STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

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Paul L. Nusbaum
Secretary

Drug Utilization Review Board Meeting Minutes
October 9, 2002

The thirty-seventh meeting of the West Virginia Medicaid Drug Utilization Review Board was called to order with the following in attendance:

Members Present:
Karen Reed, R.Ph., Chairperson
Mary Nemeth-Pyles, M.S.N., R.N., C.S.
Steve Judy, R.Ph.
Bernie Smith, R.Ph., M.B.A., M.H.A.
George Bryant, PA-C
Lester Labus, M.D.
Kerry Stitzinger, R.Ph.
Ernest Miller, D.O.
John R. Vanin, M.D.
Mitch Shaver, M.D.
David Elliott, Pharm. D.
Chris Terpening, Pharm.D., Ph.D.
Myra Chiang, M.D.

Members Absent:
Matthew Watkins, D.O.
Kevin Yingling, R.Ph., M.D.
James Bennett, M.D.
Dan Dickman, M.D.
Pat Regan, R.Ph.

Staff Present:
Sandra Joseph, M.D., Medical Director
Peggy King, R.Ph., Pharmacy Director
Gail Goodnight, R.Ph., Rebate Coordinator
Vicki Cunningham, R.Ph., DUR Coordinator

Interested Parties Present:
Robert Berringer, Heritage Information Systems, Incorporated
Kelly O'Brien, Heritage Information Systems, Incorporated
Steve Small, Rational Drug Therapy Program
Michael Smith, West Virginia University School of Pharmacy
Steve Mitchell, Glaxo, Smith-Kline
Raymona Kinneberg, Johnson and Johnson
Stacey Poole, TAP Pharmaceuticals
Jim Knott, TAP Pharmaceuticals
Kent Hunter, Pfizer
Glenda Hanstein, Pfizer
Sue Ellen Shrout, Sepracor, Inc.
Gordon Rosenberry, Schering-Plough
Rob Marsh, Schering-Plough
Feng Ho, Schering-Plough
Ed Davis, Merck
Mark Akers, Janssen Pharmaceuticals
Ryan Payne, Janssen Pharmaceuticals
Steve Miller, Janssen Pharmaceuticals
Karen Brett-Long, Bristol-Myers Squibb
Rob Leonard, Otsuka
Walter Gose, Aventis
Ed Hilts, Aventis
Jeff Hartness, Aventis
Kit Francis, Pfizer
Thom Stevens, Government Relations Specialist
Felice Joseph, PEIA

I. INTRODUCTIONS

Karen Reed, Chairperson, welcomed everyone to the Board meeting and introductions were made.

II. APPROVAL OF THE MAY 15, 2002 MINUTES

A motion was made that the minutes of the May 15, 2002 DUR Board meeting be accepted as written. The motion was seconded and passed unanimously.

III. OLD BUSINESS

A. Karen Reed, Chairperson read the revised criteria for the prior authorization of Regranex®. Vicki Cunningham explained that after reviewing the utilization data for Regranex®, it seemed more practical to institute quantity limits than a prior authorization program. A motion was made by Steve Judy and seconded by Dr. John Vanin to accept the quantity limit criteria. The motion was passed unanimously.

See Attachment A

V. NEW BUSINESS

A. Karen Reedc Chairperson read the proposal to discontinue the present policy of only allowing one refill on narcotic analgesics in Classes III, IV, and V. The new proposal would allow these classes to be refilled according to current Federal and State Law. This proposal will be voted on at the next Board meeting.

