claims data for utilizing beneficiaries and a summary of the DUR alerts for these

drugs. It was agreed that because this collaboration between the programs has not been attempted previously by the DUR team, this review could be scheduled for presentation at the May 2015 DUR Board meeting to allow additional time for analysis.

ACTION ITEM: The DUR Board recommendations for a retrospective DUR review on HIV antiretroviral medications (in collaboration with the Medi-Cal Managed Care program) will be submitted to DHCS.

f. Review of DUR Publications presented by Dr. Shalini Lynch (UCSF)

i. DUR Educational Alert (September, 2014): 2014 Immunization Updates: Influenza, Tdap, and HPV

- Dr. Lynch reported this was the first year where we did a summary of immunization updates in one alert, as suggested by the DUR Board. In collaboration with the California Department of Public Health Immunization Branch, the following three topics were presented in the alert:

1. Influenza Vaccine:

- The federal Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccine for all patients six months of age and older who do not have contraindications
- The 2014 – 2015 influenza vaccine composition is the same as in the 2013 – 2014 season
- There is now a preference for the use of live attenuated influenza vaccine (LAIV), when immediately available, for healthy children aged two through eight years without contraindications or precautions to the vaccine.

2. Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccine (Tdap):

- In October 2012, ACIP updated their recommendations for the use of Tdap among all pregnant women. Tdap is recommended during **each** pregnancy, optimally between 27 and 36 weeks gestation.
- California is currently experiencing a pertussis epidemic. As of September 15, 2014, a total of 8,278 cases of pertussis with onset in 2014 have been reported for a state rate of 21.7 cases per 100,000 population. Infants two months of age and younger are at the greatest risk of hospitalization and death from pertussis.
- Among confirmed cases of pertussis in California with onset during 2014, there were 165 cases less than four months of age where the mother's vaccination history was available. Of those, 135 mothers (82 percent) had not received Tdap between 27 – 36 weeks gestation.

- Dr. Albertson asked if general guidelines for Tdap vaccination were included in the alert. Ms. Fingado stated they were not included (beyond links to complete ACIP recommendations) and that this was an oversight. The Board agreed that future vaccine annual updates the alerts should include general guidelines on vaccine administration for each topic of interest.

3. Human Papillomavirus (HPV) Vaccine:

- The Centers for Disease Control and Prevention (CDC) reported data from the 2007 – 2013 National Immunization Survey-Teen and national post-licensure vaccine safety data
- California's rate for ≥ 1 dose of any HPV vaccine was 68% in 2013 for adolescent girls and 51% in 2013 for adolescent boys (increased from a rate of 29% in 2012)
- The survey found that 33% of parents of girls and over 50% of parents of boys reported their child's clinician had not recommended HPV vaccination for their child

ii. DUR Educational Bulletin (October, 2014): Clinical Review: Use of Nicotine Replacement Therapy for Smoking Cessation

- Dr. Lynch reported that nicotine replacement therapy (NRT) has been shown to reduce the severity of nicotine withdrawal symptoms and that all commercially available NRT formulations increase the odds of quitting by 1.5 to 2-fold. Furthermore, some data suggest that NRT combination therapy, which includes the patch once daily plus a short-acting NRT as needed, is more effective than single agent NRT. However, individual, group, and/or telephone counseling should always be recommended as adjunctive therapy for all patients using NRT medications.
- Dr. Lynch reviewed an evaluation of the use of NRT in the Medi-Cal fee-for-service population between 8/1/13 and 7/31/14 that found 5,855 beneficiaries had at least one paid claim for a smoking cessation drug during this time period, with the majority of those beneficiaries using the nicotine patch (n = 4,344; 74%). Use of gum, lozenge, oral inhaler, and nasal spray was much lower (n = 95; 2%). This is likely due to the fact that prior to July 1, 2014, the nicotine patch was the only NRT formulation available without an approved *Treatment Authorization Request* (TAR). However, starting on July 1, 2014, the gum and lozenge NRT formulations are now on the Medi-Cal List of Contract Drugs, and therefore, an approved TAR is no longer required for these medications.
- Dr. Lynch stated that the bulletin included several strategies for health care providers to improve tobacco quit rates, including the following:
 - A description of two brief interventions (less than ten minutes): the 5A's and the 5R's
 - Recommendations to providers for guidance on counseling and medications, including resources available through the California Smoker's Helpline, available at: <http://www.nobutts.org/medi-cal/> and the Rx for Change program, available at: <http://rxforchange.ucsf.edu>
 - Promotion of the Great American Smokeout on November 20, 2014

