

Idaho Drug Utilization Review Program

DUR BOARD MEETING MINUTES

June 16, 2004 9:00 am

Department of H&W, 3232 Elder Street
Boise, Idaho

Board Members Attending: K. Clifford, K. Jensen, N. Mann, M. Olson-Fisher, J. Steiner, R. Ting, G. Wilburn

DUR Staff: P. Cady, V. Culbertson, R. Force, N. Murdock, and C. Owens

Medicaid Representatives: S. Kittridge

Excused:

Guests:

	Subject	Discussion	Action/Follow up
1.	Approval of meeting minutes (April 2004) - R. Ting	Seconded by K. Jensen	Minutes approved
2.	Quarterly report - V. Culbertson		No action taken
3.	Follow-up 1st Qtr Studies	<p><u>Off-Label Use of Gabapentin</u>—C. Owens</p> <p>Gabapentin recently received increased media attention as a result of improprieties on the part of the manufacturer regarding unethical and illegal promotion of the drug’s utility for a variety of off-label indications. In May 2004, Pfizer, Inc. pleaded guilty to several civil and criminal charges for the illegal promotion of gabapentin’s off-label uses and agreed to pay nearly \$400 million in criminal fines to state and federal healthcare programs. Further information from the lawsuit indicated that off-label uses accounted for more than 90% of the drug's sales worldwide last year. According to Idaho Medicaid records, off-label indications accounts for approximately 97% of the gabapentin use. This intervention characterized gabapentin use in the Idaho Medicaid population, with a focus on off-label uses. In addition, we provided educational information to Medicaid providers regarding off-label drug use in general and gabapentin in particular. A review of pertinent literature was also provided, as well as a questionnaire to assess prescribing habits and experience with gabapentin.</p> <p>Physician Responses:</p>	Results discussed. The board recommends tracking the continued cost and utilization of the newer anti-seizure medications (gabapentin, topirimate, lamotrigine). This information will serve as a useful baseline for future discussion in the DUR and P&T committees.

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		<p>Physician letters: 97 Physicians responding: 40 (41%)</p> <p>See results in ‘Off-label Use of Gabapentin’ packet</p> <p>To follow up, another anti-seizure drug often used for off-label indications was investigated, as was requested at the previous board meeting. Topiramate (Topamax®) was ranked 12th in terms of cost in 2003 with a total of \$1.9 million spent that year by Idaho Medicaid. As follow up for this intervention, a comparison was made between topiramate and gabapentin. The follow-up information indicated that >85% of topiramate’s claims are associated with off-label uses.</p> <p><u>Antibiotics in GAS</u> –R. Force</p> <p>Group A streptococcus (GAS) is the most common cause of bacterial pharyngitis. 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 appears to be equal between the two antibiotics, and cost is minimal with either regimen. For patients allergic to penicillin, erythromycin is the first-line alternative. Although azithromycin has been recommended as an alternative to erythromycin due to better tolerability and compliance, its high cost raises concerns. First-generation cephalosporins are also an acceptable alternative for certain penicillin-allergic patients. Since antibiotic resistance has not been documented with Group A strep, the use of broad-spectrum antibiotics is unwarranted. This intervention’s objective was to identify trends in antibiotic prescribing habits for patients with a diagnosis of GAS pharyngitis and to provide information to prescribers regarding the current guidelines for treatment of this condition. Also, we summarized utilization and antibiotic cost trends associated with GAS treatment over the last 10 years. The results indicated that GAS is being treated in accordance with guidelines in 75% of patients and this trend is increasing. However, a large portion of the overall cost (40%) is due to inappropriate treatment.</p> <p>Physician Responses Physician letters: 134 Physicians responding: 67 (50%)</p> <p>See results in ‘Antibiotics in Group A Strep Pharyngitis’ packet.</p>	<p>Intervention discussed. It was agreed that it is likely too soon to see continued improvement in prescribing for GAS. It was recommended that this intervention be repeated in the future and that a more detailed analysis of recurrent cases be explored. Also, an analysis of prescribing habits of individuals who received the intervention was also recommended.</p>

