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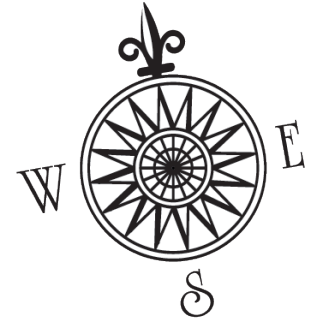
The last Pharmacy and Therapeutics (P&T) Committee Meeting held by Idaho Medicaid was February 15, 2008. Recommendations from the meeting can be found on the Medicaid website at: www.healthandwelfare.idaho.gov. Follow the Medical link to Prescription Drugs and then P&T Committee.

The next P&T Meeting will be held on July 18, 2008, at Idaho Medicaid, 3232 Elder Street, Boise, ID 83705

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The DUR Discovery



Exploring ways to improve pharmacotherapy

Controversial Use and Abuse of Atypical Antipsychotics

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Atypical antipsychotics, including clozapine (Clozaril), olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), ziprasidone (Geodon), and aripiprazole (Abilify), are FDA-approved for the treatment of schizophrenia and bipolar disorder. Aripiprazole is also indicated for adjunctive therapy in major depressive disorder. Off-label use of these drugs below labeled dosage ranges is also common in the management of several other psychosis-related conditions.

Somnolence, a commonly reported side effect of these agents, has led to their use in patients whose psychosis is accompanied by nighttime agitation and/or insomnia. This practice has led to the use of these drugs in patients with insomnia without comorbid psychosis at doses considered subtherapeutic for schizophrenia or bipolar disorder. This application is becoming more common, particularly with quetiapine, but is not FDA-approved or supported by current literature.

Due to the risks of metabolic adverse effects (weight gain, development of overt diabetes and hyperlipidemia) and the significant economic costs associated with these agents, **low dose atypical antipsychotics should not be used for insomnia in patients without comorbid psychiatric indications. Safer and less costly agents are available.**

In 2007, quetiapine was the most costly drug to Idaho Medicaid and accounted for over 36,000 claims. Approximately 10% of these

were for low doses considered subtherapeutic for schizophrenia or bipolar disorder.

Recently, numerous case reports have documented abuse and diversion of quetiapine in prisons. Known as "quell," "baby heroin," or "Susie Q," quetiapine may be abused for its sedative or anxiolytic effects.¹ Doses of up to 2400 mg have been reported.² The combination of quetiapine with illicit drugs such as cocaine (known as "Q-ball") has been reported and is thought to decrease the withdrawal or dysphoria while providing a hallucinogenic effect.

Diversion of quetiapine may not be limited to institutional settings. Patients using quetiapine legitimately may have prescriptions stolen or "borrowed" by friends or family members aware of its abuse potential. Requests for early refills or continued complaints of symptoms not common for schizophrenia may be an indication of abuse. Awareness of abuse is important for healthcare professionals and should be considered to prevent inappropriate and/or unnecessary prescriptions for atypical antipsychotics.

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Treatment of Postpartum Depression

By Rebecca Holt, PharmD and Brooke Pugmire, PharmD, BCPS

Postpartum depression is defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as a major depressive episode that begins within the first four weeks after delivery. Postpartum depression increases a woman's risk for development of major depression and also may impair her child's emotional development, attention, and cognitive skills. Postpartum depression affects 10-20% of women after delivery, and those with such a history have a 50-62% risk of a subsequent episode.^{1,2}

Postpartum depression is under diagnosed and undertreated. Obstetrician-gynecologists, pediatricians, and family physicians conduct most well-child and/or postpartum care visits, and few routinely screen for depression with validated tools such as the Edinburgh Postnatal Depression Scale*. Although a pediatrician's scope of practice does not typically include adults, the American Academy for Pediatrics states that pediatricians should assess parental environmental factors that may potentially affect a child's health. **Screening for postpartum depression with validated screening tools should be standard of practice at postpartum and new born office visits.**³

Pharmacologic treatment of postpartum depression is similar to that of major depression with special consideration given to women who breastfeed. For severe cases antidepressant medication, preferably SSRIs, and psychosocial interventions are recommended regardless of breastfeeding. Psychotherapy alone is recommended for breastfeeding women with mild postpartum symptoms.²

Data regarding the optimal timing of initiation of prophylactic treatment in asymptomatic women with a previous postpartum episode is conflicting. Initiating antidepressant medication

and psychotherapy immediately after delivery is recommended; however beginning these therapies 2-4 weeks before the due date is also appropriate. Treatment of postpartum depression should generally continue for at least 6-12 months after depression symptoms have resolved.^{2,4}

The risk and severity of antidepressant adverse effects are low in nursing infants. Sertraline and paroxetine have the fewest number of reported infant adverse effects. Although the American College of Obstetrics and Gynecology recommends avoiding the use of paroxetine (Paxil) in pregnant women and women planning to become pregnant due to increased risk of congenital cardiac malformations, the drug can safely be used for postpartum depression, even when initiated the few weeks prior to delivery. Pharmacologic treatment of postpartum depression should be individualized, with preference given to medications that patients have responded well to in the past.^{1,5}

*Edinburgh Postnatal Depression Scale can be accessed at: <http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>

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Long-Acting Beta-Agonist Therapy in Asthma

By John Holmes, PharmD and Brooke Pugmire, PharmD, BCPS

Long-acting beta-agonists (LABAs) are indicated for maintenance treatment in asthma. Salmeterol (Serevent) and formoterol (Foradil) are the two currently approved LABAs in the United States, and both are approved for use in Idaho Medicaid patients with moderate to severe persistent asthma receiving inhaled corticosteroids (ICS). Each is also available as a combination product with an inhaled steroid, salmeterol/fluticasone (Advair) and formoterol/budesonide (Symbicort).

Inhaled corticosteroids (ICSs) are the most important long-term control medications in children and adults with asthma; however, long-acting beta-agonists (LABAs) are also important for improved asthma control. In October 2007, the US National Asthma Education and Prevention Program (NAEPP) released the Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma.¹ For patients with moderate persistent asthma or asthma inadequately controlled on low-dose ICSs, these guidelines recommend that increasing the dose of ICS be given equal weight to adding an LABA. In addition, combination LABA and ICS is preferred over high-dose ICS alone in patients who have severe persistent asthma. The addition of an LABA in patients whose asthma is not controlled on low- or medium-dose ICS has been shown to improve lung function, decrease symptoms, and reduce exacerbations and use of short-acting beta-agonists to a greater extent than doubling the dose of ICSs.^{2,3}

Although beneficial effects of LABAs have been shown for a majority of patients who require more than low-dose ICSs to control asthma symptoms, clinical trial data has demonstrated **LABAs may increase the risk of severe asthma exacerbations and/or asthma related deaths in certain patients.**

Recently life-threatening and fatal reports of severe exacerbations have been associated with regular use of LABAs.^{4,5} Studies show that the increased risk of exacerbations may be greater in the African-American population, patients receiving high-dose LABAs, and patients on LABA monotherapy without an ICS.

Long-acting beta-agonists (LABAs) should not be used as monotherapy for long-term control of persistent asthma and **should always be combined with an ICS.** Doses of LABAs should not exceed 2 puffs every 24 hours (100 mcg/day of salmeterol or 24 mcg/day of formoterol) and should not be used for the treatment of acute symptoms or exacerbations. Currently, there is minimal inappropriate use of LABA therapy in the Idaho Medicaid asthma population; <1% of asthma patients in 2007 were using high-dose or monotherapy LABA drugs. Continued diligence regarding appropriate use of these medications is encouraged.

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