



STATE MEDICAID DUR BOARD MEETING
THURSDAY, October 12, 2006
7:00 a.m. to 8:30 a.m.
Cannon Health Building
Room 125



MINUTES

Board Members Present:

Charles Arena, M.D.
Lowry Bushnell, M.D.
Derek Christeinsen, R.Ph.
Don Hawley, D.D.S.

Joseph Miner, M.D.
Wilhlem T. Lehmann, M.D.
Karen Gunning, Pharm D.
Jeff Jones, R.Ph.

Board Members Excused:

Dominic DeRose, R.Ph.
Bradford Hare, M.D.
Bradley Pace, PA-C
Colin VanOrman, M.D.

Dept. of Health/Div. of Health Care Financing Staff Present:

Rae Dell Ashley, R.Ph.
Tim Morley, R.Ph.
Jennifer Zeleny, CPhT.

Brenda Strain
Merelynn Berrett, R.N.
Richard Sorenson, R.N.

Other Individuals Present:

James Gaustad, Purdue
Ron Linford, U of U
Craig Boody, Lilly
Pierre Thoumsin, Amgen
Bill Greer, LEC
Cap Ferry, LEC

P. Sony(?), M.D., VMH
Michael Stevens, M.D., Davis Beh. Health
Barbara Boner, Novartis
Alan Bailey, Pfizer
Tim Smith, Pfizer
Oscar Fuller, CMS

Meeting conducted by: Lowry Bushnell

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1. Minutes for September 14, 2006 were reviewed, corrected, and approved.
 2. Housekeeping:
 3. Human Growth Hormone - The Board reworked the criteria for Human Growth Hormone in July and asked The Department for proposed changes. The Department proposed the following changes:

- ▶ In addition to requiring a stim test, The Department will require a test demonstrating low IGF-I levels as per the testing labs' ranges.
- ▶ Patients with Prader Willi Syndrome will be required to have a sleep study in order to be eligible for a PA. A normal initial screening oximetry will be sufficient to meet the criteria; however, any patients that show abnormalities in a screening oximetry will need to undergo a polysomnography sleep study to rule out sleep disorders that would make growth hormone treatment contraindicated.
- ▶ Panhypopituitarism was added as a covered indication for growth hormone therapy.

4. Daytrana Patch - Michael Stevens, M.D. of Davis Behavioral Health addressed the Board. Daytrana is a transdermal patch that provides a unique delivery system for methylphenidate. The transdermal delivery of methylphenidate appears to be beneficial for some patients due to the methylphenidate entering the bloodstream with no first pass effect. Daytrana also appears to deliver active medication at more even levels, minimizing "rebound effect" later in the day. Onset of action does not appear to be a problem when the patch is applied in the morning. Dr. Stevens stated that he has not noticed any serious adverse events when using the Daytrana patch. However, he did state that it is important for physicians to start with the lowest dose available since the methylphenidate delivered by Daytrana is much more bioavailable than methylphenidate taken orally.

It was proposed that Prior Authorization for Daytrana be denied if the patient had not tolerated oral methylphenidate formulations in the past. The Board felt that "intolerance" of oral methylphenidate was too vague, since this could imply intolerance to either the molecule or the oral dosage form. It was pointed out that a patient who did not tolerate on oral dosage form may actually benefit from using the patch due to the steadier serum levels achieved with this delivery system. The Board suggested changing the language to only exclude patients with an allergy to methylphenidate or the adhesive in the patch.

Dr. Sony (?) from Valley Mental Health addressed the Board and stated that the patch has the potential to increase compliance and decrease abuse. Parents do not have to worry about giving the patch to a child who slept late on a weekend, because the patch can be removed at the usual time in the afternoon. Currently, many parents skip doses of oral medications when children sleep late, because of the potential disruption to a sleep routine. Children may also abuse oral stimulants by "cheeking" or trading/giving tablets to other children. Once the patch is applied, it cannot be reapplied once removed. This minimizes the risk of abuse and noncompliance due to children "cheeking" and/or sharing medications. Tim Morley, R.Ph., asked if there was a possibility of children cutting up a patch to sell, as this is currently a problem with other transdermal dosage systems such as Fentanyl patches. This does not appear to be a problem with Daytrana; however, no one knows with certainty whether or not this could become a problem.

