



**MEDI-CAL DRUG USE REVIEW BOARD  
MEETING MINUTES  
Tuesday, February 16, 2016  
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. Robert Mowers.</li> <li>• Board members present: Drs. Andrew Wong, Randall Stafford, Robert Mowers, and Patrick Finley.</li> <li>• Board members absent: Drs. Timothy Albertson, Janeen McBride, and Marilyn Stebbins.</li> <li>• Board members and attendees introduced themselves.</li> <li>• Pauline Chan, RPh, James Gasper, PharmD, Teri Miller, PharmD, and Dorothy Uzoh, PharmD were present from DHCS Pharmacy Benefits Division.</li> <li>• Ivana Thompson, PharmD (Xerox) announced that the DUR Board meeting is being recorded and reminded everyone to sign the attendance sheet.</li> </ul>
<b>2) CALL TO ORDER/ REVIEW AND APPROVAL OF NOVEMBER 2015 MINUTES</b>	<p>The Medi-Cal Drug Use Review Board (the “Board”) reviewed the November 17, 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>a. Review of Action Items from Previous Board Meeting:</p> <ul style="list-style-type: none"> <li>i. Prospective DUR: Section 20 Cleanup – Dr. Thompson reported that the Board recommendations were approved and implemented in December 2015.</li> <li>ii. Prospective DUR: Pregnancy (PG) Alert – Dr. Thompson reported that the Board recommendations were approved and implemented in December 2015.</li> <li>iii. Physician Administered Drugs: Acetaminophen and Ibuprofen – At the DUR Board meeting in November 2015, the Board had asked how these claims are reimbursed, as the reimbursement paid to providers seemed high. Dr. Thompson explained that there is a pricing ceiling based on a combination of the HCPCS code and the diagnosis (or procedure). Providers can submit their usual and customary charge, and as long as this amount is under the pricing ceiling, the claim will be paid. If this charge is above the ceiling, the claim will suspend pending further review. Dr. Thompson stated that pricing for ACETAPMINOPHEN and IBUPROFEN fall under the pricing algorithm for physician-administered drugs using the HCPCS code of Z7610: “MISC DRUGS AND MED SUPPLIES, ADMIN STAT.” Dr. Thompson clarified that this code excludes any injectable drugs and applies primarily to oral dosage forms.</li> </ul> <p>Dr. Mowers suggested the DUR Board should conduct further research into this policy, including a comparison to reimbursement paid for similar pharmacy claims that use pricing guidelines set by pharmacy policy. Dr. Thompson stated that the pricing method and table used for code Z7610 comes from medical policy, and not the Pharmacy Benefits Division. Ms. Chan suggested she could speak with someone from the medical policy side and see if they would be willing to provide the Board with more information on the pricing policy for this code at a future DUR Board meeting.</p> <p><b>ACTION ITEM:</b> The DUR Board recommendation to further research the pricing policy for code Z7610 will be submitted to DHCS.</p>

**4) NEW BUSINESS**

**a. Board Activities:**

- i. Review of Board Goals and Objectives – Dr. Mowers presented the following DUR Board Goals for the next two years (2016-2017):
- Conduct systematic review to identify therapeutic drug categories and establish relative cost comparisons that also comply with contractual requirements for cost confidentiality
  - Promote dialogue, collaboration, and recommend best practices in pharmacy utilization management on drugs that are commonly used in both Medi-Cal fee-for-service and managed care
  - Recommend prospective DUR alerts system design as part of new CAMMIS system
  - Conduct studies to evaluate various methods in the design of “dear doctor” letters
  - Collaborate with other agencies in the use of Morphine Equivalent Daily Dose (MEDD) to prevent opioid overdose
  - Establish DUR 5-year trending reports on selected measures
  - Collaborate with other agencies in improving psychotropic medication use for all populations
  - Establish a learning collaborative with managed care health plans and other agencies to promote best practices using academic detailing
  - Align DUR board goals with DHCS Quality Strategy

