Division of Medicaid

Office of the Governor

State of Mississippi

DUR Board Meeting

November 17, 2005

DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
DRUG UTILIZATION REVIEW BOARD
AGENDA

November 17, 2005

Welcome	**John Mitchell, MD**
Old Business	
Reading and Approval of September 29, 2005 DUR Board Meeting Minutes	**Lew Anne Snow, RN**
CNS Update	**Frankie Rutledge**
Updates	
Cost Management Analysis	**Dennis Smith, RPh**
Osteoporosis Targeted Intervention	**Dennis Smith, RPh**
Synagis® Prior Authorization and Utilization	**Kathleen Burns, RN** **Lew Anne Snow, RN**
Pharmacy Program Update	**Judith Clark, RPh**
New Business	**Dennis Smith, RPh**
DUR Intervention	
Marinol® Utilization	
Oxandrin® Utilization	
Lyrica® Utilization	
Second Quarter Criteria Recommendations	
Boxed Warning Update	
Next Meeting Information	**John Mitchell, MD**

Minutes of the September 29, 2005
Drug Utilization Review (DUR) Board Meeting

Members Attending: Billy Brown, Pharm.D, Randy Calvert, RPh, John Mitchell, M.D., Andrea Phillips, M.D., Lee Anne Ross, Pharm.D, Rudy Runnels, M.D.

Members Absent: Montez Carter, RPh, Lee Montgomery, M.D.

Also Present: Judith Clark, RPh, Terri Kirby, RPh, Sharon Barnett-Myers - DOM
Dennis Smith, RPh, Sam Warman, RPh, Lew Anne Snow, R.N., Kathleen Burns, R.N. –HID

Dr. John Mitchell called the meeting to order at 2:03 p.m.

Approval of the minutes of the March 31, 2005 and June 23, 2005 DUR Board meetings.
Dr. Runnels made a motion to accept the minutes of both meetings as written. Dr. Ross seconded the motion. All voted in favor of the approval.

Updates:
Sickle Cell Therapy Update:
Dennis Smith, RPh presented data regarding the use of hydroxyurea in patients with sickle cell anemia. Data reviewed from 1/1/05 through 8/26/05 identified 1,902 Medicaid beneficiaries with a diagnosis of sickle cell anemia. Of the 1,902 beneficiaries identified:

- 9% received a prescription for hydroxyurea
- 91% did not receive a prescription for hydroxyurea
- 56% received one or more narcotic RX
- 44% did not receive a narcotic prescription

As requested by the Board, the prescribing physician's specialties, the age of the beneficiary and regional area of residence of the beneficiary were identified The majority of the prescriptions were written by general practitioners for beneficiaries 21 years of age and older with most of these beneficiaries residing in Hinds county.
Dennis Smith reviewed the retrospective DUR criteria which identified beneficiaries with a diagnosis of sickle cell anemia who appear to be receiving only narcotics for associated pain. The prescribing physicians for those beneficiaries identified would receive an intervention letter which stated the patient may benefit from the addition of hydroxyurea for pain prevention. Dr. Runnels asked that HID review data for these beneficiaries identified both 120 days after intervention and 12 months after intervention to identify the impact of the intervention letter.
Leigh Ann Ross made a motion to accept this criteria recommendation. Dr. Runnels seconded the motion. All voted in favor of the motion.

Cost Management Analysis:
Dennis Smith presented a brief cost management analysis report from July 1, 2005 through July 31, 2005. This report included the top 15 therapeutic classes by total cost of claims, the top 25 drugs based on number of claims and the top 25 drugs based on total claims cost for this time period.

Pharmacy Program Update:
Judith Clark, Director of Pharmacy Bureau, gave a brief report on recent pharmacy program expenditures. She stated that CNS would present, at the December meeting, a report on the over utilization of anti-psychotics. Mrs. Clark distributed a copy of the products with quantity limits to the board members. She also provided the board members with the 90 maintenance list.
Sharon Barnett-Myers, Deputy Director of Health Services, briefly thanked the Board members for their service. She continued that many MS Medicaid beneficiaries had been affected by Hurricane Katrina and DOM is working very hard to assist these beneficiaries. Judith Clark stated that to date MS DOM beneficiaries had been relocated to 27 different States and the pharmacy division has been dealing with different issues due to this relocation. Ms. Clark distributed to the Board a list of drugs to be considered for quantity limits.
After much discussion, a motion was made by Randy Calvert to impose a quantity limit on Triptans based on the recommended guidelines for the treatment of acute migraine headaches. The motion was seconded by Dr. Ross. All voted in favor of the motion.

New Business:

Dennis Smith, RPh presented an overview of the DUR intervention process to the Board.

Osteoporosis Targeted Disease Intervention Program
Osteoporosis Targeted Disease Intervention Program was presented by Dennis Smith, RPh. Mr. Smith explained that the purpose of the program was to increase the appropriate use of medications that treat bone diseases and prevent age-related and secondary causes of bone loss. The intent of this program is to alert prescribers of beneficiaries at increased risk for adverse outcomes and to provide them with information to aid in the review of current medication therapy.

Prevention of Cardiovascular Disease
Leigh Ann Ross presented information on the prevention of cardiovascular events. Dr. Ross stated that mortality and morbidity associated with cardiovascular disease continues to be a challenge in the Medicaid population of Mississippi. She presented the following interventions associated with the prevention of cardiovascular events.

1. Diabetes/Hypertension/Cardiovascular Drugs
   This patient has a history of diabetes and hypertension and may benefit from the addition of an anti-hypertensive agent to reduce cardiovascular morbidity and mortality. The coexistence of these conditions imposes a need for a significantly lower goal blood pressure (130/80 mm Hg) than the goal recommended for a non-diabetic patient with hypertension (140/90 mm Hg). If lifestyle modifications alone are no longer effective consider JNC-7 pharmacologic treatment recommendations for the selection of the optimal anti-hypertensive therapy.

2. Certain Antihypertensive Agents/Post MI/Beta-blockers, ACEI & Aldosterone Antagonists
   This patient has a diagnosis of myocardial infarction and is on an anti-hypertensive medication. The current JNC-7 report recommends a beta-blocker, ACE inhibitor or an aldosterone antagonist as optimal antihypertensive therapy for hypertensive post myocardial infarction patients, if no contraindications are present.

3. Certain Antihypertensive Agents/Stroke/Thiazide diuretics & ACEI
   This patient has a history of stroke and is on an anti-hypertensive medication. The current JNC-7 report suggests that recurrent stroke rates are lowered by the combination of an ACE inhibitor and a thiazide-type diuretic, if no contraindications are present.

4. Certain Antihypertensive Agents/Chronic Kidney Disease/ACEI & ARB
   This patient has a diagnosis of chronic kidney disease and is on an anti-hypertensive medication. The current JNC-7 report recommends an ACE inhibitor or angiotensin II receptor antagonist as optimal antihypertensive therapy in these patients, if no contraindications are present.

5. Diabetes/Proteinuria/Negating ACEI & ARB
   Diabetics (hypertensive and normotensive) with microalbuminuria may benefit from the addition of an ACE inhibitor or an ARB to their therapy to reduce the rate of progression of renal disease.

6. Diabetes/Hypertension/Negating ACEI & ARB
   Diabetics with hypertension and nephropathy may benefit from the addition of an ACE inhibitor or angiotensin receptor antagonist to their therapy to reduce the rate of progression to renal disease.

7. Diabetes/Hypertension or Diabetic Nephropathy/Negating ACEI & ARB
   According to the JNC 7 report, the hypertension treatment goal for patients with diabetes is a blood pressure of < 130/80-mm Hg. In order to achieve this goal, multiple antihypertensive agents may be required. Adding an ACEI or an ARB should be considered if no contraindications are present. These agents also have been shown to delay the progression of nephropathy in diabetic patients with microalbuminuria.

Dr. Andrea Phillips made a motion to accept interventions # 1, #2, # 5 and # 7. The motion was seconded by Randy Calvert. All voted in favor of the motion.

Retrospective DUR Criteria Recommendations:
Dennis Smith presented the following retrospective DUR criteria recommendations:

- Tizanidine / CYP1A2 Inhibitors- Caution is recommended when considering concomitant use of tizanidine with other inhibitors of CYP1A2, such as antiarrhythmics (amiodarone, mexiletine, propafenone), cimetidine, fluoroquinolones (ciprofloxacin,

norfloxacin) and ticlopidine. The concurrent use of these agents may increase the risk of profound hypotension, somnolence and dizziness.

- Overactive Bladder Medications / Therapeutic Duplication- Therapeutic duplication of medications to treat overactive bladder may be occurring. Concomitant use of these drugs may cause additive adverse effects.
- Darifenacin / High Dose- Enablex (darifenacin) may be over-utilized. The recommended maximum dose is 15 mg per day.
- Darifenacin / Potent 3A4 Inhibitors- The daily dose of Enablex (darifenacin), a CYP 3A4 substrate, should not exceed 7.5 mg when coadministered with a potent CYP3A4 inhibitor (e.g., ketoconazole itraconazole, ritonavir, nelfinavir, clarithromycin, and nefazodone). Exceeding the recommended dose during concurrent therapy may increase the risk of adverse effects of darifenacin.
- Darifenacin / Hepatic Impairment- The daily dose of Enablex (darifenacin) should not exceed 7.5 mg once daily for patients with moderate hepatic impairment. Darifenacin is not recommended for use in patients with severe hepatic impairment.
- Darifenacin / CYP2D6 Substrates- Caution should be exercised when Enablex (darifenacin), a moderate 2D6 inhibitor, is used concomitantly with medications that are predominantly metabolized by CYP2D6 and which have a narrow therapeutic window (e.g. flecainide and thioridazine). Concurrent use with darifenacin may result in elevated plasma concentrations of the substrates and increase risk of adverse effects.
- Darifenacin / Digoxin- Caution should be exercised when Enablex (darifenacin) is used concomitantly with digoxin. Concurrent use of darifenacin (30mg daily) with digoxin (0.25mg) at steady state resulted in a 16% increase in digoxin exposure. Routine monitoring of digoxin should continue.
- Darifenacin / Narrow Angle Glaucoma-Enablex (darifenacin), an anticholinergic agent, should be used with caution in patients being treated for narrow-angle glaucoma and only when the potential benefits outweigh the risks. Darifenacin is contraindicated in patients with uncontrolled narrow-angle glaucoma.
- Darifenacin / Urinary Retention- Enablex (darifenacin), an anticholinergic agent, is contraindicated in patients with urinary retention or gastric retention and in patients who are at risk for these conditions.
- Darifenacin / GI Obstruction-Decreased GI Motility - Enablex (darifenacin), an anticholinergic agent, should be administered with caution to patients with GI obstructive disorders because of the risk of gastric retention. Darifenacin, like other anticholinergic drugs, may decrease GI motility and should be used with caution in patients with severe constipation, ulcerative colitis, and myasthenia gravis.
- Anticholinergic Agents / Therapeutic Duplication- The concomitant use of anticholinergic agents may increase the frequency and/or severity of dry mouth, constipation, blurred vision and other anticholinergic adverse effects.
- Solifenacin / High Dose -Vesicare (solifenacin) may be over-utilized. The recommended maximum dose is 10 mg per day. Higher doses have resulted in a higher incidence of adverse reactions.
- Solifenacin / Hepatic Impairment- The daily dose of Vesicare (solifenacin) should not exceed 5.0 mg for patients with moderate hepatic impairment. Solifenacin is not recommended for use in patients with severe hepatic impairment.

