Mississippi Division of Medicaid
Drug Utilization Review (DUR) Board
Minutes of the November 20, 2008 Meeting

Members Attending: William Bastian, M.D.; Alvin Dixon, R.Ph.; Edgar Donahoe, M.D.; Laura Gray, M.D.; Lee Merritt, R.Ph.; Mark Reed, M.D.; Jason Strong, Pharm D.; Vickie Veazey, R.Ph.; John Wallace, M.D.
Members Absent: Roy Arnold, R.Ph.; Lee Voulters, M.D.; Frank Wade, M.D.

Also Present:
DOM Staff: Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Paige Clayton, Pharm D., DOM DUR Coordinator
HID Staff: Ashleigh Holeman, Pharm D., Project Manager; Leslie Leon, Pharm. D., Clinical Pharmacist; Kathleen Burns, R.N., Call Center Manager

Awaiting the last members to arrive, Ms. Clark started the meeting by asking the newest members to introduce themselves to the Board. The minutes were reviewed and a motion was made by Dr. Donahoe to accept the minutes as written, seconded by Dr. Reed. All voted in favor of this motion by a yes. Ms. Clark again voiced the appreciation from the Division of Medicaid for the Board members to serve the State in this capacity.

Call To Order:
Laura Gray, Chairperson of the Board, called the meeting to order at 2:10 p.m.

Cost Management Analysis:
Dr. Holeman presented reports reflecting the last 2 months of data, indicating that since the last meeting was so close, the data was a more condensed version. She continued with the antipsychotic agents remaining in the lead for the top 15 therapeutic classes by total cost for the two months reported, July and August 2008. Once again, the top drug based on the number of claims for these two months was hydrocodone-acetaminophen. This was noted to be #1 in the national rank of based on number of claims. The top 25 drugs based on total claims cost for the two months reported was led by Prevacid® followed by Singulair®. Both of these drugs are listed on the Medicaid Preferred Drug List.

New Business:

FDA Updates:

Tumor necrosis factor-alpha blockers (TNF blockers), Cimzia (certolizumab pegol), Enbrel (etanercept), Humira (adalimumab), and Remicade (infliximab)
FDA notified healthcare professionals that pulmonary and disseminated histoplasmosis, coccidioidomycosis, blastomycosis and other opportunistic infections are not consistently recognized in patients taking tumor necrosis factor-α blockers (TNF blockers). This has resulted in delays in appropriate treatment, sometimes resulting in death. For patients taking TNF blockers who present with signs and symptoms of possible systemic fungal

infection, such as fever, malaise, weight loss, sweats, cough, dypsnea, and/or pulmonary infiltrates, or other serious systemic illness with or without concomitant shock, healthcare professionals should ascertain if patients live in or have traveled to areas of endemic mycoses. For patients at risk of histoplasmosis and other invasive fungal infections, clinicians should consider empiric antifungal treatment until the pathogen(s) are identified.

Rituxan (rituximab) Injection
Genentech informed healthcare professionals of revisions to prescribing information for Rituxan regarding a case of progressive multifocal leukoencephalopathy (PML) leading to death in a patient with rheumatoid arthritis who received Rituxan in a long-term safety extension clinical study. The patient developed a JC virus infection with resultant PML and death 18 months after taking the last dose of Rituxan. Healthcare professionals treating patients with Rituxan should consider PML in any patient presenting with new onset neurologic manifestations. Additionally, consultation with a neurologist, brain MRI and lumbar puncture should be considered as clinically indicated.

Tarceva (erlotinib) Tablets
OSI and Genentech notified healthcare professionals that cases of hepatic failure and hepatorenal syndrome, including fatalities, have been reported during use of Tarceva, particularly in patients with baseline hepatic impairment. Patients with hepatic impairment receiving Tarceva should be closely monitored during therapy and the product should be used with extra caution in patients with total bilirubin >3x ULN. Dosing should be interrupted or discontinued if changes in liver function are severe, such as doubling of total bilirubin and/or tripling of transaminases in the setting of pretreatment values outside the normal range. New information from a pharmacokinetic study in patients with moderate hepatic impairment associated with significant liver tumor burden has been provided in the revised prescribing information, and other recommendations are included in the WARNINGS and DOSAGE AND ADMINISTRATION sections.

Statin drugs and amyotrophic lateral sclerosis (ALS)
An FDA analysis provides new evidence that the use of statins does not increase incidence of amyotrophic lateral sclerosis (ALS), a neurodegenerative disease often referred to as "Lou Gehrig's Disease." The FDA analysis, undertaken after the agency received a higher than expected number of reports of ALS in patients on statins, is based on data from 41 long-term controlled clinical trials. The results showed no increased incidence of the disease in patients treated with a statin compared with placebo.
The FDA is anticipating the completion of a case-control or epidemiological study of ALS and statin use. Results from this study should be available within 6-9 months. FDA is also examining the feasibility of conducting additional epidemiologic studies to examine the incidence and clinical course of ALS in patients taking statins.
Based on currently available information, health care professionals should not change their prescribing practices for statins and patients should not change their use of statins.

