Iowa Medicaid Drug Utilization Review Commission
Meeting Minutes September 2, 2009

Attendees:

Commission Members
Rick Rinehart, M.D.; Bruce Alexander, R.Ph., Pharm.D., BCPP; Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Laurie Pestel, Pharm.D.; Larry Ambroson, R.Ph.; Casey Clor, M.D.; Mark Graber, M.D., FACEP; and Susan Parker, Pharm.D.

Staff
Thomas Kline, D.O.; Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.

Guests
Chuck Wadle, D.O., Magellan; Colleen Kacher, IME; Nick Ford, IME; Laura Wiggins, IME; Sandy Pranger, R.Ph., IME; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Thomas Kline called the meeting to order at 9:30 a.m. at the Learning Resource Center in West Des Moines. Commission members, guests, and observers were welcomed and introduced.

The minutes from the August 5, 2009 meeting were approved following a correction from Bruce Alexander. (Motion by Dr. Rick Rinehart, second by Dr. Sara Schutte-Schenck, unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

Medical Services has been investigating prior authorization of elective CTs, MRIs, PET scans, and MRAs for possible future savings. An estimated $27 million was spent on these last year, so there is an opportunity for savings. Medical Services is also in the process of developing a maternal health program with the Department of Public Health, attempting to identify all high-risk pregnant women in the state in their first trimester. Medical Services is working toward URAC accreditation. There will be a Clinical Advisory Committee meeting on September 11th; they will discuss Medipass provider reporting among other topics. The Mental Health Advisory Group meeting scheduled for Friday October 23rd has now been cancelled.

Case Studies

Pam Smith presented four intervention case studies. Recommendations by Commissioners from these three examples resulted in an annualized total savings of $16,871.65 pre-rebate (state and federal).

Public Comment

Patricia Harwood (MedImmune) and Susan Harrell (Blank Children's Hospital) both spoke about *Synagis*. Nancy Bell from Pfizer spoke about changes to the

Lyrica prior authorization criteria.

PA Criteria

Uloric: The Commission reviewed the prior authorization criteria as follows:

> *Prior authorization is required for febuxostat (Uloric). Payment for febuxostat (Uloric) will only be considered for cases in which symptoms of gout still persist while currently using 300mg per day of a preferred allopurinol product unless documentation is provided that such a trial would be medically contraindicated.*

There were four responses from members of the Iowa Pharmacy Association, in response to letters that had been sent out regarding these proposed criteria. Commission members were given a copy, but had no further changes. Bruce Alexander did suggest that the informational letter include an explanation of why the uric acid level was not part of the criteria as it had come up in discussion.

Ketorolac: The Commission reviewed the prior authorization criteria as follows:

> *Prior authorization is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a Black Box Warning. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be approved under the following conditions:*
> *1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given.*
> *2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum duration of therapy is 5 days per month.*
> *3. Diagnosis indicating moderately severe, acute pain.*
> *Requests for IV/IM ketorolac must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs.*

The Commission asked that language be added to the last sentence indicating the two nonsteroidal anti-inflammatory drug trials be at an adequate dose to keep consistent with other PA criteria. Bruce Alexander motioned to accept these criteria with the suggested change, and Craig Logemann seconded. The motion passed with no objections.

Muscle Relaxants: The Commission reviewed the prior authorization criteria as follows:

> *Prior authorization is required for non-preferred muscle relaxants. Payment for non-preferred muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least three preferred*

muscle relaxants. Requests for carisoprodol will be approved for a maximum of 120 tablets per 30 days within a six month timeframe when the criteria for coverage are met.

Dr. Rick Rinehart motioned to accept these criteria, and Larry Ambroson seconded. The motion passed unanimously.

Antihistamines: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for all non-preferred antihistamines and preferred 2nd generation prescription antihistamines.

Patients 21 years of age and older must have three unsuccessful trials with antihistamines that do not require prior authorization, prior to the approval of a preferred 1st generation or preferred 2nd generation prescription antihistamine. Two of the trials must be otc cetirizine and loratadine. Prior to approval of a non-preferred 2nd generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred 2nd generation prescription antihistamine.