- Solifenacin / Renal Impairment- The daily dose of Vesicare (solifenacin) should not exceed 5.0 mg for patients with severe renal impairment (Ccr less than 30 ml/min). Significant increases in the AUC and elimination half-life have been noted with single oral doses of solifenacin 10 mg and have been correlated to the degree of renal impairment.
- Solifenacin / Potent 3A4 Inhibitors- The daily dose of Vesicare (solifenacin), a CYP 3A4 substrate, should not exceed 5.0 mg when coadministered with a potent CYP3A4 inhibitor (e.g., ketoconazole itraconazole, ritonavir, nelfinavir, clarithromycin, and nefazodone). Exceeding the recommended dose during concurrent therapy may increase the risk of adverse effects.
- Solifenacin / Narrow Angle Glaucoma- Vesicare (solifenacin), an anticholinergic agent, should be used with caution in patients being treated for narrow-angle glaucoma and only when the potential benefits outweigh the risks. Solifenacin is contraindicated in patients with uncontrolled narrow-angle glaucoma.
- Solifenacin / Urinary Retention & Gastric Retention - Vesicare (solifenacin), an anticholinergic agent, is contraindicated in patients with urinary retention or gastric retention and in patients who are at risk for these conditions.
- Solifenacin / GI Obstruction-Decreased GI Motility -Vesicare (solifenacin), an anticholinergic agent, should be administered with caution to patients with GI obstructive disorders because of the risk of gastric retention. Solifenacin, like other anticholinergic drugs, may decrease GI motility and should be used with caution in patients with constipation, ulcerative colitis, and myasthenia gravis.
- Solifenacin / QT Prolongation & QT Prolongation Drugs -Vesicare (solifenacin) should be administered with caution to patients with a history of QT prolongation or on medications known to prolong the QT interval. A significant effect on QTc has been observed following the administration of solifenacin (10 or 30 mg) in healthy female volunteers. The QT prolonging effect was greater with the 30 mg dose as compared with the 10 mg dose and did not appear to be as great as that of the positive control moxifloxacin at its therapeutic dose.
- Tolterodine IR & XL/High Dose- Detrol/Detrol XL (tolterodine) may be over-utilized. The manufacturer's recommended dose is 4.0 mg daily.
- Tolterodine IR/Hepatic Impairment- The daily dose of Detrol or Detrol XL (tolterodine) should not exceed 2.0 mg for patients with significantly reduced hepatic or renal function.
- Tolterodine//Potent 3A4 Inhibitors -The daily dose of Detrol/ Detrol XL (tolterodine), a CYP 3A4 substrate, should not exceed 2.0 mg when coadministered with a potent CYP3A4 inhibitor (e.g., ketoconazole itraconazole, erythromycin, clarithromycin, cyclosporine and vinblastine). Exceeding the recommended dose during concurrent therapy may increase the risk of adverse effects of tolterodine.
- Oxybutynin/High Dose (Adults) - Ditropan (oxybutynin immediate-release) may be over-utilized. The manufacturer's recommended maximum dose is 5 mg 4 times per day.
- Oxybutynin/High Dose-Pediatric-Ditropan (oxybutynin immediate-release) may be over-utilized. The manufacturer's recommended maximum dose is 5 mg 3 times per day.

- Oxybutynin Extended Release/High Dose-Ditropan XL (oxybutynin extended-release) may be over-utilized. The manufacturer's recommended maximum dose is 30 mg per day.
- Oxybutynin Extended Release/Hepatic & Renal Impairment- Ditropan/Ditropan XL (oxybutynin) should be used with caution in patients with renal or hepatic impairment.
- Oxybutynin Transdermal / High Dose- Oxytrol (oxybutynin transdermal) may be over-utilized. The manufacturer's recommended dose is one 3.9 mg/day system applied twice weekly (every 3 to 4 days).
- Oxybutynin/Contraindications- Ditropan (oxybutynin), an anticholinergic agent, is contraindicated in patients with urinary retention, gastric retention and other severe conditions of decreased gastrointestinal motility, uncontrolled narrow-angle glaucoma, paralytic ileus and in patients who are at risk for these conditions.
- Oxybutynin / Disease State Precautions- Ditropan (oxybutynin), an anticholinergic agent, should be used with caution in patients with hyperthyroidism, cardiac arrhythmias, congestive heart failure, coronary heart disease, hiatal hernias, hypertension, autonomic neuropathy, ulcerative colitis and prostatic hypertrophy. Oxybutynin may aggravate the symptoms of these conditions.
- Oxybutynin / GI Obstruction-Decreased GI Motility- Ditropan/Ditropan XL (oxybutynin), an anticholinergic agent, should be administered with caution to patients with GI obstructive disorders because of the risk of gastric retention. Oxybutynin, like other anticholinergic drugs, may decrease GI motility and should be used with caution in patients with severe constipation, ulcerative colitis, and myasthenia gravis.
- Oxybutynin/GERD- Ditropan/Ditropan XL/Oxytrol (oxybutynin) should be used with caution in patients who have gastrointestinal reflux or who are concurrently taking drugs (such as bisphosphonates) that can cause or exacerbate esophagitis.
- Flavoxate/High Dose - Flavoxate may be over utilized. The manufacturer's recommended maximum dose is 800 mg (200 mg 4 times a day).
- Flavoxate/Contraindications- Flavoxate, an anticholinergic agent, is contraindicated in patients who have pyloric or duodenal obstruction, obstructive intestinal lesions or ileus, achalasia, GI hemorrhage, or obstructive uropathies of the lower urinary tract.
- Flavoxate/Glaucoma -Flavoxate should be used with caution in patients who have glaucoma. Flavoxate is an anticholinergic agent and use in these patients may aggravate the condition.
- Trospium / High Dose - Sanctura (trospium) may be over-utilized. The manufacturer's recommended daily dose is 20 mg twice daily.
- Trospium /Renal Impairment- The daily dose of Sanctura (trospium) should not exceed 20 mg once daily at bedtime for patients with severe renal impairment (Ccr less than 30 ml/min).
- A 4.5-fold and 2-fold increase in mean AUC and Cmax respectively and the appearance of an additional elimination phase with a long half-life (33hr) was detected in patients with severe renal sufficiency.
- Trospium / Urinary & Gastric Retention- Sanctura (trospium), an anticholinergic agent, is contraindicated in patients with urinary retention or gastric retention and patients at risk for these conditions.
- Trospium / Narrow Angle Glaucoma- Sanctura (trospium), an anticholinergic agent, should be used with caution in patients being treated for narrow-angle glaucoma and

only when the potential benefits outweigh the risks. Trospium is contraindicated in patients with uncontrolled narrow-angle glaucoma.

- Trospium / GI Obstruction-Decreased GI Motility- Sanctura (trospium) should be administered with caution to patients with GI obstructive disorders because of the risk of gastric retention. Trospium, like other anticholinergic drugs, may decrease GI motility and should be used with caution in patients with ulcerative colitis, intestinal atony and myasthenia gravis.
- Trospium/Drugs Eliminated by ATS- Sanctura (trospium) is eliminated via active tubular secretion and possesses the potential for pharmacokinetic interactions with other drugs that are eliminated by the same route (e.g., digoxin, procainamide, morphine, vancomycin, metformin, and tenofovir). Coadministration of trospium with drugs that are eliminated by active tubular secretion may increase the serum concentration of trospium and/or the coadministered drug because of competition for this elimination pathway. Careful patient monitoring is recommended
- Telithromycin / Pimozide- The concurrent use of Ketek (telithromycin) and pimozide is contraindicated due to increased risk of cardiotoxicity (e.g., QT prolongation, torsades de pointes, cardiac arrest). Although no formal drug interaction studies have been conducted, telithromycin may inhibit pimozide CYP 3A4-mediated metabolism causing elevated plasma levels. Both agents are known to cause QTc prolongation.
- Atypical Antipsychotics/ / FDA Approved Indications- The atypical antipsychotics are not approved for the treatment of behavioral disorders in elderly patients with dementia. The FDA has determined that patients with dementia treated with atypical antipsychotics are at an increased risk of death compared to placebo. In analysis of seventeen placebo-controlled studies of four drugs in this class, the rate of death for those elderly patients with dementia was about 1.6 to 1.7 times that of placebo.

Dr. Rudy Runnels made a motion to accept these criteria recommendations. The motion was seconded by Dr. Ross. All voted in favor of the motion,

Utilization Analysis:

Zelnorm

Data regarding the utilization of Zelnorm in Medicaid beneficiaries was presented by Dennis Smith. Utilization date using paid claims data from 8/27/04 through 8/26/05 suggested that beneficiaries received an average of three prescriptions yearly and that 57% of these recipients received this agent in the absence of an approved indication.

Based on manufacturers labeling, HID recommended that beneficiaries be able to receive Zelnorm appropriately and without restriction up to 3 months in a calendar year. However, any prescription exceeding the 90th day would require a clinical review through the prior authorization process.

A motion was made by Dr. Andrea Phillips to send this recommendation to the P& T Committee for further review. Dr. Runnels seconded the motion.

Zofran

Dennis Smith presented utilization data from 1/1/05 through 8/26/05 regarding the use of Zofran in Medicaid beneficiaries. Mr. Smith stated that the goal of this analysis was evaluate utilization trends among Mississippi Medicaid recipients and explore possible interventions to

encourage treatment consistent with the product labeling. Although this medication is an important agent in the treatment of cancer chemotherapy-related and post operative nausea and vomiting, the proper utilization offers DOM a significant opportunity for cost savings. HID recommended monthly quantity limits to discourage the use of this agent for non-approved conditions and to manage the dosage and length of therapy consistent with the diagnosis. After discussion by the board the following quantity limits were recommended:
Zofran 4 mg – 12 tablets per month
Zofran 8 mg – 12 tablets per month
Zofran 24 mg – 5 tablets per month
Zofran 4mg/ 5 ml oral solution – 100 ml

A motion was made by Dr. Runnels to accept the recommendations presented. The motion was seconded by Dr. Phillips. All voted in favor of the motions.

Childrens Medical Necessity Prior Authorization
Dennis Smith gave a brief overview of the Childrens Medical Necessity prior authorization process.

Black Box Warnings:
Dennis Smith presented black box warnings issued by the FDA concerning the following:
Duragesic transdermal system:
Janssen and FDA notified healthcare professionals of changes to the Boxed warning/warnings, contraindications, precautions and Dosage and administrations sections of the prescribing information for Duragesic. These changes include important safety information in the areas of the labeling: Use only in Opioid-tolerant patients, misuse, abuse and diversion, hypoventilations, interactions with CYP3A4 inhibitors, damage or cut patches, accidental exposure with Fentanyl, Chronic pulmonary disease, head injuries and intracranial pressure. Interactions with other CNS depressants and interactions with alcohol and drugs of abuse.

