

Idaho Drug Utilization Review Program

DUR BOARD MEETING MINUTES

January 15, 2004, 9:00 am

Commission on Aging, Conference Room

3380 West Americana Terrace

Boise, Idaho

Board Members Attending: K. Jensen, M. Olson-Fisher , D. Smith, J. Steiner, R. Ting, and G. Wilburn

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

Medicaid Representatives: T. Eide, S. Kittridge

Excused: K. Clifford , N. Mann

Guests:

	Subject	Discussion	Action/Follow up
1.	Approval of meeting minutes (Oct 2003) - R. Ting	Seconded by G. Wilburn	Minutes approved with one correction in 'proposed interventions'
2.	Quarterly report - V. Culbertson		No action taken
3.	Follow-up 3rd Qtr Studies	<u>Metformin Safety</u> –T. Pettinger Despite the proven benefits and overall tolerability and safety of metformin in the treatment of Type II DM, important contraindications and monitoring parameters must be considered to ensure patient safety, maximize benefit, and ensure that metformin remains available in the marketplace. Some evidence suggests that metformin's contraindications and monitoring recommendations are not being followed in routine medical practice. This intervention identified patients receiving metformin who may be at risk for the development of complications due to a concurrent diagnosis of congestive heart failure, advanced age (>80 years), or infrequent laboratory monitoring of renal function. Primary care providers of these patients received a letter and educational materials regarding current monitoring recommendations, methods for calculating creatinine clearance, and a description of lactic acidosis. Physician Responses:	Appears this intervention was successful. The Board was impressed by positive change in therapy for metformin patients. Should consider rerunning in the future.

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		<p>Physician letters: 95 Physicians responding: 29 (31%)</p> <p>Patients involved: 272 Patients with response: 76 (28%)</p> <p>See results in ‘Metformin Safety’ packet</p> <p>Since the conclusion of the intervention, the following changes in patient therapy have been observed:</p> <p>Using the most current data (through November 2003), the number of eligible intervention patient was 149. This indicates a positive change in therapy for 123 of the original 272 patients or a 45% improvement.</p> <p>Specifically, patients identified with an elevated SrCr have undergone the following change in therapy: SrCr 1.4: No longer taking metformin SrCr 1.5: No longer taking metformin SrCr 1.5: No longer taking metformin SrCr 1.7: No longer on Medicaid SrCr 1.8: No longer taking metformin</p> <p><u>Statin Therapy in High-Risk Patients</u> –T. Pettinger</p> <p>Several clinical trials have demonstrated the benefits of statin and other lipid-lowering therapy in patients at high risk for cardiovascular or cerebrovascular events. Such patients include those with a documented history of CAD, PAD, ischemic stroke, TIA, or diabetes mellitus. Despite existing evidence, studies have shown that a large percentage of high-risk individuals who qualify for lipid-lowering therapy do not receive it. This intervention identified high-risk patients who had no record of statin or other lipotropic therapy and provided educational information regarding Adult Treatment Panel III guidelines for hyperlipidemia, lipid lowering effects of different drug classes, potential adverse effects of lipid-lowering agents, and data from clinical trials.</p> <p>Physician Responses Physician letters: 93</p>	<p>Appears that this intervention was successful. Should consider repeating in the future.</p>

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		<p>Physicians responding: 35 (38%)</p> <p>Patients involved: 818 Patients with response: 115 (21%)</p> <p>See results in ‘Statins in High-Risk Patients’ packet</p> <p>Since the conclusion of this intervention, the following changes have been observed:</p> <p>Using the most current data (through November 2003), the number of patients identified who would have been eligible for intervention was 348, indicating a positive change in therapy for 535 patients or a 60% improvement.</p> <p>Article on this subject included in Winter DUR Newsletter.</p> <p><u>ACE Inhibitor Dosing in CHF</u> –C. Owens</p> <p>Large clinical trials have demonstrated the benefits of ACE inhibitor therapy in patients with CHF. When prescribing these medications, clinicians often use lower doses in an attempt to minimize complications; however, existing evidence including the ATLAS trial indicates that higher doses of ACE inhibitors are more effective in reducing rates of complications (hospitalizations). As a result, higher doses than are used for the treatment of hypertension are recommended. Although tolerability, adverse effects, and other patient-specific parameters must be taken into account, doses equivalent to those used in clinical trials are needed for maximum benefit in CHF patients. This intervention identified patients with CHF currently being treated with an ACE inhibitor who would potentially benefit from a dose increase. Educational materials were also provided to physicians and pharmacists regarding the role of ACE inhibitors, dosing strategies to optimize therapy, and cost information.</p> <p>Physician Responses: Physician letters: 75 Physicians responding: 32 (43%)</p> <p>Patients involved: 101 Patients with response: 32 (32%)</p>	<p>Appears that this intervention was successful.</p>

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		<p>Pharmacist Responses: Pharmacist letters: 64 Pharmacists responding: 30 (47%)</p> <p>Patients involved: 118 Patients with response: 39 (33%) See results in ‘ACEI in CHF’ packet</p> <p>Since the conclusion of the intervention, the following changes have been made:</p> <p>Using the most current data (through November 2003), the number of identified intervention patients was 81 and 75 for the two groups, respectively, indicating a positive change in therapy for 70 of the original 226 patients or a 30% improvement.</p>	
4.	Current Intervention responses	<p><u>Migraine Headache Treatment and Prophylaxis</u> –C. Owens</p> <p>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.</p>	<p>The Board was concerned by the number of patients not being prescribed migraine prophylaxis.</p> <p>The Board discussed looking at female, high frequency, triptan users to see any trends in HA with concomitant HRT usage.</p> <p>The P&T committee has chosen Imitrex®, Zomig®, and Maxalt® for the Medicaid protocol. This will cover different dosage forms. Will repeat in one year to compare trends.</p>

