

*Idaho Drug Utilization Review Program*

**DUR BOARD MEETING MINUTES**

April 1, 2004, 9:00 am

Ameri-Tel Inn; 7965 W Emerald

Boise, Idaho 83706

**Board Members Attending:** M. Olson-Fisher, N. Mann, D. Smith, J. Steiner, and R. Ting

**DUR Staff:** P. Cady, V. Culbertson, R. Force, C. Owens, and T. Pettinger

**Medicaid Representatives:** T. Eide

**Excused:** K. Clifford , G. Wilburn, K. Jensen

**Guests:**

	<b>Subject</b>	<b>Discussion</b>	<b>Action/Follow up</b>
<b>1.</b>	<b>Approval of meeting minutes (Oct 2003)</b> - R. Ting	Seconded by D. Smith	Minutes approved
<b>2.</b>	<b>Quarterly report</b> - V. Culbertson		No action taken
<b>3.</b>	<b>Follow-up 3rd Qtr Studies</b>	<b><u>Migraine Headache Treatment and Prophylaxis</u></b> –C. Owens  Although the pathogenesis of MH is not completely understood, several pharmacologic agents have been developed which have demonstrated significant clinical utility as abortive agents. Most notable among these is the class of drugs known as 5-HT receptor agonists or more commonly, the ‘triptans.’ These medications provide relief during acute attacks, but do not prevent future headaches. Additionally, excessive use of these drugs has been associated with rebound headaches, the potential for misuse, and important economic concerns. Prevention of MH is advocated by numerous headache organizations and guidelines regarding migraine prophylaxis have been published by the American Academy of Neurology. Drugs used as preventative agents for MH include beta-blockers, tricyclic antidepressants, anti-seizure medications, calcium channel blockers, and others. This intervention identified patients receiving triptans and other migraine drugs and classified them in terms of frequency of triptan use, concomitant medication use, and use of prophylaxis. Prescribers of triptan and other migraine drugs received a letter and educational leaflet as well as a questionnaire concerning prescribing habits, use of prophylactic therapy and other related topics.	Results discussed. It appears that this educational intervention was successful, particularly with regards to migraine prophylaxis. It was recommended that this intervention be run again in the future (1 year) to assess continued increases in chronic prophylaxis.

	Subject	Discussion	Action/Follow up
		<p><b>Physician Responses:</b>  Physician letters: 120  Physicians responding: 30 (25%)</p> <p>See results in ‘Migraine Headache Treatment and Prophylaxis’ packet</p> <p>Upon follow-up, cost data for 2003 were available and indicated an increase of nearly \$105,000 from 2002 to 2003 (\$1,024,306.80 to \$1,129,261.37). The total number of triptan patients increased from 1,521 to 1,634 and the number of rx’s from 7,111 to 7,485. Since the intervention, data regarding triptan use (frequency and concurrent prophylaxis) has also been tabulated using the most current 12-month period (March 2003 to February 2004). Although the total number of triptan users has increased, a decrease in high and moderate frequency users was observed post-intervention. The number of patients using chronic migraine prophylaxis increased from 25 to 88 patients post-intervention, especially in the high frequency group. Finally, it was demonstrated that one-quarter of female triptan users over the age of 50 are chronic users of ERT; 50% of high frequency users are ERT users.</p> <p><b><u>Proton-Pump Inhibitors</u></b> –T. Pettinger</p> <p>Proton-pump inhibitors are agents commonly used in the treatment of peptic ulcer disease (PUD), moderate-to-severe gastroesophageal reflux disease (GERD) and in the management of hypersecretory states such as Zollinger-Ellison syndrome. Omeprazole (Prilosec<sup>®</sup>) was the first PPI approved in 1988. Since then, four additional drugs in the class have become available: lansoprazole (Prevacid<sup>®</sup>), rabeprazole (Aciphex<sup>®</sup>), pantoprazole (Protonix<sup>®</sup>), and most recently, esomeprazole (Nexium<sup>®</sup>). PPIs are relatively expensive agents, with average wholesale prices (AWPs) ranging from \$100 to \$150 per month. In 2002, Idaho Medicaid spent over \$5.2 million on PPIs. This intervention assessed the use of proton-pump inhibitors (PPIs) and H2-receptor antagonists in the current Medicaid population. In addition, prescribers received a letter and educational leaflet and were queried regarding PPI prescribing, selection of a preferred agent in the class, H. pylori testing, and other related topics.</p> <p><b>Physician Responses</b>  Physician letters: 101  Physicians responding: 37 (36.6%)</p>	<p>Intervention discussed.  Recommended that intervention be re-run next year to assess smart PA in further reducing costs. Also, f/u should be performed for patients who stopped taking their PPI when PA was in place. As comparison look at patients who switched to H2 blockers vs. patients who didn’t initiate any acid-controlling medication.</p>