iii. Discussion/Recommendations for Future Bulletins: There were no additional discussions or recommendations for future bulletin topics.

g. Pharmacy Update:

- Ms. Chan described the following three new HEDIS® measures for 2015 that address safe and judicious use of antipsychotics in children and adolescents:
 1. Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)
 - The percentage of children and adolescents 1 – 17 years of age who were on 2 or more concurrent antipsychotic medications (concurrent is defined as at least 90 consecutive days during the measurement year)
 2. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)
 - The percentage of children and adolescents 1 – 17 years of age who had 2 or more antipsychotic prescriptions and had metabolic monitoring
 - With both of the following: at least one test of blood glucose or HbA1C and at least one test for LDL-C or cholesterol
 3. Use of First-line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)
 - The percentage of children and adolescents 1 – 17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment (psychosocial care in the 121 – day period from 90 days prior to the initial prescription start date through 30 days after the initial prescription start date)
 - Excludes those for whom first-line antipsychotic medications may be clinically appropriate (e.g. psychosis, schizophrenia, bipolar disorder)
- Ms. Chan stated that DHCS is in the process of conducting testing of these new measures and noted there are additional stratifications, including the following:
 - Age groups (1 – 5 years, 6 – 11 years and 12 – 17 years)
 - Managed care plans/FFS
 - Geographic/Regional
 - Foster care/non-foster care
 - Others
- Dr. Albertson asked if we can ask the managed care plans for the results of their HEDIS

measures to see how they're doing. Ms. Chan responded that not all HEDIS measures are included into their contracts. Integration into the health plans is ideal; however, since these are new measures, it may take some time for them to get integrated.

- Dr. Finley suggested looking at all children on antipsychotics, rather than only those on two or more agents. Ms. Chan agreed and Ms. Fingado indicated that this can be done for the article. Dr. Stafford asked if 2015 is a measure year or test year. Ms. Chan indicated that she would research and report back to the board.
- Ms. Chan also reported on the new restriction on antipsychotic medication for Medi-Cal beneficiaries 0 – 17 years of age, in which an approved *Treatment Authorization Request* (TAR) is required (effective October 1, 2014). Providers were asked to refer to the explanation of Code 1 restriction language in the Drugs: Contract Drugs List Introduction section of the Medi-Cal Pharmacy manual. Ms. Chan also reported on the following implementation challenges:
 - Providers: Coordination at hospital discharge and what type of information to submit as part of TAR
 - Pharmacies: Provision of 72-hour emergency supply of medications, uncertainty of whether TAR would be approved, and system issues with TAR submission
- Dr. Stafford asked if there are drugs in which the 72-hour emergency supply is frequently used. Ms. Chan indicated that all drugs that require a TAR are eligible for a 72-hour emergency supply, which is paid by Medi-Cal, regardless if the TAR is approved or denied.
- Ms. Chan also reported the following about the CDSS/DHCS QI Project:
 - Expert panel continues to meet on a quarterly basis, with the last meeting on November 20, 2014 and the next meeting on February 26, 2015
 - The clinical workgroup meets on a monthly basis. The next meeting is on December 2, 2014 and is a combined meeting with the data workgroup to develop outcome measures.
 - As previously reported, the clinical workgroup created draft guidelines for improving oversight and monitoring of psychotropic medication use for children and youth in foster care and developed the following four appendices to the guidelines:
 1. Appendix A – optimal prescribing standards (red flags)
 2. Appendix B – drug monitoring parameters
 3. Appendix C – addressing challenging and complex situations
 4. Appendix D – a quick guide to summarize the guideline key points
- Dr. Albertson suggested that Appendix D instead be named Executive Summary, since it is a summary of the findings and including it as an appendix may not garner as much attention as an executive summary might. Dr. Wong agreed that it should also go in front.
- Dr. Stafford suggested the Foster Care QI Project might be interested in reviewing the bulletin. Ms. Fingado reported that the first draft of the bulletin will be available for review in early February, before the Foster Care QI Project Clinical Workgroup meeting scheduled for February 19, 2015. Ms. Chan agreed this would be a good opportunity for collaboration and the Clinical Workgroup would have time to review the bulletin and provide feedback before the publication deadline in mid-March.
- Ms. Chan also reported that a frequently-asked questions (FAQ) document had been created and updated on November 12, 2014 regarding the TAR restriction on antipsychotic medications for the 0 – 17 population. The FAQ was developed based on the feedback on implementation challenges and included both prescriber and pharmacy FAQs:
 - Prescriber FAQs:
 - What information is needed to submit a TAR? Medi-Cal allows both prescribers and pharmacies to submit TARs
 - What information is required for off-label use? Information required is on an individual/case-by-case basis
 - Pharmacy FAQs:
 - Clarification of the miscommunication/misunderstanding that the 72-hour emergency supply is contingent on TAR approval

