



**MEDI-CAL DRUG USE REVIEW BOARD  
MEETING MINUTES**

**Tuesday, September 15, 2015**

9:30 a.m. – 12 p.m.

**Location: Department of Health Care Services  
1500 Capitol Avenue  
Training Rooms B+C  
Sacramento, CA 95814**

Topic	Discussion
<b>1) WELCOME/ INTRODUCTION</b>	<ul style="list-style-type: none"> <li>• The meeting was called to order by the Chair of the Board, Dr. Andrew Wong</li> <li>• Board members present: Drs. Timothy Albertson, Janeen McBride, Andrew Wong, Randall Stafford, Marilyn Stebbins, Robert Mowers, and Patrick Finley.</li> <li>• Board members absent: None.</li> <li>• Board members and attendees introduced themselves.</li> <li>• Pauline Chan, RPh and Dorothy Uzoh, PharmD were present from DHCS Pharmacy Benefits Division</li> <li>• Shalini Lynch, PharmD and Amanda Fingado, MS, were present from UCSF</li> <li>• Ivana Thompson, PharmD (Xerox) announced that the DUR Board meeting is being recorded and reminded everyone to sign in. Dr. Thompson also introduced Rajiv Chopra, MD (Xerox), the new Medical Director for the CA-MMIS account.</li> </ul>
<b>2) CALL TO ORDER/ REVIEW AND APPROVAL OF MAY 2015 MINUTES</b>	<p>The Medi-Cal Drug Use Review Board (the "Board") reviewed the May 12, 2015 minutes. Dr. Wong noted he had minor edits and motioned that the minutes be approved with these changes. There was no discussion. The Board voted unanimously to approve the minutes as edited by Dr. Wong.</p> <p><b>ACTION ITEM:</b> Incorporate Dr. Wong's edits into the minutes and post to the DUR website.</p>
<b>3) OLD BUSINESS</b>	<p><b>a. Review of Action Items from Previous Board Meeting:</b></p> <ul style="list-style-type: none"> <li>i. Annual report to CMS: Ms. Chan reported the annual report to CMS was submitted on May 28, 2015.</li> <li>ii. Ingredient duplication (ID) alerts for HIV antiretrovirals: Dr. Thompson reported the alerts have been activated and the updates have been published in the DUR manual.</li> <li>iii. High-Dose (HD) and ID alerts for acetaminophen: Dr. Thompson reported the alerts have been switched from test mode to active and the updates have been published in the DUR manual.</li> <li>iv. Outreach to providers for antipsychotic therapy metabolic monitoring: Dr. Thompson reported that the letters were mailed to providers on August 18, 2015 and that there would be additional details provided later in the meeting under new business.</li> <li>v. Second-generation antipsychotic therapy bulletin: Amanda Fingado, MPH (UCSF) reported that this bulletin has been scheduled for publication in 2016.</li> <li>vi. Retrospective DUR review for age 65 years and older: Shalini Lynch, PharmD (UCSF) stated that this review would be covered later in the meeting under new business.</li> </ul>
<b>4) NEW BUSINESS</b>	<p><b>a. Board Activities:</b></p> <ul style="list-style-type: none"> <li>i. DUR bylaws: Dr. Wong reported that the typographical errors and formatting issues in the DUR bylaws have been fixed and the updated version that was included in the DUR Board meeting packet has been approved with no further changes.</li> <li>ii. Summary of DUR Board conference calls: Dr. Wong reported that in preparation for this public meeting, the DUR Board held two conference calls this summer to discuss different prospective DUR alerts, including the high-dose alert for the pediatric population and future goals for the DUR Board under Dr. Mowers, the new DUR Board</li> </ul>