	Subject	Discussion	Action/Follow up
		<p>See results in ‘Proton-Pump Inhibitor Utilization’ packet.</p> <p>Upon follow-up, cost data for 2003 were available and indicated a further decrease in PPI spending. In 2001, PPIs peaked at \$8.1 million; this amount fell to \$5.8 million in 2002, and decreased to \$3.7 million in 2003. From 2002 to 2003, the total number of PPI patients decreased from 13,512 to 12,773 and the number of rx’s from 74,457 to 66,656. Since the intervention, data regarding PPI use (twice daily dosing and concurrent H2 blocker use) has been tabulated using the most current 12-month period (March 2003 to February 2004). The number of patients receiving 60 units monthly in 10 of the 12 months pre-intervention was 1,957. Post-intervention, this number decreased to 1,414 (28%). The number of patients concurrently using H2 blockers on a chronic basis pre-intervention was 1,652. Post-intervention, this number decreased to 1,570 (5%).</p> <p><b><u>COX-2 Inhibitors</u></b> –C. Owens</p> <p>Non-steroidal anti-inflammatory (NSAID) agents that are selective for cyclooxygenase 2 (COX-2) are relatively new additions to the armamentarium of pain control. Although benefits in terms of GI protection have been demonstrated, the analgesic efficacy of COX-2 inhibitors appears similar to that of nonselective NSAIDs. Because of the high cost of these agents and their apparent analgesic equivalence to less-expensive nonselective NSAIDs, the use of COX-2 inhibitors should be restricted to patients at moderate to high risk for serious GI complications. Patients in whom COX-2 inhibitors are appropriate include individuals requiring analgesia who are predisposed to developing complications with traditional NSAIDs. This intervention identified patients taking COX-2 inhibitors in the current Medicaid patient population and classified them according to age, indication, risk status, and concomitant medication use. Prescribers received a letter and an educational leaflet and were queried regarding agent of choice, selection of a preferred drug in the class, general treatment of osteoarthritis, and other related topics. In addition, a scoring tool developed at Stanford University by Dr. Singh and colleagues was included (with author permission) to aid physicians in identifying the most appropriate candidates for COX-2 therapy.</p>	<p>Intervention discussed. Possible newsletter article regarding COX-2 inhibitors and OTC NSAID use. Patient profiles presented indicating repeated traditional NSAID and COX-2 use may be singled out for direct intervention.</p>

	<b>Subject</b>	<b>Discussion</b>	<b>Action/Follow up</b>
		<p><b>Physician Responses:</b>  Physician letters: 99  Physicians responding: 36 (36.4%)</p> <p>See results in ‘COX-2 Inhibitor Utilization’ packet</p> <p>Upon follow-up, cost data for 2003 were available and indicated a further decrease in COX-2 inhibitor spending. In 2001, COX-2’s peaked at \$2.95 million; this amount fell to \$2.04 million in 2002, and decreased to \$1.38 million in 2003. From 2002 to 2003, the total number of COX-2 patients decreased from 5,365 to 2,471 and the number of rx’s from 22,739 to 13,817. Since the intervention, data regarding COX-2 use, specifically, patients taking COX-2 inhibitors and chronic traditional NSAIDs have been tabulated using the most current 12-month period (March 2003 to February 2004). The number of patients meeting these criteria pre-intervention was 35. Post-intervention, this number decreased to 28. Four patient profiles were provided for discussion.</p>	
4.	<b>Current Intervention responses</b>	<p><b><u>Off-label Uses of Gabapentin</u></b> –C.Owens</p> <p>Gabapentin has recently received increased media attention as a result of alleged improprieties on the part of the manufacturer regarding unethical and/or illegal promotion of the drug’s utility in a variety of non-FDA approved indications. Drug utilization review programs in other states have reported up to 95% of gabapentin claims to be associated with off-label uses. Gabapentin was approved by the FDA on December 30, 1993 with the sole indication as adjunctive therapy in the treatment of partial seizures, with or without secondary generalization, in patients over the age of 12 years. In October 2000, the FDA approved an additional indication: adjunctive therapy for partial seizures in patients age 3-12 years. Most recently, in May 2002, the FDA approved gabapentin for the treatment of postherpetic neuralgia in adults. Despite these few approved uses, gabapentin has enjoyed tremendous financial success, achieving over \$1.4 billion in retail sales in 2001 and being ranked among the top 20 drugs in the United States.</p> <p>This intervention will identify patients using gabapentin for off-label indications. Overall utilization and cost of gabapentin will be described. Information will be provided to prescribers regarding the level of evidence for various off-label uses. A questionnaire will be addressing</p>	<p>Intervention discussed. Results very interesting. Board recommended addressing off-label use of other medications, especially other high-cost anti-seizure drugs (ie topiramate). Recommended that staff continue to track gabapentin use and costs as it was ranked 7<sup>th</sup> in expenditures last year. P&amp;T committee will be addressing anti-seizure medications in the future. Note that gabapentin goes off patent in 2-3 years.</p>