The Board suggested that the language in the Prior Authorization criteria be changed to require patients to discontinue all other stimulants when initiating therapy with Daytrana. The Board also voted to drop the last item in the Prior Authorization criteria, which states that intolerance of oral methylphenidate will result in an automatic denial of the Prior Authorization. A true allergy to other methylphenidate formulations (i.e. anaphylaxis) will be the only basis for denying a PA if oral methylphenidate has been tried in the past.

5. Plan B - Tim Morley, R.Ph., addressed the Board. There is some concern that Plan B's OTC availability could cause Plan B to become a first-line contraceptive of choice for some clients. While contraceptive use is generally positive, particularly for the Medicaid population, Plan B should not be allowed to become a first-line contraceptive due to its high cost in comparison to other contraceptives that are currently available to all clients. It was proposed that a lifetime maximum limit of two cycles be placed on Plan B.

There was a general agreement that patients who chronically use Plan B do require some form of intervention to ensure that they have access to and understanding of more appropriate routine contraceptives. However, the Board did not feel that it was appropriate to attempt to restrict access to contraception, particularly in a population that may have issues with finding a primary care physician to prescribe routine contraception. A decrease in access to Plan B could also result in an increase in clients in the system. It was suggested that patients who appear to be using Plan B routinely be referred to the DRRC for intervention. Karen Gunning, PharmD., offered to write an educational article for the Amber Sheet. She also stated that the University of Utah is also planning to offer continuing education for pharmacists, so that they understand Plan B and can counsel women about more appropriate contraception while they are in the pharmacy. It was suggested that a DUR screen appear when a claim is submitted for Plan B so that pharmacists can counsel women who appear to be over-utilizing Plan B. The Board did not feel that it would be beneficial to decrease access to Plan B. No changes will be made in coverage at this time.

6. Tablet Splitting - Tim Morley, R.Ph., addressed the Board. A tablet splitting proposal was brought before the Board several months ago. At that time, the Board requested that the Utah Board of Pharmacy be consulted before any action was taken on tablet splitting. Tim Morley, R.Ph. met with the Utah Board of Pharmacy in August. At that time, the Board of Pharmacy felt that it was reasonable to pursue a tablet splitting proposal, as long as obviously inappropriate medications, such as long-acting dosage forms or medications with a narrow therapeutic index, be excluded. The Utah Board of Pharmacy did not feel that there would be any legal or regulatory problems in moving forward with this proposal. The medications that are currently under consideration are the same medications that were addressed in the article *The Potential of Pill Splitting to Achieve Cost Savings* by Randal S. Stafford, M.D., PhD. and David C. Radley, BA. The only medication that Medicaid will not consider that was included in this article is Viagra. Viagra is not a covered benefit for Medicaid clients. With 100% conversion on splittable medications, Medicaid could save roughly \$3 Million yearly. There was some concern that patients could receive a higher-dose tablet without knowing that this had occurred. If the patient did not understand that they needed to split the tablets that they received, the

result could be an increase in overall healthcare costs as a trade-off for a relatively small savings in the pharmacy program. Dr. Bushnell suggested that any attempts to move forward with tablet splitting be restricted to tablets that are already scored and easy for patients to split. The Board also requested that physicians' offices be notified if a double-strength tablet is dispensed so that physician teaching be consistent with any pharmacy teaching that occurs. The consensus was that The Department not pursue the tablet splitting proposal as a cost-saving measure.

7. Anti-fungals were not discussed due to time expiring. Discussion will be moved to the November meeting.

Next meeting set for November 9, 2006.

Meeting adjourned.

The DUR Board Prior Approval Sub-committee convened and considered 7 petitions. Drug histories were for 12 months unless otherwise noted.