- chairperson for 2016-2017.
- iii. DHCS Learning Series Presentation: Dr. Wong stated that the DUR Board conference calls this summer also helped with preparations for the DUR Board participation in this afternoon's DHCS Learning Series.
  - iv. DUR Board Elections: Ms. Chan informed the Board that the elections for the upcoming vice-chairperson will be held online following this meeting, with the results to be announced at the upcoming DUR Board meeting in November. As current vice-chair, Dr. Mowers will take over as chairperson from Dr. Wong starting with the February 2016 DUR Board meeting and will be the only DUR Board member ineligible to participate in the vice-chairperson election.
- b.** Quarterly Report – 2Q2015 (April – June 2015): Ms. Fingado reported that in 2Q2015, the greatest decrease in utilizing beneficiaries in comparison to both the prior quarter and the prior-year quarter was in the 65 years and older age group, which posted a decrease of 22% from the prior quarter and a decrease of 52% from the prior-year quarter. Ms. Fingado stated this decrease can be attributed to enrollment of seniors and people with disabilities who are dually eligible for both Medi-Cal and Medicare into the Cal MediConnect program, which began enrolling beneficiaries, on a variable timeline starting April 2014, who reside in the following seven counties: Los Angeles, Orange, Riverside, San Bernardino, Santa Clara, San Diego, and San Mateo. As of July 1, 2015, a total of 120,470 beneficiaries have enrolled into Cal MediConnect. Ms. Fingado stated that the impact of the enrollment of dual-eligible beneficiaries into Cal MediConnect can be seen in the review of the top 20 drug therapeutic categories and top 20 drugs by total utilizing beneficiaries, where the greatest decreases in total paid claims and percent of utilizing beneficiaries with a paid claim in comparison to both the prior quarter and the prior-year quarter are over-the-counter drugs (and their corresponding drug therapeutic categories). Prior to the inception of the Cal MediConnect program, these drugs were typically covered through the Medi-Cal fee-for-service program (for the majority of dual-eligible beneficiaries).
- Ms. Fingado also reported that in 2Q2015, HYDROCODONE/ACETAMINOPHEN posted increases in total utilizing beneficiaries (increased by 1%) and total paid claims (increased by 7%) in comparison to the prior quarter, the first increase since hydrocodone products were re-classified as Schedule II Controlled substances, effective October 6, 2014.
- c.** Review of Physician Administered Drugs (PADs) – 1Q2015 (January – March 2015): Ms. Fingado showed a summary of paid claims for physician-administered drugs for the 1<sup>st</sup> quarter of 2015, which includes paid claims with dates of services between January 1, 2015, and March 31, 2015. 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. Ms. Fingado reported decreases in both total utilizing beneficiaries and total paid claims in the category "PHYSICIAN ADMINISTERED DRUG – NDC NOT REQUIRED," which can be attributed to large decreases in the influenza vaccine from 4Q2014 to 1Q2015. Ms. Fingado also found decreases in this category in comparison to the prior year quarter (1Q2014), which was attributed to the migration of the 65 years and older population into Cal Medi-Connect.
- Ms. Fingado also pointed out that this report contained the brand names for all clotting factors, which the DUR Board had requested at the prior DUR Board meeting. Dr. Mowers asked about COPPER, which appeared as the 8th-ranked drug listed on Table 4. Dr. Lynch and Dr. Thompson clarified this was the HCPCS code for COPPER INTRAUTERINE DEVICES.
- d.** Prospective DUR presented by Amanda Fingado (UCSF)
- i. Review of DUR Alerts for New GCNs in 2Q2015 (April – June 2015)
    - 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 the following fourteen GCNs:

- GCN #073773: LEVONORGESTREL, Drug-Pregnancy (PG), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - GCN #073806: ALBUTEROL SULFATE, Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - GCN #048908: DARBEPOETIN ALFA IN POLYSORBATE, Drug-Allergy (DA), Drug-Disease (MC), Underutilization (LR), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - GCNs #061443, #061444, #061445, #061446, #061447, #061448, and #061449: METHYLPHENIDATE HCL, High Dose (HD), Low Dose (LD)
  - GCN #070052: MORPHINE SULFATE, Drug-Allergy (DA), Drug-Disease (MC), Additive Toxicity (AT), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - GCN #074064: TESTOSTERONE CYPIONATE, Additive Toxicity (AT), High Dose (HD), Low Dose (LD)
  - GCN #060913: FENTANYL HCL, Drug-Allergy (DA), Drug-Disease (MC), Additive Toxicity (AT), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - GCN #074184: DOXYCYCLINE HYCLATE, Drug-Pregnancy (PG)
- A motion was made – and seconded – to accept these alert profile recommendations. There was no discussion. The motion was carried.

