cens about safety and impact on patient outcomes. Attitudes about the proliferation of messages they perceive as “false-positives” could explain the inconsistency among pharmacist responses to drug interaction messages (DIMs). Our objective is to report a pilot study examining pharmacist utilization and perceptions of DIMs. 

METHODS: A semi-structured telephone interview protocol was developed using Likert scales assessing pharmacists’ utilization and attitudes regarding DIMs. Utilization measures included perception of false positive DIMs and desensitization to DIMs. Attitude assessments included confidence, usefulness, and satisfaction with the drug interaction programs, and influence of liability concerns. A convenience sample of 44 West Virginia pharmacists responded during March 2002. ANOVA was used to analyze relationships among variables in this descriptive study. RESULTS: Among respondents, 36.4% perceived that 21–30% of DIMs were insignificant; 13.5% perceived that >50% of DIMs were insignificant. Using a 5-point scale (1 = not at all, 5 = very much), pharmacists reported desensitization to DIMs (median = 4.0). Pharmacists perceiving DIMs as more insignificant also reported greater desensitization to DIMs (F = 3.04, p < .05). Pharmacists found the programs useful (median = 4.0), were somewhat confident (median = 3.5) or satisfied with the programs (median = 3.0). Those who found the program more useful (F = 6.38, p < .05), or were more confident (F = 3.09, p < .05) or satisfied with the program (F = 6.95, p < .05), were significantly less desensitized to DIMs. Also, the more desensitized to DIMs, the more the pharmacist was influenced by liability concerns in deciding to report a DIM to the patient and/or physician (F = 4.54, p < .01). CONCLUSIONS: These pilot results suggest further research is warranted. Pharmacist utilization of drug interaction programs is inconsistent; this may be influenced by attitudes towards DIMs. Information regarding attitudinal barriers can provide content for pharmacist training or for vendor development of drug interaction programs.

REVIEWS OF UTAH MEDICAID HIGH UTILIZERS TO CONTROL DRUG COSTS
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OBJECTIVES: Utah Medicaid began a process to limit patients to 7 paid non-exempt prescriptions per month (maximum 30 day supply) in early 2002. Exempt prescriptions included prescriptions for antibiotics and many chronic drugs, and more than one prescription for the same NDC in the same month. One-third of prescriptions are exempt. Prior to mandating the 7 prescription limit Utah Medicaid contracted to develop a process to improve drug use and reduce costs. The project objective is to describe and evaluate that process. METHODS: Available data include eligibility files, pharmacy claims, and medical claims, including ICD9 coding. Reviews began in May 2002 and focus on the highest utilizers. Two hundred patients are reviewed each month; 50 nursing home patients and 150 non-nursing home patients. There were 249,447 Medicaid eligibles and 147,186 utilizers in FY2002. If drug related issues are identified, letters are sent to prescribers with recommendations along with a list of all prescription claims (including cost). RESULTS: Patients with >7 non-exempt prescriptions have been reduced from 5593 in May 2002 to 2326 in September 2002. The first review cohort (May reviews) showed a reduction from 16.4 to 10.7 in mean non-exempt prescriptions. Drug costs for the May cohort in October were 46% lower than in May. The June and July cohorts were reduced by 32% and 25% respectively; June vs October, and July vs October while drug costs for non-reviewed patients increased at a 16% annual rate. Actual drug costs for the May cohort from May to October were $1,042,643. This compares with an expected cost of $1,592,564 (May costs increased by an annual 16%). Annualized cost savings for the May, June, and July cohorts are approximately $2.3M. Program costs are approximately $300,000 per year. CONCLUSION: Focused reviews of Medicaid high utilizers, and communication with prescribers, can reduce drug costs.