

**Iowa Medicaid Drug Utilization
Review Commission
Annual Report of Activities**

**Fiscal Year End 2009
(July 2008-June 2009)**

**Prepared for
Department of Human Services
By Goold Health Systems**

**Submitted by
Pamela Smith, R.Ph., Project Coordinator
Iowa Medicaid Drug Utilization Review Commission**

October 1, 2009



IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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September 15, 2009

Andi Dyksra, RN
Senior Director
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Dear Andi:

On behalf of the Iowa Medicaid Drug Utilization Review Commission, I am enclosing the Annual Report for the state fiscal year ending 2009. The Commission realized an overall direct cost savings of \$0.86* for every dollar spent on the program administratively. State money for this program is matched by the federal government at a 3 to 1 ratio (federal to state), so savings can also be stated as \$3.44* per state dollar spent.

Due to the transition to Goold Health Systems as the new DUR vendor, data for the patient-focused reviews were incomplete. This is reflected in the low numbers for profiles available for evaluation and the savings estimate.

Total annualized cost savings estimates (\$230,890.28) and savings from patient-focused reviews (\$114,357.25*) and problem-focused reviews (\$117,533.03*) while substantial, were decreased from state fiscal year ending 2008. This was largely due to the transition in vendors which resulted in incomplete information being transferred relative to patient-focused reviews.

Five problem-focused reviews were evaluated in state fiscal year ending 2009. One of the five problem-focused studies included a recommendation to add a drug to the member's medication regimen. The remaining problem-focused studies focused on duplicate therapy and chronic use of medications used to treat acute conditions.

In state fiscal year ending 2009, the Commission reviewed all prior authorization criteria and made recommendations to the Department of Human Services on categories as well as adding one new category. Three newsletters were distributed to the Medicaid provider community. The Commission met eight times during the state fiscal year, and reviewed over 2,500 profiles.

Further details of the Commission's activities during this state fiscal year are available in the enclosed Annual Report. A copy of this report was delivered to Susan Parker, Pharm.D., with the Department of Human Services on September 15, 2009.

*Savings reported are pre-rebate, total dollars

If you have any questions regarding this report or would like to discuss any part of it, please call me.
Thank you for the opportunity to contribute to this program.

Sincerely,

A handwritten signature in black ink that reads "Pamela Smith R.Ph." The signature is written in a cursive style with a large initial 'P'.

Pamela Smith, R.Ph.
FYE 2009 DUR Project Coordinator

enclosure

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The Iowa Medicaid Drug Utilization Review Commission

Goold Health Systems has developed the following report for the Iowa Department of Human Services. This report provides a summary description of the activities of the Iowa Medicaid Drug Utilization Review Commission, along with an evaluation of the Iowa Medicaid retrospective drug utilization review program. Information contained in this report covers projects completed and evaluated during the time period of July 2008 through June 2009.

Background Information

Established in 1984, the DUR Commission is charged with promoting the appropriate and cost-effective use of medications within the Iowa Medicaid member population. Acting as a professional advisory group, the Commission analyzes medication utilization by the members of Iowa Medicaid and performs educational initiatives to optimize member outcomes. The Commission performs retroDUR and educational outreach through patient-focused reviews and problem-focused reviews. The Commission supports the proDUR program through criteria review and acts as a resource to the DHS on other issues concerning appropriate medication use.

Patient-Focused Reviews

Patient-focused reviews are completed with the review of 300 member profiles at each meeting (eight times annually). The DUR subcontractor generates these profiles through a complex screening process. The first step of the screening process subjects member profiles to a therapeutic criteria screen. If a profile is found to have failed one or more therapeutic criteria, the member profiles are then assigned a level of risk based on their medication history and potential for adverse events regarding medication. The profiles with the highest level of risk are then selected for the Commission to review. Six months of prescription claims data and medical claims data, if available, are assessed to determine this risk factor.

The member profiles selected from this process are manually reviewed by the Commission to minimize false positives generated by the computer selection process. The Commission identifies situations where educational intervention might be appropriate. Through these interventions, suggestions regarding medication therapy are communicated to the care providers. Templates are developed for suggestions that are frequently communicated to providers. The reviewer may also author an individualized suggestion if a template suggestion is not applicable. These template suggestions are located in the tab labeled Therapeutic Recommendations.

Educational interventions are generally done by letters to prescribers and pharmacists, but may also be done by telephone or in person. The suggestions made by the Commission are educational and informative in nature. Suggestions may be classified as either therapeutic or cost saving in nature. In addition, these suggestions are classified by problem identified for reporting purposes. The classifications are as follows:

- Not Optimal Drug
- Not Optimal Dose
- Not Optimal Duration
- Unnecessary Drug Use
- Therapeutic Duplication
- High Cost Drug

- Drug-Drug Interaction
- Drug-Disease Interaction
- Adverse Drug Reaction
- Patient Overuse
- Patient Underuse
- Therapeutic Alternative
- Missing Drug Therapy
- Not Optimal Dosage Form
- Potential Generic Use
- Inappropriate Billing

Suggestions are intended to promote appropriate and cost-effective use of medications. When suggestions result in cost savings, these savings are calculated based on decreased cost of medications. However, several of these classes of interventions are intended to increase the use of medications. Examples are member underuse and missing drug therapy. In these cases, the addition of medication therapy will increase medication expenditures, but will be beneficial to the member and should result in cost savings in medical services and/or improved quality of life. Cost savings in these situations cannot be calculated due to data limitations. Therefore, these suggestions are considered to have a positive impact on the program with no medication cost savings. Cost savings on medical services are assumed however not calculated.

Providers are invited to respond to the Commissions' suggestions and to request additional information from the Commission. Responses are voluntary and response rates are calculated for prescribers and pharmacists.

Once a member's profile is reviewed, it is excluded from the selection process for nine months to eliminate repeat selections. After this waiting period, the current profile for each member is generated and reviewed to determine if the Commission's suggestion was implemented. If so, fiscal considerations resulting from that change are also calculated. The policy regarding these calculations is included in Appendix B.

Problem-Focused Reviews

Problem-focused reviews narrow the emphasis of review to a specific issue that has been determined to be an area where a targeted educational effort to providers may be valuable. Topics for review are selected from findings of patient-focused reviews or from reviews of medical literature. Criteria are developed to identify the members who may benefit from intervention and educational materials are disseminated to their providers. Providers are encouraged to voluntarily respond. The member profile is generated again in an appropriate amount of time (typically 6 to 9 months) to determine the impact rate of the intervention, along with any fiscal considerations. The policy regarding these calculations is also included in Appendix B.

Administrative Review

The Commission will review utilization data and medical literature to make recommendations to the Department of Human Services (DHS) regarding policy issues. These recommendations are made to promote the appropriate use of medications and positive member outcomes. Recommendations are made at the request of the DHS or at the Commission's discretion. All authority to accept or reject DUR Commission recommendations lies with the DHS. The Commission may make recommendations but does not make policy. Primary areas for recommendations include proDUR, drug prior authorization (PA), coverage of medications, and administrative and billing procedures. The prospective drug utilization review (proDUR) system is currently administered by Goold Health Systems (GHS) and was implemented statewide in July 1997. The Commission reviews the criteria utilized by GHS and provides input regarding therapeutic validity. Special attention is given to eliminating false positive messaging.

The Commission recommends new or updated guidelines for use in the drug prior authorization program. This process is based on reviews of medical literature in addition to comparisons with other public and private sector programs. Input from providers outside the Commission, particularly specialists, is often sought when developing these guidelines. Once developed, the guidelines are sent to the medical and pharmacy associations in the state for comments. After considering these comments, a final recommendation is made to the Department. The Department may or may not accept the recommendation or may alter the recommendation. These guidelines are then subject to the administrative rules process prior to any policy implementation.

The Commission also makes recommendations regarding coverage of medication or devices. As most coverage requirements are defined by OBRA '90, these recommendations generally encourage coverage of optional services. An example would be the coverage of select over-the-counter medications. If the Department accepts the Commission's recommendation, the proposed coverage change is subject to the administrative rules process prior to implementation.

The Commission reviews pharmacy claims with respect to administrative procedures. Situations where funding for medication can be obtained from other sources are relayed to the Department for their action. For instance, Medicare will pay for immunosuppressive medications for transplant patients and nebulizer solution for dual eligible patients. The Commission also identifies situations where the Department may recover funds from inappropriate billing.

Overall Results

Activities of the Commission were evaluated during the fiscal year ending 2009 for interventions performed in the previous or the current fiscal year. The direct cost savings from all activities of the Commission are calculated to be \$231,890.28*† which equates to \$0.86*† for every \$1.00 of combined federal and state dollars spent administratively. This calculation is based on estimates regarding two types of reviews: patient-focused reviews and problem-focused reviews. These results are also found in Appendix C.

Cost Savings Estimate	\$231,890.28*†
Cost of the Program (state and federal dollars)	\$270,000.00
Net cost Savings Estimate	(\$38,109.72*†)
Savings per Total Dollar Spent (state and federal)	\$0.86*†
Savings per State Dollar Spent	\$3.44*†

Patient-focused reviews resulted in \$114,357.25*† in direct cost savings, or \$323.04*† per patient evaluated. This estimate is based on the 407† suggestions made by the Commission identified from the review of the medication therapy of 2550 patients. Of these 407† suggestions, 193† suggestions were implemented by the providers, resulting in a 47.42%† impact rate.

Patient-Focused Profile Review	
Suggestions Made	407†
Therapy Changed	193†
IMPACT RATE	47.42%†
Cost Savings Estimates:	
Dollars Saved per Patient Evaluated	\$323.04*†
Dollars Saved on Medication	\$114,357.25*†

* Savings reported are pre-rebate, total dollars

† Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Problem-focused reviews resulted in an estimated cost savings of \$117,533.03*† or \$178.62 saved per patient evaluated. This estimate is based on the review of profiles with 658 patients selected for interventions. Of this group, 658 patients were eligible for evaluation. Therapy was changed for 190 patients, resulting in an impact rate of 28.88%.

Problem-Focused Profile Review	
Patients Reviewed	658
Patients Evaluated	658
Therapy Changed	190
IMPACT RATE	28.88%
Cost Savings Estimates:	
Dollars Saved on Patient Reviews	\$117,533.03*
Dollars Saved per Patient Evaluated	\$178.62*
Total Dollars Saved on Medication	\$117,533.03*

Comparison to Previous Reports

Cost savings estimates for sfye 2009 (\$231,890.28*†) were lower than previous years. This decrease is due in part to the following:

- Changes in the Preferred Drug List (PDL) are considered when evaluating the impact of the retrospective DUR program. Although the savings are reported as annualized, if the change would have eventually been prompted by changes in the PDL, the cost savings were calculated only until the time of these changes.
- A majority of cost savings opportunities that had been included in past annual reports are no longer available such as quantity limits, dose consolidation, and age edits which were implemented as ProDUR edits during the course of the sfy this report encompasses.
- Due to transition in vendors, not all data on patient-focused reviews were available for inclusion. Data is incomplete for the evaluation dates of July 2008 through May 2009.

The savings from sfye 2009 patient-focused reviews (\$114,357.25*†) were lower than sfye 2008 (\$618,566.97*). The number of suggestions made (407†) vs. (2933) and the number of suggestions that were accepted (193†) vs. (756) also decreased from sfye 2008. These decreases are largely due to the incomplete information on patient-focused reviews and cost saving opportunities (quantity limits, dose consolidation, and age edits) that are no longer available to write on due to implementation as ProDUR edits during sfye 2009.

The savings from problem-focused reviews for sfye 2009 (\$117,533.03*) were higher than sfye 2008 (\$34,219.76*). This was due to the fact that in sfye 2008, three of the interventions recommended saw the addition of a drug to the member's medication therapy.

* Savings reported are pre-rebate, total dollars

† Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Results by Review Type

Patient-Focused Review

During this evaluation period, 552 educational intervention letters were mailed to prescribers and pharmacies regarding medication therapy. Of this total, 282 letters (51.09%) were mailed to prescribers, and 270 (48.91%) letters were mailed to pharmacies. Providers are invited to voluntarily respond to Commission letters. Providers returned 171 responses to these letters, resulting in an overall response rate by the providers of 30.98%. Of this total, 153 (89.47%) responses were from prescribers and 18(10.53%) were from pharmacies. The response rate differed between physicians and pharmacies; 54% for physicians and 6% for pharmacies.

In these 552 educational letters, the Commission made 407 suggestions. Of these suggestions, 377(92.63%) were therapeutic in nature while 30(7.37%) were cost-saving in nature. The suggested change was implemented in 193 cases, resulting in an overall impact rate of 47.42%. Of these changes, 178(92%) were therapeutic in nature while 15(8%) were cost-saving in nature.

Of the 407 suggestions, four types of suggestions accounted for over 90.66% of the total. Those four suggestions were Inappropriate Billing (4.18%), Not Optimal Dosage Form (2.95%), Therapeutic Duplication (80.34%), and Not Optimal Dose (3.19%). No other single category accounted for more than 3% of the total suggestions. Of the 193 changes, the most common reasons for the Commission's inquiry were Inappropriate Billing (4.15%), Therapeutic Duplication (87.56%), Not Optimal Dose (2.07%), and Not Optimal Dosage Form (3.11%). No other single category accounted for more than 2% of the changes. Detailed information is found in Appendix D.

The suggestions that resulted in change the highest percentage of the time were Not Optimal Dosage Form (50.00%), Therapeutic Alternative (60.00%), Not Optimal Duration of Use (60.00%), and Therapeutic Duplication (51.68%).

Implementation of therapeutic suggestions resulted in direct drug cost savings of \$93,029.11*[‡]. Implementation of the cost-saving suggestions resulted in direct drug cost savings of \$21,328.14*[‡]. The total amount saved on medication utilization was calculated to be \$114,357.25*[‡] for the 354[‡] patients evaluated, or \$323.04*[‡] per patient. The complete details of the results of patient-focused studies reported monthly are also outlined in Appendix D.

Included in Appendix D are Intervention Case Summary examples presented to the Commission during the year. These summaries detail the process of specific patient-focused reviews including problem identification, intervention, provider response and outcome. The examples provide an easily understood method to demonstrate the value of retrospective patient focused DUR.

* Savings reported are pre-rebate, total dollars

‡ Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Problem-Focused Reviews

Five problem-focused reviews were evaluated during the fiscal year. In conducting these studies, 658 patient profiles were reviewed and selected for intervention. Of these patients, 190 cases showed evidence of a positive outcome, resulting in an impact rate of 28.88%. These changes in therapy resulted in annualized cost savings of \$177,533.03 or \$178.62 per patient evaluated. Results of all focus studies are detailed in Appendix E. The purpose for each problem-focused review and a complete description of results are available in Appendix F.

Administrative Review

Prior Authorization

The Commission annually reviews the prior authorization program for clinical appropriateness. Changes are recommended to the Department of Human Services. During the sfye 2009, the Commission reviewed all therapeutic categories requiring prior authorization as well as therapeutic criteria to support operations of the Preferred Drug List. Recommendations for modifications to existing criteria were made for the following categories: Growth Hormones, Linezolid (Zyvox), Serotonin 5-HT-1-Receptor Agonists, Extended Release Formulations, ADD/ADHD/Narcolepsy, and Non-Steroidal Anti-Inflammatory Drugs. The following is a list for which new categories of clinical prior authorization criteria were developed: Modified Formulations and Vusion™ Ointment.

In addition, the Commission reviewed the clinical usefulness of polyethylene glycol 3350 (OTC MiraLax) in pre-colonoscopy bowel preps and recommended the product be covered without prior authorization for children 18 years of age and under when being used as a bowel prep.

These recommendations can be found in Appendix G. The list of medications requiring prior authorization and the prior authorization criteria is also included in Appendix G.

Prospective Drug Review

The Commission reviews and recommends prospective drug utilization review criteria to be utilized by the Department. The following prospective DUR edits were recommended to the Department by the Commission in sfye 2009:

- Point of Sale a quantity edit of 30 tablets per 30 days on both the 50mg and 100mg strengths of Pristiq™.
- Point of Sale quantity edit of 5 kits per 30 days on Glucagen.

Information regarding the Commission recommendations for prospective DUR can be found in Appendix H.

Other Activities

The Commission reviews changes made to the state maximum allowable cost (SMAC) list and the federal upper limit (FUL) list for prescription drugs to determine if narrow therapeutic index concerns exist. Appendix I lists the changes to the SMAC and FUL programs that were reviewed by the Commission.

Three newsletters were written and distributed by the Commission to the Medicaid provider community during this fiscal year. A copy of these newsletters is provided in Appendix J. Topics include:

- Palivizumab (Synagis) PA Criteria 2008-2009 RSV Season
- 2008-2009 Influenza Season
- Atypical Antipsychotics and Metabolic Testing

- Quarterly Narcotic Utilization Report
- Antihistamine Prior Authorization Criteria and Other Preferred Medications Used to Treat Seasonal Allergies
- PPI Interactions with Clopidogrel and a Review of Current PPI PA Criteria
- Recommendations for Managing Elevated INRs in Patients on Vitamin K Antagonists

The Commission maintains a web site to improve communication with a variety of stakeholders. The web site is found at www.iadur.org. The site contains information regarding upcoming meeting dates, locations, agendas, minutes from the previous meeting, the Smoking Cessation Report to the Iowa Legislature, recommendation letters, as well as past issues of the provider newsletter, the *DUR DIGEST*. In addition the web site provides meeting agenda and minutes for the Drug Utilization Review Mental Health Advisory Group. A copy of this web site is found in Appendix K.

Dr. Mark Graber, M.D. was selected to serve a four-year term and attended his first meeting in September 2008.

Dan Murphy, R.Ph. and Laura Griffith, D.O. completed their terms in June. Larry Ambrosion, R.Ph. and Casey Clor, M.D. were selected to serve a four-year term beginning July 1, 2009.

Quarterly management reports were developed to allow the Commission to analyze changes in medication use across the entire Medicaid patient population. Copies are found in Appendix L. Complete meeting minutes for all Commission meetings are available in Appendix M.

The Iowa Medicaid Drug Utilization Review Mental Health Advisory Group (MHAG) was established in State FYE 2008. Descriptions of the program, as well as meeting minutes are found in Appendix N.

Pursuant to the directive contained in HF909, the Commission is responsible for monitoring the smoking cessation benefit provided under the medical assistance program and for providing a report of utilization, client success, cost effectiveness, and recommendations for any changes in the benefit. This report is located in Appendix O.

Periodically the Commission will make recommendations to the Iowa Medicaid Pharmacy & Therapeutics Committee regarding the status of a medication on the Preferred Drug List (PDL). A copy of State FYE 2009's recommendation can be found in Appendix P.

Appendix A

Commission Members

**Iowa Medicaid Drug Utilization Review
Commission Members
2008-2009**

Bruce Alexander, R.Ph., Pharm.D., BCPP

Bruce Alexander was a clinical pharmacist specialist in the Departments of Pharmacy and Psychiatry at the Iowa City Veterans Affairs Medical Center for 33 years. He is currently a Mental Health Pharmacoepidemiologist for VISN 23 of the Veterans Health Administration. He is also a Professor Emeritus (Clinical) in the College of Pharmacy and Department of Psychiatry, College of Medicine, The University of Iowa. He graduated from Drake University College of Pharmacy and received his Doctor of Pharmacy degree from the University of Minnesota. He is board certified in Psychiatric Pharmacy. He has been active in the Iowa Pharmacy Association serving in the House of Delegates, on the Board of Trustees. His second term will expire in 2010.

Laura Griffith, D.O.

Dr. Laura Griffith is a physician with Concentra healthcare specializing in occupational health. She is a 1988 graduate of the University of South Dakota with a Bachelor of Science in Biology and a minor in chemistry. Dr. Griffith then attended the University of Osteopathic Medicine and Health Sciences in Des Moines and graduated in 1993 with a Doctor of Osteopathy degree. Dr. Griffith then completed both an internship and a residency at Des Moines General Hospital from 1993-1996. Prior to joining Concentra, she was a general internist at the Mater Clinic in Knoxville and at Des Moines Internal Medicine. Dr. Griffith is also a guest lecturer at Des Moines University. She is the Vice President of Sigma Sigma Phi National Honorary Osteopathic Fraternity and is a member of the American Medical Association, the American Osteopathic Association, the Iowa Osteopathic Association, the Iowa Medical Society, and the Polk county Medical Society. Dr. Griffith joined the Commission in July 2005; her term will expire in 2009.

Mark Graber, M.D., FACEP

Dr. Graber is also a Professor of Emergency Medicine and Family Medicine at the University of Iowa Carver College of Medicine. Dr. Graber graduated from Eastern Virginia Medical School and completed his Family Practice Residency at the University of Iowa. In addition to his clinical duties, Dr. Graber serves as an advisor to medical students and residents, and has published numerous text books, reviews, and papers in publications such as *The Annals of Pharmacotherapy*, *Emergency Medicine*, and *American Family Physician*. Through his travels, Dr. Graber has presented throughout the United States as well as Ukraine, Russia, and China. In 2007, Dr. Graber was honored by appearing on the "Best Doctors In America" list. Dr. Graber was appointed to the Commission in 2008; his term will expire in 2012.

Craig Logemann, R.Ph., Pharm.D., BCPS, CDE

Craig Logemann is a clinic pharmacist with Partners in Health Clinics in Des Moines. He graduated with his Bachelor Degree in Pharmacy from the University of Iowa in 1988. He completed a pharmacy residency at the University of Iowa Hospitals and

Clinics. Later, he received his Doctor of Pharmacy degree from the University of Minnesota. He was an Assistant Professor at the University of Iowa College of Pharmacy for nine years prior to accepting his current position. His term will expire in 2012.

Dan Murphy, R.Ph.

Dan Murphy is a pharmacist practicing at Main Healthcare Pharmacy in Davenport. For the last 13 years he has been a consultant to several long-term care facilities. He graduated from the University of Iowa in 1984 and became certified in geriatric pharmacy in 1999. He has been active with the Iowa Pharmacy Association including past participation on the Medicaid Advisory Committee and the Task Force on Long-term Care. His second term will expire in 2009.

Susan Parker, Pharm.D.

Susan Parker is the Pharmacy Consultant in the Bureau of Long Term Care for the Department of Human Services and serves as liaison to the Commission. She graduated with a Doctor of Pharmacy degree from Mercer Southern School of Pharmacy in Atlanta, Georgia. She is also a graduate of Gannon University in Erie, Pennsylvania with a Bachelor of Science degree Physician Assistant. Dr. Parker brings to the Commission a variety of experience in health care as an Iowa Medicaid drug prior authorization pharmacist, community pharmacist, and physician assistant. She is a member of the American Medicaid Pharmacy Administrators Association and the Western Medicaid Pharmacy Administrators Association.

Laurie Pestel, Pharm,D

Laurie Pestel is the pharmacy manager at Hy-Vee in Red Oak, Iowa. She graduated with her Doctor of Pharmacy degree from Creighton University in 2000. She served on the Board of Professional Affairs as a member of the Iowa Pharmacy Association in 2006. Laurie has experience with both long-term care and retail pharmacy. Her term will expire in 2011.

Richard Rinehart, M.D.

Dr. Rinehart is a staff psychiatrist at the Iowa City VA Medical Center and a clinical assistant professor at the University of Iowa Hospital and Clinics. He graduated from Ohio State University and completed his residency at the University of Iowa. He was in private practice in Cedar Rapids for 12 years prior to accepting his current position. He is a member of the Iowa Psychiatric Society. Dr. Rinehart's second term will expire in 2011.

Sara Schutte-Schenck, D.O.

Dr. Schutte is a graduate of Drake University and the University of Osteopathic Medicine and Health Sciences. She completed her pediatric residency at Blank Children's Hospital and is currently in practice in Des Moines. Dr. Schutte is board certified by the American Academy of Pediatrics. She has previously served on P & T committees as well as credentialing committees for Securecare of Iowa. Currently, she serves as a member of

credentialing committees for Securecare of Iowa. Currently, she serves as a member of the Utilization Management Committee for Coventry Healthcare of Iowa. Dr. Schutte's term will expire in 2012.

Appendix B

Evaluation Procedure

EVALUATION OF THE IMPACT OF PROSPECTIVE AND RETROSPECTIVE DRUG UTILIZATION REVIEW INTERVENTIONS

The goal of Drug Utilization Review (DUR) is to evaluate cost savings and provide quality assurance of medication use. The DUR Commission works in conjunction with the pharmacy medical program at the Iowa Medicaid Enterprise to contribute to the overall success of the program. The Drug Utilization program:

- Evaluates three areas of activity including Patient-focused Drug Utilization Reviews, Problem-focused Drug Utilization Reviews, and Administrative Activities.
- Examines only direct drug costs. DUR evaluation does not have the ability to quantify its impact on other health services such as hospitalizations, ER visits, and physician visits.
- Reports pre-rebate savings since access to supplemental rebates is not within the scope of the DUR program.
- Often provides recommendations that are qualitative, such as improved health outcomes, rather than quantitative in nature.

As a general principle, evaluations are based upon an observed change in the targeted prescribing or dispensing pattern, as well as changes seen in therapy of the individual patients. One evaluation approach is to observe and quantify changes in prescribing due to a given intervention compared to a control group of providers who do not receive the intervention. The intervention's impact on prescribing may be more readily detectable by this method and could be measured by comparing the two groups of patients or prescribers. However, It is very difficult to design a scientifically sound control group given the many variables surrounding patient care. Therefore, in most instances the DUR Commission has chosen to forego use of a control group to achieve the greatest impact. Although the evaluation of the intervention may be less scientific, intervention on behalf of all the patients is more desirable. In this instance, prescribing trends may not be available for comparison, but savings and benefit can still be quantified at the individual patient level.

Patient-focused DUR

Patient-focused DUR concentrates efforts on specific suggestions made about an individual patient. Each suggestion, or template, attempts to make a change in therapy. These changes are either therapeutic or cost-saving in nature; however, these situations are not necessarily mutually exclusive. A therapeutic change -- one that improves the patient's therapy in some way -- may also produce cost savings. Cost-saving changes are attempted when a patient is not receiving a medication in the most economical form. The intervention does not change the medication but points out that the same medication could be given in a more cost-effective manner. Each template and intervention is evaluated to determine if the proposed change was implemented and, if so, what economic implications can be calculated.

The calculation relating to therapeutic and cost saving interventions is tabulated by comparing a member's initial profile with the member's re-review profile. Each member profile is a six-month snapshot of medications covered by the Medicaid program. Pertinent information such as patient name and ID, date of service, drug name, strength, and quantity, RX number, day supply, prescriber and pharmacy ID, total price submitted, and amount paid appear on each profile. There are nine months in between the initial and re-review profiles to accommodate for provider review, response, and implementation for therapeutic and or cost changes. For each intervention, the total amount paid on the initial profile for any one intervention is noted. According to the intervention at hand, the re-review profile is evaluated for change. The amount paid on the re-review profile for the same intervention is also noted. A comparison between the profiles is calculated by subtracting the total amount paid from the initial profile with the total amount paid from the re-review profile. This calculation is then annualized multiplying the number by 2 to get the pre-rebate annualized savings. Consider this *cost saving* example:

Template sent to the provider:

According to the profile, this patient is receiving Lexapro 10mg tablets. Substantial cost savings can be realized by using one-half of a Lexapro 20mg tablet which is scored and easily broken. Would this patient be a good candidate for this cost-saving measure?

Information on initial profile sent to provider:

Lexapro 10 mg #30= \$83.04
Total Amount Paid \$498.24

Information on re-review profile used internally for evaluation:

Lexapro 20 mg #15 = \$45.92
Total Amount Paid \$275.52

Calculation of annualized savings

$\$498.24 - \$275.52 = \$222.72$ (savings for 6 months)
 $\$222.72 \times 2 = \445.44 (savings for 12 months)

Reported total pre-rebate annualized savings is \$445.44

All savings for patient-focused review are based on annualized savings for one year only. Reporting on patient-focused interventions will provide the following information:

- Total number of templates mentioned
- Number of templates that were therapeutic in nature
- Number of templates that were cost-saving in nature
- Total number of changes implemented
- Number of changes that were therapeutic in nature
- Number of changes with positive impact without savings
- Number of changes that were cost-saving in nature
- Total dollars saved from therapeutic changes
- Total dollars saved from cost-saving changes
- Total dollars saved
- Impact of interventions expressed as a percentage

All templates are described by one of sixteen classifications. These classifications indicate the general type of intervention addressed by the template. Reports will also include a breakdown by classification (therapeutic or cost-saving) of the templates used in the patient-focused letters. This data will show which templates are cited most often, result in change most often, and result in higher cost savings.

Templates that are therapeutic in nature include:

- Not Optimal Drug
- Not Optimal Dose
- Not Optimal Duration of Use
- Unnecessary Drug Use
- Therapeutic Duplication
- High Cost Drug
- Drug-Drug Interaction
- Drug-Disease Interaction
- Adverse Drug Reaction
- Patient Overuse
- Patient Underuse
- Therapeutic Alternative
- Missing Drug Therapy

Templates that are cost saving in nature include:

- Not Optimal Dosage Form
- Potential Generic Use
- Inappropriate Billing

Problem-focused DUR

Problem-focused DUR concentrates efforts on a specific problem or trend in prescribing. While patient-focused reviews may address a multitude of situations, a problem-focused review addresses only one concern. The DUR Commission uses guidelines, literature and peer-group prescribing to identify particular clinical situations that need addressed. This process ensures that each intervention is unique due to the subject matter and may differ in steps of evaluation.

Reporting for problem-focused interventions will include the types of intervention done and the resulting savings. Savings are always calculated based on one year of therapy only and are calculated in the same manner as explained in the patient-focused DUR section.

Administrative Review

The Drug Utilization Review (DUR) program is a component of the Pharmacy Medical Division of the Iowa Medicaid Enterprise (IME). DUR contributes expertise and information that leads to implementation in other programmatic areas including, but not limited to: Prospective Drug Utilization Review, Prior Authorization, Preferred Drug List, Disease Management, and Supplemental Rebates. Although the DUR program impacts all of the different pharmacy programs it is difficult to determine where its impact begins and ends. Therefore, the savings associated with DUR contribution in other pharmacy areas cannot be determined. IME pharmacy programs are listed below along with a DUR impact statement and example:

- Prospective DUR

Definition: A process in which a request for a drug product for a particular patient is screened for potential drug therapy problems before the product is dispensed.

Impact: The DUR Commission reviews scientific literature regarding specific medications and makes recommendations to DHS on appropriate utilization guidelines or parameters.

Example: The DUR Commission recommended that an age edit be placed on Provigil®, restricting its use in patients to those 16 years of age and older.

- Prior Authorization

Definition: A process for obtaining approval for a drug before the drug is provided to a member, as a precondition for provider reimbursement. Prior authorization is requested at the prescriber level and is a prescriber fax-only system using the forms provided by the Iowa Medicaid Enterprise.

Impact: The DUR Commission develops sound, cost-effective medication use guidelines by reviewing peer reviewed medical information from various sources. The Commission seeks outside expertise when necessary and considers public comments prior to

recommending step therapy for appropriate drug use.

Example: The DUR Commission developed the criteria for the Nicotine Replacement Therapy prior authorization.

Prior Authorization is required for over-the-counter nicotine replacement patches and nicotine gum. Requests for authorization must include:

- 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- 2) Confirmation of enrollment in the Quitline Iowa counseling program is required for approval.
- 3) Approvals will only be granted for patients eighteen years of age and older.
- 4) The maximum allowed duration of therapy is twelve weeks within a twelve-month period.
- 5) A maximum quantity of 14 nicotine replacement patches and/or 110 pieces of nicotine gum may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4 week supply at one unit per day of nicotine replacement patches and/or 330 pieces of nicotine gum. Following the first 28 days of therapy, continuation is available only with documentation of ongoing participation in the Quitline Iowa program.

- Preferred Drug List (PDL)

Definition: A list comprised of drugs recommended to the Iowa Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program.

Impact: The DUR Commission makes referrals to and considers requests from the Pharmacy and Therapeutics (P&T) Committee to improve drug therapy.

Example: The DUR Commission recommended that the Iowa Medicaid Pharmacy and Therapeutics Committee change the status of products containing carisoprodol on the PDL from preferred to nonpreferred.

- Disease management

Definition: A coordinated process by which Iowa Medicaid identifies and treats diseases within defined patient populations. This goal is achieved by identifying and delivering the most effective and efficient combination of available resources.

Impact: The Commission reviews disease state guidelines to determine appropriate drug use, shares drug utilization information, and makes recommendations to improve therapeutic outcomes.

Example: DUR exchanged patient specific information with case management regarding utilization patterns of Advair®.

- Supplemental rebates

Definition: A rebate given in addition to rebates received under the CMS Rebate Agreement, pursuant to Section 1927 of the Social Security Act (42 USC 1396r-8).

Impact: The existence of a supplemental rebate and how it may impact the price of a medication is taken into consideration when the DUR Commission makes recommendations.

Example: The DUR Commission requested that the Iowa Medicaid P&T Committee review the different dosage forms of nicotine replacement therapy and share information as to which products were the most cost effective.

Appendix C

Overall Programs Results

PROGRAM EVALUATION/COST SAVINGS ESTIMATES
Iowa Medicaid Retrospective Drug Utilization Review
Annual Report - State FYE 2009

Patient-Focused Profile Review‡

Suggestions Made	407
Therapy Changed	193
IMPACT RATE	47.42%

Cost Savings Estimates:

Dollars Saved per Patient Evaluated	\$323.04 *
Dollars Saved on Medication	\$114,357.25 *

Problem-Focused Profile Review

Patients Evaluated	658
Therapy Changed	190
IMPACT RATE	28.88%

Cost Savings Estimates:

Dollars Saved per Patient Evaluated	\$178.62 *
Dollars Saved on Medication	\$117,533.03 *

Cost Savings Estimate‡

	\$231,890.28 *
Cost of the Program (State and Federal)	\$270,000.00
Net Cost Savings Estimate	(\$38,109.72) *

Savings Per Dollar Spent (State and Federal)

\$0.86 *

Dollars Per State Dollar Spent

\$3.44 *

* Savings reported are pre-rebate, total dollars

‡ Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Appendix D

Results Patient-Focused

Patient-Focused Reviews
State FYE 2009

Initial Review Date
Re-review Date

Oct 07 - Sep 08
Jul 08 - Jun 09

Patient Profiles Reviewed
 Patient Profiles Available for Evaluation

2550
354

Intervention Letters Sent

Prescribers
 Pharmacy
Total

282
270
552

51.09%
 48.91%
100.00%

Responses Received

Prescribers
 Pharmacy
Total

153
18
171

89.47%
 10.53%
100.00%

30.98% OVERALL RESPONSE RATE

Prescribers 54.26%
 Pharmacy 6.67%

Total Number of Suggestions

Therapeutic
 Cost-Saving

407
377
30

92.63%
 7.37%

Total Number of Changes

Therapeutic
 Cost-Saving
 Postive Impact Only

193
178
15
0

92.23%
 7.77%
 0.00%

47.42% IMPACT RATE

Prepared by the Iowa Medicaid Drug Utilization Review Commission

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

**PATIENT-FOCUSED REVIEW
MONTH BY MONTH BREAKDOWN**

State FYE 2009

Initial Review Date	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08
Evaluation Date	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08
Profiles Reviewed	0	300	300	0	300	300
Profiles Available for Evaluation	0	36	39	0	24	25
Total Number of Suggestions Made	0	36	39	0	24	25
Therapeutic	0	33	37	0	21	23
Cost-Saving	0	3	2	0	3	2
Total Number of Changes Made	0	36	39	0	24	25
Therapeutic	0	33	37	0	21	23
Cost-Saving	0	3	2	0	3	2
Positive Impact Only	0	0	0	0	0	0
Total Dollars Saved - Therapeutic Changes	\$0.00	\$14,879.93	\$22,239.48	\$0.00	\$12,094.27	\$8,694.82
Total Dollars Saved - Cost-Saving Changes	\$0.00	\$1,985.27	\$6,236.97	\$0.00	\$3,151.77	\$5,119.21
Total Dollars Saved on Medication*	\$0.00	\$16,865.20	\$28,476.45	\$0.00	\$15,246.04	\$13,814.03
Total Dollars Saved per Profile Evaluated	\$0.00	\$468.48	\$730.17	\$0.00	\$635.25	\$552.56

*Savings reported are pre-rebate total dollars.

Prepared by the Iowa Medicaid Drug Utilization Review Commission

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

**PATIENT-FOCUSED REVIEW
MONTH BY MONTH BREAKDOWN**

State FYE 2009

Initial Review Date Evaluation Date	Apr-08 Jan-09	May-08 Feb-09	Jun-08 Mar-09	Jul-08 Apr-09	Aug-08 May-09	Sep-08 Jun-09
Profiles Reviewed	0	300	300	0	450	300
Profiles Available for Evaluation	0	N/A	N/A	0	81	149
Total Number of Suggestions Made	0	0	0	0	98	185
Therapeutic	0	0	0	0	96	167
Cost-Saving	0	0	0	0	2	18
Total Number of Changes Made	0	0	0	0	26	43
Therapeutic	0	0	0	0	25	39
Cost-Saving	0	0	0	0	1	4
Positive Impact Only	0	0	0	0	0	0
Total Dollars Saved - Therapeutic Changes	\$0.00	\$0.00	\$0.00	\$0.00	\$16,081.90	\$19,038.71
Total Dollars Saved - Cost-Saving Changes	\$0.00	\$0.00	\$0.00	\$0.00	\$1,527.43	\$3,307.49
Total Dollars Saved on Medication*	\$0.00	\$0.00	\$0.00	\$0.00	\$17,609.33	\$22,346.20
Total Dollars Saved per Profile Evaluated	\$0.00	\$0.00	\$0.00	\$0.00	\$217.40	\$149.97

*Savings reported are pre-rebate total dollars.