ii. Review of Prospective DUR Criteria: Section 20 Cleanup

- Ms. Fingado reported that minor discrepancies continue to exist between what is posted in the Medi-Cal DUR Manual under “DUR: Prospective Drug Use Review - Section 20” and the actual programming in the current prospective DUR system. In preparation for the upcoming transition to a new prospective DUR system, Ms. Fingado will present some of these discrepancies to the DUR Board, in small batches, starting with today’s DUR Board meeting, and at subsequent DUR Board meetings, as needed. The following recommendations were discussed:
  - Remove TRIMETHOPRIM/SULFAMOXAZOLE combination from the main target drug list for prospective DUR (TDL) and add both SULFAMOXAZOLE and TRIMETHOPRIM as single ingredients to the main TDL.
  - Remove TRIMETHOPRIM/SULFAMOXAZOLE combination from the TDL for MC, TD, and ID alerts and add both SULFAMOXAZOLE and TRIMETHOPRIM as single ingredients to the TDL for MC, TD, and ID alerts.
  - Add TRIMETHOPRIM and SULFAMOXAZOLE to the TDL for DA alert.
  - Review all GCNs for both SULFAMOXAZOLE and TRIMETHOPRIM and make sure the alerts are consistent for all GCNs.
  - Remove AMOXICILLIN/CLAVULANATE combination from the main target drug list for prospective DUR (TDL).
  - Review all GCNs for AMOXICILLIN products and make sure the alerts are consistent across all GCNs.
  - Remove AMITRIPTYLINE/PERPHENAZINE combination from the main TDL.
  - Review all GCNs for both AMITRIPTYLINE and PERPHENAZINE single ingredient drugs and make sure the alerts are consistent for each drug across all GCNs.
  - Review all GCNs for AMITRIPTYLINE/PERPHENAZINE and turn on MC alert due to potential drug-disease contraindication from PERPHENAZINE.
  - Remove INSULIN from the main TDL.
  - Turn on DA, MC, TD, and LR alerts for all ETANERCEPT GCNs.
  - Turn on additional alerts for DICLOFENAC as described in the manual (DA, MC, TD, ID, HD, and LD), as needed to make sure the alerts are consistent across all GCNs.

- Dr. McBride suggested a review of the late refill (LR) alert as part of the ongoing Medi-Cal DUR cleanup. Ms. Fingado stated that we are planning to review the pregnancy (PG) alert at the November 2015 DUR Board meeting, but could present a review of the LR alert for the February 2016 DUR Board meeting.
- A motion was made – and seconded – to accept these recommendations. There was no discussion. The motion was carried.

**ACTION ITEM:** The following DUR Board recommendations will be submitted to DHCS: 1) remove TRIMETHOPRIM/SULFAMOXAZOLE, AMOXICILLIN/CLAVULANATE, AMITRIPTYLINE/PERPHENAZINE, and INSULIN from the main TDL; 2) add SULFAMOXAZOLE and TRIMETHOPRIM to the main TDL; 3) remove TRIMETHOPRIM/SULFAMOXAZOLE combination from the TDL for MC, TD, and ID alerts and add both SULFAMOXAZOLE and TRIMETHOPRIM as single ingredients to the TDL for DA, MC, TD, and ID alerts; 4) review all GCNs for SULFAMOXAZOLE, TRIMETHOPRIM, AMOXICILLIN, AMITRIPTYLINE, PERPHENAZINE, ETANERCEPT, and DICLOFENAC to make sure alerts are consistent among all GCNs for each drug.

iii. Review of Prospective DUR Criteria: Antidepressants

- Ms. Fingado reported that as new antidepressants have come on the market they have not been added to the main target drug list for prospective drug use review (DUR) and a review of this drug class has shown inconsistencies between drugs that appear on the main target drug list and drugs that have alerts turned on for prospective DUR. Furthermore, within drug therapeutic categories there are also inconsistencies between drugs, alert status, and whether or not drugs are on the main target drug list. She presented a summary of alert status by drug and drug therapeutic category and recommended turning on alerts in a consistent way among all drugs in the following drug therapeutic categories: SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS), SEROTONIN-2 ANTAGONIST/REUPTAKE INHIBITORS (SARIS), SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS), SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS, and TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB. Ms. Fingado also asked the DUR Board for their thoughts on updating the alert profiles for drugs not on the Medi-Cal List of Contract Drugs. For these drugs, since an approved TAR is required, the TAR will override the alerts, so it will not add any alert burden and if these drugs are added to the Medi-Cal List of Contract Drugs at a future date, the alert profiles will be in place already. Dr. McBride thought it made sense to turn on the alerts for all drugs within each drug therapeutic category, regardless of each drug's status on the Medi-Cal List of Contract Drugs. The other members of the DUR Board agreed.
- Dr. Finley suggested that the late refill (LR) and low-dose (LD) alerts for TRAZODONE not be turned on, as this drug is often used as a sleep aid and these alerts would not be valid under those circumstances. The other members of the DUR Board agreed with Dr. Finley's recommendation.
- A motion was made – and seconded – to accept these recommendations as stated above. There was no discussion. The motion was carried.

