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

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TO: Maine Drug Utilization Review Board
DATE: 01/17/2013
RE: Maine DUR Board Meeting minutes from 1/8/13

ATTENDANCE	PRESENT	ABSENT	EXCUSED
Robert Weiss, M.D., Cardiologist, Chair	X		
Amy Enos, Pharm. D. Waltz LTC Pharmacy	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		
Steve Gefvert, D.O.	X		
Lourie Paul, NP	X		
Linda Glass, M.D.	X		
Non –Voting			
Jan Yorks-Wright, Pharmacy Supervisor, OMS	X		
Kevin Flanigan, M.D., Internist, Medical Director, OMS			X

Guests of the board:

CALL TO ORDER: 6PM

PUBLIC COMMENTS

William Barker from Genzyme- Here to present Aubagio is a pyrimidine synthesis inhibitor indicated for the treatment of patients with relapsing forms of multiple sclerosis. Aubagio is a film-coated tablets in 7mg or 14mg strengths given once daily with or without food. The most common adverse effects with Aubagio are diarrhea, influenza, nausea and paresthesia. Aubagio has two boxed warnings the first is Hepatotoxicity including fatal liver failure the second boxed warning is risk of teratogenicity. This is based on animal data,may cause major birth defects if used during pregnancy which gives it a pregnancy category X. In conclusion Aubagio is a new once daily agent for patients with relapsing forms of multiple sclerosis.

Dr. Weiss asked are there are any studies comparing it to another active agent?

Mr. Barker answered that we do have one trial comparing it to Rebif and that showed that at the end of one year there was a numeric difference in the relapse rate with some superiority to the interferon product. However it is complicated because there was a higher rate of dropout with the interferon product. So from the standpoint of tolerability Aubagio was shown to be more tolerable, from the standpoint of relapse it was not shown to be superior to interferon.

Ann Birner from Astellas- Here to present Enzalutamide brand name Xtandi. It is an androgen receptor inhibitor indicated for the treatment of patients with metastatic castration-resistant prostate cancer who have previously received docetaxel. The recommended dose of Enzalutamide is 160mg (four 40 mg capsules) administrated orally once daily. Can be taken with or without food and should be swallowed whole. Weight and age do not have a clinical meaningful influence on Enzalutaminde exposure. No overall differences in safety or effectiveness were observed in a randomized clinical trial in the subset of patients who are over the age of 65 years. But the greater sensitivity of some older patients cannot be ruled out. Enzalutamide is pregnancy category X. Therefore it is contra indicated for women who are or may become pregnant. The safety and efficacies in pediatric patients has not been established for Enzalutaminde. In the affirm trail a total of 1199 patients were randomized and double blind to receive 160 mg on Enzalutamide or placebo one daily. All patients continued with androgen deprivation, they were allowed but not required to continue or initiate glucocorticoids. A preplanned interim analysis showed a statically significant improvement in overall survival on Enzalutaminde compared to the placebo with a median overall survival of 18.4 and 13.6 months respectably. The product label includes a warning, not a boxed warning, regarding seizers which occurred in 0.9% of patients receiving Enzalutaminde. There is no clinical trial experience with Enzalutaminde in patients who have had a seizure, in patients with predisposing factors for seizure, or in patients using concomitant medications that may lower the seizure threshold. For drug to drug interactions avoid strong CYP2C8 inhibitors, as they can increase the plasma exposure to Enzalutaminde. If co-administration is necessary, reduce the dose of Enzalutaminde. Avoid strong or moderate CYP3A4 or CYP2C8 inducers as they can alter the plasma exposure to Enzalutaminde. Avoid CYP3A4, CYP2C9 and CYP2C19 substrates with a narrow therapeutic index, as Enzalutaminde may decrease the plasma exposures of these drugs. If Enzalutaminde is co-administered with warfarin (CYP2C9 substrate), conduct additional INR monitoring. The most common adverse reactions (≥ 5%) are asthenia/fatigue, back pain, diarrhea, arthralgia, hot flush, peripheral edema, musculoskeletal pain, headache, upper respiratory infection, muscular weakness, dizziness, insomnia, lower respiratory infection, spinal cord compression and cauda equina syndrome, hematuria, aresthesia, anxiety, and hypertension.

Kylie Paulson from Bristol Meyer Squid- Here to present information on Orencia for Rheumatoid Arthritis. Both the intravenous and subcutaneous are indicated for moderately to severely active RA in adults. Orencia IV is also indicated for moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 6 years of age and older. ORENCIA may be used as monotherapy or concomitantly with methotrexate. Orencia is a first line biologic you do not need to fail other biologics or anti-TNF agents prior to its use. Orencia has a unique mechanism of action; it's different than any other RA biologic on the market. It's a selective T-cell co-stimulation modular and leads to inhibition of pro inflammatory cytokines that are detrimental to RA. These include TNF and MMP and CRP. It's the only current biologic that comes in two formulations both intravenous and subcutaneous. This allows the prescriber and patient to choose what the best treatment option is for the patient based on their

lifestyles. It also may address compliance issues. With Orencia there is no dose escalation the subcutaneous is a fixed dose 125mgs per week the IV is weight based dose of approximately 10mg per 1kg. The efficacy has been studies extensively in trails with over 1400 patients. Looking at the safety and tolerability of Orencia it's remained unchanged in the full prescribing information over time. There is no black box warning. When you look at real world health outcomes data it has shown that when Orencia is used as the first or second biologic used retain really high retention rates.

