

Alabama Medicaid DUR Board Meeting Minutes July 23, 2008

Members Present: Kelli Littlejohn, Christina Faulkner, Tiffany Minnifield, Clemice Hurst, Mary McIntyre, Kevin Green, Michael Gosney, Bernie Olin, Kevin Royal, Paula Thompson, Denise Thornley-Brown, Jimmy Jackson, Rhonda Harden, Gurinder Doad

Members Absent: Rob Colburn, Daniel Mims, Robert Moon

Chairman Paula Thompson called the meeting to order at 1:00 p.m.

Review and Adoption of Minutes of April 23, 2008 meeting: Paula Thompson asked if there were any additions, deletions or changes to the minutes of the April 23, 2008 meeting. Paula Thompson recommended that the Top 25 Drugs Based on Number of Claims for March 2008 be included in the minutes. She then asked for a motion to approve the minutes as amended. A motion was made by Kevin Green, and seconded by Bernie Olin. A voice vote to approve the minutes as amended was unanimous.

Prior Authorization and Overrides Update: Christina Faulkner began the Prior Authorization and Overrides Update by calling members' attention to the Monthly Manual Prior Authorization and Overrides report for the month of March, 2008. For the month of March, she reported 10,661 total requests, with an approval percentage of 68.55%. Christina reported a grand total of 15,490 requests for the Monthly Electronic Prior Authorizations and Overrides for the month of March. Referencing the Monthly Help Desk Report, Christina stated that there were 9,110 incoming calls, an average time of incoming calls of 8 minutes 52 seconds, and 10,755 incoming faxes. Christina then directed the Board to the Response Time reports. She reported that 39.65% of manual prior authorizations and 35.26% of overrides were responded to in less than two hours and 83.49% of total requests were responded to in less than two hours. 60.70% of manual prior authorizations and 57.90% of overrides were responded to in less than four hours and 89.26% of total requests were responded to in less than four hours. Additionally, 76.25% of manual prior authorizations and 75.98% of overrides were responded to in less than eight hours and 93.41% of total requests were responded to in less than eight hours. Christina noted that the response times slowed somewhat and the incoming call times increased due to the implementation of the new MMIS system. Christina told the Board that the Call Center increased their hours during the implementation period to help handle the calls and requests.

Christina reviewed the Monthly Manual Prior Authorization and Overrides report for April 2008, reporting 9,802 total requests, with a 63.08% approval percentage. Christina reported a grand total of 19,985 requests on the Monthly Electronic Prior Authorizations

and Overrides report for the month of April. From the Monthly Help Desk Report, Christina stated that there were 9,400 incoming calls, with an average incoming call time of 6 minutes 15 seconds. Christina then directed the Board to the Response Time reports. She reported that 72.37% of manual prior authorizations and 71.74% of overrides were responded to in less than two hours and 94.19% of total requests were responded to in less than two hours. 82.43% of manual prior authorizations and 82.39% of overrides were responded to in less than four hours and 96.33% of total requests were responded to in less than four hours. Additionally, 84.90% of manual prior authorizations and 84.82% of overrides were responded to in less than eight hours and 96.85% of total requests were responded to in less than eight hours.

Christina reviewed the Monthly Manual Prior Authorization and Overrides report for May 2008, reporting 9,033 total requests, with a 59.12% approval percentage. Christina reported a grand total of 17,370 requests on the Monthly Electronic Prior Authorizations and Overrides report for the month of May. From the Monthly Help Desk Report, Christina stated that there were 7,344 incoming calls, with an average incoming call time of 3 minutes 19 seconds. Christina then directed the Board to the Response Time reports. She reported that 57.78% of manual prior authorizations and 60.99% of overrides were responded to in less than two hours and 91.05% of total requests were responded to in less than two hours. 72.90% of manual prior authorizations and 75.65% of overrides were responded to in less than four hours and 94.31% of total requests were responded to in less than four hours. Additionally, 76.25% of manual prior authorizations and 79.26% of overrides were responded to in less than eight hours and 95.06% of total requests were responded to in less than eight hours.