See Attachment B

B. The proposal to institute a "hard edit" to prevent the therapeutic duplication of narcotic analgesics from two different prescribers was presented by the Chairperson. When this would occur, the pharmacist would have to call Rational Drug Therapy for approval before the prescription could be filled.. The committee discussed the proposal and stated that both physicians should be notified if a patient presents prescriptions for narcotic analgesics from two or more prescribers. It was their suggestion that letters be sent to the physicians who prescribed the drugs. Peggy King stated that this was routinely done by Heritage Information Systems in conjunction with the monthly RetroDUR reviews. She also stated that a mailing campaign for each incident would be expensive for the Bureau to undertake. Steve Small, RDTP, stated that letters could be faxed from RDTP to the prescribing physicians. Vicki Cunningham stated that, even if the patient offered to pay cash for the second prescription, both of the physicians should be notified.
Concerns were raised that two physicians in the same group might see a patient and write prescriptions for narcotic analgesics, while covering for one another. Peggy King stated that the therapeutic duplication alert would not occur unless the time periods for the use of the medication overlapped. Vicki Cunningham suggested that the proposal be presented at the next meeting, along with the additional comments made by the Board. The proposal will be voted on at the next meeting.

See Attachment C

C. Karen Reed read the new prior approval criteria for the Proton Pump Inhibitor (PPI) group. Peggy King explained that the revision relaxed the criteria, allowing patients with GERD to remain on a PPI for a year. The present criteria requires that patients with GERD step down to a histamine-2 receptor antagonist (H2RA) after ninety days. Dr. Miller suggested that the section regarding conditions that are presently approved for one year be placed after the paragraph regarding initial therapeutic dosing for 90 days. It was the consensus of the Board that this would make the proposed policy clearer.

The Chairperson mentioned a letter from the West Virginia University renal transplant unit requesting that PPI's be available without prior approval for patients taking immunosuppressants. The studies that were used as references were not current and they will be requested to provide more

information before the Board can consider the request.

The second part of the discussion regarding the peptic ulcer drugs was the H2RA group and, since the prior authorization has been removed, whether duration of therapy and maximum dose limits should be instituted. The Board recommended that no limits be imposed and that utilization should be observed for six months. If excessive doses are requested and overutilization is observed, the Board will consider instituting limits.

See Attachment D

D. The proposal was presented for removing the current prior authorization on Claritin,® Claritin-D® 12-hour, Claritin-D® 24-hour, and Clarinex® preparations. Claritin® (loratidine), Claritin® combination formulations, and Clarinex® (desloratidine) are the products that have been chosen for the Preferred Drug List. All of the other non-sedating antihistamines will require prior approval. Providers requesting authorization for the products that are not preferred will need to state that Claritin®, Claritin® combinations and Clarinex® have been tried with their patients and do not alleviate their allergic symptoms. The members of the Board were in agreement that this was an acceptable policy for the non-sedating antihistamines and the current policy should be replaced by this one.

Letters of complaint about the current policy were included in the information packets and they were discussed by the Board. Members noted that the physicians writing some of the letters did not seem to have read the policy that had been adopted by the Board. Vicki Cunningham stated that the staff attempted to answer each letter of complaint and explain the policies instituted and why they are necessary. Dr. John Vanin commented that it was helpful to see these letters and our responses to them.

See Attachment E

E. Copies of the first phase of the Preferred Drug List (PDL) were reviewed by the Board. Karen Reed, Chairperson, stated that we needed to develop criteria for the non-preferred drugs and that a prior authorization form used by the state of Louisiana was included.

Members of the Board asked if the increased volume of calls to RDTP, due to the PDL, would affect the turn around time for prior approval requests. Peggy King stated that we were required to turn around prior approval requests within 24 hours. Vicki Cunningham stated that Rational Drug Therapy had expanded their staff and their hours to be able to handle the additional volume of calls generated by the PDL. The form for prior approval was discussed. Peggy King also stated that we would be working with providers to help them to expedite the approval process in the most efficient way. She added that we plan to meet with the State Medical Association to determine the information that physicians would like in advance about patients that are not on preferred drugs.

Members of the Board felt that the form included in their packet for prior authorization was straightforward and easy to use. However, they requested that the section for the date of use of the non-preferred drugs be eliminated. Their feeling was that this request would put too much of burden on the providers.