	<ul style="list-style-type: none"> ▪ Other general questions were answered, including complaints on TAR processing, the 1-800 number, and how to speak to a supervisor • Dr. McBride asked what percentage of TARs are approved. Ms. Chan answered that the information is not yet available but there was an increase in TAR volume of 19,000 in October compared to September. It is unknown whether this is attributed to the TAR restriction for atypical antipsychotics, but it is a factor. • Ms. Chan reminded the group that this is the first DUR Board meeting of Federal Fiscal Year 2015 and that the Board's goals and objectives are due for a review in February.
5) PUBLIC COMMENTS	None.
6) CONSENT AGENDA	<ul style="list-style-type: none"> • The next Board meeting will be held from 9:30 a.m. to 12 p.m. on February 17, 2015, in DHCS Training Rooms B+C located at 1500 Capitol Avenue, Sacramento, CA 95814.
7) ADJOURNMENT	<ul style="list-style-type: none"> • The meeting was adjourned at 11:41 p.m.

Action Items	Ownership
Incorporate Dr. Wong and Dr. Stafford's edits into the minutes and post to the DUR website.	Amanda/Ivana
The DUR Board recommendations to contact the California Division of Worker's Compensation and to present the revised morphine milligram equivalency document at the February DUR Board meeting will be submitted to DHCS.	Pauline/Ivana/Shalini
The DUR Board recommendations to revise Section 35 of the DUR Manual will be submitted to publications for DHCS approval.	Amanda/Ivana
The DUR Board recommendations for revisions to the retrospective DUR review on the use of metformin, ACE inhibitors/ARBs, and/or statins among beneficiaries with at least one paid claim for a second-generation antipsychotic medication will be submitted to DHCS.	Amanda/Shalini
The DUR Board recommendations for revisions to the retrospective DUR review on the use of benztropine mesylate among beneficiaries with at least one paid claim for an antipsychotic medication will be submitted to DHCS.	Amanda/Shalini
The DUR Board recommendations for a DHCS summary of coverage of non-capitated drugs – specifically, whether or not paid claims for all HIV antiretroviral medications and psychotropic medications are included in the SURS claims database – will be submitted to DHCS.	Pauline/Ivana
The DUR Board recommendations for a retrospective DUR review on HIV antiretroviral medications (in collaboration with the Medi-Cal Managed Care program) will be submitted to DHCS.	Pauline/Amanda/Shalini