

Iowa Medicaid Drug Utilization Review Commission

Meeting Minutes February 4, 2009

Attendees:

Commission Members
Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Laura Griffith, D.O.; Laurie Pestel, Pharm.D.; Mark Graber, M.D.; and Susan Parker, Pharm.D.

Staff
Timothy Gutshall, M.D. (Medicaid Medical Director pro-temp); Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.

Guests
Sandy Pranger, R.Ph., IME; Chuck Wadle, D.O., Magellan; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Timothy Gutshall called the meeting to order at 9:29 a.m. at the West Des Moines Learning Resource Center. Commission members, guests, and observers were welcomed and introduced.

The minutes from the December 3, 2008 meeting were approved. (Motion by Bruce Alexander, second by Dan Murphy, unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

The new Preferred Drug List has been posted on the website, reflecting all the recent brand-generic status changes due to SMAC price updates.

Management Reports

Chad Bissell noted that the average cost per claim, total dollars paid, and number of claims paid has all increased significantly from the first quarter of the state fiscal year to the second. This is due in large part to the dispensing of palivizumab (*Synagis*), as well as increased use of antibiotics and cough and cold products. However, the percentage of controlled substances has remained at approximately 18.9%. Cheratussin Syrup was #5 on the top drugs by NDC report for the second quarter, and palivizumab (*Synagis*) was #1 on the top drugs by dollars spent report, at \$4,595,424.22. The line-up of the top therapeutic class by total prescriptions report and the top therapeutic class by dollars spent report has remained constant and both are dominated by mental health drug categories. In addition, generic utilization has continued to increase.

Smoking Cessation Report for Legislature

The Commission reviewed the final version of this report that had been sent to the legislature with slight formatting revisions.

P&T Recommendations on Select Mental Health Drugs

The Mental Health Advisory Group was unable to reach a recommendation at their December 12th meeting due to questions from the members in regards to administrative procedures and policies. They will meet again on February 13th, so their recommendations can then be brought to the next DUR meeting on March 4th and discussed prior to the March 12th P&T meeting.

ProDUR

Expansion of the Quantity Limits List, in regard to the short-acting narcotics, was discussed. Other states have implemented quantity limits on controlled substances in order to control costs, prevent over-utilization, and help prevent diversion. Pam Smith reviewed the report generated per the Commission's request at their previous meeting, which illustrated that there would currently only be 16 members affected by the proposed quantity limits. However, 10 of those members together accounted for 27 claims for generic propoxyphene/APAP (*Darvocet-N 100*) which exceeded the daily acetaminophen dosage. A FDA panel recently discussed propoxyphene/APAP (*Darvocet*) and propoxyphene (*Darvon*) and recommended removing them from the U.S. market based on efficacy concerns and safety risk. A column will be added to the posted quantity limits list to clarify allowable daily dosing. Dan Murphy motioned to accept the limits as recommended, and Bruce Alexander seconded. However, both were later withdrawn after a discussion of the benefits of holding off on these quantity limit changes. Since there would potentially be more additions in the near future, only one education release would need to be sent to prescribers and providers. Chad Bissell will bring a report entailing utilization on all pain medications that contain acetaminophen to the next meeting for further discussion.

Quarterly Narcotics Report

The first batch of letters will be mailed to prescribers in April, and there will be an article in the next DUR Digest. Dr. Charles Wadle asked if substance abuse programs would have access to IMERS to ease monitoring. Chad Bissell will look into this. The cover letter draft will be reworded to make sure that prescribers know they can actually refer patients to the Lock-In program.

Focus Studies

Long Term Muscle Relaxants: Pam Smith presented the follow-up information from a study wherein letters were sent to 197 members who were identified as having 5 or more claims of a 30-day supply for a muscle relaxant (excluding baclofen) between 10-1-07 and 3-31-08. Letters were sent to the prescribers and pharmacies in May of 2008. At the end of the evaluation period on 12-31-08, the following impact was observed: 14 members discontinued use of muscle relaxants, and 98 surveys were returned. This resulted in a cost savings of \$4,559.79 (state and federal dollars, pre-rebate), of which \$2,814.76 (pre-rebate) was savings to the state.