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		<p>Upon follow-up, it appeared that no change had been observed pre-intervention to post-intervention. This is likely due to the fact that the intervention went out in December and a true reflection of the impact of this educational intervention is not yet available.</p> <p><u>Appropriate Use of Synagis® in RSV</u> –P. Cady</p> <p>At the direction of Medicaid Administration, the Medicaid Pharmacy Program requested that the DUR Board undertake a study of the outcomes associated with the department’s prior authorization (PA) of palivizumab (Synagis®). The PA of palivizumab went into effect for the 2003-2004 RSV season and restricted use of the agent to high risk infants as defined by a policy statement established by the American Academy of Pediatrics in 1998. This study has begun to characterize RSV trends in the state of Idaho as well as the use of palivizumab. This interim report sums up some important early findings and outlined results that will be presented at the September meeting.</p> <p>For part one of the report, Idaho Medicaid claims were queried to identify cases of RSV infection per season (season was defined as July to June, starting in 1998). Diagnosis codes used to identify patients were 079.6 (RSV) and 466.11 (acute bronchiolitis due to RSV). Drug costs per patient and overall costs per season were also tabulated.</p> <p>In the April board meeting, the coding for RSV was discussed. It was suggested that restricting a definition of RSV diagnosis to only the ICD-9 codes mentioned (079.6 and 466.11) may inadequately reflect all cases of RSV diagnosed in Idaho. It was further suggested that many physicians will use ICD-9 codes indicative of bronchiolitis (466, 466.1, and 466.19) to identify RSV patients as well. For this report we included a comparison of these two methods of identifying RSV as well cost data up through the end of the 2003-2004 RSV season. A complete analysis of all the data up through the end of the current season will be reported at the September board meeting,</p> <p>Physician Responses: Physician letters: 0 Physicians responding: 0</p>	<p>Study discussed. The board recommended that the most important points to be presented in the final report are compliance and hospitalization issues. A comparison of overall morbidity, mortality, and healthcare costs should be made between patients who received Synagis vs. patients who are denied Synagis. A doctor’s office visit followed by a home health visit to administer the drug should also be identified. Patients who received the drug should be followed up to ensure that they received all necessary doses (up to 5) per season. A chart review or provision of prior authorization forms to identify patient specific risk factors will also be provided. S. Kittridge will follow-up to provide the DUR staff with this information.</p>

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		See results in ‘Appropriate Use of Synagis®’ interim report packet	
4.	Current Intervention responses	<p><u>Carisoprodol (Soma®) Safety</u> –C. Owens</p> <p>Introduced in the late 1950s, carisoprodol (Soma®) is a widely prescribed skeletal muscle relaxant (SMR) with similar efficacy to other members of its class. It is relatively inexpensive and until recently, has been considered safe. However, beginning in the late 1980s, concern regarding its abuse has been growing. Anecdotal descriptions of a “buzz” or euphoria have been documented with carisoprodol, particularly when combined with opioids. Additionally, documented cases of withdrawal symptoms, drug-seeking behavior, and fatalities related to carisoprodol have been reported.</p> <p>This intervention characterized SMR use in the Idaho Medicaid population, with a focus on carisoprodol utilization, especially chronic use (≥ 3 consecutive months) and/or concomitant hydrocodone use. In addition, its aim was to provide educational information to Medicaid providers regarding the abuse potential of carisoprodol and the appropriate use of SMRs in general. A review of pertinent literature was also provided, as well as a questionnaire to assess prescribing habits and experience with SMRs.</p> <p>Results indicated that carisoprodol was the second most prescribed SMR in 2003 with approximately 2,000 patients and 10,000 claims that year. In terms of cost, carisoprodol was ranked third among the SMRs in 2003, with a total expenditure of \$280,709. The majority of carisoprodol users in 2003 were prescribed the agent for longer than 2 weeks of therapy and a significant number also received concomitant opioids.</p> <p>For further results, see results in ‘Carisoprodol Safety’ packet</p> <p><u>COX-2 Inhibitors and Worsening HTN</u>–N. Murdock</p> <p>It has been determined that hypertension prevalence is increasing in the United States. While many factors are believed to play a role, the use of certain medications, including non-steroidal anti-inflammatory drugs (NSAIDs) has been associated with increasing incidence of hypertension. NSAID use is substantial, with an estimated 106 million prescriptions</p>	<p>Intervention discussed. Results very interesting. Board recommended that intervention be followed up with a Summer newsletter article to ensure that all Medicaid providers and pharmacies receive the message. V. Culbertson suggested that a pharmacist driven patient-specific intervention program to discourage the use of Soma in favor of equivalent, safer options be undertaken on a state-wide basis. The board agreed and asked the DUR staff to follow up with state pharmacy agencies to discuss feasibility and implementation. Suggestions for implementation included pharmacists faxing prescribers upon refills of a Soma prescription to remind them of safety issues and recommending alternatives. S. Kittridge requested that this intervention and its results be presented at the P&T meeting in July.</p> <p>Intervention discussed. Board appreciated information presented. It was recommended that a more detailed analysis of individual agents be undertaken in the future to isolate (if possible) agents most apt to increased BP. Also, other</p>