There being no other business, Dr. Mitchell asked for a motion to adjourn the meeting. Dr. Rudy Runnels made a motion to adjourn. Dr. Phillips seconding the motion. All voted in favor of the motion. The meeting was adjourned at 4:07 p.m.

Respectfully submitted:
Health Information Designs

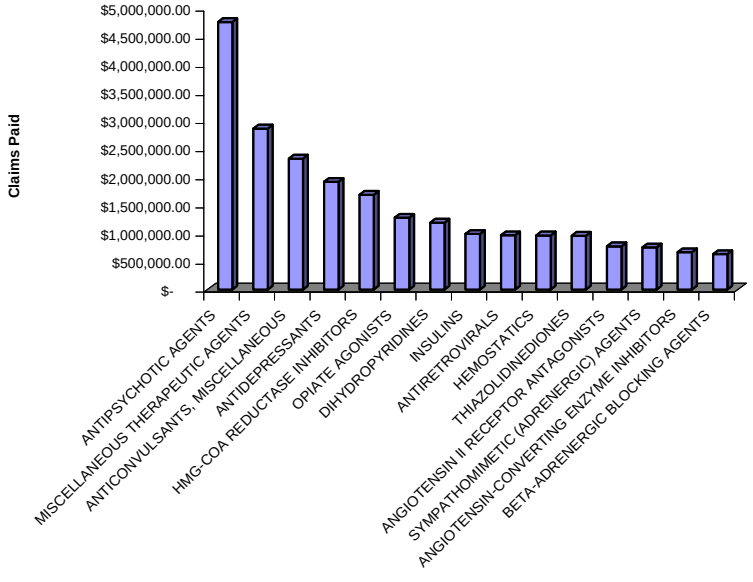
MISSISSIPPI MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 08/01/05-08/31/05

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	18,659	$ 4,760,290.97	$ 255.12	2.42%
MISCELLANEOUS THERAPEUTIC AGENTS	23,121	$ 2,863,665.18	$ 123.86	3.00%
ANTICONVULSANTS, MISCELLANEOUS	16,479	$ 2,328,253.44	$ 141.29	2.14%
ANTIDEPRESSANTS	31,812	$ 1,916,606.95	$ 60.25	4.13%
HMG-COA REDUCTASE INHIBITORS	16,747	$ 1,687,185.34	$ 100.75	2.17%
OPIATE AGONISTS	41,785	$ 1,278,807.90	$ 30.60	5.42%
DIHYDROPYRIDINES	18,538	$ 1,191,151.28	$ 64.25	2.40%
INSULINS	10,440	$ 988,791.28	$ 94.71	1.35%
ANTIRETROVIRALS	1,778	$ 966,254.95	$ 543.45	0.23%
HEMOSTATICS	50	$ 963,225.87	$19,264.52	0.01%
THIAZOLIDINEDIONES	6,848	$ 956,276.19	$ 139.64	0.89%
ANGIOTENSIN II RECEPTOR ANTAGONISTS	13,064	$ 770,830.83	$ 59.00	1.69%
SYMPATHOMIMETIC (ADRENERGIC) AGENTS	13,800	$ 750,727.19	$ 54.40	1.79%
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	20,519	$ 663,557.08	$ 32.34	2.66%
BETA-ADRENERGIC BLOCKING AGENTS	19,248	$ 630,745.86	$ 32.77	2.50%
TOTAL TOP 15	252,888	$ 22,716,370.31	$ 89.83	32.81%

Total Rx Claims	770,878
From 08/01/05-08/31/05	

Top 15 Therapeutic Classes
Based on Total Cost of Claims



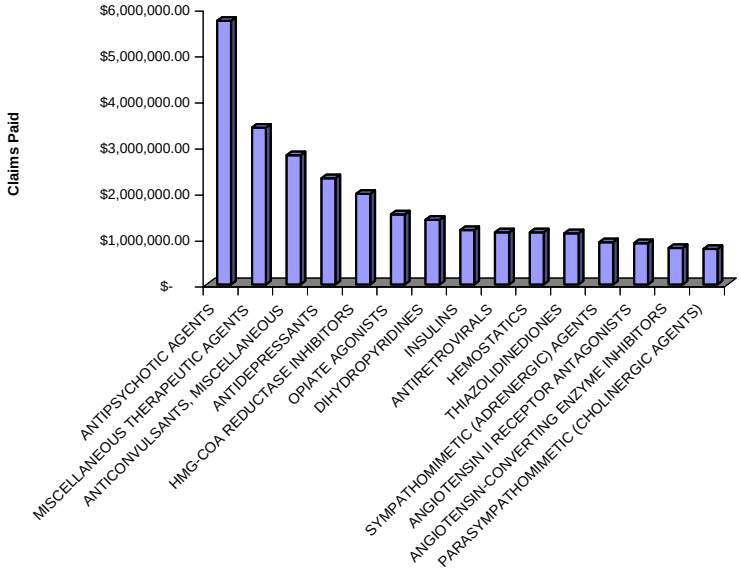
MISSISSIPPI MEDICAID
Cost Management Analysis

TOP 15 THERAPEUTIC CLASSES BY TOTAL COST OF CLAIMS FROM 09/01/05-09/30/05

AHFS Therapeutic Class	Rx	Paid	Paid/Rx	% Total Claims
ANTIPSYCHOTIC AGENTS	22,960	$ 5,727,626.87	$ 249.46	3.05%
MISCELLANEOUS THERAPEUTIC AGENTS	27,819	$ 3,408,247.90	$ 122.52	3.69%
ANTICONVULSANTS, MISCELLANEOUS	20,261	$ 2,809,839.25	$ 138.68	2.69%
ANTIDEPRESSANTS	38,777	$ 2,310,732.47	$ 59.59	5.15%
HMG-COA REDUCTASE INHIBITORS	19,560	$ 1,966,650.79	$ 100.54	2.60%
OPIATE AGONISTS	51,448	$ 1,522,474.85	$ 29.59	6.83%
DIHYDROPYRIDINES	21,917	$ 1,402,518.61	$ 63.99	2.91%
INSULINS	12,602	$ 1,183,004.65	$ 93.87	1.67%
ANTIRETROVIRALS	2,079	$ 1,134,193.87	$ 545.55	0.28%
HEMOSTATICS	62	$ 1,133,508.59	$ 18,282.40	0.01%
THIAZOLIDINEDIONES	7,975	$ 1,113,952.15	$ 139.68	1.06%
SYMPATHOMIMETIC (ADRENERGIC) AGENTS	17,261	$ 915,429.26	$ 53.03	2.29%
ANGIOTENSIN II RECEPTOR ANTAGONISTS	15,240	$ 898,344.82	$ 58.95	2.02%
ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	24,639	$ 794,620.27	$ 32.25	3.27%
PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS	5,361	$ 771,716.36	$ 143.95	0.71%
TOTAL TOP 15	287,961	$ 27,092,860.71	$ 94.09	38.23%

Total Rx Claims From 09/01/05-09/30/05	753,172

Top 15 Therapeutic Classes
Based on Total Cost of Claims



Health Information
Designs, Inc.

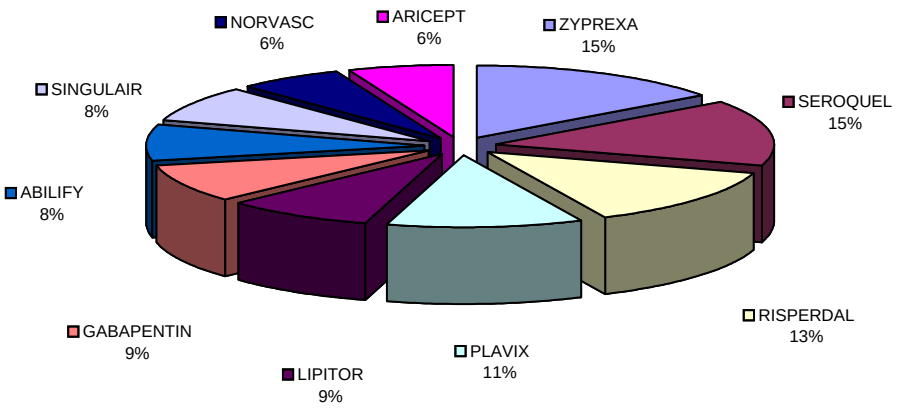
MISSISSIPPI MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 08/01/05-08/31/05

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx
ZYPREXA	ANTIPSYCHOTIC AGENTS	3,833	$ 1,433,959.70	$ 374.11
SEROQUEL	ANTIPSYCHOTIC AGENTS	5,921	$ 1,421,841.26	$ 240.14
RISPERDAL	ANTIPSYCHOTIC AGENTS	5,409	$ 1,280,328.39	$ 236.70
PLAVIX	MISCELLANEOUS THERAPEUTIC AGENTS	8,882	$ 1,098,053.20	$ 123.63
LIPITOR	HMG-COA REDUCTASE INHIBITORS	9,305	$ 839,209.36	$ 90.19
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	7,407	$ 820,832.70	$ 110.82
ABILIFY	ANTIPSYCHOTIC AGENTS	2,125	$ 794,165.92	$ 373.73
SINGULAIR	MISCELLANEOUS THERAPEUTIC AGENTS	8,248	$ 761,224.95	$ 92.29
NORVASC	DIHYDROPYRIDINES	10,527	$ 605,505.04	$ 57.52
ARICEPT	PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS)	4,032	$ 580,862.90	$ 144.06
ZOLOFT	ANTIDEPRESSANTS	5,899	$ 568,919.55	$ 96.44
LOTREL	DIHYDROPYRIDINES	6,646	$ 558,715.03	$ 84.07
ZYRTEC	SECOND GENERATION ANTIHISTAMINES	10,697	$ 548,065.74	$ 51.24
ACTOS	THIAZOLIDINEDIONES	3,326	$ 508,340.43	$ 152.84
TOPAMAX	ANTICONVULSANTS, MISCELLANEOUS	1,998	$ 507,429.46	$ 253.97
ADVAIR DISKUS	SYMPATHOMIMETIC (ADRENERGIC) AGENTS	3,289	$ 504,473.51	$ 153.38
ZOCOR	HMG-COA REDUCTASE INHIBITORS	3,483	$ 453,228.65	$ 130.13
LEXAPRO	ANTIDEPRESSANTS	5,819	$ 427,151.99	$ 73.41
AVANDIA	THIAZOLIDINEDIONES	3,451	$ 423,049.66	$ 122.59
FENTANYL	OPIATE AGONISTS	1,693	$ 397,958.13	$ 235.06
COREG	BETA-ADRENERGIC BLOCKING AGENTS	3,764	$ 364,440.82	$ 96.82
DEPAKOTE	ANTICONVULSANTS, MISCELLANEOUS	2,281	$ 358,918.27	$ 157.35
GEODON	ANTIPSYCHOTIC AGENTS	1,246	$ 355,672.18	$ 285.45
EFFEXOR XR	ANTIDEPRESSANTS	2,700	$ 355,075.15	$ 131.51
AMBIEN	ANXIOLYTICS, SEDATIVES & HYPNOTICS,MISC.	3,801	$ 325,697.10	$ 85.69
TOTAL TOP 25		125,782	$ 16,293,119.09	$ 129.53

Total Rx Claims From 08/01/05-08/31/05	770,878

Top 10 Drugs
Based on Total Claims Cost



Health Information
Designs, Inc.