**b. Pharmacy Update:**

i. DUR Program Review 2015

- Antipsychotic Drug Use in Children (ADC) Affinity Group – Ms. Chan reminded the DUR Board that in early 2015 the Office of the Inspector General recommended that CMS work with state Medicaid programs to:
  - Perform utilization review of second generation antipsychotic (SGA) drugs prescribed to children
  - Conduct periodic review of medical records related to SGAs
  - Consider other methods of enhanced oversight of SGAs

One response proposed by CMS was to form the ADC Affinity Group. The ADC Affinity Group will focus on strategies to improve the quality of care for children who are prescribed antipsychotic drugs. The group also will identify and encourage strategies aimed at reporting on the 2016 Child Core Set measure for Medicaid/CHIP: Use of Multiple Concurrent Antipsychotics in Children and Adolescents. CMS plans to support states’ efforts to improve quality of care by providing learning opportunities, regular meetings and communications between states. Interested state Medicaid agencies were asked to submit an expression of interest form identifying team members and indicating leadership support.

DHCS is planning to submit an interest form for participation in the ADC Affinity Group, and is including DUR team members in the application. Monthly 1:1 calls begin in March 2016 and will continue for 12 months, in addition to quarterly group calls with other states and QI experts. Activities of the ADC Affinity Group will be shared with the DUR Board at each meeting and input from the Board will be welcomed.

- A report entitled, “Comprehensive Medication Management Programs: Description, Impacts and Status in Southern California, 2015” was published on 12/23/2015. Ms. Chan commended the California Department of Public Health for making this report available and congratulated Board member Dr. Marilyn Stebbins for her contribution to this important report.

ii. Medicaid Drug Utilization Review State Comparison/Summary Report for FFY2014 – Ms. Chan reported that CMS has posted the FFY 2014 DUR Annual State Reports on

the CMS website at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/prescription-drugs/downloads/2014-dur-summary-report.pdf>. Ms. Chan encouraged attendees to read the summary report, specifically the following sections:

- Generic Policy and Utilization Data (pages 15-17)
- Program Evaluation/Cost Savings/Cost Avoidance (pages 18-20)
- Fraud, Waste, and Abuse Detection (pages 21-43)

Ms. Chan reminded the Board that this summary report was for FFY 2014, which covered October 1, 2013 through September 30, 2014.

- c. FFY2015 DUR Annual Report to CMS – Ms. Chan informed the Board that the Centers for Medicare & Medicaid Services (CMS) notified states this week about proposed revisions to the DUR Annual Report to CMS for federal fiscal year (FFY) 2015. CMS stated that revisions are being made to the report with input from a committee of members from the American Drug Utilization Review Society (ADURS). CMS provided a link to review the draft of the proposed FFY2015 survey at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-153.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending>. Ms. Chan stated that further information regarding the final version of the report template will be available in late March 2016 and that the submission due date has been extended from June 30, 2016 to November 30, 2016. In light of this information, the Board discussion on the draft of the FFY 2015 DUR Annual Report to CMS was postponed until September.
- d. Presentation by the Inland Empire Health Plan – Chris Chan, PharmD, the Senior Director of Pharmacy Services for the Inland Empire Health Plan (IEHP) gave a presentation entitled, “IEHP Pharmacy Pay For Performance (P4P) Program.” Dr. Chan stated that the IEHP covers over one million Medi-Cal beneficiaries residing in one of two Southern California counties (Riverside and San Bernardino). In October 2013, IEHP began the rollout of the P4P program for pharmacy providers to improve pharmacy services provided by IEHP community pharmacy providers. IEHP used financial incentives to help transition community pharmacies to an outcome-based medication therapy management model.