**ACTION ITEM:** The following DUR Board recommendations will be submitted to DHCS: 1) add all antidepressant drugs within SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS), SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS), SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS, and TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB drug therapeutic categories to the main TDL; 2) turn on MC, TD, LR, AT, ID, PA, HD, and LD alerts for these drugs as outlined in the table; and 3) review all GCNs for these drugs to make sure alerts are consistent across all GCNs.

e. Review of DUR Educational Outreach to Providers

i. Update: Asthma Letter

- Ms. Fingado reported that a total of 33 beneficiaries with asthma medications prescribed by 77 different providers met the inclusion/exclusion criteria for the asthma letter. Two providers had more than one beneficiary in the cohort (one had two beneficiaries, and one had three beneficiaries), so in order to avoid these prescribers being randomized into separate groups, they were randomized as a batch. The randomization included a total of 17 beneficiaries and 42 prescribers in the control group and a total of 16 beneficiaries and 35 prescribers in the intervention group. Prescribers randomized to the control group were mailed a packet containing a letter describing the Medi-Cal DUR article on asthma quality-of-care, the Medi-Cal DUR article on asthma quality-of-care, and a general survey. The prescribers randomized to the intervention group were mailed a packet containing a letter describing the Medi-Cal DUR article on asthma quality-of-care that included the recommendation to schedule an outpatient visit for each patient profile included with the mailing, patient profile(s) with patient name, date of birth, history of paid pharmacy claims for asthma rescue and asthma controller medications (from September 1, 2011 through April 30, 2015), history of emergency department visits and inpatient hospitalizations where the primary diagnosis or secondary diagnosis was listed as asthma (from September 1, 2011 through April 30, 2015), the Medi-Cal DUR article on asthma quality-of-care, a general survey, and one patient-specific survey for each patient profile. Due to multiple address listings for some providers, a total of 46 control letters and 37 intervention letters were drafted for mailing.

Ms. Fingado shared three outcomes from the mailing that are available at this time (direct cost, rate of undeliverable mail, and provider response rate), with the remainder of the outcomes to be assessed at a later date and presented at subsequent DUR Board meetings. The direct costs associated with the mailing totaled \$82.93. Each of the 83 letters was estimated to have cost \$0.9991, which equals the cost of two envelopes and postage for two envelopes, as a self-addressed stamped envelope was included with each letter. The rate of undeliverable packets was 30% in the control group (14 packets out of 46) and 19% in the intervention group (7 packets out of 37), for an overall rate of undeliverable packets of 25% (21 packets out of 83). The provider response rate (within 90 days) was 2% in the control group (1 survey out of 46) and 24% in the intervention group (9 surveys out of 37).

Ms. Fingado reported that responses collected through provider surveys remain unanimously positive, which supports continued direct mailing of letters to providers as an acceptable mechanism for future DUR educational outreach efforts. However, she noted that a continued limitation of the mailings involves the use of the existing database of Medi-Cal provider addresses, which led to an overall undeliverable rate of 25% even among those providers with addresses in the database. Ms. Fingado estimated a little over 50% of providers they attempted to mail letters to were not in the database at all, and therefore did not have any mailing sent to them. Several suggestions were given by the DUR Board to improve the rate of undeliverable mail, including using email addresses and looking up current business addresses through search engines. Dr. Thompson noted that the Xerox contract with DHCS only allows contact to be made with providers who have mailing addresses listed in the database and, in addition, all early provider enrollment forms did not include email address as a variable.

ii. Update: Antipsychotic Metabolic Monitoring Letter

- Ms. Fingado informed the group that a total of 548 beneficiaries met inclusion/exclusion criteria for the metabolic monitoring letter. In the 57 cases where a beneficiary had multiple prescribers, the most recent prescriber was

usually selected to receive the letter (data were reviewed by both Ms. Fingado and Dr. Thompson). A total of 264 prescribers were identified for educational outreach letters, although some prescribers had more than one address listed as their physical location, so a total of 274 prescriber letters were prepared for mailing. Each prescriber was mailed a letter with a summary of clinical recommendations, a list of all patients (name and date of birth) from the study population linked to this prescriber, the Medi-Cal DUR article on appropriate antipsychotic medication use among children and adolescents, and one provider response survey for each patient. All packets were mailed on August 18, 2015 and outcomes will be presented at future DUR Board meetings, as available.