Anticonvulsant Drugs used in Mental Health Disorders: The IME identified unique members with two or more fills for any one or combination of the following drug classes; all typical antipsychotics, all atypical antipsychotics, clozapine, lithium, *Lamictal* (lamotrigine), valproic Acid (which includes *Depakote*, *Depakote ER*, *Divalproex*, valproate sodium, *Depakene*, and *Stavzor*), and carbamazepine (which includes *Tegretol*, *Tegretol XR*, *Equetro*, and *Carbatrol*). From this list, members with a diagnosis code in their claims history for epilepsy, seizure disorder, migraine, fibromyalgia, diabetic peripheral neuropathy, and post-herpetic neuralgia were removed. From the remaining members, those who also have two or more fills for an anticonvulsant(s) during the same time frame other than carbamazepine, valproic acid and/or *Lamictal* were identified. There was also an age break-down as requested. Of the 487 unique members taking a single anticonvulsant, 216 were under 18 years old. Of the 38 unique members taking multiple anticonvulsants, 11 were under 18. There were 339 members who were not taking carbamazepine, *Lamictal*, and/or valproic acid, but who were taking: *Trileptal*/oxcarbazepine (194), gabapentin/*Neurontin* (67), *Topamax*/topiramate (36), *Zonegran*/zonisamide (15), *Lyrica* (pregabalin) (11), *Gabitril* (tiagabine) (7), *Mysoline*/primidone (5), *Dilantin*/*Dilantin Infatabs* (2), *Keppra* (levetiracetam) (1), or phenytoin (1). There were 140 members taking an anticonvulsant in addition to carbamazepine or *Lamictal* or valproic acid, and 8 members taking 2 anticonvulsants in combination with 2 of the approved mood-stabilizer medications. No one was taking an additional anticonvulsant on top of all 3 of them. There were 87 members on multiple anticonvulsants; 48 of which were not on any of the approved drugs, and 39 of which were only on 1 of the 3 approved medications. A table was provided illustrating the most popular anticonvulsant drug pairings among the 87 members on multiple anticonvulsants. The top 3 were: *Keppra* with *Diastat* (diazepam), *Lyrica* with gabapentin, and gabapentin with *Topamax*. The Commission recommended letters continue to be sent to these prescribers during the normal member profile review process.

New Clozapine Users and Frequency of Monitoring: The purpose of this study was to identify new starters of clozapine and follow monitoring for White Blood Count (WBC), Absolute Neutrophil Count (ANC), and clozapine blood levels from May 1, 2008 to October 31, 2008. A secondary purpose was to determine the effect, if any, of clozapine use on doses of atypical antipsychotics. Testing is supposed to be done every week for the first 6 months of therapy, then every 2 weeks until a year of usage, and finally every 4 weeks provided no adverse reactions are observed. For the members identified, only 20% of the required testing is getting done. Out of the 35 members listed on the report, there were 28 that had no lab work done. There were 9 members using clozapine in combination with some other second-generation antipsychotic, and there were no checks for clozapine blood levels in their claim history. Bruce Alexander said that the high-risk period was 6-18 weeks after starting the medication, and many members are not being monitored during that period. Susan Parker asked that the filter criteria be re-examined to be sure that

hospitalized patients were not included. Due to billing procedures, it could have been possible for hospitalized members to receive tests that would not appear in the claims data that had been retrieved. Research results will be brought to the next meeting.