Atypical Antipsychotic Utilization in Children:
Dr. Holeman reminded the Board that at the September 25, 2008 meeting, the Board had responded to the HID presentation with several concerns regarding the use of these medications in children. One concern was: What was the breakdown of pediatric beneficiaries receiving atypical antipsychotics regarding their diagnosis? More specifically, how many of these beneficiaries have an ADHD diagnosis and how many have an ODD diagnosis? The chart presented by HID revealed that 75% of all patients 18 years old or younger who received an atypical antipsychotic had a diagnosis of ADHD, while 55% had a diagnosis of ODD. 46% were found to have both diagnoses of ADHD and ODD. The second request from the Board was for the utilization data for pediatric beneficiaries with an ADHD and/or ODD diagnosis who had received an atypical antipsychotic concurrently with stimulants or Strattera®. HID reported that of the 4287 beneficiaries under the age of 19 on atypical antipsychotic treatment for these diagnoses, 59% also received treatment with a stimulant or Strattera®. This indicated that although the use of the atypical antipsychotics in pediatric patients for these diagnoses is off-label, the majority of providers treating these patients have attempted trials of conventional treatment modalities for these diagnoses and for whatever reason have had to continue on to other options. A final observation made at the September meeting was the increased risk of metabolic adverse effects when being treated with atypical antipsychotics. An analysis was done on the pediatric beneficiaries who received atypical antipsychotics to determine how many also had a diagnosis of Type 2 Diabetes, one of the more common and frightening risks associated with these medications. Only 2% of the pediatric beneficiaries receiving an atypical antipsychotic also had a diagnosis of Type II Diabetes Mellitus. However, the potential risk for metabolic side effects with these medications must not be disregarded based on these results. Dr. Donahoe posed a request that HID report at the next meeting what specialty is prescribing the atypical antipsychotics to these children. He suggested that with this report the Board might require that a psychiatric consult be required before a pediatrician/family medicine physician could prescribe these medications for Mississippi Medicaid pediatric beneficiaries. Dr. Bastian asked if the Board might obtain a number of pediatric psychiatrists in the State treating Medicaid patients. He was concerned that these patients might not have access to these physicians in all areas of the State. The Board continued with discussions that these general practitioners might have a phone consultation with a psychiatrist before prescribing this class of medications in geographic areas where accessibility is limited. Dr. Bastian continued that in the pediatric population with Type II diabetes , use of the atypical antipsychotics is commonly associated with weight gain. This also poses additional problems in this population. He requested reports from HID on these two diagnoses and the use of atypicals as a further study for the Board to review.

Cost Savings Potential- Preventative Treatment of Migraine Headaches:
Dr. Holeman began the report indicating that triptans and narcotic analgesics are considered rescue medications for migraine headaches. However, there are some treatment options available that help prevent the occurrence of migraines. These include amitriptyline, propranolol, Topamax® and Depakote®. HID conducted claims analyses to determine how many beneficiaries receiving rescue treatment with a triptan for

migraines also received a deterrent medication. Utilization data for this report was gathered over a 6-month interval from 3/27/2008 to 9/26/2008. These searches were then intersected to determine the number of beneficiaries who received both types of treatment versus those who received rescue medication only. Triptan only use was identified in 1236 or 27% of the beneficiaries. Triptan and maintenance medications were noted in 350 or 73% of these identified beneficiaries.

Recommendations:

HID recommends in an effort to increase the number of beneficiaries who may benefit from the use of a preventive medication, a consistent review be made of a current RDUR criterion identifying those patients with a diagnosis of migraine and claims history of an acute migraine treatment, but no claims history of one of the preventive medications. Dr. Wallace asked what type of interaction would be made to the provider. Dr. Holeman answered that an educational letter would be generated when the system identified the beneficiary and physician with this criterion. Dr. Donahoe asked if HID might report internally at the next meeting on the trend of these Migraine patients and their narcotic/triptan use. All agreed on this recommendation by show of hands.

Duplicate Therapy with Sedative/Hypnotics:

Dr. Holeman continued with the sedative/hypnotic agents and their treatment for insomnia. There is some concern that these agents are potentially being abused. Through HID reporting it was discovered that some beneficiaries were receiving multiple prescriptions for different agents within this class. Based on the total claims count for the months of July and August 2008, there was widespread duplication therapy on the agents targeted.

Recommendation:

Based on the potential for addiction associated with this therapeutic class, coupled with the high costs of some of the agents, a duplicate therapy edit at the point of sale was recommended by HID. This would prevent beneficiaries from receiving multiple prescriptions of differing agents within this class and require the physician to submit a prior authorization explaining the need for the additional medication. Dr. Donahoe made a motion to allow the first agent to go through at a 31-day supply and then deny the second agent by requiring a PA with explanation of medical justification from the physician. Dr. Reed seconded the motion. All voted in favor of the motion by show of hands.

