

Alabama Medicaid DUR Board Meeting Minutes January 28, 2009

Members Present: Bernie Olin, Clemice Hurst, Kelli Littlejohn, Tiffany Minnifield, Christina Faulkner, Robert Moon, Jimmy Jackson

Members Present via web conferencing: Gurinder Doad, Paula Thompson, Rhonda Harden, Kevin Royal, Daniel Mims

Members Absent: Kevin Green, Paul Nagrodzki, Michael Gosney, Denyse Thornley-Brown

Kevin Royal, Chairman, called the meeting to order at 1:00pm.

Kelli Littlejohn welcomed the board members to the meeting. As the meeting was the first Alabama Medicaid DUR meeting to be conducted by the agency's web conferencing capabilities, Kelli asked all members to identify themselves, both in the meeting room and via the web conferencing line.

Review and Adoption of Minutes of October 22, 2008 meeting: Kevin Royal asked if there were additions, deletions, or changes to the minutes of the October 22, 2008 meeting. No changes were brought to the attention of the Board. Kevin Royal asked for a motion to approve the minutes as presented. Jimmy Jackson made a motion to accept the minutes. The motion was seconded by Paula Thompson. A voice vote was unanimous to accept the minutes as presented.

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 September, 2008. She reported 10,256 total requests and a 67.03 % approval rate. Christina then called the board members' attention to the Explanation of Miscellaneous Requests Received for September 2008. During the October 2008 meeting, Gurinder Doad had asked what was included in the Miscellaneous category of the Manual Prior Authorization and Overrides report. Christina explained that occasionally, a request is received for a medication that doesn't require a prior authorization, or the requested item is a non-drug entity that is paid through Durable Medical Equipment (DME) services. These requests are filed in the Miscellaneous category, and a letter is sent to the provider explaining what, if any, action needs to be taken. Christina asked if there were questions regarding the Miscellaneous drug category. There were no questions. Christina moved on to review the Monthly Electronic Prior Authorization and Overrides report for September. This report showed 14,910 total requests. The Monthly Help Desk Report for the same month showed 6,366 incoming calls, 1,996 outgoing calls and a Longest Wait Time of 2 minutes and 45 seconds. Citing the Prior Authorization and Override Response Time Ratio Report, also for September, Christina noted that 87.29% of total overrides, 85.19% of manual prior authorizations and 97.17% of total prior authorizations were responded to in less than eight hours. A short discussion took place regarding the effect of InterChange, Medicaid's Management Information System (MMIS), on response times, which included the process of validating the data in the MMIS system, and inputting an approved PA into the HID system. EDS and HID are working together to improve the PA functionality to decrease PA response times.

Christina continued the Prior Authorization Update with the October Monthly Manual Prior Authorizations and Overrides. She reported 11,507 total requests and an approval rate of 55.08%. Christina reviewed the Miscellaneous Requests report for October 2008. From the Monthly Electronic Prior Authorizations and Overrides Report for the month of October, she reported 17,207 requests. The Monthly Help Desk Report showed an average time for incoming calls of approximately three minutes and a total of 9,086 incoming calls. From the Prior Authorization and Override Response Time Ratio Report for October, Christina reported between 36-42% of manual prior authorizations responded to in less than two hours, 58-64% responded to in less than four hours and 81-84% responded to in less than eight hours.

For the month of November, from the Monthly Manual Prior Authorizations and Overrides Report, Christina reported 10,107 requests and an approval percentage of 57.46%. Christina briefly reviewed the Explanation of Miscellaneous Requests Received for November 2008. For the month of November, from the Monthly Electronic Prior Authorizations and Overrides Report, Christina reported 14,161 requests. From the November Monthly Help Desk Report, Christina reported an average call time of three minutes 32 seconds. From the Prior Authorization and Override Response Time Ratio Report for November, Christina noted that between 78% and 81% of requests were responded to in less than eight hours.

Christina reported to the Board that HID had recently updated their RDUR data, which allowed a DUR intervention cycle to be run. When a cycle is run, criteria chosen by the board is compared to patient data and patients who meet the intervention criteria are selected for review by a pharmacist. After review, educational intervention letters are sent to selected physician(s). Information received from the January cycle will be provided to the Board at the DUR meeting in April.