Christina asked if there were any questions and Kevin Green inquired about claims that are rejected through the electronic PA system. Christina explained that for many of these requests, the necessary information is not found in the medical or pharmacy claims history. Kelli Littlejohn added that the electronic PA numbers are a little lower than normal and that there can be multiple reasons, including not finding appropriate prior therapies in the claims history, for these denials. Christina noted that when a claim does not meet the criteria electronically, a message is sent to the pharmacy requesting a manual prior authorization

Review of CMS Annual Report: Christina directed the Board Members' attention to the Fiscal Year (FY) 2007 CMS report. She explained that the Alabama Medicaid Agency is required to summarize the Drug Utilization Review (DUR) Board activities and submit a written report each year. For FY 2007, it is estimated that the retrospective DUR (RDUR) program saved the Alabama Medicaid Program approximately \$366,001 and 4,768 prescriptions. There were 1,391 education letters mailed for 976 recipients during FY 2007, with a 22% voluntary response rate from prescribers.

The Board Members reviewed Table 1, which gave a summary of the number of Alert letters and responses during each quarter. It was noted that 16% of the Alert letters mailed were drug-disease conflicts, 24% drug-drug interactions, 6% over-utilization, 14% under-utilization, and 40% clinical or therapeutic appropriateness.

Christina then briefly reviewed the procedures used to analyze RDUR data, explaining that there is an intervention group and a comparison group. The comparison group evaluated was similar to the intervention group, and acted as the standard, non-variable group. In patients with a single intervention, the costs decreased by 5.45% (cost decrease of \$103,938) in the intervention group and increased by 163.96% (cost increase of \$271,014) in the comparison group. This resulted in an estimated cost savings of \$374,952. In patients with multiple interventions, such as those patients evaluated in the asthma program, costs increased by 9.58% (cost increase of \$10,331) in the intervention group and increased by 22.98% (cost increase of \$1,380) in the comparison group. This resulted in a cost increase of \$8,951. The overall average savings for the interventions was \$366,001, which is \$482.85 per recipient.

Asthma Disease State Management: During FY 2007, the DUR Board focused on asthma. Christina presented the results of the asthma project that were included in the CMS annual report.

The criteria that was used to select patients was reviewed: over-utilization of beta agonists, utilization of beta agonists without regular use of a controller medication (in patients with and without a diagnosis of asthma), use of bronchodilators with recent asthma related hospital or emergency room visits, and appropriate utilization of long-acting beta agonists. Christina reminded the Board Members that recipients with other chronic lung diseases (such as cystic fibrosis, chronic obstructive pulmonary disease, and emphysema) were not included in the evaluation.

The asthma project was run for six months, but there were only five cycles run during the fiscal year, so only those five cycles were included in the CMS report. Christina reviewed Table 1, which showed that there were a total of 569 recipients included. She also reviewed Table 2 and 3, which showed a \$165,926.84 difference in drug costs, a 3,398 difference in number of prescriptions, and a \$534,537.62 difference in medical costs during the study period. Table 3 showed changes in selected asthma drugs. Paula Thompson noted that she expected drug costs to increase in this type of educational intervention. Christina reported that one possible explanation was that there was too little time between the intervention and the reports being generated.

Christina reviewed Table 4 which noted a \$16,324.73 savings in medical costs that could be directly associated to a diagnosis of asthma. Table 5 gave a summary of the patient demographics for the intervention group.

Christina then explained that Alabama Medicaid has many cost saving programs in place, and the exact cost savings associated with this intervention is difficult to estimate. Kelli Littlejohn reported that no changes to the Preferred Drug List (PDL) during the intervention period were associated with the respiratory agents, so the impact of the PDL should have been minimal on the asthma study.

Proposed Future Interventions/RDUR Criteria: Christina presented 24 sets of criteria to the Board for proposed future intervention. After discussion, the Board agreed to table criteria #3, pending more research by HID. The Board suggested adding the typical antipsychotics to Util B column, and removing the phrase ‘and costly’ from criteria #4. Christina introduced criteria #5 (atypical antipsychotics/therapeutic appropriateness) and Kelli Littlejohn informed the Board that the P&T Committee was looking into the appropriate use of atypical antipsychotic agents and had formed a work group for this task. After deliberation, the Board recommended that this criterion be used to gather information, but that letters not be sent, and the information presented to the Board at the next meeting. After reviewing criteria #15-17 (polypharmacy/therapeutic duplication), Rhonda Harden suggested that the anticonvulsants and sympatholytics be added into this set of criteria. Michael Gosney indicated that it might be useful to expand the criteria to include other CNS depressant agents, such as carisoprodol, narcotics, and other muscle relaxants. Christina presented the remaining criteria. Kevin Green asked for more information on criteria #20-23. After discussion, it was determined that criteria #20-23 would be tabled, pending more research by HID. Paula Thompson instructed Board Members to mark criteria ballots and return them to Tiffany Minnifield.