Dr. Chan reported that the eligibility criteria for participation in the P4P program included the following:

- Must be a Contracted IEHP (via IEHP contracted PBM) Community Pharmacy Provider
- Must be an IEHP Pharmacy Provider in good standing (free of outstanding fraud, waste and abuse investigation)
- Store location must be within San Bernardino and Riverside Counties
- Must have an annual IEHP prescription volume of greater than 1,000 (500 every 6 months)
- Pharmacy must be in business during the entire evaluation period
- Must have at least 10 members qualifying for 4 out of 7 clinical measures under the IEHP P4P Program (this criteria was new for 2015 - 2016)

Dr. Chan also summarized the scoring methodology used for the P4P program, which included three separate measures evaluating the proportion of days covered (hypertension, diabetes, and statins), the appropriate treatment of hypertension in diabetes, medication therapy for persons with asthma, use of high-risk medications in the elderly, and the generic rate. For 2015-2016, the criteria were changed to include asthma suboptimal control and statin use in diabetes. Results for each metric of the P4P program were presented, with each metric showing results trending in a promising direction.

Dr. Chan then described IEHP's Pharmacy Transformation Project that was established to assist independent pharmacy providers to evaluate their current capabilities for additional services. Assessments are made based on current pharmacy setting, demographic information, latest technologies available, and targeted/future enhancements. The goal of this project is to optimize pharmacy efficiency and to assist pharmacists to be successful in integrating other clinical services. The tentative start date for this project is June 2016 and in

order to participate, pharmacies must be high-performing (with a rating of 4 or 5 stars) and members must be a patient of an eligible pharmacy with two out of three metabolic syndrome conditions (diabetes, hypertension, hyperlipidemia, or asthma). Outcome targets include: 1) an A1C < 8 with at least two labs in the last 12 months; 2) blood pressure < 140/90; 3) LDL < 100; and 4) adherence measure (controller) and number of albuterol fills. Tentative proposed payments to successful pharmacies would be \$20 per MTM consultation (with a maximum of \$240 per patient, per year). Future outcome-based MTM payments will be adjusted based on the actual experience in the first year of the program.

Dr. Chan concluded by stating that the mission and goals of the P4P program is to disrupt the current pharmacy services delivery model by helping to craft the next-generation pharmacy model, which will include clinical services. This program will be able to evaluate the return on investment of community pharmacist-delivered services and allow payors to create a reasonable payment model for future pharmacist-run outcome-based MTM services.

**e. Presentations by the California State Board of Pharmacy**

- i. Naloxone Protocol for Pharmacists – Virginia Herold, the Executive Director of the California State Board of Pharmacy, presented information on the naloxone protocol for pharmacists. Effective January 28, 2016, there is now statutory authority for pharmacists to distribute naloxone, replacing an emergency regulation that took effect on April 10, 2015. This regulation appears in the California Business and Professions Code (section 4052.01) and enables pharmacists to furnish naloxone to patients to reverse opioid overdoses. It also requires pharmacists to provide education to patients about naloxone and how to use it. The screening questions for naloxone use were described and the California State Board of Pharmacy is in the process of translating these screening questions into additional languages (patient fact sheets are currently available in six languages). Distribution of naloxone will be available for any pharmacist with at least one hour of approved continued-education in the use of naloxone in all routes of administration, or the equivalent curriculum-based training program in a school of pharmacy. The naloxone protocol is not limited to advanced practice pharmacists (APP).
- ii. Drug Take Back Regulations – Ms. Herold also reported that the California State Board of Pharmacy is in the process of developing drug take-back regulations. These regulations will mirror the federal requirements put forth by the United States Drug Enforcement Administration (DEA) that allow authorized manufacturers, distributors, reverse distributors, narcotic treatment programs, hospitals/clinics with an on-site pharmacy, and retail pharmacies to collect pharmaceutical controlled substances from ultimate users by voluntarily administering mail-back programs and maintaining collection receptacles. The federal regulations allow authorized hospitals/clinics and retail pharmacies to voluntarily maintain collection receptacles at long-term care facilities. California will permit mailing of prescription drugs to a destruction site or placement in a mailbox collection receptacle that has the capability to track the contents, which will then be sent to a reverse distributor or to an incineration site. Finalized regulations are expected from the California State Board of Pharmacy in six-nine months.

Pauline Chan commented that James Gasper, PharmD, formerly clinical pharmacist at San Francisco Department of Public Health and now with the Department of Health Care Services, has been instrumental in developing the pharmacist protocol for naloxone.