Patients 20 years of age and younger must have unsuccessful trials with otc cetirizine and loratadine prior to the approval of a non-preferred 1st generation or preferred 2nd generation prescription antihistamine. Prior to approval of a non-preferred 2nd generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred 2nd generation prescription antihistamine.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Craig Logemann motioned to accept these criteria, and Bruce Alexander seconded. The motion passed unanimously.

Fentanyl – Short Acting Oral Products: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for short acting oral fentanyl products. Payment will be considered only if the diagnosis is for breakthrough cancer pain in opioid tolerant patients. These products carry a Black Box Warning. Actiq®, Fentora®, & Onsolis™:

- *Are indicated only for the management of breakthrough cancer pain in patients with malignancies already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.*

Are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use in opioid non-tolerant patients.

Bruce Alexander motioned to accept these criteria, and Dr. Rick Rinehart seconded. The motion passed unanimously.

Pregabalin (Lyrica): The Commission reviewed the prior authorization criteria as follows:

> *Prior authorization is required for pregabalin (Lyrica®). Payment will be considered under the following conditions:*
> *1. A diagnosis of partial onset seizures, as adjunct therapy.*
> *2. A diagnosis of post-herpetic neuralgia and previous treatment failure with at least two of the following agents at a therapeutic dose to treat post-herpetic neuralgia: tricyclic antidepressant, topical lidocaine, or gabapentin.*
> *3. A diagnosis of diabetic peripheral neuropathy and previous treatment failure with at least two of the following agents at a therapeutic dose to treat diabetic peripheral neuropathy: tricyclic antidepressant, topical lidocaine, tramadol, or gabapentin.*
> *4. A diagnosis of fibromyalgia and a previous treatment failure with a preferred agent at a therapeutic dose to treat fibromyalgia.*

This topic was deferred to a future meeting so as to give time to review why the original language did not have "a therapeutic dose" added to #2 and #3. Bruce Alexander motioned that all references to "adequate" dose on all PA forms be replaced with "therapeutic" dose. Dr. Mark Graber seconded, and the motion passed with no objections.

Palivizumab (Synagis): In August 2009, the American Academy of Pediatricians modified their guidelines for use of palivizumab *(Synagis)* for RSV prevention in high-risk infants and young children. Using additional data regarding the seasonality of RSV and risk factors for babies born between 32 and 35 weeks gestation, the guidelines for use have been modified to ensure cost/benefit optimization. The updated recommendations include:

1. *Modification of recommendations for initiation and termination of RSV prophylaxis based on current CDC descriptions of seasonality in different areas of the United States.*
2. *Emphasis on need for no more than a maximum of 5 doses in all geographic areas.*
3. *Modification of risk factors for severe disease (congenital abnormalities of the airway or neuromuscular disease) in infants less than 12 months of age and born before 35 weeks of gestation.*
4. *For infants 32 through 35 weeks of gestation who qualify for prophylaxis based on presence of risk factors, prophylaxis is recommended beyond 90 days of age (maximum of 3 doses)*

Dr. Mark Graber motioned to move the start date for *Synagis* coverage back to November 16th and to allow for 5 doses, which would bring some cost savings for the State. Dr. Casey Clor seconded, and the motion passed unanimously. As the Commission then seemed to be at a standstill regarding their opinion of adopting the new Red Book guidelines, Dr. Mark Graber motioned to accept the Red Book guidelines/AAP policy statement and Dr. Casey Clor seconded.

However, upon voting, the majority opposed this motion, as well as 3 (Laurie Pestel, Dr. Mark Graber, and Dr. Sarah Schutte-Schenck) abstaining. Therefore, the *Synagis* PA criteria will remain the same as last year, but with the modified start date and maximum of 5 doses for the season.

Public Comment

There were no speakers in this public comment section.

Focus Studies

Tiotropium plus Ipratropium: The purpose of this study was to follow-up on the 35 unique members identified as having duplicate inhaled anticholinergics (tiotropium and ipratropium) in their claims history between the time period of 9/1/2008 through 11/30/2008. Letters were sent to providers in March, 2009. Following the intervention, there were only 17 members using duplicate therapy, a change which brought about a cost savings of $60,629.33 (state and federal pre-rebate).

