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DUR DIGEST

The Bulletin of Medicaid Drug Utilization Review in Iowa

Commission Welcomes New Members

The DUR Commission welcomes the addition of Jason Wilbur, M.D. and Kellen Ludvigson, Pharm.D.


Jason Wilbur, M.D.


Kellen Ludvigson, Pharm.D.

Dr. Wilbur graduated from the Saint Louis University School of Medicine in 1999. He then completed his Family Medicine Residency at the University of Iowa, where he was Chief Resident 2001-2002, followed by a Geriatric Medicine Fellowship 2002-2003. He is currently Associate Professor of Clinical Family Medicine for the Roy J. & Lucille A. Carver College of Medicine at the University of Iowa. Prior to that, he was Medical Director of the Family Medicine Clinic in Iowa City from 2006 to 2011. The University of Iowa Hospitals and Clinics awarded him the Above and Beyond Reward in 2006 and again in 2007, along with the Teacher of the Year Award, presented by the University of Iowa Family Medicine residents, in 2008. Dr. Wilbur was appointed to the DUR Commission in 2012; his first term will expire in June 2016.

Dr. Ludvigson graduated with distinction from the University of Iowa College of Pharmacy in 2007, and he is kept busy working full-time at three different independent pharmacies: both the Holstein and Cherokee branches of Main Street Pharmacy, and also the Cherokee Mental Health Institute in Cherokee. Additionally, he is employed as a relief pharmacist at the Sioux City Target. This diversity in employment allows him to encounter a variety of prescribers and patients in the Medicaid program, and has resulted in a great deal of experience with the Iowa Medicaid PDL. Dr. Ludvigson was appointed to the DUR Commission in 2012; his first term will expire in June 2016.

Outgoing Members of the DUR Commission

Dr. Sara Schutte-Schenck, D.O., FAAP and Dr. Craig Logemann, R.Ph., Pharm.D., BCPS both recently completed an eight year term of service on the Iowa Drug Utilization Review Commission.

Additionally, Dr. Casey Clor, M.D. has resigned from the Iowa Drug Utilization Review Commission after three years of service.

The Commission and the Department of Human Services wish to thank Dr. Clor, Dr. Schutte-Schenck and Dr. Logemann for their many years of service to the Commission and the members of Iowa Medicaid.

Stimulant Use in Children Less Than Four Years Old

There are several central nervous system agents that are approved by the FDA for the treatment of ADHD. This includes cerebral stimulants (amphetamines and methylphenidate derivatives) and atomoxetine. The stimulants are available in a variety of dosage forms, which primarily differ in their release mechanism and duration of action. Although the exact mechanism in ADHD is unknown, the stimulants are thought to block the reuptake of norepinephrine and dopamine into the presynaptic neuron and increase the release of these monoamines into the extraneuronal space. Due to their potential for abuse, the stimulants are classified as Schedule II controlled substances. Atomoxetine is a selective norepinephrine reuptake inhibitor and it is not a controlled substance.[1]

In October 2011, the American Academy of Pediatrics (AAP) updated their clinical practice guideline, *ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents*. The new guideline contains the following recommendations: 1) Evaluation for ADHD for children 4 through 18 years of age (previously children 6 through 12 years of age) who present with academic or behavior problems and symptoms of inattention, hyperactivity, or impulsivity; 2) Determine the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* criteria have been met; 3) Include assessment for other conditions that may coexist with ADHD; and 4) Recognize ADHD is a chronic condition.[2]

Recommendations for the treatment of ADHD in children and adolescents vary depending on the patient's age. Evidence-based parent- and/or teacher-administered behavior therapy is recommended as first line treatment for patients 4 to 5 years of age (quality of evidence A). Methylphenidate may be prescribed if patient does not show significant improvements with behavior therapy and there is moderate-to-severe continuing disturbance with the patients function. If evidenced based behavioral treatments are not available, the prescriber must weigh the risks of starting medication at an early age versus the harm of delaying diagnosis and treatment (quality of evidence B).[2]

FDA Approved Age for Stimulant Use[1]

Drug Name	FDA Approved Age
Amphetamine-dextroamphetamine (*Adderall, Adderall XR*)	IR: ≥ 3 years of age XR: ≥ 6 years of age
Atomoxetine (*Strattera*)	≥ 6 years of age
Dexmethylphenidate (*Focalin, Focalin XR*)	≥ 6 years of age
Dextroamphetamine (*Dexedrine, Dexedrine CR*)	IR: ≥ 3 years of age CR: ≥ 6 years of age
Lisdexamfetamine (*Vyvanse*)	≥ 6 years of age
Methamphetamine (*Desoxyn*)	≥ 6 years of age
Methylphenidate (*Metadate CD, Ritalin LA, Ritalin SR, Ritalin, Concerta, Daytrana*)	≥ 6 years of age