- f. Quarterly Report – 4Q2015 (October – December 2015): Ms. Fingado reported that in 2015 Q4, all age groups except the 0-12 year age group and the 65+ age group posted decreases in total utilizing beneficiaries and total paid claims in comparison to the prior quarter. Ms. Fingado stated that among the 65+ age group this increase may be attributed to the increase in seniors and people with disabilities who are dually eligible for both Medi-Cal and Medicare opting-out of the Cal MediConnect program. On October 1, 2015, there

were a total of 117,179 beneficiaries enrolled in Cal MediConnect, with a projected December enrollment of 126,299. However, as of December 1, 2015 the enrollment actually decreased to 115,743.

In addition, Ms. Fingado reported that one year after being re-classified as a Schedule II controlled substance (effective October 6, 2014), HYDROCODONE/ACETAMINOPHEN continues to post decreases in total paid claims in comparison to the prior quarter (decreased by 8%) and to the prior-year quarter (decreased by 9%).

- g.** Review of Physician Administered Drugs (PADs) – 3Q2015 (July – September): Ms. Fingado showed a summary of paid claims for physician-administered drugs for the 3<sup>rd</sup> quarter of 2015, which includes paid claims with dates of services between July 1, 2015 and September 30, 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 increases in both total utilizing beneficiaries (a 19% increase) and total paid claims (a 9% increase) from 2Q2015 to 3Q2015 in the category “PHYSICIAN ADMINISTERED DRUG – NDC NOT REQUIRED,” which can be attributed to large increases in the influenza vaccine starting in September 2015. Within this same category, Ms. Fingado pointed out large decreases in both total utilizing beneficiaries (a 55% decrease) and total paid claims (a 50% decrease) from 3Q2014 to 3Q2015. Ms. Fingado stated that this decrease may be due to the migration of dually-eligible beneficiaries from the Medi-Cal Fee-for-Service Program to the MediConnect program, which occurred during this same time period.

- h.** Prospective DUR reports were presented by Amanda Fingado

- i.** Review of DUR Alerts for New GCNs in 4Q2015 (October – December 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 thirteen GCNs:
  - GCNs #074851 and #074853: MORPHINE SULFATE - Drug-Allergy (DA), Drug-Disease (MC), Additive Toxicity (AT), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD), Low Dose (LD)
  - GCNs #074887, #074888, and #074889: ARIPIRAZOLE - Drug-Disease (MC), Additive Toxicity (AT), Therapeutic Duplication (TD), Ingredient Duplication (ID), Underutilization (LR), High Dose (HD), Low Dose (LD)
  - GCN #063478: FLUCONAZOLE IN NAACL,ISO-OSM - High Dose (HD), Low Dose (LD)
  - GCN #075065: PSEUDOEPH/DM/ GUAIFEN/ACETAMIN - Ingredient Duplication (ID), High Dose (HD)
  - GCN #075115: NAPROXEN CAPSAICIN/MENTHOL- Drug-Allergy (DA), Drug-Pregnancy (PG), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD)
  - GCN #075117: ELVITEG/COBI/ EMTRIC/TENOFO ALA - Ingredient Duplication (ID)
  - GCN #075135: NAPROXEN SODIUM/MENTHOL- Drug-Allergy (DA), Drug-Pregnancy (PG), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD)
  - GCNs #075207 and #075208: MELOXICAM, SUBMICRONIZED - Drug-Pregnancy (PG)
  - GCNs #075237: DICLOFENAC SODIUM, MICRONIZED - Drug-Allergy (DA), Drug-Pregnancy (PG), Drug-Disease (MC), Therapeutic Duplication (TD), Ingredient Duplication (ID), High Dose (HD)
- Due to a lack of quorum, a motion could not be made to accept these alert profile recommendations. It was agreed that the Board would be polled after the DUR

meeting to approve these recommendations. There was no further discussion.