Proposed Future Interventions/RDUR Criteria: Christina briefly reviewed the set of criteria presented for use in future interventions. After reviewing the criteria set, Tiffany Minnifield asked board members to mark their ballots. Marked ballots were turned in and tabulated. The set of 11 criteria was approved as follows: Criteria 1, 2, 7, 8, 9, 10, and 11 were approved as presented. Criteria 3, 4, 5 and 6 were approved as amended.

Medicaid Pharmacy Update: Kelli Littlejohn introduced a new board member, Dan McConaghy. Dan is a practicing pharmacist from Axis, Alabama.

Tiffany Minnifield reminded board members to complete and return vouchers. She called the members' attention to the PDL and the "Provider Insider" contained in the packet. She asked members mailing in ballots to return ballots within one week of the meeting. Kelli reminded members that if they are participating in the meeting via web conferencing their packets including ballots will be sent in the mail. Vouchers must be mailed back via regular mail. Ballots may be returned by mail or email. Kelli encouraged all members attending the meeting through the web conference to provide feedback to the agency.

Tiffany Minnifield thanked Letrice Ware and Robin Rawls of the Medicaid Communications Division for their assistance with the meeting.

P & T Update: Clemice Hurst provided a brief update of the P & T Committee. She informed the Board that at the last meeting in December the committee reviewed the Respiratory Agents, Intranasal Corticosteroids, EENT Agents, Anti-Allergics and Vasoconstrictors. Clemice announced that the next P & T meeting will be held on February 11th at 9am and will cover the Opiates, Skeletal Muscle Relaxants and PPIs.

New Business: Kevin Royal, Chair, asked if there was new business to be brought before the Board. Bernie Olin suggested that the Board consider the new FDA guidelines on Pediatric Cough and Cold for Retrospective DUR. Christina said that she would research the topic and if not previously covered, would prepare criteria for the Board's review.

Gurinder Doad announced that he is withdrawing from the Alabama Medicaid DUR Board. He has accepted a faculty position in a family practice residency program in Albany, GA. Kelli Littlejohn thanked him for his service to the DUR Board and wished him well in his new endeavor.

Next Meeting Date: Tiffany announced that the next DUR meeting would be held on April 22, 2009.

Kevin Royal asked if there was any more new business to be brought before the Board. There being none, Gurinder Doad made a motion to adjourn. Daniel Mims offered a second. A voice vote to adjourn the meeting was unanimous. The meeting was adjourned at 2:15pm.

Respectfully submitted,



Christina Faulkner, PharmD.

ALABAMA MEDICAID RETROSPECTIVE DRUG UTILIZATION REVIEW CRITERIA RECOMMENDATIONS

Recommendations

Approved Approved Rejected
As
Amended

1. Exenatide / Therapeutic Appropriateness

_____ ✓ _____

Alert Message: Postmarketing cases of acute pancreatitis have been reported in patients treated with Byetta (exenatide). Patients receiving exenatide should be informed that persistent severe abdominal pain, with or without vomiting, is the hallmark symptom of acute pancreatitis. If pancreatitis is suspected all suspect drugs should be discontinued, diagnosis confirmed and appropriated treatment initiated. Exenatide should not be restarted unless an alternative etiology is identified.

Conflict Code: TA – Therapeutic Appropriateness

Drug/Disease:

Util A

Util B

Util C

Exenatide

References:

Facts & Comparisons, 2008 Updates.

MedWatch: The FDA Safety Information and Adverse Reporting Program, 2008.

2. Becaplermin / Therapeutic Appropriateness

_____ ✓ _____

Alert Message: An increased rate of mortality secondary to malignancy was observed in patients treated with 3 or more tubes of Regranex (topical becaplermin gel) in a postmarketing retrospective cohort study. Use becaplermin only when the benefits can be expected to outweigh the risks. Use becaplermin with caution in patients with known malignancy.

Conflict Code: TA – Therapeutic Appropriateness (**Black Box Warning**)

Drug/Disease:

Util A

Util B

Util C

Becaplermin

References:

Facts & Comparisons, 2008 Updates.

MedWatch: The FDA Safety Information and Adverse Reporting Program, 2008.

Regranex Prescribing information, 2008, Ortho-McNeil.