Prepared by the Iowa Medicaid Drug Utilization Review Commission

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

**PATIENT-FOCUSED REVIEW
MONTH BY MONTH BREAKDOWN**

State FYE 2009

Initial Review Date Evaluation Date	TOTAL	
Profiles Reviewed	2550	
Profiles Available for Evaluation	354	
Total Number of Suggestions Made	407	
Therapeutic	377	92.63%
Cost-Saving	30	7.37%
Total Number of Changes Made	193	47.42%
Therapeutic	178	92.23%
Cost-Saving	15	7.77%
Positive Impact Only	0	0.00%
Total Dollars Saved - Therapeutic Changes	\$93,029.11	81.35%
Total Dollars Saved - Cost-Saving Changes	\$21,328.14	18.65%
Total Dollars Saved on Medication*	\$114,357.25	
Total Dollars Saved per Profile Evaluated	\$323.04	

*Savings reported are pre-rebate total dollars.

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Medicaid DUR Impact Assessment Report
Patient-Focused Reviews
State FYE 2009

Initial Review Date	Oct-07	Nov-07	Dec-07
Evaluation Date	Jul-08	Aug-08	Sep-08
Profiles Available for Evaluation	0	300	300
Profiles Reviewed	0	36	39
<u>Letters Sent</u>			
Prescribers	0	5	4
Pharmacy	0	N/A	N/A
Total	0	5	4
<u>Responses Received</u>			
Prescribers	0	5	4
Pharmacy	0	N/A	N/A
Total	0	5	4
Total Number of Templates Mentioned	0	36	39
Therapeutic	0	33	37
Cost-Saving	0	3	2
Total Number of Changes Made	0	36	39
Therapeutic	0	33	37
Cost-Saving	0	3	2
Positive Impact Only	0	0	0
Total Dollars Saved-Therapeutic Changes	\$0.00	\$14,879.93	\$22,239.48
Total Dollars Saved-Cost Saving Changes	\$0.00	\$1,985.27	\$6,236.97
Total Dollars Saved on Medication	\$0.00	\$16,865.20	\$28,476.45
Total Dollars Saved per Profile Evaluated	\$0.00	\$468.48	\$730.17

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

**Medicaid DUR Impact Assessment Report
Patient-Focused Reviews
State FYE 2009**

Initial Review Date Evaluation Date	Jan-08 Oct-08	Feb-08 Nov-08	Mar-08 Dec-08
Profiles Reviewed	0	300	300
Profiles Available for Evaluation	0	24	25
<u>Letters Sent</u>			
Prescribers	0	4	4
Pharmacy	0	N/A	N/A
Total	0	4	4
<u>Responses Received</u>			
Prescribers	0	4	4
Pharmacy	0	N/A	N/A
Total	0	4	4
Total Number of Templates Mentioned	0	24	25
Therapeutic	0	21	23
Cost-Saving	0	3	2
Total Number of Changes Made	0	24	25
Therapeutic	0	21	23
Cost-Saving	0	3	2
Positive Impact Only	0	0	0
Total Dollars Saved-Therapeutic Changes	\$0.00	\$12,094.27	\$8,694.82
Total Dollars Saved-Cost Saving Changes	\$0.00	\$3,151.77	\$5,119.21
Total Dollars Saved on Medication	\$0.00	\$15,246.04	\$13,814.03
Total Dollars Saved per Profile Evaluated	0	\$635.25	\$552.56

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

**Medicaid DUR Impact Assessment Report
Patient-Focused Reviews
State FYE 2009**

Initial Review Date Evaluation Date	Apr-08 Jan-09	May-08 Feb-09	Jun-08 Mar-09
Profiles Reviewed	0	300	300
Profiles Available for Evaluation	0	N/A	N/A
<u>Letters Sent</u>			
Prescribers	0	N/A	N/A
Pharmacy	0	N/A	N/A
Total	0	N/A	N/A
<u>Responses Received</u>			
Prescribers	0	N/A	N/A
Pharmacy	0	N/A	N/A
Total	0	N/A	N/A
Total Number of Templates Mentioned	0	N/A	N/A
Therapeutic	0	N/A	N/A
Cost-Saving	0	N/A	N/A
Total Number of Changes Made	0	N/A	N/A
Therapeutic	0	N/A	N/A
Cost-Saving	0	N/A	N/A
Positive Impact Only	0	N/A	N/A
Total Dollars Saved-Therapeutic Changes	\$0.00	\$0.00	\$0.00
Total Dollars Saved-Cost Saving Changes	\$0.00	\$0.00	\$0.00
Total Dollars Saved on Medication	\$0.00	\$0.00	\$0.00
Total Dollars Saved per Profile Evaluated	\$0.00	\$0.00	\$0.00

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Medicaid DUR Impact Assessment Report
Patient-Focused Reviews
State FYE 2009

Initial Review Date Evaluation Date	Jul-08 Apr-09	Aug-08 May-09	Sep-08 Jun-09
Profiles Reviewed	0	450	300
Profiles Available for Evaluation	0	81	149
<u>Letters Sent</u>			
Prescribers	0	81	184
Pharmacy	0	81	189
Total	0	162	373
<u>Responses Received</u>			
Prescribers	0	39	97
Pharmacy	0	3	15
Total	0	42	112
Total Number of Templates Mentioned	0	98	185
Therapeutic	0	96	167
Cost-Saving	0	2	18
Total Number of Changes Made	0	26	43
Therapeutic	0	25	39
Cost-Saving	0	1	4
Positive Impact Only	0	0	0
Total Dollars Saved-Therapeutic Changes	\$0.00	\$16,081.90	\$19,038.71
Total Dollars Saved-Cost Saving Changes	\$0.00	\$1,527.43	\$3,307.49
Total Dollars Saved on Medication	\$0.00	\$17,609.33	\$22,346.20
Total Dollars Saved per Profile Evaluated	\$0.00	\$217.40	\$149.97

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

**Medicaid DUR Impact Assessment Report
Patient-Focused Reviews
State FYE 2009**

Initial Review Date Oct 07 - Sep 08
Evaluation Date Jul 08 - Jun 09

Profiles Reviewed 2550
Profiles Available for Evaluation 354

Letters Sent

Prescribers	282	51.09%
Pharmacy	270	48.91%
Total	552	100.00%

Responses Received

Prescribers	153	89.47%
Pharmacy	18	10.53%
Total	171	100.00%

Total Number of Templates Mentioned	407	
Therapeutic	377	92.63%
Cost-Saving	30	7.37%

Total Number of Changes Made	193		47.42%
Therapeutic	178	92.23%	
Cost-Saving	15	7.77%	
Positive Impact Only	0	0.00%	

Total Dollars Saved-Therapeutic Changes	\$93,029.11	81.35%
Total Dollars Saved-Cost Saving Changes	\$21,328.14	18.65%
Total Dollars Saved on Medication	\$114,357.25	100.00%
Total Dollars Saved per Profile Evaluated	\$323.04	

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Initial Review Date Evaluation Date	Oct-07 Jul-08		Nov-07 Aug-08		Dec-07 Sep-08	
<u>Template Classification</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>
Not Optimal Drug	0	0	N/A	N/A	N/A	N/A
Not Optimal Dose	0	0	N/A	N/A	N/A	N/A
Not Optimal Duration of Use	0	0	1	1	2	2
Unnecessary Drug Use	0	0	N/A	N/A	N/A	N/A
Therapeutic Duplication	0	0	32	32	35	35
High Cost Drug	0	0	N/A	N/A	N/A	N/A
Drug-Drug Interaction	0	0	N/A	N/A	N/A	N/A
Drug-Disease Interaction	0	0	N/A	N/A	N/A	N/A
Adverse Drug Reaction	0	0	N/A	N/A	N/A	N/A
Patient Overuse	0	0	N/A	N/A	N/A	N/A
Patient Underuse	0	0	N/A	N/A	N/A	N/A
Therapeutic Alternative	0	0	N/A	N/A	N/A	N/A
Missing Drug Therapy	0	0	N/A	N/A	N/A	N/A
Not Optimal Dosage Form	0	0	2	2	1	1
Potential Generic Use	0	0	N/A	N/A	N/A	N/A
Inappropriate Billing	0	0	1	1	1	1
TOTAL	0	0	36	36	39	39

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Initial Review Date
Evaluation Date

Jan-08
Oct-08

Feb-08
Nov-08

Mar-08
Dec-08

<u>Template Classification</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>
Not Optimal Drug	0	0	N/A	N/A	N/A	N/A
Not Optimal Dose	0	0	N/A	N/A	1	1
Not Optimal Duration of Use	0	0	N/A	N/A	N/A	N/A
Unnecessary Drug Use	0	0	N/A	N/A	N/A	N/A
Therapeutic Duplication	0	0	21	21	22	22
High Cost Drug	0	0	N/A	N/A	N/A	N/A
Drug-Drug Interaction	0	0	N/A	N/A	N/A	N/A
Drug-Disease Interaction	0	0	N/A	N/A	N/A	N/A
Adverse Drug Reaction	0	0	N/A	N/A	N/A	N/A
Patient Overuse	0	0	N/A	N/A	N/A	N/A
Patient Underuse	0	0	N/A	N/A	N/A	N/A
Therapeutic Alternative	0	0	N/A	N/A	1	1
Missing Drug Therapy	0	0	N/A	N/A	N/A	N/A
Not Optimal Dosage Form	0	0	2	2	N/A	N/A
Potential Generic Use	0	0	N/A	N/A	N/A	N/A
Inappropriate Billing	0	0	1	1	1	1
TOTAL	0	0	24	24	25	25

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Initial Review Date
Evaluation Date

Apr-08
Jan-09

May-08
Feb-09

Jun-08
Mar-09

<u>Template Classification</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>
Not Optimal Drug	0	0	N/A	N/A	N/A	N/A
Not Optimal Dose	0	0	N/A	N/A	N/A	N/A
Not Optimal Duration of Use	0	0	N/A	N/A	N/A	N/A
Unnecessary Drug Use	0	0	N/A	N/A	N/A	N/A
Therapeutic Duplication	0	0	N/A	N/A	N/A	N/A
High Cost Drug	0	0	N/A	N/A	N/A	N/A
Drug-Drug Interaction	0	0	N/A	N/A	N/A	N/A
Drug-Disease Interaction	0	0	N/A	N/A	N/A	N/A
Adverse Drug Reaction	0	0	N/A	N/A	N/A	N/A
Patient Overuse	0	0	N/A	N/A	N/A	N/A
Patient Underuse	0	0	N/A	N/A	N/A	N/A
Therapeutic Alternative	0	0	N/A	N/A	N/A	N/A
Missing Drug Therapy	0	0	N/A	N/A	N/A	N/A
Not Optimal Dosage Form	0	0	N/A	N/A	N/A	N/A
Potential Generic Use	0	0	N/A	N/A	N/A	N/A
Inappropriate Billing	0	0	N/A	N/A	N/A	N/A
TOTAL	0	0	0	0	0	0

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Initial Review Date
Evaluation Date

Jul-08
Apr-09

Aug-08
May-09

Sep-08
Jun-09

<u>Template Classification</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>	<u>Suggestions</u>	<u>Invoked Change</u>
Not Optimal Drug	0	0	0	0	5	0
Not Optimal Dose	0	0	4	0	8	3
Not Optimal Duration of Use	0	0	0	0	2	0
Unnecessary Drug Therapy	0	0	1	0	4	0
Therapeutic Duplication	0	0	85	25	132	34
High Cost Drug	0	0	0	0	0	0
Drug-Drug Interaction	0	0	5	0	7	0
Drug-Disease Interaction	0	0	0	0	0	0
Adverse Drug Reaction	0	0	0	0	0	0
Patient Overuse	0	0	1	0	5	0
Patient Underuse	0	0	0	0	0	0
Therapeutic Alternative	0	0	0	0	4	2
Missing Drug Therapy	0	0	0	0	0	0
Not Optimal Dosage Form	0	0	1	0	6	1
Potential Generic Use	0	0	0	0	0	0
Inappropriate Billing	0	0	1	1	12	3
TOTAL	0	0	98	26	185	43

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Initial Review Date
Evaluation Date

Oct 07 - Sep 08
Jul 08 - Jun 09

<u>Template Classification</u>	<u>Suggestions</u>	<u>Changes</u>	<u>% of Total Suggestions</u>	<u>% of Total Change</u>	<u>% Change</u>
Not Optimal Drug	5	0	1.23%	0.00%	0.00%
Not Optimal Dose	13	4	3.19%	2.07%	30.77%
Not Optimal Duration of Use	5	3	1.23%	1.55%	60.00%
Unnecessary Drug Use	5	0	1.23%	0.00%	0.00%
Therapeutic Duplication	327	169	80.34%	87.56%	51.68%
High Cost Drug	0	0	0.00%	0.00%	0.00%
Drug-Drug Interaction	12	0	2.95%	0.00%	0.00%
Drug-Disease Interaction	0	0	0.00%	0.00%	0.00%
Adverse Drug Reaction	0	0	0.00%	0.00%	0.00%
Patient Overuse	6	0	1.47%	0.00%	0.00%
Patient Underuse	0	0	0.00%	0.00%	0.00%
Therapeutic Alternative	5	3	1.23%	1.55%	60.00%
Missing Drug Therapy	0	0	0.00%	0.00%	0.00%
Not Optimal Dosage Form	12	6	2.95%	3.11%	50.00%
Potential Generic Use	0	0	0.00%	0.00%	0.00%
Inappropriate Billing	17	8	4.18%	4.15%	47.06%
TOTAL	407	193	100.00%	100.00%	47.42%

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Patient-Focused Reviews

State FYE 2009

Template Classification	Suggestions	Changes	% of Total Suggestions	% of Total Changes	% of Suggestions Changed	% of Dollars Saved
Not Optimal Drug	5	0	1.23%	0.00%	0.00%	0.00%
Not Optimal Dose	13	4	3.19%	2.07%	30.77%	5.68%
Not Optimal Duration of Use	5	3	1.23%	1.55%	60.00%	1.89%
Unnecessary Drug Use	5	0	1.23%	0.00%	0.00%	0.00%
Therapeutic Duplication	327	169	80.34%	87.56%	51.68%	70.03%
High Cost Drug	0	0	0.00%	0.00%	0.00%	0.00%
Drug-Drug Interaction	12	0	2.95%	0.00%	0.00%	0.00%
Drug-Disease Interaction	0	0	0.00%	0.00%	0.00%	0.00%
Adverse Drug Reaction	0	0	0.00%	0.00%	0.00%	0.00%
Patient Overuse	6	0	1.47%	0.00%	0.00%	0.00%
Patient Underuse	0	0	0.00%	0.00%	0.00%	0.00%
Therapeutic Alternative	5	3	1.23%	1.55%	60.00%	7.25%
Missing Drug Therapy	0	0	0.00%	0.00%	0.00%	0.00%
Not Optimal Dosage Form	12	6	2.95%	3.11%	50.00%	6.05%
Potential Generic Use	0	0	0.00%	0.00%	0.00%	0.00%
Inappropriate Billing	17	8	4.18%	4.15%	47.06%	9.10%
TOTAL	407	193	100.00%	100.00%	47.42%	100.00%

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Savings by Template Class

Profile Review Evaluation	Oct-07 Jul-08 No Profiles	Nov-07 Aug-08	Dec-07 Sep-08	Jan-08 Oct-08 No Profiles	Feb-08 Nov-08	Mar-08 Dec-08	Apr-08 Jan-09 No Profiles	May-08 Feb-09	Jun-08 Mar-09	Jul-08 Apr-09 No Profiles	Aug-08 May-09	Sep-08 Jun-09	Template Total	% of Total Savings
<u>Template Classification</u>														
Not Optimal Drug	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Not Optimal Dose	\$0.00	\$1,885.16	\$2,706.62	\$0.00	N/A	\$1,907.48	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$6,499.26	5.68%
Not Optimal Duration of Use	\$0.00	N/A	\$2,157.26	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$2,157.26	1.89%
Unnecessary Drug Use	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Therapeutic Duplication	\$0.00	\$12,994.77	\$17,375.60	\$0.00	\$12,094.27	\$8,694.82	\$0.00	N/A	N/A	\$0.00	\$16,081.90	\$12,846.71	\$80,088.07	70.03%
High Cost Drug	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Drug-Drug Interaction	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Drug-Disease Interaction	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Adverse Drug Reaction	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Patient Overuse	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Patient Underuse	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Therapeutic Alternative	\$0.00	N/A	N/A	\$0.00	N/A	\$2,103.64	\$0.00	N/A	N/A	\$0.00	\$0.00	\$6,192.00	\$8,295.64	7.25%
Missing Drug Therapy	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Not Optimal Dosage Form	\$0.00	\$677.48	\$4,076.76	\$0.00	\$791.86	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$1,366.92	\$6,913.02	6.05%
Potential Generic Use	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	N/A	N/A	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
Inappropriate Billing	N/A	\$1,307.79	\$2,160.71	N/A	\$2,359.91	\$1,108.09	\$0.00	N/A	N/A	\$0.00	\$1,527.43	\$1,940.07	\$10,404.00	9.10%
TOTAL	\$0.00	\$16,865.20	\$28,476.95	\$0.00	\$15,246.04	\$13,814.03	\$0.00	\$0.00	\$0.00	\$0.00	\$17,609.33	\$22,345.70	\$114,357.25	100.00%

Prepared by the Iowa Medicaid Drug Utilization Review Commission

Savings estimate and reported profile review numbers are low for Patient-Focused Profile Review due to incomplete data being available for review with transition to new DUR vendor

Intervention Case Summaries August 2008

The Commission reviewed the profile of a 45 year-old male receiving **Zyprexa Zydis** 15mg daily. The Commission asked if the member is a candidate to use Zyprexa 15mg tablets for cost saving purposes. Upon re-review, Zyprexa Zydis was changed to Zyprexa tablets.

Annualized pre-rebate savings = \$388.08

The Commission reviewed the profile of a 37 year-old female receiving **Alprazolam** 1mg and **Clonazepam** 0.5mg concurrently. The Commission asked if one of the medications could be discontinued and the dose of the other be adjusted if needed. Upon re-review, Alprazolam 1mg was discontinued.

Annualized pre-rebate savings = \$149.82

The Commission reviewed the profile of a 38 year-old female receiving 60mg of **Prevacid** daily. The Commission asked if a trial with a maintenance dose could be attempted. The member was also receiving **Cyclobenzaprine** and **Tizanidine** concurrently. The Commission asked if one of the medications could be discontinued and the dose of the other medication be adjusted. Upon re-review, The Prevacid was decreased to 30mg daily and the Tizanidine was discontinued.

Annualized pre-rebate savings for Prevacid = \$1885.16

Annualized pre-rebate savings for Tizanidine = \$279.31

The Commission reviewed the profile of a 40 year-old female receiving 10mg of **Lipitor** per day. The Commission asked if the patient was a good candidate to use a half tablet of Lipitor 20mg for cost saving purposes. Upon re-review, the same dose was delivered using a half tablet of Lipitor 20mg.

Annualized pre-rebate savings = \$289.40

Intervention Case Studies September 2008

The Commission reviewed the profile of a 47 year old female receiving Duragesic 50 mcg/hr patches monthly. The Commission asked if the unique transdermal dosage form offered significant therapeutic benefit over oral alternatives. Upon re-review, Duragesic was discontinued and nothing was prescribed in its place. (The member was also taking Endocet 10/325 mg which was continued)

Annualized total pre-rebate savings (state and federal) = \$4,076.76

The Commission reviewed the profile of a 56 year old male receiving Aricept 10 mg. The Commission asked if significant therapeutic benefit was still being achieved to justify the ongoing use of the medication. Upon re-review, Aricept 10mg was discontinued.

Annualized total pre-rebate savings (state and federal) = \$2,157.26

The Commission reviewed the profile of a 41 year old female receiving Geodon 160 mg daily, Haloperidol 20 mg daily, and Haloperidol Decanoate 100 mg/ml every 28 days. The Commission asked if one of the medications could be discontinued and dosage titration of the other be an option since long acting injectable antipsychotics are warranted when patient compliance cannot be assured with oral dosing. Upon re-review, Geodon was discontinued and the dosage of both forms of Haloperidol did not change.

Annualized total pre-rebate savings (state and federal) = \$5,107.31

The Commission reviewed the profile of a 51 year old female receiving Celebrex 200 mg bid. The Commission asked if a trial reduction of the dose could be attempted to determine if the patient could be maintained at a lower dose. Upon re-review, Celebrex was discontinued.

Annualized total pre-rebate savings (state and federal) = \$2,706.62

Intervention Case Summaries

November 2008

The Commission reviewed the profile of a 39 year old female receiving 10mg of Lipitor per day. The Commission asked if the patient was a good candidate to use a half tablet of Lipitor 20mg for cost saving purposes. Upon re-review, the same dose was delivered using a half tablet of Lipitor 20mg.

Annualized total pre-rebate savings (state and federal) = \$289.40

The Commission reviewed the profile of a 44 year old female receiving both Prilosec OTC 40mg daily and Ranitidine 300mg daily. The Commission noted the therapeutic duplication and asked if one med could be discontinued and the dose of the other medication be adjusted. Upon re-review, the Ranitidine was discontinued.

Annualized total pre-rebate savings (state and federal) = \$85.08

The Commission reviewed the profile of an 18 year old female receiving Abilify 20mg daily and clozapine 700mg daily. The Commission noted that there were two different providers involved and asked if they were aware another provider was providing similar care. It was asked if one of the medications could be discontinued and the dose of the other medication be adjusted. Upon re-review, the Abilify was discontinued and the dose of clozapine remained the same.

Annualized total pre-rebate savings (state and federal) = \$549.16

The Commission reviewed the profile of a 48 year-old female receiving 10mg of Lexapro per day. The Commission asked if the patient was a good candidate to use a half tablet of Lexapro 20mg for cost saving purposes. Upon re-review, the same dose was delivered using a half tablet of Lexapro 20mg.

Annualized total pre-rebate savings (state and federal) = \$502.46

Intervention Case Summaries December 2008

The Commission reviewed the profile of a 50 year old male receiving OxyContin 20mg twice daily. The Commission asked if the patient would be a candidate to switch to methadone for cost saving purposes. Upon re-review, OxyContin was discontinued and the patient was switched to Methadone 5mg twice daily.

Annualized total pre-rebate savings (state and federal) = \$2103.64

The Commission reviewed the profile of a 28 year old female receiving Nexium 40mg capsules; 80mg per day. The Commission noted that this patient had received high dose PPI therapy for several months and asked if a trial reduction to a maintenance dose could be attempted. Upon re-review, the dose of Nexium was decreased to 40mg daily.

Annualized total pre-rebate savings (state and federal) = \$1907.48

The Commission reviewed the profile of a 55 year old male receiving both Risperdal tablets and Risperdal Consta. The Commission asked what the clinical situation was that required the patient to receive the same medication in different dosage forms. Upon re-review, Risperdal tablets were discontinued.

Annualized total pre-rebate savings (state and federal) = \$2732.15

The Commission reviewed the profile of a 56 year old female receiving both clonazepam and alprazolam. The Commission noted the duplication and asked if it was possible to discontinue one of the medications and adjust the dose of the other (if needed) to control the patient's clinical situation. Upon re-review, alprazolam was discontinued and the dose of clonazepam was increased.

Annualized total pre-rebate savings (state and federal) = \$94.08

Intervention Case Summaries

May 2009

The Commission reviewed the profile of an 18 year-old male receiving *Seroquel* 50mg and *Risperdal* 0.25mg concurrently. The Commission asked if the therapeutic benefit of using two low dose atypical antipsychotics outweighs the significant expense. Upon re-review, *Seroquel* was discontinued. *Risperdal* was maintained at the same dose for two months then discontinued.

Annualized pre-rebate savings (state and federal) = \$1604.43

The Commission reviewed the profile of a 64 year-old female receiving both strengths of *Symbicort* (160/4.5 and 80/4.5). The Commission asked what the medical rationale was for using both strengths concurrently. Upon re-review, *Symbicort* 80/4.5 was discontinued.

Annualized pre-rebate savings (state and federal) = \$2089.74

The Commission reviewed the profile of a 56 year-old female receiving lorazepam and clonazepam concurrently. The Commission asked if one agent could be discontinued and adjust the dose of the other benzodiazepine, if needed. Upon re-review, lorazepam was discontinued.

Annualized pre-rebate savings (state and federal) = \$84.48

The Commission reviewed the profile of a 49 year-old female receiving *Sular* and amlodipine concurrently. The Commission asked what the clinical situation was requiring the combined use of both calcium channel blockers and if one could be discontinued. Upon re-review, amlodipine was discontinued.

Annualized pre-rebate savings (state and federal) = \$119.08

Intervention Case Summaries

June 2009

The Commission reviewed the profile of a 43 year-old female receiving *Lamictal*, *Topamax*, and *Trileptal* concurrently. The Commission asked what the clinical situation was for the combined use of the medications and if one or more of the medications could be discontinued and the dose of the other medication(s) be adjusted if needed. Upon re-review, *Trileptal* was discontinued.

Annualized pre-rebate savings (state and federal) = \$10,090.01

The Commission reviewed the profile of a 61 year-old female receiving *Spiriva* and *Combivent* concurrently. The Commission asked what the clinical situation was requiring duplicate anticholinergic therapy. Upon re-review, *Spiriva* was discontinued.

Annualized pre-rebate savings (state and federal) = \$2,173.49

The Commission reviewed the profile of a 59 year-old female receiving *Duragesic* 50 mcg patches monthly. The Commission asked if the unique transdermal dosage for offers a significant therapeutic benefit over oral alternatives and if the member was a candidate to switch to a therapeutic alternative that would provide a significant cost savings. Upon re-review, *Duragesic* was discontinued. Oxycodone 5 mg tablets 60/7 days was added and filled sporadically (in combination with Oxycodone/APAP 5/325 that the member was taking concurrently with the *Duragesic*).

Annualized pre-rebate savings (state and federal) = \$4,475.47

Oxycodone 5mg SMAC rate = \$0.10962 per tablet

Appendix E

Results Problem-Focused

**Problem-Focused Studies
State FYE 2009**

Focus	Review Period	Evaluation Period	Patients Reviewed	Patients Selected	Cost Savings Calculated
Duplicate Antipsychotic Use in Children	05/01/2007-10/31/2007	02/01/2008-07/31/2008	52	52	\$31,070.70 *
Chronic Triptan Use without Migraine Prophylaxis	04/07/2008-07/07/2008	09/22/2008-03/22/2009	195	195	\$41,357.07 *
Duplicate Benzodiazepines	04/01/2007-09/30/2007	01/01/2008-06/30/2008	101	101	\$29,389.06 *
Long Term Muscle Relaxants	10/01/2007-03/31/2007	05/01/2008-12/31/2008	197	197	\$4,559.79 *
Chronic Bactroban/Mupirocin Use	01/01/2008-09/30/2008	02/01/2009-04/30/2009	113	113	\$11,156.41 *
					*
					*
					*
TOTAL			658	658	\$117,533.03 *

*Savings reported are pre-rebate, total dollars.

**Problem-Focused Studies Impact Rate
State FYE 2009**

Focus	Review Period	Evaluation Period	Patients Evaluated	Positive Impact	Impact Rate
Duplicate Antipsychotic Use in Children	05/01/2007-10/31/2007	02/01/2008-07/31/2008	52	18	34.62%
Chronic Triptan Use without Migraine Prophylaxis	04/07/2008-07/07/2008	09/22/2008-03/22/2009	195	26	13.33%
Duplicate Benzodiazepines	04/01/2007-09/30/2007	01/01/2008-06/30/2008	101	23	22.77%
Long Term Muscle Relaxants	10/01/2007-03/31/2007	05/01/2008-12/31/2008	197	14	7.11%
Chronic Bactroban/Mupirocin Use	01/01/2008-09/30/2008	02/01/2009-04/30/2009	113	109	96.46%
TOTAL			658	190	28.88%

Appendix F

Descriptions Problem-Focused



IOWA DUR FOCUS STUDY
Based on Iowa Paid Non-reversed Claims
Dates of Service between 1/1/2008 and 6/30/2008

Duplicate Benzodiazepines

Purpose: To re-evaluate the list of 101 members who received a letter for the Concurrent Benzodiazepine and Sedative Hypnotic Focus Study for the time frame of 4/1/2007 through 9/30/2007. The list of 101 members was then re-evaluated during 1/1/2008 and 6/30/2008 to see who was still using both Benzodiazepines and Sedative Hypnotics, who discontinued using Benzodiazepines while continuing the use of Sedative Hypnotics, and who discontinued the Sedative Hypnotics while continuing the Benzodiazepines.

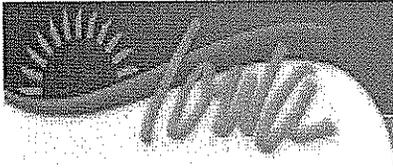
* Includes members with no claim history during the most recent run.

** Total Cost is calculated as the sum of Total State Dollars (pre-rebate) paid for all drugs in the study.

Number of members who discontinued Benzodiazepines and kept using Sedative Hypnotics	1
Number of members who discontinued Sedative Hypnotics and kept using Benzodiazepines.	17
Number of members who discontinued both *	5
Number of members who discontinued neither	78
Number of members with no claims	4

Costs	4/1/2007 - 9/30/2007	1/1/2008 - 6/30/2008	Cost Savings
Total Dollars (State and Federal)	\$73,384.28	\$43,991.63	\$29,392.65
Total Dollars Federal	\$45,483.58	\$27,156.03	\$18,327.54
Total Dollars State	\$27,900.70	\$16,835.60	\$11,065.11

Review of claims history shows that those members who discontinued the use of either Benzodiazepines and or Sedative Hypnotics did not use another drug in its place.



IOWA DUR FOCUS STUDY
Based on Iowa Paid Non-reversed Claims
Dates of Service between 2/1/2008 and 7/31/2008

Duplicate Antipsychotic use in Children

Purpose: To re-evaluate the list of 52 members who received a letter for the Duplicate Antipsychotic Use in Children Focus Study for the time frame of 5/1/2007 through 10/31/2007. The list of 52 members was re-evaluated during the time frame of 2/1/2008 through 7/31/2008 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotic.

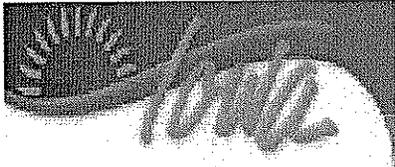
* Includes members with no claim history during the most recent run.

** Total Cost is calculated as the sum of Total Dollars (pre-rebate) paid for all drugs in the study.

Number of members who discontinued one or more Antipsychotics. *	18
Number of members who continued using the same antipsychotics regimen.	34
Number of members with no claims	5

Number of different Antipsychotics	Prior Member Count	Current Member Count
1	5	11
2	18	12
3	15	15
4	6	4
5	6	2
6	1	2
8	1	0

Costs	5/1/2007 - 10/31/2007	2/1/2008 - 7/31/2008	Cost Savings
Total Dollars (State and Federal)	\$176,756.90	\$151,362.37	\$25,394.53
Total Dollars Federal	\$109,553.93	\$93,435.99	\$16,117.94
Total Dollars State	\$67,202.97	\$57,926.38	\$9,276.59



IOWA DUR FOCUS STUDY
Based on Iowa Paid Non-Reversed Claims
Dates of Service between 10/1/2008 and 3/31/2009

Duplicate Antipsychotic Use in Children

Purpose: To re-evaluate the list of 52 members whose prescriber received a letter for the Duplicate Antipsychotic Use in Children Focus Study for the time frame of 5/1/2007 through 10/31/2007. The list of 52 members was re-evaluated during the time frame of 2/1/2008 through 7/31/2008 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotic(s). The list of 52 members was re-evaluated a second time from 10/1/2008 - 3/31/2009 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotic(s).

Number of members who discontinued one or more Antipsychotic(s) (2/1/2008 - 7/31/2008)	18
Number of members who continued using the same antipsychotic regimen (2/1/2008 - 7/31/2008)	14
Number of members who added an antipsychotic (2/1/2008 - 7/31/2008)	14
Number of members with no claims (2/1/2008 - 7/31/2008)	6

During the second follow-up period of 10/1/2008 - 3/31/2009, the following were observed:

	Of the 18 members who discontinued one or more antipsychotic(s) initially, the following changes occurred	Of the 14 members who continued using the same antipsychotic regimen initially, the following changes occurred	Of the 14 members who added an antipsychotic to their regimen initially, the following changes occurred
Number of members who discontinued one or more Antipsychotic(s)	7	2	1
Number of members who continued using the same antipsychotic regimen	4	7	3
Number of members who added an antipsychotic	3	2	8
Number of members with no claims	4	3	2



IOWA DUR FOCUS STUDY
Based on Iowa Paid Non-Reversed Claims
Dates of Service between 10/1/2008 and 3/31/2009

Duplicate Antipsychotic Use in Children

Purpose: To re-evaluate the list of 52 members whose prescriber received a letter for the Duplicate Antipsychotic Use in Children Focus Study for the time frame of 5/1/2007 through 10/31/2007. The list of 52 members was re-evaluated during the time frame of 2/1/2008 through 7/31/2008 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotic(s). The list of 52 members was re-evaluated a second time from 10/1/2008 - 3/31/2009 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotic(s).

Number of different Antipsychotics	Initial Member Count (5/1/2007 - 10/31/2007)	First Follow Up Member Count (2/1/2008 - 7/31/2008)	Second Follow Up Member Count (10/1/2008 - 3/31/2009)
1	5	11	14
2	18	12	13
3	15	15	6
4	6	4	3
5	6	2	0
6	1	2	1
8	1	0	0



IOWA DUR FOCUS STUDY
Based on Iowa Paid Non-Reversed Claims
Dates of Service between 5/1/2008 and 12/31/2008

Follow Up - Long-term Muscle Relaxant Users

Purpose: Letters were sent to 197 members who were identified as having 5 or more claims of a 30-day supply for a muscle relaxant (excluding baclofen) between 10-1-07 and 3-31-08. Letters were sent to the prescribers and pharmacies in May, 2008. At the end of the evaluation period on 12-31-08, the following impact was observed:

Number of members who discontinued Muscle Relaxants 14

Number of members who lost Medicaid Eligibility since 5/1/2008 0

Number of Surveys received from prescribers: 98

Costs	Original Costs (10/1/2007 - 3/31/2008)	Costs After DUR Intervention (5/1/2008 - 12/31/2008)	Cost Savings
Total Dollars (State and Federal)	\$20,203.09	\$15,643.30	\$4,559.79
Total Dollars Federal	\$12,471.37	\$9,656.61	\$1,745.03
Total Dollars State	\$7,731.72	\$5,986.69	\$2,814.76



IOWA DUR FOCUS STUDY
Based on Iowa Paid Non-Reversed Claims
Dates of Service between 9/22/2008 and 3/22/2009
Follow-Up - Chronic Triptan Use without Migraine Prophylactic

Purpose: Follow up on the 195 unique members who were identified as having two or more fills for a migraine treatment (triptans) within a three month time frame without trying a prophylactic medication* between 4/1/2008 and 7/1/2008.

Number of Unique Members from Original Study 195 Number of Unique Members after DUR Intervention 98

Member Counts Original Study	Drug Name	Member Counts After DUR Intervention
0	FROVA	0
1	AMERGE	1
104	IMITREX	52
8	IMITREX STATDOSE REFILL	3
5	IMITREX STATDOSE SYSTEM	1
25	MAXALT	11
30	MAXALT-MLT	25
35	RELPAX	19
1	ZOMIG	1

Number of members who lost Medicaid Eligibility since 4/1/2008	8		
Number of surveys sent	343		
Total Number of surveys received	134	Percent of surveys received	39.07%
Number of surveys received from Prescribers	112	Percent of surveys from Prescribers	83.58%
Number of surveys received from Pharmacies	22	Percent of surveys from Pharmacies	16.42%
Number of members who started a prophylactic medication.	26		

Costs (all costs pre-rebate)	Original Costs for Acute Treatment (4/1/2008 - 7/1/2008)	Costs for Acute Treatment After DUR Intervention (9/22/2008 - 3/22/2009)	Costs of Adding Prophylactic*	Cost Savings
Total Dollars (State and Federal)	\$97,693.13	\$51,689.80	\$4,646.26	\$41,357.07
Total Dollars Federal	\$60,364.59	\$32,254.44	\$2,899.27	\$25,210.88
Total Dollars State	\$37,328.54	\$19,435.36	\$1,746.99	\$16,146.19

* Prophylactic drugs consist of: propranolol, Inderal LA, timolol, amitriptyline, Depakote, Topamax, and verapamil.