ACE Inhibitors combined with Angiotensin Receptor Blockers: The purpose of this study was to identify instances where Iowa Medicaid members are using Angiotensin Converting Enzyme (ACE) Inhibitors in combination with Angiotensin Receptor Blockers (ARB). The ONgoing Tehnisartan Alone, in combination with Ramipril Global Endpoint Trial (ONTARGET) was a multi-year study that examined 25,620 patients to compare the effects of telmisartan (*Micardis*) alone, telmisartan in combination with ramipril (*Altace*), and an ACE Inhibitor alone in patients with established atherosclerotic vascular disease or diabetes with end-organ damage who were 55 years of age or older. Patients who used the ACE Inhibitor and ARB combination had 2-3 mm/Hg lower overall blood pressure compared to patients using monotherapy; however, more patients experienced hypotensive side effects when using the combination. Overall, the primary outcome (death from cardiovascular causes, myocardial infarction, stroke, hospitalization for heart failure, time to first dialysis, doubling of serum creatinine, or death) was the same in all three groups of patients. Therefore, the combination of ACE Inhibitors and ARBs is not recommended as it does not reduce poor outcomes and actually increases the likelihood of adverse drug events compared to either drug used alone. However, these findings do not apply to patients with congestive heart failure, as this group of patients was specifically excluded from the ONTARGET trial. Potential benefits of combining ACE Inhibitors and ARBs have been found in studies of patients with poorly controlled congestive heart failure. Reports also show that the combination of an ACE Inhibitor and an ARB is superior to either therapy alone in decreasing proteinuria in patients with diabetic nephropathy. An analysis was performed looking at three months worth of pharmacy claims history (April 1, 2009 - June 30, 2009). Members using ACE Inhibitors and ARBs were identified, in addition to members using the combination as defined as two or more consecutive months. Six thousand, nine hundred nineteen (6,919) unique members were identified, of which only 73 met the criteria for further analysis. Just 12 of them

had a diagnosis of congestive heart failure, and nine had diabetes with renal manifestations. The prescribers of the remaining members without a valid diagnosis will be contacted at the request of the Commission.

Ophthalmic Fluoroquinolones and Macrolides for Bacterial Conjunctivitis: The purpose of this study was to identify instances where Iowa Medicaid members are prescribed ophthalmic fluoroquinolones as first line treatment of bacterial conjunctivitis. Bacterial conjunctivitis is a highly contagious bacterial infection of the eye that affects both adults and children. It is spread by direct contact with infected secretions and contaminated objects. A patient with bacterial conjunctivitis will typically present with redness and discharge from one or both eyes, and is often times described as being "stuck shut" in the morning. A thick, globular, purulent discharge continues throughout the day and may appear yellow, white, or green. The most common organisms responsible for bacterial conjunctivitis include Staphylococcus aureus, Streptococcus pneumoniae, Haemophilius influenzae, and Moraxella catarrhalis. Staphylococcus aureus is the most common cause in adults, where other organisms listed are more commonly found in children. The American Academy of Ophthalmology guidelines on treating bacterial conjunctivitis state that "The choice of antibiotic is usually empirical. Since a 5-to-7-day course of a broad-spectrum topical antibiotic is usually effective, the most convenient or least expensive option can be selected." The recommended first line treatment options for bacterial conjunctivitis include erythromycin ophthalmic ointment (particularly for children), sulfacetamine ophthalmic drops, or polymyxin/trimethoprim drops. Most common organisms responsible for bacterial conjunctivitis respond to these agents within one to two days with a marked decrease in discharge, irritation, and redness. Alternative treatments include bacitracin ointment, sulfacetamide ointment, polymyxin/bacitracin ointment, fluoroquinolone drops or azithromycin drops. Aminoglycoside drops are not recommended as they can be toxic to the corneal epithelium and can cause reactive keratoconjunctivitis after several days use. Due to the considerable cost difference between the recommended first line therapy ophthalmic antibiotics, fluoroquinolone drops, and azithromycin drops, it would be most cost effective to initiate therapy with a preferred first line therapy ophthalmic antibiotic drop or ointment. It would be desirable to shift prescribing practices away from fluoroquinolones and azithromycin drops to preferred first line therapy ophthalmic antibiotics, except for cases in which patients have had ocular surgery or are contact lens wearers. An analysis was performed looking at three months worth of pharmacy claims history (March 1, 2009 - May 31, 2009). Members who had claims for fluoroquinolone drops or azithromycin drops without a claim for a preferred first line therapy ophthalmic antibiotic solution/ointment (suggesting that the recommended first line therapy ophthalmic antibiotic product was not tried prior to switching to a fluoroquinolone or azithromycin product after a therapeutic failure) were identified. 94.8% of identified members were using a fluoroquinolone or macrolide ophthalmic antibiotic as first line therapy. Dr. Rick Rinehart motioned that this issue be referred to the P&T Committee, with the hope that they would make ophthalmic fluoroquinolones and macrolides non-preferred on the PDL. Dr. Sara Schutte-Schenck seconded, and the motion passed unanimously.