**ACTION ITEM:** Survey the DUR Board members regarding alert profile recommendations for GCNs added in Q4 2015 and report these recommendations at the upcoming DUR meeting in May.

ii. Review of Prospective DUR Criteria: Late Refill (LR) Alert

- Ms. Fingado reported that in the Medi-Cal System, the LR alert is generated when a sub-therapeutic pattern of prescription drug use is detected. Specifically, alerts are generated when patients fail to renew prescriptions for selected maintenance drugs before more than 125 percent of the days' supply of the previous prescription has been used. A review of the LR alert showed the following inconsistencies between drugs that appear on the Medi-Cal LR target drug list and drugs with the LR alert turned on in the Medi-Cal prospective DUR system:
  - Some drugs appear in the DUR manual on the LR target drug list (TDL) but the LR alert is not turned on in the system
  - Some drugs that are generally not used as maintenance therapy appear on the LR target drug list and/or have the LR alert turned on in the system
- Ms. Fingado summarized the current prospective DUR criteria in a table that included the name of the drug, whether or not the drug had the LR alert on, whether or not the drug appeared on the LR TDL, and a recommended action, if any.
- Ms. Fingado recommended removing the following drugs from the LR target drug list: CELECOXIB, CIPROFLOXACIN, CLONAZEPAM, EPOETIN ALFA, FENTANYL, LEVOFLOXACIN, MEGESTROL, MORPHINE/OPIUM, NITROGLYCERIN, OXYCODONE, PHENOBARBITAL, TESTOSTERONE, TRAMADOL, and ZOLPIDEM
- Ms. Fingado also recommended turning off the LR alert for the following drugs (all GCNs): CELECOXIB, CLONAZEPAM, EPOETIN ALFA, MEGESTROL, MORPHINE/OPIUM, NITROGLYCERIN, PHENOBARBITAL, and TESTOSTERONE and turning on the LR alert for the following drugs (all GCNs): GABAPENTIN and LEVOTHYROXINE.
- Dr. Stafford wondered why we would want to turn off PHENOBARBITAL, as it can be used chronically for seizure disorders. Dr. Thompson stated that we had recommended turning off LR alerts for all scheduled drugs, but she agreed with Dr. Stafford that it would make sense to keep the LR alert on for single-ingredient PHENOBARBITAL products only. Dr. Stafford agreed the LR alert did not need to remain on for PHENOBARBITAL combination drugs. Drs. Wong and Mowers also agreed with Dr. Stafford and suggested accepting all other recommendations (besides single-ingredient PHENOBARBITAL, which will remain on). There was no further discussion.
- Due to a lack of quorum, a motion could not be made to accept these recommendations. It was agreed that the Board would be polled after the DUR meeting to approve these recommendations. There was no further discussion.

**ACTION ITEM:** Survey the DUR Board members regarding LR alert recommendations and report these recommendations at the upcoming DUR meeting in May.

i. Review of DUR Educational Outreach to Providers

i. Updated Proposal: MEDD Letter

- Ms. Fingado presented updated information about the target population for this intervention. She described that between July 1, 2015 and December 31, 2015 a total of 39,713 paid claims exceeded > 80 mg MEDD, representing 10,167 Medi-Cal fee-for-service beneficiaries. Ms. Fingado then stated that the following inclusion/exclusion criteria were applied in a stepwise order to these 10,167 beneficiaries, in order to determine the size of the study population:
  - A total of 5,157 beneficiaries were excluded as they were currently receiving buprenorphine as part of a narcotic withdrawal treatment plan between July 1, 2015 and December 31, 2015;

- A total of 1,848 beneficiaries had approved Treatment Authorization Requests (TARs) on file for opioid paid claims between July 1, 2015 and December 31, 2015;
- A total of 1,084 beneficiaries were not continuously-eligible in the Medi-Cal fee-for-service program since July 1, 2015 (including January 2016);
- A total of 336 beneficiaries had a primary or secondary diagnosis of cancer between January 1, 2015 and December 31, 2015;
- A total of 321 beneficiaries resided in a long-term care facility or received hospice care between January 1, 2015 and December 31, 2015.

