



The DUR Discovery

Exploring ways to improve pharmacotherapy

Statins: Just another tool in the shed

by Nikki Murdock, PharmD and
Chris Owens, PharmD

Imagine a fisherman who is preparing for a day at the river. He has tied several flies, has plenty of extra line, and has purchased the best rod money can buy. Everything is stowed ever so neatly into his tackle box, with the glistening rod placed beside it. He is ready to go and with all of his preparation, surely his trip will be a success. He comes to the perfect spot in the river, the one which only experience and the trained eye will find. While unloading his equipment for a great day of fishing, he takes hold of his rod and realizes he is without a reel. How could this be so? He took such painstaking efforts to ensure he had the most important tools... but forgot an essential one.

Often times the most important tools in each sport or trade can be easily identified, much like the fisherman's rod and tackle, but it is important to remember that many tools working

together are necessary in order to get the job done right. The carpenter with a hammer but no nails or the mason who has bricks but no mortar are other examples of individuals with some, but not all of the necessary tools of their trade. It is impractical to think that any tradesman would actually forget such important components, or is it?

Medical professionals have their own tools of the trade as well. Medications and surgical techniques are two broad types of medical tools, utilized for the benefit of patients. Some of these tools are used more often than others and sometimes many are required in concert to achieve the desired result. This is as true in medicine as it is in fly fishing, wood-working, or masonry.

Statin drugs are an important tool of the medical profession. Several major clinical trials have

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HIPAA and the DUR Program

by Chris Owens, PharmD and
Tami Eide, PharmD

The Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was passed into law by the U.S. Congress for the purpose of *'improving portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and healthcare delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes...'*

Although encompassing many different aspects of healthcare administration and delivery, HIPAA may be most well-known for its Privacy Rule section, compliance with which was mandated by April 14, 2003. Under the Privacy Rule, certain aspects of patients' medical information became classified as protected health information (PHI) with strict requirements for its disclosure and use between health plans and professionals (referred to as covered entities or entities).

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Attention Medicaid Pharmacist: Correct Prescriber Numbers Now Required

By Chris Owens, PharmD and Tami Eide, PharmD

Over the last four years, the number of prescriptions in the DUR database with valid prescriber information has decreased significantly. In 2002, over 60% of pharmacy claims were ineligible for DUR intervention and education activities for this reason.

Effective October 20, 2003, Idaho Medicaid has required pharmacy providers to report prescribers' valid state license numbers in order to receive payment. This requirement applies to all electronic, batch, and paper claims. Claims with invalid prescriber license numbers or "77777" will be denied payment.

To help facilitate implementation of this new requirement, Medicaid has made available an electronic version of the prescriber list which will be updated quarterly. This list contains the name, address, and Medicaid prescriber ID number for all Medicaid physicians in the state of Idaho and is available at www.idahohealth.org under the

Over the last four years...valid prescriber information has decreased significantly.

Pharmacy Program link. Alternatively, a hard copy of this list may be obtained by contacting provider services at (800) 685-3757. A \$10.00 handling fee will be charged.

During normal business hours, pharmacies should obtain the license number before submitting the claim. If the claim is rejected, the pharmacy should contact provider services and request that the prescriber be added to the list. If the pharmacy claim is submitted after normal business hours or the pharmacy is unable to obtain the license number or contact provider services, the pharmacy may input the current date (MMDDYY format) in the prescriber number field for that claim. The pharmacy will be contacted by Medicaid for verification.

The implementation of this policy is intended to result in more accurate information in the DUR database, which will in turn be of benefit for profiling, intervention, and educational purposes.

HIPAA and the DUR Program *(continued from page 1)*

In essence, HIPAA mandates that PHI may only be used or released with consent of the patient, with three important exceptions:

1. **Treatment:** entities with a direct treatment relationship with the patient may use and disclose PHI for their own purposes during treatment.
2. **Payment:** entities may use and disclose PHI in order to obtain payment or reimbursement for the provision of healthcare.
3. **Operations:** entities may use and disclose PHI during the course of their normal non-treatment, non-payment operations. Such operations include quality assurance,

training and educational purposes, internal research, and customer service.

Idaho Medicaid is defined as a health plan under HIPAA and is considered a covered entity which must abide by the Privacy Rule. The Drug Utilization Review Program (DUR) is an operational component of Idaho Medicaid with responsibilities in quality assurance, internal research, and education. Educational leaflets and provider and pharmacy interventions are all operations activities of Idaho Medicaid designed to improve healthcare in the state. By conducting these activities, DUR is both in support of and in compliance with HIPAA.

