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
Toll Free (866) 796-2463; Fax: (207) 287-8601
TTY Users: Dial 711 (Maine Relay)

TO: Maine Drug Utilization Review Board
DATE: March 14, 2014
RE: Maine DUR Board **Meeting** minutes from March 11, 2014

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. Thibodeau, R.Ph., Staff Pharmacist Community Pharmacy – Pittsfield- Co-Chair			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
Roger Bondeson, Director of Operations, OMS	X		

Guests of the Board: Laureen Biczak, DO, Jeffrey S. Barkin MD, DFAPA

CALL TO ORDER: 6PM

PUBLIC COMMENTS

Ronald Jones from AstraZeneca here to discuss Farxiga. FARXIGA is part of a newer class of medicines called sodium-glucose cotransporter 2 (SGLT2) inhibitors, which remove glucose via the kidneys. They did extensive studies; it's been study in 10,000 people before coming to market. It not only is good for blood glucose but it helps with weight loss and lowering blood pressure in that regard it has a nice profile. The most common adverse reaction associated with Farxiga was female genital mycotic infections, nasopharyngitis and urinary tract infections.

Barry Patel from GlaxoSmithKline here to give an overview of Anoro Ellipta.In December it was approved for long-term, once-daily, maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD). The unique aspect of Anoro Ellipta making it a first class drug is a dual bronchodilator it's a combination of umeclidinium, an anticholinergic, and vilanterol, a long-acting beta$_2$-adrenergic agonist (LABA). Mr. Patel reviewed some of the clinical and primary ends points from four pivotal studies. There were three head to head studies done and across all head to head studies we saw greater lung function with Anoro Ellipta.

Dr. Weiss asked how is this medication any different from combivent.

Mr. Patel asked that Anoro Ellipta is a once a day dosing and it is suggested that only have to use one inhaler is better than using two inhalers or multiple inhalers.

OLD BUSINESS

DUR MINUTES

The February 11, 2013 minutes were approved.

PSYCH WORK GROUP MONTHY UPDATE

No update at this time

NEW BUSINESS

ADURS UPDATE

Mr. Ouellette updated the board on topics discussed at ADURS. As you look through the handout provided you will see many of the topics and concerns that the board has discussed over the years. Some examples are the new Hepatitis C and Oncology medication that are coming out as well as how new federal updates in regards to legislative policy that will have an impact on Medicaid.

Dr. Tweed asked if there was anything that Mr. Ouellette found of interest for Maine.

Mr. Ouellette answered that they are all so different some states are able to put hard limits; some states have legislative restriction that some categories the DUR cannot make changes. Many states borrow ideas from one another.

SOVALDI CRITERIA UPDATE

Dr. Biczak presented the proposed Sovaldi criteria. The criteria will be very aggressive and is a result of looking at the guidelines, literature, reviewing what other states are doing and taking into consideration of the cost to the state. The first page is a variety of requirements: evidence of a Hep C diagnosis,

treatment regimen has been prescribed by or based on a documented consult that included a recommendation for the requested treatment by a gastroenterologist, hepatologist, infectious disease specialist or other practitioner specializing in the treatment of hepatitis. Consult must be within the year prior to request and include a recommendation for the requested therapy and be attached. Several requirements are regarding women of childbearing years requiring the use of effective non-hormonal contraception and documented pregnancy test. Sovaldi will only be dosed at 400mg once daily. Sovaldi will be added to the 15 day limit list and compliance will be required in order to continue treatment. For most patients genotype 1,3,4,5 or 6 the preferred regimen will be Sovaldi 84days plus PEG/IFN plus ribavirin. If prior treatment with PEG/IFN plus a protease inhibitor (boceprevir or telaprevir) with null or partial response, plan must be to continue PEG/IFN for an additional 12 weeks (24 weeks total). All the criteria will be public once approved and set into place. It is primarily following the guidelines but where we strayed is where the data and efficacy rate it made more sense for Medcaid to spend that money elsewhere.

Ms. Wendler asked if there was a reason that we couldn't do a 7 day initial script. Dr. Braun concurred if this was possible.

Dr. Biczak answer that we had talked about it however it is very difficult for those to get to the pharmacy that many times within the first month.

Dr. Barkin added that you really have to weigh compliance as well.

Dr. Biczak added another reason to have it be 14day rather than 7day is that patients are also taking interferon's and may stop taking it for a day or two while they get care for that. If they need to be seen it's hard for them to get in within a week. Some states are only allowing 14 day fills.

Dr. Braun stated that he would go for that too because this is a huge amount of money.

Motion was made to accept the Sovaldi criteria.

The board voted on the criteria and it passed.

Next a motion was made to have it be a 7day fill, 7day fill followed by a 14day fill and 28days thereafter.

The board voted and passed the above motion.

LYME DISEASE AND ANTIBIOTIC USE UPDATE

Dr. Weiss stated that the reason that the board is looking into this is because it was found a tremendous disparity of how long and with what medication prescribers are treating Lyme disease.