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

i. Review of Retrospective DUR Criteria: Age  $\geq$  65 Years

- Dr. Lynch reminded the group that at the DUR Board meeting on May 12, 2015 a decrease of 42% of beneficiaries was reported in the Q1 2015 DUR quarterly report among the 65 years and older age group, in comparison to the prior-year quarter (Q1 2014). It was hypothesized at this time that this decrease might be attributed to enrollment of seniors into the Cal MediConnect program, a three-year project between Medi-Cal and Medicare to promote coordinated health care delivery to seniors and people with disabilities who are dually eligible for both of these public health insurance programs. The DUR Board had requested a formal review of this age group, along with a retrospective utilization review of drugs appearing on the 2012 AGE Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.
- Dr. Lynch showed that between March 2014 and May 2015, there was a 59% decrease in total utilizing beneficiaries 65 years and older in the Medi-Cal fee-for-service program. Almost all of the decrease occurred in the following Cal MediConnect counties currently enrolling beneficiaries: Los Angeles, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. Ms. Fingado noted that Orange County began enrollment into Cal MediConnect in July, so there may be additional decreases in enrollment from the Medi-Cal fee-for-service program observed over the next few months.
- Dr. Lynch also presented utilization of drugs appearing on the 2012 Beers Criteria during a one-year period (July 1, 2014 through June 30, 2015). The top drugs by total number of utilizing beneficiaries included DIPHENHYDRAMINE (n=1,633), IBUPROFEN (n=523), QUETIAPINE (n=508), and INSULIN GLARGINE (n=486).
- Dr. Lynch reported that it has not yet been determined whether the Cal MediConnect program will continue beyond the three-year pilot. Therefore, the DUR Board recommended that awaiting more information on the future of this program before pursuing additional analyses in this age group.
- Ms. Chan suggested that for future consideration, Medi-Cal DUR may wish to conduct a similar utilization review for age group 40-65 years of age, as many newly insured Medi-Cal beneficiaries fall into this age group as a part of Medicaid expansion efforts in California under the Affordable Care Act.

ii. Review of Retrospective DUR Criteria: Narcotic Analgesics

- Dr. Lynch reported that on July 2, 2014, the DEA published in the Federal Register the final rule placing TRAMADOL into schedule IV of the Controlled Substances Act, effective on August 18, 2014 and on August 22, 2014, the DEA published in the Federal Register the final rule placing HYDROCODONE (in bulk, single entity products, and combinations) into schedule II of the Controlled Substances Act, effective on October 6, 2014. Since that time, Dr. Lynch stated that while both monthly and quarterly DUR reports showed decreased utilization of both TRAMADOL and HYDROCODONE, it was unknown if these decreases represent a shift to other narcotic analgesics, or if there was a reduction in overall utilization of narcotic analgesics.
- Dr. Lynch reported that prior to rescheduling, the total paid claims for TRAMADOL were almost double those of ACETAMINOPHEN W/CODEINE. By January 2015,

five months after the rescheduling, claims for ACETAMINOPHEN W/CODEINE surpassed claims for TRAMADOL.

- Dr. Lynch reported that between September 2014 and May 2015, total paid claims for HYDROCODONE/ACETAMINOPHEN decreased by 33%. In addition, Dr. Lynch stated that since February 2014, a slight increase in paid claims was noted for medications containing BUPRENORPHINE, along with a decrease of 46% in paid claims for METHADONE.
- Dr. Lynch described additional analyses performed with a subset of beneficiaries continuously eligible for pharmacy benefits between February 1, 2014 and May 31, 2015, in order to determine if there was a change in use of additional narcotic analgesics among these beneficiaries. To be included in the TRAMADOL population, beneficiaries had to have at least one paid claim with a total billed quantity > 240 tablets in the 6 month period prior to scheduling of TRAMADOL (2/17/14-8/17/14). A total of 3,400 beneficiaries had paid claims with a total billed quantity > 240 tablets in the 6 months prior to rescheduling of TRAMADOL. In the 6-month period post-rescheduling, there was a 51% decrease in the number of beneficiaries that had paid claims for TRAMADOL with a total billed quantity > 240 tablets and there was a 26% decrease in total utilizing beneficiaries with paid claims for other narcotic analgesics besides TRAMADOL. To be included in the HYDROCODONE population, beneficiaries had to have at least one paid claim for HYDROCODONE with a total billed quantity of > 120 tablets between April 5, 2015 and October 5, 2015. In the 6-month period post-rescheduling, there was a 61% decrease in the number of beneficiaries that had paid claims for HYDROCODONE with a total billed quantity > 120 tablets and there was a 34% decrease in total utilizing beneficiaries with paid claims for other narcotic analgesics besides HYDROCODONE.
- Dr. Albertson suggested continued review of these trends, as he hypothesizes this initial reduction in utilization may be followed by a steady increase. He also suggested reviewing other CNS depressants beyond narcotic analgesics. The DUR Board agreed this would be an interesting topic for consideration and recommended continued evaluation of narcotic analgesic utilization over time.

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

**i. DUR Educational Alert (August, 2015): NSAIDs**

- Dr. Lynch reported that the FDA issued a drug safety communication on July 9, 2015 regarding NSAIDs and the risk of heart attack and stroke. Based on information acquired by the FDA since 2005, the existing NSAID label warning will be strengthened to advise patients to seek immediate medical attention if symptoms of heart attack/stroke are experienced, such as chest pain, shortness of breath or trouble breathing, weakness in one part or side of the body or slurred speech.

