

## Recommendation Regarding ECG Monitoring in Patients on Methadone by the CSAT

In January, 2009, the following recommendation was issued: The Center for Substance Abuse and Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration has developed a consensus guideline statement outlining recommendations regarding ECG monitoring in patients being considered for and being treated with methadone regardless of indication. Of note, these recommendations should not supersede clinical judgment or patient preferences and may not apply to patients with terminal, intractable cancer pain.

Five recommendations have been developed:

**Recommendation 1 [Disclosure]:** Clinicians should inform patients of arrhythmia risk when methadone is prescribed.

**Recommendation 2 [Clinical History]:** Clinicians should inquire about any history of structural heart disease, arrhythmia, and syncope.

**Recommendation 3 [Screening]:** Clinicians should obtain pretreatment ECG for all patients to measure QT<sub>c</sub> interval, follow up ECG within 30 days, then annually (monitor more frequently if patient receiving >100 mg/day or if unexplained syncope or seizure occurs while on methadone).

**Recommendation 4 [Risk Stratification]:** If before or at anytime during therapy:

*QT<sub>c</sub> >450-499 msec:* Discuss potential risks and benefits; monitor QT<sub>c</sub> more frequently

*QT<sub>c</sub> ≥500 msec:* Consider discontinuation or reducing methadone dose or eliminate factors promoting QT<sub>c</sub> prolongation (eg, potassium-wasting drugs) or use alternative therapy (eg, buprenorphine)

**Recommendation 5 [Drug Interactions]:** Clinicians should be aware of interactions between methadone and other drugs that either prolong the QT interval or reduce methadone elimination.

The panel also concluded that the arrhythmia risk is directly associated with methadone's ability to block the delayed rectifier potassium channel (I<sub>kr</sub>) and prolong repolarization. The guideline further states that the use of the Bazett formula is adequate even though it is likely to overcorrect with high heart rates. The patient should remain supine for at least 5 minutes prior to obtaining ECG. In addition, screening for QT<sub>c</sub> prolongation using automated readings does not require a specialist (eg, cardiologist) and may be performed in a primary care setting. However, in cases when uncertainty exists about whether or not clinically significant QT<sub>c</sub> prolongation is present, the ECG should be repeated or interpreted by a cardiologist.

Methadone is a preferred drug on the Iowa Medicaid PDL. Other preferred options within the long acting narcotics PDL category include morphine sulfate ER, Kadian<sup>®</sup>, and Avinza<sup>®</sup>. No PA is required, but quantity limits do apply.

Krantz MJ, Martin J, Stimmel B, et al, "QT<sub>c</sub> Interval Screening in Methadone Treatment," *Ann Int Med*, 2009, 150(1):1-10.

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### ***The Bulletin of Medicaid Drug Utilization Review in Iowa***

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### Clinical Information

- At a recent meeting of the American Society of Clinical Oncology, two observational studies were presented looking at the effect of strong CYP2D6 inhibitors in patients taking tamoxifen in preventing recurrence of breast cancer. One of these two studies found that women who took CYP2D6 inhibitors, such as SSRIs, had a higher recurrence rate. Tamoxifen is a prodrug that requires metabolism by CYP2D6 to its active metabolite. SSRIs such as fluoxetine and paroxetine are potent inhibitors of CYP2D6. Sertraline is a moderate inhibitor of CYP2D6, and citalopram and escitalopram are less potent inhibitors of CYP2D6. Since there is no good evidence that one SSRI is more effective than another for treating depression, citalopram or escitalopram may be the safest choice for women that are taking tamoxifen and need to start an SSRI.
- The FDA is reminding health care professionals about the increased risk of neural tube defects and other major birth defects, such as craniofacial defects and cardiovascular malformations, in babies exposed to valproate sodium and related products (valproic acid and divalproex sodium) during pregnancy. The FDA will be working with the manufacturers of these products to address labeling changes. Healthcare practitioners should inform women of childbearing potential about these risks, and consider alternative therapies, especially if using valproate to treat migraines or other conditions not usually considered life-threatening. Women of childbearing potential should only use valproate if it is essential to manage their medical condition. Those who are not actively planning a pregnancy should use effective contraception, as birth defect risks are particularly high during the first trimester, before many women know they are pregnant.