	<b>Subject</b>	<b>Discussion</b>	<b>Action/Follow up</b>
		<p>prescribing habits, off-label experience, and related topics.</p> <p>See results in ‘Off-label Use of Gabapentin’ packet</p> <p><b><u>Antibiotic Prescribing in Strep A Pharyngitis</u></b>–T. Pettinger</p> <p>Group A streptococcus is the most common cause of bacterial pharyngitis. It is the causative agent in approximately 15-30% of cases in children and 5-10% of cases in adults. Current guidelines recommend penicillin as the agent of choice in children and adults. Amoxicillin is an acceptable alternative to oral penicillin in young children due to better taste. Efficacy seems to be equal between the two antibiotics, and cost is minimal with both regimens. For those patients allergic to penicillin antibiotics, erythromycin is the first-line alternative. Azithromycin has been recommended as an alternative to erythromycin due to better tolerability and compliance, but its cost raises concerns. First-generation cephalosporins are also an acceptable alternative for penicillin-allergic patients and are associated with a minimal financial burden. Since antibiotic resistance has not been documented with Group A strep, the use of broad-spectrum antibiotics is unwarranted.</p> <p>This intervention will identify trends in antibiotic prescribing habits for patients with a diagnosis of Group A streptococcal pharyngitis. Inappropriate antibiotic prescribing will be identified and information will be provided to prescribers regarding the current guidelines for treatment of strep pharyngitis.</p> <p>See results in ‘Strep Pharyngitis’ packet</p> <p><b><u>Appropriate Use of Palivizumab (Synagis®)</u></b> –C. Owens</p> <p>RSV is a leading cause of lower respiratory illness in children, particularly among those with prematurity, chronic lung disease, congenital abnormalities, certain immunodeficiencies, and other “high-risk” factors. In the United States, RSV infection is associated with more</p>	<p>Intervention discussed. Board appreciated information presented. Responses indicate that this intervention was helpful and will be useful to providers in their future treatment of GAS.</p> <p>Intervention discussed. Part 1 presented at meeting today. Background information regarding RSV in Idaho and trends in Synagis prescribing and use provided. Since</p>

	<b>Subject</b>	<b>Discussion</b>	<b>Action/Follow up</b>
		<p>than 90,000 pediatric hospitalizations and 4,500 deaths annually. The American Academy of Pediatrics recently revised the guidelines for the use of palivizumab in the prevention of RSV as a result of recently completed clinical trials; Idaho Medicaid adopted these recommendations into a prior authorization program for use of this agent earlier this year.</p> <p>This intervention will identify the incidence of respiratory syncytial virus (RSV) infection over the past three years and its correlation with the advent of a new prophylactic agent, palivizumab. Also, it will describe any change in incidence associated with the introduction of prior authorization criteria for use of palivizumab. National incidence rate will be reported for comparison. Key questions formulated by the Medicaid Pharmacy department will be addressed.</p> <p>For more information, see 'RSV and Synagis' proposal.</p>	<p>the RSV season is only half over at this time (data available up through Feb 2004), most questions will need to be addressed at September meeting. At that time will better be able to assess overall cost differences in patients treated vs. those denied Synagis. It was noted that certain questions formulated would not be able to be answered given the data available. Example (For patients developing RSV, was there a difference in risk factors – certain risk factors such as school age siblings, day-care attendance, smoking in the home, cannot be identified with the database. It was further discussed that information regarding patients receiving Synagis in the home (through home infusion services) would be forwarded to DUR staff. Include all bronchiolitis codes in identifying RSV patients (as they are often not specifically coded 'RSV'). Check procedure codes for individuals actually tested for RSV.</p>
5.	<b>Future interventions for next quarter</b>	<p><b><u>Carisoprodol Safety</u></b> –C.Owens</p> <p>Centrally-acting skeletal muscle relaxants, including baclofen (Lioresal®), carisoprodol (Soma®), chlorzoxazone (Parafon Forte®), cyclobenzaprine (Flexeril®), metaxalone (Skelaxin®), methocarbamol (Robaxin®) and orphenadrine (Norflex®) are agents used in the treatment of spasticity associated with upper motor neuron syndromes and acute painful musculoskeletal conditions of local origin. By convention, these drugs are classified into a single group; however, their mechanisms of action differ and are incompletely understood. Likewise, the evidence for the efficacy of these agents is limited and is likely due to their sedative properties.</p> <p>The abuse of skeletal muscle relaxants in general has been reviewed in the literature. Carisoprodol is of particular concern and is a schedule IV</p>	<p>Approved as intervention for 2<sup>nd</sup> quarter. Board recommends that issue be included in Summer newsletter, so that all Medicaid providers are aware of safety issues surrounding this drug. The board believes that information on this subject is not widely held; information from P&amp;T committee discussion likewise indicates that addictive potential not being fully recognized among prescribers. May also want to do GIS study of carisoprodol use in the state of Idaho.</p>