Reference

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Cost Corner: Statin Drugs

by Tracy Pettinger, PharmD and Chris Owens, PharmD

The use of HMG-CoA reductase inhibitors or "statins" has been shown to be effective in several studies for primary and secondary prevention of cardiovascular disease. Randomized, controlled trials from the literature especially support the use of lovastatin, simvastatin, pravastatin, and atorvastatin. While suspected, it is still unknown whether the effects seen in these individual agents extend to an overall "class effect" for statins in general. Of note, statins are among the most expensive outpatient drugs and Idaho Medicaid spent over \$2.7 million on statin therapy in 2002 alone. Furthermore, some of the agents with the best clinical evidence (simvastatin, pravastatin, and atorvastatin) are also three of the most expensive (see table 1 below).

In the United States, there is only one generic statin available at this time, lovastatin. The AFCAPS/TexCAPS was a primary prevention study that showed a 37% risk reduction of first acute major coronary event associated with the use of lovastatin (RR 0.63, CI 0.50-0.79). These events, defined as fatal or non-fatal myocardial infarction, unstable angina, or sudden cardiac death, were reduced with lovastatin therapy of 20-40mg daily. Patients enrolled in this study were men (age 45-73 years) and postmenopausal women (age 55-73 years) with 'normal cholesterol levels' – defined as: total cholesterol of 180-264 mg/dL, LDL-C of 130-190 mg/dL, TG of <400

mg/dL, and HDL-C of >45mg/dL for men and >47 mg/dL for women. The results of this study demonstrate that the use of lovastatin is effective for primary prevention of coronary events and offers an alternative to higher priced, name brand medications, which can lead to cost savings in the long term.

Table 1: Cost of Statins

Generic	Brand	Strength	Cost*
Lovastatin	Mevacor®	10 mg	\$44.85
		20mg	\$79.10
		40mg	\$142.38
Rosuvastatin	Crestor®	5 mg	\$75.60
		10 mg	\$75.60
		20 mg	\$75.60
		40 mg	\$75.60
Atorvastatin	Lipitor®	10 mg	\$71.57
		20 mg	\$109.31
		40 mg	\$109.31
		80 mg	\$109.31
Fluvastatin	Lescol®	20 mg	\$53.42
		40 mg	\$53.42
Pravastatin	Pravachol®	Lescol XL® 80 mg	\$68.43
		20 mg	\$92.41
		40 mg	\$135.61
Simvastatin	Zocor®	80 mg	\$135.61
		5 mg	\$58.84
		10 mg	\$78.85
		20 mg	\$137.56
		40 mg	\$137.56
		80 mg	\$137.56

* Cost is based on AWP for once daily dosing of a statin over one month. AWP may not accurately represent actual pharmacy cost.

While sample medications can be provided free of charge to the patient, especially when initiating statin therapy, it is important to consider that either Medicaid or the patients themselves may eventually assume the cost of these higher priced medications. Using therapeutically equivalent generic drugs when possible is beneficial in terms of patient outcomes and economic savings.

References

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Schwartz GG et al. Effect of atorvastatin on early recurrent ischaemic events in acute coronary syndromes, the MIRACL study. J Am Med Assoc 2001; 285: 1711-18.

The Idaho Drug Utilization Review Program welcomes physician and pharmacist input. To offer suggestions and comments, please contact the DUR program.

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demonstrated the effectiveness of these agents in primary and secondary prevention of cardiovascular events. The Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III or ATP III) represents the most up-to-date clinical guidelines for cholesterol screening and management. According to these guidelines, patients with existing coronary artery disease, peripheral artery disease, or diabetes (a cardiovascular risk equivalent) are in the highest risk category for a coronary or cerebral vascular event and have a low-density lipoprotein (LDL) goal of <100 mg/dL. To achieve this goal, the guidelines recommend a combination of lifestyle modifications and oftentimes, drug therapy.

Despite these recommendations, many at-risk patients still go without lipid-lowering therapy. Studies have shown that less than half of high-risk persons who qualify for lipid therapy receive it, and only half of those patients prescribed therapy are still taking it six months later. Unfortunately, the results of a recent DUR database

analysis demonstrate that a substantial number of Idaho Medicaid high-risk patients who are candidates for lipid-lowering therapy are not receiving it.

As healthcare professionals, we often focus on and treat the most important conditions of our high-risk patients, such as glucose control in people with diabetes or beta-blocker therapy post MI. But sometimes we forget that all of our tools working together are needed to accomplish the ultimate goal. Although many drugs have been approved for reducing LDL levels, the statins are most effective and often the best tolerated. Trial after trial demonstrates the survival benefit of these agents, especially in high-risk patients.

The Idaho DUR Program encourages regular assessment of lipid levels in high-risk patients, statin therapy initiation when needed, and regular follow-up thereafter. These life saving drugs will only work if prescribed and taken. Now is the time to consider statin drug therapy for what it really is and not just as another tool in the shed.