Dr. Myra Chiang expressed concern that Norvasc® was not included on the PDL. She stated that this is the only drug for hypertension that is acceptable for use in pediatric patients, and that obtaining a prior approval for each new patient that needed it would be burdensome. She requested that it be made available for pediatric patients without prior approval. Peggy King said that she would check to see if that would be feasible.

Dr. Mitch Shaver asked if the Bureau would really save money if hypertensive patients could not get their medication and a prior approval was not readily available. Vicki Cunningham stated that a 3-day emergency supply would always be available for patients and that no one should leave the pharmacy without their medication.

Peggy King stated that we are writing a letter to recipients to inform them about the PDL. She asked if the Board recommended that we inform each patient if they are presently taking medications that will require a change in therapy or prior approval and suggest that they call their physician. Board members suggested that the letter should tell the patients to schedule an appointment with their physician to discuss this.

Questions were asked as to whether only cost was considered or if therapeutic value was also a consideration. Peggy King explained the present cost basis for reimbursement for prescription drugs and how a PDL would help us to obtain supplemental rebates. If there are several drugs in a class that have similar therapeutic properties, then the product whose manufacturer offers the best rebate will be chosen. However, in many instances, because of therapeutic implications, the product with the lowest net price is not always selected. Vicki Cunningham gave the selection of Singulair® as an example. Although it is more expensive than the other agents in its class, it was included on the PDL because it was determined that it was the most therapeutically effective agent, with the least number of side effects.

Members of the Board asked if we were going to follow the outcomes for the population that had to have changes in their drug therapy because of the PDL. Peggy King replied that the outcomes of the PDL implementation would be tracked. There were also questions about whether all of the preferred agents would have to be tried before the non-preferred agents would be approved. There was a consensus that the criteria for each group of medications would vary. Peggy King stated that we would be asking the Board for their recommendations for these criteria. There were also questions about the possibility of “grandfathering” some agents for patients. Peggy King said that she would take this consideration back to the Bureau. She also asked the Board members which group of drugs would be the most problematic for physicians to change. The Board members responded that the calcium channel

blockers and the HMG-CoA Reductase Inhibitors would present the most problems with therapy changes.

David Elliott asked how long the contracts for these preferred agents would be in effect. Peggy King replied that the contracts were negotiated for one year and, that it is hoped, that patients will not have to change medications after the first year. Hopefully, these supplemental rebates will continue and others will be added to the list. David Elliott also asked if a Pharmacy Benefit Manager (PBM) would benefit from this PDL. Peggy King replied that we are our own PBM and that no one but the Bureau for Medical Services would realize the savings. Provider Synergies, the company contracted to develop the list, only receives a one-time fee for their work with Medicaid.

See Attachment F

F. STATUS REPORTS

A. Heritage Information Systems

Robert Berringer presented an ad hoc report on Polypharmacy, which was defined as the concurrent use of eight or more unique chronic prescription medications. This review was done on patients who had their prescriptions filled in the past sixty days.

See Attachment G

Peggy King explained that this idea originated with the United Mine Workers insurance program. They contracted with Advance PCS to address this issue and offered a program at Marshall University. The Board members agreed that this was an important issue and that it may be beneficial to present this information to the Board of Medicine. They also suggested that programs about this be offered at annual meetings of the Medical Societies.

B. Rational Drug Therapy Program

Steve Small presented the Rational Drug Therapy Program report for the months of July, August and September.

See Attachment H

G. OPEN TO THE FLOOR-None.

There were no comments.

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H. NEXT MEETING AND ADJOURNMENT

A motion was made and seconded that the meeting be adjourned. All were in favor. The meeting was concluded at 6:00 p.m. The next meeting will be held on Wednesday, December 4, 2002 at 4:00 p.m.

Respectfully submitted,

Vicki M. Cunningham, R.Ph.
DUR Coordinator