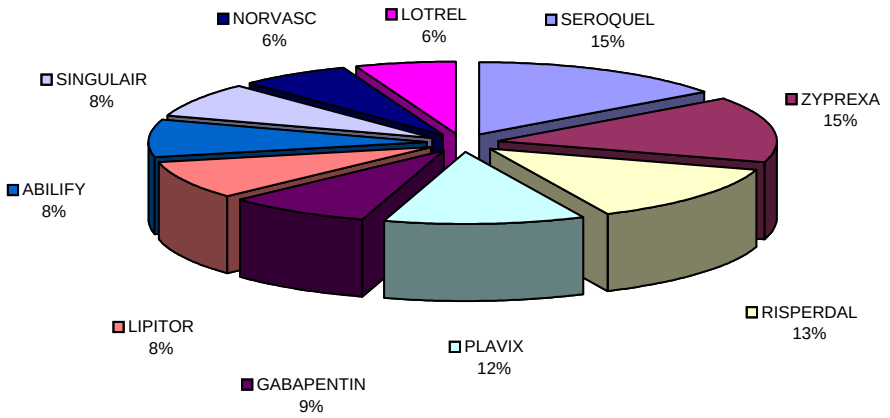
MISSISSIPPI MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON TOTAL CLAIMS COST FROM 09/01/05-09/30/05

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx
SEROQUEL	ANTIPSYCHOTIC AGENTS	5,851	$ 1,431,307.41	$ 244.63
ZYPREXA	ANTIPSYCHOTIC AGENTS	3,675	$ 1,386,734.05	$ 377.34
RISPERDAL	ANTIPSYCHOTIC AGENTS	5,171	$ 1,264,046.33	$ 244.45
PLAVIX	MISCELLANEOUS THERAPEUTIC AGENTS	8,867	$ 1,090,885.67	$ 123.03
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	7,400	$ 811,336.76	$ 109.64
LIPITOR	HMG-COA REDUCTASE INHIBITORS	8,928	$ 802,913.47	$ 89.93
ABILIFY	ANTIPSYCHOTIC AGENTS	2,103	$ 788,160.88	$ 374.78
SINGULAIR	MISCELLANEOUS THERAPEUTIC AGENTS	7,932	$ 732,754.35	$ 92.38
NORVASC	DIHYDROPYRIDINES	10,487	$ 601,256.99	$ 57.33
LOTREL	DIHYDROPYRIDINES	6,728	$ 563,778.30	$ 83.80
ZOLOFT	ANTIDEPRESSANTS	5,771	$ 558,808.39	$ 96.83
ARICEPT	PARASYMPATHOMIMETIC (CHOLINERGIC AGENTS)	3,893	$ 557,668.19	$ 143.25
ACTOS	THIAZOLIDINEDIONES	3,342	$ 516,408.02	$ 154.52
ZYRTEC	SECOND GENERATION ANTIHISTAMINES	9,794	$ 500,279.02	$ 51.08
TOPAMAX	ANTICONVULSANTS, MISCELLANEOUS	1,977	$ 494,433.30	$ 250.09
ADVAIR DISKUS	SYMPATHOMIMETIC (ADRENERGIC) AGENTS	3,105	$ 479,638.11	$ 154.47
ZOCOR	HMG-COA REDUCTASE INHIBITORS	3,406	$ 441,166.19	$ 129.53
AVANDIA	THIAZOLIDINEDIONES	3,370	$ 413,680.81	$ 122.75
LEXAPRO	ANTIDEPRESSANTS	5,637	$ 410,964.71	$ 72.90
FENTANYL	OPIATE AGONISTS	1,696	$ 404,527.12	$ 238.52
FEIBA VH IMMUNO	HEMOSTATICS	12	$ 375,463.87	$ 31,288.66
COREG	BETA-ADRENERGIC BLOCKING AGENTS	3,771	$ 364,428.91	$ 96.64
DEPAKOTE	ANTICONVULSANTS, MISCELLANEOUS	2,218	$ 346,905.15	$ 156.40
GEODON	ANTIPSYCHOTIC AGENTS	1,150	$ 336,015.51	$ 292.19
EFFEXOR XR	ANTIDEPRESSANTS	2,532	$ 330,031.39	$ 130.34
TOTAL TOP 25		118,816	$ 16,003,592.90	$ 134.69

Total Rx Claims From 09/01/05-09/30/05	753,172

Top 10 Drugs
Based on Total Claims Cost



Synagis® Utilization Analysis
October 1, 2004-March 31, 2005

Introduction

Synagis® is indicated for use in high-risk children for prophylaxis of respiratory syncytial virus (RSV). Synagis requires prior authorization for all MS Division of Medicaid beneficiaries. This agent is prescribed during the RSV season which begins in October and ends the following March. The criteria, approved by the P&T Committee and Division of Medicaid, are based on manufacturer labeling. These criteria are included in the following pages. All requests for prior authorization of Synagis are reviewed by the clinical staff of Health Information Designs, Inc.

The clinical staff also conducts a post-season analysis of the Synagis® prior authorization program. The analysis includes a review of:

- Adherence of the criteria to current Centers for Disease Control (CDC) recommendations regarding RSV
- Beneficiary compliance
- Claims data for duplicate billing transactions.

Analysis results

The results of the post season analysis are:

- 1,556 prior authorization requests received
- 1,365 approved (88%); 191 denied (12%)
- 92% of the prior authorizations utilized (High compliance); 8% of the prior authorizations not utilized
- Average cost per dose $1,200 (recommended 6 doses X $1,200 = $7,200 per season)
- 21 hospitalizations* during recent season. Average hospital stay was 3.4 days at an average cost of $2,362.67
- There were no prior authorization requests for Synagis received for these 21 beneficiaries.

*Note: Health Information Designs, Inc. does not receive discharge ICD-9 diagnoses therefore these hospital admissions were based on an admission ICD-9 diagnosis of suspected RSV.

Cost

During the RSV season between October 1, 2004 and March 31, 2005, MS Division of Medicaid reimbursed for 8,090 doses of Synagis®. The total cost for these claims was $9,726,522.44.

Conclusion

The current prior authorization program for Synagis® has been extremely effective. Ease of access to appropriate Synagis therapy has resulted in both high compliance and low hospitalizations due to suspected RSV infection. Most prior authorization requests received have met the criteria for approval.

Synagis
Prior Authorization Criteria

PALVIZUMAB (SYNAGIS)

Prescriber completes PA request form and submits to HID.

Beneficiaries must meet criteria in one of four categories:

Category 1. Prematurity of ≤ 28 weeks gestation Age: ≤ 1 year	Category 2. Prematurity of 29-32 weeks gestation Age: ≤ 6 months at the start of Respiratory Syncytial Virus season.
Category 3. Prematurity of ≤ 35 weeks gestation Age: 0 - 2 years old Diagnosis of Chronic Lung Disease(CLD) and ongoing medical treatment for CLD such as supplemental oxygen, steroids, bronchodilators or diuretics within the last 6 months.	Category 4. 33-35 weeks gestation Age: 0-6 months old during RSV season Risk factors as noted below are present and documented. No diagnosis of CLD is required.

Authorization will end at age two (last day of child's birthday month) extending beyond age 2 years will be considered on an individual basis when supported by clinical documentation of extreme necessity.

Authorization is granted during the RSV season only (usually October through March).

RSV Risk Factors:

One of the following are considered sufficient

- Hemodynamically significant Congenital Heart Disease (simple, small Atrial Septal Defects's (ASD), Ventricular Septal Defects's (VSD), and Patent Ductus Arteriosus (PDA) are not eligible).
- Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Deficiency Syndrome (AIDS)

Or

Must have TWO of the following

- Exposure to tobacco smoke in the home
- School age Siblings
- Multiple Birth
- Day Care

Marinol® Utilization
10/1/2004 – 9/30/2005

Introduction

Dronabinol, a synthetic version of the naturally-occuring compound delta-9-THC, is indicated for the treatment of nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional treatments. It is also approved to treat appetite loss associated with weight loss in people with AIDS.

In July, megestrol acetate (Megace®) was re-categorized in terms of its primary therapeutic class. Whereas its therapeutic class was previously steroid antineoplastics, the classification is now appetite stimulants. As a result of this change, megestrol acetate suspension is no longer covered by Medicaid. This has resulted in a search for a substitute agent for the treatment of cachexia, particularly for elderly patients in long-term care settings.

Dosing and Administration

The pharmacologic effects of dronabinol capsules are dose-related and subject to considerable interpatient variability. Therefore dosage individualization is critical in achieving the maximum benefit of Marinol® treatment.

Appetite Stimulation:
The majority of patients in clinical trials were treated with 5 mg/day, although the dosages ranged from 2.5 to 20 mg/day. For adults, start with 2.5 mg before lunch and supper. Most CNS symptoms, when they occur, resolve within the first 3 days of continued treatment. If CNS symptoms are severe or persistent, reduce the dose to 2.5 mg before supper. Also, the evening dose can be taken closer to bedtime to reduce symptom severity.

When well-tolerated, the dose can be increased to 2.5 mg before lunch and 5 mg before supper or 5 mg before both lunch and supper. Although most patients respond to 2.5 mg BID, doses as high as 10 mg BID have been tolerated by about half of patients in appetite stimulations studies.

Antiemetic:
While most patients respond to 5 mg TID-QID, dosage may be escalated during a chemotherapy cycle or at subsequent cycles, based upon initial results. Therapy should be initiated at the lowest recommended dosage and titrated to clinical response. Concurrent administration with phenothiazines, such as prochlorperazine, has resulted in improved efficacy as compared to either drug alone, without additive toxicity.

Adverse Effects

Cannabinoid dose-related "high" (easy laughing, elation and heightened awareness) has been reported by patients receiving Marinol® in both the antiemetic (24%) and the lower dose appetite stimulant clinical trials (8%).

Abuse Potential

As one of the psychoactive compounds present in cannabis, dronabinol is abusable and classified as a schedule III controlled substance. Both psychological and physiological dependence have been noted in healthy individuals receiving dronabinol, but addiction is uncommon and has only been seen after prolonged high dose administration. An abstinence syndrome has been reported after the abrupt discontinuation of dronabinol in volunteers receiving dosages of 210 mg/day for 12 to 16 consecutive days. Within 12 hours after discontinuation, these volunteers manifested symptoms such as irritability, insomnia, and restlessness and within 24 hours, withdrawal symptoms intensified.