Carl Possidente from Pfizer- Here to present information on Xejanz, an inhibitor of Janus kinases (JAKs), is indicated for the treatment of adult patients with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to methotrexate. It may be used as monotherapy or in combination with methotrexate or other nonbiologic disease-modifying antirheumatic drugs (DMARDs). XELJANZ should not be used in combination with biologic DMARDs or potent immunosuppressants such as azathioprine and cyclosporine. Xejanz does have a Boxed Warning of serious infections and malignancy. The recommended dose of XELJANZ is 5 mg twice daily given orally with or without food. The dose of Xejanz should be reduced to 5 mg once daily in patients: with moderate or severe renal insufficiency with moderate hepatic impairment receiving potent inhibitors of Cytochrome P450 3A4 (CYP3A4) (e.g., ketoconazole) receiving one or more concomitant medications that result in both moderate inhibition of CYP3A4 and potent inhibition of CYP2C19 (e.g., fluconazole). Serious and sometimes fatal infections due to bacterial, mycobacterial, incasize fungal,viral, or other opportunistic pathogens have been reported in rheumatoid arthritis patients receiving Xeljanz. The most common serious infections reported with Xeljanz included pneumonia, cellulitis, herpes zoster and urinary tract infection. Xejanz is a Janus kinase (JAK) inhibitor. JAKs are intracellular enzymes which transmit signals arising from cytokine or growth factor-receptor interactions on the cellular membrane to influence cellular processes of hematopoiesis and immune cell function. Within the signaling pathway, JAKs phosphorylate and activate Signal Transducers and Activators of Transcription (STATs) which modulate intracellular activity including gene expression. Xeljanz clinical development program included two dose-ranging trials and five confirmatory trials.

Dr. Weiss why should we use Xejanz over a biologic?

Mr. Possidente answered that one unique aspect is that it is an oral product.

Ann Woloson from Prescription Policy Choices a nonprofit, nonpartisan organization with the goal of improving access to effective, safe and affordable prescription drugs in Maine. I would like to bring to your attention a report released last year by Kaiser Commission on Medicaid and the Uninsured, The Role of Clinical and Cost Information in Medicaid Pharmacy Benefit Decisions: Experience in Seven States. Today I would like to ask that DUR board consider adding a consumer representative to this board. As you can see, from the handout that was provided three out of the seven states had at least one consumer representative.

Justin Bakhshai from Novo Nordisk - Here to discuss Diabetes and Novo Nordisk product Victoza. A common asked question when reviewing medications is where are the head to head comparisons? Victoza has been studied head to head against insulin, Sulfonylurea, Byetta, and DDP-4 Inhibitor Januvia. For a detailed review I will direct you to the label. I would like to point out a few points. Twice as many patients with Victoza are reaching goal compared to Januvia. Similar incidences of minor hypoglycemic events, significant less weight gain and higher incidences GI adverse effect. Also we are looking at cost effectiveness, what we are doing is adjusting cost based on outcomes. In conclusion, whenever the

board has the opportunity I would appreciate the consideration of Victoza to be added to the preferred side of the PDL.

Brian Denton from Pfizer- Here to discuss Bosulif, it's a kinase inhibitor indicated for the treatment of adult patients with chronic, accelerated, or blast phase Ph+ chronic myelogenous Leukemia (CML) with resistance or intolerance to prior therapy. The recommended Dose: 500 mg orally once daily with food.

Dr. Weiss asked if this medication is thought to be a second line indication.

Mr. Denton answered that the current indication for Bosulif is a second line agent or third line for CML patients.

OLD BUSINESS

DUR MINUTES

November minutes were approved.

PSYCH WORK GROUP MONTHY UPDATE

No comments made

NEW BUSINESS

SUBOXONE LIMITS UPDATE

Mr. Ouellette explained that new Suboxone edit that was put into place as of January 1st. Suboxone has a 24month lifetime limit. The state sent the members and provides letters letting them know either that they are over the 24month limit or will be soon. These letters were sent out in November to allow the prescriber time to submit a prior authorization if continuing treatment is needed. As of this date we have sent out 1400 letters to members of that about 700 were past the two year limit. So far we have received approximately 400 PA request. The new PA forms are posted on the mainecarepdl.com web site.

Dr. Braun asked if the 24 month limit is a "hard limit".

Mr. Ouellette answered that they have the option of sending in a PA.

Dr. Barkin added that the hope is that this will drive the dose down.

