Drug Utilization Review Board Meeting Minutes
May 21, 2003

The fortieth 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
Steve Judy, R.Ph.
Bernie Smith, R.Ph., M.B.A., M.H.A.
Lester Labus, M.D.
Kerry Stitzinger, R.Ph.
Chris Terpening, PharmD., Ph.D.
Mary Nemeth-Pyles, M.S.N., R.N., C.S.
Pat Regan, PharmD.
Matthew Watkins, D.O.
Myra Chiang, M.D.
James Bennett, M.D.
George Bryant, PA-C
Mitch Shaver, M.D.
Ernest Miller, D.O.

Members Absent:
David Elliott, PharmD.
Dan Dickman, M.D.
Kevin Yingling, R.Ph., M.D.
John R. Vanin, M.D

Interested Parties Present:
Merck: Larry Swann
Roche: Archie Shew
Bristol Myers Squibb: Bob Beatty

DHHR/BMS 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
Lynda Edwards, Secretary

Contract Staff:
Steve Small, Rational Drug Therapy Program
Rob Berringer, Heritage Information Systems

Other State Government Agency Staff Present:
Felice Joseph, PEIA

I. INTRODUCTIONS

Karen Reed, Chairperson, welcomed everyone to the Board meeting.

II. APPROVAL OF THE FEBRUARY 19, 2003, MINUTES

A motion was made that the minutes of the February 19, 2003, DUR Board meeting be accepted as written. The motion was seconded and passed unanimously.

III. OLD BUSINESS

A. Review of Comments to the Rational Drug Therapy Program Regarding Prior Authorization for Non-Preferred Drugs

Steve Small presented slides showing statistical information related to Rational Drug Therapy Program's prior authorization approvals, denial rates, requests for grandfathering of non-preferred agents and other pertinent information. (See attached.) Grandfathering of selected non-preferred agents was back dated to 60 days before the implementation date. Non-compliant patients were not entered if they were drug free for 60 days. He reported that most of the requests had been for the non-preferred atypical antipsychotics. There had been instances of these agents being used for anxiety, sleep disorders, and being given multiple times in a 24-hour period. Because some profiles of patients who were stabilized on non-preferred anti-psychotics were missed by ACS, there were more calls about these agents than were anticipated. Since that problem has been corrected, things have gone well. Mr. Small also mentioned that the physician's signature on a form saying that samples have been given for two weeks is accepted as a legal document. This is proof that the patient is stabilized on a non-preferred drug, when there is no claims history available. This information will be put on the RDTP website so that all providers will understand the rules that apply to prior authorization criteria for the atypical antipsychotics.

Mr. Small reported that prior approval requests for the SSRI class had been an intense issue for RDTP. He reported that there were patients who were switched from Celexa to Lexapro before the PDL was implemented and were reluctant to switch back. He also reported that the volume of calls had decreased and that authorization was given for Lexapro when patients had documented failures on Celexa. He stated that there had been about 2600 requests for the non-preferred anti-depressants. He reported that there had been six or seven requests for Prozac Weekly and that the biggest issue for handling the SSRI agents is dosage compliance, with high dosing being the most problematic.

A committee member asked about the difference between a pended claim and a denied claim. Steve Small stated that claims were being pended for lack of information and had been acted upon when the information requested had been received. He explained that the turn around time on prior authorization requests can be from two hours by fax to three days by mail. He also pointed out that patients are always entitled to a three-day emergency supply of any medication. The question of privacy with faxes was also discussed. Mr. Small said that they assumed that the machine faxed to in the physician's office or pharmacy was a secure one. He also said that he would look further into the faxing process of RDTP to make sure that HIPAA standards are being upheld.

Mr. Small reported that there had been many prior authorization requests for Effexor XR. Many requests are for higher than recommended dosing of this agent, with some requests being for as much as 600 mg., 450 mg. and 300 mg. daily. Requests for

multiple daily dosing are also numerous. Mr. Small pointed out that there was an opportunity for cost savings and for more appropriate utilization of this drug if physicians were provided information on dose optimization and FDA guidelines for maximum dosage recommendations.