Duplicate Benzodiazepine Utilization: The purpose of this study is to identify unique members using duplicate benzodiazepines, a benzodiazepine in combination with a nonbenzodiazepine sedative/hypnotic, or a benzodiazepine in combination with buspirone from 9/1/08 to 11/30/08. In order for the members to appear in this report, they had to have duplication all three months, which eliminated any cross tapering of products. A total of 519 unique members were identified, of which 300 were on duplicate benzodiazepines, 137 on a benzodiazepine in combination with a nonbenzodiazepine sedative/hypnotic, and 91 on a benzodiazepine in combination with buspirone. Some of these 519 unique members appeared in more than one sub-classification. The majority of these members are going to the same prescriber and pharmacy for all their medications (involved in this study). Bruce Alexander asked that the report detail be summarized and broken down into ratios for future trend analysis such that the number from each group was the numerator and the total (519) was the denominator. The medications will be further broken down into groups of short-acting, intermediate, and long-acting medications. It was recommended that this be taken to the Mental Health Advisory Group. Dr. Mark Graber also recommended that the Commission consider adding benzodiazepines to the Quarterly Narcotic Report to Prescribers.

Duplicate Long-Acting Narcotic Utilization: The purpose of this study was to identify unique members using duplicate long-acting narcotics (*Duragesic*, fentanyl, methadone, *Kadian*, *MS Contin*, morphine sulfate sr or er, *Oramorph SR*, *Avinza*, *Oxycontin*, oxycodone er, and *Opana ER*). Members with a diagnosis of cancer were excluded. There were 21 unique members on duplicate long-acting therapy. There were also many instances where methadone was combined with other long-acting narcotics, and letters will be sent to the corresponding prescribers regarding this. Buprenorphine (*Subutex*) and Buprenorphine/Naloxone (*Suboxone*) combinations with other narcotics were also mentioned, and will be discussed at a future meeting.

Public Comment

Nancy Bell from Pfizer spoke about pregabalin (*Lyrica*), as well as antiepileptics and a letter that had gone out regarding metabolic testing. Leah McWilliams from the Iowa Osteopathic Association spoke of her concerns regarding the proposed quantity limit additions and possible titration issues.

Prior Authorization

Incretin Mimetic (Byetta): The Commission reviewed the PA criteria as had been requested by the P&T Committee as follows:

Prior authorization is required for incretin mimetics (Byetta®). Payment will be considered under the following conditions:

- 1) *Diagnosis of Type 2 diabetes mellitus,*
- 2) *Unless otherwise contraindicated, the member has not achieved HbA1C goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum tolerated doses.*

Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbA1C since the beginning of the initial prior authorization period.

Both the Iowa Diabetes and Endocrinology Center in Des Moines, and the Endocrinology Department at the University of Iowa Hospitals and Clinics were contacted in December, and twice in January soliciting their comments. After reviewing input from one endocrinologist from Des Moines, and two other unsolicited comments from general practitioners, the Commission decided that the existing criteria were sufficient and recommended no changes.

Biologicals for Arthritis: The Commission reviewed the following PA criteria as several studies have come out in the last few years that suggest that certain patients with severe rheumatoid arthritis benefit more from using methotrexate plus a biological as initial therapy rather than using the traditional step therapy with a DMARD to a biological.

Prior authorization is required for biologicals used for arthritis. Payment will be considered following an inadequate response to a preferred disease modifying antirheumatic drug such as hydroxychloroquine, sulfasalazine, methotrexate, leflunomide, d-penicillamine, azathioprine, oral gold, or intra-muscular gold. Prior authorization is required for all non-preferred biologicals for arthritis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

After a review of the journal articles, the Commission members agreed that no recommended changes were required at this time.

Public Comment

Shawn Ahearn from Wyeth spoke about desvenlafaxine (*Pristiq*), and Christine Soltwedel from Abbott Labs spoke about the prior authorization process.

Miscellaneous

DUR Digest 2009 Volume 21, Number 2: The Commission members offered suggested changes to the draft.

MedWatch: There were recall notices for hydromorphone HCl 2mg tablets as well as 25 various tainted weight loss tablets and capsules. There was also a letter from the Celgene Corporation concerning the safety of tinzaparin (*Innohep*).

Notification of FUL Updates: Notification of the FUL change letter dated 12-12-08 was provided to the commission.

A unanimous vote was made at 12:20 to adjourn the meeting and move to closed session (1st Craig Logemann, 2nd by Bruce Alexander).

The next meeting will be held at 9:30 a.m. on Wednesday, March 4, 2009 at the Learning Resource Center in West Des Moines, Iowa.