IOWA DUR FOCUS STUDY
Based on Iowa Paid Non-reversed Claims
Dates of Service for a Three Month Time Frame (2/1/2009 to 4/30/2009)

Follow Up - Chronic Bactroban / Mupirocin Use

Purpose: Follow-up on the 113 unique members identified as having three or more fills of Bactroban and/or mupirocin in their claims history for a nine month time frame (1/1/08 to 9/30/08). Letters were sent to providers at the end of November, 2008.

Number of unique members from original study	113		
Number of unique members still using Bactroban / mupirocin chronically after DUR intervention	4		
Number of members who lost Medicaid eligibility since 4/1/2008	9		
Number of surveys sent	254	Percent of surveys received	34.65%
Number of surveys received from prescribers	44	Percent of surveys from prescribers	50.00%
Number of surveys received from pharmacies	44	Percent of surveys from pharmacies	50.00%
Number of members who started an OTC topical antibiotic	6		

Costs (pre-rebate)	Original Costs (7/1/2008 - 9/30/2008)	Costs After DUR Intervention (2/1/2009 - 4/30/2009)	Costs of adding a Topical Antibiotic	Cost Savings
Total Dollars (State and Federal)	\$12,170.50	\$740.15	\$273.94	\$11,156.41
Total Dollars Federal	\$7,594.39	\$461.85	\$170.94	\$6,961.60
Total Dollars State	\$4,576.11	\$278.30	\$103.00	\$4,194.81

Appendix G

Prior Auth Recommendations

2008-2009 Therapeutic Prior Authorization Criteria Review

During the fiscal year ending 2008, the Commission reviewed the following categories of medications covered under the prior authorization program.

The following criteria were reviewed with recommended changes:

- Growth Hormones – Modifications were made to requiring an annual bone age test for the diagnosis of growth hormone deficiency and excluding the FDA approved indication of idiopathic short stature for growth hormone therapy as it is not considered medically necessary.
- Linezolid (Zyvox) – Modifications were made to ensure the patient has an active infection and meets certain diagnostic criteria.
- Serotonin 5-HT-1-Receptor Agonists – Modifications were made to limit the number of doses to 12 unit doses per 30 days.
- Extended Release Formulations – Was reviewed twice; modifications were made to apply the criteria to Luvox CR, and also to require a previous trial and therapy failure with the preferred immediate release product of the same chemical entity for all non-preferred extended release formulations.
- ADD/ADHD/Narcolepsy – Modifications were made coincide with the changes to the Extended Release Formulations PA criteria to include a trial with a preferred immediate release and extended release product if a non-preferred long acting medication is requested.
- Nonsteroidal Anti-Inflammatory Drugs – Modifications were made to coincide with the changes to the Extended Release Formulations PA criteria to include a trial with the immediate release form of the non-preferred long acting medication.

The following are new classes for which clinical prior authorization criteria were developed and recommended:

- Vusion Ointment – Prior authorization criteria was developed and accepted for Vusion to require a trial and therapy failures with both miconazole 2% cream, and nystatin cream or ointment.
- Modified Formulations – Prior authorization criteria was developed and accepted to require a trial and therapy failure with the original parent drug product of the same chemical entity for a non-preferred isomer, pro-drug, metabolite, and/or alternative delivery system.

In addition, the Commission reviewed the clinical usefulness of polyethylene glycol 3350 (OTC MiraLax) in pre-colonoscopy bowel preps and recommended the product be covered without prior authorization for children 18 years of age and under when being used as a bowel prep.



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Craig Logemann, R.Ph., Pharm.D., BCPS

Dan Murphy, R.Ph.

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Chad Bissell, Pharm.D.
Director, (515) 725-1271

Pamela Smith, R.Ph.

August 7, 2008

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 6, 2008. On behalf of the DUR Commission, I respectfully submit the following recommendation:

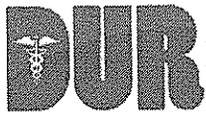
1) The DUR Commission reviewed the recommendation from the Pharmacy and Therapeutics (P&T) Committee meeting on June 16, 2008 regarding the drug, Pristiq™. The P&T Committee had recommended that due to a lack of documented benefit at doses greater than 50mg per day, a quantity limit of 30 tablets per 30 days be implemented on both the 50mg and 100mg strengths of Pristiq™. The DUR Commission expressed no objections to this recommendation. The Commission will further discuss this issue at their September meeting with updated information on the ability to split the 100mg tablet and may modify their recommendation on the quantity limit for the 100mg strength.

Thank you in advance for the Department's consideration of these recommendations.

Sincerely,

Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

Cc: Eileen Creager, IME
Susan Parker, Pharm.D., IME
Andi Dykstra, IFMC
Thomas Kline, D.O., IFMC
Sandy Pranger, R.Ph., GHS



IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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Pamela Smith, R.Ph.

November 6, 2008

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, November 5, 2008. On behalf of the DUR Commission, I respectfully submit the following recommendations:

- 1) The DUR Commission voted in favor of placing a quantity limit of 5/30 on the preferred drug Glucagen, to mirror the current edit in place for Glucagon Emergency Kit, which is now non-preferred.
- 2) The DUR Commission voted to apply clinical prior authorization (PA) criteria to Vusion™ Ointment as follows:
Prior Authorization is required for Vusion Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.
- 3) The DUR Commission voted to revise the PA criteria for Growth Hormones as follows:
Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. All of the following criteria must be met for approval for prescribing of growth hormones:
 1. Standard deviation of 2.0 or more below mean height for chronological age.
 2. No intracranial lesion or tumor diagnosed by MRI.
 3. Growth rate below five centimeters per year.
 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.
 5. *Annual bone age testing is required for a diagnosis of growth hormone deficiency.* Bone age must be 14 to 15 years or less in females and 15 to 16 years or less in males is required.
 6. Epiphyses open.

Prior authorization will be granted for 12-month periods per *member* as needed.

The following FDA approved indication for growth hormone therapy is considered not medically necessary and requests will be denied:

1. Idiopathic short stature

If the request is for **Zorbtive®** [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.

4) The DUR Commission voted to revise the PA criteria for Linezolid (Zyvox) as follows:
Prior authorization is required for Zyvox®. Payment for Zyvox® will be considered when there is documentation that:

1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable).
2. Patient *has an active infection and meets one of the following diagnostic criteria:*
 - Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract**.
 - Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin*
 - Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin*

*Severe intolerance to vancomycin is defined as:

- Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration
- Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine)

**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

5) The DUR Commission voted to revise the PA criteria for Serotonin 5-HT₁-Receptor Agonists as follows:

Prior authorization is required for preferred serotonin 5-HT₁-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT₁-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Prior authorization will be required for all non-preferred serotonin 5-HT₁-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT₁-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents.

6) The DUR Commission voted to revise the PA criteria for Extended Release Formulations as follows:

Payment for the extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

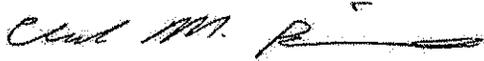
Prior authorization is required for the following extended release formulation(s):

1. Seroquel® XR
2. Luvox® CR

- 7) The DUR Commission voted in favor of implementing a Quarterly Narcotic Utilization Report to be sent to prescribers. This report will be provided to prescribers on a quarterly basis and will highlight members using narcotics prescribed by multiple providers and/or filled at multiple pharmacies. The Commission recommends the algorithm look at members using 3 or more physicians and/or 3 or more pharmacies to generate the report.

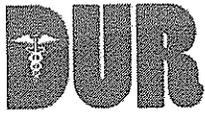
Thank you in advance for the Department's consideration of these recommendations.

Sincerely,



Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

Cc: Eileen Creager, IME
Andi Dykstra, IFMC
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DUR Director, (515) 725-1271

Pamela Smith, R.Ph.

March 5, 2009

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, March 4, 2009. The DUR Commission members discussed the Mental Health Advisory Group's review of the Pharmacy and Therapeutics Committee's recommendations to move select mental health drugs from the Recommended Drug List to the Preferred Drug List. These recommendations include the following:

- 1) Recommended to change Nardil from Recommended to Preferred
- 2) Recommended to change Emsam from Non-Recommended to Preferred
- 3) Recommended to change Parnate from Recommended to Preferred.
- 4) Recommended to change Lexapro from Recommended to Preferred and accept the DUR Commission recommendation to split Lexapro 20mg tablets to achieve a 10mg dose and to split Lexapro 10mg tablets to achieve a 5mg dose.
- 5) Recommended to change Luvox CR from Non-Recommended to Non-Preferred with Conditions and include under the Extended Release Formulations PA category.
- 6) Recommended to change Paxil Susp from Recommended to Preferred.
- 7) Recommended to change Pexeva from Non-Recommended to Non-Preferred.
- 8) Recommended to change Pristiq from Non-Recommended to Non-Preferred with Conditions and add clinical prior authorization to this drug. The DUR Commission would need to develop the PA criteria for this drug.
- 9) Recommended to change Cymbalta from Non-Recommended to Preferred.
- 10) Recommended to change Maprotiline from Recommended to Preferred.
- 11) Recommended to change Wellbutrin XL from Recommended to Preferred.
- 12) Recommended to change Effexor XR from Non-Recommended to Preferred.
- 13) Recommended to change Amoxapine from Recommended to Preferred.
- 14) Recommended to change Tofranil-PM from Non-Recommended to Preferred.
- 15) Recommended to change Vivactil from Recommended to Preferred.
- 16) Recommended to change Surmontil from Recommended to Preferred.
- 17) Recommended to change Invega from Non-Recommended to Non-Preferred with Conditions and add clinical prior authorization to this drug. The DUR Commission would need to develop the PA criteria for this drug.

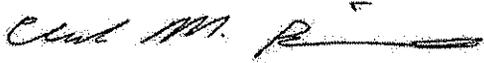
- 18) Recommended to change Risperdal from Recommended to Preferred.
- 19) Recommended to change Risperdal M-Tab from Non-Recommended to Non-Preferred with Conditions and add clinical prior authorization to this drug. The DUR Commission would need to develop the PA criteria for this drug.
- 20) Recommended to change Risperdal Consta from Non-Recommended to Preferred.
- 21) Recommended to change Seroquel from Recommended to Preferred.
- 22) Recommended to change Seroquel XR from Non-Recommended to Non-Preferred with Conditions and keep the clinical prior authorization requirement. PA criteria already exists for this drug under the PA category Extended Release Formulations.
- 23) Recommended to change Zyprexa from Non-Recommended to Preferred.
- 24) Recommended to change Zyprexa Zydys from Non-Recommended to Non-Preferred with Conditions and add clinical prior authorization to this drug. The DUR Commission would need to develop the PA criteria for this drug.
- 25) Recommended to change Abilify from Non-Recommended to Preferred.
- 26) Recommended to change Abilify Discmelt from Non-Recommended to Non-Preferred with Conditions and add clinical prior authorization to this drug. The DUR Commission would need to develop the PA criteria for this drug.
- 27) Recommended to change Geodon from Recommended to Preferred.
- 28) Recommended to change Moban from Non-Recommended to Preferred.
- 29) Recommended to change all strengths of Vyvanse from Recommended to Preferred.
- 30) Recommended to change Adderall XR from Recommended to Preferred
- 31) Recommended to change Focalin from Recommended to Preferred.
- 32) Recommended to change Focalin XR from Recommended to Preferred.
- 33) Recommended to change Daytrana from Recommended to Preferred.
- 34) Recommended to change Metadate CD from Non-Recommended to Non-Preferred.
- 35) Recommended to change Concerta from Recommended to Preferred.
- 36) Recommended to change Ritalin LA from Non-Recommended to Non-Preferred.
- 37) Recommended to change Strattera from Non-Recommended to Preferred.
- 38) Recommended to change Provigil from Non-Recommended to Preferred.

Additionally, the P&T Committee recommended that all drugs changing to a non-preferred status in these categories be grandfathered. Grandfathering allows members currently on a drug to remain on the drug. The pharmacy claims processing system identifies members on a particular drug by looking back in the claims system 180 days to see which members have had paid claims for the specific drug and allows the members to continue to get the same drug without restrictions. This grandfathering process remains in place for the duration of the member's eligibility. The change in drug status to non-preferred would only stop pharmacy claims from paying for "new users" or those members that have not had the drug previously paid by Medicaid. If the member does not have a history of the requested drug in the Medicaid paid claims system, a prior authorization would be required.

The Mental Health Advisory Group met on December 12, 2008, and February 13, 2009, to discuss these recommendations. At the conclusion of their meeting on February 13, 2009, the members of the Mental Health Advisory Group unanimously approved the original recommendations put forth by the P&T Committee. Following discussion at the March 4, 2009 DUR Commission meeting, the DUR Commission had no concerns with these recommendations to be sent back to the P&T Committee. As a result of this recommendation, the DUR Commission is in the processes of revising the existing clinical prior authorization criteria for Extended Release Products and is developing clinical prior authorization criteria for Modified Formulations.

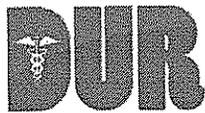
Thank you in advance for the Department's consideration of accepting the DUR Commission's endorsement of the P&T Committee's recommendations on select mental health drugs.

Sincerely,

A handwritten signature in black ink, appearing to read "Chad M. Bissell", with a horizontal line extending to the right.

Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

Cc: Eileen Creager, IME
Andi Dykstra, IME
Thomas Kline, D.O., IME
Sandy Pranger, R.Ph., IME



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DUR Director, (515) 725-1271

Pamela Smith, R.Ph.

May 7, 2009

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, May 6, 2009. At this meeting, the DUR Commission members discussed the Modified Formulations Prior Authorization Criteria for a second time, OTC *MiraLax*, and *Trilipix*. The following recommendations have been made by the DUR Commission:

Since no comments were received from medical associations or the Iowa Pharmacy Association in response to a March 5th letter that was sent to them detailing the proposed Modified Formulations criteria, the DUR Commission recommends the following criteria be considered for implementation:

Modified Formulations:

Newly Proposed Criteria: Payment for a non-preferred isomer, pro-drug, metabolite, and/or alternative delivery system will only be considered for cases in which there is documentation of a recent trial and therapy failure with the original parent drug product of the same chemical entity, unless evidence is provided that use of the original product would be medically contraindicated.

Prior authorization is required for the following modified formulations: Abilify Discmelt®, Invega®, Pristiq™, Risperdal® M-Tab®, and Zyprexa® Zydis®.

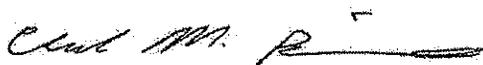
The Commission would like to discuss the possibility of adding other modified formulations to these criteria (e.g. *Xopenex*). Other examples of modified formulations will be discussed at the June DUR meeting.

The DUR Commission reviewed the clinical usefulness of polyethylene glycol 3350 (*OTC MiraLax*) in pre-colonoscopy bowel preps. The Commission did not recommend changes to the existing age limitations on *OTC MiraLax* (0-12 years: no PA required; 13-19 years: PA required; 19+ years: not covered), but did recommend the product be covered without a prior authorization for children 18 years of age and under when being used as a bowel prep. The programmers for the Pharmacy Point of Sale system will investigate ways to best accomplish this, and will report back to the Commission at their June meeting.

Finally, at the request of the Pharmacy and Therapeutics Committee, the DUR Commission reviewed the safety of statins plus *Tricor*. The purpose was to determine if utilization data suggested that prescribers were concerned with the safety of combining statins and *Tricor* thus making the case that *Trilipix* offered a clinical advantage over *Tricor* and be recommended for preferred status on the Preferred Drug List. The DUR Commission did not feel as though a change in the Preferred Drug List status of *Trilipix* was warranted based on a review of the available clinical information and utilization data.

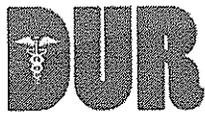
Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendation for clinical prior authorization criteria for Modified Formulations, and coverage of *OTC MiraLax* for use in pre-colonoscopy bowel preps without a prior authorization.

Sincerely,

A handwritten signature in black ink, appearing to read "Chad M. Bissell", with a horizontal line extending to the right.

Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

Cc: Eileen Creager, IME
Andi Dykstra, IME
Thomas Kline, D.O., IME
Sandy Pranger, R.Ph., IME



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DUR Director, (515) 725-1271

Pamela Smith, R.Ph.

June 4, 2009

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, June 3, 2009. At this meeting, the DUR Commission members discussed drugs to be added to the Modified Formulations and Extended Release Formulations Prior Authorization Criteria, as well as changes to the ADD/ADHD/Narcolepsy Agents Prior Authorization Criteria, the Nonsteroidal Anti-Inflammatory Drugs Prior Authorization Criteria, and the Palivizumab (*Synagis*®) Prior Authorization Criteria. The following recommendations have been made by the DUR Commission:

Modified Formulations:

In addition to *Abilify Discmelt*, *Inega*, *Pristiq*, *Risperdal-M Tabs*, and *Zyprexa Zydis*, the Commission discussed adding the following drugs to the Modified Formulations Prior Authorization Criteria: *Flector*, *Voltaren Gel*, *Kapidex*, *Xyzal*, *Trilipix*, and *Xopenex*. Following their discussion, the Commission voted in favor of adding *Trilipix* and *Xopenex* to the Modified Formulations Prior Authorization Criteria.

Extended Release Formulations:

Since no comments were received from medical associations or the Iowa Pharmacy Association in response to a May 8th letter that was sent to them detailing the proposed Extended Release Formulations criteria, the DUR Commission recommends the following criteria be considered for implementation:

Existing Criteria: Payment for the extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Prior authorization is required for the following extended release formulation(s):

- 1) Luvox CR®
- 2) Seroquel XR™

Newly Proposed Criteria: Payment for a non-preferred extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the preferred immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Prior authorization is required for the following extended release formulation(s):
Adoxa, Amrix, Cardura XL, Cipro XR, Coreg CR, Doryx, Flagyl ER, glipizide ER, Glucotrol XL, Luvox CR, metronidazole SR, Prozac Weekly, Requip XL, Ryzolt, Seroquel XR, Solodyn ER, tramadol SR, Ultram ER.

ADD/ADHD/Narcolepsy:

Comments received from medical associations and the Iowa Pharmacy Association members in response to a May 8th letter that was sent to them detailing the proposed changes to the ADD/ADHD/Narcolepsy criteria were reviewed. The DUR Commission recommends the following criteria be considered for implementation:

Existing Criteria: Prior authorization is required for ADD/ADHD/Narcolepsy agents for members 21 years of age or older.

Newly Proposed Criteria: Prior Authorization (PA) is required for ADD/ADHD/Narcolepsy Agents for members 21 years of age or older. PA is also required for all non-preferred agents, regardless of age, the first day of therapy. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. *If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required, unless evidence is provided that use of these products would be medically contraindicated.

Nonsteroidal Anti-Inflammatory Drugs:

Since no comments were received from medical associations or the Iowa Pharmacy Association in response to a May 8th letter that was sent to them detailing the proposed changes to the Nonsteroidal Anti-Inflammatory Drugs criteria, the DUR Commission recommends the following criteria be considered for implementation:

Existing Criteria: Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all non-preferred COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs.

1. Requests for a non-preferred nonsteroidal anti-inflammatory drug must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs.
2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with two preferred COX-2 preferentially selective nonsteroidal anti-inflammatory drugs.

Newly Proposed Criteria: Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all non-preferred COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs.

1. Requests for a non-preferred nonsteroidal anti-inflammatory drug must document previous trials

and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs.

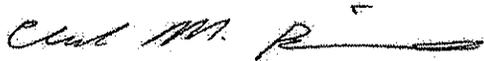
2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with two preferred COX-2 preferentially selective nonsteroidal anti-inflammatory drugs.

* If a non-preferred long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested product, unless evidence is provided that use of the immediate release product would be medically contraindicated.

The Commission reviewed utilization trends of palivizumab (*Synagis*®) over the past four RSV seasons and reviewed the existing prior authorization criteria for use during the 2009-2010 RSV season. There were no recommended changes to the existing clinical prior authorization criteria. The Commission also discussed the need to change the refill tolerance on palivizumab to ensure doses were not administered earlier than the 29-32 days as recommended. The Committee did not feel as though changing the refill tolerance was necessary at this time due to the low occurrence of early billing.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendation for clinical prior authorization criteria changes which include drugs to be added to the Modified Formulations and Extended Release Formulations Prior Authorization Criteria, as well as changes to the ADD/ADHD/Narcolepsy Agents Prior Authorization Criteria, and the Nonsteroidal Anti-Inflammatory Drugs Prior Authorization Criteria.

Sincerely,



Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

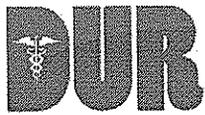
Cc: Eileen Creager, IME
Andi Dykstra, R.N., IME
Thomas Kline, D.O., IME
Sandy Pranger, R.Ph., IME
Erin Halverson, R.Ph., IME

Appendix H

Prospective DUR

The following prospective DUR edits were recommended to the Department by the Commission in sfye 2009:

- Point of Sale a quantity edit of 30 tablets per 30 days on both the 50mg and 100mg strengths of Pristiq™.
- Point of Sale quantity edit of 5 kits per 30 days on Glucagen.



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Pamela Smith, R.Ph.

August 7, 2008

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, August 6, 2008. On behalf of the DUR Commission, I respectfully submit the following recommendation:

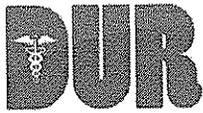
1) The DUR Commission reviewed the recommendation from the Pharmacy and Therapeutics (P&T) Committee meeting on June 16, 2008 regarding the drug, Pristiq™. The P&T Committee had recommended that due to a lack of documented benefit at doses greater than 50mg per day, a quantity limit of 30 tablets per 30 days be implemented on both the 50mg and 100mg strengths of Pristiq™. The DUR Commission expressed no objections to this recommendation. The Commission will further discuss this issue at their September meeting with updated information on the ability to split the 100mg tablet and may modify their recommendation on the quantity limit for the 100mg strength.

Thank you in advance for the Department's consideration of these recommendations.

Sincerely,

Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

Cc: Eileen Creager, IME
Susan Parker, Pharm.D., IME
Andi Dykstra, IFMC
Thomas Kline, D.O., IFMC
Sandy Pranger, R.Ph., GHS



IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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Director, (515) 725-1271

Pamela Smith, R.Ph.

November 6, 2008

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, November 5, 2008. On behalf of the DUR Commission, I respectfully submit the following recommendations:

- 1) The DUR Commission voted in favor of placing a quantity limit of 5/30 on the preferred drug Glucagen, to mirror the current edit in place for Glucagon Emergency Kit, which is now non-preferred.
- 2) The DUR Commission voted to apply clinical prior authorization (PA) criteria to Vusion™ Ointment as follows:
Prior Authorization is required for Vusion Ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.
- 3) The DUR Commission voted to revise the PA criteria for Growth Hormones as follows:
Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. All of the following criteria must be met for approval for prescribing of growth hormones:
 1. Standard deviation of 2.0 or more below mean height for chronological age.
 2. No intracranial lesion or tumor diagnosed by MRI.
 3. Growth rate below five centimeters per year.
 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.
 5. *Annual bone age testing is required for a diagnosis of growth hormone deficiency.* Bone age must be 14 to 15 years or less in females and 15 to 16 years or less in males is required. .
 6. Epiphyses open.

Prior authorization will be granted for 12-month periods per *member* as needed.

The following FDA approved indication for growth hormone therapy is considered not medically necessary and requests will be denied:

1. Idiopathic short stature

If the request is for **Zorbtive®** [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.

4) The DUR Commission voted to revise the PA criteria for Linezolid (Zyvox) as follows:
Prior authorization is required for Zyvox®. Payment for Zyvox® will be considered when there is documentation that:

1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable).
2. Patient *has an active infection and meets one of the following diagnostic criteria:*
 - Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract**.
 - Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin*
 - Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin*

*Severe intolerance to vancomycin is defined as:

- Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration
- Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine)

**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

5) The DUR Commission voted to revise the PA criteria for Serotonin 5-HT1-Receptor Agonists as follows:

Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents.

6) The DUR Commission voted to revise the PA criteria for Extended Release Formulations as follows:
Payment for the extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

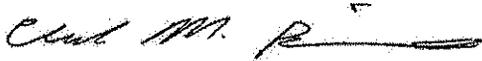
Prior authorization is required for the following extended release formulation(s):

1. Seroquel® XR
2. Luvox® CR

- 7) The DUR Commission voted in favor of implementing a Quarterly Narcotic Utilization Report to be sent to prescribers. This report will be provided to prescribers on a quarterly basis and will highlight members using narcotics prescribed by multiple providers and/or filled at multiple pharmacies. The Commission recommends the algorithm look at members using 3 or more physicians and/or 3 or more pharmacies to generate the report.

Thank you in advance for the Department's consideration of these recommendations.

Sincerely,



Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

Cc: Eileen Creager, IME
Andi Dykstra, IFMC
Thomas Kline, D.O., IFMC
Sandy Pranger, R.Ph., GHS



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May 7, 2009

Susan L. Parker, R.Ph., Pharm.D.
Pharmacy Director
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Susan:

The Iowa Medicaid Drug Utilization Review (DUR) Commission met on Wednesday, May 6, 2009. At this meeting, the DUR Commission members discussed the Modified Formulations Prior Authorization Criteria for a second time, OTC *MiraLax*, and *Trilipix*. The following recommendations have been made by the DUR Commission:

Since no comments were received from medical associations or the Iowa Pharmacy Association in response to a March 5th letter that was sent to them detailing the proposed Modified Formulations criteria, the DUR Commission recommends the following criteria be considered for implementation:

Modified Formulations:

Newly Proposed Criteria: Payment for a non-preferred isomer, pro-drug, metabolite, and/or alternative delivery system will only be considered for cases in which there is documentation of a recent trial and therapy failure with the original parent drug product of the same chemical entity, unless evidence is provided that use of the original product would be medically contraindicated.

Prior authorization is required for the following modified formulations: Abilify Discmelt®, Invega®, Pristiq™, Risperdal® M-Tab®, and Zyprexa® Zydis®.

The Commission would like to discuss the possibility of adding other modified formulations to these criteria (e.g. *Xopenex*). Other examples of modified formulations will be discussed at the June DUR meeting.

The DUR Commission reviewed the clinical usefulness of polyethylene glycol 3350 (*OTC MiraLax*) in pre-colonoscopy bowel preps. The Commission did not recommend changes to the existing age limitations on *OTC MiraLax* (0-12 years: no PA required; 13-19 years: PA required; 19+ years: not covered), but did recommend the product be covered without a prior authorization for children 18 years of age and under when being used as a bowel prep. The programmers for the Pharmacy Point of Sale system will investigate ways to best accomplish this, and will report back to the Commission at their June meeting.

Finally, at the request of the Pharmacy and Therapeutics Committee, the DUR Commission reviewed the safety of statins plus *Tricor*. The purpose was to determine if utilization data suggested that prescribers were concerned with the safety of combining statins and *Tricor* thus making the case that *Trilipix* offered a clinical advantage over *Tricor* and be recommended for preferred status on the Preferred Drug List. The DUR Commission did not feel as though a change in the Preferred Drug List status of *Trilipix* was warranted based on a review of the available clinical information and utilization data.

Thank you in advance for the Department's consideration of accepting the DUR Commission's recommendation for clinical prior authorization criteria for Modified Formulations, and coverage of *OTC MiraLax* for use in pre-colonoscopy bowel preps without a prior authorization.

Sincerely,



Chad M. Bissell, Pharm.D.
Director, Drug Utilization Review
Iowa Medicaid Enterprise

Cc: Eileen Creager, IME
Andi Dykstra, IME
Thomas Kline, D.O., IME
Sandy Pranger, R.Ph., IME

Appendix I
FUL

**Iowa Medicaid Enterprise
State Maximum Allowable Cost (State MAC) Rate Updates**

Rate Decreases

Drug Name	State MAC Rate
FLUTICASONE PROPIONATE 50MCG SPRAY	1.18072

Rate Additions

Drug Name	State MAC Rate
RISPERIDONE 0.25MG TABLET	2.93397
RISPERIDONE 0.5MG TABLET	3.31855
RISPERIDONE 1MG TABLET	3.53808
RISPERIDONE 2MG TABLET	6.27634
RISPERIDONE 3MG TABLET	7.02806
RISPERIDONE 4MG TABLET	9.37870
ZALEPLON 10MG CAPSULE	0.94643
ZALEPLON 5MG CAPSULE	0.92067

**Iowa Medicaid Enterprise
State Maximum Allowable Cost (SMAC)
Rate Updates**

Rate Additions

Drug Name	State MAC Rate
BENZONATATE 200 MG CAPSULE	0.33138
BETHANECHOL CHLORIDE 50 MG TABLET	0.99473
DRONABINOL 10 MG CAPSULE	18.15951
DRONABINOL 5 MG CAPSULE	10.64228
GALANTAMINE HYDROBROMIDE 12 MG TABLET	2.43181
GALANTAMINE HYDROBROMIDE 8 MG TABLET	2.54877
LAMOTRIGINE 100 MG TABLET	0.75393
LAMOTRIGINE 150 MG TABLET	0.85302
LAMOTRIGINE 200 MG TABLET	0.92768
LAMOTRIGINE 25 MG TABLET	0.65535
LAMOTRIGINE 5 MG TAB DISPER	0.43047
RAMIPRIL 1.25 MG CAPSULE	0.17681
TOPIRAMATE 100 MG TABLET	1.18597
TOPIRAMATE 200 MG TABLET	1.37252
TOPIRAMATE 25 MG TABLET	0.46228
TOPIRAMATE 50 MG TABLET	0.86800
VENLAFAXINE HCL 100 MG TABLET	0.69496
VENLAFAXINE HCL 25 MG TABLET	0.63552
VENLAFAXINE HCL 37.5 MG TABLET	0.90951
VENLAFAXINE HCL 50 MG TABLET	0.87872
VENLAFAXINE HCL 75 MG TABLET	0.97297
VERAPAMIL HCL 100 MG CAP24H PEL	1.67006
VERAPAMIL HCL 200 MG CAP24H PEL	1.46873
VERAPAMIL HCL 300 MG CAP24H PEL	2.40163

**Iowa Medicaid Enterprise
State Maximum Allowable Cost (SMAC)
Rate Updates**

Rate Decreases

Drug Name	State MAC Rate
BENZONATATE 100 MG CAPSULE	0.20336
LEVETIRACETAM 250 MG TABLET	0.74098
LEVETIRACETAM 500 MG TABLET	0.90647
LEVETIRACETAM 750 MG TABLET	1.16193
OXYBUTYNIN CHLORIDE 10 MG TAB OSM 24	2.43907
OXYBUTYNIN CHLORIDE 5 MG TAB OSM 24	2.56500
ROPINIROLE HCL 5 MG TABLET	0.54456

Appendix J

Newsletters

2008

Vol. 21, No. 1

DUR DIGEST

The Bulletin of Medicaid Drug Utilization Review in Iowa

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Pamela Smith, R.Ph.
DUR Project Coordinator

Palivizumab (Synagis) PA Criteria

2008-2009 RSV Season

RSV season typically begins in November and lasts through April, but it can begin earlier or persist later in certain communities. This year, Synagis Prior Authorization requests will be approved for a start date of October 30th and will be valid through March 31st for infants who meet the criteria. An additional sixth dose beyond March 31st will be determined based on epidemiological data at that time. PA's will be approved for a 30 day supply with a quantity limit of one-50mg vial and two-100mg vials per month. The new Palivizumab (Synagis) PA form is available online at www.iowamedicaidpdl.com under PA forms.

Current PA criteria:

Prior authorization is required for therapy with palivizumab. Payment for palivizumab will be considered for patients who meet one of the following criteria:

Chronic Lung Disease (CLD)

- Patient is less than 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, corticosteroid, or diuretic therapy) or oxygen within six months before the anticipated start of RSV season.

Prematurity

- Patient is less than 12 months of age at start of therapy with a gestational age of less than or equal to 28 weeks.
- Patient is less than 6 months of age at start of therapy with a gestational age between 28 weeks and 31 weeks.
- Patient is less than 6 months of age at start of therapy with a gestational age of 32 weeks to 35 weeks and has at least two risk factors.

Congenital Heart Disease (CHD)

- Patient is less than 24 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following: Receiving medication to control congestive heart failure, moderate to severe pulmonary hypertension, or cyanotic congenital heart disease.

Severe Immunodeficiency

- Patient is less than 24 months of age at start of therapy and has severe immunodeficiencies (e.g., severe combined immunodeficiency or advanced acquired immunodeficiency syndrome).

2008-2009 Influenza Season

Source: CDC, Prevention and Control of Influenza: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR 2008;57

Vaccination of all children aged 6 months to 18 years should begin before or during the 2008-09 influenza season if feasible, but no later than the 2009-10 influenza season. **Vaccination of all children aged 5-18 years is a new ACIP recommendation.**

Children and adolescents at high risk for influenza complications should continue to be a focus of vaccination efforts. **Recommendations for these children have not changed.** Children and adolescents at higher risk for influenza complication are those:

- Aged 6 months to 4 years
- Who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus)
- Who are immunosuppressed (including those by medications or HIV)
- Who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorder) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration
- Who are receiving long-term aspirin therapy who might be at risk of Reye syndrome after influenza virus infection
- Who are residents of chronic-care facilities
- Who are pregnant during the influenza season

Annual recommendations for adults have not changed in 2008. Annual vaccination against influenza is recommended for any adult who wants to reduce the risk for becoming ill with influenza or transmitting it to others. Vaccination is also recommended for all adults in the following groups because these persons are either at high risk for influenza complications, or are close contacts of persons at higher risk:

- Persons aged 50 years or older
- Women who are pregnant during the influenza season
- Who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological or metabolic disorders (including diabetes mellitus)
- Who are immunosuppressed (including those by medications or HIV)
- Who have any condition (e.g., cognitive dysfunction, spinal cord injuries, seizure disorders, or other neuromuscular disorder) that can compromise respiratory function or the handling of respiratory secretions or that can increase the risk for aspiration
- Residents of nursing homes and other chronic-care facilities
- Health-care personnel
- Household contacts and caregivers of children ages < 5 years and adults ages 50 or more years, with particular emphasis on vaccinating contacts of children aged < 6 months
- Household contacts and caregivers of persons with medical conditions that put them at risk for severe complications from influenza

Prevention and treatment of influenza

Influenza vaccination is payable for Iowa Medicaid members who are not dual eligible for Medicare. The trivalent inactivated influenza (injectable) vaccine (TIV) is preferred for members aged 19 to 64. Flumist® nasal spray, the live, attenuated influenza vaccine (LAIV) is preferred for members aged 19 to 49 until March 2009. Children aged 6 months to 18 years should be referred to the Vaccines for Children (VFC) program through the Department of Public Health.

Antiviral medications, such as Tamiflu® and Relenza®, are preferred on the PDL. Tamiflu has a quantity limit of 14 units per 30 days which for the suspension, is 7.5ml per day or 3 bottles. **The ACIP is also recommending that amantadine or rimantidine not be used alone for the treatment or prevention of influenza as resistance has increased over the past several years.**

Atypical Antipsychotics and Metabolic Testing

Source: Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care 2004; 27(2):596-601.

There is a growing body of evidence showing that patients on atypical antipsychotics have a higher prevalence of metabolic syndrome compared to those in the general population. Metabolic syndrome is defined as the presence of at least three of five of the following clinical features: abdominal obesity (measured by waist circumference), impaired fasting glucose or diabetes, high triglycerides, low high-density lipoprotein (HDL) cholesterol, and hypertension. Metabolic syndrome greatly increases the risk of cardiovascular disease and the development of Type II diabetes.

The Iowa Medicaid Drug Utilization Review Commission recently reviewed medical claims for incidence of metabolic testing (fasting blood glucose, HgbA1C, lipids) for members with at least three prescriptions for atypical antipsychotics for the period of January 1, 2008 through July 1, 2008. The query found 9,957 total members with three or more atypical antipsychotics, of which, 8,876 members did not have any metabolic tests performed during the same time period.

The American Diabetes Association (ADA) and the American Psychiatric Association (APA) Consensus panel have developed guidelines highlighting the importance of monitoring for metabolic syndrome in patients taking atypical antipsychotics. Given the known metabolic risks associated with atypical antipsychotics such as weight gain, glucose intolerance or diabetes, and dyslipidemia, baseline screening and regularly monitoring patients should become a standard of care. Patients taking atypical antipsychotics should have baseline (or as soon as clinically feasible) and periodic screening of six measures to ensure any changes are caught early and the appropriate interventions taken.

