

Alabama Medicaid DUR Board Meeting Minutes

April 27, 2011

Members Present: Paula Thompson, Kelli Littlejohn, Robert Moon, Bernie Olin, David Harwood, David Frazer, Dan McConaghy

Also Present: Clemice Hurst, Tiffany Minnifield, Christina Faulkner, Commissioner Mullins

Present via Conference Line: Donald Marks, Jimmy Jackson, Rhonda Harden, Daniel Mims

Members Absent: Kevin Green, Kevin Royal, Denyse Thornley-Brown

Call to Order: Paula Thompson, Vice-Chair filled in for Chair, Kevin Green. Paula called the meeting to order at 1:00p.m.

Review and Adoption of Minutes of January 26, 2011 meeting: Regarding the October 27, 2010 DUR Board minutes, Paula Thompson requested that the minutes be amended to reflect a request by the Board for information on AAC pricing for colchicines, venlafaxine and valacyclovir. Paula asked if there were any further changes to the minutes. There being no further changes requested, Paula asked for a voice vote to approve the minutes as amended. Robert Moon made a motion. The motion was seconded by Bernie Olin. A voice vote to approve the minutes as amended was unanimous, however, there was not a quorum, so all voting will be postponed until the July 2011 DUR Board meeting.

Paula Thompson recognized Commissioner Mullins.

Prior Authorization and Overrides Update: Christina Faulkner began the Prior Authorization and Overrides Update with the Monthly Manual Prior Authorizations and Overrides Report for the month of December, 2010. She reported 7,951 total requests and an approval rate of 65.35%. She reported 14,912 electronic requests for the same time frame. From the Prior Authorization and Override Response Time Ratio report for December 2010 she reported that approximately 70% of all manual PAs were responded to in less than two hours, more than 85% in less than four hours and more than 88% in less than eight hours. For the month of January 2011, Christina reported 8,845 manual PA requests and 17,349 electronic PA requests. She reported that more than 65% of PAs were responded to in less than two hours, approximately 80% in less than four hours and approximately 86% in less than eight hours. For the month of February, Christina reported 8,500 manual PA requests and 14,443 electronic PA requests for the same time frame. For February, Christina reported between 76 and 77% approved in less than two hours, approximately 87% in less than four hours and between 88 and 89% approved in less than eight hours.

Program Summary Review: Christina briefly reviewed the Alabama Medicaid Program Summary beginning on page 27. She compared the Pre-AAC Implementation and the Post-AAC Implementation. The average paid per prescription Pre-AAC Implementation was approximately \$61 per prescription. The average paid per prescription Post-AAC was \$56.81. From the Six Month Assessment on page 28, Christina reported an average paid per prescription of \$58.52; an average of 221,481 recipients per month and an average paid per recipient per month of \$194.02.

Cost Management Analysis: Christina reported for January 2009 an average cost per claim of \$61.28 and for December 2010 an average cost per claim of \$55.39. Christina noted the information in graph form on pages 30 and 31. From the Drug Analysis 4th Quarter 2010, Christina reported 74.62% generic utilization, 15.85% brand single-

source, 3.32% brand multi-source and 6.21% OTC and “other”. From the Top 25 Drugs Based on Total Claims from 12/01/2010 – 12/31/2010, Christina reported the top five drugs: amoxicillin, hydrocodone-acetaminophen, azithromycin, Singulair® and alprazolam. She then reported the top five drugs from the Top 25 Drugs Based on Claims Cost from 12/01/2010 – 12/31/2010: Singulair, Abilify®, Synagis®, Seroquel® and Tamiflu®. From the Top 15 Therapeutic Classes by Total Cost of Claims for the same time frame, Christina reported the top five classes: Antipsychotic Agents, Adrenals, Leukotriene Modifiers, Hemostatics and Amphetamines. A board member asked that Christina clarify the agents in the Adrenal group. Christina will bring that information back to the Board at the next meeting.

Top 25 Prescribers for AHFS Classes 280808, 281208 and 282408: Christina informed the Board that HID has received a response rate of more than 50% from the Top 25 Prescribers letter. She reported that many prescribers found the information in the letter “useful”, many treat patients that live in rural areas and cannot travel to pain clinics, all used pain scales, many treat chronic pain and most stated that they would modify treatment as appropriate based on the information in the letter.

