

WYDUR Board Meeting Minutes
Thursday, September 24, 2009
Cheyenne, WY
11 a.m. – 3 p.m.

Members present: Becky Drnas, Steen Goddik, Kurt Hopfensperger, Richard Johnson, Scott Johnston, Kevin Robinett, Scot Schmidt, Dean Winsch, Tonja Woods

Excused: Joe Farrell

Ex-officio: Antoinette Brown, James Bush, Melissa Hunter

Guests: Dr. Steve Brown (by phone), Kerri Powell (GHS), Nikki Yost (GHS)

Becky called the meeting to order at 11:05 a.m.

Aimee announced the resignation of Bill Keenan and introduced the new member Scot Schmidt, Pharm.D. Scot is a pharmacist at Hoy's in Cheyenne. Introductions were made.

Minutes of July 2009

The minutes of the July 30, 2009 meeting were approved as presented.

Department of Health

A. State pharmacist report: None

B. Pharmacy Program Manager Report: The PDL was expanded in July to include Asthma and allergy agents, ophthalmic agents and ADD/ADHD medications. There were some issues with the ADHD class, specifically with the diagnosis requirement. It seems that some prescribing offices do not consistently include the diagnosis of ADHD on the medical bill. The pharmacy claims system is dependent on those diagnoses being entered through the medical billing process. Lack of a diagnosis on file will cause the claims to require prior authorization. There is also an issue with Medicaid recipients having more than one active identification number in the system. This has resulted in the prescribing office putting the diagnosis on one ID and the pharmacy using another ID for the prescription. There is currently not a way for the pharmacy system to match up these separate IDs, though a solution is being pursued. There were a number of requests for stimulants in children under age 5. The Board needs to give GHS some guidance on when to approve and when not to. Otherwise, the implementation of new PDL classes went very smoothly.

Expanding the PDL is not something that we greatly enjoy, however, the Governor has given directive to decrease the budget significantly within a rather short period of time. This means that we must expand and we must do it quickly. We will have to increase our limits in many areas to meet the budget benchmark that has been set.

C. Psychiatry Advisory Board Report: Dr. Robinett gave the PAB report. At the last meeting the group spent the majority of their time discussing the proposed criteria for limits on psychotropic agents. With that, the Board decided to discuss these limits first.

Four provider responses were received and were reviewed by the Board. Dr. Brown asked where the data had come from for the dosing limits on atypical antipsychotics in children. Dr. Bush explained that this is an issue that has been on the national radar. He has worked with a multi-state group reviewing these issues. The doses came from this multi-state group. He has provided this information as a starting place and is interested in feedback from providers. He is working through the process of contracting with an outside psychiatrist to be available for second opinions and to review these high doses. This is a part of a much larger project that will attempt to streamline processes occurring with Department of Family Services and other agencies. The atypical antipsychotics make up 37% of the Medicaid pharmacy budget. There are instances where he has seen the medications used as chemical restraints. Approximately 1/3 of prescribers are psychiatrists, 1/3 non-psychiatrist physicians and 1/3 physician extenders. There was discussion of setting allowances for child psychiatrists to have the latitude to work outside the limits. From a system perspective, this is not realistic. The claims system does not identify prescribers by specialty.

The issue of having a psychiatrist to speak to when a PA is required was raised. Dr. Bush is supportive of having a psychiatrist to review these PAs and as mentioned previously, is working through the process of getting someone hired. GHS also has a psychiatrist on staff at the Maine office who could be available if requested.

The Board asked for additional information, including lists of diagnoses that we would accept, lists of medications that would be included, and a literature search on appropriate doses in children as this has not been researched for a while.

The cost of mirtazapine has been reviewed. The 15, 30 and 45 mg doses will be moved to Step 1 of the Antidepressant Step Therapy. The 7.5 mg dose is still priced at a high level. It is requested that the 15 mg tablets be split when this dose is necessary.

A list of drugs that will be included in the tablet splitting program were circulated. Due to time constraints, it was requested that the Board review and follow up by email if there are concerns with the proposed classes.

Utilization of Provigil was discussed. A recommendation was made to limit Provigil to the approved indications. A motion was made, seconded and all were in favor. Specific exceptions to prior authorization will be brought back in November.

Utilization of Lidoderm was reviewed. The recommendation was made to limit its use to all peripheral neuropathies. The data in radiculitis and other central neuropathies does not support its use. There was a motion, a second and all were in favor.