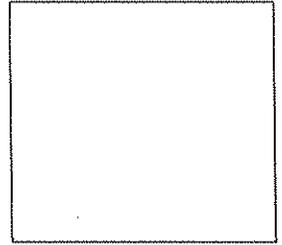
Monitoring Protocol and Diagnostic Criteria for Patients Taking Atypical Antipsychotics

Measurement	Diagnostic Criteria	Baseline	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 Years
Family History	N/A	X					X	
Weight (BMI)	> 30 kg/m ²	X	X	X	X	X		
Waist Circumference	-men > 40 inches -women > 35 inches	X					X	
Blood Pressure	≥ 130/85 mm Hg Or taking antihypertensive medications	X			X		X	
Fasting Plasma Glucose or HbA1c	≥ 110 mg/dL (NCEP ATP III definition) ≥ 100mg/dL (NHLBI/AHA definition) or using insulin, hypoglycemic medications	X			X		X	
Fasting Lipid Profile	Triglycerides ≥150mg/dL HDL -men < 40mg/dL -women < 50mg/dL	X			X			X

Abbreviations: NCEP, National Cholesterol Education Program; NHLBI, National Heart Lung and Blood Institute; AHA, American Heart Association



Iowa Medicaid Drug Utilization Review
Iowa Medicaid Enterprise
100 Army Post Road
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DUR Commission News

The Iowa Medicaid Drug Utilization Review (DUR) Commission contract has been held by the Iowa Foundation for Medical Care (IFMC) since 1985. IFMC has transitioned the administration responsibilities for this contract from the Iowa Pharmacy Association to Goold Health Systems (GHS), as a subcontractor to IFMC. GHS began its DUR management responsibilities on July 1, 2008. IFMC, working in collaboration with GHS, will attempt to make this transition as seamless as possible. However, you may see minor changes in some aspects of the day-to-day operations in the near future.

GHS is a healthcare management company that specializes in providing pharmacy benefit services, clinical data reviews and analyses, health care assessments, data capture, data center and other support services to State Medicaid agencies, the Federal Government, private sector companies and non-profit organizations. Present State Medicaid Agency clients include the States of: Alabama, Iowa, Maine, Utah, Vermont, West Virginia and Wyoming.

GHS staffs the Medicaid DUR Commission in the State of Maine and interacts with the Medicaid DUR Commissions in West Virginia and Wyoming. GHS is the vendor for the Sovereign States Drug Consortium, a multi-state drug rebate pool presently comprised of Iowa, Maine, Utah and Vermont, with West Virginia and Wyoming poised to join in 2008.

GHS has been in business since 1974. The company has offices in Des Moines, Iowa and Augusta, Maine, employs over 160 people and was named one of the 5,000 fastest growing, privately-held companies by *INC Magazine* in 2007.

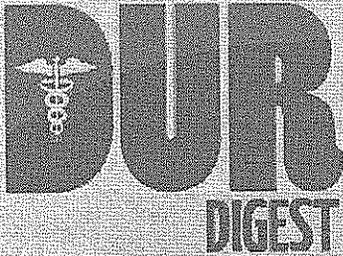
Welcome Dr. Mark Graber, M.D. to the DUR Commission



Dr. Mark Graber is an emergency medicine physician at the University of Iowa Hospitals and Clinics. Dr. Graber graduated from Eastern Virginia Medical School and completed his Family Practice Residency at the University of Iowa. In addition to his duties in the Emergency Department, Dr. Graber is also a Professor of Emergency Medicine and Family Medicine at the University of Iowa Carver College of Medicine, serves as an advisor to medical students and residents, and has published numerous text books, reviews, and papers in publications such as *The Annals of Pharmacotherapy*, *Emergency Medicine*, *American Family Physician*. Through his travels, Dr. Graber has presented throughout the United States as well as Ukraine, Russia, and China. In 2007, Dr. Graber was honored by appearing on of the "Best Doctors In America" list. Dr. Graber was appointed to the Commission in 2008; his term will expire in 2012.

2009

Vol. 21, No. 2



The Bulletin of Medicaid Drug Utilization Review in Iowa

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DUR Project Coordinator

Beginning the first quarter of 2009, the DUR Commission will be providing prescribers with the *Quarterly Narcotic Utilization Report*. This report will highlight Medicaid members who are using three or more prescribers and/or pharmacies for narcotic medications. Members with a diagnosis of cancer will be excluded from the report. The intent of the report is to make the prescriber aware of his or her patients' use of narcotic medications and to help the prescriber make informed decisions in the future. It is not intended to penalize or identify prescribers, but to help avoid over utilization or diversion of narcotic medications.

This report will be produced and mailed four times a year. Contained in the report will be the member's name(s), date the prescriptions were dispensed, drug names, quantities dispensed, days supply, prescriber names, pharmacy names, and pharmacy phone number. Pharmacies will not receive a copy of this report. Prescribers will be directed to contact the dispensing pharmacy first if there are concerns about the accuracy of the data since the most common explanation is usually an incorrect NPI number entered by the pharmacy. Further questions can be directed to the DUR Project Coordinator at (515) 725-1287.

This report may help prescribers make referrals to the lock-in program. The goal of the lock-in Program is to promote quality health care for Medicaid members by preventing harmful practices including: duplication of scheduled and non-scheduled medications, unintended medication interactions, duplication of medical services and treatments, and medication abuse. Referrals can be made by calling 1-800-383-1173 or (515) 725-1338.

Also available to active Iowa Medicaid providers is the Iowa Medicaid Electronic Record System (I-MERS); a web-based tool that gives providers up-to-date information about what services and prescriptions have been paid for by Iowa Medicaid. I-MERS allows treating providers to view Medicaid members' medical procedures, prescriptions, and other services that are currently in the Medicaid computer system. I-MERS only provides information on currently eligible Medicaid Members. This is not a substitute for eligibility verification through Iowa Medicaid Enterprise's (IME) eligibility verification systems (e.g. phone or website). Sensitive information such as AIDS/HIV, substance abuse, and mental health related information is not currently available through this system. Registration is required to access the system and is accomplished on an organizational basis (e.g. Clinic, Group Practice, Hospital, Pharmacy, etc). Information on how to register as an I-MERS user can be found on the Iowa Medicaid Enterprise website; <http://www.ime.state.ia.us>. Please click on providers, then I-MERS under quick links on the right side of the page, and then click to register for access.

Antihistamine Prior Authorization Criteria and Other Preferred Medications Used to Treat Seasonal Allergies

With the start of the allergy season shortly on the way, it will soon be time to restart those medications used for seasonal allergies. When considering therapeutic options for seasonal allergies for Medicaid patients, it is important to keep in mind the following:

Prior authorization is required for all non-preferred antihistamines and preferred second generation prescription antihistamines. Patients 21 years of age and older must have two unsuccessful trials with an antihistamine that does not require prior authorization, prior to the approval of a non-preferred first generation or preferred second generation prescription antihistamine. One of the trials must be OTC cetirizine or loratadine. Prior to the approval of a non-preferred second generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred second generation prescription antihistamine. Patients 20 years of age and younger must have an unsuccessful trial of OTC cetirizine or loratadine prior to the approval of a non-preferred first generation or preferred second generation prescription antihistamine. Prior to approval of a non-preferred second generation antihistamine, in addition to the above criteria, there must be an unsuccessful trial with a preferred second generation prescription antihistamine.

Preferred First Generation OTC Antihistamines	Preferred Second Generation OTC Antihistamines	Preferred Second Generation Legend Antihistamines*
Chlorpheniramine maleate	Cetirizine tablets or syrup	Clarinetx, Clarinetx D, Clarinetx syrup, ClarinetxRetitabs
Cyproheptadine	Loratadine (Alavert, Tavist ND)	
Diphenhydramine		

*PA required; OTC antihistamines are payable with a prescription

In addition to antihistamines, intranasal corticosteroids may be used to treat allergic rhinitis and can be of benefit for ophthalmic symptoms. Current practice parameters developed by the Joint Task Force on Practice Parameters, representing the American Academy of Allergy, Asthma and Immunology; the American College of Allergy, Asthma and Immunology; and the Joint Council of Allergy, Asthma and Immunology, state that intranasal corticosteroids are the most effective medications for treating allergic rhinitis.

The oral decongestant, pseudoephedrine, can be used to reduce nasal congestion associated with allergic rhinitis.

Leukotriene receptor antagonists (LTRA's) are effective in the treatment of seasonal and perennial allergic rhinitis.

The intranasal anticholinergic, ipratropium bromide, can effectively reduce rhinorrhea caused by allergic rhinitis.

Ophthalmic products are the treatment of choice when ocular allergy symptoms are predominant. There are limited clinical studies comparing brand name products, therefore all brand products are comparable to each other and offer no significant clinical advantages over another.

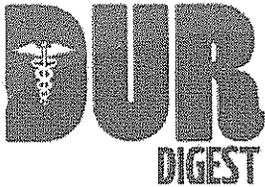
Preferred Intranasal Corticosteroids	Preferred Oral Decongestant	Preferred LTRA	Preferred Intranasal Anticholinergic	Preferred Ophthalmic Antihistamine/Mast-Cell Stabilizers	Preferred Ophthalmic NSAID's
fluticasone propionate	OTC pseudoephedrine	Singulair	ipratropium bromide	Optivar	Acular or Acular LS
Nasonex				Patanol	Voltaren ophthalmic solution

DUR Activities

- ❖ The DUR Commission recently looked at data for members using dopamine agonists (*Mirapex*, *Requip*, *Requip XL*, and *ropinirole*) and *carbidopa/levodopa* for Restless Leg Syndrome (RLS). A total of 442 members were found to have a diagnosis for RLS in their medical claims history. Of those 442 members, only 72 were tested for iron deficiency. Recent studies indicate that iron deficiency is a possible cause of RLS. While the findings are not conclusive, they warrant the measurement of serum ferritin levels in patients with RLS and a trial of oral iron therapy when ferritin levels are low. Connor JR, Menzies SL, Dellinger B, Allen RP, Ondo WG, Early CJ. "Neuropathological Examination Suggests Impaired Brain Iron Acquisition in Restless Legs Syndrome." *Neurology*, August 12, 2003, Vol. 61, No. 3, pp. 304-309.
- ❖ The DUR Commission recently looked at claims data for members using duplicate selective-serotonin reuptake inhibitors (SSRI's) between the dates of August 1, 2008 and September 30, 2008. While individual SSRI's in comparison to each other have been found to be equally effective, there is no literature available to support the use of duplicative SSRI therapy. Duplicative therapy also increases the risk for serotonin syndrome. Providers will be receiving a letter from the DUR Commission addressing the issue.
- ❖ The DUR Commission recently looked at utilization data for *Bactroban* between the dates of January 1, 2008 and September 30, 2008. A total of 125 members were identified as having two or more fills of *Bactroban* during this time frame with several members receiving more than five fills. Of those 125 members, none were receiving an oral antibiotic concurrently. *Bactroban* cream is indicated for the treatment of secondary infected traumatic skin lesions due to susceptible strains of *S. aureus* and *S. pyrogens*. *Bactroban* ointment is indicated for the topical treatment of impetigo due to *S. aureus* and *S. pyrogens*. Providers will be receiving a letter from the DUR Commission addressing the issue.
- ❖ On January 15, 2009, the DUR Commission submitted the 2008 Smoking Cessation Report to the Legislature, which outlines the progress of the Medicaid Smoking Cessation Program between January 1, 2008 and September 30, 2008. The University of Northern Iowa (UNI) conducts follow-up interviews to assess quit rates among Iowa Medicaid participants of the Quitline program.

Number of faxed referrals for Iowa Medicaid members received by Quitline Iowa	5,184
Number of Iowa Medicaid members who successfully enrolled in the Quitline program	3,324 (64.1%)
Number of members who dropped out of the Quitline program	1,809 (54.4%)
Number of prescriptions for varenicline	4,316 (71.1%)
Number of prescriptions for nicotine patches	1,435 (23.7%)
Number of prescriptions for nicotine gum	155 (2.6%)
Number of prescriptions for bupropion	161 (2.7%)
Number of follow-up interviews conducted by UNI between July 1, 2008 and September 30, 2008	188
Number of members considered smoke free from the follow-up interviews *	42/188 (22.3%)

*Smoke free is defined as not having had a cigarette in the 30 days prior to the follow-up interview.



Iowa Medicaid Drug Utilization Review
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

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ANNUAL CALL FOR NEW COMMISSION MEMBERS

Attention Pharmacists: Are you looking for a new professional opportunity?

CMS requires state Medicaid programs to have a drug utilization review (DUR) program consisting of prospective DUR, retrospective DUR, and an educational program. The goal of the DUR program is to ensure appropriate medication therapy, while permitting appropriate professional judgment to individualize medication therapy. In Iowa, the DUR Board is referred to as the Iowa Medicaid DUR Commission. The Iowa DUR Commission is composed of four Iowa licensed physicians and four Iowa licensed pharmacists who serve four-year terms, as well as a representative from the Department of Human Services. The Commission meets on the first Wednesday eight months of the year from 9:30 a.m. to 1:30 p.m.

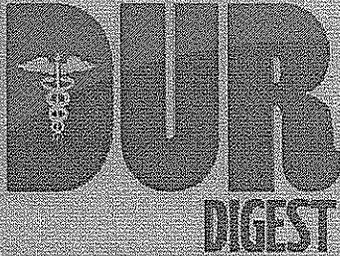
The DUR Commission is currently seeking a Pharmacist who serves Medicaid members to join the committee. Any Pharmacist interested in serving in this capacity should send a resume or curriculum vitae, as well as a letter indicating their interest to Chad Bissell at the address shown below. Candidates that would like more information about the Commission or who would like to speak to a present Commissioner are encouraged to call.

The deadline for applications is May 1, 2009.

Chad Bissell, Pharm. D.
DUR Director
Iowa Medicaid Drug Utilization Review Commission
100 Army Post Road
Des Moines, IA 50315
(515) 725-1271
info@iadur.org

2009

Vol. 21, No. 3



The Bulletin of Medicaid Drug Utilization Review in Iowa

DUR Commission Members

- Bruce Alexander, R.Ph., Pharm.D., BCPP
Mark Graber, M.D., FACEP
Laura Ann Griffith, D.O.
Craig Logemann, R.Ph., Pharm.D., BCPS
Dan Murphy, R.Ph.
Susan Parker, Pharm.D.
Laurie Pestel, Pharm.D.
Richard M. Rinehart, M.D.
Sara Schutte-Schenck, D.O., FAAP

DUR Professional Staff

- Thomas Kline, D.O., IME Medical Director
Chad Bissell, Pharm.D., DUR Commission Director
Pamela Smith, R.Ph., DUR Project Coordinator

PPI Interactions with Clopidogrel and a Review of Current PPI PA Criteria

Recent reports suggest that omeprazole and other proton pump inhibitors (PPIs) could interfere with the antiplatelet effect of clopidogrel (Plavix). Clopidogrel is a prodrug that is activated by CYP450 enzymes in the liver primarily by CYP2C19. All PPI's may inhibit CYP2C19 to some extent, with omeprazole being a strong inhibitor of CYP2C19; pantoprazole (Protonix) appears to be the weakest inhibitor.

More data is needed to clarify the clinical significance of the interaction between clopidogrel and PPIs. Studies are being conducted to obtain additional information that will give a better understanding of the effects of other drugs, especially PPIs, on the effectiveness of clopidogrel. In the mean time, the FDA recommends the following:

- Healthcare providers should continue to prescribe and patients should continue to take clopidogrel as directed.
Healthcare providers should re-evaluate the need for starting or continuing treatment with a PPI in patients taking clopidogrel.

PA Criteria

Currently, prior authorization is not required for the preferred PPIs for a cumulative 60-days of therapy per 12-months. Prior authorization is required for all non-preferred PPIs beginning the first day of therapy. Non-preferred PPIs will be considered only when there is documentation of previous trials and therapy failures with three preferred agents.

Table with 2 columns: PREFERRED PPI (PA REQUIRED AFTER 60 DAYS) and NON-PREFERRED PPI (PA REQUIRED FROM DAY 1). Rows include Prevacid Capsules, Prevacid SoluTabs*, Prilosec OTC, Protonix, Aciphex, Nexium, Omeprazole, Pantoprazole, Prilosec (RX), and Zegerid.

*Prevacid SoluTabs are preferred for children 12 years of age or younger for the first 60 days of therapy. Payment for Prevacid SoluTabs for patients over 12 years of age will be considered for those patients who cannot tolerate a solid oral dosage form.

References

PPI interactions with clpidogrel revisited. Med Lett Drugs Ther 2009; 51:13.

Recommendations for Managing Elevated INRs in Patients on Vitamin K Antagonists

On average, Iowa Medicaid has 45 paid claims for *Mephyton* per month. The following information is based on the American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th edition) on how to manage patients with INRs above therapeutic range, with or without bleeding.¹ In patients with mild-to-moderately elevated INRs without major bleeding, it is recommended that oral vitamin K be given. An article in the March 3, 2009 issue of the *Annals of Internal Medicine* reports that low-dose oral vitamin K did not reduce bleeding in warfarin recipients with INRs of 4.5 to 10.0 and that withdrawal of warfarin may be all that is necessary to manage elevated INRs.²

Condition	Intervention
INR above therapeutic range but < 5.0; no significant bleeding	Lower or omit dose of warfarin, monitor more frequently, resume therapy at appropriate adjusted dose when INR is in therapeutic range. No dose adjustment may be needed if INR only minimally above therapeutic range
INR \geq 5.0 but < 9.0; no significant bleeding	Omit the next one or two doses of warfarin, monitor more frequently, and resume therapy at appropriate adjusted dose when INR is in therapeutic range. Alternatively, omit a dose and administer 1 to 2.5mg vitamin K orally especially if the patient is at risk of bleeding. If rapid reversal is required, administer vitamin K (\leq 5mg) orally with the expectation that INR reduction will occur in 24 hours. If the INR is still high, additional vitamin K (1 to 2mg) orally can be given.
INR \geq 9.0; no significant bleeding	Hold warfarin and administer higher dose of vitamin K (2.5 to 5mg) orally, with the expectation that the INR will be reduced substantially in 24 to 48 hours. Monitor INR more frequently and administer additional vitamin K if necessary. Resume warfarin therapy at appropriately adjusted dose when INR reaches therapeutic range.
Serious bleeding at any elevation of INR	Hold warfarin and administer vitamin K (10mg) by slow IV infusion. Supplement with fresh frozen plasma, prothrombin complex concentrate, or recombinant factor VIIa depending on urgency of the situations. May repeat vitamin K every 12 hours for persistent INR elevation.
Life threatening bleeding at any elevation of INR	Hold warfarin and administer fresh frozen plasma, prothrombin complex concentrate, or recombinant factor VIIa supplemented with vitamin K, 10mg by slow IV infusion, repeat if necessary depending on the INR.

1. Ansell J, Hirsh J, Hylek E, Jacobson A, Crowther M, Palareti G. Pharmacology and management of the vitamin K antagonists: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition). *Chest* 2008 Jun; 133(6 Suppl):160S-98S.

2. Crowther et al. (2009). Oral vitamin K fails to prevent bleeding due to excess warfarin anticoagulation [abstract]. *Annals of Internal Medicine*. 2009;150:293-300. <http://www.mdconsult.com/das/news/body/125596174-3/itwj/0/26135/1.html?nid=20613>. Accessed March 12, 2009.

DUR Activities

- The DUR Commission recently looked at data for new starters of clozapine and the frequency of monitoring. Thirty-five members were identified as recently starting clozapine. In order to start clozapine, the WBC must be at least 3500 mm³, and the ANC must be at least 2000 mm³. Both values are required before clozapine can be dispensed. For the first 6 months of therapy, patients are required to have blood work drawn weekly and the pharmacist may dispense a 1-week supply of medication. After 6 months of continuous therapy (without interruptions due to a low WBC and/or ANC), blood work can be drawn every 14 days and a 2-week supply of medication can be dispensed. After 12 months of continuous therapy, blood monitoring can be done every 4 weeks and a 4-week supply of medication can be dispensed. The blood work draw date must be within seven days of the clozapine order and the pharmacist must review the results to ensure they are within the normal range before dispensing the medication. A review of the medical claims data showed all members were receiving the appropriate lab work before clozapine was dispensed.
- The DUR Commission recently looked at claims data for members using duplicate long acting narcotics (*Duragesic*, fentanyl, methadone, *Kadian*, *MS Contin*, morphine sulfate er/sr, and *Opana ER*). Twenty-one unique members were found on duplicate long acting narcotics, of which 16 members were combining methadone with another long acting narcotic. Letters were sent to the providers of those 16 members in March.
- The DUR Commission looked at data for members using a thiazolidinedione (TZD) who also had a diagnosis of congestive heart failure (CHF) in their medical claims data. Letters were sent to providers of 81 members in March.

Medicaid Statistics for Prescription Claims from January 1, 2009 to March 31, 2009

Top Drugs by Number of Prescriptions	Top Drugs by Dollars Spent	Top Therapeutic Class by Dollars Spent
<i>ProAir HFA</i> \$43.58/Rx	<i>Synagis</i> 100mg/ml \$1,948.93/Rx	Antipsychotics – Atypicals \$12,146,285.67
Hydrocodone/APAP 5-500 \$5.59/Rx	<i>Adderall XR</i> 20mg \$229.41/Rx	Anticonvulsants \$5,619,091.67
<i>Lexapro</i> 20mg \$84.85/Rx	<i>Lexapro</i> 20mg \$84.85/Rx	Antidepressants – Selected SSRI's \$4,150,693.23
Cheratussin AC syrup \$6.13/Rx	<i>Abilify</i> 10mg \$392.96/Rx	Stimulants – Amphetamines – Long Acting \$3,458,650.99
Loratadine 10mg \$10.44/Rx	<i>Abilify</i> 5mg \$386.52/Rx	RSV Prophylaxis \$3,289,406.47

Average amount paid per claim, generic: \$65.71

Number of claims paid: 1,013,911

Average amount paid per claim, brand: \$192.58

Percent controlled substances: 18.47%

Total dollars paid: \$66,620,729.87



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Outgoing Members of the DUR Commission



Dan Murphy, R.Ph., recently completed an eight year term of service with the Iowa Drug Utilization Review Commission. The Commission and the Department of Human Services wish to thank Mr. Murphy for his many years of service to the Commission and the members of Iowa Medicaid.



Dr. Laura Griffith, D.O., recently completed a four year term of service with the Iowa Drug Utilization Review commission. The Commission and the Department of Human Services wish to thank Dr. Griffith for her four years of service to the Commission and the members of Iowa Medicaid.

Appendix K

Web Site

Iowa Medicaid Drug Utilization Review Commission

- [DUR Information](#)
 - [Home](#)
- [Meeting Information](#)
 - [Agendas](#)
 - [Minutes](#)
 - [Newsletters](#)
 - [Members](#)
 - [Meeting Archive](#)
 - [Report Archive](#)
- [Mental Health Advisory Group](#)
- [Advisory Group Meeting Information](#)
 - [Advisory Group Minutes](#)
 - [Advisory Group Agendas](#)
 - [Contact](#)
- [DUR Commission](#)

Iowa Medicaid Drug Utilization Review Commission

Recent Site Updates

New [meeting information](#) has been added.

A new [DUR Digest](#) has been added.

DUR Commission Members

- Larry Ambrosion, R.Ph.
- Bruce Alexander, R.Ph., Pharm.D., BCPP
 - Casey Clor, M.D.
 - Mark Graber, M.D., FACEP
- Craig Logemann, R.Ph., Pharm.D., BCPS
 - Susan Parker, Pharm.D.
 - Laurie Pestel, Pharm.D.
 - Richard Rinehart, M.D.
- Sara Schutte-Schenck, D.O., FAAP

More information

Professional Staff

- Thomas Kline, D.O. — Medical Director, Iowa Medicaid Enterprise
 - Pam Smith, R.Ph. - DUR Project Coordinator
 - Chad Bissell, R.Ph., Pharm.D.

Visitor

Appendix L
Quarterly Management Reports



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 1	07/01/2008 through 09/30/2008
State Quarter 4	04/01/2008 through 06/30/2008

IOWA MEDICAID MANAGEMENT REPORT SUMMARY

COMPARISON OF QUARTERLY REPORTS

Average Amount Paid Per Claim:

State Fiscal Year:	\$62.08
State Quarter 1	\$63.06
State Quarter 4	\$62.33

Total Dollars Paid

State Fiscal Year:	\$233,540,533.28
State Quarter 1	\$57,728,896.61
State Quarter 4	\$57,831,665.10

Number of Claims Paid:

State Fiscal Year:	3,761,771
State Quarter 1	915,485
State Quarter 4	927,849

Number of Eligible Members:

State Fiscal Year:	324,510
State Quarter 1	333,753
State Quarter 4	328,843

Number of Utilized Members:

State Fiscal Year:	281,557
State Quarter 1	165,628
State Quarter 4	169,529

Average Number of Claims per Utilized Member:

State Fiscal Year:	13.36
State Quarter 1	5.53
State Quarter 4	5.47

Percent Controlled Substances:

State Fiscal Year:	18.42%
State Quarter 1	18.86%
State Quarter 4	18.59%



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 1	07/01/2008 through 09/30/2008
State Quarter 4	04/01/2008 through 06/30/2008

Top Drugs per NDC by Number of Prescriptions

State Fiscal Year	State Quarter 1	State Quarter 4
1 XOPENEX HFA AER	1 HYDROCO/APAP TAB 5-500MG	1 XOPENEX HFA AER
2 HYDROCO/APAP TAB 5-500MG	2 PROAIR HFA AER	2 HYDROCO/APAP TAB 5-500MG
3 LORATADINE TAB 10MG	3 LORATADINE TAB 10MG	3 LORATADINE TAB 10MG
4 LEXAPRO TAB 20MG	4 LEXAPRO TAB 20MG	4 LEXAPRO TAB 20MG
5 LEXAPRO TAB 10MG	5 HYDROCO/APAP TAB 5-500MG	5 LEXAPRO TAB 10MG

Drugs:	Current Number of Claims
1 XOPENEX HFA AER	55,956
2 HYDROCO/APAP TAB 5-500MG	39,552
3 LORATADINE TAB 10MG	30,260
4 LEXAPRO TAB 20MG	25,413
5 LEXAPRO TAB 10MG	20,432

Top Drugs by Dollar Spent

State Fiscal Year	State Quarter 1	State Quarter 4
1 SYNAGIS INJ 100MG/ML	1 CONCERTA TAB 36MG	1 ABILIFY TAB 10MG
2 XOPENEX HFA AER	2 ABILIFY TAB 10MG	2 CONCERTA TAB 36MG
3 ABILIFY TAB 10MG	3 PREVACID CAP 30MG DR	3 PREVACID CAP 30MG DR
4 CONCERTA TAB 36MG	4 RISPERDAL TAB 1MG	4 ADDERALL XR CAP 20MG
5 PREVACID CAP 30MG DR	5 ADDERALL XR CAP 20MG	5 XOPENEX HFA AER

Drugs:	Total Paid:
1 SYNAGIS INJ 100MG/ML	\$4,603,044.68
2 XOPENEX HFA AER	\$2,944,592.75
3 ABILIFY TAB 10MG	\$2,840,403.29
4 CONCERTA TAB 36MG	\$2,752,392.18
5 PREVACID CAP 30MG DR	\$2,689,194.97



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 1	07/01/2008 through 09/30/2008
State Quarter 4	04/01/2008 through 06/30/2008

Therapeutic Class by Total Prescription

- | State Fiscal Year | State Quarter 1 | State Quarter 4 |
|-------------------------------------|-------------------------------------|-------------------------------------|
| 1 ANTIDEPRESSANTS - SELECTED SSRI's | 1 ANTIDEPRESSANTS - SELECTED SSRI's | 1 ANTIDEPRESSANTS - SELECTED SSRI's |
| 2 ANTICONVULSANTS | 2 ANTICONVULSANTS | 2 ANTICONVULSANTS |
| 3 NARCOTICS - MISC. | 3 NARCOTICS - MISC. | 3 NARCOTICS - MISC. |
| 4 ANXIOLYTICS - BENZODIAZEPINES | 4 ANXIOLYTICS - BENZODIAZEPINES | 4 ANXIOLYTICS - BENZODIAZEPINES |
| 5 ANALGESICS - MISC. | 5 ANALGESICS - MISC. | 5 ANALGESICS - MISC. |

Comparisons	State Quarter 1		State Quarter 4	
	Total Claims	Percent Total Claims	Total Claims	Percent Total Claims
Trends:				
ANTIDEPRESSANTS - SELECTED SSRI's	68,635	7.50	68,989	7.44
ANTICONVULSANTS	48,031	5.25	47,591	5.13
NARCOTICS - MISC.	46,490	5.08	44,643	4.81
ANXIOLYTICS - BENZODIAZEPINES	44,091	4.82	43,516	4.69
ANALGESICS - MISC.	40,200	4.39	41,362	4.46

Therapeutic Class by Dollars Spent

- | State Fiscal Year | State Quarter 1 | State Quarter 4 |
|--|--|--|
| 1 ANTIPSYCHOTICS - ATYPICALS | 1 ANTIPSYCHOTICS - ATYPICALS | 1 ANTIPSYCHOTICS - ATYPICALS |
| 2 ANTICONVULSANTS | 2 ANTICONVULSANTS | 2 ANTICONVULSANTS |
| 3 ANTIDEPRESSANTS - SELECTED SSRI's | 3 ANTIDEPRESSANTS - SELECTED SSRI's | 3 ANTIDEPRESSANTS - SELECTED SSRI's |
| 4 STIMULANTS - AMPHETAMINES - LONG ACTING | 4 STIMULANTS - AMPHETAMINES - LONG ACTING | 4 STIMULANTS - AMPHETAMINES - LONG ACTING |
| 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING | 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING | 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING |

Comparisons	State Quarter 1		State Quarter 4	
	Total Cost	Average Cost/Claim	Total Cost	Average Cost/Claim
Trends:				
ANTIPSYCHOTICS - ATYPICALS	\$10,644,168.53	\$297.61	\$10,517,186.09	\$290.79
ANTICONVULSANTS	\$5,583,075.49	\$116.24	\$5,405,132.83	\$113.57
ANTIDEPRESSANTS - SELECTED SSRI's	\$4,163,458.54	\$60.66	\$4,140,861.15	\$60.02
STIMULANTS - AMPHETAMINES - LONG ACTING	\$2,444,107.04	\$146.67	\$2,361,127.81	\$146.10
STIMULANTS - METHYLPHENIDATE - LONG ACTING	\$2,014,802.50	\$133.32	\$2,030,924.07	\$127.65



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 1	07/01/2008 through 09/30/2008
State Quarter 4	04/01/2008 through 06/30/2008

Generic Utilization:

BRAND MULTISOURCE

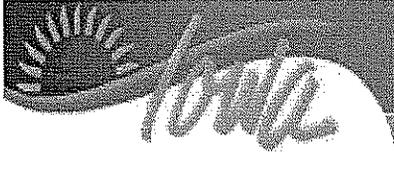
	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	9.56	\$118.28
State Quarter 1	6.79	\$149.88
State Quarter 4	7.80	\$137.43

BRAND SINGLESOURCE

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	25.87	\$161.61
State Quarter 1	25.89	\$170.40
State Quarter 4	25.90	\$166.00

GENERIC

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	64.57	\$13.88
State Quarter 1	67.33	\$13.03
State Quarter 4	66.30	\$12.98



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 2	10/01/2008 through 12/31/2008
State Quarter 1	07/01/2008 through 09/30/2008

IOWA MEDICAID MANAGEMENT REPORT SUMMARY

COMPARISON OF QUARTERLY REPORTS

Average Amount Paid Per Claim:

State Fiscal Year:	\$61.85
State Quarter 2	\$64.81
State Quarter 1	\$62.95

Total Dollars Paid

State Fiscal Year:	\$232,721,931.30
State Quarter 2	\$62,815,500.37
State Quarter 1	\$57,973,158.83

Number of Claims Paid:

State Fiscal Year:	3,762,765
State Quarter 2	969,228
State Quarter 1	920,872

Number of Eligible Members:

State Fiscal Year:	324,779
State Quarter 2	340,571
State Quarter 1	336,870

Number of Utilized Members:

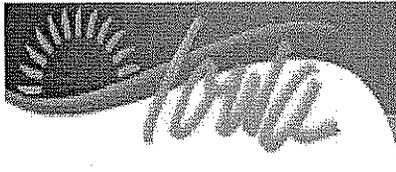
State Fiscal Year:	281,663
State Quarter 2	177,192
State Quarter 1	166,190

Average Number of Claims per Utilized Member:

State Fiscal Year:	13.36
State Quarter 2	5.47
State Quarter 1	5.54

Percent Controlled Substances:

State Fiscal Year:	18.42%
State Quarter 2	18.84%
State Quarter 1	18.87%



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 2	10/01/2008 through 12/31/2008
State Quarter 1	07/01/2008 through 09/30/2008

Top Drugs per NDC by Number of Prescriptions

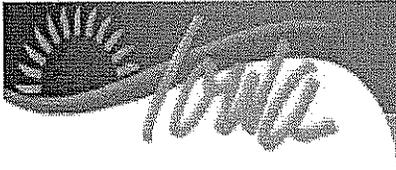
State Fiscal Year	State Quarter 2	State Quarter 1
1 XOPENEX HFA AER	1 PROAIR HFA AER	1 HYDROCO/APAP TAB 5-500MG
2 HYDROCO/APAP TAB 5-500MG	2 HYDROCO/APAP TAB 5-500MG	2 PROAIR HFA AER
3 LORATADINE TAB 10MG	3 LORATADINE TAB 10MG	3 LORATADINE TAB 10MG
4 LEXAPRO TAB 20MG	4 LEXAPRO TAB 20MG	4 LEXAPRO TAB 20MG
5 LEXAPRO TAB 10MG	5 CHERATUSSIN SYP AC	5 HYDROCO/APAP TAB 5-500MG

Drugs:	Current Number of Claims
1 XOPENEX HFA AER	55,953
2 HYDROCO/APAP TAB 5-500MG	39,554
3 LORATADINE TAB 10MG	30,274
4 LEXAPRO TAB 20MG	25,428
5 LEXAPRO TAB 10MG	20,439

Top Drugs by Dollar Spent

State Fiscal Year	State Quarter 2	State Quarter 1
1 SYNAGIS INJ 100MG/ML	1 SYNAGIS INJ 100MG/ML	1 CONCERTA TAB 36MG
2 XOPENEX HFA AER	2 ABILIFY TAB 10MG	2 ABILIFY TAB 10MG
3 ABILIFY TAB 10MG	3 CONCERTA TAB 36MG	3 PREVACID CAP 30MG DR
4 CONCERTA TAB 36MG	4 ADDERALL XR CAP 20MG	4 RISPERDAL TAB 1MG
5 PREVACID CAP 30MG DR	5 RISPERDAL TAB 1MG	5 ADDERALL XR CAP 20MG

Drugs:	Total Paid:
1 SYNAGIS INJ 100MG/ML	\$4,595,424.22
2 XOPENEX HFA AER	\$2,939,955.01
3 ABILIFY TAB 10MG	\$2,808,196.56
4 CONCERTA TAB 36MG	\$2,722,635.86
5 PREVACID CAP 30MG DR	\$2,687,558.19



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 2	10/01/2008 through 12/31/2008
State Quarter 1	07/01/2008 through 09/30/2008

Therapeutic Class by Total Prescription

- | | | |
|--|--|--|
| <p>State Fiscal Year</p> <ol style="list-style-type: none"> 1 ANTIDEPRESSANTS - SELECTED SSRI's 2 ANTICONVULSANTS 3 NARCOTICS - MISC. 4 ANXIOLYTICS - BENZODIAZEPINES 5 ANALGESICS - MISC. | <p>State Quarter 2</p> <ol style="list-style-type: none"> 1 ANTIDEPRESSANTS - SELECTED SSRI's 2 ANTICONVULSANTS 3 NARCOTICS - MISC. 4 ANXIOLYTICS - BENZODIAZEPINES 5 ANALGESICS - MISC. | <p>State Quarter 1</p> <ol style="list-style-type: none"> 1 ANTIDEPRESSANTS - SELECTED SSRI's 2 ANTICONVULSANTS 3 NARCOTICS - MISC. 4 ANXIOLYTICS - BENZODIAZEPINES 5 ANALGESICS - MISC. |
|--|--|--|

Comparisons	State Quarter 2		State Quarter 1	
	Total Claims	Percent Total Claims	Total Claims	Percent Total Claims
ANTIDEPRESSANTS - SELECTED SSRI's	70,710	7.30	68,970	7.49
ANTICONVULSANTS	48,658	5.02	48,314	5.25
NARCOTICS - MISC.	46,899	4.84	46,772	5.08
ANXIOLYTICS - BENZODIAZEPINES	44,811	4.62	44,536	4.84
ANALGESICS - MISC.	40,841	4.21	41,275	4.48

Therapeutic Class by Dollars Spent

- | | | |
|---|---|---|
| <p>State Fiscal Year</p> <ol style="list-style-type: none"> 1 ANTIPSYCHOTICS - ATYPICALS 2 ANTICONVULSANTS 3 ANTIDEPRESSANTS - SELECTED SSRI's 4 STIMULANTS - AMPHETAMINES - LONG ACTING 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING | <p>State Quarter 2</p> <ol style="list-style-type: none"> 1 ANTIPSYCHOTICS - ATYPICALS 2 ANTICONVULSANTS 3 ANTIDEPRESSANTS - SELECTED SSRI's 4 STIMULANTS - AMPHETAMINES - LONG ACTING 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING | <p>State Quarter 1</p> <ol style="list-style-type: none"> 1 ANTIPSYCHOTICS - ATYPICALS 2 ANTICONVULSANTS 3 ANTIDEPRESSANTS - SELECTED SSRI's 4 STIMULANTS - AMPHETAMINES - LONG ACTING 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING |
|---|---|---|

