MaineCare Services
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
MaineCare Services
Pharmacy Unit
11 State House Station
Augusta, Maine 04333-0011
Tel. (207) 287-7131; Fax (207) 287-8601
Toll Free (866) 796-2463; TTY (800) 423-4331

TO: Maine Drug Utilization Review Board

DATE: 04/17/12

RE: Maine DUR Board Meeting minutes from 04/10/12

ATTENDANCE	PRESENT	ABSENT	EXCUSED
Robert Weiss, M.D., Cardiologist, Chair	X		
Laurie Roscoe, R.Ph., Vice Chair	X		
Amy Enos, Pharm. D. Waltz LTC Pharmacy	X		
Laureen Biczak, D.O., Infectious Disease, GHS			X
Lisa Wendler, Pharm. D., Clinical Pharmacy Specialist, Maine Medical CTR	X		
Lindsey Tweed, M.D., Psychiatrist	X		
Mark Braun, M.D., FACP, Internist/Geriatrician	X		
Mike Ouellette, R.Ph., GHS	X		
Rebecca M. St. Amand, R.Ph., Staff Pharmacist Community Pharmacy - Pittsfield	X		
Timothy Clifford, M.D., Family Practice, GHS			X
Kevin Flanigan, M.D., Internist, Medical Director, OMS		X	
Non –Voting			
Jennifer Palow, Pharmacy Manager, OMS	X		

Guests of the board: April Piirainen Pharm D. Candidate, Dr. Jeff Barkin

CALL TO ORDER: 6PM

PUBLIC COMMENTS

Mr. Craig Morgan URL- Would like the DUR Board to consider changing the PA requirements for Colcrys. Currently failure on therapeutic dose of Allopurinol is required in order to be approved for Colcrys. Colcrys is an alkaloid unlike Allopurinol and Uloric which it is grouped with. Allopurinol and Uloric are used to reduce

uric acid where Colcrys is used to manage pain from the acute gout flare or to be used in combination. From a pharmacological as well as from an indication point of view Colcrys should be grouped with the non-steroid anti-inflammatory and if a PA is going to be required it should be after an nsaid has failed or in contra indicated. The way the PA is set up right now it is not pharmacologically sound. Please consider amending the current PA process for this drug and do you have a time frame when this might be considered?

Dr. Weiss asked why the cost of this drug is so expensive.

Mr. Morgan responded that the FDA was going to pull the drug off the market so 17 different studies were done looking at genetics, drug to drug interactions, physiological aspects as well as changing the dosing regimen. After the studies were completed there was a short period of time when they have exclusivity.

Dr. Barkin asked was the generic available?

Mr. Morgan responded it was up until about a year ago then the FDA state was those supplies run out they aren't going to restock until the exclusivity runs out.

Dr. Barkin asked what is the difference between this formulation and the prior generic formulation.

Mr. Morgan responded that it is patented to being produced under different lighting, instead on white lighting it's produced under yellow lighting as well as its fillers are slightly different to reflect the sunlight.

OLD BUSINESS

DUR MINUTES

- March minutes were approved with no changes.

PSYCH WORK GROUP MONTHY UPDATE

Dr. Tweed stated they discussed some interest in finding out more information about the new laws regarding methadone treatment as well as following progress of the antipsychotic metabolic monitoring.

NEW BUSINESS

STATIN/LIPID UPDATE

Mr. Ouellette discussed the analysis that was completed on Coronary Heart Disease (CHD). The analysis was narrowed down to 417 members with CHD diagnosis, eligible between 1/1/2011 and 3/7/2012, no statin utilization, with other utilization between 1/1/2012 and 3/7/2012. Before letters are sent out to the providers Mr. Ouellette wanted to get feedback from the board as to should send out all 417 letters or should we somehow limit it further. If that's the case how should we do that; a sample of the 417 profiles and diagnosis were provided for review.

Dr. Weiss felt that looking at the profile and diagnosis was unnecessary. He expressed that no matter what other diagnosis the patients may have if they have CHD and are not on a statin the provider should get a letter.

Dr. Tweed agreed that it is a pilot program and we should send out all the letters. If we need to limit the number we could do it randomly.

After discussion between all board members it is agreed that they letters will be sent out the providers of the 417 members that were identified as having CHD.

Mr. Ouellette added that at the next meeting he will provide preliminary results.