3. Simvastatin / Amiodarone

_____ ✓ _____

Alert Message: Concurrent use of amiodarone and simvastatin may increase the risk of myopathy/rhabdomyolysis, particularly with simvastatin doses greater than 20 mg daily. Doses of simvastatin greater than 20 mg per day in patients taking amiodarone should be avoided unless the clinical benefit outweighs the increased risk of myopathy/rhabdomyolysis.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease:

Util A

Util B

Util C

Simvastatin 40 & 80 mg Amiodarone

References:

Facts & Comparisons, 2008 Updates.

MedWatch: The FDA Safety Information and Adverse Reporting Program, 2008.

Micromedex Healthcare Series, DrugDex Drug Evaluations, 2008.

Zocor Prescribing Information, June 2008, Merck & Co., Inc.

***New alert message will read:**

Concurrent use of amiodarone and simvastatin may increase the risk of myopathy/rhabdomyolysis, due to the inhibition, by amiodarone, of CYP3A4-mediated simvastatin metabolism. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4. If co-administration with these agents is unavoidable, the dose of simvastatin should not exceed 20 mg per day.

Recommendations

Approved Approved Rejected
As
Amended

4. Simvastatin / Verapamil

Alert Message: Concurrent use of simvastatin and verapamil may increase the risk of myopathy/rhabdomyolysis, particularly with simvastatin doses greater than 20 mg daily. Doses of simvastatin greater than 20 mg per day in patients taking verapamil should be avoided unless the clinical benefit outweighs the increased risk of myopathy/rhabdomyolysis.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease:

Util A Util B Util C
Simvastatin 40 & 80 mg Verapamil

References:

Facts & Comparisons, 2008 Updates.

MedWatch: The FDA Safety Information and Adverse Reporting Program, 2008.

Micromedex Healthcare Series, DrugDex Drug Evaluations, 2008.

✓
**New alert message will read:*

Concurrent use of verapamil and simvastatin may increase the risk of myopathy/rhabdomyolysis, due to the inhibition, by verapamil, of CYP3A4-mediated simvastatin metabolism. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4. If co-administration with these agents is unavoidable, the dose of simvastatin should not exceed 20 mg per day.

5. Lovastatin / Amiodarone

Alert Message: Concurrent use of amiodarone and lovastatin may increase the risk of myopathy/rhabdomyolysis, particularly with lovastatin doses greater than 40 mg daily. Doses of lovastatin greater than 40 mg per day in patients taking amiodarone should be avoided unless the clinical benefit outweighs the increased risk of myopathy/rhabdomyolysis. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease:

Util A Util B Util C
Lovastatin 60 mg Amiodarone

References:

Facts & Comparisons, 2008 Updates.

Micromedex Healthcare Series, DrugDex Drug Evaluations, 2008.

Mevacor Prescribing Information, Sept. 2008, Merck & Co., Inc.

✓
**New alert message will read:*

Concurrent use of amiodarone and lovastatin may increase the risk of myopathy/rhabdomyolysis, due to the inhibition, by amiodarone, of CYP3A4-mediated lovastatin metabolism. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4. If co-administration with these agents is unavoidable, the dose of lovastatin should not exceed 40 mg per day.

6. Lovastatin / Verapamil

Alert Message: Concurrent use of verapamil and lovastatin may increase the risk of myopathy/rhabdomyolysis, particularly with lovastatin doses greater than 40 mg daily. Doses of lovastatin greater than 40 mg per day in patients taking verapamil should be avoided unless the clinical benefit outweighs the increased risk of myopathy/rhabdomyolysis. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease:

Util A Util B Util C
Lovastatin 60 mg Verapamil

References:

Facts & Comparisons, 2008 Updates.

Micromedex Healthcare Series, DrugDex Drug Evaluations, 2008.

Mevacor Prescribing Information, Sept. 2008, Merck & Co., Inc.

✓
**New alert message will read:*

Concurrent use of verapamil and lovastatin may increase the risk of myopathy/rhabdomyolysis, due to the inhibition, by verapamil, of CYP3A4-mediated lovastatin metabolism. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4. If co-administration with these agents is unavoidable, the dose of lovastatin should not exceed 40 mg per day.