UPDATES

Anti-convulsants, Miscellaneous AHFS Class 281292: In July 2010, the Miscellaneous Anticonvulsant class was the third leading drug class based on claims cost. There were 23,058 prescriptions reported at a cost of \$1,900,969, approximately \$82 per paid prescription. The DUR Board requested information about the number of patients using anticonvulsants for diagnoses other than epilepsy. The Board also requested that HID more closely review the Anticonvulsants, Miscellaneous class and determine the unique number of recipients for each drug. That information was reported to the Board in January of 2011. At that meeting, the Board requested that HID provide information on common unlabeled indications for these drugs. In response to that request, Christina reviewed the information on page 36 of the meeting manual. Chrissy reported that HID identified 15,220 patients without a diagnosis of epilepsy or seizure disorder or any of the other label and common unlabeled indications. She reported 17,665 patients without a seizure disorder diagnosis. She reported the following unlabeled uses: restless legs syndrome, essential tremor, neuropathic pain, migraine prophylaxis and HIV polyneuropathy. The Board requested that HID provide the top diagnoses for those 15,220 patients. The Board also requested the top prescribers and their network regions.

Low Dose Quetiapine: The Board, at the January meeting, requested that HID develop criteria for low dose Seroquel for patients on injectable antipsychotics. Christina presented the criteria on page 40 for the Board’s consideration. The Board recommended amending the alert message to read “please consider using an alternative agent bearing in mind evidence based medicine and cost.”

AAC: Christina reported that on September 30, 2010, the FDA took action against companies that manufacture, distribute and/or market unapproved single-ingredient oral colchicines, commonly used in the treatment of gout and Familial Mediterranean Fever (FMF). These products have been on the market for decades and have not been through the FDA-approval process which is now required for all prescription drugs. The companies received notice and must stop manufacturing colchicines within 45 days and stop shipping within 90 days. The only FDA-approved single ingredient colchicines that is available on the U.S. market is Colcrys. For a period after the FDA notification, some pharmacies still had supplies of colchicines available in their pharmacies. These products were assigned a generic Average Acquisition Cost (AAC) and remained covered. As a result, claims for Colcrys would pay at the generic rate when dispensed unless a Dispense as Written (DAW) code of 8 was submitted on each claim. In light of the fact that the generic products are considered unapproved by the FDA and no longer available in most pharmacies, the AAC rate for the generic products has been removed. Christina reported that this has resolved the reimbursement issue and is allowing claims for Colcrys to reimburse at the correct rate without having to enter a DAW code of 8. Chrissy reviewed the AAC information on venlafaxine, valacyclovir and colchicine presented on pages 42 and 43 of the meeting manual, which included NDC, GSN, lowest price prior to 9/22/10 and the AAC (effective 9/22/10) for each available dosage form of the three agents.