Utilization

During the year between 10/1/2004 and 9/30/2005, there were 1545 claims for this agent at cost of over $760,000. Among these claims, there was only one beneficiary with a diagnosis of HIV or AIDS and we were unable to associate a cancer diagnosis with any of these beneficiaries. There has been no significant increase in the number of claims for this agents since the re-categorization of megestrol acetate suspension.

Conclusion

Based on the above information, almost all of the patients receiving treatment with Marinol® do not have a diagnosis related to the approved indications for this agent.

Recommendation

An intervention letter which identifies patients who have received Marinol® without a diagnosis of HIV, AIDS, or cancer is recommended. This letter would be sent to prescribers and would include information about the approved indications, appropriate use and abuse potential of this agent.

Recommended Alert Message: Marinol (dronabinol) is a medication with the potential for abuse. It is an oral form of delta-9-tetrahydrocannabinol indicated for the treatment of anorexia associated with weight loss in patients with AIDS and for the treatment of refractory nausea and vomiting associated with cancer chemotherapy. A review of the patient's recent diagnostic history did not reveal a FDA approved indication for use. Consider prescribing dronabinol for approved indications only to discourage abuse and/or diversion.

Oxandrin® Utilization
10/22/2004 – 10/21/2005

Introduction

Oxandrolone, an anabolic steroid, is a synthetic derivative of testosterone. The actions of anabolic steroids are similar to those of male sex hormones. Oxandrin is indicated as adjuctive therapy to promote weight gain after weight loss following extensive surgery, chronic infections, or severe trauma, and in some patients who without definite pathophysiologic reasons fail to gain or to maintain normal weight. It is also indicated to offset the protein catabolism associated with prolonged administration of corticosteroids Lastly it is indicated for the relief of the bone pain frequently accompanying osteoporosis.

In July, megestrol acetate (Megace®) was re-categorized in terms of its primary therapeutic class. Whereas its therapeutic class was previously steroid antineoplastics, the classification is now appetite stimulants. As a result of this change, megestrol acetate suspension is no longer covered by Medicaid. This has resulted in a search for a substitute agent for the treatment of cachexia, particularly for elderly patients in long-term care settings.

Dosing and Administration

Therapy with anabolic steroids is adjunctive to and not a replacement for conventional therapy. The duration of therapy with oxandrolone will depend on the response of the patient and the possible appearance of adverse reactions. Therapy should be intermittent.

Adults: The response of individuals to anabolic steroids varies. The daily adult dosage is 2.5 mg to 20 mg in 2 to 4 divided doses. A course of therapy of 2 to 4 weeks is usually adequate. This may be repeated intermittently as indicated.

Children: The total dose of oxandrolone is ≤0.1 mg per kilogram body weight or ≤0.45 mg per pound of body weight. This may be repeated intermittently as indicated.

Adverse Effects

A black box warning is included on the labeling of Oxandrin®. This warning addresses the risk of peliosis hepatis and liver cell tumors associated with androgenic anabolic steroid therapy.

Abuse Potential

Due to the potential for diversion and misuse of this agent, oxandrolone is classified as a schedule III controlled substance under the Anabolic Steroids Control Act of 1990.

Utilization

Between 10/22/2004 and 10/21/2005, there were 474 claims for this agent at a cost of over $205,000. The number of claims has not significantly increased since the re-categorization of megestrol acetate suspension. Because oxandrolone is indicated for weight gain promotion in patients who have lost weight due to a wide range of etiologies, it is difficult to target inappropriate therapy based on diagnosis.

Conclusion

Although oxandrolone has the potential for increased utilization since megestrol acetate suspension is no longer covered by Medicaid, no significant increase has been seen as yet. There is no evidence to support inappropriate use of this agent in this population. Also of note, the impact of Medicare Part D implementation on the utilization of drugs for the treatment of cachexia is expected to be significant because the majority of long-term care residents will move to Part D.

Recommendation

No intervention is recommended at this time, although continued monitoring of Oxandrin® prescribing patterns after Medicare Part D implementation is advised.

Lyrica® (pregabalin)

Indications

Pregabalin is indicated for the management of neuropathic pain associated with diabetic peripheral neuropathy and postherpetic neuralgia. It is also indicated as adjunctive therapy for adult patients with partial onset seizures.

Mechanism of Action

Although a structural derivative of GABA (gamma-aminobutyric acid) and structurally related to gabapentin, the mechanism of action of this agent is not known. With high affinity for the alpha$_2$-delta receptor site in central nervous system tissues, pregabalin reduces the calcium-dependent release of several neurotransmitters. This binding may be involved in this agent's antinociceptive and antiseizure effects.

Dosing and Administration

The dosing recommendations for this agent are dependent upon the indication being treated. The maximum recommended dose is 100 mg TID in patients with creatinine clearance of at least 60 mL/min.

Diabetic peripheral neuropathy: Dosing should begin at 50 mg TID and may be increased to 300 mg per day within one week based on efficacy and tolerability.

Postherpetic neuralgia: The dose is 75 to 150 mg BID or 50 to 100 mg TID in patients with creatinine clearance of at least 60 mL/min. Patients who do not experience sufficient pain relief following 2 to 4 weeks of treatment with 300 mg/day, and who are able to tolerate pregabalin, may be treated with up to 300 mg two times a day, or 200 mg three times a day (600 mg/day). Due to dose-dependent adverse effects and the higher rate of treatment discontinuation due to adverse events. Dosing above 300 mg/day should be reserved only for those patients who have on-going pain and are tolerating 300 mg daily.

Epilepsy: doses of 150 to 600 mg/day have been shown to be effective as adjunctive therapy in the the treatment of partial onset seizures in adults. The total daily dose should be divided and given either two or three times daily.

Due to its primary elimination through renal excretion, the dose should be adjusted for patients with reduced renal function.

Utilization

The chart on the following page represents all utilization of this agent since its introduction to the market through September 23, 2005.

Lyrica (pregabalin) Utilization

Beneficiary	Dose (mg)	Date of claim	Other Anticonvulsant	Age	Diabetes Diagnosis	Diabetes medications	Gabapentin (most recent fill date)
1	50	21-Sep	none	72	No	none	none
2	50	13-Sep	none	50	Yes	none	18-Aug
3	50	9-Sep	none	63	Yes	none	none
4	50	2-Sep	none	85	No	none	none
5	50	22-Sep	phenytoin (9/22)	31	No	none	none
6	50	23-Sep	none	48	Yes	Humalog	none
7	50	23-Sep	Topamax, phenytoin	49	No	none	none
8	50	22-Sep	none	65	No	none	28-Jun
9	75	22-Sep	none	67	Yes	none	none
10	75	23-Sep	clonazepam	53	No	none	none
11	75	23-Sep	none	53	Yes	glipizide	none
12	75	22-Sep	topamax	52	No	none	none
13	75	22-Sep	none	46	No	none	15-Aug
14	75	22-Sep	trileptal	39	No	none	none
15	75	22-Sep	diazepam	38	Yes	none	6-Sep
16	75	21-Sep	none	62	No	none	none
17	75	22-Sep	none	58	Yes	none	none
18	75	21-Sep	none	58	Yes	Actos	none
19	75	21-Sep	diazepam	45	No	none	19-Aug
20	75	21-Sep	none	60	Yes	none	none
21	75	20-Sep	none	35	No	none	25-Aug
22	75	20-Sep	none	50	No	none	9-Apr
23	75	20-Sep	none	50	No	none	20-Sep
24	75	20-Sep	none	44	Yes	Humalog, Humulin	25-Jun
25	75	20-Sep	none	78	No	none	21-Jun
26	75	12-Sep	zonegran, carbatrol, primidone	43	No	none	none
27	75	19-Sep	none	50	No	none	none
28	75	13-Sep	zonegran	43	No	none	none
29	100	20-Sep	none	68	No	none	none
30	150	22-Sep	none	74	No	none	22-Aug
31	300	21-Sep	none	48	No	none	18-Aug

Conclusions

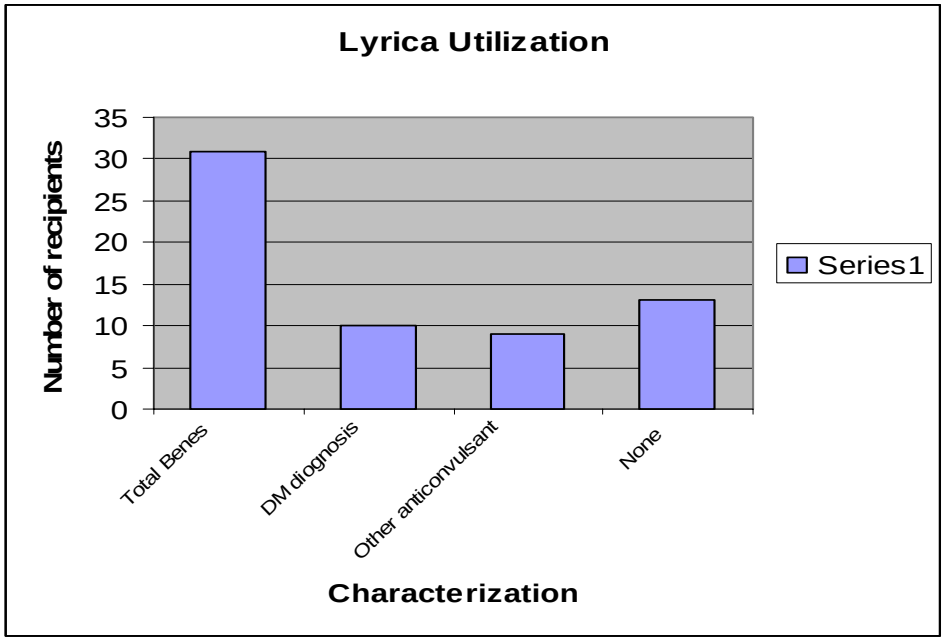
Based on the claims information above, the following conclusions can be made:

1. 10 beneficiaries, or 32 percent, of 31 total beneficiaries on Lyrica® have a diagnosis of diabetes.

2. Of the 10 beneficiaries with a diabetes diagnosis, only 4 have claims for anti-diabetic medications.

3. 9 beneficiaries or 29 percent have at least one recent claim for another anticonvulsant medication.

4. None of the recipients who have received Lyrica® have a diagnosis of herpes zoster or postherpetic neuralgia.



Recommendation

Although this new medication has seen limited utilization to this point, this analysis indicates that a significant number of the patients who have received Lyrica® do not have a diagnosis for which it is indicated. It is recommended that this agent be monitored over the coming months to evaluate utilization trends. As more data is available, retro-DUR interventions encouraging proper utilization could be implemented if needed.

