

# Wyoming Drug Utilization Review

## Antiepileptic Drug Tapering for Discontinuation

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The optimal tapering regimen for antiepileptic drug (AED) discontinuation in seizure disorder is controversial. While some studies have shown that gradual withdrawal over six weeks is just as effective as tapering-down over a period of nine months, other studies have demonstrated that at least three months is required to decrease the risk of seizure relapse<sup>1,2</sup>. Even if AED serum levels remain elevated, seizures may be triggered in epileptic patients during rapid withdrawal<sup>3</sup>. To complicate the matter, newer AEDs are now being prescribed for various indications in patients who have no history of seizure disorder. Upon abrupt discontinuation, certain medications are associated with new-onset seizures in patients with no prior history of epilepsy<sup>4,5,6,7,8</sup>. The pathophysiology of seizure precipitation is likely related to the mechanism of AEDs on neuronal receptors and the potential to decrease seizure threshold in patients undergoing abrupt or rapid withdrawal.

The inconsistent data in clinical studies makes it apparent that rate and duration of the tapering period of AEDs should be based on the patient's past medical history, current disease state, and the specific drug therapy that is being discontinued. A brief overview of AED discontinuation guidelines, or lack thereof, is provided in Table 1 on page 2.

Due to the implications and risks associated with relapse and failure in medication tapering, AED therapy should be discontinued at the discretion of the provider and preparedness of the patient. Because withdrawal of AED therapy in patients with and without seizure disorders may be associated with an increased risk of precipitating epileptic events, additional patient monitoring needs to be employed, and restrictions on certain patient activities, such as driving, may need to be mandated.

Although literature relevant to abrupt AED withdrawal

demonstrates increased risk and frequency of epileptic events in patients with and without a history of seizure disorder, consistent protocols of medication tapering for discontinuation are unavailable. Due to the controversy and limited information available, decisions regarding the regimen used in discontinuation of AEDs primarily remain a clinical decision based on the medication profile and patient-specific parameters.

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## WY-DUR Board Meeting Update

The DUR Board met for its bimonthly business meeting on May 31, 2007. Highlights of this meeting include:

- The Department of Health is implementing a Mental Health Quality Prescribing Initiative. A Psychiatrist Advisory Board is being formed as a part of this initiative. The Psychiatrist Advisory Board will provide support to the DUR Board when mental health policies are considered. In addition, the Psychiatrist Advisory Board will be a resource for non-specialists in the state who are providing mental health services.
- The public comments for the carisoprodol prior authorization criteria were reviewed and the criteria were approved with no changes. The final criteria can be viewed at [www.uwyo.edu/DUR](http://www.uwyo.edu/DUR).
- The public comments relating to prior authorization criteria for the ADHD/ADD medications were reviewed. The criteria were approved with significant changes. The final criteria can be viewed at [www.uwyo.edu/DUR](http://www.uwyo.edu/DUR).

- Prior authorization criteria for antidepressant medications will be sent out for public comment in mid-June. A letter will be sent to a random sample of providers in the state. In addition, the criteria will be posted on the website at <http://www.uwyo.edu/DUR/>. If you do not receive a letter and wish to comment, please email comments to [alewis13@uwyo.edu](mailto:alewis13@uwyo.edu) or [lgm@uwyo.edu](mailto:lgm@uwyo.edu). In addition, comments may be mailed to

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The next meeting will be held July 19, 2007 in Laramie, Wyoming. Items for discussion will include prior authorization criteria for antidepressants, utilization of Aloxi and Invega. An agenda will be available prior to the meeting at <http://www.uwyo.edu/DUR/>.