Desmopressin and Enuresis Alarms: Christina presented the following background information to the Board: Nocturnal enuresis affects around 15-20% of five year olds, and up to 2% of young adults. Primary nocturnal enuresis occurs when the nocturnal urine production is more than the bladder's capacity and the child fails to awaken in response to a full bladder. Enuresis can also be secondary to a medical, psychological, or behavioral problem, although this is less common. There are several treatment options; including behavioral therapies, enuresis alarms, and pharmacological interventions. In 2009, there were 1389 children under the age of 12 using desmopressin tablets. There were a total of 4513 prescriptions at a total cost of \$724,780 (average of \$160.59 per prescription). However, with the new AAC pricing structure, the same number of prescriptions would cost approximately \$324,595, which averages out to \$71.92 per prescription. Enuresis alarms have a one-time cost of approximately \$50, so if all patients were given an alarm, the cost to Medicaid would be approximately \$69,450. If the alarms worked in all cases, the savings to Medicaid would be close to \$255,000, using the new AAC pricing guidelines. Christina continued by explaining the supporting literature. According to the International Children's Continence Society, there are currently two valid first line therapies: desmopressin and enuresis alarms. Alarm therapy results in dryness in about two-thirds of children (grade Ia evidence), and should be considered for children with primary nocturnal enuresis without polyuria. Patients generally require a trial of two to three months. If positive results have not been noted at the end of this time, the alarm therapy should be discontinued. Desmopressin works best for children with nocturnal polyuria and normal bladder reservoir function, and for families in whom alarm treatment has failed. Approximately 30% of children are full responders and 40% have a partial response (grade Ia evidence). The AAFP guidelines state that there are two first-line therapies, enuresis alarms and desmopressin. The AAFP states that an enuresis alarm is effective in children with monosymptomatic nocturnal enuresis (evidence grade A) and that desmopressin is most effective in children who have enuresis with nocturnal polyuria and normal bladder capacity (evidence grade A). The article indicates that about two-thirds of children have success with the enuresis alarm and nearly one-half of children remain dry after discontinuation. There is a 60-70% response rate with desmopressin although about 80% of children relapse after discontinuing therapy. A Cochrane Literature Review of 56 studies involving 3257 children provided much the same evidence. Alarms take longer than desmopressin to reduce bedwetting, but the effects continue even after discontinuation of the alarm. Until recently, alarms have not been covered by Medicaid. They are now covered under Medicaid's DME (Durable Medical Equipment) program. Christina presented a draft letter informing prescribers of the recommended treatment options and explaining the new coverage of alarms. Christina asked the Board to consider a recommendation to Alabama Medicaid to approve the letter to be sent to the top prescribers of desmopressin.

Proposed Criteria: Christina presented the proposed set of 39 criteria to the Board. The following amendments to the criteria were requested by the Board: Criteria #1 – The word “death” will be added to the last sentence so that the sentence will read “Respiratory depression, hypotension, profound sedation, coma or death may result.” Criteria#3 – the phrase “cardiac hypertrophy” will be removed. Criteria #4 – “methadone” will be removed from Util B. Criteria #5 – The word “Agonist” will be added to the title of the criteria. Criteria #13– “e.g., thioridazine and pimozide” will be removed. Util B list will be included in the body of the Alert message. Criteria # 23 – wording will be changed to read “please prescribe only an FDA...”. Due to inclement weather resulting in a lack of physical quorum, the criteria vote was tabled until the next DUR meeting.

Medicaid Update: Tiffany Minnifield called the board members' attention to their Medicaid packets and reminded them to complete and turn in their vouchers. Tiffany also informed the Board that the Gold Standard program began April 1. The top 3% of prescribers will be released from PA requirement for select classes. Kelli Littlejohn informed the Board that the FY2012 budget has not been finalized but is currently in the State Legislature. She also informed the Board that there is a budget proposal of an eight prescription limit with two brands and no overrides or exceptions. She also mentioned the possibility of placing a PA requirement on the antipsychotic class. She stated that she will keep the Board informed as the budget is finalized by the Legislature and signed by the Governor. Kelli also informed the Board of the progress of the Patient Care Network of Alabama (PCNA) project, currently awaiting CMS approval.

P & T Committee Update: Clemice Hurst began the P&T Update by informing the Board that at the last meeting on February 9, the Committee reviewed the Respiratory Agents and the EENT Preparations. She stated that the next P&T meeting will be held on May 11. At the May meeting the committee will review the Pain Medications, Skeletal Muscle Relaxants, Antiemetics and the PPIs.

New Business: Paula Thompson, Vice-chair, asked the Board if there was any new business. There being no new business brought before the Board, Paula Thompson asked for a motion to adjourn. David Harwood made a motion to adjourn the meeting. The motion was seconded by Bernie Olin. A voice vote to adjourn was unanimous. The meeting was adjourned at 2:30p.m.

Next Meeting Date: The next DUR Board meeting will be held on July 27, 2011.

Respectfully submitted,



Christina Faulkner, PharmD

R. Bob Mullins, Jr.
R. Bob Mullins, Jr., M.D., Commissioner

Approve () Deny

9-15-11
Date

Kathy Hall
Kathy Hall, Deputy Commissioner

Approve () Deny

9/13/11
Date

RM
Robert Moon, M.D., Medical Director

Approve () Deny

9-15-11
Date