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		<p>filled annually in the US. In 2002, ibuprofen, celecoxib, and rofecoxib ranked 17th, 21, and 29 respectively, in number of prescriptions filled in the United States. Various studies have shown an association between destabilization of blood pressure and both COX-2 selective and nonselective NSAID use. Conflicting data exist as to which class is associated with a more substantial effect on blood pressure. To date, studies have yet to determine an association with new onset hypertension and the use of these agents.</p> <p>The objective of this intervention was to determine the incidence of hypertension or worsening of preexisting hypertension with the use of chronic cyclooxygenase-2 (COX-2) selective or nonselective non-steroidal anti-inflammatory drugs (NSAIDs) as compared with a control group. Also, to provide information to prescribers regarding the potential for worsening hypertension in patients taking these drugs and reinforce the importance of blood pressure monitoring.</p> <p>Results: Patients who use COX-2 inhibitors appear to be at a higher risk of developing hypertension than those patients taking nonselective NSAIDs. However, our study failed to show a difference in new onset HTN with COX-2 inhibitor or nonselective NSAID use vs. a matched control patient population.</p> <p>For further results, see results in ‘COX-2 Inhibitors and HTN’ packet</p> <p><u>Stimulants and Strattera®</u>—C. Owens</p> <p>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 include methylphenidate and amphetamine. Although these agents remain first-line therapy, other non-stimulants are used, including atomoxetine (Strattera®). Research to date has not shown clear advantages of one stimulant over another, but titration to the highest recommended dose of one agent should be attempted before trying another. Because evidence is lacking at this time, the use of two or more ADHD medications in combination is discouraged. Also, duration of activity should be taken into account when prescribing stimulants, with particular attention paid to single daily dosing of agents considered to be long-acting. The</p>	<p>cardiovascular and renal adverse effects may also be worth considering, such as worsening CHF or hyperkalemia.</p> <p>Intervention discussed. Board appreciated information presented. The appropriate utilization of this group of agents is an area of intense debate as was indicated by the numerous responses and comments generated by this intervention. The prior authorization criteria is questioned by many prescribers, but it is important to note that with appropriate documentation, stimulants can be obtained for the vast majority of patients. Their use as adjunctive therapy in depression and for the elderly in long-term care facilities are</p>

