Attachment C

West Virginia Department of Health and Human Resources
Bureau for Medical Services

Drug Utilization Review
Administered By:
ACS, A Xerox Company
2810 N. Parham Road, Ste. 210
Richmond, VA. 23294

Date

Joe Black
2810 N. Parham Road
Richmond, VA 23294

RE: Caring for Your Patients on Gastrointestinal Medications

Dear Dr. <<NAME>>:

The goal of this quality management program is to assist you in caring for your patients using gastrointestinal medications. This program is based on treatment guidelines provided by the American College of Gastroenterology and the American Gastroenterological Association and is designed to assist you in maximizing patient outcomes and promoting patient safety.[1-5]

Claims data indicates that in the West Virginia Medicaid Program there are over 16,000 individuals being treated with anti-secretory agents. This treatment included 71,866 prescriptions for anti-secretory therapy in a recent 90 day period at the total cost of $5,388,495.

West Virginia Specific Data

Gastrointestinal Medication Management Indicators	Number of Patients with Opportunities*
• Promote appropriate duration of use of proton pump inhibitors (PPIs)/H_2 recepto antagonists (H2RAs) in patients with an unknown diagnosis	2,862
• Identify patients with peptic ulcer disease (PUD) who may be candidates for *H pylori* testing secondary to an extended duration of PPI therapy	212
• Identify patients receiving duplicate anti-secretory therapy	101
• Identify patients who may be at risk for developing an adverse event with a nonsteroidal anti-inflammatory drug (NSAID)	518
• Identify patients receiving medications that may exacerbate gastroesophagea reflux disease (GERD) symptoms	12,974
• Promote once-daily dosing of proton pump inhibitors	738

*Based on data through September, 2012

The enclosed patient profile(s) reflect one or more of the above issues and are provided as a chart reminder for when your patient(s) return for their next appointments.

We acknowledge that there may be clinical variables influencing an individual patient's management that are not apparent in claims data or that a patient may have been inadvertently identified as being under your care. We thank you for reviewing this information and caring for West Virginia Medicaid patients and welcome the opportunity to discuss any comments or concerns you may have about our quality management program. Please feel free to call our office at 1-866-923-7208 with questions or concerns.

Sincerely,

Lyle Henry, MD, FACS,
Medical Director

West Virginia Department of Health and Human Resources
Bureau for Medical Services

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Gastrointestinal Medication Management Indicator Summary

- **Promote appropriate duration of use of PPIs/H2RAs in patients with an unknown diagnosis:** Anti-secretory therapy is indicated for 8 weeks or less in the majority of PUD patients, with maintenance therapy used in patients at high risk for ulcer recurrence (e.g., recurrent or *H. pylori* negative ulcers, or patients with a history of ulcer complications such as bleeding or perforation). Due to the high rate of placebo response and variable efficacy of drug regimens for non-ulcer dyspepsia, periodic reevaluation of anti-secretory therapy and trial off medication, if appropriate, should be considered.
- **Identify patients with PUD who may be candidates for *H. pylori* testing secondary to an extended duration of PPI therapy:** PPIs effectively heal peptic ulcers in 4 to 8 weeks and are not generally indicated for maintenance therapy in PUD, except for refractory cases. Currently *H. pylori* testing is recommended in all patients with a history of, or active PUD. Treatment for *H. pylori* has been shown to decrease ulcer recurrence greater than acid suppression alone. Once patients have been treated for *H. pylori,* the PPI can be discontinued.
- **Identify patients receiving duplicate anti-secretory therapy:** Within-class (H2RA or PPI) duplicate therapy increases cost without increasing efficacy. Patients may have continued therapy when therapy is changed from a PPI to H2RA (or vice versa) due to misunderstanding directions. When multiple prescribers are involved, coordination of care issues may also result in duplication of therapy. Additionally, combination therapy with a PPI and H2RA is not routinely recommended.
- **Identify patients who may be at risk for developing an adverse event with a NSAID:** NSAID use is one of the critical factors underlying recurrent or refractory ulceration. Every effort should be made to reduce or eliminate NSAID use in patients with PUD.
  - **Patients with risk factors for a NSAID-induced ulcer and receiving chronic NSAID and H2RA therapy:** NSAID use is an important factor in the development of PUD. Several factors have been identified that place patients with NSAID use at risk for GI complications (e.g., increased age, high dose NSAID, multiple NSAIDs, and concurrent use of corticosteroids or anticoagulants). Every effort should be made to reduce or eliminate NSAID use in patients with these risk factors. Additionally, H2RAs are not recommended for the prevention of NSAID-induced ulcers.
    - **Patients with PUD receiving a NSAID plus an H2RA:** H2RAs are not recommended for the prevention of NSAID-induced ulcers.
    - **Patients with PUD receiving a NSAID and anti-secretory agent from different prescribers:** When multiple prescribers are involved, coordination of care issues may need to be resolved.
- **Identify patients who are receiving medications that may exacerbate GERD symptoms:** A number of medications have been reported to worsen the symptoms of GERD. Avoiding use of these medications in patients with GERD, may reduce the risk of potentially worsening symptoms.
- **Promote once-daily dosing of PPIs:** Current literature does not strongly support the use of higher than standard doses of PPIs for most indications. Additionally, the majority of efficacy studies for PPIs utilize once-daily dosing. If inadequate symptom response is obtained with once-daily dosing in patients with GERD, twice-daily dosing is recommended.

Selected References (full reference list available upon request)**:**

1. American Gastroenterological Association Institute Technical Review on the Management of Gastroesophageal Reflux Disease. Gastroenterology 2008;135:1392-1413.
2. Soll AH. Medical Treatment of Peptic Ulcer Disease: Practice Guidelines. JAMA 1996;275(8):622-629.
3. Chey WD and Wong BCY. American College of Gastroenterology Guideline on the Management of *Helicobacter pylori* Infection. Am J Gastroenterol 2007;102:1808-25.
4. Lanza FL, Chan FKL, Quigley EM et al. Guidelines for the prevention of NSAID-related ulcer complications. *Am J Gastrenterol* 2009;104:728-38.
5. Bhatt DL, Sceiman J, Abraham NS, et al. ACCF/ACG/AHA 2008 Expert consensus document on reducing the gastrointestinal risks of antiplatelet therapy and NSAID use: a report of the American College of Cardiology Foundation Task Force on Clinical Expert Consensus Documents. Am J Gastroenterol 2008;103:2890-2907.