**ii. Discussion/Recommendations for Future Educational Bulletins**

- The calendar for future DUR educational bulletins was reviewed. The morphine milligram equivalency bulletin and the annual immunization update are both scheduled to be published on September 30, 2015, the concomitant use of anticholinergics bulletin is scheduled for publication in Q4 of 2015, and the bulletin on concomitant use of metformin, statins and/or ACE/ARBs with atypical antipsychotics is scheduled for publication in 2016. The Board did not recommend a change to the proposed order of bulletin publication. Additional proposed topics were reviewed. Dr. Albertson suggested reviewing pain guidelines and utilization of narcotic analgesics among a population with co-morbid mental health conditions, specifically looking at those beneficiaries with co-morbid substance abuse, either as its own topic or as a sub-analysis of the main bulletin.
- Dr. Finley suggested a review of QT prolongation among beneficiaries taking SSRIs and/or antipsychotic medications. He suggested reviewing work published by the University of Arizona that looks at drugs that prolong the QT interval.
- Dr. Stebbins thought it might be of interest to the group to evaluate use of CARISPRODOL in the Medi-Cal fee-for-service population.

- Dr. Stafford suggested a review of concurrent use of benzodiazepines and opioids. Ms. Chan reported that the Pharmacy Quality Alliance (PQA), a national organization, has established a workgroup to develop a new measure called the triple threat, which measures concurrent use of opioids, benzodiazepines and muscle relaxants. Ms. Chan represents DHCS in this workgroup and can provide future updates.
- Dr. Mowers asked if DHCS was currently working on a policy for the new PSCK9 inhibitors to treat hypercholesterolemia. Ms. Chan said that to her knowledge, the Pharmacy Benefits Division was not actively working on a formal policy, but the Pharmacy Benefits Division does conduct ongoing evaluations of new drugs as they become available on the market. Dr. Mowers suggested reviewing utilization of these drugs and other expensive drugs such as those used to treat the hepatitis C virus at future DUR meetings.

**h. Pharmacy Update:**

- i. DHCS Medical Policy: Hepatitis C Policy (Revised, Effective July 1, 2015) – Ms. Chan introduced updates to the existing policy for hepatitis C drugs, which are based on a review of the medical literature, the most recent guidelines and reports published by the American Association for the Study of Liver Disease (AASLD) and other guidelines, and expert recommendations. Candidates for treatment are identified based on a) disease prognosis and severity, b) patient readiness and adherence, and c) age requirements. The revised policy also addresses the following considerations:

- Quantity limits
- Criteria for Reauthorization/continuation of therapy
- Laboratory testing
- Populations unlikely to benefit from Hepatitis C virus treatment
- Retreatment
- Criteria for coverage of investigational services (Title 22 § 51303)
- Authorization of unlabeled use of medication

- ii. Supplemental Form for Treatment Authorization Request – Ms. Chan presented the new TAR supplemental form to help aid providers in submitting TAR documentation for use of antipsychotic medication in children ages 0-17. This supplemental form became effective in August 2015, and is intended to help providers to collect and document relevant information needed in the approval process. Use of this TAR supplemental form is voluntary and it can be filled out by prescribers and sent to the pharmacy along with the prescription.

Dr. Stebbins asked why this form would be voluntary, instead of mandatory. Ms. Chan responded that the form serves the purpose to help providers document relevant information necessary for TAR processing, but doesn't ask providers for any new information beyond what is required under the medical necessity section on the TAR form. In contrast to the TAR form, which is almost all free-text, the supplemental form consists of check boxes and a small area of free text. This form is designed for use only for antipsychotic medications.

Ms. Chan reported that the supplemental form can be found on the DHCS website at: [http://www.dhcs.ca.gov/provgovpart/Documents/PharmacyBenefits/Antipsych/Antipsych\\_TAR\\_Supplement.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/PharmacyBenefits/Antipsych/Antipsych_TAR_Supplement.pdf).

- iii. Carved-out Drugs Report – Ms. Chan reported on an improvement project initiated in December 2014 involving the Medi-Cal Managed Care Division Quality & Monitoring Division, DHCS Pharmacy Benefits Division, and Medi-Cal managed care health plan contacts (mostly pharmacy directors). The purpose of this project was to reassess the reports provided to health plans on a quarterly basis that contain information about members' fee-for-service claims for carved-out drugs. These reports support care coordination by providing data that might otherwise be unavailable to managed care plans.