The next category of drugs mentioned was the amphetamines and the reasons for appeals to Dr. Joseph for these agents. Mr. Small stated that the generics in this class were not readily accepted. If there was a failure on therapy with the amphetamines, the occurrence of side effects was usually the reason. He also said that Strattera was being requested because of a lower incidence of side effects and because it was not a controlled substance.

Mr. Small discussed the problem of Oxycontin being prescribed three times a day. He also said that some physicians did not know that there were other long-acting products available for the alleviation of pain. The pharmacists at RDTP have been providing educational materials and conversion charts for dosing of other drugs in this category. Acceptance of the preferred products has increased since physicians have had an opportunity to become more familiar with them.

Prior approval requests for Zetia were also discussed. Mr. Small reported that it is being used in combination with other lipid lowering agents and also alone for reducing triglycerides. Vicki Cunningham asked for a discussion about the issues raised in e-mails from Steve Small about trials of fibrates before approving Zetia. Also, she asked that they discuss whether statins should be stopped when muscle pain occurs or if the statin dose should be reduced and another agent, such as Zetia or Welchol, be added. Mr. Small stated that they have been very lenient with the approval of Zetia until the Board could review prior authorization criteria. Vicki stated that RDTP needed the guidance of the Board on this issue and that whether to stop statins when myalgia occurred or to lower the dose and add another agent was a very important issue. Dr. Joseph said she thought it was risky to continue a person on a statin who had myalgia, even without documentation of the CK elevation. Some people have elevated CKs and do not have muscle pain, but those people who have myalgia and have been tried on two or three statin agents could be at risk. Another member stated that the adverse side effects seem to be dose related. Many patients do not have muscle aches on a low dose of the statin, but they do if the dose is increased. The Board members agreed that it was not wise to issue a blanket statement that the statins had to be discontinued if mayalgia occurred. Vicki Cunningham pointed out that the original criteria stated that the patient needed to try the highest tolerable dose of a statin before another non-preferred drug would be authorized. In this case, the occurrence of myalgia would indicate that the highest tolerable dose had been exceeded and that the dose should be decreased. If the patient still had not reached the desired lipid goals, then another agent should be added. Board members said that the fibrates should not be added to statins, so that a trial of the agents in that group would not be recommended. A motion was made to approve the addition of Zetia, when requested, after the patient had reached the maximum tolerable dose of a statin for 12 weeks and had not reached their

goal therapy. RDTP is not to ask for a statin to be stopped when Zetia is approved for add-on therapy.

Vicki Cunningham requested that the Board members formalize their recommendations for treatment of bipolar disorder. Although the members discussed the use of preferred agents and prior authorization requirements for non-preferred agents at the previous meeting, no recommendations were formalized. It was decided that lithium, valproic acid and Zyprexa could all be used as first-line agents for this disorder.

George Bryant asked if an information piece could be included in the DUR newsletter to let physicians know that their patients could be switched to Zyprexa if they were denied a PA for it initially. Peggy King stated she would need to check on the possibility of doing that.

B. **Review of Reports requested at last meeting (See attached)**

1. **PA requests for muscle relaxants for recipients over 65**
2. **Number of recipients taking antianxiety benzodiazepines for a period between 31 and 170 days in the last 180 days**
3. **Number of recipients taking hypnotic benzodiazepines for more than 60 days in the last 180 days**
4. **Number of recipients with history of a long duration of therapy with skeletal muscle relaxants**
   The Board would like to see this report again with Soma included.

IV. **NEW BUSINESS**

Karen Reed, Chairperson, asked the audience to introduce themselves.

A. **Quantity Limits for Strattera (atomoxetine) (See Attachment)**

Ms. Reed read the proposed criteria for quantity limits on Strattera. The Board added the word "daily" to maximum daily limits and maximum daily quantity. They also directed that no more than two strengths should be used together. Strattera will not be approved for concurrent administration with amphetamines or the methylphenidates. The Board suggested that the phrase, with the exception of doses needed for overlapping while switching or tapering drugs with no more than 30 days supply, be added to the last sentence of the criteria. A committee member asked if there were restrictions on amphetamines for patients under six years of age. Peggy King replied that the only restriction was the requirement for prior approval for those over the age of 18.