References:

1. Micromedex Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed April 2012.
2. American Academy of Pediatrics, Subcommittee on Attention- Deficit/Hyperactivity Disorder, Steering Committee on Quality Improvement and Management. ADHD: Clinical practice guideline for the diagnosis, evaluation, and treatment of attention-deficit/hyperactivity disorder in children and adolescents. Pediatrics. 2011; 128(5): 1-16.

FDA Updates and New/Updated Drug PA Criteria

FDA Update

The U.S. Food and Drug Administration (FDA) issued a reminder to patients, caregivers and healthcare professionals regarding the importance of appropriate storage, use, application, and disposal of fentanyl patches to prevent potential life-threatening harm from accidental exposure to fentanyl.

The FDA notified healthcare professionals of the possible risks when using medications containing aliskiren with angiotensin converting enzyme inhibitors (ACEIs) and angiotensin receptor blockers (ARBs) in patients with diabetes or renal impairment. These drug combinations are contraindicated in patients with diabetes. In addition, the use of aliskiren with ARBs or ACEIs in patients with moderate to severe renal impairment (GFR < 60 mL/min).

New and Updated Drug Prior Authorization Criteria

Sedative/Hypnotics – Non-Benzodiazepines

Preferred agents are available without Prior Authorization (PA). Although intermittent therapy is recommended, quantity limits will allow 30 tablets per 30 days supply without PA for preferred medications. Prior authorization is required for all non-preferred non-benzodiazepine sedative/hypnotics. Payment for non-preferred non-benzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment for non-preferred non-benzodiazepine sedative/hypnotics will be considered when there is:

1. A diagnosis of chronic insomnia (insomnia lasting ≥ 6 months,
2. Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued,
3. Enforcement of good sleep hygiene is documented.
4. All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses
5. Patient has a documented trial and therapy failure with zaleplon.

Chronic Pain Syndromes

In addition to the current prior authorization criteria, a new diagnosis has been added to the existing criteria:

Chronic musculoskeletal pain (Cymbalta®)

A trial and therapy failure at a therapeutic dose with at least three drugs from three distinct therapeutic classes from the following: NSAIDs, opioids, tramadol, or tricyclic antidepressants.

Ivacaftor (Kalydeco™)

Prior authorization is required for Kalydeco™ (ivacaftor). Payment will be considered for patients when the following criteria are met:

1. Patient is 6 years of age or older; and
2. Has a diagnosis of cystic fibrosis with a G551D mutation in the CFTR gene as detected by an FDA-cleared CF mutation test; and
3. Prescriber is a CF specialist or pulmonologist; and
4. Patient does not have one of the following infections: *Burkholderia cenocepacia*, *dolosa*, or *Mycobacterium abscessus.*

DUR Activities

Medicaid Statistics for Prescription Claims

from January 1, 2012 to March 31, 2012*

Number of claims paid: 1,155,117

Total dollars paid: $69,078,933.52

Percent controlled substances: 18.43%

Average amount paid per claim: $60.44

Average amount paid per claim, brand: $221.19

Average Amount paid per claim, generic: $12.15

Top Drugs by Number of Prescriptions	Top Drugs by Dollars Spent	Top Therapeutic Class by Dollars Spent
ProAir HFA $48.46/RX	*Synagis 100mg/ml* $1,897,997 $2,534.04/RX	Antipsychotics – Atypicals $13.4 million
Hydrocodone/APAP 5-500 $4.65/RX	*Concerta* 36mg $1,439,383 $243.92/RX	Stimulants – Amphetamines – Long Acting $4.9 million
Lexapro 20mg $111.73/RX	*Abilify* 5mg $1,354,567 $443.68/RX	Stimulants – Methylphenidate-Long Acting $3.9 million
APAP 325mg $5.38/RX	*Abilify 10mg* $992,847 $465.69/RX	Anticonvulsants $3.2 million
Concerta 36mg $243.92/RX	*Concerta 54mg* $949,809 $215.87/RX	Antidepressants – Selected SSRIs $3.0 million

*All dollars reported are Pre-Rebate