	<b>Subject</b>	<b>Discussion</b>	<b>Action/Follow up</b>
		<p>drug in several states. This intervention will characterize carisoprodol use in Idaho with a focus on chronic use and use in conjunction with opioids. Educational materials will be provided to prescribers and experience with the drug will be polled.</p> <p>For more information, see ‘Carisoprodol Safety’ proposal</p> <p><b><u>Stimulants and Strattera®</u></b>–C. Owens</p> <p>Attention deficit/hyperactivity disorder (ADHD) is estimated to affect up to 10% of school-age children, with 10-60% of these individuals exhibiting symptoms that persist into adulthood. Although a variety of social and behavioral modifications are employed in the treatment of ADHD, drug therapy continues to be a mainstay. Until November 2002, agents in the CNS stimulant class were the only drugs FDA-approved for the treatment of ADHD and included methylphenidate and amphetamine. Strattera® is a relatively new non-stimulant agent for ADHD. Other non-stimulants use to treat the disorder include clonidine and TCAs. This intervention will assess the use of these agents in the current and past Medicaid population with a focus on chronic use, combination therapy, and concomitant medication use. In addition, educational materials will be sent to prescribers regarding appropriate use of the se agents.</p> <p>For more information, see ‘Stimulants and Strattera®’ proposal</p> <p><b><u>COX-2 Inhibitors and HTN</u></b></p> <p>Several trials have been conducted which have evaluated the destabilization or worsening of hypertension in patients who receive nonselective NSAIDs or selective COX-2 inhibitors, with some data indicating that COX-2 inhibitors may have a more pronounced deleterious effect on preexisting hypertension than nonselective NSAIDs. The clinical significance of this has not yet been determined. Many elderly patients receive NSAIDs (selective or nonselective) on a chronic basis for various conditions including osteoarthritis. This proposed intervention is designed to identify a correlation between NSAID use and new-onset hypertension. In addition, it may be useful in characterizing an association between the incidence of hypertension in patients taking nonselective versus selective NSAIDs and compare this to new-onset hypertension in the general population.</p>	<p>Approved as intervention for 2<sup>nd</sup> quarter. Board recommended that cost information be provided with educational materials. Dosing of long-acting agents in particular should be addressed.</p> <p>Approved as intervention for 2<sup>nd</sup> quarter.</p>

	<b>Subject</b>	<b>Discussion</b>	<b>Action/Follow up</b>
<b>6.</b>	<b>By-laws</b> - T. Eide	No discussion	No action taken
<b>7.</b>	<b>Medicaid Update</b> -T Eide	Administration is pleased with DUR activities as they relate to P&T. COX-2 inhibitors on PA as of March 1 (Vioxx® preferred). PPI's on PA as of April 1 (Prevacid®, Aciphex®, Prilosec OTC® preferred). Triptans will be on PA May 1 (Imitrex®, Zomig®, Maxalt®)—new quantity limits 800mg/month. Statins will be on PA June 1 (Pravachol®, lovastatin, Altecor®, Lescol®, Lescol XL®). With all preferred agents, two must be tried and failed before a non-preferred agent may be used. P&T reviewed skeletal muscle relaxants and long-acting opioids at last meeting.  Idaho Medicaid web address: <a href="http://www.idahohealth.org">www.idahohealth.org</a>  Annual report format still not available	C. Owens will attend P&T meetings. When f/u on statins look for increases in Zetia® use for patients on Zocor® or Lipitor®. DUR to do carisoprodol educational intervention.  Tami will keep us informed
<b>8.</b>	<b>Other business</b>	SUMMER NEWSLETTER <ol style="list-style-type: none"> <li>1. Purpose of DUR</li> <li>2. Soma Safety</li> <li>3. Tablet Splitting: cost savings &amp; safety issues</li> <li>4. Cost Corner: Muscle relaxants</li> </ol> Idaho DUR mentioned in JAPhA article as conducting beneficial activities.  TOP 50 Highest cost patients, Most popular drugs (number of claims), and highest cost drugs for 2003 presented.	Articles approved for inclusion in DUR Newsletter. The newsletter will be sent out July-August. Several positive responses regarding last newsletter.  This will be included in newsletter article regarding the purpose of DUR.  The Board found this information useful for determining future interventions.
<b>9.</b>	<b>Meeting Dates</b>	June 17, September 16, January 20, 2005	
<b>10.</b>	<b>Adjournment</b>	Meeting adjourned at 2:30 PM	