Ms. Fingado stated that after all listed inclusion/exclusion criteria were applied there was a total study population of 1,421 beneficiaries with 3,340 paid claims that exceeded > 80 mg MEDD (for a total of 1,147 providers). As described in the prior version of the methods, which was presented to the DUR Board on November 17, 2015, Ms. Fingado reported that because the total number of provider letters for this mailing would exceed 500 letters, the MEDD threshold would be adjusted to > 120 mg MEDD and the days' supply filtered to only include those paid claims with a days' supply greater than 14 days. This brought the number of providers to 380, representing 464 beneficiaries and 1,542 paid claims. Ms. Fingado reported that only 218 of these providers had mailing addresses listed in the Medi-Cal Provider Master File (representing 276 beneficiaries and 951 paid claims).

Dr. Stafford inquired as to why the provider address is still limiting the sample so significantly. He suggested that DHCS take whatever steps necessary to fix this issue so physician addresses are not a limiting factor in the DUR program's educational outreach to providers. Ms. Chan agreed and said she would work with Xerox and UCSF to explore ways to use alternate data sources for future provider mailings.

Ms. Fingado also reported that after the materials were submitted for this meeting, it was suggested by Dr. Gasper (DHCS) that patient profiles be included with this mailing to show clinically-relevant hospitalizations and/or emergency department visits, if any. She stated he also recommended the inclusion of all opioid claims in the profile, as well as additional paid claims for high-risk concomitant medications like benzodiazepines. The Board agreed this would be very helpful to providers.

Dr. Mowers stated that he thought this educational outreach letter should move forward, although a motion could not be made to recommend this outreach due to a lack of quorum. It was agreed that the Board would be polled after the DUR meeting to approve these recommendations. There was no further discussion.

**ACTION ITEM:** Survey the DUR Board members regarding educational outreach to providers using the updated parameters described in the MEDD proposal and report these recommendations at the upcoming DUR meeting in May

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

**i.** Review of Retrospective DUR Criteria: Skeletal Muscle Relaxants

- The DUR Board had expressed an interest in finding out more information about the utilization of CARISOPRODOL and other SKELETAL MUSCLE RELAXANTS in the Medi-Cal fee-for-service population. Dr. Lynch reported that as of January 11, 2012, CARISOPRODOL is listed as a schedule IV controlled substance and currently is only available to Medi-Cal fee-for-service beneficiaries with an approved *Treatment Authorization Request (TAR)*. Dr. Lynch stated that combining prescription opioids with other drugs, such as benzodiazepines and skeletal muscle relaxants, may increase the risk of morbidity and mortality due to additive effects on the respiratory and central nervous systems and that the simultaneous use of opioids, benzodiazepines, and skeletal muscle relaxants (colloquially known as the "triple threat") may result in a feeling of euphoria similar to that produced by heroin. Dr. Lynch also reported that the combination of hydrocodone, carisoprodol, and alprazolam is also referred to in street

terms as the “holy trinity”.