Recommendations

Approved Approved Rejected
As
Amended

7. Atorvastatin / Amiodarone

_____ ✓ _____

Alert Message: Concurrent use of amiodarone and atorvastatin may increase the risk of myopathy/rhabdomyolysis due to inhibition, by amiodarone, of CYP3A4-mediated atorvastatin metabolism. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4. If coadministration cannot be avoided, use the lowest possible dose of atorvastatin.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease:

| | | |
|-----------------------------|---------------|---------------|
| <u>Util A</u> | <u>Util B</u> | <u>Util C</u> |
| Atorvastatin 20, 40 & 80 mg | Amiodarone | |

References:

Facts & Comparisons, 2008 Updates.
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2008.
Lipitor Prescribing information, Nov. 2007, Pfizer.

8. Atorvastatin / Verapamil

_____ ✓ _____

Alert Message: Concurrent use of verapamil and atorvastatin may increase the risk of myopathy/rhabdomyolysis due to inhibition, by verapamil, of CYP3A4-mediated atorvastatin metabolism. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4. If coadministration cannot be avoided, use the lowest possible dose of atorvastatin.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease:

| | | |
|-----------------------------|---------------|---------------|
| <u>Util A</u> | <u>Util B</u> | <u>Util C</u> |
| Atorvastatin 20, 40 & 80 mg | Verapamil | |

References:

Facts & Comparisons, 2008 Updates.
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2008.
Lipitor Prescribing information, Nov. 2007, Pfizer.

9. Oxandrolone / Warfarin

_____ ✓ _____

Alert Message: Concurrent dosing of oxandrolone, a synthetic derivative of testosterone, and warfarin should be avoided due to a large increase in INR or PT. When oxandrolone is prescribed to patients being treated with warfarin, doses of warfarin may need to be decreased significantly to maintain a therapeutic INR level and diminish the risk of serious bleeding.

Conflict Code: DD – Drug/Drug Interaction

Drug/Disease:

| | | |
|---------------|---------------|---------------|
| <u>Util A</u> | <u>Util B</u> | <u>Util C</u> |
| Oxandrolone | Warfarin | |

References:

Facts & Comparisons, 2008 Updates.
Oxandrin Prescribing Information, May 2005, Savient Pharmaceuticals Inc.

Recommendations

Approved Approved Rejected
As
Amended

10. Narcotic Cough Syrups / Therapeutic Appropriateness

Alert Message: The patient has received multiple prescriptions for narcotic cough syrup in recent months. Diversion and abuse are concerns with these medications. Re-evaluation of the patient's condition may be necessary in order to rule out abuse and dependence. The chronic use of cough medication may suggest the existence of a more serious health condition (e.g. acid reflux, asthma, pneumonia, lung disease).

Conflict Code: TA - Therapeutic Appropriateness

Drug/Disease:

Util A Util B Util C

Codeine

Hydrocodone

Dihydrocodeine

References:

Facts & Comparisons, 2008 Updates.

Micromedex Healthcare Series, DrugDex Drug Evaluations, 2008.

11. Nitrofurantoin / Renal Impairment or Failure

Alert Message: The use of nitrofurantoin is contraindicated in patients with anuria, oliguria, or significant impairment of renal function (creatinine clearance [CrCl] less than 60 mL/min or clinically significant elevated serum creatinine) due to the increased risk of accumulation and toxicity.

Conflict Code: DB – Drug-Drug Marker and/or Diagnosis

Drug/Disease:

Util A Util B Util C

Nitrofurantoin

Lanthanum

Renal Impairment ICD-9s

Sevelamer

Renal Failure ICD-9s

Doxercalciferol

Paricalcitol

Calcitriol

References:

Facts & Comparisons, 2008 Updates.

Clinical Pharmacology, Gold Line Media, 2008.

Macrobid Prescribing Information, Oct. 2007, Procto and Gamble Pharmaceuticals, Inc.

The minutes of the January 28, 2009 DUR Board Meeting have been reviewed and approved as submitted.

Carol H. Steckel Approve () Deny 2/24/09
Carol H. Steckel, Commissioner Date

Kathy Hall Approve () Deny 2/25/09
Kathy Hall, Deputy Commissioner Date

Robert Moon Approve () Deny 2/25/09
Robert Moon, M.D., Medical Director Date