Rate of Compliance with Atypical Antipsychotics: A medication possession ratio was run on new starters (with continuous Medicaid eligibility during the timeframe of April 1st through June 30th) of an antipsychotic regimen. An NPR of greater than 80% was enough to signify that a patient had sufficient adherence to the therapy. There were 2,958 new starters total, of which 93.5% had sufficient adherence. *Geodon* (ziprasidone), which is dosed twice daily, actually had the highest adherence rate. The Commission asked that a longer time frame (six months minimum) be examined, as well as focusing on quantity and days supply to see where compliance drops off.

Drugs that cause Edema: The purpose of this study was to identify instances where prescribers were prescribing medications that typically cause edema as a side effect in disease states that often have edema present as a symptom. Edema is defined as palpable swelling as a result of interstitial fluid volume expansion. There are many different clinical conditions that can cause edema such as heart failure, cirrhosis, and nephroitic syndrome. Certain medications can also cause edema as a side effect. When used in patients with peripheral edema, the addition of these drugs can cause worsening symptoms of edema such as swollen legs, difficulty walking, increased abdominal girth, and shortness of breath due to pressure on the diaphragm. These patients become high utilizers of prescribers' offices and emergency departments seeking medical care for the discomfort caused by the worsening edema. An analysis was performed to identify instances where prescribers were prescribing medications that typically cause edema as a side effect in Iowa Medicaid members who have disease states that commonly cause edema. The Commission asked that these findings be narrowed down to members who have had a heart failure diagnosis resulting in hospital admission, and take out those already on diuretics.

Tamoxifen Interactions with Select SSRIs: The purpose of this study was to identify instances where members were combining tamoxifen with selective serotonin re-uptake inhibitors (SSRIs). Two observational studies were presented at a meeting of the American Society of Clinical Oncology that looked at the effect of strong CYP2D6 inhibitors in patients taking tamoxifen in preventing recurrence of breast cancer. One of these two studies found that women who took CYP2D6 inhibitors, such as SSRIs, had a higher recurrence rate. Women being treated for breast cancer with tamoxifen are frequently prescribed SSRIs to help manage depression and decrease hot flashes (off label use). Tamoxifen requires metabolization by CYP2D6 to become pharmacologically active. SSRIs such as fluoxetine and paroxetine, are strong inhibitors of CYP206. Sertraline is a mild inhibitor of CYP2D6, and citalopram and escitalopram are weak inhibitors of CYP2D6. Since there is no good evidence that one SSRI is more effective than another for treating depression, it may be appropriate to recommend use of citalopram or escitalopram for treatment of depression in women who are also taking tamoxifen. An analysis was done over a three month time period (5-1-09 through 7-31-09) to determine how many women using tamoxifen were also using an SSRI. Of those members identified, a total of 32 (23.4%) were using tamoxifen with an SSRI during the

past three months (5/1/09 through 7/31/09). The prescribers of the 16 members who were identified as using SSRIs that are inhibitors of CYP2D6 in combination with tamoxifen will be contacted, and an article reminding prescribers of this drug-drug interaction will be published in the next DUR Digest.

Miscellaneous

DUR Digest: The Commission members offered suggested changes to the draft for 2009 Volume 22, Number 1.

FUL Update: The Commission members were given a copy of the CMS FUL changes that were implemented August 28, 2009.

MedWatch: The Commission members received FDA announcements concerning new Black Box Warnings.

A unanimous vote was made at 12:00 to adjourn the meeting and move to closed session (1st by Dr. Casey Clor, 2nd by Bruce Alexander).

The next meeting will be held at 9:30 a.m. on Wednesday, November 4, 2009 at the Learning Resource Center in West Des Moines, IA.