Appropriate Use of Benzodiazepines:

Benzodiazepines are agents used in the treatment of symptoms associated with anxiety disorders. Dr. Holeman reviewed the most recent treatment guidelines that recommend these medications for short-term use only and that the maintenance of these anxiety disorders should be managed with either a selective serotonin reuptake inhibitor or a serotonin and norepinephrine reuptake inhibitor. HID gathered utilization for the months of July and August 2008 for each of the benzodiazepines. Based on the results, it was clear that there is some degree of duplication of therapy in the Medicaid population. The rate varied from 10- 15 % depending on the agent. The rate was noted much higher (30%) in the long-acting benzodiazepine category. It was recently bought to the attention of the HID staff by a Mental Health Provider that Medicaid had no limits on these agents

and that they had had repeated requests for high doses of these agents. The conclusion of this report was that even though there is an appropriate role in the treatment of anxiety disorders for these agents, this role should be limited and restricted to two to four weeks based on the treatment guidelines.

Recommendations:

HID recommended that edits be placed at the point of sale to curb the trend of duplicate therapy for benzodiazepines. HID also recommends that quantity limits be set in hopes to discourage this potential abuse. Dr. Donahoe made a motion to limit this class to 62 tablets per month with a limit of one prescription per 31 days of these agents. Ms. Veazey seconded the motion. Votes were approved by show of hands with the exception of Dr. Wallace who had left the room at the time of the voting.

Suboxone/Subutex Prior Authorization Process:

Dr. Holeman noted at present that these two medications require prior authorization for Mississippi Medicaid beneficiaries. A review of utilization for these agents confirms a significant increase of volume in the last few months. When compared to the same time period for 2006-2007, utilization has increased more than threefold and the cost to the Division of Medicaid increased by over 400%. While some of this growth can be attributed to increased marketing of the agents, such a jump is troublesome.

The purpose of this presentation to the DUR Board was to gather insight from the members to determine if the current criteria being used for prior authorization are appropriate. Currently, these agents have DOM-implemented quantity limits of 62 tablets per 31 days. This is consistent with the recommended dosing according to the prescribing information. It is the goal of the Division to ensure that the beneficiaries who truly need these products for treatment of their abuse condition are able to receive them. DOM maintains the stance that they are to be used appropriately and prescribed appropriately. Discussion was opened to the Board on these agents.

Recommendation:

After extensive discussion by the Board, there was acknowledgement of the urgency to implement policies immediately that would benefit the pharmacy program of Mississippi Medicaid without neglecting the needed treatment for the diagnosis of opioid dependency. The Board voted on the first of ongoing requirements that must be met by the prescribing provider and the beneficiary. The Board will also revisit these options at the February meeting should additional requirements be identified. Dr. Donahoe motioned that the Suboxone/Subutex PA be limited to a two month approval only without additional treatment. He continued that these medications should be limited to 62 pills per month according to the dosing guidelines in the prescribing information by the manufacturer. Dr. Reed suggested that, in this motion, a letter be sent to every prescriber of these agents defining the new guidelines mandated by the Board which would be delivered with the new Suboxone/Subutex prior authorization form by HID's Academic Detailers. Dr. Donahoe noted this addition and continued with there must be a signed statement by the patient on the prior authorization form that he/she is narcotic free at the time of the prescription, and additional information must be noted by the physician that a drug screen for the beneficiary was negative to opioids and positive to Suboxone/Subutex on the second request. Any deviation would be a denial of treatment. A positive pregnancy test with date of test must be noted on every request for Subutex. Dr Gray

suggested that this would only be a start to the prior authorization criteria and that in February there would be a need to modify the criteria for this medication. Dr. Gray then seconded the motion and all voted in favor of implementing, as soon as possible, the suggested prior authorization criteria for Suboxone/Subutex by a show of hands. Dr. Donahoe asked DOM how soon this policy could be implemented as this was of an urgent need due to the potential danger of abuse. He continued by noting that in his area there had been a "code" due to the beneficiary misusing this medication with other drugs of abuse. Dr. Gray supported this urgent need stating that this medication poses a danger to the Mississippi Medicaid Population when misused and inappropriately prescribed.

Criteria Recommendations for 4th Quarter 2008:
Dr. Holeman reviewed the criteria submitted by HID and all voted in favor by show of hands to adopt the submitted criteria without any additions or changes. HID asked the Board for a set quantity limit for the PPI's. The Board voted for the limit to be set at 62 units per 31 days. HID then recommended that a quantity limit of 31 units per 31 days be set on Singulair®. All voted for this recommendation. Next, the Board was asked to consider a vote on an educational letter to the prescribing physician for HIV patients who are noncompliant with their treatment. This letter would be in response to RDUR criteria that identify the beneficiaries who do not fill their medications on a month by month basis for either one or all or HIV medications. All voted to accept this recommendation.
Dr. Gray reminded the Board of the next meeting on February 19, 2009 and requested a motion for the meeting to be adjourned at 3:45pm. Motioned: Dr. Reed; Seconded: Dr. Strong

Respectfully Submitted:
Health Information Designs, Inc.