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		<p>appropriate use of stimulant medications in the treatment of ADHD will result in improved patient care and important economic savings.</p> <p>The objective of this intervention was to characterize ADHD drug utilization in the Idaho Medicaid population, with a focus on Strattera® use and inappropriate prescribing of long-acting stimulants. In addition, to identify concomitant drug use including CNS depressants (opioids, benzodiazepines, and sleep aids). Finally, to provide educational information to Medicaid providers regarding the appropriate use of drugs for the treatment of ADHD to include a review of pertinent comparison information. A questionnaire was also created to assess prescribing habits and experience with these agents.</p> <p>Results indicated that ADHD is being diagnosed and treated more frequently every year. The drug budget for ADHD increased from \$2.1 million in 2002 to \$3.2 million in 2003. Drug holidays appear to occur in most patients as only a small percentage actually receive the drug for 10 fills of a 12-month period. The use of long-acting agents either at high doses or more frequently than QD occurs in approximately 80% of patients prescribed these agents.</p> <p>For more information, see ‘Stimulants & Strattera®’ packet.</p>	<p>additional areas of discussion. The information provided by this intervention will act as a baseline and reference for future discussions by the DUR and P&T committees.</p>
5.	Future interventions for next quarter	<p><u>Appropriate Use of Methadone</u> –C.Owens</p> <p>Chronic nonmalignant pain is a common cause of disability and is estimated to affect one in five adult Americans. The American Pain Society and the American Academy of Pain Medicine have endorsed the use of opioids for refractory chronic non-cancer pain when used according to published guidelines. Long-acting opioids are especially useful in the treatment of this type of pain due to an extended duration of action, dosing convenience, and a tolerable adverse effect profile for most patients. At the Idaho Medicaid P&T Meeting held in March 2004, long-acting opioids were discussed and comparative evidence was presented. While all agents are available to Medicaid patients, three preferred drugs were selected to be used first-line: two long-acting morphine sulfate preparations, Avinza® and Kadian®, and methadone.</p> <p>Morphine sulfate enjoys regular clinical use with readily available dosing and equipotent dose conversion guidelines. Methodone, on the other</p>	<p>Approved as intervention for 3rd quarter. Board recommends that the focus of the intervention be on the treatment of chronic non-malignant pain with opioids to include important prescribing, monitoring, and safety guidelines for methadone. They also asked that this topic be included in the Summer newsletter to further support the P&T committee’s selection of methadone as one of the State’s preferred agents. It was recommended that published VA guidelines for use of methadone be used as a reference and dosage conversions and costs of agents be included in the educational leaflet.</p>

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		<p>hand, is less commonly used and possesses pharmacodynamic and pharmacokinetic properties that can make it difficult to use safely. In addition, significant interpatient variability is more marked with methadone and the lack of published guidelines adds to the complexity of appropriately using this drug.</p> <p>Clinicians should not be deterred from using methadone in their patients with chronic pain, as it is an extremely effective agent in this regard; however, a good understanding of its pharmacodynamic and kinetic intricacies is essential.</p> <p>The objective of this intervention will be to evaluate the use of long-acting opioids among Idaho Medicaid patients and provide educational materials to prescribers and pharmacists regarding preferred agents with a focus on the appropriate use of methadone.</p> <p>For more information, see ‘Appropriate Use of Methadone’ proposal</p> <p><u>Hormone Replacement Therapy</u>—N. Murdock</p> <p>Long-term use of hormone replacement therapy (HRT) has come under increased scrutiny in recent years due to the well-publicized findings from the Women’s Health Initiative (WHI). For decades, peri- and postmenopausal patients have enjoyed significant benefits from HRT including vasomotor and genitourinary symptom control and osteoporosis prevention. In addition, purported cardiovascular benefits were also thought to be derived from HRT. However, results from the Heart and Estrogen/Progestin Replacement Study (HERS) in 1998 suggested that combined estrogen/progestin therapy did not in fact confer the long-believed cardiovascular benefits. HERS looked at postmenopausal women with established heart disease using conjugated equine estrogen (CEE) and medroxyprogesterone (MPA) and found that after one-year of treatment these women were at increased risk of coronary heart disease (CHD) events. This analysis was carried out an additional 2.7 years in the HERS II trial to examine the long-term CHD effects of combined CEE+MPA. Investigators found with additional HRT treatment, women with established CHD still did not have a reduced rate of CHD events. The WHI study published in 2002 addressed the use of CEE alone and in combination with MPA in healthy postmenopausal women in terms of cardiovascular and cancer risks.</p>	<p>Approved as intervention for 3rd quarter.</p>