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		<p>Physician Responses: Physician letters: 120 Physicians responding: 30 (25%)</p> <p>See results in ‘Migraine Headache Treatment and Prophylaxis’ packet</p> <p><u>Proton-Pump Inhibitors</u> –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®) was the first PPI approved in 1988. Since then, four additional drugs in the class have become available: lansoprazole (Prevacid®), rabeprazole (Aciphex®), pantoprazole (Protonix®), and most recently, esomeprazole (Nexium®). 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>Physician Responses Physician letters: 101 Physicians responding: 37 (36.6%)</p> <p>See results in ‘Proton-Pump Inhibitor Utilization’ packet</p> <p><u>COX-2 Inhibitors</u> –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</p>	<p>The Board was concerned over the number of patients and the cost of the therapy in this population.</p> <p>The Board is interested in a geographic breakdown of twice daily PPI prescribers.</p> <p>Preferred agents in this class are Prevacid®, Prilosec OTC®, and Aciphex®</p> <p>The number of patients receiving PPIs without a coded diagnosis of GERD or PUD was high, indicating a possible deficiency in proper coding. Recommended that database be screened again in one year to compare trends.</p> <p>The number of patients receiving COX-2 inhibitors for “other” reasons was overwhelming.</p> <p>Regarding the P&T committee,</p>

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		<p>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>Physician Responses: Physician letters: 99 Physicians responding: 36 (36.4%)</p> <p>See results in ‘COX-2 Inhibitor Utilization’ packet</p>	<p>Vioxx® is the choice for COX-2 inhibitors.</p> <p>The Board would like follow up on patients taking chronic NSAIDs and COX-2 concomitantly.</p> <p>The Board was impressed by the graphs, charts, and illustrations for all three interventions. The information provided by the DUR staff for these three interventions was greatly appreciated and useful. Should consider repeating database searches again in one year to compare trends in usage.</p>
5.	Future interventions for next quarter	<p><u>Off-label Uses of Gabapentin</u> –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-</p>	<p>Approved as an intervention for first quarter 2004. It is recommended that this be an educational intervention showing the level of evidence of the use of gabapentin in several conditions.</p>

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		<p>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 prescribing habits, off-label experience, and related topics.</p> <p>For more information, see ‘Off-label Use of Gabapentin’ proposal</p> <p><u>Antibiotic Prescribing in Strep A Pharyngitis</u>–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</p>	<p>Individual patients receiving chronic gabapentin therapy may be identified and the questionnaire and leaflet sent to their prescribing physicians.</p> <p>The Board is interested in characterizing this agent’s use in our population.</p> <p>Approved as intervention for first quarter 2004. Subject is timely and results will be of benefit in addressing appropriate antibiotic usage in our population.</p> <p>Questionnaire and leaflet should be similar in structure and format to previous ‘otitis media’ antibiotic prescribing intervention.</p>

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		<p>treatment of strep pharyngitis.</p> <p>For more information, see ‘Strep Pharyngitis’ proposal</p> <p><u>Appropriate Use of Palivizumab (Synagis®)</u> –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 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. Lastly, information will be provided to prescribers regarding established guidelines from the American Academy of Pediatrics for the appropriate use of the agent.</p> <p>For more information, see ‘Palivizumab and RSV’ proposal.</p>	<p>Approved as intervention for first quarter 2004. The Board also recognizes that this intervention will take more time than usual. A progress report is expected at next Board meeting and final results in Third Quarter’s meeting.</p> <p>This intervention will not involve educational leaflets or questionnaires. It will seek to describe Synagis® use and RSV trends in Idaho Medicaid population before and since prior authorization May 2003.</p> <p>The DUR staff made it clear that more information will be needed (prior auth status of patients, JCodes, procedure codes) in order to complete this intervention as presented.</p>
6.	By-laws - T. Eide	No discussion	No action taken
7.	Medicaid Update -T Eide	Discussed throughout meeting. Preferred agents in class were announced and rationale for them discussed during current intervention discussion. The DUR Board wants a staff representative at the P&T committee meeting tomorrow.	C. Owens will attend P&T meeting.
8.	Other business	WINTER NEWSLETTER 1. Statins: Just another tool in the shed?	Articles approved for inclusion in DUR Winter Newsletter. The

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		<p>2. Prescriber numbers now required 3. HIPAA and the DUR 4. Cost Corner: Statins</p> <p>SUMMER NEWSLETTER IDEAS -Prescribers writing diagnoses on prescriptions</p> <p>P&T committee meeting will discuss ACEI's and calcium-channel blockers tomorrow.</p> <p>Non-adherence to HIV treatment protocols research project proposed by Paul Cady.</p> <p>TOP 40 Highest cost patients, patients with most prescriptions, and patients seeing the most physicians was presented based on last 3 months of data</p>	<p>newsletter will be sent out shortly.</p> <p>Board will discuss and respond at a later date.</p> <p>Larger, more detailed report (including patient profiles) requested for discussion at next meeting</p> <p>The Board was impressed by the results of this search. Would like more information on these patients as this discussion is beneficial.</p>
9.	Meeting Dates	Undecided at this time. Will try to coordinate with P&T	Tami will follow up with DUR staff when dates are settled
10.	Adjournment	Meeting adjourned at 2:00 PM	