Dr. Biczak stated that GHS looking into this what we would like to propose is to require a Pa for any member on an anti-infective drug for more than 12 weeks in any running year (consecutive or not). Including antibacterial and antiparasitic agents on members only 22-64 years of age and excluding antivirals and antifungals, those with an acne or HIV diagnosis, and exclude Macrodantin as it is frequently used for UTI. If we did this for the current people in our system we would be doing 190 PAs.

Dr. Braun asked if the system in capable of doing this.

Dr. Biczak answered yes.

Dr. Weiss added that it was a completely reasonable proposal.

CHOLESTEROL ANALYSIS

Dr. Weiss stated that last meeting there was discussion on the new cholesterol guidelines for those of you unaware of what those are they are no longer looking for a numeral LDL level. They only require that a high potency drugs are being used depending on what the diagnosis. Looking at distinct eligible members with diagnosis of CAD, PAD, DM or Stroke and total of 25,677 only 7,736 are on the recommended Atorva 40MG or 80MG or Rosuva 10MG, 20MG or 40MG. The analysis also broke it down by diagnosis only 24% are following the recommendation with the stroke diagnosis.

Dr. Braun asked is the entire MaineCare population of a certain age bracket.

Dr. Weiss answered it is the entire MaineCare population excluding the dual eligible.

Ms. Wendler asked if we could send out an educational newsletter to make providers more aware of the new guidelines.

Dr. Weiss answered that he would rather pick the top ten prescribers and send them a letter.

Dr. Braun stated that we have had a better effect when we have done personal contact is that something that could be done.

Dr. Biczak and Dr. Weiss stated that with the amount of prescribers it was not be possible.

Dr. Weiss added that we could look at the top ten offended and send them a letter and then he would call them.

Dr. Biczak asked if we can break this down by prescriber.

Mr. Ouellette asked how does zetia play into this.

Dr. Weiss stated that it doesn't play a big enough role to worry about it.

Dr. Braun asked Dr. Weiss if he saw any DDI issues.

Dr. Weiss answered no.

BENZO/ STIMULANT/OPIATE UPDATE

Dr. Barkin presented the board with a detailed analyst of patients being prescribed chronic benzos/Stimulants/opiates. This was done by breaking it into two groups one with patients on benzo/stimulants/opiate or benzo/stimulant and suboxone as the opiate. These show that the medications are being prescribed by different providers. This leads to the question to the board is a clinical reason for a patient to be on all three medications.

Dr. Braun answered that he imagined that it is possible that it might be valid in a few cases.

Dr, Barkin suggested that we put a PA in place that once the third one of these medications tries to be filled a PA would be require.

Dr. Tweed stated that another one of the reasons that we started looking at this was because the combination of drugs there is a high risk of diversion.

Dr. Barkin added that the prescribers are across the board no rhyme or reason.

Mr. Ouellette added also this is chronic use not for the acute need for example broke bone, tooth ache.

Dr. Weiss stated that the motion in front of the board is to require a PA form members when the third drug hits.

Mr. Ouellette stated that we do not need to create a new PA from doctors can use the Misc. form. However, we will need to come up with criteria to put on the PDL outlining the requirements.

Dr. Biczak stated that if it is done when the third drug hits you will get a much larger number because you will get the short scripts for acute pain.

Dr. Barkin agreed that it should be either after 30 or 60 days of overlap.

Mr. Ouellette stated that he will need to bring it back to the board next month after reviewing if and how the programming would work.

Mr. Ouellette stated that in talking about opiates provided in the packets to the board if a presentation that Dr. Flanigan put together in regards to the impact of the MaineCare Pain Management policy. This showed that after putting in the 15day limits and PA requirements after that we have been able to bend the curve.

Dr. Barkin added that in doing the PA we did not just deny them we were looking for correct diagnosis, contract, urine screens, pill count and alternative treatment.

ASTHMA MANAGEMENT-OVER AND UNDER UTILIZATION

Tabled until next month

NEW DRUG REVIEWS

Anoro Ellipta common name umeclidinium & vilanterol in the PDL category Antiasthmatics- Adrenergic Anticholinergic the recommendation is for it to be non- preferred.

Farxiga common name dapagliflozin in the PDL category Diabetic-Other the recommendation is for it to be non-preferred.

Velphoro common name sucroferric oxyhydroxide in the PDL category Phosphate Binders the recommendation is for it to be non-preferred.

Mr. Ouellette stated the recommended starting dose is 500mg TID with meals. The average patient takes 3-4 tablets a day to control phosphorus levels, with the highest dose studied being 6 tablets per day.

Zohydro ER common name hydrocodone bitartrate extended-release in the PDL category Narcotics, Long-Acting the recommendation is for it to be non-preferred.

The board voted and passed all the above recommendations.

ADJOURNMENT: 6PM

The next meeting will be held on **April 08, 2014**, 6:00p.m. – 8:00p.m at the Armory.