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DUR DIGEST

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Palivizumab (Synagis) PA Criteria
2008-2009 RSV Season

RSV season typically begins in November and lasts through April, but it can begin earlier or persist later in certain communities. This year, Synagis Prior Authorization requests will be approved for a start date of October 30th and will be valid through March 31st for infants who meet the criteria. An additional sixth dose beyond March 31st will be determined based on epidemiological data at that time. PA's will be approved for a 30 day supply with a quantity limit of one-50mg vial and two-100mg vials per month. The new Palivizumab (Synagis) PA form is available online at www.iowamedicaidpdl.com under PA forms.

Current PA criteria:

Prior authorization is required for therapy with palivizumab. Payment for palivizumab will be considered for patients who meet one of the following criteria:

Chronic Lung Disease (CLD)

- Patient is less than 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, corticosteroid, or diuretic therapy) or oxygen within six months before the anticipated start of RSV season.

Prematurity

- Patient is less than 12 months of age at start of therapy with a gestational age of less than or equal to 28 weeks.
- Patient is less than 6 months of age at start of therapy with a gestational age between 28 weeks and 31 weeks.
- Patient is less than 6 months of age at start of therapy with a gestational age of 32 weeks to 35 weeks and has at least two risk factors.

Congenital Heart Disease (CHD)

- Patient is less than 24 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following: Receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension, or cyanotic congenital heart disease.

Severe Immunodeficiency

- Patient is less than 24 months of age at start of therapy and has severe immunodeficiencies (e.g., severe combined immunodeficiency or advanced acquired immunodeficiency syndrome).

2008-2009 Influenza Season

Source: CDC, Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2008;57

Vaccination of all children aged 6 months to 18 years should begin before or during the 2008-09 influenza season if feasible, but no later than the 2009-10 influenza season. ***Vaccination of all children aged 5-18 years is a new ACIP recommendation.***

Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts. **Recommendations for these children have not changed.** Children and adolescents at higher risk for influenza complication are those:

- Aged 6 months to 4 years
- Who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus)
- Who are immunosuppressed (including those by medications or HIV)
- Who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorder) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration
- Who are receiving long-term aspirin therapy who might be at risk of Reye syndrome after influenza virus infection
- Who are residents of chronic-care facilities
- Who are pregnant during the influenza season

Annual recommendations for adults have not changed in 2008. Annual vaccination against influenza is recommended for any adult who wants to reduce the risk for becoming ill with influenza or transmitting it to others. Vaccination is also recommended for all adults in the following groups because these persons are either at high risk for influenza complications, or are close contacts of persons at higher risk:

- Persons aged 50 years or older
- Women who are pregnant during the influenza season
- Who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus)
- Who are immunosuppressed (including those by medications or HIV)
- Who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorder) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration
- Residents of nursing homes and other chronic-care facilities
- Health-care personnel
- Household contacts and caregivers of children ages < 5 years and adults ages 50 or more years, with particular emphasis on vaccinating contacts of children aged < 6 months
- Household contacts and caregivers of persons with medical conditions that put them at risk for severe complications from influenza

Prevention and treatment of Influenza

Influenza vaccination is payable for Iowa Medicaid members who are not dual eligible for Medicare. The trivalent inactivated influenza (injectable) vaccine (TIV) is preferred for members aged 19 to 64. Flumist® nasal spray, the live, attenuated influenza vaccine (LAIV) is preferred for members aged 19 to 49 until March 2009. Children aged 6 months to 18 years should be referred to the Vaccines for Children (VFC) program through the Department of Public Health.

Antiviral medications, such as Tamiflu® and Relenza®, are preferred on the PDL. Tamiflu has a quantity limit of 14 units per 30 days which for the suspension, is 7.5ml per day or 3 bottles. **The ACIP is also recommending that amantadine or rimantidine not be used alone for the treatment or prevention of influenza as resistance has increased over the past several years**.

Atypical Antipsychotics and Metabolic Testing

Source: Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care 2004; 27(2):596-601.

There is a growing body of evidence showing that patients on atypical antipsychotics have a higher prevalence of metabolic syndrome compared to those in the general population. Metabolic syndrome is defined as the presence of at least three of five of the following clinical features: abdominal obesity (measured by waist circumference), impaired fasting glucose or diabetes, high triglycerides, low high-density lipoprotein (HDL) cholesterol, and hypertension. Metabolic syndrome greatly increases the risk of cardiovascular disease and the development of Type II diabetes.