DHCS collected feedback from health plans and pharmacy directors through a survey questionnaire that was emailed to managed care health plan contacts. Survey results were reviewed at the managed care health plan pharmacy directors meeting. An internal workgroup finalized specifications for the revised reports, which include updates to content (expanded data fields, rolling 12 months data) and frequency (delivery schedule changed from quarterly to monthly). Ms. Chan noted that the electronic delivery of reports will begin in September 2015

- iv. Drug Medi-Cal Organized Delivery System (ODS) Waiver – Ms. Chan reported this waiver was approved by Centers for Medicare and Medicaid Services in August 2015. Ms. Chan provided a quote by Jennifer Kent, DHCS Director, where she states, “The new waiver allows California to improve the state’s alcohol and drug abuse treatment system by organizing it into a coordinated continuum of care – from outpatient treatment to residential centers, withdrawal management, recovery services and physician consultation.”

Ms. Chan stated that this program is expected to focus more on evidence-based treatment practices, transfer more control and accountability to the counties, promote stronger oversight, and use resources more efficiently, in part by better coordination with other systems of care. Ms. Chan reported that counties will implement Waiver services in four phases and each county had to complete an Expression of Interest Survey regarding their interest to opt-in to the four phases of implementation. She also noted that participation in the Waiver is voluntary, and that thus far 53 counties have expressed interest.

Dr. Stafford asked if any of the larger counties were going to opt-out. Ms. Chan responded that it didn’t seem likely that they would and that, in general, the counties are very enthusiastic about participating.

- v. Global Data Sharing Agreement: M. Akhtar Khan, PhD, the Chief of CDSS Research Services Branch, presented information on the global data sharing efforts between the California Department of Social Services (CDSS), the Department of Health Care Services (DHCS), and counties and tribes that opt-in. Initial data sharing agreements involved psychotropic medications data (executed on January 1, 2014) and mental health data (executed October 1, 2014) between CDSS and DHCS.

Dr. Khan reported that under the global data sharing agreement, both the CDSS and the DHCS have agreed to share both confidential and non-confidential data and match their records for all children in the child welfare system. The purpose of these agreements is to explore, identify, and support effective strategies in overseeing and monitoring health and human service interventions for children and youth in the child welfare system and provide counties with easy access to health and human services data. Available data includes medical information (e.g., mental health services, pharmaceutical services and medications), Medi-Cal eligibility and payment data, and includes all children and non-minor dependents receiving child welfare services.

Dr. Khan described the process for counties to opt-in to data sharing as a simple, three-step process consisting of a signatory page, authorized requestor form, and data request form. As of the date of this presentation, five counties are already signed up, with three or four additional counties in the pipeline waiting to finalize paperwork.

- vi. Overview of Psychotropic Medication Use: Linette Scott, MD, MPH, California’s Chief Medical Information Officer (CMIO) presented a review of psychotropic medication use in foster care children who receive Medi-Cal benefits. These data reports are available online at the Quality Improvement Project Webpage at: <http://www.dhcs.ca.gov/services/Pages/qip-expert-panel.aspx>.

Dr. Scott presented utilization data that compared utilization between those children in foster care who receive their medical care in the fee-for-service delivery system to

those in the managed care delivery system, with a focus on the children who are placed in a group home environment and who also receive psychotropic medications. She found that in 2013-2014, as compared to 2012-2013, the overall number of children in foster care increased slightly from 63,565 to 64,475 while at the same time, the number of children in group homes decreased from 4,673 to 4,493. Further stratification of these data was presented, including the following:

- Medi-Cal fee-for-service vs. Medi-Cal managed care: Among children in foster care who received one or more psychotropic medications, utilization was unchanged from 2012-2013 to 2013-2104 among the fee-for-service population, but decreased among those in managed care programs.
- Gender: Utilization rates decreased among both females and males in Medi-Cal managed care, but most prominently among males (went from 14% to 12% in one year).
- Diagnosis: Dr. Scott reported that because pharmacy claims do not always include diagnosis codes, a direct correlation was not possible. Instead, medical and other claims were evaluated for those individuals who receive psychotropic medication in order to identify diagnoses. Ms. Fingado asked if they went back further than the timeframe used to evaluate pharmacy claims and Dr. Scott reported that they included all medical claims data in order to capture the most accurate diagnoses for each beneficiary. Dr. Scott reported the five most common diagnoses were ADD/ADHD, mood disorders, adjustment reaction, disturbance of conduct, NEC, and disturbance of emotion, child/adolescent. In children 0 through 11 years of age the most common diagnosis was ADD/ADHD, and among adolescents 16 and 17 years of age, mood disorders were the most common. On average, about 70% of the children in foster care who are taking psychotropic medications have at least two of the top five diagnoses.
- Drug class: Among children who received at least one psychotropic medication, the most prevalent drug classes were stimulants (most common in the 0-11 year age group), antipsychotics (most common in the 12-15 year age group), and antidepressants (most common in the 16-17 year age group). There were 354 children in foster care who had multiple medications in the same drug class (stimulants, antipsychotics, and antidepressants) for two or more months. Additionally, the report provided the breakdown by number of drugs and length of overlapping therapy.