ANTIPSYCHOTIC METABOLIC MONITORING UPDATE

Dr. Barkin discussed an analysis of atypicals by county for calendar years 2008-2011 looking at lipid and blood sugar testing in age bands 0-18, 19-44, 45-64, 65 and up. By breaking it into county we are able to see to surprisingly that the southern counties have less monitoring then counties that would be considered to have more remote access to monitoring. Looking across all of the data the good news that people are doing it the bad news is that they aren't doing it enough. Our goal in doing this is the increase monitoring and to do this at a time to be helpful in the transition of medications going generic. In the future, it would be great to be able to send out reports to providers with patient level detail. This could be very useful to prescribers as well as to medical directors to be able to see prescribers are doing the appropriate monitoring.

Dr. Weiss commented that in looking at the data the testing in the age group 45-65 is almost double then the age group 19-44 across the counties. Is that because people worry more in the older age group?

Dr. Tweed answered that it may be because in the age group 19-44 considered more unstable.

Dr. Braun asked if the information can be broken down further by provider.

Dr. Barkin answered that yes the information can be drilled down much further but for this initial data pull the goal was just to see composite sense of the data.

Dr. Weiss asked what percentages of people are being treated by a psychiatrist or primary care provider.

Dr. Tweed answered in general state wide for adult 60% primary care and 40% psychiatrist and for children 92% psychiatrist 8% primary care.

Dr. Weiss felt that comparing primary care and psychiatrist to the lipid and blood sugar testing would be helpful to find out which groups of prescribers are doing the monitoring.

Dr. Barkin agreed that this would be good data to pull.

Dr. Tweed asked with the intervention of the PA requirement in place will we be able to tell how much of an effect this has.

Dr. Barkin answered yes.

Ms. Piirainen spoke about the responses that have come in thus far.

- Response Rate
    - 516 Total Forms
    - 148, 29% Returned
    - 368, 71% Not Returned
- Patient taking an atypical antipsychotic
    - 62% Yes
    - 32% No
    - 5% No longer patient there
    - 1%
- Results
    - 47% Plan to perform requisite monitoring within 8 weeks
    - 46% Have performed and submitted necessary monitoring
    - 5% No response
    - 2% Have **not** performed any testing on patient
- Of the 42 that checked they submitted the necessary information
    - 21, 50% Submitted some information
    - 12, 29% Submitted all required information
    - 9, 21% Submitted **no** information

OSTEOPOROSIS PREVENTION IN STEROID USERS UPDATE

Mr. Ouellette discussed the analysis that was done at the request of the DUR Board to further break down if members on chronic Oral Steroids are taking Calcium and Vitamin D. The analysis is divided by age, gender and day supply of steroids.

Dr. Weiss stated that it is hard to get accurate data because Vitamin D and Calcium can be purchased over the counter

After discussion between all board members it is agreed that an educational piece on the importance of Calcium and Vitamin D supplementation for patients on steroids should be put out in the quarterly newsletter.

The Board also discussed whether a joint effort with data, either requesting MHDO data or partnering with Martin's Point or Anthem for commercial data. This will be reviewed as a potential collaboration in the future.

POTENTIAL DRUG DDI UPDATES

1. **Inlyta**-
    a. DDI: Recommended to be non-preferred; however, perhaps adding a note on the PDL regarding the DDI when used concomitantly with a strong CYP3A4/5 inhibitor (such as ketoconazole) should be avoided. ALSO, if the combination of a strong CYP3A4/5 MUST be used with Inlyta, the Inlyta dose should be reduced by 1/2.
    b. The concomitant use of strong CYP3A4/5 inducers (such as rifampin, phenytoin, carbamazepine) should be avoided.

2. **Bydureon**:
    a. Although non-preferred, would recommend specifying Dose limits of 1 injection per week (4/28 days).
    b. NOT recommended as 1st-line therapy

3. **Celexa/Citalopram:**
    a. Citalopram is not recommended for use at doses greater than 40 mg per day because such doses cause too large an effect on the QT interval and confer no additional benefit.
    b. Citalopram is not recommended for use in patients with congenital long QT syndrome, bradycardia, hypokalemia, or hypomagnesemia, recent acute myocardial infarction, or uncompensated heart failure.
    c. Citalopram use is also not recommended in patients who are taking other drugs that prolong the QT interval.
    d. The maximum recommended dose of citalopram is 20 mg per day for patients with hepatic impairment, patients who are older than 60 years of age, patients who are CYP 2C19 poor metabolizers, or patients who are taking concomitant cimetidine (Tagamet) or another CYP2C19 inhibitor, because these factors lead to increased blood levels of citalopram, increasing the risk of QT interval prolongation and Torsade de Pointes.

After discussion between all board members the proposed DDI's were agreed upon. It was suggested that on Celexa to include a common list on CYP2C19 inhibitors for the physicians. It was also decided that another important point to highlight is that patients older than 60years of age have the maximum recommended dose of Celexa 20mg/day.

ADJOURNMENT: 8PM

- The next meeting will be held on May 8, 2012.