### Preferred Drug List (PDL) Information

- **Antihistamines:** Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require prior authorization, prior to the approval of a non-preferred first generation or preferred second generation antihistamine. *Two* of the trials must be with cetirizine and loratadine. Patients 20 years of age and younger must have unsuccessful trials with cetirizine and loratadine prior to approval of a non-preferred first generation or preferred second generation prescription antihistamine.
- **Muscle Relaxants:** Requests for carisoprodol will be approved for a maximum of 120 tablets per 180 days at a maximum dose of 4 tablets per day when the criteria for coverage are met.
- The following generics are now preferred over the brand name: bupropion XL (*Wellbutrin XL*), ipratropium bromide/albuterol (*Duoneb*), medroxyprogesterone acetate IM (*Depo-Provera*), nifedipine ER (*Adalat CC*), norethindrone & ethinyl estradiol 1/35 (*Ortho-Novum 1/35*), ranitidine syrup (*Zantac Syrup*), sumatriptan (*Imitrex*), topiramate (*Topamax*), venlafaxine ER (*Effexor XR*).

- The Commission reported back on a focus study looking at duplicate inhaled anticholinergics. As a result of the intervention, the Commission reported a total cost savings of \$60,629.33 (State & Federal Dollars, pre-rebate) over a three month time frame.
- The Commission mailed out the first Quarterly Narcotic Utilization Report to Prescribers in September 2009. It is important for pharmacies to enter the correct prescriber information. Several phone calls were made to Iowa Medicaid by prescribers stating they do not have record of treating a listed member. The most common reason for this was incorrect information entered by the pharmacy. Prescribers need to contact the listed dispensing pharmacy to correct the information as Iowa Medicaid cannot correct this. Prescribers also need to keep their information current with Iowa Medicaid by contacting Prescriber Services any time their information changes. Provider Services can be reached at 1-800-338-7909 or 515-725-1004.

## Medicaid Statistics for Prescription Claims from October 1, 2009 to December 31, 2009

Number of claims paid: 1,073,953

Average amount paid per claim: \$59.81

Total dollars paid: \$64,236,696.20

Average amount paid per claim, brand: \$184.52

Percent controlled substances: 18.67%

Average Amount paid per claim, generic: \$13.09

Top Drugs by Number of Prescriptions*	Top Drugs by Dollars Spent (Pre-Rebate)	Top Therapeutic Class by Dollars Spent (Pre-Rebate)
<i>ProAir HFA</i> \$43.15/Rx	Synagis 100mg/ml \$1.1 million	Antipsychotics – Atypicals \$10.6 million
Hydrocodone/APAP 5-500 \$5.27/Rx	Concerta 36mg \$950,121	Anticonvulsants \$4.3 million
<i>Lexapro 20mg</i> \$82.05/Rx	<i>Adderall XR 20mg</i> \$936,561	Antidepressants – Selected SSRI's \$4.2 million
Cheratussin AC \$6.14/RX	<i>Abilify 5mg</i> \$900,442	Stimulants – Amphetamines – Long Acting \$3.9 million
Loratadine 10mg \$7.37/RX	<i>Lexapro 20mg</i> \$840,780	Stimulants – Methylphenidate-Long Acting \$2.6 million

\*Reported cost per prescription is pre-rebate



**Iowa Medicaid Drug Utilization Review**

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## Annual Call for New Commission Member

Attention Pharmacists: Are you looking for a new professional opportunity?

CMS requires state Medicaid programs to have a drug utilization review (DUR) program consisting of prospective DUR, retrospective DUR, and an educational program. The goal of the DUR program is to ensure appropriate medication therapy, while permitting appropriate professional judgment to individualize medication therapy. In Iowa, the DUR Board is referred to as the Iowa Medicaid DUR Commission. The Iowa DUR Commission is composed of four Iowa licensed physicians and four Iowa licensed pharmacists who serve four-year terms, as well as a representative from the Department of Human Services. The Commission meets on the first Wednesday six months of the year from 9:30 a.m. to 1:30 p.m.

The DUR Commission is currently seeking a Pharmacist who serves Medicaid members to join the committee. Any Pharmacist interested in serving in this capacity should send a resume or curriculum vitae, as well as a letter indicating their interest to Pam Smith at the address shown below. Candidates that would like more information about the Commission or who would like to speak to a present Commissioner are encouraged to call.

**The deadline for applications is May 1, 2010.**

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