MISSISSIPPI MEDICAID
RETROSPECTIVE DUR
CRITERIA RECOMMENATIONS
4TH QUARTER 2005

Criteria Recommendations	*Approved*	*Rejected*

1. Ramelteon / High Dose _____ _____

Alert Message: Rozerem (ramelteon) may be over-utilized. The manufacturer's recommended dose is 8 mg taken within 30 minutes of going to bed. It is recommended that ramelteon not be taken with or immediately after a high-fat meal due to decreased absorption.
Conflict Code: HD – High Dose
Drug/Disease

Util A	Util B	Util C
Ramelteon		

Max Dose: 8 mg/day
References:
Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

2. Ramelteon / Hepatic Impairment _____ _____

Alert Message: Rozerem (ramelteon) should be used with caution in patients with moderate hepatic impairment. Exposure to ramelteon increases significantly (more than 10-fold) in these patients. Ramelteon should not be used by patients with severe hepatic impairment.
Conflict Code: MC – Drug (Actual) Disease Precautions
Drug/Disease

Util A	Util B	Util C
Ramelteon	Hepatic Impairment	

References:
Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

3. Ramelteon / Fluvoxamine _____ _____

Alert Message: Rozerem (ramelteon), a CYP 1A2 substrate, should not be used in combination with fluvoxamine, a potent CYP 1A2 inhibitor. Co-administration of these agents may cause significant increases in the AUC and Cmax of ramelteon, 190-fold and 70-fold respectively. Concurrent use of ramelteon and less potent CYP 1A2 inhibitors have not been adequately studied and caution is recommended for co-administration.
Conflict Code: DD – Drug/Drug Interaction
Drug/Disease

Util A	Util B	Util C
Ramelteon	Fluvoxamine	

References:
Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

Criteria Recommendations	*Approved*	*Rejected*

4. Ramelteon / Less Potent CYP 1A2 Inhibitors _____ _____

Alert Message: Caution should be exercised when co-administering Rozerem (ramelteon), a CYP 1A2 substrate, with CYP 1A2 inhibitors (e.g. theophylline, amiodarone, cimetidine, ciprofloxacin, norfloxacin). Concurrent use of these agents may result in elevated ramelteon concentrations. Ramelteon should not used in combination with the potent CYP 1A2 inhibitor fluvoxamine.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease

Util A	Util B	Util C
Ramelteon	Theophylline	
	Amiodarone	
	Cimetidine	
	Ciprofloxacin	
	Norfloxacin	

References:

Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

5. Ramelteon / Rifampin _____ _____

Alert Message: Caution should be exercised when administering Rozerem (ramelteon) and rifampin, a potent CYP inducer. Concurrent use of these agents may result in loss of efficacy of ramelteon. Ramelteon is metabolized predominantly by the CYP 1A2 isozyme and to a minor extent by CYP 3A4 and the 2C subfamily. Rifampin is an inducer of all these isozymes.

Conflict Code: DD – Drug/drug Interaction

Drug/Disease

Util A	Util B	Util C
Ramelteon	Rifampin	

References:

Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

6. Ramelteon / Ketoconazole _____ _____

Alert Message: Caution should be exercised when co-administering Rozerem (ramelteon) with ketoconazole. Ketoconazole is a strong inhibitor of CYP 3A4 isozyme which is involved in ramelteon metabolism. Concurrent use of these agents has resulted in a significant increase in the AUC and Cmax of ramelteon, 84% and 36%, respectively.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease

Util A	Util B	Util C
Ramelteon	Ketoconazole	

References:

Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

7. Ramelteon / Fluconazole _____ _____

Alert Message: Caution should be exercised when co-administering Rozerem (ramelteon) with fluconazole. Fluconazole is a strong inhibitor of CYP 2C9 isozyme which is involved in ramelteon metabolism. Concurrent use of these agents has resulted in a significant increase (approximately 150%) in the AUC and Cmax of ramelteon.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease

Util A	Util B	Util C
Ramelteon	Fluconazole	

References:

Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

Criteria Recommendations	*Approved*	*Rejected*

8. Ramelteon / Sleep Apnea & COPD _____ _____

Alert Message: Rozerem (ramelteon) has not been studied in patients with severe sleep apnea and COPD and is not recommended for use in those populations.
Conflict Code: MC – Drug (Actual) Disease Precaution
Drug/Disease

Util A	Util B	Util C
Ramelteon	Sleep Apnea	
	COPD	

References:
Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

9. Ramelteon / Hormone-Related Problems _____ _____

Alert Message: Rozerem (ramelteon) has been associated with decreased testosterone levels and increased prolactin levels. If unexplained symptoms occur such as amenorrhea, galactorrhea, decreased libido or problems with fertility consider assessing prolactin or testosterone levels. Ramelteon has not been studied in children or adolescents, and the effects in these populations are unknown.
Conflict Code: MC – Drug (Actual) Disease Precaution
Drug/Disease

Util A	Util B	Util C
Ramelteon	Amenorrhea	
	Galactorrhea	
	Decreased Libido	
	Infertility	

References:
Rozerem Prescribing Information, Aug. 2005, Takeda Pharmaceutical Company Limited.

Boxed Warning Update

Avinza (morphine sulfate extended-release capsules)

Audience: Pain specialists, other healthcare professionals and consumers

[Posted 11/03/2005] Ligand Pharmaceuticals Inc. and FDA notified healthcare professionals of revisions to BOXED WARNING, WARNINGS, PRECAUTIONS, CLINICAL PHARMACOLOGY, and DOSAGE AND ADMINISTRATION sections of the prescribing information to highlight and strengthen the warning that patients should not consume alcohol while taking Avinza. Additionally, patients must not use prescription or non-prescription medications containing alcohol while on Avinza therapy.

Cylert and generic pemoline products

Audience: Neuropsychiatric healthcare professionals, Pediatricians, Pharmacists and consumers

[Posted 10/24/2005] FDA has concluded that the overall risk of liver toxicity from Cylert and generic pemoline products outweighs the benefits of this drug. In May 2005, Abbott chose to stop sales and marketing of Cylert in the U.S. All generic companies have also agreed to stop sales and marketing of this product. Cylert, a central nervous system stimulant indicated for the treatment of Attention Deficit Hyperactivity Disorder (ADHD), is considered second line therapy for ADHD because of its association with life threatening hepatic failure. Health care professionals who prescribe Cylert, or any of its generics, should transition their patients to an alternative therapy. Cylert will remain available through pharmacies and wholesalers until supplies are exhausted. No additional product will be available.

Cymbalta (duloxetine hydrochloride)

Audience: Neuropsychiatric and other healthcare professionals

[Posted 10/17/2005] Eli Lilly and FDA notified healthcare professionals of revision to the PRECAUTIONS/Hepatotoxicity section of the prescribing information for Cymbalta (duloxetine hydrochloride), indicated for treatment of major depressive disorder and diabetic peripheral neuropathic pain. Postmarketing reports of hepatic injury (including hepatitis and cholestatic jaundice) suggest that patients with preexisting liver disease who take duloxetine may have an increased risk for further liver damage. The new labeling extends the Precaution against using Cymbalta in patients with substantial alcohol use to include those patients with chronic liver disease. It is recommended that Cymbalta not be administered to patients with any hepatic insufficiency.

Strattera (atomoxetine)

Audience: Neuropsychiatric and other Healthcare Professionals, and Consumers

[Posted 09/29/2005] The FDA directed Eli Lilly and Company (Lilly), the manufacturer of Strattera (atomoxetine), to revise the prescribing information to include a boxed warning and additional warning statements that alert health care providers of an increased risk of suicidal thinking in children and adolescents being treated with this medication. FDA also informed Lilly that a Patient Medication Guide (MedGuide) should be provided to patients when Strattera is dispensed. The MedGuide advises patients of the risks associated with and precautions that can be taken when Strattera is dispensed. Further, pediatric patients being treated with Strattera should be closely observed for clinical worsening, as well as agitation, irritability, suicidal thinking or behaviors, and unusual changes in behavior, especially during the initial few months of a course of drug therapy, or at times of dose changes, either increases or decreases.

Paxil (paroxetine HCL)
Paxil CR Controlled-Release Tablets

Audience: Neuropsychiatric and other healthcare professionals

[Posted 09/27/2005] GlaxoSmithKline (GSK) and FDA notified healthcare professionals of changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information for Paxil and Paxil CR Controlled-Release Tablets to describe the results of a GSK retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy. This study suggested an increase in the risk of overall major congenital malformations for paroxetine as compared to other antidepressants [OR 2.2; 95% confidence interval, 1.34-3.63]. Healthcare professionals are advised to carefully weigh the potential risks and benefits of using paroxetine therapy in women during pregnancy and to discuss these findings as well as treatment alternatives with their patients.

Toprol-XL (metoprolol succinate) extended release tablets
Topamax (topiramate) tablets

Audience: All healthcare professionals

[Posted 09/26/2005] AstraZeneca and FDA notified healthcare professionals reports of medication dispensing or prescribing errors between Toprol-XL (metoprolol succinate) extended release tablets, indicated for the treatment of hypertension, long-term treatment of angina pectoris, and heart failure NYHA Class II or III, and Topamax (topiramate), a product of Ortho-McNeil Neurologics, Inc, indicated for the treatment of epilepsy and migraine prophylaxis. There have also been reports of medication errors involving

confusion between Toprol-XL and Tegretol or Tegretol-XR (carbamazepine), products of Novartis Pharmaceuticals Corporation, indicated for the treatment of complex partial seizures, generalized tonic-clonic seizures, and trigeminal neuralgia. These reports include instances where Toprol-XL was incorrectly administered to patients instead of Topamax, Tegretol, or Tegretol-XR, and vice versa, some of them leading to adverse events.

Addendums

The following materials were distributed to DUR Board members at the November 17, 2005 meeting.

Management of Narcotic Over-utilization

The Problem
As many Mississippi Medicaid providers are aware, abuse and drug-seeking behavior associated with opioid agonists are common occurrences in this population. There are certainly many who qualify for Medicaid coverage based on disabilities which are often painful in nature and have legitimate need for such medications. However, reasonable steps to discourage overuse of these agents are appropriate.

National Statistics
Hydrocodone, which is a schedule III agent, is particularly problematic. With over 100 million prescriptions for hydrocodone-containing products dispensed annually, hydrocodone is the most frequently prescribed opiate in the United States. According to data collected by the DEA, the abuse of hydrocodone is associated with significant public health risks, including a substantial number of deaths.[i]

Mississippi Medicaid Statistics
In the first nine months of 2005, there were over 83,000 claims for hydrocodone-containing products billed to Medicaid. Anecdotally, there are many stories of Medicaid beneficiaries expending monthly prescription allowances for these agents, preventing them from receiving much needed therapies for chronic disease management.

In order to evaluate narcotic overuse among Medicaid recipients, a search of pharmacy claims was made to identify all beneficiaries who have received narcotic prescriptions from more than one prescriber within a 30 day time frame. Beneficiaries with a cancer diagnosis were excluded from this search. An analysis of the search results yielded the following observations.

- 4,075 beneficiaries received more than one narcotic within 30 days from more than one prescriber.

- 1,864 beneficiaries received three or more narcotics from more than one prescriber during the 90 day search period.

- 884 beneficiaries received narcotics from three or more prescribers during the 90 day search period.

Responses from Other States
Due to the national scope of this problem as addressed earlier, many state Medicaid programs have responded in various ways to counter this problem. The most common policy is the imposition of monthly quantity limits on these products. Some states have implemented a prospective or concurrent edit of any duplicate narcotic prescription claim within a set time frame. Another common action is “lock-in” of high-utilizing beneficiaries to a specific prescriber and pharmacy.