The Iowa Medicaid Drug Utilization Review Commission recently reviewed medical claims for incidence of metabolic testing (fasting blood glucose, HgbA1C, lipids) for members with at least three prescriptions for atypical antipsychotics for the period of January 1, 2008 through July 1, 2008. The query found 9,957 total members with three or more atypical antipsychotics, of which, 8,876 members did not have any metabolic tests performed during the same time period.

The American Diabetes Association (ADA) and the American Psychiatric Association (APA) Consensus panel have developed guidelines highlighting the importance of monitoring for metabolic syndrome in patients taking atypical antipsychotics. Given the known metabolic risks associated with atypical antipsychotics such as weight gain, glucose intolerance or diabetes, and dyslipidemia, baseline screening and regularly monitoring patients should become a standard of care. Patients taking atypical antipsychotics should have baseline (or as soon as clinically feasible) and periodic screening of six measures to ensure any changes are caught early and the appropriate interventions taken.

Monitoring Protocol and Diagnostic Criteria for Patients Taking Atypical Antipsychotics

Measurement	Diagnostic Criteria	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 Years
Family History	N/A	X					X	
Weight (BMI)	> 30 kg/m^2	X	X	X	X	X		
Waist Circumference	-men > 40 inches -women > 35 inches	X					X	
Blood Pressure	≥ 130/85 mm Hg Or taking antihypertensive mediations	X			X		X	
Fasting Plasma Glucose or HbA1c	≥ 110 mg/dL (NCEP ATP III definition) ≥ 100mg/dL (NHLBI/AHA definition) or using insulin, hypoglycemic medications	X			X		X	
Fasting Lipid Profile	Triglycerides ≥150mg/dL HDL –men < 40mg/dL -women < 50mg/dL	X			X			X

Abbreviations: NCEP, National Cholesterol Education Program; NHLBI, National Heart Lung and Blood Institute; AHA, American Heart Association

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DUR Commission News

The Iowa Medicaid Drug Utilization Review (DUR) Commission contract has been held by the Iowa Foundation for Medical Care (IFMC) since 1985. IFMC has transitioned the administration responsibilities for this contract from the Iowa Pharmacy Association to Goold Health Systems (GHS), as a subcontractor to IFMC. GHS began its DUR management responsibilities on July 1, 2008. IFMC, working in collaboration with GHS, will attempt to make this transition as seamless as possible. However, you may see minor changes in some aspects of the day-to-day operations in the near future.

GHS is a healthcare management company that specializes in providing pharmacy benefit services, clinical data reviews and analyses, health care assessments, data capture, data center and other support services to State Medicaid agencies, the Federal Government, private sector companies and non-profit organizations. Present State Medicaid Agency clients include the States of: Alabama, Iowa, Maine, Utah, Vermont, West Virginia and Wyoming.

GHS staffs the Medicaid DUR Commission in the State of Maine and interacts with the Medicaid DUR Commissions in West Virginia and Wyoming. GHS is the vendor for the Sovereign States Drug Consortium, a multi-state drug rebate pool presently comprised of Iowa, Maine, Utah and Vermont, with West Virginia and Wyoming poised to join in 2008.

GHS has been in business since 1974. The company has offices in Des Moines, Iowa and Augusta, Maine, employs over 160 people and was named one of the 5,000 fastest growing, privately-held companies by *INC Magazine* in 2007.

Welcome Dr. Mark Graber, M.D. to the DUR Commission

Dr. Mark Graber is an emergency medicine physician at the University of Iowa Hospitals and Clinics. Dr. Graber graduated from Eastern Virginia Medical School and completed his Family Practice Residency at the University of Iowa. In addition to his duties in the Emergency Department, Dr. Graber is also a Professor of Emergency Medicine and Family Medicine at the University of Iowa Carver College of Medicine, serves as an advisor to medical students and residents, and has published numerous text books, reviews, and papers in publications such as *The Annals of Pharmacotherapy, Emergency Medicine, American Family Physician*. Through his travels, Dr. Graber has presented throughout the United States as well as Ukraine, Russia, and China. In 2007, Dr. Graber was honored by appearing on of the “Best Doctors In America” list. Dr. Graber was appointed to the Commission in 2008; his term will expire in 2012.