Dr. Scott reported that DHCS is working on the following HEDIS measures for public reporting:

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (HEDIS 2015 APP Measure) – New in 2014
- Follow-Up Care for Children Prescribed ADHD Medication (HEDIS ADD) – Initiation Phase and Continuation Phase
- Use of Multiple Antipsychotics in Children and Adolescents (HEDIS APC) – New in 2014
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (HEDIS APM) – New in 2014

For other reports, Dr. Scott stated that data were stratified by insurance (Medi-Cal fee-for-service vs. Medi-Cal managed care), age, gender, ethnicity (white, Hispanic, black, and other), and placement type. Dr. Scott reported that data on placement type groupings was provided by CDSS under the global data sharing agreement, and allowed for stratification of data by placement type. Finally, data were stratified by region using CDSS geographical regions: Dr. Scott reported the highest rate of 60-75 days with overlapping psychotropic medications for two drugs was reported in the Los Angeles and Tri Coastal Region, and for three drugs, in the San Diego Region.

Dr. Albertson asked if the report has information on distribution of the group that had two or more antipsychotic medications. Dr. Scott explained that this was an initial cut of the data, and that future efforts will use the HEDIS measures and will look at entire

	<p>population across Medi-Cal. Dr. Finley pointed out that concomitant use of more than one psychotropic medication is sometimes an indicator of good care and that not all drug classes should be grouped together. For example, he stated that use of two or more antidepressant drugs may mean a patient is receiving proper care under clinical guidelines recommending amplification, while there is no evidence that a child or adolescent should be on two or more antipsychotics at the same time. Dr. Stebbins asked if the report looked at children in group homes. Dr. Scott pointed to different slides showing utilization in different placement types. Dr. Finley wanted to know if this study looked at benzodiazepines. Dr. Scott explained that benzodiazepines may have been mixed in but not identified separately as one of the most common drug classes. Dr. Wong was interested if there was any difference in data by county, for example, if there were differences between San Francisco and Los Angeles County. Dr. Scott said that the report did not look at county data, and that some of the counties that have received data from the data sharing agreement have highlighted areas of data quality issues that will need to be addressed down the line. Dr. Finley commented on movement of foster children within California. He stated there is a data warehouse that tracks individual children and asked if that system had been utilized to get a more accurate representation about where these children are receiving their health care. Dr. Scott stated that DHCS is very engaged in that front and is moving in a positive direction.</p>
<b>5) PUBLIC COMMENTS</b>	None.
<b>6) CONSENT AGENDA</b>	<ul style="list-style-type: none"> <li>The next Board meeting will be held from 9:30 a.m. to 12:00 p.m. on November 17, 2015 in in DHCS Training Rooms B+C located at 1500 Capitol Avenue, Sacramento, CA 95814.</li> </ul>
<b>7) ADJOURNMENT</b>	<ul style="list-style-type: none"> <li>The meeting was adjourned at 11:50 a.m.</li> </ul>

Action Items	Ownership
Incorporate Dr. Wong's edits into the minutes and post to the DUR website.	Ivana
The following DUR Board recommendations will be submitted to DHCS: 1) remove TRIMETHOPRIM/SULFAMOXAZOLE, AMOXICILLIN/CLAVULANATE, AMITRIPTYLINE/PERPHENAZINE, and INSULIN from the main TDL; 2) add SULFAMOXAZOLE and TRIMETHOPRIM to the main TDL; 3) remove TRIMETHOPRIM/SULFAMOXAZOLE combination from the TDL for MC, TD, and ID alerts and add both SULFAMOXAZOLE and TRIMETHOPRIM as single ingredients to the TDL for DA, MC, TD, and ID alerts; 4) review all GCNs for SULFAMOXAZOLE, TRIMETHOPRIM, AMOXICILLIN, AMITRIPTYLINE, PERPHENAZINE, ETANERCEPT, and DICLOFENAC to make sure alerts are consistent among all GCNs for each drug.	Pauline/Ivana
The following DUR Board recommendations will be submitted to DHCS: 1) add all antidepressant drugs within SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRIS), SEROTONIN-NOREPINEPHRINE REUPTAKE-INHIB (SNRIS), SSRI & SEROTONIN RECEPTOR MODULATOR ANTIDEPRESSANTS, and TRICYCLIC ANTIDEPRESSANTS & REL. NON-SEL. RU-INHIB drug therapeutic categories to the main TDL; 2) turn on MC, TD, LR, AT, ID, PA, HD, and LD alerts for these drugs as outlined in the table; and 3) review all GCNs for these drugs to make sure alerts are consistent across all GCNs.	Pauline/Ivana