**Table 1: A brief overview of AED discontinuation guidelines**

Medication	Discontinuation in Seizure Disorder	Discontinuation in non-epileptic events
Carbamazepine* (Tegretol®)	Use 100 mg decrements every 4 weeks for minimum of 6 months <sup>9</sup>	Abrupt withdrawal cautioned due to MOA <sup>+</sup>
Oxcarbazepine* (Trileptal®)	Gradual withdrawal recommended to minimize risk of increasing seizure frequency <sup>10</sup>	Abrupt withdrawal cautioned due to MOA <sup>+</sup>
Valproic Acid* (and derivatives)	Many tapering regimens used, abrupt discontinuation is avoided <sup>2</sup>	Abrupt discontinuation associated with more severe adverse effects <sup>11</sup>
Zonisamide* (Zonegran®)	Medication should be tapered for discontinuation at same rate of dose escalation at initiation <sup>12</sup>	Abrupt withdrawal cautioned due to MOA <sup>+</sup>
Lamotrigine (Lamictal®)	Use step-wise reduction of dose by 50% per week over a duration of at least two weeks <sup>4,5</sup>	New-onset seizures possible with abrupt withdrawal; Use step-wise reduction dose by 50% over a duration of at least two weeks <sup>4,5</sup>
Pregabalin* (Lyrica®)	Withdraw gradually over a duration of at least one week. <sup>13,14</sup>	Abrupt or rapid discontinuation associated with adverse effects <sup>13</sup>
Levetiracetam (Keppra®)	Use dose reductions of 500 mg per week over duration of at least two weeks, and/or down-titrate in a similar schedule as used for dose escalation during initiation. <sup>15,16</sup>	Abrupt withdrawal cautioned due to MOA <sup>+</sup>
Topiramate (Topamax®)	Use gradual withdrawal; suggested dose reduction of 50 to 100 mg per week <sup>17</sup>	Use gradual withdrawal; suggested 25 to 50 mg weekly dose reductions when used for migraine prophylaxis <sup>17</sup>
Tiagabine* (Gabitril®)	Avoid abrupt discontinuation; During trials, therapy was gradually tapered-down at the same rate that was used for dose escalation <sup>8</sup>	Associated with new-onset seizures, not recommended for non-epileptic indications <sup>6,7,8</sup>
Gabapentin* (Neurontin®)	Use gradual dose reduction over a minimum of one week. <sup>15</sup>	Abrupt withdrawal cautioned due to MOA <sup>+</sup>

+MOA = mechanism of action

\*No guidelines or protocols suggested by the manufacturer

## Office of Pharmacy Services Lock-In Program

In February 2003, the Office of Pharmacy Services implemented the Medicaid Pharmacy Lock-In Program. Any Medicaid recipient who receives narcotic prescriptions from 2 or more prescribers and utilizes 2 or more pharmacies within a 60 day period are candidates for the program. Medical histories are reviewed to ensure that recipients with certain diagnoses, including cancer, are excluded from lock-in. For the first offense the recipient is locked in for 1 year, second offense is for 2 years, and the third offense is for 6 years. Since the program's inception, 285 recipients have been locked in and 19 recipients have been locked in a second time.

The objectives of the Pharmacy Lock-In Program include:

- Enhanced recipient quality of care
- Decrease controlled substance abuse
- Save taxpayer dollars
- Detect prescriber issues

Physician and pharmacist referrals for possible lock-in candidates are welcomed and will be reviewed on a case by case basis. We have reviewed 101 referrals to date. If the recipient does not meet lock in criteria then we refer the case to other programs or agencies as we feel appropriate. Please feel free to contact the Pharmacy Case Manager if you have any questions, concerns, or referrals.

Sandra Deaver, CPhT  
Pharmacy Case Manager  
307-777-8773 or 800-438-5785  
Fax 307-777-8623  
sdeave@state.wy.us

## Lock-in Facts February 2003 - May 2007

**Number of recipients from 2/2003 through 5/2007: 285**

**101 referrals; 47 out of 101 referrals locked-in**

**51 months of lock-in; average 6 recipients per month**

**Number of 2<sup>nd</sup> time offenders locked-in for 2 years: 19**

**Average age: 37**

**Number of women: 232**

**Number of men: 53**

## Wyoming PharmAssist Program Telephone Number Change

The number for the Wyoming PharmAssist Program will change, effective July 1, 2007. The new number is 1-888-792-0067. The goal of the Wyoming PharmAssist Program is to offer all Wyoming citizens an opportunity to meet one-on-one with a pharmacist to discuss patient medications, including interactions, available generics, and duplications. The cost is only \$5.

Wyoming PharmAssist is a program created by the Wyoming Department of Health and the University of Wyoming. It is supported by AARP and funded by the Wyoming State Legislature.

**Wyoming PharmAssist Numbers**  
**1-877-246-4114 (through June 30, 2007)**  
**1-888-792-0067 (effective July 1, 2007)**

## Wyoming Medicaid Pharmacy Program Preferred Drug List Effective 04/01/2007

Drugs listed are preferred and do not require prior authorization.  
All other medications within the following classes are non-preferred and require prior authorization.

### Long Acting Opioids

Morphine Sulfate

### Statins

Lovastatin  
Pravastatin

### Calcium Channel Blockers

Verapamil  
Felodipine  
Diltiazem

### Overactive Bladder Agents

Oxybutynin  
Detrol (tolterodine)  
Ditropan XL (oxybutynin)

### Skeletal Muscle Relaxants

Cyclobenzaprine

### ACE Inhibitors

Captopril and Captopril/HCTZ  
Enalapril and Enalapril/HCTZ  
Lisinopril and Lisinopril/HCTZ

### Proton Pump Inhibitors

Prilosec OTC (omeprazole)  
Protonix (pantoprazole)

### NSAIDs

Ibuprofen  
Naproxen

### 2<sup>nd</sup> Generation Antihistamines

Loratadine  
Loratadine-D

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