B. **Prior Authorization Criteria for Fuzeon (enfuvirtide) (See Attachment.)**

A question was asked about the maximum dose of Fuzeon and whether it should be included in the criteria. Vicki Cunningham replied that she would see if there was any

recommendation from the manufacturer about a maximum dose. She suggested that there would be more studies available by the September meeting and that a maximum dose should be included in the criteria if it is available by then.

Dr. Watkins asked about the availability of a program from the State Board of Pharmacy to help physicians know their patient's history with controlled substances. He also stated that he wanted the program to be expedient and hopefully web-based. He said that the only way to stop the abuse of prescriptions drugs was to have a system that could quickly give a physician access to his patient's drug profile.

V. REPORTS

A. Heritage Information Systems

Rob Berringer, Heritage Information Systems, presented several population based interventions for the Board to review. Karen Reed, Chairperson, stated that the Intervention Proposals for Diabetes Mellitus Disease Management and Treatment of Depression could be the most beneficial for our Medicaid recipients. The Board members approved these two interventions.

See Attachment

B. Rational Drug Therapy Program (RDTP)

A written report was distributed.

See Attachment

C. ACS First Quarter Report

There were no comments from the Board regarding the ACS quarterly report.

See Attachment.

VI. OTHER BUSINESS

A committee member asked if Ultracet could be available without prior authorization. It was stated that the Pharmaceutical and Therapeutics Committee was responsible for choosing the drugs on the Preferred Drug list It was noted that the P & T Committee could review this in the fall when the class was reopened.

Vicki asked for suggestions about projects for the DUR Board to oversee, such as providing interventions that would provide better care for recipients with diabetes and other chronic conditions. She also suggested that it is part of the role of the Board to be an oversight group that would help to promote the utilization of disease management

programs. She asked the Board members if they would consider reviewing disease management programs and developing their roles in them for the coming year.

VII. OPEN TO THE FLOOR

Thom Stevens, representative of the WV Academy of Family Physicians, reported that he engaged in a meeting with the Board of Pharmacy after they had originally promulgated the rule to require tamperproof prescription pads for all controlled substances. The Board of Medicine, State Medical Association and the WV Academy of Family Physicians objected to the nature of the design and use of the tamper proof prescription forms. The Board of Pharmacy amended the rule and made it a recommended policy rather than a required policy. Although it has not officially gone into effect, it is included in a rule the Board of Pharmacy has implemented in the Controlled Substances Monitoring Program. That program actually requires that every prescription written for controlled substances in Schedules II, III and IV be electronically transmitted from the pharmacy to the Board of Pharmacy, which will electronically create a database for controlled substances. This information will be available to prescribers and pharmacies. Information from this database can be selected on a case-by-case basis for criminal investigations. All of this was included in a rule that was passed in legislation a year ago. The rule was adopted at the last legislative session. This rule was vetoed by Governor Wise, because it was included in a bill that would have adversely affected the availability of dental care in this State. Those problems have been worked out with the legislature, the Governor and the Board of Dentistry. The prescription pads will be recommended as part of the new rule. This rule will be resubmitted to the legislature this year. The new prescription pads are expensive and studies show that states that have both the monitoring program and the new prescription pads are the most effective in curbing the inappropriate use of narcotics and stopping forgeries. Utah and Colorado have been the most successful with these programs, because they have shared their information with border states. With this new program, prescribers and pharmacies will have information that has been updated on a minute-to-minute basis.

VIII. NEXT MEETING AND ADJOURNMENT

A motion was made and seconded that the meeting be adjourned. All were in favor. The meeting was concluded at 5:45 p.m. The next meeting will be held on Wednesday, September 17, 2003, from 4:00 p.m. to 6:00 p.m.

Respectfully submitted,

Lynda L. Edwards
Secretary