Minutes of the May 18, 2006
Drug Utilization Review (DUR) Board Meeting

Members Attending: John Mitchell, M.D., Chair; Billy Brown, PharmD; Frank Marascalco, RPh; Lee Montgomery, M.D.; Rudy Runnels, M.D.; Andrea Phillips, M.D.; Wallace Strickland.

Members Absent: Montez Carter, RPh; Troy Griffin; Harold Blakely, RPh; Randy Calvert, RPh.

Also Present: DOM Staff: Judith Clark, RPh; Terri Kirby, RPh; Susan Brown, RPh.
HID Staff: Dennis Smith, RPh; Sam Warman, RPh; Kathleen Burns, R.N.; Gina Pardue, R.N.

Dr. John Mitchell called the meeting to order at 2:00 p.m.

Approval of the minutes for the November 17, 2005 and February 23, 2006 meetings:
Dr. Rudy Runnels made a motion to accept the minutes for both meetings as submitted. Mr. Frank Marascalco seconded the motion. All voted in favor of approval.

CNS Update:
Due to the absence of Ms. Frankie Rutledge, the CNS update was tabled.

HID Updates:

Cost Management Analysis:
Mr. Dennis Smith presented a brief cost management analysis report for the months of February 2006 and March 2006, detailing the top 25 drugs based on number of claims and total cost of claims. During February 2006, Amoxicillin was the top drug with 9,553 claims, followed by Hydrocodone w/Acetaminophen (8,401) and Zyrtec (8,301). The top drug for cost in February 2006 was Synagis with 1,297 claims totaling $1,612,217, with an average $1,243 per claim. The drug with the highest cost per claim was Feiba HV Immuno ($43,109). For March 2006, Zyrtec was the top drug based on number of claims with 9,797, followed by Hydrocodone w/Acetaminophen (8,886) and Amoxicillin (8,117). The top drug for cost in March 2006 was again Synagis with 1,156 claims totaling $1,443,029, with an average of $1,248 per claim. Three hemostatic drugs had the highest cost per claim in March 2006: Feiba HV Immuno ($41,417), Advate ($31,756), and Recombinate ($28,134).

DUR Activity Report:
Mr. Smith reported on the RDUR activities for the periods of October-December 2005, November 2005-January 2006, and April 2006-present. The data from the first two periods are currently being tabulated with a report to be available at the next DUR Board meeting. For the current activity, Pediatric Use of Potent Topical Corticosteroids, Mr. Smith reported there were 159 unduplicated cases in April 2006, based on claims data. Dr. Mitchell suggested that educational materials be distributed to providers regarding the use of these potent and super potent drugs. Mr. Smith stated that the HID Academic Detailers would be

provided information to present to the physicians. Dr. Lee Montgomery suggested that the number of refills versus a one time fill would be useful information to obtain. Dr. Mitchell suggested that the total number of claims for this classification be provided with a breakdown in percentages of the potent and super potent agents. The Board recommended that HID continue to monitor and report findings at subsequent board meetings.

New Business:

Statins and Diabetes:
Mr. Smith reported that a few years ago, the DUR Board approved criteria and an intervention to encourage appropriate use of statins in patients with diabetes and hypercholesterolemia. The goals of this criterion were to reduce hospitalizations with subsequent improvement in the quality of life and reduced work days. This review assessed the same set of parameters based on data from 2005. Overall the number of beneficiaries with both diagnoses and on statin therapy increased 46% since the implementation of this intervention in 2003. Additionally, the number of hospitalizations per patient decreased from 0.68 in 2002 to 0.40 in 2005.

Recommendations:
Continue to monitor results.

Opioid Utilization – Impact of Hurricane Katrina:
Mr. Smith reported on the Opioid Utilization Review comparing patterns of narcotic medication three months before and three months after Hurricane Katrina, specifically comparing utilization rates from 6/1/05-8/29/05 to those from 8/30/05-11/30/05. Included were the number of prescriptions and the quantity dispensed by generic name, as well as a comparison of county utilization. Based on the data examined for this analysis, there were no significant changes in prescribing or dispensing trends between the three month periods prior to and following the disaster. Ms. Judith Clark reported that this study was driven by requests from the Center for Medicaid and Medicare Services (CMS) and the Office of the Inspector General (OIG). A full report will be forwarded to these federal agencies by DOM.

Recommendation:
No further activity recommended at this time.

Second Quarter Criteria Recommendations:
Mr. Smith presented the following retrospective DUR criteria recommendations:

- Stimulants and Sedatives/Therapeutic Appropriateness – Sleep disturbances are common in patients with ADHD. Stimulant therapy may exacerbate or directly cause sleep disturbances. If the disturbances persist during stimulant therapy, adjusting the dosing schedule of the stimulant may reduce/alleviate the need for the sedative. The last daily dose may be given earlier in the day, or a trial of low-dose stimulant in the evening may be useful.
- Ranolazine/High Dose – Ranexa (ranolazine) may be over-utilized. The maximum recommended daily dosage is 2000 mg (1000 mg b.i.d.). Ranolazine has been shown

to prolong the QTc interval in a dose-related manner. Baseline and follow-up ECGs should be obtained to evaluate the effects on QT interval.

