Mississippi Division of Medicaid

Drug Utilization Review (DUR) Board

Minutes of the November 18, 2010 Meeting

Members Attending: William Bastian, M.D.; Gera Bynum, R.Ph.; Edgar Donahoe, M.D.; Lee Merritt, R.Ph.; Mark Reed, M.D.; Paul Read, Pharm.D.; Jason Strong, Pharm.D.; Vickie Veazey, R.Ph. **Members Absent:** Alvin Dixon, R.Ph.; Jason Dees, D.O.; Laura Gray, M.D.; Frank Wade, M.D.

Also Present: DOM Staff: Judith Clark, R.Ph., DOM Pharmacy Bureau Director; Shannon Hardwick, R.Ph., DOM Clinical Pharmacist; Delvin Taylor, DOM Pharmacy Bureau; Andrea McNeal, DOM Bureau of Program Integrity **HID Staff:** Ashleigh Holeman, Pharm.D., Project Manager

Call to Order: Dr. Mark Reed, Chairman of the Board, called the meeting to order at 2:00 p.m. Dr. Reed asked for a motion to accept the minutes from the meeting of August 19, 2010. Dr. William Bastian made a motion to accept the minutes with a second from Lee Merritt. All voted in favor of the motion.

Dr. Reed continued the meeting by asking Dr. Holeman to review the cost analysis with the Board.

Cost Management Analysis:
Dr. Holeman began the presentation with the Top 15 Therapeutic Classes, based on total cost of claims, from June 2010 through August 2010. The top three drug classes consistently remained antipsychotics, hemostatics, and anticonvulsants. Dr. Holeman noted that the fourth and fifth positions fluctuated between the leukotriene modifiers, amphetamines and antiretrovirals for the months of June through August 2010. The second report, Top 25 Drugs based on the number of claims, for the time frame of June through August 2010, revealed that the top five drugs were hydrocodone- acetaminophen, amoxicillin, cetirizine, Singulair® and azithromycin for all three months reviewed. The third report, the Top 25 Drugs, based on total claims cost report, showed that the tops three medications were Abilify®, Singulair®, and Seroquel®. In this same report, the fourth and fifth positions based on total claims cost alternated between Feiba VH®, Zyprexa®, and Adderall XR® for the three months analyzed. In the aforementioned reports, all drug strengths are incorporated into claims totals.

Pharmacy Program Update:
Ms. Clark began by informing the DUR Board that there would be a new contractor for Retrospective Drug Utilization services beginning in 2011. The University of Mississippi School of Pharmacy will be supporting the Division of Medicaid in this capacity going forward, and representatives from the School of Pharmacy were introduced. Ms. Clark also announced that there would be updates to the PDL on January 1, 2011, and that the updates will be posted to

the DOM website no later than the close of business on December 1, 2010. Ms. Clark concluded by announcing that DOM would also be implementing a new prior authorization process beginning January 1, 2011, and she asked that DUR Board members check the DOM website for further news and instructions regarding this change.

New Business:

Lovenox® Utilization Review

DOM recently received comments from the Centers for Medicare and Medicaid Services (CMS) regarding extended low molecular heparin utilization in the Medicaid population. Since the majority of claims are for Lovenox®, DOM requested that HID conduct a utilization review of Lovenox® products in the Mississippi Medicaid population. According to the manufacturer's prescribing information for the product, Lovenox® is approved for outpatient administration for up to17 days for the indication of acute DVT without pulmonary embolism. However, there are clinical situations that warrant longer therapy. DOM asked HID review Lovenox® paid claims data to determine if long-term treatment with the product was an issue within the Mississippi Medicaid population. HID gathered Lovenox® claims data for several individual months and then intersected these searches to determine the number of beneficiaries receiving therapy consistently from month to month. This analysis showed that the number of claims and/or beneficiaries receiving Lovenox® remains relatively constant from month to month, with claims counts ranging from 130's – 150's and beneficiary counts ranging from 110-120. When the searches were intersected, the results provided indicate that the number of beneficiaries being treated longer than one month with Lovenox® is not substantial. The largest number identified was 50 beneficiaries who received Lovenox® during the months February and March. Dr. Donahoe made a motion to implement a duration of therapy edit of 17 days for Lovenox® products; claims for a longer duration of therapy would trigger a prior authorization requirement. Dr. Donahoe also would like to add the requirement of an appropriate diagnosis at a later time. The motion was seconded by Dr. Paul Read, and all voted in favor of the motion.