Comparisons	State Quarter 2		State Quarter 1	
	Total Cost	Average Cost/Claim	Total Cost	Average Cost/Claim
ANTIPSYCHOTICS - ATYPICALS	\$11,370,160.53	\$308.22	\$10,662,918.30	\$296.65
ANTICONVULSANTS	\$5,761,707.01	\$118.41	\$5,587,190.12	\$115.64
ANTIDEPRESSANTS - SELECTED SSRI's	\$4,275,498.81	\$60.47	\$4,167,389.31	\$60.42
STIMULANTS - AMPHETAMINES - LONG ACTING	\$2,894,064.72	\$153.51	\$2,439,270.15	\$146.10
STIMULANTS - METHYLPHENIDATE - LONG ACTING	\$2,163,165.56	\$132.19	\$2,010,084.84	\$132.78



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 2	10/01/2008 through 12/31/2008
State Quarter 1	07/01/2008 through 09/30/2008

Generic Utilization:

BRAND MULTISOURCE

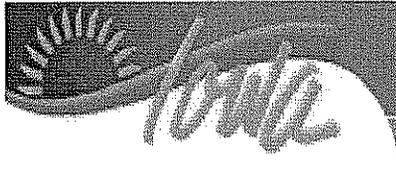
	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	9.71	\$120.20
State Quarter 2	7.21	\$150.56
State Quarter 1	6.95	\$152.87

BRAND SINGLESOURCE

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	25.82	\$159.77
State Quarter 2	25.39	\$178.39
State Quarter 1	25.75	\$169.31

GENERIC

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	64.47	\$13.84
State Quarter 2	67.40	\$12.85
State Quarter 1	67.30	\$12.98



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 3	01/01/2009 through 03/31/2009
State Quarter 2	10/01/2008 through 12/31/2008

IOWA MEDICAID MANAGEMENT REPORT SUMMARY COMPARISON OF QUARTERLY REPORTS

Average Amount Paid Per Claim:

State Fiscal Year:	\$61.52
State Quarter 3	\$65.71
State Quarter 2	\$64.39

Total Dollars Paid

State Fiscal Year:	\$231,579,499.71
State Quarter 3	\$66,620,729.87
State Quarter 2	\$62,764,109.05

Number of Claims Paid:

State Fiscal Year:	3,764,136
State Quarter 3	1,013,911
State Quarter 2	974,784

Number of Eligible Members:

State Fiscal Year:	324,983
State Quarter 3	347,513
State Quarter 2	344,474

Number of Utilized Members:

State Fiscal Year:	281,822
State Quarter 3	191,537
State Quarter 2	177,948

Average Number of Claims per Utilized Member:

State Fiscal Year:	13.36
State Quarter 3	5.29
State Quarter 2	5.48

Percent Controlled Substances:

State Fiscal Year:	18.43%
State Quarter 3	18.47%
State Quarter 2	18.88%



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 3	01/01/2009 through 03/31/2009
State Quarter 2	10/01/2008 through 12/31/2008

Top Drugs per NDC by Number of Prescriptions

State Fiscal Year	State Quarter 3	State Quarter 2
1 XOPENEX HFA AER	1 PROAIR HFA AER	1 PROAIR HFA AER
2 HYDROCO/APAP TAB 5-500MG	2 HYDROCO/APAP TAB 5-500MG	2 HYDROCO/APAP TAB 5-500MG
3 LORATADINE TAB 10MG	3 LEXAPRO TAB 20MG	3 LORATADINE TAB 10MG
4 LEXAPRO TAB 20MG	4 CHERATUSSIN SYP AC	4 LEXAPRO TAB 20MG
5 LEXAPRO TAB 10MG	5 LORATADINE TAB 10MG	5 CHERATUSSIN SYP AC

Drugs:	Current Number of Claims
1 XOPENEX HFA AER	55,954
2 HYDROCO/APAP TAB 5-500MG	39,561
3 LORATADINE TAB 10MG	30,283
4 LEXAPRO TAB 20MG	25,459
5 LEXAPRO TAB 10MG	20,437

Top Drugs by Dollar Spent

State Fiscal Year	State Quarter 3	State Quarter 2
1 SYNAGIS INJ 100MG/ML	1 SYNAGIS INJ 100MG/ML	1 SYNAGIS INJ 100MG/ML
2 XOPENEX HFA AER	2 ADDERALL XR CAP 20MG	2 ABILIFY TAB 10MG
3 ABILIFY TAB 10MG	3 LEXAPRO TAB 20MG	3 CONCERTA TAB 36MG
4 CONCERTA TAB 36MG	4 ABILIFY TAB 10MG	4 ADDERALL XR CAP 20MG
5 PREVACID CAP 30MG DR	5 ABILIFY TAB 5MG	5 RISPERDAL TAB 1MG

Drugs:	Total Paid:
1 SYNAGIS INJ 100MG/ML	\$4,599,844.58
2 XOPENEX HFA AER	\$2,933,750.32
3 ABILIFY TAB 10MG	\$2,779,347.98
4 CONCERTA TAB 36MG	\$2,685,191.31
5 PREVACID CAP 30MG DR	\$2,683,567.96



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 3	01/01/2009 through 03/31/2009
State Quarter 2	10/01/2008 through 12/31/2008

Therapeutic Class by Total Prescription

State Fiscal Year	State Quarter 3	State Quarter 2
1 ANTIDEPRESSANTS - SELECTED SSRI's	1 ANTIDEPRESSANTS - SELECTED SSRI's	1 ANTIDEPRESSANTS - SELECTED SSRI's
2 ANTICONVULSANTS	2 BETA-LACTAMS / CLAVULANATE COMBO'S	2 ANTICONVULSANTS
3 NARCOTICS - MISC.	3 ANTICONVULSANTS	3 NARCOTICS - MISC.
4 ANXIOLYTICS - BENZODIAZEPINES	4 NARCOTICS - MISC.	4 ANXIOLYTICS - BENZODIAZEPINES
5 ANALGESICS - MISC.	5 ANXIOLYTICS - BENZODIAZEPINES	5 ANALGESICS - MISC.

Comparisons	State Quarter 3		State Quarter 2	
	Total Claims	Percent Total Claims	Total Claims	Percent Total Claims
Trends: ANTIDEPRESSANTS - SELECTED SSRI's	72,172	7.12	70,959	7.28
BETA-LACTAMS / CLAVULANATE COMBO'S	50,225	4.95	39,024	4.00
ANTICONVULSANTS	49,275	4.86	49,030	5.03
NARCOTICS - MISC.	47,586	4.69	47,183	4.84
ANXIOLYTICS - BENZODIAZEPINES	45,019	4.44	45,500	4.67

Therapeutic Class by Dollars Spent

State Fiscal Year	State Quarter 3	State Quarter 2
1 ANTIPSYCHOTICS - ATYPICALS	1 ANTIPSYCHOTICS - ATYPICALS	1 ANTIPSYCHOTICS - ATYPICALS
2 ANTICONVULSANTS	2 ANTICONVULSANTS	2 ANTICONVULSANTS
3 ANTIDEPRESSANTS - SELECTED SSRI's	3 ANTIDEPRESSANTS - SELECTED SSRI's	3 ANTIDEPRESSANTS - SELECTED SSRI's
4 STIMULANTS - AMPHETAMINES - LONG ACTING	4 STIMULANTS - AMPHETAMINES - LONG ACTING	4 STIMULANTS - AMPHETAMINES - LONG ACTING
5 STIMULANTS - METHYLPHENIDATE - LONG ACTING	5 RSV PROPHYLAXIS	5 STIMULANTS - METHYLPHENIDATE - LONG ACTING

Comparisons	State Quarter 3		State Quarter 2	
	Total Cost	Average Cost/Claim	Total Cost	Average Cost/Claim
Trends: ANTIPSYCHOTICS - ATYPICALS	\$12,146,285.67	\$321.60	\$11,300,568.49	\$304.66
ANTICONVULSANTS	\$5,619,091.67	\$114.04	\$5,715,230.09	\$116.57
ANTIDEPRESSANTS - SELECTED SSRI's	\$4,150,693.23	\$57.51	\$4,260,565.28	\$60.04
STIMULANTS - AMPHETAMINES - LONG ACTING	\$3,458,650.99	\$174.64	\$2,852,493.88	\$151.10
RSV PROPHYLAXIS	\$3,289,406.47	\$1,542.87	\$2,039,102.95	\$1,555.38



State Fiscal Year:	07/01/2007 through 06/30/2008
State Quarter 3	01/01/2009 through 03/31/2009
State Quarter 2	10/01/2008 through 12/31/2008

Generic Utilization:

BRAND MULTISOURCE

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	10.56	\$122.80
State Quarter 3	7.26	\$159.70
State Quarter 2	8.00	\$152.49

BRAND SINGLESOURCE

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	24.97	\$158.82
State Quarter 3	23.45	\$192.58
State Quarter 2	24.51	\$177.69

GENERIC

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	64.47	\$13.80
State Quarter 3	69.29	\$12.93
State Quarter 2	67.49	\$12.79

State Fiscal Year:	07/01/2008 through 06/30/2009
State Quarter 4	04/01/2009 through 06/30/2009
State Quarter 3	01/01/2009 through 03/31/2009

IOWA MEDICAID MANAGEMENT REPORT SUMMARY COMPARISON OF QUARTERLY REPORTS

Average Amount Paid Per Claim:

State Fiscal Year:	\$63.88
State Quarter 4	\$63.88
State Quarter 3	\$65.71

Total Dollars Paid:

State Fiscal Year:	\$247,344,050.47
State Quarter 4	\$62,497,731.53
State Quarter 3	\$67,017,456.27

Number of Claims Paid:

State Fiscal Year:	3,890,294
State Quarter 4	978,425
State Quarter 3	1,019,834

Number of Eligible Members:

State Fiscal Year:	347,913
State Quarter 4	356,583
State Quarter 3	352,059

Number of Utilized Members:

State Fiscal Year:	293,760
State Quarter 4	182,901
State Quarter 3	192,288

Average Number of Claims per Utilized Member:

State Fiscal Year:	13.24
State Quarter 4	5.35
State Quarter 3	5.30

Percent Controlled Substances:

State Fiscal Year:	18.75%
State Quarter 4	18.82%
State Quarter 3	18.50%



State Fiscal Year:	07/01/2008 through 06/30/2009
State Quarter 4	04/01/2009 through 06/30/2009
State Quarter 3	01/01/2009 through 03/31/2009

Top Drugs per NDC by Number of Prescriptions

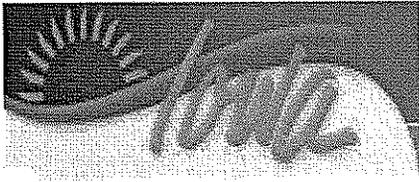
State Fiscal Year	State Quarter 4	State Quarter 3
1 PROAIR HFA AER	1 PROAIR HFA AER	1 PROAIR HFA AER
2 HYDROCO/APAP TAB 5-500MG	2 HYDROCO/APAP TAB 5-500MG	2 HYDROCO/APAP TAB 5-500MG
3 LEXAPRO TAB 20MG	3 LEXAPRO TAB 20MG	3 LEXAPRO TAB 20MG
4 LORATADINE TAB 10MG	4 LORATADINE TAB 10MG	4 CHERATUSSIN SYP AC
5 CHERATUSSIN SYP AC	5 FERROUS SULF TAB 325MG	5 LORATADINE TAB 10MG

Drugs:	Current Number of Claims
1 PROAIR HFA AER	44,607
2 HYDROCO/APAP TAB 5-500MG	43,936
3 LEXAPRO TAB 20MG	33,694
4 LORATADINE TAB 10MG	30,058
5 CHERATUSSIN SYP AC	20,831

Top Drugs by Dollar Spent

State Fiscal Year	State Quarter 4	State Quarter 3
1 SYNAGIS INJ 100MG/ML	1 LEXAPRO TAB 20MG	1 SYNAGIS INJ 100MG/ML
2 ABILIFY TAB 10MG	2 ABILIFY TAB 5MG	2 ADDERALL XR CAP 20MG
3 ADDERALL XR CAP 20MG	3 ADDERALL XR CAP 20MG	3 LEXAPRO TAB 20MG
4 LEXAPRO TAB 20MG	4 ABILIFY TAB 10MG	4 ABILIFY TAB 10MG
5 ABILIFY TAB 5MG	5 CONCERTA TAB 36MG	5 ABILIFY TAB 5MG

Drugs:	Total Paid:
1 SYNAGIS INJ 100MG/ML	\$5,089,149.33
2 ABILIFY TAB 10MG	\$3,119,661.27
3 ADDERALL XR CAP 20MG	\$3,018,810.43
4 LEXAPRO TAB 20MG	\$2,896,627.12
5 ABILIFY TAB 5MG	\$2,864,285.24



State Fiscal Year:	07/01/2008 through 06/30/2009
State Quarter 4	04/01/2009 through 06/30/2009
State Quarter 3	01/01/2009 through 03/31/2009

Therapeutic Class by Total Prescription

- | State Fiscal Year | State Quarter 4 | State Quarter 3 |
|-------------------------------------|-------------------------------------|--------------------------------------|
| 1 ANTIDEPRESSANTS - SELECTED SSRI's | 1 ANTIDEPRESSANTS - SELECTED SSRI's | 1 ANTIDEPRESSANTS - SELECTED SSRI's |
| 2 ANTICONVULSANTS | 2 ANTICONVULSANTS | 2 BETA-LACTAMS / CLAVULANATE COMBO'S |
| 3 NARCOTICS - MISC. | 3 NARCOTICS - MISC. | 3 ANTICONVULSANTS |
| 4 ANXIOLYTICS - BENZODIAZEPINES | 4 ANXIOLYTICS - BENZODIAZEPINES | 4 NARCOTICS - MISC. |
| 5 ANALGESICS - MISC. | 5 ANALGESICS - MISC. | 5 ANXIOLYTICS - BENZODIAZEPINES |

Comparisons	State Quarter 4		State Quarter 3	
	Total Claims	Percent Total Claims	Total Claims	Percent Total Claims
Trends:				
ANTIDEPRESSANTS - SELECTED SSRI's	72,468	7.41	72,488	7.11
ANTICONVULSANTS	49,467	5.06	49,635	4.87
NARCOTICS - MISC.	48,418	4.95	47,959	4.70
ANXIOLYTICS - BENZODIAZEPINES	45,114	4.61	45,543	4.47
ANALGESICS - MISC.	39,831	4.07	41,645	4.08

Therapeutic Class by Dollars Spent

- | State Fiscal Year | State Quarter 4 | State Quarter 3 |
|--|--|---|
| 1 ANTIPSYCHOTICS - ATYPICALS | 1 ANTIPSYCHOTICS - ATYPICALS | 1 ANTIPSYCHOTICS - ATYPICALS |
| 2 ANTICONVULSANTS | 2 ANTICONVULSANTS | 2 ANTICONVULSANTS |
| 3 ANTIDEPRESSANTS - SELECTED SSRI's | 3 ANTIDEPRESSANTS - SELECTED SSRI's | 3 ANTIDEPRESSANTS - SELECTED SSRI's |
| 4 STIMULANTS - AMPHETAMINES - LONG ACTING | 4 STIMULANTS - AMPHETAMINES - LONG ACTING | 4 RSV PROPHYLAXIS |
| 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING | 5 STIMULANTS - METHYLPHENIDATE - LONG ACTING | 5 STIMULANTS - AMPHETAMINES - LONG ACTING |

Comparisons	State Quarter 4		State Quarter 3	
	Total Cost	Average Cost/Claim	Total Cost	Average Cost/Claim
Trends:				
ANTIPSYCHOTICS - ATYPICALS	\$10,970,535.07	\$291.50	\$12,152,658.36	\$319.84
ANTICONVULSANTS	\$5,549,690.45	\$112.19	\$5,625,631.85	\$113.34
ANTIDEPRESSANTS - SELECTED SSRI's	\$4,281,145.47	\$59.08	\$4,152,766.69	\$57.29
STIMULANTS - AMPHETAMINES - LONG ACTING	\$3,503,009.27	\$176.53	\$3,449,592.45	\$173.85
STIMULANTS - METHYLPHENIDATE - LONG ACTING	\$2,327,287.49	\$139.44	\$2,364,653.54	\$137.50



State Fiscal Year:	07/01/2008 through 06/30/2009
State Quarter 4	04/01/2009 through 06/30/2009
State Quarter 3	01/01/2009 through 03/31/2009

Generic Utilization:

BRAND MULTISOURCE

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	7.31	\$158.62
State Quarter 4	5.88	\$173.59
State Quarter 3	7.38	\$160.72

BRAND SINGLESOURCE

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	23.94	\$180.19
State Quarter 4	23.68	\$187.65
State Quarter 3	23.28	\$192.92

GENERIC

	Percent of Claims	Average Amount Paid per Claim
State Fiscal Year	68.75	\$12.87
State Quarter 4	70.43	\$13.08
State Quarter 3	69.34	\$12.90

Appendix M
Meeting Minutes

Iowa Medicaid Drug Utilization Review Commission

Meeting Minutes August 6, 2008

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Rick Rinehart, M.D.; Laura Griffith, D.O.; and Susan Parker, Pharm.D.

Staff

Thomas Kline, D.O.; Chad Bissell, R.Ph., Pharm.D.; and Pam Smith, R.Ph.

Guests

Daryl Richardson, U of I Pharmacy Student; Eileen Creager, DHS Bureau Chief; Colleen Kacher, IME; Sandy Pranger, IME; Dr. Chuck Wadle, Magellan; Nick Ford, IME; Kelly Espeland, IME; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Thomas Kline called the meeting to order at 9:33 a.m. at the Iowa Medicaid Enterprise. Commission members, guests, and observers were welcomed and introduced. A new commission member, Dr. Mark Graber from the University of Iowa, was announced and will attend the next meeting.

The minutes from the June 4, 2008 meeting were approved. (Motion by Dr. Laura Griffith, second by Craig Logeman, unanimous approval by voice vote.) Bruce Alexander did have a suggestion for future minutes, however. He asked that the generic names for the drugs be included as well as the brand name version. Dr. Kline also volunteered to have Medical Services nurse care managers to work from a members' perspective to improve the numbers for utilization of ACE Inhibitors, ARBs, and Beta Blockers in post MI patients, as the percentages of compliance, even after mailings, seem to be a little low. Chad Bissell mentioned that all meeting materials will now be posted on the DUR website www.iadur.org in advance of future meetings.

Case Reviews

Pam Smith presented four intervention case studies. Recommendations by commissioners from these four examples resulted in annualized total savings of \$2,603.69 pre-rebate (State and Federal dollars).

Management Reports

Chad Bissell presented the Management Report Summary. The average amount paid per claim for the last fiscal year was \$62.47, and the total amount spent on pharmacy claims was \$234,406,031.03. Percent of controlled substances paid for was 18.41%. The top drugs by number of prescriptions have not changed much. However, the top drug, Xopenex HFA (levalbuterol tartrate), boasting

almost 56,000 claims, has now been changed to non-preferred on the PDL, so it will soon move down in the ranks. In fact, on the top drugs by amount spent report, it has already gone from second to fifth place. The top therapeutic classes by dollars spent were Atypical Antipsychotics, Anticonvulsants, and Antidepressants for the last state fiscal year. Generic utilization was 64.5%, which should increase as more generic drug equivalents become available by the end of this year. Dummy prescriber code usage has dropped off since the installation of NPI.

ProDUR

The quantity limit edits that would restrict both strengths of Pristiq (desvenlafaxine) to 30/30 as recommended by the P&T Committee on June 12th were discussed. The Commission agreed to place an edit on both strengths (even though the 100mg tablets cannot be split). The issue adjusting the quantity limit to 15/30 on the 100mg tablet will also be re-evaluated at the September DUR meeting with additional information as to whether or not the tablet can be split.

Focus Studies

Underutilization of Inhaled Corticosteroids: Intervention letters were mailed in October to providers of 134 recipients that had 5 or more fills of a short acting beta agonist and zero fills of an inhaled corticosteroid. Twenty-seven profiles showed concurrent therapy with Singulair (montelukast sodium). Of the 102 profiles (76%) available for evaluation, three profiles (2%) showed the addition of inhaled corticosteroid. An additional two profiles (2%) and 4 profiles (3%) showed the addition of an inhaled corticosteroid/long-acting beta agonist (LABA) combination or Singulair, respectively. Therapy with an inhaled corticosteroid, inhaled corticosteroid/LABA combination, or Singulair was started but not maintained in 18 profiles (13%). The remaining 75 profiles (56%) were available for re-review, but did not add any therapy. These medication changes added \$14,571.36 pre-rebate to the SFY 2008 drug budget. Dr. Kline will ask the IME nurse managers to follow up with the providers of the 75 profiles that did not add any therapy.

Concurrent Benzodiazepine & Sedative Hypnotics: 101 member profiles were re-evaluated to see who was still using both Benzodiazepines and Sedative Hypnotics (78), who discontinued use of Benzodiazepines while continuing use of Sedative Hypnotics (1), and who chose to continue using Benzodiazepines and stop use of Sedative Hypnotics (17). There also were 5 that discontinued of both, and 4 that did not have any claims during the re-evaluation period. Only 10 surveys were returned. Review of claims history shows that members who discontinued use of one of these drugs did not add another in its place. \$29,392.56 in pre-rebate, total (State & Federal) was saved as a result of this study.

Chronic Triptan Use without Migraine Prophylaxis: This study was proposed at the March meeting as a potential topic. Chad Bissell reviewed the preliminary search results that identified 195 unique members who are regularly using migraine treatments, sometimes even in multiples, without trying a prophylactic medication. The commission agreed to make this into a focus study. However, the search criteria will be adjusted to also allow for ER and office visits, as well as all medical claims relative to migraine treatment.

Chronic Lidoderm Patch Use: Dr. Wadle mentioned at the last meeting that there was increased use of Lidoderm (lidocaine) patches. Chad Bissell ran a report to see how many were using them for several consecutive months. There were only a very small number of people (25) using them for more than a few months. The commission did not believe these numbers warranted a focus study.

Narcotic Utilization Report: Chad Bissell thought the commission might be interested in reviewing a quarterly narcotics utilization report that would highlight members receiving narcotics from multiple prescribers. The providers could then be contacted to make them aware of the duplicate therapy. This could increase referrals to the lock-in program as well. Chad will bring a model report and template letter to the September meeting, as well as a breakdown of the exact criteria that would prompt a letter to physicians.

Committee Member Interests on Future Focus Studies: Bruce Alexander asked that the commission be provided with a list of all focus studies that have been done thus far, and that this topic be added to the next meeting agenda.

Public Comment

James Wilson from GlaxoSmithKline spoke about their new migraine medication Treximet (sumatriptan-naproxen sodium).

Direction of DUR

Public Comment Policy: The commission voted to keep dividing public speakers into 2 sessions, but a 5 minute time limit per speaker will now be enforced. (Drug manufacturers with multiple speakers must share that time allotment.) This motion was made by Bruce Alexander, seconded by Dr. Richard Rinehart, and approved unanimously.

Prior Authorization

Vusion Ointment (miconazole-zinc oxide-white petrolatum): This is the new proposed clinical PA criteria:

Prior Authorization is required for Vusion ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents

would be medically contraindicated.

Annual Review of Clinical PA Criteria: Bruce Alexander pointed out there was a new FDA warning on Erythropoiesis Stimulating Agents, but Chad Bissell said that the IA Medicaid criteria already stipulates that these agents can not be used in patients with hemoglobin over 10. Dr. Sarah Schutte-Schenck questioned the origins of the Synagis PA timeline. The start date has been moved back to allow for only 5 doses, every 30 days. Dr. Schutte-Schenck had not heard anything about this decision and wondered how it had been made. Dr. Kline said it was a collaborative effort between multiple departments within the IME and the Clinical Advisory Committee, comparing other state programs' criteria based on positive culture test results within nearby regions (CDC Surveillance Data), to create an appropriate schedule and dosing. The Commission believes that any PA Criteria that lists criteria not established by DUR, to note where the criteria originated from and how it came to be.

Proposed PA Criteria Changes for Future Meetings: It was recommended that a sentence be added to the Growth Hormones criteria, stating coverage for the treatment of idiopathic short stature is not a covered diagnosis. Also, it was recommended to slightly change the wording on the Zyvox (linezolid) criteria, from "patient is being treated for one of the following diagnoses" to "patient meets one of the following diagnostic criteria with an active infection." Lastly, it was recommended that the commission revisit the subject of the 18 unit doses per 30 days of Serotonin 5-HT₁-receptor Agonists currently allowed. Also, Chantix criteria could be a future topic of interest due to recent safety warnings. These topics will be addressed at subsequent meetings.

Public Comment

There were no speakers in this public comment session.

Strategies, Challenges, and Initiatives

Metabolic Testing in Members on Atypical Antipsychotics: Members profiles that had at least 3 prescriptions for second generation antipsychotic from 1/1/08 to 7/1/08 were cross-referenced with medical claims for lipid, hemoglobin A1C, and fasting blood sugar tests in the past year. Of the 9957 members that met the 3-prescription criteria, 8876 have received no tests in the last year. Since this is such a large group of recipients, the topic will be highlighted in an upcoming DUR Digest as opposed to becoming a focus study at this point in time.

Miscellaneous

DUR Digest – 2008 Vol. 20 No. 3: This is posted on the DUR website.

MedWatch: Chad Bissell turned the commission's attention to the safety notices

included in their packet titled: *Increased risk of tendon problems with fluoroquinolones prompts FDA action* and *Possible association between cancers in young persons and use of TNF blockers prompts FDA investigation*.

A unanimous vote was made at 12:00 to adjourn the meeting and move to closed session (1st by Bruce Alexander, 2nd by Dan Murphy).

The next meeting will be held at 9:30 a.m. on Wednesday, September 3, 2008 at the Iowa Medicaid Enterprise in Des Moines.

Iowa Medicaid Drug Utilization Review Commission **Meeting Minutes September 3, 2008**

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Rick Rinehart, M.D.; Laura Griffith, D.O.; Mark Graber, M.D.; Laurie Pestel, Pharm.D.; and Susan Parker, Pharm.D.

Staff

Thomas Kline, D.O.; Chad Bissell, R.Ph., Pharm.D.; and Pam Smith, R.Ph.

Guests

Jenny Vitzthum, Pharm.D. Candidate; Eileen Creager, DHS Bureau Chief; Colleen Kacher, IME; Sandy Pranger, IME; Chuck Wadle, Magellan; Nick Ford, IME; Kelly Espeland, IME; John Grotton, IME; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Thomas Kline called the meeting to order at 9:35 a.m. at the Iowa Medicaid Enterprise. Dr. Kline introduced the newest DUR Commission member, Dr. Mark Graber, and highlighted his career accomplishments. Commission members, guests, and observers were welcomed and introduced.

The minutes from the August 6, 2008 meeting were approved, after a correction to the first paragraph on page 4 from Dr. Schutte-Schenck. (Motion by Dan Murphy, second by Bruce Alexander, unanimous approval by voice vote.)

Case Reviews

Pam Smith presented four intervention case studies. Recommendations by Commissioners from these four examples resulted in annualized total savings of \$14,047.95 pre-rebate (state and federal).

Smoking Cessation Report for Legislature

The Commission was asked to review the proposed draft of the letter outlining the progress of the smoking cessation program due to the legislature January 15, 2009. They had several suggestions, including adding 3, 9, and 12 month outcomes data as well as the 6 month data that was included, to paint a better picture of success rates overall. Also, Bruce Alexander suggested that the additional administration costs due to adding Chantix (varenicline) needed to be figured into the reported costs along with the prescription expenditures. Notes will be added to a couple paragraphs reiterating that the DUR Commission did not make the decision to cover Chantix (varenicline), since they, in fact, recommended the opposite action. The members also requested some additional reporting from Quitline, specifically Medicaid vs. non-Medicaid quit rates and comparisons with other Medicaid populations, as they felt it was

necessary to get a grasp on the program's efficacy to date before attempting to make changes to improve it.

ProDUR

The Commission agreed to place an edit on both strengths of Pristiq (desvenlafaxine) restricting them to 30/30 at the August meeting. Chad Bissell quoted the manufacturer's policy on splitting these tablets: "the Pristiq tablets must be swallowed whole with fluid, and not divided, crushed, or chewed." There was also a Wyeth representative in attendance who said the matrix delivery system would be compromised after splitting, making the tablets immediate release. The Commission commented that there is no evidence that the 100mg works any better than the 50mg. This is a mental health drug, but could still be limited by a potential clinical PA. This issue will be referred to the Mental Health Work Group, which consists of both child and adult psychiatrists.

Focus Studies

Underutilization of Inhaled Corticosteroids: 88 members of the 134 members who received a letter for the Underutilization of Inhaled Corticosteroids Focus Study for the time frame of 2/1/2007 through 7/31/2007 were re-evaluated. These 88 members were identified as having a diagnosis code for asthma. The list of 88 members was re-evaluated during the time frame of 11/1/2007 through 4/30/2008 to see who had corresponding physician office or emergency room visits pertaining to the treatment/management of asthma as a result of the intervention letter from the Commission. The results of the study show an increase in the amount spent on ER visits (\$1146.67 pre-rebate state and federal) and a decrease in office visit expenditures (\$1744.33 pre-rebate state and federal). Bruce Alexander suggested making adjustments for inflation in the future in studies such as this.

Quarterly Narcotic Utilization Report to Prescribers: Chad Bissell provided the Commission with an example of what this report would look like. It is hoped mailings to providers for members using narcotics either prescribed by 3 or more physicians and/or filled at 3 or more different pharmacies can begin going out by the end of the year. If there are too many members for the initial mailing using these criteria, the threshold may be raised to 5 or more initially. Chad will present additional information at the next meeting to determine whether the algorithm should look at 3 or more vs. 5 or more pharmacies and/or physicians.

Duplicate Antipsychotic Use in Kids: The list of 52 members who received a letter for the Duplicate Antipsychotic Use in Children Focus Study for the time frame of 5/1/2007 through 10/31/2007 was re-evaluated. The list of 52 members was re-evaluated during the time frame of 2/1/2008 through 7/31/2008 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotics. 18 members (5 of which had no claims during the re-evaluation period) discontinued use of 1 or more antipsychotic drugs, while 34 continued using the same regimen. This was referred to the Mental Health Work Group for review. Also, Bruce Alexander

suggested a follow-up study in 6 months focusing on the same members to see if the stats change.

Chronic Singulair Use without Asthma or Allergic Rhinitis Diagnosis: Pharmacy claims data for the drug; Singulair (montelukast), from 8-1-07 through 7-31-08 was reviewed and compared for medical claims data. Singulair is FDA approved for the treatment of asthma, allergic rhinitis, and exercised-induced bronchoconstrictions. There is insufficient data available to suggest Singulair would be effective for other disease states. During this time frame, 32,901 unique members received a total of 147,705 prescriptions for Singulair. For the members who had prescriptions for a documented non-FDA approved diagnosis, an additional review of the pharmacy claims history uncovered that 4,294 of those members also did not have any paid claims for beta-adrenergics. The Commission members believe this number is misleading, and possibly a claim coding issue, rather than misuse of the drug. The findings will be broken down by member age and dosage to highlight any true problem, to be discussed further at the next meeting.

Review of Recently Completed Focus Studies: The Commission would like to look at long-term PPI usage (perhaps exploring a link between a higher risk of community acquired pneumonia and PPI use), cognitive enhancers, and drugs used for restless leg syndrome for possible future studies.

Public Comment

There were no speakers in this public comment session.

Prior Authorization

Growth Hormone: The commission voted to revise the PA criteria as follows:

Prior authorization is required for therapy with growth hormones. Payment for non-preferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. All of the following criteria must be met for approval for prescribing of growth hormones:

- 1. Standard deviation of 2.0 or more below mean height for chronological age.*
- 2. No intracranial lesion or tumor diagnosed by MRI.*
- 3. Growth rate below five centimeters per year.*
- 4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.*
- 5. Annual bone age testing is required for a diagnosis of growth hormone deficiency. Bone age must be 14 to 15 years or less in females and 15 to 16 years or less in males is required. .*
- 6. Epiphyses open.*

Prior authorization will be granted for 12-month periods per member as needed.

The following FDA approved indication for growth hormone therapy are considered not medically necessary and requests will be denied:

1. Idiopathic short stature

If the request is for **Zorbtive®** [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.

The motion to accept was made by Dan Murphy, and seconded by Dr. Sara Schutte-Schenck. All other members were in agreement; however, Dr. Rick Rinehart abstained as he was not in the room when voting took place.

Linezolid (Zyvox): The commission voted to revise the PA criteria as follows:

Prior authorization is required for Zyvox®. Payment for Zyvox® will be considered when there is documentation that:

1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable).
2. Patient has an active infection and meets one of the following diagnostic criteria:
 - Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract**.
 - Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin*
 - Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin*

**Severe intolerance to vancomycin is defined as:*

- Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration
- Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine)

***VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.*

The motion to accept was made by Dr. Rick Rinehart, and seconded by Craig Logemann. The roll call vote passed unanimously.

Serotonin 5-HT1-receptor Agonists: The commission voted to revise the PA criteria as follows:

Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Prior authorization will be required for all non-preferred serotonin 5-HT₁-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT₁-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents.

The motion to accept was made by Dr. Laura Griffith, and seconded by Dr. Rich Rinehart. Craig Logemann suggested rearranging the wording. The vote was unanimous.

Extended Release Formulation: The commission voted to revise the PA criteria as follows:

Payment for the extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Prior authorization is required for the following extended release formulation(s):

1. Seroquel® XR
2. Luvox® CR

The motion to accept was made by Bruce Alexander, seconded by Dr. Laura Griffith, and was approved by all the members.

Chantix: The commission compared the current Iowa Medicaid PA criteria to those used by the VA. No changes were made. However, Chad Bissell suggested putting an article in the next DUR Digest warning physicians of the dangers of prescribing Chantix (varenicline) in combination with mental health drugs.

Public Comment

There were no speakers in this public comment session.

Miscellaneous

SMAC Interim Update Notice: The State MAC rate decreased for Fluticasone Propionate Spray, and increased for Risperidone and Zaleplon.

DUR Digest – 2008 Vol. 21 No. 1: The Commission reviewed the draft and offered some corrections.

MedWatch: Chad Bissell turned the commission's attention to the safety notice included in their packet titled *FDA warns of risk of rhabdomyolysis when amiodarone administered with higher doses of simvastatin.*

A unanimous vote was made at 12:00 to adjourn the meeting and move to closed session (1st Laurie Pestel, 2nd by Dan Murphy).

The next meeting will be held at 9:30 a.m. on Wednesday, November 5, 2008 in Room 116 at the State Capitol in Des Moines.

Iowa Medicaid Drug Utilization Review Commission **Meeting Minutes November 5, 2008**

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Rick Rinehart, M.D.; Laura Griffith, D.O.; Mark Graber, M.D.; Laurie Pestel, Pharm.D.; and Susan Parker, Pharm.D.

Staff

Thomas Kline, D.O.; Chad Bissell, R.Ph., Pharm.D.; and Pam Smith, R.Ph.

Guests

Erin Miusich, University of Iowa Pharm.D. Candidate; Colleen Kacher, IME; Sandy Pranger, IME; Chuck Wadle, D.O., Magellan; Nick Ford, IME; Kelly Espeland, IME; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Thomas Kline called the meeting to order at 9:29 a.m. in Capitol Room 116. Commission members, guests, and observers were welcomed and introduced.

The minutes from the September 3, 2008 meeting were approved, after a spelling correction on page 3. (Motion by Dan Murphy, second by Dr. Sara Schutte-Schenck, unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

Dr. Thomas Kline said that the Clinical Advisory Committee (CAC) had discussed Synagis protocol at their last meeting. He commented that the RSV season had begun, with very few issues thus far. Some of the large providers with large groups of members needing the immunization had logistical problems with timing, but IME staff worked with those providers to meet their needs. The CAC also discussed "Never Events", and decided to support the Department's decision to follow the Medicare guidelines implemented October 1st. There will be an informational letter regarding this topic going out to all providers. Also, the IME is working to improve the Iowa Medicaid Electronic Records System (IMERS) website to make it more useful to providers. The CAC also adapted guidelines for computerized coronary tomography and angiography, based on the American Cardiology guidelines. An informational letter will be sent to providers notifying them of this change in benefits. The IME is working on a new program called Medicaid Value Management, designed to try to determine what value the Medicaid programs are getting for the money spent, with the intent of improving quality and controlling costs. Care Management and Disease Management projects, such as the congestive heart failure program, have been rolled over into the new year. They are currently in the process of enrolling

people in the Diabetes Disease Management program, and there is an asthma project in the works as well. IFMC has purchased a predictive modeling system in the hopes of enhancing all of IME's Medical Services programs. Dr. Thomas Kline announced his resignation as Medical Director, effective probably within the next 6 months. Chad Bissell mentioned that the Commission members had received an updated DHS flowchart with their packets, given the recent personnel changes within the Department. He also talked about the Mental Health Workgroup's last meeting, in particular their discussion of possible quantity limits on Seroquel® (quetiapine). This Work Group had not wanted to offer recommendations yet, instead asking that more detailed data be brought to their December 12th meeting. They will also be discussing multiple second-generation antipsychotic utilization at that time.