**Lidoderm criteria
September 24, 2009**

Lidoderm will be approved for all types peripheral neuropathy.

The ophthalmic prostaglandin analogs were discussed. The following criteria were proposed:

**Ophthalmic prostaglandin criteria
September 24, 2009**

Preferred agents: Travatan and Lumigan

Non-preferred agent: Xalatan

Criteria for non-preferred: Trial and failure of both preferred agents.

There was a motion, second and all were in favor of approval.

The utilization of multiple antidepressants was reviewed. The Board felt that the vast majority of utilization was very appropriate. We will continue to monitor trends.

Though botulinum toxin is typically billed through the medical side, the Board was asked to consider what limits should be placed on botulinum toxin. As it may be billed through the pharmacy system, it is important to have continuity in policy on the medical and pharmacy side.

Allergan provided public comment.

Dr. Hopfensperger mentioned that he had helped to develop a policy for WinHealth. Maine limits the use of Botox to approved indications and also has injection limits set. The WinHealth policy will be requested and disseminated by email to the Board for review. The Maine policy will be disseminated for review as well.

Stimulant use in ADHD-like symptoms has been a fairly common request at the PA call center. This is not currently included in the criteria. The Board felt that an ADHD diagnosis should be made and that ADHD-like symptoms should not be accepted.

The combination of a stimulant and Strattera was discussed. There is very little information regarding the combination. The Board felt that this was acceptable for ADHD-like disease. There are also requests for use in depression and anxiety. The Board did not feel that Strattera was an appropriate drug in depression and stimulants should not generally be used in anxiety.

Currently, a prior authorization is required for children under age 5 in the ADHD class. However, criteria have not been set as to when these should be approved or denied. The data is all in methylphenidate immediate release and studies are all relatively short-term. However, the Board felt that at this time we do not have strong justification to deny these claims. They will be approved until further research can be done to assess when it should be approved and when it should not.

New drugs were reviewed beginning with Effient (prasugrel). Lilly provided comment. Dean mentioned that the doses were not comparable (though Lilly pointed out that they used Plavix labeled dose). There is a clear boxed warning about who is at much higher risk of bleeding. Dr. Johnston is concerned that this drug will be viewed as a “Plavix too” and will be used in patients with PAD and will be used with aspirin. Lilly indicated that the study was done in combination with aspirin. The drug will likely only be used by cardiologists and will be started in the hospital. We will leave it open access and monitor utilization.

Saphris was discussed next. Schering-Plough provided comments. The PAB recommended age, dose and diagnosis limits and a trial of all other atypical agents prior to use of Saphris and Fanapt. The Board agreed with the recommendation but asked for clozapine to be excluded.

Saphris and Fanapt criteria September 24, 2009

Saphris and Fanapt require prior authorization.

A trial of all atypicals (except clozapine) will be required at max dose for 30 days for approval either drug. Adverse events will constitute an end to any trial.

Hepatitis C agents were discussed. Utilization of Peg-Intron is very limited. It is recommended that Pegasys be preferred and all Peg-Intron patients be grandfathered. Schering-Plough and Genentech gave public comment. The Board recommended that Peg-Intron be approved in pediatrics, for retreatment and for dosage adjustments that cannot be achieved with Pegasys. There was a motion, second and all were in favor of approval.

Hepatitis C agents criteria September 24, 2009

Preferred: Pegasys

Non-preferred: Peg-Intron

Criteria for approval of non-preferred: Trial and failure of Pegasys. Peg-Intron will be approved for pediatric patients (aged 18 and under), for retreatment, and for dosage adjustments that cannot be achieved with Pegasys.

Other new drugs were discussed including Onsolis and Embeda. There was a motion, second and all were in favor of the following criteria.

Onsolis criteria September 24, 2009

Use of Onsolis will require trial and failure of fentanyl transmucosal and fentanyl buccal tablet. In addition, Onsolis will be limited to the indication of breakthrough cancer pain.

Embeda will require prior authorization.

The following items were tabled until the November meeting:

New drugs: Invega Sustenna, Intuniv
Anticoagulants (injectables) duration of therapy
Insulins

Open Comments:

There were no additional comments.

The meeting adjourned at 3:00 pm.

Respectfully submitted,

Aimee Lewis
WYDUR Manager