- Dr. Lynch presented utilization data for all paid claims for SKELETAL MUSCLE RELAXANTS in the Medi-Cal fee-for-service program between September 1, 2014 and August 31, 2015. Dr. Lynch reported a total of 25,797 Medi-Cal fee-for-service beneficiaries had at least one paid claim for a SKELETAL MUSCLE RELAXANT during this measurement year, with the majority of beneficiaries (n=24,258; 94%) having at least one paid claim during the year for BACLOFEN. A further review of the 703 beneficiaries with at least one paid claim for CARISOPRODOL found the majority of these beneficiaries (n=647; 92%) also had at least one paid claim for an opioid and/or a benzodiazepine during the measurement year, with a total of 256 beneficiaries (36%) having at least one paid claim for both opioids and benzodiazepines. Of these 256, Dr. Lynch reported that at least seven of these beneficiaries (3%) are now deceased, and three of them all received medical care from the same small town (population less than 16,000). Further, a review of demographic characteristics for the CARISOPRODOL study population showed those beneficiaries with a paid claim for any opioid AND any benzodiazepine were predominantly female, between 18 and 39 years of age, and white/Caucasian, non-Hispanic. Finally, Dr. Lynch explained that the distribution of beneficiaries by California region of residence showed the fewest beneficiaries in the study population resided in the Bay Area and Los Angeles regions, while the more rural North and Mountain region had the greatest number of beneficiaries in the study population. Of note, Dr. Lynch stated that almost half of the study population (n=120; 47%) resided in one of two California counties: one in the Southern California without Los Angeles region (n=63; 25%) and one in the North and Mountain region (n=57; 22%).
- Dr. Lynch recommended the following to the DUR Board for their consideration:
  - Conduct a retrospective DUR outreach to prescribers for patients in the CARISOPRODOL study population who also have paid claims for opioids and benzodiazepines. The proposed outreach would include 1) patient profiles with all paid claims for these drugs, including dates of service, drug strength and quantity, and prescriber name and city and 2) information on the dangers of the triple threat.
  - Write a DUR bulletin to promote the appropriate prescribing of SKELETAL MUSCLE RELAXANTS, including 1) an overview of the safety considerations when prescribing SKELETAL MUSCLE RELAXANTS (especially drug interactions); 2) a description of the triple threat, highlighting the potential lethal consequences of concomitant use of SKELETAL MUSCLE RELAXANTS, opioids, and benzodiazepines; 3) an evaluation of concomitant use of opioids and benzodiazepines across beneficiaries with a paid claim for any SKELETAL MUSCLE RELAXANT; and 4) links to prescription drug abuse resources for prescribers and pharmacists

Dr. Stafford recommended including CYCLOBENZAPRINE in addition to CARISOPRODOL in the evaluation. Drs. Wong and Mowers stated that they agreed with these recommendations, although a motion could not be made due to a lack of quorum. It was agreed that the Board would be polled after the DUR meeting to approve these recommendations. There was no further discussion.

**ACTION ITEM:** Survey the DUR Board members regarding both educational outreach to providers and the writing of an educational bulletin (as outlined in the retrospective DUR review of skeletal muscle relaxants, with the addition of CYCLOBENZAPRINE) and report these recommendations at the upcoming DUR meeting in May.

- k. Review of DUR Publications presented by Dr. Shalini Lynch (UCSF)
  - i. DUR Educational Bulletin (November 2015): Anticholinergics and Antipsychotics
    - Dr. Lynch presented a summary of the DUR educational bulletin entitled, “Clinical Review: Concomitant Use of Anticholinergics and Antipsychotics.” This bulletin had the following learning objectives:
      - Understand the role of anticholinergic medications in the prevention and treatment of antipsychotic-induced extrapyramidal symptoms (EPS)

- Describe factors that should be considered when deciding to initiate and/or continue the concomitant use of anticholinergic with antipsychotic medication therapy.
- Dr. Lynch reported that while anticholinergic medications are frequently prescribed to prevent or treat EPS the long-term benefit of these drugs has not been established and the need for continued therapy is frequently not re-assessed and many patients may remain on these agents for years or decades. She described a general ranking of selected first- and second-generation antipsychotic medication by propensity for EPS and summarized current treatment guidelines.
- Dr. Lynch described utilization of anticholinergic medications in the Medi-Cal population, including a description of beneficiaries with at least one claim for an anticholinergic medication during a one-year time period. She reported that among Medi-Cal beneficiaries with a paid claim for an anticholinergic medication with ≥ 30 days supply, almost all beneficiaries (96%) also had at least one paid claim for an antipsychotic medication during the same time period and of the 34,879 beneficiaries with a paid claim for benztropine and/or trihexyphenidyl with ≥ 30 days supply, 51% had at least 6 paid claims during the measurement year and 17% had at least 12 paid claims during the measurement year.
- Dr. Lynch also reported that in the study population, clozapine had the highest rate of chronic use of anticholinergic medications (21%) among all second-generation antipsychotics even though it is generally thought to have the lowest propensity for EPS.
- The bulletin recommended that prophylactic use of anticholinergic medications is not recommended for patients taking second-generation antipsychotics and for patients taking first-generation antipsychotics, prophylactic use of anticholinergic medications to prevent extrapyramidal symptoms should be determined on a case-by-case basis, with patient-specific and medication-specific factors considered. In addition, continued use of anticholinergic medications should be re-evaluated in patients with controlled symptoms every three months and should be discontinued in older patients and/or persons with high genetic risk of cognitive disorder who use anticholinergic medications and are at increased risk of cognitive decline and dementia.