Case Reviews

Pam Smith presented four intervention case studies. Recommendations by Commissioners from these four examples resulted in annualized total savings of \$1,426.10 pre-rebate (state and federal). Chad Bissell also pointed out that tablet splitting for Lexapro would be required effective January 1, 2009, so the IME is beginning to contact providers.

Management Reports

Chad Bissell summarized reports from the first quarter of State Fiscal Year 2009. The average amount paid per claim for the first quarter of the new fiscal year was \$63.06, while the number of claims has decreased slightly. The percentage of controlled substance use has increased. With the PDL status change of Xopenex HFA (levalbuterol) to non-preferred, it has fallen off the top 5 drugs list for the first quarter of State Fiscal Year 2009, after being the #1 drug of the fourth quarter of 2008 as well as the last fiscal year overall. Four of the top five drugs by dollars spent for the first quarter were mental health drugs. Generic utilization is up to 67.3% in the first quarter. Average cost per claim increased anyway, because of the dispensing fee increase to \$4.57.

Smoking Cessation Report for Legislature

The Commission was asked to review the proposed draft of the letter outlining the progress of the smoking cessation program due to the legislature January 15, 2009. Chad Bissell highlighted the changes to this document since the last meeting, including the Commission's suggested changes and corrections. Bruce Alexander asked that a statement explaining that the literature that had been given did not include patients with multiple chronic conditions be added to the fifth paragraph of page 2, to further support the Commission's decision not to support coverage of Chantix™ (varenicline). Susan Parker also requested a wording change to the sentence stating the department's decision to cover Chantix. Dr. Laura Griffith asked that the program results from the University of Northern Iowa be broken down by treatment. Dr. Thomas Kline offered to ask a representative from the University of Northern Iowa (UNI) to attend a DUR meeting to explain their process. More details need to be added to the report as

recommended by the Commission members. The finalized report will be brought to the December meeting.

ProDUR

Effective April 30, 2008, Glucagen became preferred and Glucagon non-preferred. There was a recommendation to limit Glucagen to a quantity of 5 per 30 days to mirror the current edit for the Glucagon Emergency Kit. Dr. Laura Griffith motioned to accept this recommendation, and Dan Murphy seconded. The roll call vote passed unanimously.

Focus Studies

Underutilization of Inhaled Corticosteroids: Chad Bissell updated the Commission on a study that had been discussed at the last meeting. Emergency room and office visit claims coded for asthma diagnoses were re-evaluated, removing reversals and identifying claims in which Medicaid was the secondary payer. Between 2/1/06 and 7/31/06, there was only one such claim. It was also confirmed that the reported dollar amounts were solely for the treatment of asthma, and did not include other services. There seemed to be a wide disparity between the billed amounts and the paid amounts on the reviewed claims.

Quarterly Narcotic Utilization Report to Prescribers: Chad Bissell provided the Commission with an example of what this report would look like, designed around real Iowa claims data for the fourth quarter of Iowa fiscal year 2008. The private health information had been removed for the meeting. If the reporting algorithm had been set at 3 or more physicians and/or pharmacies, approximately 5300 letters would have been generated for this quarter alone. With the algorithm set at 5 or more physicians and/or pharmacies, there would have been approximately 1100 letters. Bruce Alexander suggested that quantity and days supply needed to be evaluated as well to identify chronic misuse. He also thought it would be wise to add a consecutive month restriction. Dr. Laura Griffith suggested that anything greater than one month would better target the intended population. Dr. Thomas Kline mentioned that this information would also be located on the IMERS website, updated weekly. The Commission agreed to set the limits at 3 or more pharmacies and/or physicians. There were no additional recommended changes to the report from the Commission. It is hoped mailings can begin going out after the end of the first quarter of 2009, since an educational letter informing physicians will need to be sent beforehand. Dr. Chuck Wadle suggested mentioning IMERS in the letters.

Chronic Singulair Use without Asthma or Allergic Rhinitis Diagnosis: Chad Bissell updated the Commission on a study that had been discussed at the last meeting, in which pharmacy claims data for the drug, Singulair (montelukast), from 8/1/07 through 7/31/08 was reviewed and compared for medical claims data. Singulair is FDA approved for the treatment of asthma, allergic rhinitis, and exercised-induced bronchoconstrictions. There is insufficient data available to

suggest Singulair would be effective for other disease states. During this time frame, 13,983 unique members received a total of 57,961 prescriptions for Singulair. For the members who had prescriptions for a documented non-FDA approved diagnosis, an additional review of the pharmacy claims history uncovered that 4,237 of those members also did not have any paid claims for beta-adrenergics. These findings were broken down into 2 groups: members with no accepted diagnosis and no antiasthmatic-beta adrenergic, and members with no accepted diagnosis and no antiasthmatic-beta adrenergic that did have claims for antiasthmatic steroid inhalants. These groups were further broken down by age range. It was agreed that incorporating the secondary diagnosis codes could make a big impact on these counts. Dan Murphy recommended that letters at least be mailed to the 15+ age group (with no inhalers). Chad Bissell suggested narrowing the field by adding in the secondary diagnosis codes first. Dr. Laura Griffith and Dr. Sara Schutte-Schenck advocated overlooking this anomaly, as they were unaware of any possible off-label uses, and this information most likely resulted from clerical error. The Commission agreed that there were other more worthy projects than this one.

Long Term Gastric Acid Suppressive Drug Use and Risks of Pneumonia and Clostridium difficile: Craig Logemann and Dr. Mark Graber mentioned this topic at the last meeting. With the pneumonia diagnosis, the analysts looked at members who were on gastric acid suppressive drugs for 12 consecutive months and excluded members who had claims for Amoxicillin and Clarithromycin or Pevpak or Tetracycline and Metronidazole in the same month as a GI - Proton Pump Inhibitor fill. Patients that had a past medical claim for pneumonia prior to starting a GI - Proton Pump Inhibitor were also excluded. Even with these exclusions, there were 1,168 members identified (though some may appear in more than one category), of which only 36 (all on H2-Antagonists) had a new pneumonia diagnosis. These findings conflict with current literature. The Commission asked if this data will be re-run, looking for people that have a new diagnosis of pneumonia within 2 months of initiating an acid suppressant. With the *Clostridium difficile* diagnosis, 2 years of data was reviewed. If a diagnosis was found, claim data 2 years from that diagnosis date was searched for gastric acid suppressive drugs. Members with a hospital stay within a year before diagnosis of *Clostridium difficile* were excluded. There was just one member with the combination of a PPI and H2, two members with a PPI, and seven members with a H2. Eighteen members had none of these. This also disagrees with literature, as it states that PPI's have an increased tendency of causing *Clostridium difficile*.

Public Comment

There were no speakers in this public comment session.

Prior Authorization

Vusion Ointment: The Commission voted to recommend the new PA criteria as

follows:

Prior Authorization is required for Vusion™ ointment. Payment will only be considered for cases in which there is documentation of previous trials and therapy failures with 1) over-the-counter miconazole 2% cream (payable with a prescription) AND 2) nystatin cream or ointment, unless evidence is provided that use of these agents would be medically contraindicated.

The Commission reviewed comments provided by select members of the Iowa Pharmacy Association and one physician. The motion to accept this final recommendation was made by Dan Murphy, and seconded by Craig Logemann. The roll call vote passed unanimously.

Growth Hormone: The Commission voted to revise the PA criteria as follows:

Prior authorization is required for therapy with growth hormones. Payment for nonpreferred growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. All of the following criteria must be met for approval for prescribing of growth hormones:

1. Standard deviation of 2.0 or more below mean height for chronological age.
2. No intracranial lesion or tumor diagnosed by MRI.
3. Growth rate below five centimeters per year.
4. Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.
5. *Annual bone age testing is required for a diagnosis of Growth Hormone Deficiency. A bone age of 14 to 15 years or less in females and 15 to 16 years or less in males is required.*
6. Epiphyses open.

Prior authorization will be granted for 12-month periods per member as needed.

The following FDA approved indication for growth hormone therapy is considered not medically necessary and requests will be denied: Idiopathic Short Stature (ISS).

If the request is for **Zorbitive®** [somatropin (rDNA origin) for injection] approval will be granted for the treatment of Short Bowel Syndrome in patients receiving specialized nutritional support. Zorbitive® therapy should be used in conjunction with optimal management of Short Bowel Syndrome.

The motion to accept this final recommendation was made by Craig Logemann, and seconded by Dr. Sara Schutte-Schenck. The roll call vote passed unanimously. The Commission was also provided a list of the top 10 growth hormone prescribers as requested at the last September meeting.

Linezolid (Zyvox): The Commission voted to revise the PA criteria as follows:

Prior authorization is required for Zyvox®. Payment for Zyvox® will be considered when there is documentation that:

1. Prescriber is an infectious disease (ID) physician or has consulted ID physician (Telephone consultation is acceptable).
2. *Patient has an active infection and meets one of the following diagnostic criteria:*

- Vancomycin-resistant Enterococcus (VRE) and no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract**.
- Methicillin-resistant Staph aureus (MRSA) and patient is intolerant to vancomycin*
- Methicillin-resistant Staph epidermis (MRSE) and patient is intolerant to vancomycin*

*Severe intolerance to vancomycin is defined as:

- Severe rash, immune-complex mediated, determined to be directly related to vancomycin administration
- Red-man's syndrome (histamine-mediated), refractory to traditional counter measures (e.g., prolonged IV infusion, premedicated with diphenhydramine)

**VRE in lower urinary tract, considered to be pathogenic, may be treated with linezolid if severe renal insufficiency exists and/or patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

The motion to accept this final recommendation was made by Dan Murphy, and seconded by Bruce Alexander. The roll call vote passed unanimously.

Serotonin 5-HT1-receptor Agonists: The Commission voted to revise the PA criteria as follows:

Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 12 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. For consideration, the following information must be supplied:

1. The diagnosis requiring therapy.
2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents.

The motion to accept this final recommendation was made by Bruce Alexander, and seconded by Dr. Sara Schutte-Schenck. The roll call vote passed unanimously.

Extended Release Formulation: The Commission voted to revise the PA criteria as follows:

Payment for the extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Prior authorization is required for the following extended release formulation(s):

1. Seroquel® XR
2. Luvox® CR

The motion to accept this final recommendation was made by Bruce Alexander, seconded by Dr. Rick Rinehart, and was approved by all the members by roll call vote.

Public Comment

There were no speakers in this public comment session.

Miscellaneous

DUR Digest – 2008 Vol. 21 No. 1: These are currently being mailed.

MedWatch: Bruce Alexander commented that a varenicline update just came out.

A unanimous vote was made by roll call vote at 11:11 to adjourn the meeting and move to closed session (1st by Dr. Mark Graber, 2nd by Dr. Rick Rinehart).

The next meeting will be held at 9:30 a.m. on Wednesday, December 3, 2008 in Room 116 at the State Capitol in Des Moines.

Iowa Medicaid Drug Utilization Review Commission **Meeting Minutes December 3, 2008**

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Rick Rinehart, M.D. (via phone); Laura Griffith, D.O.; Laurie Pestel, Pharm.D.; and Susan Parker, Pharm.D.

Staff

Thomas Kline, D.O.; Chad Bissell, R.Ph., Pharm.D.; and Pam Smith, R.Ph.

Guests

Rachael Doebel, Pharm.D. Candidate; Archana Jhawar, Pharm.D. Candidate; Sandy Pranger, IME; Chuck Wadle, Magellan; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Thomas Kline called the meeting to order at 9:36 a.m. at Capitol Room 116. Commission members, guests, and observers were welcomed and introduced.

The minutes from the November 5, 2008 meeting were approved. (Motion by Dan Murphy, second by Bruce Alexander, unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

Dr. Thomas Kline informed the Commission of the activity occurring within the other Iowa Medicaid committees. The Synagis administration project is going well with no major problems so far this season. The congestive heart failure program has been successful with more than 200 enrolled so far. There are also more than 200 enrolled in the diabetes care management program, and it is going well. IME is also in the process of defining eligible members for an asthma program, expanding upon the initial program that was tried in the IME's first year of operation. DHS will appear at the Rebalancing Healthcare meeting on 12/4/08, discussing components of House File 2539 in hopes of bridging the time that legislation is passed until the next legislative session and building momentum for the next year. DHS Director, Gene Gessow, and Medicaid Director, Jennifer Vermeer, will be panel members. DHS is also participating in the Healthcare Reform Medical Home Project and the Chronic Care and Prevention Advisory Councils. IME is currently undertaking a project reviewing state facilities to ensure that the state's mentally retarded members are getting the appropriate and adequate high quality care. A taskforce had been convened in cooperation with the Department of Public Health addressing the connection between maternal health treatments and low birth weight. The Clinical Advisory Committee will meet in January.

P&T Recommendations

Susan Parker asked the Commission to review the P&T Committee's recommendations for PDL status changes on Mental Health Drugs from their November meeting. Commission members were provided with hand-outs that the P&T meeting had used to make their recommendations, as well as detailed minutes of the P&T meeting. These recommendations were referred to the Mental Health Workgroup, for discussion at their December 12th meeting. If the Workgroup has any concerns with the clinical aspects of the recommendations, such issues will then be brought back to the DUR Commission for the February 4, 2009 meeting.

Case Reviews

Pam Smith presented four intervention case studies. Recommendations by Commissioners from these four examples resulted in annualized total savings of \$6,837.35 pre-rebate (state and federal).

Smoking Cessation Report for Legislature

Jeremy Whitaker and Bonnie Mapes from the Iowa Department of Public Health and Disa Cornish from the University of Northern Iowa presented information regarding the data collection and research methods of the smoking cessation program. Disa Cornish explained how evaluations assess participant satisfaction, program consistency, and quit rates. As of the end of October, there were nearly 1300 Quitline completions, and just over 200 cessation completions for the Department of Public Health clinic program. Commission members were provided a copy of the questionnaire being used. There has been a huge drop in smoking rates in Iowa in the past two years, almost more than any state has ever had since 1998. They use the CDC definition of a non-smoker which is someone who has not smoked in 30 days. Following the presentation, the Commission was asked to review the finalized version of the letter outlining the progress of the smoking cessation program due to the Legislature January 15, 2009. Chad Bissell highlighted the changes to this document since the last meeting, including the Commission's suggested changes and corrections. Bruce Alexander asked that one paragraph be reworded to emphasize that the statistics it contained were not solely based on the Medicaid population. The Commission otherwise had no objections to the document moving forward to the Department as presented.

ProDUR

Expansion of the Quantity Limits List, to include the most costly short-acting narcotics and benzodiazepines, was discussed. Other states have implemented quantity limits on controlled substances, such as Alabama, Mississippi, Arkansas, and Georgia in order to control costs, prevent over-utilization, and help prevent diversion. One potential drawback to the edits presented would be the increased chance of duplicative therapy; there are currently no edits in place on the POS system to prevent duplicative therapy. Limits on short-acting narcotics were tabled until the next meeting, when the Commission will be provided with

more information about POS programming possibilities prior to voting. Dr. Rick Rinehart suggested referring the topic of quantity limits on benzodiazepines to the Mental Health Work Group. Susan Parker asked that Chad Bissell request a utilization report to show if any members were currently going over the proposed limits for the most costly short-acting narcotics. This information will be brought to the next meeting in February.

Focus Studies

Anticonvulsant Drugs used in Mental Health Disorders: IME identified 32,293 unique members with two or more fills for any one or combination of the following drugs; all Typical Antipsychotics, all Atypical Antipsychotics, Clozapine, Lithium, Lamictal, Valproic Acid (which includes Depakote, Depakote ER, Divalproex, valproate sodium, Depakene, and Stavzor), Equetro, and Carbamazepine (which includes Tegretol, Tegretol XR, and Carbatrol). From this list, members with a diagnosis code in their claims history for epilepsy, seizure disorder, migraine, fibromyalgia, diabetic peripheral neuropathy, and post-herpetic neuralgia were removed. From the remaining members, those who also have two or more fills for an anticonvulsant(s) other than carbamazepine, valproic acid and/or lamotrigine (Lamictal) during the same time frame were identified. Four hundred and thirty-two members were taking a single anticonvulsant other than carbamazepine, valproic acid, or lamotrigine (Lamictal), and 76 were taking multiple anticonvulsants other than carbamazepine, valproic acid, or lamotrigine (Lamictal) in combination. Bruce Alexander asked if the results could be broken down into age groups and diagnosis classifications, also taking the approved anticonvulsants into account as well. Further analysis will be provided at the February meeting.

Drugs used for Restless Leg Syndrome: Members who had pharmacy claims for drugs typically used for Restless Leg Syndrome (RLS) were reviewed between 1/1/08 and 9/30/08. These members' medical claims were reviewed between the time period of 1/1/05 through 9/30/08 for corresponding ICD-9 codes for Parkinsons, RLS, Parkinsons and RLS, and Compulsive Gambling. Quinine Sulfate was not included in this report as Iowa Medicaid has not covered this drug since April 2007. There were 442 members diagnosed with RLS, 15 of which were on more than one of the following: Carbidopa/Levodopa, pramipexole (Mirapex), brand name ropinirole (Requip), extended release ropinirole (Requip XL), or generic ropinirole. The average length of therapy for members with a RLS diagnosis was five months. Only 72 of those members with an RLS diagnosis were tested for iron deficiency. This topic will appear as a column in the next DUR Digest.

Chronic use of Mupirocin: Based on an increase in the number of claims for mupirocin, as seen in monthly utilization reports, IME looked at claims for Bactroban®/mupirocin from 1/1/2008 to 09/30/2008. There are some studies where mupirocin has been studied for "decolonization regimens" for durations

around 30 days, though this is not a compendia listed indication. These regimens are used for recurrent furunculosis or other recurrent Staph infections. When used in some protocols, it is common to see two-to-six 30-day courses over a year in combination with dicloxacillin and rifampin. One hundred and twenty-five members using two or more refills of Bactroban and/or mupirocin were identified. Of those 125 members, none were also on more than one month of oral antibiotics in this same time frame. Susan Parker suggested re-running the data to see how many of the members were institutional and how many outpatient. Letters will be sent to providers as part of a focus study.

Duplicate SSRI Utilization: Members with two or more months of duplicate SSRI's in their claims histories from 8/1/08 to 9/30/08 were examined. Eighteen distinct members were found. Thirteen of these members continued duplicate usage into October as well. All the members were receiving both of their SSRI's from the same prescriber and the same pharmacy. In fact, three members actually had the same prescriber; a primary care physician. Letters will be sent to the providers as part of a focus study

Public Comment

Amy Blickensderfer, Pharm.D. from Amylin spoke about Byetta relative to the Iowa Medicaid clinical prior authorization criteria.

Prior Authorization

Incretin Mimetic (Byetta): The Commission reviewed the PA criteria as requested by the P&T Committee as follows:

Prior authorization is required for incretin mimetics (Byetta®).

Payment will be considered under the following conditions:

- 1) Diagnosis of Type 2 diabetes mellitus,*
- 2) Unless otherwise contraindicated, the member has not achieved HbgA1C goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum tolerated doses.*

Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.

There were 59 paid claims for Byetta for the month of October. Six prior authorizations were approved, three denied, and three were incomplete of the 12 received in October. Following clinical discussion of the updated consensus algorithm, *Medical Management of Hyperglycemia in Type 2 Diabetes: A consensus Algorithm for the Initiation and Adjustment of Therapy*, Dr. Laura Griffith asked for input from endocrinologists before the Commission votes

whether or not to revise the criteria. This topic was tabled until the next meeting.

Sedative/Hypnotics-Non-Benzodiazepine: The Commission voted to revise the PA criteria as follows:

Prior authorization is required for preferred nonbenzodiazepine sedative/hypnotic medications for quantities exceeding 15 units per 30 days. Payment for nonbenzodiazepine sedative/hypnotics beyond this limit will be considered when there is:

- 1) A diagnosis of chronic insomnia (insomnia lasting \geq 6 months) following at least a two consecutive month trial of an approved quantity (15/30) of the requested drug,*
- 2) Medications with a side effect of insomnia (i.e. stimulants) are decreased in dose, changed to a short acting product, and/or discontinued,*
- 3) Enforcement of good sleep hygiene is documented.*
- 4) All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.*

Prior authorization is required for all non-preferred nonbenzodiazepine sedative/hypnotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred nonbenzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of a previous trial and therapy failure(s) on all preferred agent(s).

The motion to accept this final recommendation was made by Bruce Alexander, and seconded by Dan Murphy. All other members were in agreement.

Public Comment

There were no speakers in this public comment session.

Miscellaneous

MedWatch: There were two Blackbox Warning updates for Aceon and Raptiva.

Auralgan Otic CMS Notification: As of July, 2008, CMS lists this as a deleted product through the rebate program.

Notification of FUL Updates: Notification of FUL change letters dated 10/7/08 and 10/28/08 were provided to the Commission.

A unanimous vote was made at 12:29 p.m. to adjourn the meeting and move to closed session (1st Dan Murphy, 2nd by Craig Logemann).

The next meeting will be held at 9:30 a.m. on Wednesday, February 4, 2009 at a site to be determined.

Iowa Medicaid Drug Utilization Review Commission

Meeting Minutes February 4, 2009

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Laura Griffith, D.O.; Laurie Pestel, Pharm.D.; Mark Graber, M.D.; and Susan Parker, Pharm.D.

Staff

Timothy Gutshall, M.D. (Medicaid Medical Director pro-temp); Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.

Guests

Sandy Pranger, R.Ph., IME; Chuck Wadle, D.O., Magellan; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Timothy Gutshall called the meeting to order at 9:29 a.m. at the West Des Moines Learning Resource Center. Commission members, guests, and observers were welcomed and introduced.

The minutes from the December 3, 2008 meeting were approved. (Motion by Bruce Alexander, second by Dan Murphy, unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

The new Preferred Drug List has been posted on the website, reflecting all the recent brand-generic status changes due to SMAC price updates.

Management Reports

Chad Bissell noted that the average cost per claim, total dollars paid, and number of claims paid has all increased significantly from the first quarter of the state fiscal year to the second. This is due in large part to the dispensing of palivizumab (*Synagis*), as well as increased use of antibiotics and cough and cold products. However, the percentage of controlled substances has remained at approximately 18.9%. Cheratussin Syrup was #5 on the top drugs by NDC report for the second quarter, and palivizumab (*Synagis*) was #1 on the top drugs by dollars spent report, at \$4,595,424.22. The line-up of the top therapeutic class by total prescriptions report and the top therapeutic class by dollars spent report has remained constant and both are dominated by mental health drug categories. In addition, generic utilization has continued to increase.

Smoking Cessation Report for Legislature

The Commission reviewed the final version of this report that had been sent to the legislature with slight formatting revisions.

P&T Recommendations on Select Mental Health Drugs

The Mental Health Advisory Group was unable to reach a recommendation at their December 12th meeting due to questions from the members in regards to administrative procedures and policies. They will meet again on February 13th, so their recommendations can then be brought to the next DUR meeting on March 4th and discussed prior to the March 12th P&T meeting.

ProDUR

Expansion of the Quantity Limits List, in regard to the short-acting narcotics, was discussed. Other states have implemented quantity limits on controlled substances in order to control costs, prevent over-utilization, and help prevent diversion. Pam Smith reviewed the report generated per the Commission's request at their previous meeting, which illustrated that there would currently only be 16 members affected by the proposed quantity limits. However, 10 of those members together accounted for 27 claims for generic propoxyphene/APAP (*Darvocet-N 100*) which exceeded the daily acetaminophen dosage. A FDA panel recently discussed propoxyphene/APAP (*Darvocet*) and propoxyphene (*Darvon*) and recommended removing them from the U.S. market based on efficacy concerns and safety risk. A column will be added to the posted quantity limits list to clarify allowable daily dosing. Dan Murphy motioned to accept the limits as recommended, and Bruce Alexander seconded. However, both were later withdrawn after a discussion of the benefits of holding off on these quantity limit changes. Since there would potentially be more additions in the near future, only one education release would need to be sent to prescribers and providers. Chad Bissell will bring a report entailing utilization on all pain medications that contain acetaminophen to the next meeting for further discussion.

Quarterly Narcotics Report

The first batch of letters will be mailed to prescribers in April, and there will be an article in the next DUR Digest. Dr. Charles Wadle asked if substance abuse programs would have access to IMERS to ease monitoring. Chad Bissell will look into this. The cover letter draft will be reworded to make sure that prescribers know they can actually refer patients to the Lock-In program.

Focus Studies

Long Term Muscle Relaxants: Pam Smith presented the follow-up information from a study wherein letters were sent to 197 members who were identified as having 5 or more claims of a 30-day supply for a muscle relaxant (excluding baclofen) between 10-1-07 and 3-31-08. Letters were sent to the prescribers and pharmacies in May of 2008. At the end of the evaluation period on 12-31-08, the following impact was observed: 14 members discontinued use of muscle relaxants, and 98 surveys were returned. This resulted in a cost savings of \$4,559.79 (state and federal dollars, pre-rebate), of which \$2,814.76 (pre-rebate) was savings to the state.

Anticonvulsant Drugs used in Mental Health Disorders: The IME identified unique members with two or more fills for any one or combination of the following drug classes; all typical antipsychotics, all atypical antipsychotics, clozapine, lithium, *Lamictal* (lamotrigine), valproic Acid (which includes *Depakote*, *Depakote ER*, *Divalproex*, valproate sodium, *Depakene*, and *Stavzor*), and carbamazepine (which includes *Tegretol*, *Tegretol XR*, *Equetro*, and *Carbatrol*). From this list, members with a diagnosis code in their claims history for epilepsy, seizure disorder, migraine, fibromyalgia, diabetic peripheral neuropathy, and post-herpetic neuralgia were removed. From the remaining members, those who also have two or more fills for an anticonvulsant(s) during the same time frame other than carbamazepine, valproic acid and/or *Lamictal* were identified. There was also an age break-down as requested. Of the 487 unique members taking a single anticonvulsant, 216 were under 18 years old. Of the 38 unique members taking multiple anticonvulsants, 11 were under 18. There were 339 members who were not taking carbamazepine, *Lamictal*, and/or valproic acid, but who were taking: *Trileptal*/oxcarbazepine (194), gabapentin/*Neurontin* (67), *Topamax*/topiramate (36), *Zonegran*/zonisamide (15), *Lyrica* (pregabalin) (11), *Gabitril* (tiagabine) (7), *Mysoline*/primidone (5), *Dilantin*/*Dilantin Infatabs* (2), *Keppra* (levetiracetam) (1), or phenytoin (1). There were 140 members taking an anticonvulsant in addition to carbamazepine or *Lamictal* or valproic acid, and 8 members taking 2 anticonvulsants in combination with 2 of the approved mood-stabilizer medications. No one was taking an additional anticonvulsant on top of all 3 of them. There were 87 members on multiple anticonvulsants; 48 of which were not on any of the approved drugs, and 39 of which were only on 1 of the 3 approved medications. A table was provided illustrating the most popular anticonvulsant drug pairings among the 87 members on multiple anticonvulsants. The top 3 were: *Keppra* with *Diastat* (diazepam), *Lyrica* with gabapentin, and gabapentin with *Topamax*. The Commission recommended letters continue to be sent to these prescribers during the normal member profile review process.

New Clozapine Users and Frequency of Monitoring: The purpose of this study was to identify new starters of clozapine and follow monitoring for White Blood Count (WBC), Absolute Neutrophil Count (ANC), and clozapine blood levels from May 1, 2008 to October 31, 2008. A secondary purpose was to determine the effect, if any, of clozapine use on doses of atypical antipsychotics. Testing is supposed to be done every week for the first 6 months of therapy, then every 2 weeks until a year of usage, and finally every 4 weeks provided no adverse reactions are observed. For the members identified, only 20% of the required testing is getting done. Out of the 35 members listed on the report, there were 28 that had no lab work done. There were 9 members using clozapine in combination with some other second-generation antipsychotic, and there were no checks for clozapine blood levels in their claim history. Bruce Alexander said that the high-risk period was 6-18 weeks after starting the medication, and many members are not being monitored during that period. Susan Parker asked that the filter criteria be re-examined to be sure that

hospitalized patients were not included. Due to billing procedures, it could have been possible for hospitalized members to receive tests that would not appear in the claims data that had been retrieved. Research results will be brought to the next meeting.

Duplicate Benzodiazepine Utilization: The purpose of this study is to identify unique members using duplicate benzodiazepines, a benzodiazepine in combination with a nonbenzodiazepine sedative/hypnotic, or a benzodiazepine in combination with buspirone from 9/1/08 to 11/30/08. In order for the members to appear in this report, they had to have duplication all three months, which eliminated any cross tapering of products. A total of 519 unique members were identified, of which 300 were on duplicate benzodiazepines, 137 on a benzodiazepine in combination with a nonbenzodiazepine sedative/hypnotic, and 91 on a benzodiazepine in combination with buspirone. Some of these 519 unique members appeared in more than one sub-classification. The majority of these members are going to the same prescriber and pharmacy for all their medications (involved in this study). Bruce Alexander asked that the report detail be summarized and broken down into ratios for future trend analysis such that the number from each group was the numerator and the total (519) was the denominator. The medications will be further broken down into groups of short-acting, intermediate, and long-acting medications. It was recommended that this be taken to the Mental Health Advisory Group. Dr. Mark Graber also recommended that the Commission consider adding benzodiazepines to the Quarterly Narcotic Report to Prescribers.

Duplicate Long-Acting Narcotic Utilization: The purpose of this study was to identify unique members using duplicate long-acting narcotics (*Duragesic*, fentanyl, methadone, *Kadian*, *MS Contin*, morphine sulfate sr or er, *Oramorph SR*, *Avinza*, *Oxycontin*, oxycodone er, and *Opana ER*). Members with a diagnosis of cancer were excluded. There were 21 unique members on duplicate long-acting therapy. There were also many instances where methadone was combined with other long-acting narcotics, and letters will be sent to the corresponding prescribers regarding this. Buprenorphine (*Subutex*) and Buprenorphine/Naloxone (*Suboxone*) combinations with other narcotics were also mentioned, and will be discussed at a future meeting.

Public Comment

Nancy Bell from Pfizer spoke about pregabalin (*Lyrica*), as well as antiepileptics and a letter that had gone out regarding metabolic testing. Leah McWilliams from the Iowa Osteopathic Association spoke of her concerns regarding the proposed quantity limit additions and possible titration issues.

Prior Authorization

Incretin Mimetic (Byetta): The Commission reviewed the PA criteria as had been requested by the P&T Committee as follows:

Prior authorization is required for incretin mimetics (Byetta®). Payment will be considered under the following conditions:

- 1) Diagnosis of Type 2 diabetes mellitus,*
- 2) Unless otherwise contraindicated, the member has not achieved HbgA1C goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum tolerated doses.*

Initial authorizations will be approved for six months; additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.

Both the Iowa Diabetes and Endocrinology Center in Des Moines, and the Endocrinology Department at the University of Iowa Hospitals and Clinics were contacted in December, and twice in January soliciting their comments. After reviewing input from one endocrinologist from Des Moines, and two other unsolicited comments from general practitioners, the Commission decided that the existing criteria were sufficient and recommended no changes.

Biologicals for Arthritis: The Commission reviewed the following PA criteria as several studies have come out in the last few years that suggest that certain patients with severe rheumatoid arthritis benefit more from using methotrexate plus a biological as initial therapy rather than using the traditional step therapy with a DMARD to a biological.

Prior authorization is required for biologicals used for arthritis. Payment will be considered following an inadequate response to a preferred disease modifying antirheumatic drug such as hydroxychloroquine, sulfasalazine, methotrexate, leflunomide, d-penicillamine, azathioprine, oral gold, or intra-muscular gold. Prior authorization is required for all non-preferred biologicals for arthritis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

After a review of the journal articles, the Commission members agreed that no recommended changes were required at this time.

Public Comment

Shawn Ahearn from Wyeth spoke about desvenlafaxine (*Pristiq*), and Christine Soltwedel from Abbott Labs spoke about the prior authorization process.

Miscellaneous

DUR Digest 2009 Volume 21, Number 2: The Commission members offered suggested changes to the draft.

MedWatch: There were recall notices for hydromorphone HCl 2mg tablets as well as 25 various tainted weight loss tablets and capsules. There was also a letter from the Celgene Corporation concerning the safety of tinzaparin (*Innohep*).

Notification of FUL Updates: Notification of the FUL change letter dated 12-12-08 was provided to the commission.

A unanimous vote was made at 12:20 to adjourn the meeting and move to closed session (1st Craig Logemann, 2nd by Bruce Alexander).

The next meeting will be held at 9:30 a.m. on Wednesday, March 4, 2009 at the Learning Resource Center in West Des Moines, Iowa.

Iowa Medicaid Drug Utilization Review Commission

Meeting Minutes March 4, 2009

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Rick Rinehart, M.D.; Laura Griffith, D.O.; Laurie Pestel, Pharm.D.; Mark Graber, M.D., FACEP; and Susan Parker, Pharm.D.

Staff

Thomas Kline, D.O.; Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.

Guests

Sandy Pranger, R.Ph., IME; Chuck Wadle, D.O., Magellan; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Thomas Kline called the meeting to order at 9:30 a.m. at the West Des Moines Learning Resource Center. Commission members, guests, and observers were welcomed and introduced.

The minutes from the February 4, 2009 meeting were approved, with a few wording corrections and additions as requested by Bruce Alexander. (Motion by Dan Murphy; second by Dr. Mark Graber; unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

To address old business from the February meeting, Dr. Kline said that substance abuse centers would have access to I-MERS, except that certain designated parties would need to be assigned permission. He also reviewed the topics brought up at the February 20th Clinical Advisory Committee meeting. That committee is still searching for one more primary care member. Also, a SURS coding project will bring savings; they also plan on researching emergency room coding. He also mentioned LTC waiver assessment forms had been discussed, and there will be ICFMR reviews to check quality of care. Dr. Wadle mentioned that it might be helpful to have Iowa Medicaid members evaluate the clarity and wording of questions on the LTC waiver assessment forms, and Susan Parker suggested there were some on the MAC committee who might help with that. IFMC is currently conducting interviews for a new Medical Director; they hope to have a replacement for Dr. Kline chosen by the end of March. Chad Bissell addressed the query from the February meeting regarding profiles, saying that the 300 profiles reviewed each meeting were whittled down from over 62,000 possibilities after the initial algorithms were applied. After being chosen for review and intervention, each member ID number is sequestered for nine months, so that profile will not be revisited at each meeting. A newsletter has been posted on the website www.iowamedicaidpdl.com saying that OTC

cetirizine is now available without a prior authorization; it also has an OTC MAC price on it. The P&T Committee will meet on March 12th, and a subsequent informational letter and PDL updates will go out sometime in April.

P&T Recommendations on Select Mental Health Drugs

The Commission reviewed the P&T Committee's recommendations to move 38 mental health drugs from the Recommended Drug List to the Preferred Drug List. Only 10 of these drugs would become non-preferred, however. These changes would only affect new users as existing users would be grandfathered. The Mental Health Advisory Group has voted unanimously in favor of making these proposed PDL status changes during their meetings in December and February. The Commission also reviewed the letter sent from the Iowa Psychiatric Society (IPS) in response to these recommended changes, and the corresponding response from the Department of Human Services. Sandy Pranger and Susan Parker have been invited to attend the spring IPS meeting, and DHS has also composed a frequently asked questions sheet to help ease the transition for mental health providers unaccustomed to the PA process. As the DUR Commission had no concerns with the recommendations, this topic will return to the P&T Committee for finalization. These changes should be implemented within 60 days.

PA Criteria

Extended Release Formulations: The Commission voted to change the prior authorization criteria as follows:

Payment for a non-preferred extended release formulation will be considered only for cases in which there is documentation of a previous trial and therapy failure with the immediate release product and/or a preferred extended release formulation of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

The drugs that would be affected are: Adoxa, Amrix, Allegra D 24 hr, Brovex CT, Cardura XL, Cipro XR, Coreg CR, diclofenac ER, Doryx, etodolac ER/CR, Extendryl SR, Flagyl ER, glipizide ER, Glucotrol XL, indomethacin ER, InnoPran XL, Luvox CR, **Metadate CD**, Opana ER, Prozac Weekly, Quibron-T/SR, Requip XL, **Ritalin LA**, Seroquel XR, Sinemet CR, Solodyn ER, Ultram ER, and Xanax XR.

A motion was made by Dan Murphy to approve the proposed criteria, and Bruce Alexander seconded that motion. It passed the roll call vote unanimously.

Modified Formulations: The Commission voted to add the prior authorization criteria as follows:

Payment for a non-preferred isomer, pro-drug, metabolite, and/or alternative delivery system will only be considered for cases in which there is documentation

of a recent trial and therapy failure with the original parent drug product of the same chemical entity, unless evidence is provided that use of the original product would be medically contraindicated.

Prior Authorization is required for the following modified formulations:

- 1) *Invega®*
- 2) *Pristiq®*
- 3) *Risperdal-M® Tabs*
- 4) *Zyprexa Zydys®*
- 5) *Abilify Discmelt®*

The individual drugs will be listed on the PA form, at least for a while, but the form might be condensed and generalized in the future. A motion was made by Dr. Rick Rinehart to approve the proposed criteria, and Bruce Alexander seconded that motion. It passed the roll call vote unanimously.

Public Comment

Jen Stoffel from Ortho McNeill Janssen spoke about Invega, and Mark Tacelosky from Wyeth spoke about Pristiq.