Utilization Review of Avandia®

In late September 2010, the FDA announced that access to Avandia® will be restricted due to data suggesting an increased risk of cardiovascular events in patients taking the medication. These restrictions follow the addition of black box warnings to the product's label in August and November 2007 regarding heart failure and myocardial infarction, respectively. Under the new restricted access program, patients currently taking Avandia® and benefitting from treatment will be allowed to continue to do so, but new patients will only be allowed access to the medication if they are unable to achieve blood glucose control with other diabetes medications, are unable to take Actos®, and are made aware of the drug's considerable risks to the heart. As a result of this announcement, DOM asked HID to review utilization data for Avandia® to determine what the current utilization in the Mississippi Medication population is as well as what the recent trend has been for the product. HID gathered claims data for the last several years, up to August 27, 2010, and compared the results to find any identifiable trends. This analysis revealed that there was a large decrease of approximately 50% in utilization of Avandia® from 2007 to 2008. This drop corresponds with the highly publicized addition of the

black box warnings to the product's label in the second half of 2007. Dr. Holeman continued by reporting that with each year there has been a steady decline in utilization of the medication, with only 942 claims in 2010. Although the restricted access of Avandia will undoubtedly impact a significant number of Mississippi Medicaid beneficiaries, the results of the utilization analysis provided to the DUR Board indicate than many prescribers have already made the decision to employ other measures in the treatment of their diabetic patients. Ms. Clark added that, because of the recent announcement regarding restricted access of Avandia®, the P&T committee voted to move the product, as well as Avandamet®, to non-preferred status beginning January 1, 2011.

Analyzing the Effectiveness of Maximum Age Limits for ADHD Agents

On January 1, 2010, the Division of Medicaid implemented a maximum age limit of 21 years on ADHD agents to ensure appropriate utilization of these medications. HID analyzed claims data pre- and post-implementation of the maximum age limit to determine if the age limit is serving its intended purpose. The claims analysis conducted by HID showed a 41% decrease in the number of claims for ADHD agents in the target population. That is, there were 2,973 claims in the six months prior to the implementation of the age edit and 1,741 claims in the six months following the age edit implementation. HID further analyzed claims data for these agents based on diagnoses. In addition to attention deficit hyperactivity disorder, other diagnoses accepted on prior authorization requests include narcolepsy and traumatic brain injury, among others. In the six months before the maximum age limit implementation, 72% of all claims for ADHD agents in beneficiaries over 21 years old were for a diagnosis of ADHD, traumatic brain injury, or narcolepsy. In the six months after the implementation, 80% of all claims for ADHD agents in the target population were for the aforementioned diagnoses. Dr. Holeman concluded the report by noting that the maximum age limit appears to be serving the intended purpose of promoting appropriate utilization of the ADHD agents in adult beneficiaries. Ms. Clark also added that this age limit was a direct recommendation from the DUR Board, and thanked them for their direction on the subject.

Other Topics

Dr. Donahoe asked if there were any plans to begin step therapy for the atypical antipsychotics. Ms. Clark's response was that there was no step therapy, other than step therapy associated with non-preferred agents and the PDL. Ms. Clark reminded the Board of ICD-10 requirements for all claims beginning in 2013. Ms. Clark asked Dr. Donahoe for recommendations on this issue. Dr. Donahoe's professional opinion was that beneficiaries stable on the medication should be allowed to continue, but that new atypical antipsychotic starts for any Mississippi Medicaid beneficiary should trigger a prior authorization request documenting a clinically appropriate diagnosis. Ms. Clark responded that this subject would be reviewed at the next meeting. The DOM would consider an edit of this type later, possibly in 2011.

Other Criteria Recommendations

No RDUR criteria were submitted for approval this quarter.

Dr. Reed called for the meeting to be adjourned at 2:55 p.m. The next meeting will be held at 2:00 p.m. on February 17, 2011.

Respectfully Submitted,
Health Information Designs, Inc.

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Mark Reed, M.D.
Chair, DUR Board