ii. DUR Educational Alert (January 2016): CURES 2.0

- Dr. Lynch summarized the educational alert entitled, “Alert: California Upgrades Prescription Drug Monitoring Program to CURES 2.0.” Dr. Lynch reported that as of January 8, 2016, California has updated their prescription drug monitoring program, the Controlled Substance Utilization Review and Evaluation System (CURES) to CURES 2.0. This upgraded database offers a significantly improved user experience and features a number of added functionalities, including the ability to delegate report queries and new practitioner-identified patient alerts. Dr. Lynch described the streamlined registration process that has been implemented for new users. Licensed health care prescribers and pharmacists can now request access to the CURES database and validate their credentials entirely online using a secure web browser (Microsoft Internet Explorer 11 or higher, Mozilla Firefox, Google Chrome, or Safari). Users attempting to access the new CURES 2.0 database with noncompliant web browsers will be redirected to the previous CURES system.
- Finally, Dr. Lynch reminded the Board that all health care practitioners authorized to prescribe or dispense Schedule II – IV controlled substances must be registered to use CURES by July 1, 2016.

iii. Discussion/Recommendations for Future Educational Bulletins

- The calendar for future DUR educational bulletins was reviewed. The Board did not have any suggested changes or additions/deletions at this time.
- Ms. Fingado advocated for moving forward the publication of a DUR educational bulletin on buprenorphine, using data presented in the retrospective DUR review at the November 2015 Board meeting. She noted that recent Medi-Cal policy changes have allowed for increased access of beneficiaries to buprenorphine and that a bulletin would be timely and could help increase awareness among providers about

	<p>the expanded access. She referred to a recent DUR publication on nicotine replacement therapy as a model for this type of bulletin. Both DHCS and CDPH have worked to expand access to buprenorphine and these efforts could be highlighted in the bulletin.</p> <ul style="list-style-type: none"> <li>• Drs. Wong, Stafford, and Mowers stated that they agreed with the recommendation to write a DUR bulletin on buprenorphine, as outlined in the review, although a motion could not be made due to a lack of quorum. It was agreed that the Board would be polled after the DUR meeting to approve this recommendation. There was no further discussion.</li> </ul> <p><b>ACTION ITEM:</b> Survey the DUR Board members regarding a DUR educational bulletin on buprenorphine and report these recommendations at the upcoming DUR meeting in May.</p>
<b>5) PUBLIC COMMENTS</b>	<ul style="list-style-type: none"> <li>• None.</li> </ul>
<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 May 17, 2016 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 12 p.m.</li> </ul>

<b>Action Items</b>	<b>Ownership</b>
Incorporate Dr. Wong's edits into the minutes and post to the DUR website.	Ivana
The DUR Board recommendation to further research the pricing policy for code Z7610 will be submitted to DHCS.	Pauline/Ivana
Survey the DUR Board members regarding alert profile recommendations for GCNs added in Q4 2015 and report these recommendations at the upcoming DUR meeting in May.	Amanda
Survey the DUR Board members regarding LR alert recommendations and report these recommendations at the upcoming DUR meeting in May.	Amanda
Survey the DUR Board members regarding educational outreach to providers using the updated parameters described in the MEDD proposal and report these recommendations at the upcoming DUR meeting in May	Amanda
Survey the DUR Board members regarding both educational outreach to providers and the writing of an educational bulletin (as outlined in the retrospective DUR review of skeletal muscle relaxants, with the addition of CYCLOBENZAPRINE) and report these recommendations at the upcoming DUR meeting in May.	Amanda
Survey the DUR Board members regarding a DUR educational bulletin on buprenorphine and report these recommendations at the upcoming DUR meeting in May.	Amanda