ProDUR

The Commission reviewed the proposed quantity limits for acetaminophen-containing analgesics. It was reported that there are more deaths associated with acetaminophen toxicity than with any other pharmaceutical agent. Toxicity is likely to occur with a single ingestion greater than 12 grams in a 24-hour period. The suggested quantity limits are based on the maximum daily dose of acetaminophen (4000mg per 24 hours). Dan Murphy asked if the refill-too-soon repeat offenders could be identified and referred to the lock-in program. Dr. Griffith motioned to accept the recommended limits, after 3 quantity corrections from Dan Murphy, and he himself seconded. However, the Commission later voted to withdraw the motion after discussing the topic and deciding to run some test scenarios through the pharmacy point of sale system before instigating quantity limits. This topic will be carried over to the next meeting.

Focus Studies

New Clozapine Users and Frequency of Monitoring: The purpose of this study was to identify new starters of clozapine and follow monitoring for White Blood Count (WBC), Absolute Neutrophil Count (ANC), and clozapine blood levels from May 1, 2008 and October 31, 2008. A secondary purpose was to determine the effect, if any, of clozapine use on doses of atypical antipsychotics. Testing is supposed to be done every week for the first 6 months of therapy, then every 2 weeks until a year of usage, and finally every 4 weeks. For the members identified, only 20% of the required testing is getting done. Out of the 35 members listed on the report, there were 28 that had no lab work done. There were 9 members using clozapine in combination with some other second-generation anti-psychotic, and there were no checks for blood levels in their

claims history. These numbers had been re-run after the January meeting, as the Commission believed there might have been some data capture errors. Additional investigation into capture procedures determined that the lab monitoring data on this report was 90% inclusive; there is a potential that some monitoring may have been done on an inpatient basis that would not have showed up in this report. Additional claims data were added to include November and December claims. The number of members who did not receive lab monitoring did not change. An additional search was performed to identify members who may have developed agranulocytosis. There were no members identified with ICD-9 codes commonly associated with clozapine adverse drug reactions. The Commission decided that the pharmacies and prescribers should be contacted directly by phone to hasten a solution to this problem. Dr. Wadle volunteered to call the doctors, and Pam Smith and Chad Bissell will be calling the pharmacists.

Use of Metered Dose Inhalers vs. Nebulizers: The purpose of this study was to identify unique members, 40 years of age and older, with three or more fills of albuterol nebulizer solution and/or Duoneb who also have one or more fills of a metered dose inhaler between the dates 7/1/2008 to 12/31/2008. According to the evidence-based guidelines published by the American College of Chest Physicians and the American College of Asthma, Allergy, and Immunology, efficacy should not be the basis for selecting one inhalation delivery device over another, as inhalation delivery devices have been found to be equally effective. There is a significant difference in cost between the nebulized solutions of albuterol and Duoneb and the cost of the albuterol and Combivent metered dose inhalers. There were 533 unique members identified using the parameters above. These parameters were then used to refine the data and looked only for those members who combined the nebulizer delivery system with a metered dose inhaler delivery system. There were 327 unique members (61.4% of those identified) who were combining inhalation delivery devices. However, in reviewing the claim level detail, not all of these 327 members were combining delivery devices concurrently. There were some who switched from one to the other, and there were other instances where there was only one fill of a particular delivery system. Only 223 members (68.2% of those combining devices) were using both delivery devices concurrently. Dr. Griffith commented that the portability factor would warrant use of both devices. This topic will be included as an educational piece in the next DUR Digest newsletter.

Concurrent Inhaled Anticholinergics: The purpose of this study was to identify unique members using duplicate inhaled anticholinergics. Inhaled anticholinergics are primarily used in the treatment of chronic obstructive pulmonary disease (COPD). Currently, there are two inhaled anticholinergics available: ipratropium and tiotropium. The current Global Initiative for Chronic Obstructive Lung Disease (GOLD) guidelines recommend regular use of a short- or long-acting inhaled anticholinergic to improve symptoms; it does not support the use of combining the two inhaled anticholinergics. Furthermore, the *Spiriva* (tiotropium) package insert states that "the co-administration of *Spiriva HandiHaler* with other anticholinergic containing drugs (e.g., ipratropium) has not

been studied and is therefore not recommended.” A report was run looking for duplicate therapy with inhaled anticholinergics (ipratropium inhalation solution, *Duoneb*, ipratropium/albuterol inhalation solution, *Combivent*, *Atrovent HFA*, *Atrovent*, and *Spiriva*) between the time period of 9/1/2008 and 11/30/2008. Those members who continued the duplicative therapy in December are also reported. There were 215 distinct members found with duplicate inhaled anticholinergics in their claim histories. Ninety-nine (or 46%) of those members were combining tiotropium and ipratropium. Seventy-five members continued duplicate therapy with inhaled anticholinergics in December. Thirty-six (or 48%) of those 75 members continued using tiotropium in combination with ipratropium in December. Letters will be sent to the prescribers of these 36 members inquiring about the duplicative therapy and asking if one of the inhaled anticholinergics could be discontinued.

Protease Inhibitors with HMG CoA Inhibitors: The purpose of this study was to identify Iowa Medicaid members who are using protease inhibitors in combination with HMG CoA reductase inhibitors. Since the introduction of antiretroviral drugs in 1987, and the introduction of combination therapy referred to as highly active antiretroviral therapy (HAART), AIDS mortality has decreased dramatically. As people who are HIV positive are living longer, it is becoming more and more common for these patients to also develop hypertension, high cholesterol, diabetes, etc. There have been anecdotal reports from infectious disease specialist physicians that there has been an increase in the inadvertent combination of HMG CoA reductase inhibitors (statins) and protease inhibitors. When protease inhibitors are combined with statins, the serum concentration of the statin is increased and there is a higher risk of developing rhabdomyolysis. Lovastatin and simvastatin are contraindicated with any protease inhibitor. With the exception of fluvastatin, which does not appear to interact with protease inhibitors, other statins may be used at low doses and when closely monitored. There are also limited data to suggest that use of pravastatin decreases the serum concentrations of protease inhibitors. Due to the potential severity of this interaction, data were pulled on Iowa Medicaid members using both a protease inhibitor and a statin to see if this was a potential problem within the Iowa Medicaid population. Five distinct members were identified. None of them were using lovastatin or simvastatin, and there was only one instance where different prescribers were involved. Since this does not appear to be a problem within the Iowa Medicaid population, it is recommended that awareness of this interaction be communicated in the next DUR Digest newsletter.

Thiazolidinediones in Congestive Heart Failure: The purpose of this study was to identify unique members with a diagnosis of congestive heart failure who are also taking a thiazolidinedione (TZD). The American Heart Association and the American Diabetes Association first issued a consensus statement in 2003 regarding the use of thiazolidinediones and the increased risk of worsening congestive heart failure due to fluid retention. Since the publication of the 2007 *New England Journal of Medicine* article, “Effect of rosiglitazone on the risk of myocardial infarction and death from cardiovascular causes”, the safety of thiazolidinediones has come under further scrutiny. This study concluded that

rosiglitazone utilization was associated with a significant increase in the risk of myocardial infarction and increase risk of death from other cardiovascular events. While the *New England Journal of Medicine* article had its limitations, the Food and Drug Administration has since required the manufacturers of thiazolidinediones to add language to their labels including the statement that these drugs may worsen heart failure. A report was run showing TZD utilization in Iowa Medicaid members with a diagnosis code for congestive heart failure. All Iowa Medicaid members who received a paid pharmacy claim for a product containing a thiazolidinedione (*Actos, Avandia, Duetact, Avandaryl, Avandamet, Actosplus Met*) between the time period of 7/1/08 and 12/31/08 who also had a diagnosis of congestive heart failure (ICD-9 codes 428.00 – 428.90) in their medical claims history between 1-1-05 and 12-31-08 were included. There were 1,242 distinct members using thiazolidinediones. Eighty-one (or 6.5%) of those members were on a TZD with a diagnosis of congestive heart failure. Educational letters will be sent to the prescribers of these 81 members reminding them of the potential risks and inquire if the risk versus benefits of using TZDs in patients with CHF has been evaluated recently. In addition, this member list will be compared to one maintained by the nurse care managers at the IME who assist in the care of CHF patients.

Public Comment

There were no speakers in this public comment session.

Miscellaneous

DUR Digest 2009 Volume 21, Number 2: The Commission members offered suggested changes to the updated draft.

MedWatch: The Commission members received 2 FDA announcements concerning a serious adverse event with the psoriasis drug Raptiva, as well as a required boxed warning and risk mitigation strategy for metoclopramine-containing drugs.

A unanimous vote was made at 12:10 to adjourn the meeting and move to closed session (1st by Bruce Alexander 2nd by Craig Logemann).

The next meeting will be held at 9:30 a.m. on Wednesday, May 6, 2009 at the Hoover Building (Level A, Conference Room 5) in Des Moines, Iowa.

Iowa Medicaid Drug Utilization Review Commission

Meeting Minutes May 6, 2009

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Craig Logemann, R.Ph., Pharm.D., BCPS; Sara Schutte-Schenck, D.O., FAAP; Laura Griffith, D.O.; Laurie Pestel, Pharm.D.; and Susan Parker, Pharm.D.

Staff

Thomas Kline, M.D.; Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.

Guests

Sandy Pranger, R.Ph., IME; and Chuck Wadle, D.O., Magellan.

Welcome & Introductions

Thomas Kline called the meeting to order at 9:36 a.m. at the Hoover Building (Level A Conference Room 5) in the Capitol Complex. Commission members, guests, and observers were welcomed and introduced.

The minutes from the March 4, 2009 meeting were approved. (Motion by Bruce Alexander, second by Dan Murphy, unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

There is a new Department of Human Services Director, Charlie Krogmeier, as Gene Gessow was not confirmed by the legislature for that position. Mr. Krogmeier was previously Governor Culver's Chief of Staff. He will be up for confirmation at the next legislative session. The last Clinical Advisory Committee meeting was cancelled due to Easter, so no updates on that. Dr. Kline explained a new Medical Home Certification program and meetings being held for that. The lock-in program just received their first physician referral from the pharmacy-sponsored physician/pharmacy surveillance program for controlled substances. There are approximately 150 diabetics enrolled in the Disease Management program. The *Synagis* season is almost finished; utilization data will be presented at the next DUR meeting.

Management Reports

Pamela Smith reviewed the quarterly reports from State Quarter 3 (1/1/09-3/31/09). The average amount paid per claim as \$65.71, with a total amount paid of \$66,620,729.87. There were 1,013,911 paid claims last quarter. The average number of claims per member was down to 5.29, which was considerably less than the 13.36 average for the fiscal year. The percentage of controlled substances was 18.47%. The top 5 drugs per NDC by number of prescriptions were the same as the prior quarter, only in a slightly different order. *Synagis* topped the top drugs by dollars spent report, and the rest of the top 5 was comprised of mental health drugs. There was a large increase in utilization

of Beta-Lactams/Clavulanate Combinations, and this category moved to second place on the therapeutic class by total prescriptions report. The generic utilization rate is continuing to increase, and was up to 69.29% last quarter.

Case Reviews

Pam Smith presented four intervention case studies. Recommendations by commissioners from these four examples resulted in annualized total savings of \$5,512.22 pre-rebate (state and federal).

PA Criteria

Modified Formulations: No feedback was received from the letters that were sent out after the last meeting. The Commission agreed to move forward with the prior authorization criteria as follows:

Payment for a non-preferred isomer, pro-drug, metabolite, and/or alternative delivery system will only be considered for cases in which there is documentation of a recent trial and therapy failure with the original parent drug product of the same chemical entity, unless evidence is provided that use of the original product would be medically contraindicated.

Prior Authorization is required for the following modified formulations:

- 1) Invega®
- 2) Pristiq®
- 3) Risperdal-M® Tabs
- 4) Zyprexa Zydis®
- 5) Abilify Discmelt®

The individual drugs will be listed on the PA form, at least for a while, but the form might be condensed and generalized in the future. These criteria will be re-reviewed in June to determine if additional drugs need to be added to the form.

Extended Release Formulations: The Commission voted to change the prior authorization criteria as follows:

Payment for a non-preferred extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the preferred immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Prior authorization is required for the following extended release formulation(s):

Adoxa, Amrix, Cardura XL, Cipro XR, Coreg CR, Doryx, Flagyl ER, glipizide ER, Glucotrol XL, InnoPran XL, Luvox CR, Prozac Weekly, Requip XL, Seroquel XR, Solodyn ER, Ultram ER.

A motion was made by Dan Murphy to approve the new proposed criteria, after any extended release product that has a preferred generic is removed from the list and a caveat allowing the Department discretion to add or remove new products and make changes to the drug list is added. Craig Logemann seconded that motion. It passed the roll call vote unanimously. The list of affected drugs will be re-reviewed at the June meeting.

ADD/ADHD/Narcolepsy Agents: The Commission voted to change the prior authorization criteria as follows:

*Prior Authorization (PA) is required for ADD/ADHD/Narcolepsy Agents for members 21 years of age or older. PA is also required for all non-preferred agents, regardless of age, the first day of therapy. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. *If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required, unless evidence is provided that use of these products would be medically contraindicated.*

A motion was made by Dr. Laura Griffith to approve the proposed criteria, and Dan Murphy seconded that motion. It passed the roll call vote unanimously.

Nonsteroidal Anti-Inflammatory Drugs: The Commission voted to change the prior authorization criteria as follows:

Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all non-preferred COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs.

1. Requests for a non-preferred nonsteroidal anti-inflammatory drug must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs.

2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with two preferred COX-2 preferentially selective nonsteroidal anti-inflammatory drugs.

** If a non-preferred long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested product, unless evidence is provided that use of the immediate release product would be medically contraindicated.*

A motion was made by Craig Logemann to approve the proposed criteria, and Dr. Laura Griffith seconded that motion. It passed the roll call vote unanimously.

Thrombopoietin Receptor Agonists: The Commission reviewed the proposed prior authorization criteria as follows:

Payment for a preferred thrombopoietin receptor agonist will only be considered

for cases in which there is a diagnosis of chronic immune thrombocytopenic purpura (ITP) in addition to there being documentation of a recent trial and therapy failure with a preferred corticosteroid, a preferred immunoglobulin, and/or the member has undergone a splenectomy. Payment for a non-preferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.

The Commission members asked for input from hematologists before proceeding with PA criteria for this new drug class. Craig Logemann suggested keeping the PA wording as close to the package insert as possible. The DUR staff will contact hematologists prior to the June meeting and the criteria will be re-reviewed.

Polyethylene Glycol 3350: Effective April 23rd CMS changed the DESI status of PEG such that the prescription-only version is no longer payable through Medicaid programs. Only the over-the-counter formulation will be payable by the Iowa Medicaid Enterprise. Notification will be sent out to pharmacies to let them know that as of Friday May 8, 2009, the OTC PEG will be covered without a prior authorization for kids up to 12 years of age. A PA will be required for ages 13-18. This drug will not be covered for anyone 19 or older. In February, Warren Bishop, M.D., a pediatric GI specialist at the University of Iowa sent an email to DHS expressing concerns over not having palatable effective bowel prep for children undergoing colonoscopy. He stated they have been using PEG without electrolytes and have been having a high degree of success. Children cannot typically drink the *GoLytely* or the equivalents in quantities sufficient to cleanse the bowel because of the salty musty taste and the discipline needed to drink large quantities over a short period of time. Instead, they have been using a gentle and efficient bowel prep of PEG without electrolytes, which is given over 4 days. This has been widely adopted across the nation by pediatric gastroenterologists. This same doctor also published a paper which has now become the standard of practice in most regions. There is a considerable cost difference between *GoLytely* or one of the equivalents and *Miralax*. There is a 45% cost differential when comparing the 255 gram bottle of *GoLytely* to one bottle of *Miralax*. However, the *Miralax* bottle is about twice as large. There will be an OTC MAC rate on OTC *Miralax*, but it will still cost \$11 more. Commission members were provided with utilization data for the last 2 years, and asked if a change needed to be made to the criteria for ages 13 to 18. Dr. Bishop was asked to provide his public comments at this time by the members of the Commission. There was a lengthy discussion debating cost and efficacy, but in the end the Commission members decided to wait 6-9 months to re-evaluate changing the PA criteria and possibly negotiate better pricing. In the meantime, the Commission made a motion to allow payment of OTC *Miralax* for children less than 19 years of age without a preferred drug trial when used as a bowel prep over 4 days (motion by Bruce Alexander, second by Dr. Sara Schutte-Schenck.) The motion carried by unanimous roll call vote by those present. At the June meeting, an update will be provided as to how this can be done through the pharmacy POS system.

Public Comment

Warren Bishop, M.D. from the University of Iowa spoke about polyethylene glycol 3350 without electrolytes.

ProDUR

Test scenarios were ran through the pharmacy point of sale system for daily quantity limits, and found there are issues with claims due to the days supply entered, such as pharmacies rounding the days supply down or arbitrarily putting in a days supply. There was concern that this would generate a large number of phone calls to the help desk that are not due to over utilization. The Commission suggested more education be provided to prescribers and pharmacies and to look at other states that may have quantity limits on acetaminophen containing products. This will be a future topic in the DUR Digest.

Focus Studies

New Clozapine Users and Frequency of Monitoring: Pam Smith reported that she contacted 16 pharmacies of those members that were identified as using clozapine but had no lab work in their medical claims history. She found that all members were receiving the appropriate lab work. Most members were receiving their lab work through the hospital lab which is the most likely reason it was not found in medical claims. There was only one pharmacy that was not verifying the WBC and ANC prior to dispensing clozapine which affected two members. The members were in a nursing home that was monitoring the lab work. The remaining pharmacies reported they do not dispense clozapine until the lab work was obtained.

Chronic Triptan Use without Prophylaxis: The purpose of this study was to follow up on the 195 unique members who were identified as having two or more fills for a migraine treatment (triptans) within a three month time frame without trying a prophylactic medication (propranolol, Inderal LA, timolol, amitriptyline, Depakote, Topamax, or verapamil) between 4/1/2008 and 7/1/2008. Imitrex, which had the highest member count in the original study, dropped from 104 members to 52 after the DUR intervention. Relpax also experienced a significant drop from 35 to 19 members. There were 343 surveys sent out, of which 134 were returned. Twenty-six members were started on a prophylactic following intervention. Also impacting these data were the change in the clinical prior authorization criteria for triptans; beginning January 1, 2009, a PA was required for 12 or more triptan tablets per 30 days as opposed to 18. In total, these changes resulted in a savings of \$41,357.07 (state and federal), with \$16,146.19 for the State.

Multiple Antipsychotic Use in Children: This review was tabled due to time constraints. It will be reviewed at the June meeting.

Safety of Statins Plus Tricor: The P&T Committee reviewed *Trilipix* (delayed-release fenofibric acid) at their March 12th meeting. Prior to making a recommendation to the Department regarding the PDL status of *Trilipix* (delayed-release fenofibric acid), the P&T Committee was interested in the DUR Commission reviewing utilization data to determine if the safety concerns of combining *Tricor* with a statin was significant enough that *Trilipix* (delayed-release fenofibric acid) should be recommended to have a preferred status. *Trilipix* (delayed-release fenofibric acid) is the active metabolite of *Tricor* (fenofibrate) which was approved by the FDA in December, 2008. It is indicated for use in the treatment of reducing triglyceride levels and increasing HDL levels in patients with mixed dyslipidemia and CHD (or a CHD risk equivalent) in combination with a statin. *Trilipix* (delayed-release fenofibric acid) is the only fibrate approved for use in combination with a statin. Other fibrates, such as *Lopid* (gemfibrozil) and *Tricor* (fenofibrate) can produce myopathy and rhabdomyolysis when combined with statins. Post-marketing data have reports of there being more than a 5-fold increase in the risk of rhabdomyolysis in patients taking a statin in combination with a fibrate compared to monotherapy. Studies looking at statins plus *Tricor* (fenofibrate) show that in addition to greater improvements in lipid levels compared to monotherapy, there were no cases of myopathy, rhabdomyolysis, or other drug-related adverse events reported. In a review published in *The Pharmacist's Letter/Prescriber's Letter* (February 2009), it is stated that, "based on available data, there appears to be no significant difference in the safety and efficacy of combining either fenofibric acid or fenofibrate with a statin." The Commission was asked to review utilization data from 1/1/09-2/28/09 to determine if the data suggests that prescribers are concerned with the safety of combining statins and *Tricor*, therefore making the case that *Trilipix* offers a clinical advantage over *Tricor* and that there should be a recommendation to the P&T Committee to reconsider the PDL status of *Trilipix*. The Commission members reviewed the data and asked for clarifications from the studies reported in *The Pharmacist's Letter*. The Commission members also discussed their personal experiences with dealing with the interaction. The DUR Commission did not feel it necessary to recommend a change in PDL status to the P&T Committee.

Duplicate NSAIDs (including topical diclofenac): This topic was tabled until the June meeting due to time constraints.

Public Comment

Dr Mohamed Morsy spoke on behalf of Abbott for the drug, *Trilipix*.

Miscellaneous

DUR Digest 2009 Volume 21, Number 3: The Commission members offered suggested changes to the updated draft.

FUL Updates Effective 4-30-09: The Commission members were given a copy of the CMS FUL changes that had gone into effect April 30th.

MedWatch: The Commission members received FDA announcements concerning OsmoPrep, Visicol, Premarin Vaginal Cream, and Truvada.

A unanimous vote was made at 12:40 to adjourn the meeting and move to closed session (1st by Bruce Alexander, 2nd by Craig Logemann).

The next meeting will be held at 9:30 a.m. on Wednesday, June 3, 2009 at the West Des Moines Learning Center, 3550 Mills Civic Parkway in West Des Moines, Iowa.

Iowa Medicaid Drug Utilization Review Commission

Meeting Minutes June 3, 2009

Attendees:

Commission Members
Rick Rinehart, M.D.; Bruce Alexander, R.Ph., Pharm.D., BCPP; Dan Murphy, R.Ph., Sara Schutte-Schenck, D.O., FAAP; Laura Griffith, D.O.; Laurie Pestel, Pharm.D.; and Susan Parker, Pharm.D.
Staff
Thomas Kline, D.O.; Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.
Guests
Chuck Wadle, D.O., Magellan; Colleen Kacher, IME; Nick Ford, IME; Kelly Espeland, IME; Sandy Pranger, R.Ph., IME; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Thomas Kline called the meeting to order at 9:32 a.m. at the West Des Moines Learning Resource Center. Commission members, guests, and observers were welcomed and introduced.

Chad Bissell announced that Dr. Laura Griffith and Dan Murphy had each completed their terms on the DUR Commission. He presented them with certificates and letters of appreciation signed by the Iowa Medicaid Director, Jennifer Vermeer. He also introduced the new DUR member in attendance in the audience, Larry Ambroson, R.Ph.

The minutes from the May 6, 2009 meeting were approved following some noted corrections. (Motion by Dan Murphy, second by Bruce Alexander, unanimous approval by voice vote.)

Iowa Medicaid Enterprise Updates

The IME SURS department reviewed questionable billing practices of a pharmacy that had been brought to light in DUR member profiles. They recently completed an overpayment recovery from this pharmacy of over \$36,000 as an indirect result of the Commission's profile review. Also, Medical Services has acquired a new quality assurance tool called a Care Analyzer, a product of John Hopkins University, used for predictive modeling. The Clinical Advisory Committee met and approved a number of policies, and helped the Long Term Care division, as well as the waiver program, develop a level of care checklist for nursing home admission. Nine physicians agreed that the end product was much more user-friendly. Susan Parker mentioned that recommendations for the State Fiscal Year 2011 budget, including improvements to care and cost containment initiatives, were in process on both the DHS and IME levels. Iowa Medicaid membership has increased from 350,000 to 400,000 in the last six months. Dr. Kline noted that Director Vermeer stated that the federal stimulus

package would allow for unchanged Medicaid benefits for the next year. However, there would be no guarantee beyond that. Dr. Chuck Wadle announced that the IowaPlan enrollment had almost doubled since 1995. Magellan was just awarded the re-bid for the IowaPlan. They're working with the IME pharmacy unit to interface the two systems for better diagnostic implications. The discussion regarding literature for public comment was postponed as Dr. Graber was not in attendance and he had been the one to mention it initially.

Case Reviews

Pam Smith presented three intervention case studies. Recommendations by Commissioners from these three examples resulted in annualized total savings of \$16,738.97 pre-rebate (state and federal).

Public Comment

There were no speakers in this public comment session.

PA Criteria

Modified Formulations: The Commission reviewed the prior authorization criteria as follows:

Payment for a non-preferred isomer, pro-drug, metabolite, and/or alternative delivery system will only be considered for cases in which there is documentation of a recent trial and therapy failure with the original parent drug product of the same chemical entity, unless evidence is provided that use of the original product would be medically contraindicated.

Drugs to be affected: Abilify Discmelt, Invega, Pristiq, Risperdal-M Tabs, and Zyprexa Zydis.

Other potential candidates:

Flector & Voltaren Gel (both currently non-preferred within the NSAIDs PA Criteria; requires trials with two preferred NSAIDs prior to consideration)

Kapidex (soon to be added to the PPI PA Criteria; requires trials with three preferred PPIs prior to consideration)

Xyzal (currently non-preferred within the Antihistamine PA Criteria; requires trials with OTC loratadine/cetirizine plus a preferred first generation (if over 21) plus a preferred legend second generation antihistamine prior to consideration).

Trilipix and Xopenex, (both are currently non-preferred on the PDL)

Flector & Voltaren Gel, Kapidex, and Xyzal will not be added to this PA form, as they are already managed on other PA forms. Dr. Wadle mentioned that preferred agents other than the parent compounds might need to be considered as well, and Susan Parker recommended that be a second phase of this PA form process. That topic has come up before, but Committee members have had differing opinions. Dan Murphy motioned to add Trilipix and Xopenex to the

Modified Formulations PA Form. Dr. Griffith seconded, and the motion passed with no objections. These two drugs will be added to the already agreed upon PA criteria.

Extended Release Formulations: The Commission discussed the prior authorization criteria as follows:

Payment for a non-preferred extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the preferred immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Prior authorization is required for the following extended release formulation(s):

Adoxa, Amrix, Cardura XL, Cipro XR, Coreg CR, Doryx, Flagyl ER, glipizide ER, Glucotrol XL, Luvox CR, metronidazole SR, Prozac Weekly, Requip XL, Ryzolt, Seroquel XR, Solodyn ER, tramadol SR, Ultram ER.

There was no vote as this had already been discussed at a previous meeting; no concerns were raised.

ADD/ADHD/Narcolepsy Agents: The Commission discussed the prior authorization criteria as follows:

*Prior Authorization (PA) is required for ADD/ADHD/Narcolepsy Agents for members 21 years of age or older. PA is also required for all non-preferred agents, regardless of age, the first day of therapy. Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents would be medically contraindicated. *If a non-preferred long-acting medication is requested, a trial of the preferred immediate release and extended release product of the same chemical entity is required, unless evidence is provided that use of these products would be medically contraindicated.*

Chad Bissell read the responses to the letters that had been sent out to medical and pharmacy associations regarding this proposed PA criteria. There was no vote as this had already been discussed at a previous meeting; no concerns were raised.

Nonsteroidal Anti-Inflammatory Drugs: The Commission discussed the prior authorization criteria as follows:

Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all non-preferred COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs.

1. Requests for a non-preferred nonsteroidal anti-inflammatory drug must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs.

2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with two preferred COX-2 preferentially selective nonsteroidal anti-inflammatory drugs.

* If a non-preferred long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested product, unless evidence is provided that use of the immediate release product would be medically contraindicated.

There was no vote as this had already been discussed at a previous meeting; no concerns were raised.

Thrombopoietin Receptor Agonists: The Commission reviewed the prior authorization criteria as follows:

Payment for a preferred thrombopoietin receptor agonist will only be considered for cases in which there is a diagnosis of chronic immune thrombocytopenic purpura (ITP) in addition to documentation of an insufficient response to a corticosteroid, an immunoglobulin, or the member has undergone a splenectomy. Payment for a non-preferred thrombopoietin receptor agonist will be considered following documentation of a recent trial and therapy failure with a preferred thrombopoietin receptor agonist unless such a trial would be medically contraindicated.

The Commission members had asked for input from hematologists before proceeding with PA criteria for this new drug class. Chad Bissell reviewed the comments received. Dr. Griffith agreed that these are not intended to be first line therapies. Bruce Alexander moved to accept the proposed criteria, Dan Murphy seconded, and the motion passed with no objections.

Polyethylene Glycol 3350 - Programming: Effective April 23rd CMS changed the DESI status of PEG such that the prescription-only version is no longer payable through Medicaid programs. Only the over-the-counter formulation will be payable. Notification was sent out to pharmacies to let them know that as of Friday May 8, 2009, the OTC PEG will be covered without a prior authorization for kids up to 12 years of age. PA will be required for ages 13-18. This drug will not be covered for anyone 19 or older. The POS programming is currently in the works. If a pharmacy enters a 5 days supply or less for the three approved NDC numbers it will pay. The POS system will be programmed so this can be billed without requiring a PA provided the patient is in the proper age cohort. There is no limit set for these claims, but they will be tracked on a report. Any member with more than one fill of a 5 days supply will be tracked. This will be added to an informational letter once the programming has been completed within the next 30 to 60 days.

Public Comment

There were no speakers in this public comment section.

Focus Studies

Multiple Antipsychotic Use in Children: The purpose of this study was to re-evaluate the list of 52 members whose prescribers received a letter for the Duplicate Antipsychotic Use in Children Focus Study for the time frame of 5/1/2007 through 10/31/2007. The list of 52 members was re-evaluated during the time frame of 2/1/2008 through 7/31/2008 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotic(s). The list of 52 members was re-evaluated a second time from 10/1/2008 - 3/31/2009 to see whose regimen of duplicate antipsychotics had remained the same and who discontinued using one or more antipsychotic(s). Of the 18 members who discontinued one or more antipsychotic(s) initially, 7 discontinued one or more during the second follow-up, 4 continued with the same regimen as before, and 3 added an antipsychotic. Of the 14 members who continued using the same regimen initially, 2 discontinued one or more antipsychotic(s), 7 continued the same regimen, and 2 added an antipsychotic. Finally, of the 14 members who added an antipsychotic to their regimen initially, 1 member discontinued one or more antipsychotic(s), 3 continued with the same regimen, and 8 added an antipsychotic. The number of members taking multiple antipsychotics dropped significantly between the initial analysis and the second follow-up. For instance, there were 15 members taking 3 different antipsychotic drugs initially, but only 6 were found during the second follow-up. This topic will be discussed at the next Mental Health Advisory Group meeting as well.

Chronic Bactroban Use: The purpose of this study was to follow-up on the 113 unique members identified as having three or more fills of Bactroban and/or mupirocin in their claims history for a nine month time frame (1/1/08 to 9/30/08). Letters were sent to providers at the end of November 2008. Of the 113 unique members identified in the original study, only 4 were still using Bactroban/mupirocin chronically after the DUR intervention. Six members started an OTC topical antibiotic. These therapy changes resulted in a cost savings of \$11,156.41 (pre-rebate), of which \$4,194.81 were state dollars.

Duplicate NSAIDs (including topical diclofenac): The purpose of this study was to identify instances where Iowa Medicaid members are using oral NSAIDs and topical diclofenac (*Flector Patch* or *Voltaren Gel*) in combination. In reviewing claims data between November, 2008 and February, 2009, there were no incidences of duplicate oral NSAID use with a topical diclofenac product. However, other duplicate NSAID use was found in 33 unique members. The DUR Commission currently sends intervention letters to these prescribers when members' profiles are reviewed. The Pharmacy Point of Sale Helpdesk staff has also been calling the individual prescribers requesting one of the NSAIDs be

discontinued on a monthly basis. The Commission agreed that so few claims would not justify any further action or POS programming at this time.

Synagis Utilization: The RSV season has just concluded. Commission members were given statistics from this year, as well as previous years for comparison. The current PA criteria allows for 5 doses, with a sixth contingent on Iowa virology data. Most Iowa Medicaid patients did get a sixth dose this year, as the Iowa RSV season began later than usual. More than 90% of Synagis PA requests are approved. Claims data was reviewed for duplications between the doctor's offices and pharmacies. There were only a couple of true duplicate billings, and those cases have been addressed. The Commission discussed the possibility of changing the refill tolerance for Synagis, as some providers filled every 24 or 25 days, thereby supplying extra doses to the members. Since only a few pharmacies engaged in this practice, the Commission members agreed that this should not be an issue for all the providers and that just a few pharmacies should be contacted and dealt with. No recommended changes to the PA criteria were recommended at this time.

Proton Pump Inhibitors plus Plavix: The purpose of this study was to identify Iowa Medicaid Members using clopidogrel (Plavix) for two or more consecutive months between 11/1/08 and 4/30/09 who are also using a proton pump inhibitor. Within the Iowa Medicaid population, the following utilization data was observed during a six month time period (11/1/2008 through 4/30/2009): 153 members using *Plavix* plus any PPI, with 73 of those members continuing the combination into April 2009; and 34 members using *Plavix* plus omeprazole, with 9 members continuing the combination into April, 2009. The Commission did not believe an intervention needed to occur at this time.

Benzodiazepines without SSRI/SNRI: The purpose of this study was to determine how many Iowa Medicaid members are being treated for various anxiety disorders with benzodiazepines but not a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI). At the February 2009 DUR Meeting, a report was generated which looked at duplicate benzodiazepine utilization for members between the time period of 9/1/2008 through 11/30/2008. This report found 300 unique members who were using two or more benzodiazepines concurrently. In the discussion, an interest was expressed to look at members who were being treated for anxiety disorders with benzodiazepines but not an SSRI/SNRI. A report was run looking at members with a diagnosis code of anxiety, panic disorder without agoraphobia, generalized anxiety disorder, phobic disorder, obsessive-compulsive disorder, and dysthymic disorder at anytime in their medical claims history. Members identified with a diagnosis of mood disorder and/or depressive disorder were excluded from the sample. These members' pharmacy claims histories were reviewed to identify utilization with SSRI/SNRIs and benzodiazepines between the dates of 3/1/2008 and 3/1/2009. Of the 17,120 members who fit the criteria, 894 had consecutive months of BZD but no SSRI/SNRI (548 of whom were still using BZD but no SSRI/SNRI as of 3/09); 2,821 were using both SSRI/SNRI and BZD concurrently (1,786 of whom were still using both SSRI/SNRI and BZD concurrently as of

3/09); and 3,067 with consecutive months of SSRI/SNRI but no BZD (1,732 of whom were still using SSRI/SNRI but no BZD as of 3/09). Claim diagnosis codes will be whittled down to panic disorder without agoraphobia, panic disorder with agoraphobia, obsessive-compulsive disorder, and dysthymic disorder. The updated data will be brought to the next meeting for further evaluation.

Impact of Methadone Conversion & Dosing Information: The purpose of this study was to assess the impact of the methadone educational letter sent to providers in February 2007. In February 2007, the DUR Commission sent out an educational letter with detailed information on how to convert members on a long acting opioid to methadone. The goal was to encourage prescribers to switch members from more expensive long acting narcotics to methadone. At the time of the intervention, *Oxycontin CR*, *Avinza*, and morphine sulfate were the preferred long acting narcotics. Since then, *Oxycontin CR* has moved to a non-preferred status and *Kadian* is now preferred. A report was run looking at utilization data for long acting narcotics and methadone between the dates of 2/1/06 and 1/31/09. The dates of 2/1/06 to 1/31/07 were run as a baseline and the dates of 2/1/07 to 1/31/08 were run as the first year after intervention. Long-acting narcotic usage has remained fairly constant. Methadone utilization, however, has increased gradually, though this is possibly just a reflection of an increased Medicaid population.

Subutex/Suboxone plus Narcotics: The purpose of this study was to identify Iowa Medicaid members during a six month time frame (September, 2008 through February, 2009), who have two or more fills for *Subutex/Suboxone* plus any prescriptions for narcotics (including tramadol-containing products). Due to the small number of members being treated, it was recommended this be an article in a DUR Digest as opposed to writing letters to the prescribers.

Miscellaneous

DUR Digest 2009 Volume 21, Number 3: The Commission members offered suggested changes to the updated draft.

SMAC Updates: The Commission members were given a copy of the SMAC changes that would soon go into effect.

FUL Updates: The Commission members were given a copy of the CMS FUL changes that would be implemented by June 13, 2009.

MedWatch: The Commission members received FDA announcements concerning new Black Box Warnings.

A unanimous vote was made at 11:49 to adjourn the meeting and move to closed session (1st by Bruce Alexander 2nd by Dr. Rick Rinehart).

The next meeting will be held at 9:30 a.m. on Wednesday, August 5, 2009 at the Hoover Building, Level A, Conference Room 6, Des Moines, IA.

Appendix N
Mental Health Work Group

The Iowa Medicaid Drug Utilization Review Mental Health Advisory Group (MHAG), formerly known as the Mental Health Work Group, was established in State FYE 2008. It is currently comprised of three members of the Drug Utilization Review Commission (one pediatrician, one psychiatrist, and one psychiatric pharmacist), several pediatric and adolescent psychiatrists, an adult psychiatrist, and a psychiatrist from Magellan Health Services.