Current Mississippi Medicaid Policy

Mississippi Medicaid has the following actions and limitations in place to respond to this problem. Monthly quantity limits are in place for narcotic analgesic combination products. A copy of the current list of quantity limits is included for reference. Retrospective DUR letters are mailed to providers addressing high-utilizing beneficiaries. Such an intervention includes a prescription profile for the patient, which lists narcotic claims from any prescriber. There is also a lock-in program in place which is managed by Program Integrity.

Recommendations

1. Evaluate and explore a prospective DUR edit in the POS system for any duplicate narcotic prescription from a second prescriber within a 31 day period, excluding beneficiaries with a cancer diagnosis.

2. Intensify the quantity limits.

3. Encourage a robust lock-in program which would limit high-utilizing beneficiaries to a specific primary care physician and/or pain management specialist and a specific pharmacy.

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[i] Drugs and Chemicals of Concern: Hydrocodone. DEA Office of Diversion Control. April 2004. Accessed on-line November 14, 2005.

Addendum
Mississippi Medicaid P & T Committee
November 8, 2005

Opioid Agonist Utilization

In response to requests from the committee during the review of this class on October 11, the following information is presented regarding the utilization of opioid agonists.

Diagnosis

In order to analyze diagnosis trends associated with claims for sustained-release opioid products, all PAs submitted year-to-date for these agents were analyzed to determine the most common diagnoses for which they are prescribed. The data in the cancer column includes any and all types of cancer. The data in the back/spinal pain column captures several different specific diagnoses, including lumbago, radiculopathy, degenerative disk disease and other similar descriptions. While the other column represents a large number of diagnoses, some of the more common include osteoarthritis, neuropathic pain and myalgia. Incidence of each diagnosis is expressed as an approximate percentage of the total number of PA requests for the particular agent.

Agent	Cancer	Back/spinal Pain	Other
Avinza	4%	69%	27%
Kadian	8%	79%	13%
Oxycodone ER	11%	45%	44%

Utilization by Agent and DEA Schedule

The chart below details the utilization of all opioid agents with one or more claims year-to-date. In addition, the agents are grouped according to their DEA schedule classification.

Rx Num	Label Name	Alternate Name	DEA Schedule
Schedule II Products			
76	ACTIQ LOZENGE	Fentanyl	II
530	AVINZA CAPSULE	Morphine Sulfate	II
8	BELLADONNA & OPIUM SUPPOS	B & O Supprettes	II
2	CODEINE PHOSPHATE 30 MG TAB	Codeine Phosphate	II
28	CODEINE SULFATE TABLET	Codeine Sulfate	II
27	COMBUNOX TABLET	Oxycodone/IBU	II
13	DEMEROL	Meperidine	II
97	DILAUDID	Hydromorphone	II
3740	DURAGESIC PATCH	Fentanyl	II
3699	ENDOCET TABLET	Oxycodone/APAP	II
154	ENDODAN TABLET	Oxycodone/ASA	II

Rx Num	Label Name	Alternate Name	DEA Schedule
5	ETH-OXYDOSE SOLUTION	Oxycodone	II
10662	FENTANYL PATCH	Duragesic	II
286	HYDROMORPHONE TABLET	Dilaudid	II
346	KADIAN CAPSULE SR	Morphine Sulfate	II
219	MEPERIDINE	Demerol	II
25	MEPERIDINE/PROMETHAZINE CAP	Mepergan Fortis	II
2657	METHADONE	Methadose	II
73	MORPHINE SULFATE SOLUTION	Roxanol	II
3529	MORPHINE SULFATE TABLET SA	MS Contin	II
4	MORPHINE SULF 20 MG SUPPOS	RMS	II
626	MORPHINE SULFATE TABLET IR	MSIR	II
75	MS CONTIN TABLET SA	Morphine Sulfate SR	II
10	MSIR 30 MG TABLET	Morphine Sulfate	II
18	OPIUM TINCTURE	Opium	II
176	ORAMORPH SR TABLET	Morphine Sulfate SR	II
1143	OXYCODONE IR	OxyIR	II
2142	OXYCODONE HCL TABLET SA	Oxycontin	II
4840	OXYCODONE W/APAP TABLET	Percocet	II
45	OXYCODONE/ASA TABLET	Percodan	II
3497	OXYCONTIN TABLET SA	Oxycodone SR	II
14	OXYIR 5 MG CAPSULE	Oxycodone	II
8	PALLADONE CAPSULE	Hydromorphone	II
109	PERCOCET TABLET	Oxycodone/APAP	II
4	PERCODAN TABLET	Oxycodone/ASA	II
14	ROXANOL 20 MG/ML SOLUTION	Morphine Sulfate	II
209	ROXICET 5/325 TABLET	Percocet	II
189	ROXICODONE TABLET	Oxycodone	II
Schedule III Products			
4611	ACETAMINOPHEN/COD TABLET	Tylenol with Codeine	III
720	ACETAMINOPHEN/COD ELIXIR	Tylenol with Codeine	III
10	ACETAMINOPHEN/COD SOLUTION	Tylenol with Codeine	III
8	ANEXSIA TABLET	Hydrocodone/APAP	III
206	ASCOMP W/CODEINE CAPSULE	Fiorinal with Codeine	III
4	ASPIRIN/CODEINE 325/30 TAB	ASA/Codeine	III
1	BUPRENEX 0.3 MG/ML AMPUL	Buprenorphine	III
347	BUTALBITAL COMP/COD #3 CAP	Fiorinal with Codeine	III
17	CARISOPRODOL CPD/CODEINE TB	Soma Cpd w/ Codeine	III
8	FIORICET W/CODEINE CAPSULE	Butalbital/APAP/Codeine	III
3	HYCET SOLUTION	Hydrocodone/APAP	III
1793	HYDROCODONE BT-IBUPROFEN TB	Vicoprofen	III
81336	HYDROCODONE/APAP TAB	Lortab, Lorcet, Vicodin	III
23	LORCET	Hydrocodone/APAP	III
12	LORTAB TABLET	Hydrocodone/APAP	III
298	PANLOR DC CAPSULE	Dihydrocodeine	III
974	PANLOR SS TABLET	Dihydrocodeine	III

Rx Num	Label Name	Alternate Name	DEA Schedule
13	REPREXAIN 5-200 MG TABLET	Hydrocodone/Ibuprofen	III
8	STAGESIC 5/500 CAPSULE	Hydrocodone/APAP	III
80	SUBOXONE TABLET	Naloxone/Buprenorphine	III
23	SUBUTEX TABLET	Buprenorphine	III
1	TYLENOL W/CODEINE #4 TABLET	APAP/Codeine	III
1	VICODIN ES TABLET	Hydrocodone/APAP	III
2	VICOPROFEN 200/7.5 TABLET	Hydrocodone/Ibuprofen	III
17	VOPAC TABLET	Codeine/APAP	III
632	XODOL TABLET	Hydrocodone/APAP	III
143	ZYDONE TABLET	Hydrocodone/APAP	III
1298	PANLOR DC CAPSULE	Dihydrocodeine/APAP/caffeine	III
4243	PANLOR SS TABLET	Dihydrocodeine/APAP/caffeine	III
5	PHRENILIN W/CAFF/CODEINE CP	APAP/Codeine/Caffeine	III
Schedule IV Products			
35	BALACET 325 TABLET	Darvocet-N	IV
191	BUTORPHANOL 10 MG/ML SPRAY	Stadol	IV
171	DARVOCET	Propoxyphene/APAP	IV
87	DARVON	Propoxyphene	IV
165	PENTAZOCINE/ACETAMIN TABLET	Talacen	IV
187	PENTAZOCINE/NALOXONE TABLET	Talwin-NX	IV
26923	PROPOXYPHENE-NAPSYLATE/APAP	Darvocet-N	IV
851	PROPOXYPHENE HCL 65 MG CAP	Darvon	IV
1	TALACEN CAPLET	Pentazocine/APAP	IV
1	TALWIN NX TABLET	Pentazocine/Naloxone	IV
Schedule V Products			
3	CAPITAL W/CODEINE ORAL SUSP	APAP/Codeine	V
Non-schedule Products			
12	NALBUPHINE 10 MG/ML AMPUL	Nubain	NC
1	NUBAIN 20 MG/ML VIAL	Nalbuphine	NC
20340	TRAMADOL HCL 50 MG TABLET	Ultram	NC
5155	TRAMADOL HCL/APAP	Ultracet	NC
5129	ULTRACET TABLET	Tramadol/APAP	NC
33	ULTRAM 50 MG TABLET	Tramadol	NC

Medicaid and Medicare Part D

On January 1, 2006, Medicare's Drug benefit plan, otherwise known as Medicare Part D, will bring significant changes to Medicaid's prescription drug program. As federally mandated, Medicare becomes the primary source of drug reimbursement. This is a sweeping change for providers, beneficiaries, and Medicaid agencies nationwide. After January 1, 2006, the Medicaid drug program focus will be for children, families and the newly disabled or those individuals whose disability precludes them from working.

Since today's recommendations for preferred drugs are to become effective on January 1, 2006, and the demographics of MS Medicaid program change on that same date, it is important to note the following statistics and bear this in mind when recommending medications for preferred and non-preferred status:

- In FY 2005 there were approximately 748,000 Medicaid beneficiaries;
- Of the 748,000 Medicaid beneficiaries, in FY 2005, approximately 130,000 individuals have both Medicare and Medicaid
    - About 70,000 of the130,000 are dually eligible by federal definitions and will retain Medicaid coverage for necessary medical services and Medicare excluded drugs.
    - About 60,000 of the 130,000 beneficiaries will lose all Medicaid coverage for medical services. These individuals are commonly referred to as PLADs and Medicare will be their sole source of drug coverage. Medicaid will not pay for any medications, only cost sharing by payments of deductibles or premiums.
- Most, but not all, LTC beneficiaries are classified as dually eligible beneficiaries. There will be some beneficiaries, probably less than 5% of the total LTC population, who have Medicaid only.
- In FY 2005, there were approximately 100 dually eligible beneficiaries under the age of 21.
- After Part D implementation, over 70% of the Medicaid beneficiary pool will be under the age of 21.

Coordination of benefits between Medicare and Medicaid after January 1, 2006.

Medicare's drug benefit will be comprehensive; however, all Part D plans will exclude 3 specific drug classes. Mississippi Medicaid has selected to provide coverage for these excluded categories. This will only impact the 70,000 dual eligible individuals. As of January 1, 2006, Medicaid will cover the following drugs with limitations:

● Barbiturates – coverage of single-entity barbiturates will be limited to phenobarbital and mephobarbital (Mebaral) for <u>all</u> beneficiaries. Butabarbital, amobarbital, pentobarbital, secobarbital, and amobarbital/secobarbital combination product will not be covered for any Medicaid beneficiary. Note that butabarbital combination agents' coverage will not change.