Dr. Braun asked if we accept disagreements between the providers and the decisions being made on the PA's.

Mr. Ouellette answered that he doesn't think so because Dr. Flanigan has been in touch with prescribers giving them the guidelines of the PAs.

OPIATE LIMIT UPDATE

Mr. Ouellette explained that the new opiate limits are you can get 15 days of opiates without a PA per calendar year. After the first 15 days you can get up to three PA's of 14 days supplies each. Nursing home patients, Cancer, Hospice and HIV/ADIS patients are all exempt from the limits. Also we are going to incorporate a Morphine Sulfate Equivalent that if it is under 30 MSE's then it will go through. The state will be posting the MSE chart on the web site.

COUNTY DATA REVIEW

Mr. Ouellette explained that another analysis was done looking at the same three counties Oxford, Cumberland and Aroostook. In this analysis we looked more into the prescribers and their specialties as well as percentage of those that had each diagnoses.

Dr. Barkin added that this is done over a span of a year. So the antibiotic may not be linked the episode of when the patient had the diagnosis of for example bronchitis. Dr. Barkin's suggestion is to link the diag and the medication closer together. For example, if the patient is diagnosed with bronchitis look within 14days of that to see if an antibiotic is being filled.

Dr. Weiss asked if that was something that was able to be done.

Mr. Ouellette answered yes.

Dr. Braun felt that he found it hard to find useful data from this.

Mr. Weiss stated that looking at this would be interesting to see if doctors are over using antibiotics and that is why they are no longer working as well.

Mr. Ouellette added that the CDC just recently sent out information on antibiotic use. We will be sending out newsletters again it may be worth putting the CDC information in that.

Dr. Weiss said that when we dig into this farther it may be that some areas are seeing more patients then another and that might be why some areas or prescribers are higher.

BENZO AND STIMULANT UNTILIZATION

Dr. Barkin discussed an analysis that was done to look at co-prescribing Benzodiazepines, Stimulants and Opiates with a 60day overlap. The analysis is looking at benzodiazepines and stimulant by state fiscal year (SFY) and age ban. Benzodiazepines and stimulants being co-prescribed in 2007 the total was 661 and in 2012 the total was 1,834 that's a 300% increase. Then it was looked at benzodiazepine, stimulants, and Opiates in 2007 the total was 173 and in 2012 the total was 506 again another significant increase. Next we decided to look at prescribers that were co-prescribing both

Benzodiazepines and stimulants. The number one prescriber for SFY 2012 was also number one for 2011 and 2010. Dr. Barkin did call the individual based off this information. The individual is a psychiatrist and the uses of these drugs are not really justifiable. The provider understands this and understands why it might not be the best idea. The second highest prescriber for SFY 2012 is also a psychiatrist and Dr. Barkin also spoke with the providers. What was interesting is that most of the use makes sense. It shows that you do have to drill a little bit more detail. What Dr. Barkin would like to suggest is to send letters to the top 10% of prescribers informing them that we are doing these analysis and what the average numbers of co-prescribing and where they are compared to their peers.

Dr. Braun is okay with sending out letters but really would like it to be positive because my response to this would be what I can do to make it better.

Dr. Barkin answered that he will draft up a letter for the DUR board to review and then decide who to send it out to. It may end up in doing chart reviews of the extreme outliers.

Mr. Ouellette asked will we be splitting apart family practice verse psychiatrist.

Dr. Weiss stated that the board will look more into this next meeting when we have a draft of the letter to providers to look at.

NEW DRUG REVIEWS

Aubagio common name teriflunomide in the PDL category Multiple Sclerosis- Non Interferons the recommendation is for it to be Non-Preferred.

Dr. Weiss stated that he agrees that it should be Non-Preferred but what needs to be in place in order for the PA to be approved.

Mr. Ouellette answered that we will discuss PDL criteria at our next meeting.

Bosulif common name Bosutinib in the PDL category Cancer the recommendation is Non-Preferred.

Linzess common name linaclotide in the PDL category GI-Miscellaneous the recommendation is for it to be Non-Preferred.

Mr. Ouellette stated that currently we aren't see any comparative studies to supportive that is more efficacies or safer.

Stivarga common name regorafenib in the PDL category Cancer the recommendation is Non-Preferred.

Mr. Ouellette added that this is a film coated tablet.

Xeljanz common name toacitinib in the PDL category Rheumatoid Arthritis the recommendation is Non-Preferred.

Mr. Ouellette added that it is an immediate release film coated tablet.

Xtandi common name enzalutamide in the PDL category Cancer the recommendation is Non-Preferred.

Lorzone common name chlorzoxazone in the PDL category Muscle Relaxants the recommendation is Non-Preferred

Binosto common name alendronate sodium in the PDL category Osteoporosis the recommendation is Non-Preferred

All recommendations were voted and passed.

ADJOURNMENT: 8PM

The next meeting will be held on February 12, 2013 between 6 to 8 p.m.