The Mental Health Advisory Group is a separate entity from the Iowa Medicaid Drug Utilization Review (DUR) Commission. All recommendations from the MHAG must be approved by the DUR Commission before they can be implemented.

The original goal of the MHWG was to address issues that developed specific to the pediatric and adolescent psychiatrists within the State of Iowa when mental health drug consolidation edits were implemented in October, 2007. Since then, the DUR Commission has made the decision to refer other issues that have developed that affect the entire mental health population of Iowa Medicaid, regardless of the members' age.

Iowa Medicaid DUR Mental Health Work Group Meeting Minutes September 26, 2008

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Rick Rinehart, M.D.; Terry Augspurger, M.D.; Samuel Kuperman, M.D.; Chris Okishi, M.D.; Kevin Took, M.D.; and Chuck Wadle, D.O.

Staff

Thomas Kline, D.O.; Chad Bissell, R.Ph., Pharm.D.; and Pam Smith, R.Ph.

Guests

Susan Parker, DHS; Sandy Pranger, IME; and Melissa Biddle, IME.

Welcome & Introductions

Dr. Kline called the meeting to order at 8:00 a.m. at the Iowa Medicaid Enterprise. Commission members, guests, and observers were welcomed and introduced.

The minutes from the April 11, 2008 meeting were approved. (Motion by Dr. Kevin Took, second by Bruce Alexander, unanimous approval by voice vote.)

Pro-DUR Edits (Seroquel)

When this Committee met in April, quantity limits for Seroquel were discussed and tabled (based on the data that had been provided) until additional information could be provided. Chad Bissell referenced a table that illustrated how many unique members received the various strengths of Seroquel. This table is a reproduction of the table provided at the April meeting, except it contains updated claim information spanning 1/1/08 through 6/30/08. A column showing how many members were taking only 1 tablet a day was also added. The Committee discussed possible quantity limits for this drug, and also a quantity limit purely for once a day use of low dosages to prevent off-label use as a sedative. The members seemed to think the 25mg and 50mg doses of Seroquel were most often prescribed, at least for children, to treat disruptive behavior and aggression, rather than as a sleep aid. There are also metabolic concerns when using Seroquel as a sleep aid. Susan Parker clarified that the pharmacy point of sale system could not differentiate when the medicine was to be administered, merely that it was to be taken once a day judging from quantity and days supply provided on the claim. Chad Bissell shared Maine's strategy for allowing low-dose Seroquel claims to pay without a prior authorization: 1) the patient is 65 or older or less than 18 years of age, 2) dosage is for 3 or more tablets per day, or 3) Seroquel 25mg is in the profile within the last 45 days or the following dosages (100mg, 200mg, 300mg, 400mg) are being used in combination with any daily dose of Seroquel 25mg. Last year a quantity limit was

implemented that allowed only 2 tablets a day on all strengths of Seroquel, but that was rescinded 4-6 weeks later. Dr. Kevin Took proposed approaching this in a step-wise fashion, limiting the low dosages and then re-evaluating claim data to see if further quantity limits needed to be added to the higher doses if they continued to be an issue. Dr. Chris Okiishi asked if an edit could be added to the system to display, "Is this being prescribed just for sleep?" when a claim with less than 100mg per day was entered, as an education point for the less experienced prescribers. A consensus could not be reached on which strategy should be taken, therefore, the Committee agreed to table this discussion until a future meeting. Chad Bissell will email Maine's proposal to the Committee members for future reference, as well as study findings in Excel file format so the data can be manipulated.

Discussion of Drugs Prescribed for Mental Illness

Chad Bissell mentioned a discussion from the September 11, 2008 P&T Committee meeting, wherein the Committee reviewed the language in Iowa Code 249A.20A, which addresses how to deal with the recommended drugs, stating: *"With the exception of drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation, or cancer and drugs prescribed for mental illness with the exception of drugs and drug compounds that do not have a significant variation in a therapeutic profile or side effect profile within a therapeutic class, prescribing and dispensing of prescription drugs not included on the preferred drug list shall be subject to prior authorization"*. During the initial implementation of the PDL, the P&T Committee at that point in time adopted the narrowest view of the law, including mental health drugs on the PDL only if a generic form was available for the brand. The P&T Committee intends to discuss this topic further at their November meeting, and possibly move some mental health drugs from the RDL to the PDL. Depending on the outcome of that meeting, this may be a topic brought before the Mental Health Sub-Committee to review for feedback. Dr. Wadle said that the mental health field has battled to be treated as equal to other medical services for years, and he believes there is an inconsistency with that sentiment and those of the same field regarding their medicines. He thinks it would be only fair to hold psych drugs to PDL restrictions as well. Bruce Alexander said that the psychotropic drugs are going to make up 40-45% of the Iowa Medicaid drug budget; it's difficult to explain to members with diabetes, hypertension, or renal disease why their medications are coming under formulary review and the mental health drugs are not. Dr. Wadle agreed that treating mental health was no more a greater science than treating the above mentioned diagnoses at times. Bruce Alexander asked about the possibility of shifting funds into other areas of support for patients with mental health diseases. Dr. Chris Okiishi commented that there was a pretty wide disparity in the number of psychiatric providers in Iowa compared to other medical providers, and he believes moving toward more restrictions will only exacerbate the problem. In addition, of those providers who are located in Iowa, many of them are unwilling to treat Medicaid recipients. Dr. Chuck Wadle said that there had been such a

shortage for 20 years, and he doesn't think these changes, which are similar to those being imposed in many other states, will make much of a difference, since Iowa will still be an unattractive location to many providers for the same reasons as always.

Prioritize Topics Referred to Mental Health Work Group

The Committee was asked to prioritize the back-log of subjects that had been referred to them by the DUR Commission. The members agreed that use of multiple second generation antipsychotics was the most important topic, followed by Modified Formulations (Clinical) Prior Authorization Criteria.

The meeting adjourned at 9:03 a.m. The next meeting will be held at 8:00 a.m. on Friday, December 12, 2008 at the Iowa Medicaid Enterprise in Des Moines. The Committee also scheduled February 13, 2009 as a future meeting date.

Iowa Medicaid DUR Mental Health Work Group
Meeting Minutes December 12, 2008

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Terry Augspurger, M.D.; Samuel Kuperman, M.D.; Chris Okiishi, M.D.; Kevin Took, M.D.; Sara Schutte-Schenck, D.O., FAAP; Alan Whitters, M.D.; and Chuck Wadle, D.O.

Staff

Thomas Kline, D.O.; Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.; Tim Clifford, M.D.

Guests

Susan Parker, DHS; Sandy Pranger, IME; and Melissa Biddle, IME.

Welcome & Introductions

Chad Bissell called the meeting to order at 8:07 a.m. at the Iowa Medicaid Enterprise. Commission members, guests, and observers were welcomed and introduced.

The minutes from the September 26, 2008 meeting were approved. (Motion by Dr. Kevin Took, second by Bruce Alexander, unanimous approval by voice vote.)

P&T Recommendations on Select Mental Health Drugs

Dr. Tim Clifford discussed recommendations from the November 13, 2008 P&T Committee meeting, wherein the Committee re-evaluated the language in Iowa Code 249A.20A, which addresses how to deal with the Recommended drugs, stating: *"With the exception of drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation, or cancer and drugs prescribed for mental illness with the exception of drugs and drug compounds that do not have a significant variation in a therapeutic profile or side effect profile within a therapeutic class, prescribing and dispensing of prescription drugs not included on the preferred drug list shall be subject to prior authorization"*. When the Preferred Drug List was first established, the Committee interpreted this language to mean that drugs used for mental health would be excluded from the PDL. Until now, the P&T Committee has only examined brand-generic issues among mental health drugs, and all other mental health drugs got "a free pass". However, the cost of the mental health drugs is increasing rapidly, more than inflation would account for. Thus, after reviewing therapeutic class reviews on Antidepressants, Anti-psychotics, and Stimulants, as well as other prepared reports and comparative tables focusing primarily on head-to-head studies, the P&T Committee voted to move several mental health drugs from the RDL to the PDL at their November meeting, and referred their recommendations to the Mental Health Work Group. Minutes

from the November P&T meeting were provided for the Mental Health Work Group to review. Since the sub-Committee had less time for this discussion, Dr. Clifford merely outlined the drugs slated to become non-preferred beginning with Luvox CR and Pristiq. There are not any head-to-head studies to indicate that the new formulations are superior to the parent compounds in a clinically meaningful way. With Pristiq, there are studies versus placebo, but nothing head-to-head that would work in the drug's favor. The only identified potential advantage of Pristiq over Effexor and some of the other SSRI's is the apparently reduced risk of drug-drug interactions. However, citalopram and sertraline also have low incidences of drug-drug interactions. There are no head-to-head data comparing Luvox CR to fluvoxamine to show therapeutic outcome improving, or even a large difference in side effects. In the interest of time, Dr. Kevin Took recommended that instead of reviewing the highlights of therapeutic class reviews, the Iowa Psychiatric Society get together to review the data for recommendations and then get back to Iowa Medicaid with their thoughts on the process. Susan Parker clarified that the P&T Committee had asked that the DUR Mental Health Work Group have access to all data that had been reviewed at their meeting prior to the recommendations, to better understand the process and reasoning behind the PDL status changes, which had resulted in this type of meeting format. If the Work Group has areas of concern with the recommendations, those would then be referred back to the P&T Committee for further review. The P&T recommendations will not be final without feedback from the Work Group. Dr. Chris O'kiishi asked if Dr. Clifford had pertinent information that had not been included in the minutes from the November P&T meeting, so the Work Group could focus more on that given the time constraints. Dr. Clifford brought attention to the letter from Janssen regarding a comparison of Invega and Risperdal, which Dr. Clifford felt was irrelevant to the recommendation as the issue is not equivalence of the two drugs but if there were any significant differences in the therapeutic outcomes or safety. He then reviewed the recommendations that came out of the P&T meeting. There were nine brand name drugs in the three reviewed drug classes that were recommended to become preferred purely based on clinical evidence, even though there were also supplemental rebate offers on the table. There were three drugs (Seroquel XR, Luvox CR, and Invega) with a possible supplemental rebate offer that the Committee decided not to prefer based on clinical evidence. There were 19 brand drugs with no offer attached that the Committee recommended be preferred based on clinical findings, and four brands with no offer that were recommended as non-preferred for the same reason. The three dissolvable versions of anti-psychotics (with no offers) were recommended to be non-preferred with conditions. If the P&T Committee had been allowed to look at cost, there would have been a status change swing on seven products. Cymbalta, Zyprexa, Abilify, Strattera, Provigil, and Daytrana would have all been non-preferred, and Invega preferred, using the standard P&T process. All drugs changing to a non-preferred status in these categories will be grandfathered. The Work Group discussed the specifics of this process when applied to several different scenarios including change in dosage. Susan Parker outlined the prior

authorization and appeal process as Dr. Took requested. She reiterated that this was written out on the back on the Notice of Decision letter mailed to the prescriber, pharmacy, and member. The provider could request an exception to policy as well. Sandy Pranger assured them that more often than not denied PA requests did not progress to appeals, as the issues were resolved with more information being sent. Susan Parker said there would really be just 10 mental health drugs that would be non-preferred. Letters will be sent out to providers in advance, and the criteria requirements and forms are posted on the website. Dr. Schutte-Schenck told the other members of the Work Group that the overall PA process had gone much more smoothly for her office than she had previously anticipated when first rolled out in 2005. The Committee ran out of time for further discussion of recommendations on mental health drugs, so they scheduled an additional meeting to finish the recommendations, in the hopes that the Iowa Psychiatric Society would send their written recommendations before then to be discussed by the Work Group at that time.

The meeting adjourned at 9:38 a.m. (1st by Dr. Chuck Wadle, 2nd by Dr. Kevin Took.) The next meeting will be held at 7:00 a.m. on Friday, January 23, 2008 at the Iowa Medicaid Enterprise in Des Moines.

Iowa Medicaid DUR Mental Health Advisory Group
Meeting Minutes February 13, 2009

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Terry Augspurger, M.D.; Samuel Kuperman, M.D.; Kevin Took, M.D.; Sara Schutte-Schenck, D.O., FAAP; and Chuck Wadle, D.O.

Staff

Thomas Kline, D.O.; Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.

Guests

Susan Parker, Pharm.D., DHS; Sandy Pranger, R.Ph., IME; and Melissa Biddle, IME.

Welcome & Introductions

Chad Bissell called the meeting to order at 8:07 a.m. at the Iowa Medicaid Enterprise. Commission members, guests, and observers were welcomed and introduced.

The minutes from the December 12, 2008 meeting were approved. (Motion by Dr. Kevin Took, second by Dr. Chuck Wadle, unanimous approval by voice vote.)

P&T Recommendations on Select Mental Health Drugs

Dr. Kline began: The P&T Committee and the DUR Commission have been discussing behavioral health drugs. These medications make up 45% of the pharmacy budget, so controlling costs in these categories would have a major impact on the pharmacy budget and the cost to the Department of Human Services. The Mental Health Advisory Group has been asked to review the recommended Preferred Drug List changes, and offer further insight and clinical discussion. Dr. Took motioned to accept the recommendations as presented on Attachment 1 of the meeting packet (though he did ask for clarification on the prior authorization process), and Dr. Wadle seconded. Dr. Wadle suggested that the timeline for these changes might be a good discussion point. The Advisory Group voted unanimously in favor of the recommendations by roll call vote, and then Susan Parker spoke of the steps that would be taken to notify prescribers and pharmacies prior to the PDL status changes. Based on what's been done following past PDL changes, Susan Parker stated that an informational letter will be sent to all providers stating that within a specified amount of time from the date of receipt these changes will go into effect. Typical notification consists of 30 days, but more complicated issues are usually given a higher allotment of time to prevent confusion and added work to the PA department. These mental health drug status changes will involve more programming on the POS system, as everyone currently taking one of these medications will be grandfathered. If

the P&T Committee recommends that prior authorization criteria be created, these are referred to the DUR Commission to establish. After being on the agenda for two DUR meetings, the criteria will have been finalized, which prompts notification letters to medical organizations and pertinent specialty groups that the criteria might affect for feedback. This feedback is sent back to the DUR Commission, who can re-evaluate the criteria if they so choose. At that point, the recommendation goes to DHS. It is anticipated that this topic will be on the March 4, 2009 DUR Commission agenda. Given their previous conversations regarding these changes, they might decide to finalize criteria on that date. However, letters to medical organizations and specialty groups would still need to be sent before a recommendation is given to DHS. The DUR meeting on May 6, 2009 would be the earliest possible date the Department would receive the recommendations. Sandy Pranger noted that the programming would take longer with these changes, since the grandfathering would include a 180-day look-back for all members currently on medications that would be changing to non-preferred. Given all of the aforementioned steps, it will be at least 60 to 90 days before status changes would go into effect. An informational letter outlining frequently asked questions about this topic is also in the works, and will be mailed to all providers. It was asked that this also be made available as a downloadable PDF file. The rules for the 72-hour and 30-day pharmacy override options were also explained. Chad Bissell will send an email to the Advisory Group members with proposed topics for the next meeting, also verifying there will be enough members available to meet on the proposed date of April 17, 2009. They each will prioritize those topics, so that the agenda may be set.

The meeting adjourned at 8:52 a.m. (1st by Dr. Chuck Wadle, 2nd by Dr. Kevin Took.) The next meeting will be held at 8:00 a.m. on Friday, April 17, 2009 at the Iowa Medicaid Enterprise in Des Moines.

Iowa Medicaid DUR Mental Health Advisory Group

Meeting Minutes April 17, 2009

Attendees:

Commission Members

Bruce Alexander, R.Ph., Pharm.D., BCPP; Terry Augspurger, M.D.; Kevin Took, M.D.; and Loren Olson, M.D.

Staff

Thomas Kline, D.O.; Chad Bissell, Pharm.D.; and Pam Smith, R.Ph.

Guests

Susan Parker, DHS; Sandy Pranger, IME; and Melissa Biddle, IME.

Welcome & Introductions

Chad Bissell called the meeting to order at 8:07 a.m. at the Iowa Medicaid Enterprise. Commission members and guests were welcomed and introduced.

The minutes from the December 12, 2008 meeting were approved. (Motion by Dr. Kevin Took, second by Dr. Terry Augspurger, unanimous approval by voice vote.)

Use of Multiple Second Generation Antipsychotics

A report focusing on Atypical Antipsychotics for the period of 9/1/08 through 2/28/09 was reviewed. There were a total of 10,402 unique members who were on some form of an atypical antipsychotic regimen, of which 54.7% were over the age of 18 and 45.3% were under 18. A total of 778 members were using 2 atypical antipsychotics for 2 or more consecutive months, and only 30 of them were using 3 atypical antipsychotics for 2 or more consecutive months. There were also 12 members using clozapine in combination with 2 atypical antipsychotics. However, of the 6 members that were under 18 years of age, 5 of them discontinued use of the Atypicals, leaving only clozapine. Typical Antipsychotic usage was thrown in for comparison; there were 737 unique members on such a regimen, only 19 of which were using 2 Typical Antipsychotics for 2 or more months. Sixty-six members were identified using Typical and Atypical Antipsychotics in combination, the most common mixture being 2 Atypicals and 1 Typical. The committee had a clinical discussion of these findings. They agreed that 2 consecutive months did not allow enough time for cross-titrating and asked that report parameter be increased to 6 consecutive months. They also discussed whether it would be better to exceed recommended drug doses or add on additional drugs, though no common consensus was reached as there is no literature on this topic. Bruce Alexander commented that most prescribers associate a higher instance of side effects upon exceeding the maximum doses; however, all drug-drug interactions are not known, so that could pose a greater danger. They suggested that the

prescribers needed attention as well, maybe via peer-to-peer discussions regarding prescribing practices. The psychiatrist shortage in Iowa results in more non-psychiatrist prescribers, so this likely contributes to questionable prescribing practices. The report will be re-run based more on claim level detail for the next meeting, taking into account the suggested changes.

Proposed PA Criterion

Extended Release Formulations – PA criteria still in progress and will be taken to the May DUR Commission meeting.

Modified Formulations – The committee was given a copy of the proposed criteria that would be finalized at the May DUR meeting. They did not have any issues or suggestions.

The meeting adjourned at 9:02 a.m. (1st by Dr. Terry Augspurger, 2nd by Dr. Kevin Took.) The next meeting will be held at 8:00 a.m. on Friday, July 10, 2009 at the Iowa Medicaid Enterprise in Des Moines.

Appendix O

Smoking Cessation Report

This section contains a report which was prepared pursuant to the directive contained in HF909, which is listed below:

11. The Drug Utilization Review commission shall monitor the smoking cessation benefit provided under the medical assistance program and shall provide a report of utilization, client success, cost effectiveness, and recommendations for any changes to the benefit to the persons designated in this Act to receive reports by January 15, 2009. If a prescriber determines that all smoking cessation aids on the preferred drug list are not effective or medically appropriate for a patient, the prescriber may apply for an exception to policy for another product approved by the United States Food and Drug Administration for smoking cessation pursuant to 441 IAC 24 27 1.8(1).



STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

January 15, 2009

Michael Marshall
Secretary of Senate
State Capitol
LOCAL

Mark Brandsgard
Chief Clerk of the House
State Capitol
LOCAL

Dear Mr. Marshall and Mr. Brandsgard:

Enclosed please find copies of reports to the General Assembly relative to the Iowa Medicaid smoking cessation benefit as prepared by the Iowa Medicaid Drug Utilization (DUR) Commission.

These reports were prepared pursuant to directive contained in Section 10 of Senate File 2425 which is listed below:

- 10. The Drug Utilization Review Commission shall monitor the smoking cessation benefit provided under the medical assistance program and shall provide a report of utilization, client success, cost-effectiveness, and recommendations for any changes in the benefit to the persons designated in this Act to receive reports by January 15, 2009. If a prescriber determines that all smoking cessation aids on the preferred drug list are not effective or medically appropriate for a patient, the prescriber may apply for an exception to policy for another product approved by the United States Food and Drug Administration for smoking cessation pursuant to 441 IAC 5 1.8(1).

Members of the DUR Commission are appointed by the Department of Human Services and include health care professionals who possess knowledge and expertise in appropriate prescribing of drugs. The Commission meets eight times each year. Their purpose is advisory to DHS for the federally mandated retrospective drug utilization review program and for clinical prior authorization criteria development. Membership is as follows:

Table with 2 columns: Member and Area of Clinical Expertise. Rows include Bruce Alexander, Mark Graber, Laura Ann Griffith, Craig Logemann, Dan Murphy, Laurie Pestel, Richard Rinehart, and Sara Schutte-Schenck.

The enclosed report was adopted by the members of the DUR Commission at their December 3, 2008 meeting following deliberations during their September and November (2008) meetings. The DUR Commission includes the evaluation of the Medicaid Smoking Cessation Program as part of their regular business and did not meet for the sole purpose of generating this report. Data exists to validate the clinical impacts of the recommendations made to the Department of Human Services.

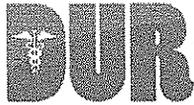
The Department of Human Services has adopted the recommendations from the DUR Commission. Please contact me if I may be of further assistance.

Sincerely,

Molly Kottmeyer
Legislative Liaison

Enclosure

cc: Governor Chet Culver
Legislative Service Agency
Kris Bell, Senate Majority Caucus
Peter Matthes, Senate Minority Caucus
Zeke Furlong, House Majority Caucus
Brad Trow, House Minority Caucus



IOWA MEDICAID DRUG UTILIZATION REVIEW COMMISSION

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Director, (515) 725-1271

Pamela Smith, R.Ph.

To: The Iowa General Assembly
From: The Iowa Medicaid Drug Utilization Review Commission
Regarding: The Iowa Medicaid Smoking Cessation Program
Date: January 15, 2009

Enclosed please find copies of reports to the General Assembly relative to the Iowa Medicaid Smoking Cessation Program.

These reports were prepared pursuant to the directive contained in SF2425, which is listed below:

10. The Drug Utilization Review Commission shall monitor the smoking cessation benefit provided under the medical assistance program and shall provide a report of utilization, client success, cost-effectiveness, and recommendations for any changes in the benefit to the persons designated in this Act to receive reports by January 15, 2009. If a prescriber determines that all smoking cessation aids on the preferred drug list are not effective or medically appropriate for a patient, the prescriber may apply for an exception to policy for another product approved by the United States Food and Drug Administration for smoking cessation pursuant to 441 IAC 5 1.8(1).

This report by the Iowa Medicaid Drug Utilization Review (DUR) Commission is in response to a request by the Iowa General Assembly to monitor the smoking cessation benefit for Iowa Medicaid members. This review is performed on an ongoing basis to ensure all the elements of the legislation are met.

This report is divided into three sections: Background, Program Results, and DUR Review and Recommendations.

Background

A. Program Review

- The 2005-2006 General Assembly passed HF825 and HF841 requesting that the Department expand coverage under the medical assistance program to cover smoking cessation drugs.

This was to be done in collaboration with the Iowa Department of Public Health programs relating to tobacco use prevention and cessation.

- Iowa Medicaid requested that the Iowa Medicaid Drug Utilization Review (DUR) Commission develop prior authorization criteria for the smoking cessation program incorporating counseling through Quitline Iowa, (Studies have shown that smoking cessation programs that incorporate counseling in conjunction with medication therapy have higher success rates).
- The Pharmaceutical and Therapeutics (P&T) Committee were requested to review the smoking cessation products for inclusion on the Preferred Drug List.
- Effective January 1, 2007, the Iowa Medicaid Program expanded coverage to include select over-the-counter nicotine replacement patches and gum, and generic bupropion sustained-release (SR) products that are FDA-indicated for smoking cessation (generic Zyban®). Bupropion 150mg sustained-release products that are FDA-indicated for smoking cessation (generic Zyban®) are available without prior authorization (PA). Over-the-counter nicotine replacement patches and gum are covered with a prior authorization.
- The Iowa Medicaid DUR Commission reviewed the clinical information available for varenicline (Chantix™) on several occasions and had recommended to the Department of Human Services the drug not be covered until more safety and efficacy data were made available. Specifically, the Commission was interested in seeing safety and efficacy data on varenicline (Chantix™) used in medically complex patients with multiple chronic conditions that more closely resembled the Medicaid population. To date, such data is not available. The Department of Human Services made the decision, however, to provide coverage of varenicline (Chantix™) since safety and efficacy had already been proven as part of the Food and Drug Administration's (FDA) approval process. Therefore, effective February 18, 2008, the Iowa Medicaid Program again expanded coverage to include the prescription product, varenicline (Chantix™) with a prior authorization.

B. Prior Authorization (PA) Criteria for Nicotine Replacement Therapy and Varenicline (Chantix™)

Following recommendations from both the DUR and P&T Committees, the prior authorization criterion were established as follows:

Prior Authorization is required for over-the-counter nicotine replacement patches and nicotine gum. Requests for authorization must include:

- 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- 2) Confirmation of enrollment in the Quitline Iowa counseling program is required for approval.
- 3) Approvals will only be granted for patients eighteen years of age and older.
- 4) The maximum allowed duration of therapy is twelve weeks within a twelve-month period.
- 5) A maximum quantity of 14 nicotine replacement patches and/or 110 pieces of nicotine gum may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4-week supply at one unit per day of nicotine replacement patches and /or 330 pieces of nicotine gum. Following the first 28 days of therapy,

continuation is available only with documentation of ongoing participation in the Quitline Iowa program.

6) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation

Prior Authorization is required for varenicline (Chantix™). Requests for authorization must include:

- 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- 2) Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage.
- 3) Approvals will only be granted for patients eighteen years of age and older.
- 4) The duration of therapy is initially limited to twelve weeks within a twelve-month period. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a twelve-month period.
- 5) Requests for varenicline to be used in combination with bupropion SR that is FDA indicated for smoking cessation or nicotine replacement therapy will not be approved.
- 6) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation

C. Prior Authorization (PA) Process

- Iowa Medicaid members who want assistance in quitting smoking need to be referred to Quitline Iowa by their healthcare provider.
- If it is determined that the member would benefit from using over-the-counter nicotine replacement patches and/or gum, a Nicotine Replacement Therapy Prior Authorization form must be completed by the member and the prescriber. Alternatively, if it is determined that the member would benefit from using varenicline (Chantix™), a Varenicline (Chantix™) Prior Authorization form must be completed by the member and the prescriber. The completed form(s) is then faxed to Quitline Iowa. Quitline Iowa will follow up with the member and assess the member's smoking cessation counseling needs.
- Following this initial consultation, Quitline Iowa will submit the prior authorization request to the Iowa Medicaid Pharmacy Prior Authorization Unit for coverage of the necessary smoking cessation products.
- In the event that the member chooses to disenroll from the Quitline Iowa program, all approved prior authorizations will be cancelled and notification will be faxed to the provider and pharmacy, while a letter will be mailed to the member.

Program Results

Quitline Program

National Jewish Medical and Research Center began providing Quitline services for the state of Iowa on January 1, 2008. The University of Northern Iowa has partnered with National Jewish to evaluate participant satisfaction and quit rates.

Current literature for all populations, not solely Medicaid members, that examine quit rates for various interventions reports that the odds ratio of maintaining abstinence from smoking at six months following multiple proactive call back counseling sessions after contact was initiated by a motivated quitter (similar to how the Quitline Iowa program works) is 1.41.¹ When smoking cessation counseling is combined with drug therapy, the odds of achieving cessation are often times doubled. When looking at the smoking cessation products available to Iowa Medicaid members, current literature (not exclusively looking at a Medicaid population) reports the odds ratio of maintaining abstinence from smoking six months after using pharmacotherapy are as follows: nicotine patches – 1.81; nicotine gum – 1.66; bupropion – 2.06. When compared to varenicline (Chantix™), the odds ratio of maintaining abstinence from smoking after 12 weeks of therapy ranges from 2.70 to 5.50.²

Quitline Iowa received 5,184 faxed referrals for Iowa Medicaid members between January 1, 2008 and September 30, 2008. From these referrals, 3,324 members were enrolled in the Quitline program. The inability to reach the member was a barrier to the enrollment process as Quitline counselors often received constant busy signals, invalid phone numbers, or disconnected phones; 1,418 members could not be reached by the Quitline counselors, 201 members declined enrollment, and 241 members requested information only.

For the time period of January 1, 2008 through September 30, 2008, Quitline Iowa reports 3,324 Medicaid members that successfully enrolled in the smoking cessation program. Outcomes data of these members is highlighted below:

- Quitline Iowa reports 1,809 members dropped out of the Quitline program between January 1, 2008 through September 30, 2008, which is defined by the following scenarios:
 1. The counselors made multiple attempts to reach 1,362 members by phone and mail and the member did not call them back.
 2. 109 members made a conscious decision to not continue with the counseling and informed the counselor of that during their last counseling call.
 3. 338 members were disenrolled from the program due to completion of the entire program or successfully quitting smoking and requesting to be disenrolled, as they no longer felt they required assistance.
 4. 37 unique members re-enrolled in the Quitline program after originally dropping out. Of the 37 re-enrolled members, 18 were disenrolled from Quitline a second time due to completing the program during the second attempt (10) or dropping out of the counseling program (8). At the time of this report, 19 of the 37 members who re-enrolled were still actively participating.

¹ Meites, Elissa. Telephone Counseling Improves Smoking Cessation Rates. *Am Fam Physician*. 2007; 75(5): 650.

² Nides, M. Update on Pharmacologic Options for Smoking Cessation Treatment. *Am J Medicine*. 2008; 121(4 suppl 1): S20-31.

- The University of Northern Iowa is responsible for completing follow-up interviews with Iowa Medicaid members who participated in the Quitline Iowa counseling program. They perform 3, 6, and 12 month follow-up interviews with a random sample of Medicaid members who participated in the program. This is done by a computer-assisted telephone interview lasting 7 – 9 minutes. At the time of this report, the University of Northern Iowa has completed surveys of 188 unique members enrolled in Quitline between July 1, 2008 and September 30, 2008. Of these 188 members, 47 (25%) completed eight or more counseling calls.
 - Of these 47 members, 42 individuals were considered smoke free at the completion of counseling, which is defined as not having had a cigarette in the 30 days prior to the follow-up interview.

The mean time of participation in the Quitline program for all Medicaid members who enrolled was 74.53 days. The mean time of participation in the Quitline program for Medicaid members who re-enrolled in the program was 68.46.

At this time, Quitline is unable to provide data on the number of unique individuals who were smoke free at 6 and/or 12 months.

Prior Authorization Program

For the time period of January 1, 2008 through September 30, 2008, members received a total of 6,067 prescriptions for smoking cessation products. Of this number, 4,316 prescriptions were for varenicline, 1,435 prescriptions were for nicotine patches, 155 for nicotine gum, and 161 for bupropion. The total cost (federal and state dollars before applicable rebates) for these smoking cessation products was \$568,541.63.

Through September 2008, 5,637 Prior Authorizations (PAs) were approved for varenicline (Chantix™), 1,547 PAs were approved for nicotine patches, and 124 PAs were approved for nicotine gum. Reasons for denials were: member was under 18 years of age, member was not originally enrolled in Quitline, the PA request form was incomplete, the PA request was for varenicline (Chantix™) and the member was dual eligible for Medicaid and Medicare Part D, or the member disenrolled from Quitline. There were 27 requests for noncovered products; two of which resulted in requests for an Exception to Policy, which were not granted.

DUR Review and Recommendations

The Commission continues to monitor utilization, client success, and cost effectiveness for the Iowa Medicaid Smoking Cessation Program. From January 1, 2008 through September 30, 2008, there were 1,671 prior authorizations for nicotine replacement products that have been approved for a total cost (federal and state dollars before applicable rebates) of \$72,756.74. There were 5,637 prior authorizations for varenicline (Chantix™) that have been approved for a total cost (federal and state dollars before applicable rebates) of \$482,540.59. In addition, \$13,244.30 (federal and state dollars before applicable rebates) was spent on 161 prescriptions for bupropion SR. The total cost (federal and state dollars before applicable rebates) for the program for drug therapy between January 1, 2008 and September 30, 2008 was \$568,541.63. There has also been an additional cost of \$102,083 during this time frame to administer the pharmacy prior authorization component of the smoking cessation program.

Any additional costs for administration of the Quitline Iowa program would be incurred by the Iowa Department of Public Health.

The Commission continues to evaluate the safety and efficacy data that becomes available for varenicline (Chantix™). At their meeting held in September 2008, the Commission reviewed new safety information relative to use of varenicline in various mental health disorders. The clinical prior authorization criteria were reviewed and compared to the Veteran's Administration prior authorization criteria. The Commission came to the consensus that no recommended changes to the Medicaid clinical prior authorization criteria were required at this time. However, the Commission will continue to monitor safety data and other third party payers' prior authorization criteria to determine if any changes would be appropriate in the future.

The Commission recommends that Quitline continue to establish ways to collect better efficacy data on the program and product utilization. Specifically, long-term cessation data collected beyond three months of completion of the counseling program (i.e. at six months, nine months, and twelve months following the completion of the counseling program). This will aid in the Commission's future recommendations to the Department of Human Services as to what products should be included or excluded. In addition, the Commission recommends that Quitline continue to develop strategies to identify and resolve communication barriers with Iowa Medicaid enrollees. At this time, the Commission has no recommended changes on the products currently covered under the smoking cessation program.

The Iowa Medicaid DUR Commission appreciates the opportunity to make these recommendations to the Iowa General Assembly.

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Attachments (3)

Smoking Cessation PA Statistics

	Nicotine Patches						Nicotine Gum						Chantix						Total				
	Approved		Denied		Incomplete		Approved		Denied		Incomplete		Approved		Denied		Incomplete			Not Required			
Jan-08	211	38.93%	291	53.69%	12 of the original 291 denials ended up getting a pa	40	7.38%	25	37.31%	40	59.70%	0 out of the 40 denials ended up getting a pa	2	2.99%	Not Covered Until February 2008								
Feb-08	211	51.21%	181	43.93%	8 of the original 181 denials ended up getting a pa	20	4.85%	11	36.67%	18	60.00%	1 out of the original 18 denials ended up getting a pa	1	3.33%	77	72.64%	13	12.26%	16	15.09%	0	0.00%	106
Mar-08	203	78.38%	24	9.27%	5 of the original 24 denials ended up getting a pa	32	12.36%	19	76.00%	4	16.00%	1 of the original 4 denials ended up getting a pa	2	8.00%	1046	81.15%	34	2.64%	201	15.59%	8	0.62%	1289
Apr-08	181	87.44%	11	5.31%	9 of the original 11 denials ended up getting a pa	15	7.25%	18	85.71%	0	0.00%		3	14.29%	1036	83.68%	22	1.78%	135	10.90%	45	3.63%	1238
May-08	129	66.49%	48	24.74%	6 of the original 48 denials ended up getting a pa	17	8.76%	8	80.00%	1	10.00%	0 of the original 1 denial ended up getting a pa	1	10.00%	972	79.09%	93	7.57%	112	9.11%	52	4.23%	1229
Jun-08	141	58.02%	88	36.21%	8 of the original 88 denials ended up getting a pa	14	5.76%	11	55.00%	6	30.00%	0 of the original 6 denials ended up getting a pa	3	15.00%	571	61.66%	245	26.46%	84	9.07%	26	2.81%	926
Jul-08	168	88.89%	6	3.17%	6 of the original 6 denials ended up getting a pa	15	7.94%	12	63.16%	1	5.26%	0 of the original 1 denial ended up getting a pa	6	31.58%	763	85.73%	26	2.92%	79	8.88%	22	2.47%	890
Aug-08	176	78.92%	30	13.45%	1 of the original 30 denials ended up getting a pa	17	7.62%	12	70.59%	3	17.65%	0 of the original 3 denials ended up getting a pa	2	11.76%	674	75.14%	138	15.38%	70	7.80%	15	1.67%	897
Sep-08	127	85.81%	4	2.70%	0 of the original 4 denials ended up getting a pa	17	11.49%	8	100.00%	0	0.00%	0 of the original 0 denials ended up getting a pa	0	0.00%	498	85.13%	16	2.74%	58	9.91%	13	2.22%	585
Oct-08																							
Nov-08																							
Dec-08																							
YTD Total	1547		683			187		124		73			20		5637		587		755		181		7160
Average	172	64.00%	76	28.26%		21	7.74%	14	57.14%	8	33.64%		2	9.22%	705	78.73%	73	8.20%	94	10.54%	23	2.53%	895

Smoking Cessation Total Prescriptions, Unique Client Count, and Disenrolled

		Total Prescription for Patches, Gum, Bupropion, and Chantix	Total Monthly Unique Client Count Per Month for Patches, Gum, Bupropion, and Chantix	Disenrolled
2 0 0 8	Jan	324	255	326
	Feb	229	191	199
	Mar	723	662	23
	Apr	974	903	15
	May	904	855	124
	Jun	745	688	355
	Jul	779	727	15
	Aug	744	693	158
	Sep	645	599	15
	Oct			
	Nov			
	Dec			
YTD Total		6067	5573	1230
Average		674	619	137

Quitline did not report all disenrolls this month
Quitline did not report all disenrolls this month

Appendix P
Recommendations to the P&T

Periodically the Commission makes recommendations to the Iowa Medicaid Pharmacy & Therapeutics Committee regarding the status of a medication on the Preferred Drug List (PDL). In sfye 2009, no recommendations were made.