- Ranolazine & QT Prolongation/Drug-Drug Marker and/or Diagnosis - Ranexa may have an additive effect on the QT interval and is contraindicated in patients with known QT prolongation, known history of ventricular tachycardia, and in patients receiving drugs that prolong the QTc interval (e.g. Class Ia and III antiarrhythmics and antipsychotics).
- Ranolazine & Hepatic Impairment/Drug Disease Precaution – Ranexa is contraindicated in patients with mild, moderate or severe liver disease, since it is extensively metabolized by the liver as well as intestine. Hepatic dysfunction may increase the QTc-prolonging effect approximately 3-fold.
- Ranolazine & Potent CYP3A4/Drug-Drug Interaction – Ranexa is contraindicated in patients taking potent or moderately potent CYP3A4 inhibitors, such as diltiazem, azole antifungals, verapamil, macrolides, and protease inhibitors. Ranexa is primarily metabolized by the CYP3A4 pathway and inhibition will increase plasma levels and QTc prolongation.
- Ranolazine & Amlodipine, Beta Blockers, & Nitrates/Therapeutic Appropriateness – Ranexa should only be used in combination with amlodipine, beta blockers or nitrates
- Ranolazine & Digoxin/Drug-Drug Interaction - Concomitant use of Ranexa and digoxin, a P-glycoprotein (P-gp) substrate, may result in a 1.5-fold increase in the digoxin plasma concentrations. Ranexa is a P-gp inhibitor and the concurrent use of these agents may result in the increased absorption and decreased elimination of digoxin. Dose reduction of digoxin may be necessary.
- Ranolazine & Renal Impairment/Drug-Disease Precaution – The use of Ranexa should be avoided in patients with severe renal impairment. In clinical trials, subjects with severe renal impairment receiving Ranexa 500 mg b.i.d., the mean diastolic blood pressure was increased approximately 10 to 15 mmHG. Patients receiving Ranexa therapy need regular blood pressure monitoring.
- Ranolazine & P-gp Inhibitors/Drug-Drug Interaction – Concomitant use of Ranexa and P-glycoprotein (P-gp) inhibitors may result in elevated ranolazine plasma concentrations. Inhibition of the efflux pump may result in increased absorption of ranolazine.
- Ranolazine & CYP2D6 Substrates/Drug-Drug Interaction – Concomitant use of Ranexa, a CYP2D6 inhibitor, with a CYP2D6 substrate such as tricyclic antidepressants, may result in increased plasma concentration of the CTP2D6 substrate. Dose reduction of the substrate may be necessary
- Ranolazine & Simvastatin/Drug-Drug Interaction – Concomitant use of Ranexa and Zocor (simvastatin) may result in a 2-fold increase in plasma concentrations of simvastatin and its active metabolite. Dose reduction of simvastatin may be necessary.

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

Boxed Warning Update:
Mr. Smith presented black box warnings issued by the FDA concerning the following:

- **Promethazine HCL (Phenergan)**
  Audience: Pediatricians, emergency service professionals, and patients
  [Posted 4/25/06] FDA notified healthcare professionals and patients that cases of breathing problems, some causing death, have been reported to the FDA when the drug was used in children less than two years old. Parents and caregivers should also be careful and get a doctor's advice about giving promethazine HCL in any form to children age two and older. The labeling on all products, brand name and generic, has been changed to reflect these strengthened warnings.

- **Tequin (gatifloxacin)**
  Audience: Healthcare professionals and patients
  [Posted 2/16/2006] BMS notified FDA and healthcare professionals about proposed changes to the prescribing information for Tequin, including an update of the existing WARNING of hypoglycemia and hyperglycemia, and a CONTRADICTION for use in diabetic patients. The changes also include information identifying other risk factors for developing low blood sugar or high blood sugar, including advanced age, renal insufficiency, and concomitant glucose-altering medications while taking Tequin.
  NOTE: This drug has become unavailable since the printing of the information, making this labeling change unnecessary.

- **Tracleer (bosentan)**
  Audience: Cardiopulmonary healthcare professionals
  [Posted 3/2/2006] Actelion and FDA notified healthcare professionals of changes to the prescribing information based on cases of hepatotoxity reported. The notification underscored the need to continue monthly liver function monitoring for the duration of Tracleer treatment and the need to adhere to the recommended dosage adjustment and monitoring guidelines described in the product labeling

Pharmacy Program Update:
Ms. Clark presented information regarding the number of claims submitted and paid in April 2006 (approx. 350,000) compared to December 2005 (approx. 800,000) due in part to Medicare Part D. A review of claims reveal a 59% generic utilization compared to 40% a year ago. The average cost per prescription is $131 for brands, $24 for generic, and $30 for DAW1. Ms. Clark distributed an updated Preferred Drug List (PDL) which will be effective July 1, 2006. A copy of the PDL will be available on the DOM website. Generic drugs are not listed on the abbreviated list, but most are preferred and do not require prior authorization.

Next Meeting Information:
Ms. Clark stated that the next DUR Board meeting is scheduled for August 24, 2006

As there was no further business or discussions, Dr. Mitchell adjourned the meeting at 3:30 p.m.

Respectfully submitted:
Health Information Designs, Inc.