● Benzodiazepines – coverage will be limited to generic versions of these agents for all beneficiaries.
● Over-the-counter (OTC) drugs – Coverage will be limited to the Division of Medicaid's OTC Medicaid formulary for all beneficiaries. The exception to OTC coverage will be OTC insulin products, which will have coverage in Medicare's Part D plans and will not have coverage via Medicaid.

Health Information
Designs, Inc.

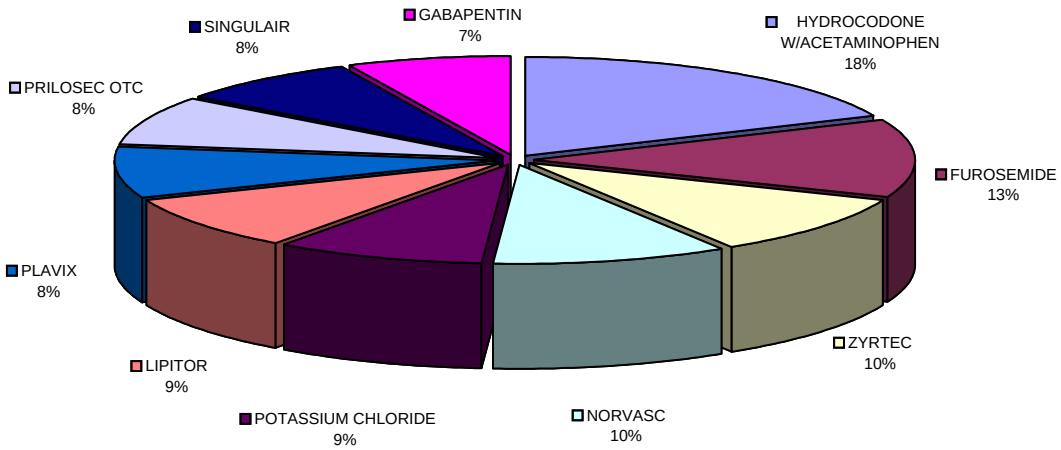
MISSISSIPPI MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 08/01/05-08/31/05

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx
HYDROCODONE W/ACETAMINOPHEN	OPIATE AGONISTS	19,428	$ 255,410.60	$ 13.15
FUROSEMIDE	DIURETICS	13,593	$ 78,245.05	$ 5.76
ZYRTEC	SECOND GENERATION ANTIHISTAMINES	10,697	$ 548,065.74	$ 51.24
NORVASC	DIHYDROPYRIDINES	10,527	$ 605,505.04	$ 57.52
POTASSIUM CHLORIDE	REPLACEMENT PREPARATIONS	9,604	$ 155,984.02	$ 16.24
LIPITOR	HMG-COA REDUCTASE INHIBITORS	9,305	$ 839,209.36	$ 90.19
PLAVIX	MISCELLANEOUS THERAPEUTIC AGENTS	8,882	$ 1,098,053.20	$ 123.63
PRILOSEC OTC	PROTON-PUMP INHIBITORS	8,522	$ 187,049.10	$ 21.95
SINGULAIR	MISCELLANEOUS THERAPEUTIC AGENTS	8,248	$ 761,224.95	$ 92.29
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	7,407	$ 820,832.70	$ 110.82
ZITHROMAX	MACROLIDES	7,159	$ 320,065.12	$ 44.71
RANITIDINE HCL	HISTAMINE H2-ANTAGONISTS	7,065	$ 138,847.78	$ 19.65
ALBUTEROL	SYMPATHOMIMETIC (ADRENERGIC) AGENTS	7,014	$ 68,588.79	$ 9.78
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	7,006	$ 203,475.27	$ 29.04
AMOXICILLIN	PENICILLINS	6,840	$ 56,492.49	$ 8.26
LOTREL	DIHYDROPYRIDINES	6,646	$ 558,715.03	$ 84.07
IBUPROFEN	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	6,643	$ 51,564.49	$ 7.76
HYDROCHLOROTHIAZIDE	DIURETICS	6,584	$ 37,776.97	$ 5.74
PROPOXYPHENE NAPSYLATE W/APAP	OPIATE AGONISTS	6,509	$ 73,948.49	$ 11.36
CEPHALEXIN	CEPHALOSPORINS	6,424	$ 99,057.51	$ 15.42
TOPROL XL	BETA-ADRENERGIC BLOCKING AGENTS	6,178	$ 212,648.93	$ 34.42
SEROQUEL	ANTIPSYCHOTIC AGENTS	5,921	$ 1,421,841.26	$ 240.14
ZOLOFT	ANTIDEPRESSANTS	5,899	$ 568,919.55	$ 96.44
ALPRAZOLAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	5,881	$ 46,955.69	$ 7.98
LEXAPRO	ANTIDEPRESSANTS	5,819	$ 427,151.99	$ 73.41
TOTAL TOP 25		203,801	$ 9,635,629.12	$ 47.28

Total Rx Claims From 08/01/05-08/31/05	770,878

Top 10 Drugs
Based on Number of Claims



Health Information
Designs, Inc.

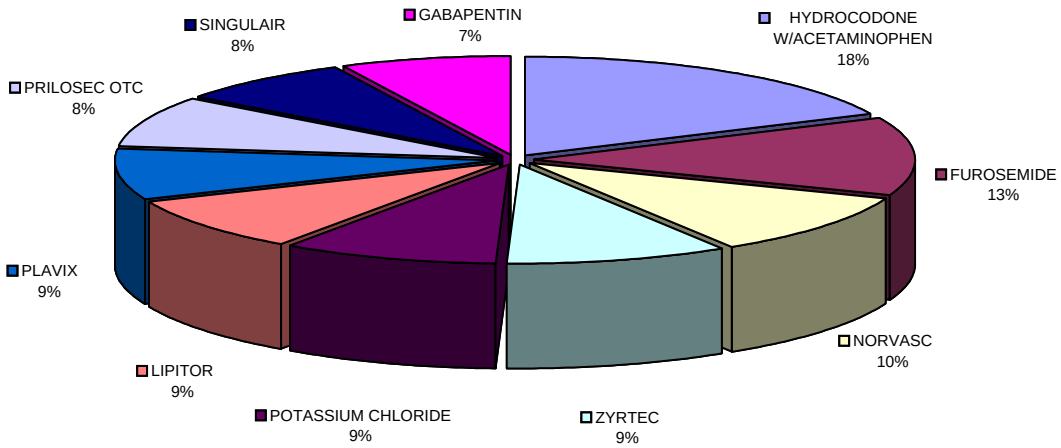
MISSISSIPPI MEDICAID
Cost Management Analysis

TOP 25 DRUGS BASED ON NUMBER OF CLAIMS FROM 09/01/05-09/30/05

Drug	AHFS Therapeutic Class	Rx	Paid	Paid/Rx
HYDROCODONE W/ACETAMINOPHEN	OPIATE AGONISTS	18,662	$ 250,308.39	$ 13.41
FUROSEMIDE	DIURETICS	13,267	$ 75,397.69	$ 5.68
NORVASC	DIHYDROPYRIDINES	10,487	$ 601,256.99	$ 57.33
ZYRTEC	SECOND GENERATION ANTIHISTAMINES	9,794	$ 500,279.02	$ 51.08
POTASSIUM CHLORIDE	REPLACEMENT PREPARATIONS	9,690	$ 156,093.86	$ 16.11
LIPITOR	HMG-COA REDUCTASE INHIBITORS	8,928	$ 802,913.47	$ 89.93
PLAVIX	MISCELLANEOUS THERAPEUTIC AGENTS	8,867	$ 1,090,885.67	$ 123.03
PRILOSEC OTC	PROTON-PUMP INHIBITORS	8,401	$ 185,002.19	$ 22.02
SINGULAIR	MISCELLANEOUS THERAPEUTIC AGENTS	7,932	$ 732,754.35	$ 92.38
GABAPENTIN	ANTICONVULSANTS, MISCELLANEOUS	7,400	$ 811,336.76	$ 109.64
ZITHROMAX	MACROLIDES	7,292	$ 321,680.23	$ 44.11
RANITIDINE HCL	HISTAMINE H2-ANTAGONISTS	6,862	$ 123,659.78	$ 18.02
AMOXICILLIN	PENICILLINS	6,740	$ 55,297.22	$ 8.20
LOTREL	DIHYDROPYRIDINES	6,728	$ 563,778.30	$ 83.80
ALBUTEROL	SYMPATHOMIMETIC (ADRENERGIC) AGENTS	6,687	$ 64,221.42	$ 9.60
LISINOPRIL	ANGIOTENSIN-CONVERTING ENZYME INHIBITORS	6,646	$ 182,499.71	$ 27.46
HYDROCHLOROTHIAZIDE	DIURETICS	6,498	$ 37,279.20	$ 5.74
IBUPROFEN	NONSTEROIDAL ANTI-INFLAMMATORY AGENTS	6,365	$ 49,305.70	$ 7.75
CEPHALEXIN	CEPHALOSPORINS	6,348	$ 97,307.74	$ 15.33
PROPOXYPHENE NAPSYLATE W/APAP	OPIATE AGONISTS	6,272	$ 71,494.39	$ 11.40
ALPRAZOLAM	BENZODIAZEPINES (ANXIOLYTIC,SEDATIV/HYP)	6,061	$ 47,962.25	$ 7.91
TOPROL XL	BETA-ADRENERGIC BLOCKING AGENTS	6,020	$ 205,858.71	$ 34.20
SEROQUEL	ANTIPSYCHOTIC AGENTS	5,851	$ 1,431,307.41	$ 244.63
ZOLOFT	ANTIDEPRESSANTS	5,771	$ 558,808.39	$ 96.83
LEXAPRO	ANTIDEPRESSANTS	5,637	$ 410,964.71	$ 72.90
TOTAL TOP 25		199,206	$ 9,427,653.55	$ 47.33

Total Rx Claims From 09/01/05-09/30/05	753,172

Top 10 Drugs
Based on Number of Claims



Prophylaxis with Palivizumab (Synagis®)[i]

Categories of Risk

1. Infants and children less than two years of age with known CLD who required medical therapy for CLD within six months of the anticipated start of the RSV season.

2. Preterm infants born at 28 weeks of estimated gestational age or earlier may benefit from prophylaxis during their first RSV season, whenever that occurs during the first year of life, even if CLD is not present.

3. Preterm infants born at 29 to 32 weeks of estimated gestational age or earlier may benefit from prophylaxis during their first RSV season, whenever that occurs during the first six months of life, even if CLD is not present.

4. Infants born at 32 to 35 weeks of estimated gestational age must have two of the following risk factors to be candidates for prophylaxis: attendance at a child-care center, school-aged siblings, exposure to environmental pollution, abnormalities of the airways, or severe neuromuscular problems.

CLD = chronic lung disease; RSV = respiratory syncytial virus.

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[i] American Academy of Pediatrics, Committee on Infectious Diseases. Respiratory syncytial virus. In: Pickering LK, ed. Red book: 2003 report of the Committee on Infectious Diseases. 26th ed. Elk Grove Village, Ill.: American Academy of Pediatrics, 2003:523-8.