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		<p>The objective of this intervention will be to evaluate the use of estrogen preparations among Idaho Medicaid patients and provide educational materials to physicians, pharmacists, and patients regarding the appropriate use of hormone replacement therapy in light of recent clinical study findings. The information from this intervention will also serve as a baseline for the P & T committee, who recently reviewed estrogen preparations. This intervention was done two years ago when the WHI had released its initial results and will now be repeated to assess differences in prescribing since that time.</p> <p><u>Appropriate Medication Use in the Elderly</u></p> <p>Inappropriate medication use in the elderly (≥ 65 years) has been associated with a substantial number of adverse drug reactions, worsening physical function, and excessive healthcare utilization. For these reasons, vigilant monitoring in this population is important to improve patient safety and relieve unnecessary economic burden on healthcare resources.</p> <p>Criteria identifying inappropriate drug use in the elderly population have been developed and reviewed by a number of expert panels in geriatric medicine and pharmacology, the most well-known being led by Mark Beers, M.D. The Beers Criteria, as they have come to be known, were first established in 1991, but have since been revised and updated.</p> <p>A total of 48 individual medications or classes of medications to avoid in older adults were originally identified by the Beers group. Further categorization by Zhan and colleagues classified these medications as drugs that should always be avoided (AA), those that are rarely appropriate (RA), and those that have some indications for use in the elderly but are often misused (SI).</p> <p>The objective of this intervention will be to identify elderly patients who may be at risk for adverse events due to inappropriate medication use and provide information to physicians and pharmacists regarding the Beers Criteria.</p>	<p>Approved as intervention for 3rd quarter. It was reiterated that the current database is limited in its ability to identify long-term care facility residents and this information would be extremely useful in such interventions as this one.</p>
6.	Annual Report -V. Culbertson	A look at cost savings and enhanced patient care resulting from DUR activities in 2003 was presented.	Board pleased with increased use of lipotropic medications by patients who benefit from them and attribute

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			<p>this to interventions and newsletter educational materials prepared and conducted by DUR staff to enhance awareness and importance of appropriate lipid control.</p>
7.	<p>Medicaid Update -S. Kittridge</p>	<p>Administration is pleased with DUR activities as they relate to P&T. A report from the Mercer Consultation group outlining opportunities for improvement of Medicaid activities was presented. It included recommendations such as quantity dose limits, SMAC, and a decrease in pharmacists dispensing fees. The P&T committee continues to meet every other month to discuss drug classes for preferred drug lists and enhanced PA. At the next meeting in July, ARBs and beta-blockers will be discussed. All agents currently discussed are open for re-bid and discussion every year. P&T committee recommendations for COX-2s, statins, triptans, ACEI, CA channel blockers, LA opioids, SMRs, estrogens, urinary incontinence drugs, and oral hypoglycemics presented.</p> <p>Idaho Medicaid web address: www.idahohealth.org</p> <p>Annual report due June 30</p>	<p>C. Owens will continue to attend P&T meetings.</p> <p>DUR board recommends better coordination between P&T and its activities in the enhanced PA program. Educational activities on the part of DUR for P&T chosen preferred agents should be preformed prior to or concurrent with P&T deliberation activities.</p> <p>K. Jensen expressed concern regarding below cost reimbursement for pharmacies serving Medicaid patients.</p>
8.	<p>Other business</p>	<p>SUMMER NEWSLETTER</p> <ol style="list-style-type: none"> 1. Purpose of DUR 2. Soma Safety 3. Opioids in the treatment of chronic non-malignant pain 4. Cost Corner: Opioids, NSAIDs 5. Web address and information regarding intervention educational leaflets available online. <p>Idaho DUR mentioned in JAPhA article as conducting beneficial activities.</p> <p>TOP 50 Highest cost patients, Most popular drugs (number of claims), and highest cost drugs for first quarter presented. In addition, top users of Soma® and long-acting stimulants.</p> <p>Conflict of interest statement.</p>	<p>Articles reevaluated for inclusion in DUR Newsletter. The newsletter will be sent out July-August. Several positive responses regarding last newsletter. Tablet splitting is an important topic that should be covered in a future newsletter.</p> <p>This will be included in newsletter article regarding the purpose of DUR. Copies distributed to interested board members.</p> <p>The Board found this information useful for determining future interventions and for possible patient specific interventions to ensure</p>

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			appropriate and cost-effective use of medications. Conflict of interest statement tabled until next meeting.
9.	Meeting Dates	September 16, January 20, 2005	
10.	Adjournment	Meeting adjourned at 3:00 PM	