Medicaid Pharmacy Update: Tiffany Minnifield began the Medicaid Pharmacy Update by reviewing the latest ALERTs. She explained that the Part D Pharmacy recoupments, which are claims that have been paid by Medicaid for patients with an active Part D plan, have begun. Tiffany also reminded the Board that starting October 1, 2008, providers will be required to have all three characteristics stated in the Tamper Resistant ALERT. Kelli Littlejohn added that she had just received a letter from the National Association of State Medicaid Directors (NASMD) stating that providers printing prescriptions from electronic medical records (EMRs) may not have to use tamper resistant paper, that plain paper will be acceptable as long as the prescription has at least one feature from each of the three tamper resistant categories. She stated that there will be more information forthcoming on this subject.

Tiffany announced that the Board would be voting on a vice-chair at the next meeting and that Kevin Royal would be taking over as chair at the October meeting. Kelli thanked Paula Thompson for her service and excellent leadership of the Board during the last year.

Tiffany reminded the members to sign in and to complete and return their vouchers before leaving the meeting.

P & T Update: Clemice Hurst presented the P & T report to the Board. She announced that the Agency has awarded the Pharmacy Clinical Support Services contract to Goold Health Systems (GHS) of Augusta, Maine. The last PDL update was on July 1, 2008 and included updates to the respiratory agents. The next P & T Committee meeting will be September 10, 2008 and antihypertensive agents are on the agenda to be reviewed.

Gurinder Doad requested information about top reasons for electronic denials for classes such as the diabetic agents and antihypertensive agents. Kelli Littlejohn suggested that

HID research that issue and bring back information on the diabetic agents for the next meeting.

The next meeting date, October 22, was announced. Paula Thompson asked if there was any further business to be brought before the Board. There being none, she asked for a motion to adjourn. Kevin Green made a motion to adjourn. The motion was seconded by Denise Thornley-Brown. A voice vote to approve the motion was unanimous. The meeting was adjourned at 2:30 pm.

Respectfully Submitted,

Christina Faulkner, Pharm.D.

Christina Faulkner, Pharm.D.

Recommendations

Approved Approved Rejected
As
Amended

4. Risperdal Consta / Oral Atypical Antipsychotics

_____ ✓ _____

Alert Message: Patients prescribed Risperdal Consta (risperidone injection) should receive oral antipsychotic supplementation until risperidone has achieved steady-state plasma concentrations, typically after 4 injections. The use of oral antipsychotics with risperidone injection beyond the recommended transition time period may represent an unnecessary and costly duplication of therapy.

Conflict Code: TD – Therapeutic Duplication (DD-100P)

Drugs/Disease

Util A

Risperdal Consta

Util B

Clozapine
Risperidone (except Consta)
Olanzapine
Quetiapine
Ziprasidone
Aripiprazole
Paliperidone

Util C

**Typical antipsychotic agents will be added to Util B and the words “and costly” will be removed from the alert message.*

References:

Risperdal Consta Prescribing Information, Sept 2007, Janssen Pharmaceuticals, Ltd.
Facts & Comparisons, 2007 Updates.
Clinical Pharmacology, Gold Standard, 2007.
Micromedex Healthcare Series, DrugDex Drug Evaluations, 2007.

5. Atypical Antipsychotics / Therapeutic Appropriateness

_____ ✓ _____

Alert Message: The patient is under the age of 5 with a diagnosis of ADHD and/or ODD and is receiving an atypical antipsychotic with no evidence in their diagnostic history of an FDA approved indication for use. Atypical antipsychotics have not been shown to be safe and effective for the treatment of ADHD or ODD. These agents have significant adverse effects which can be more prevalent and severe in pediatric patients.

Conflict Code: TA - Therapeutic Appropriateness

Drugs/Diseases:

Util A

Clozapine
Risperidone
Quetiapine
Olanzapine
Ziprasidone
Aripiprazole
Paliperidone

Util B

ADHD
ODD

Util C(Negating)

Schizophrenia
Autism
Bipolar
Major Depressive Disorder

Age Range: < 5 years of age

References:

Facts & Comparisons, 2008 Updates.
Olfson M, Blanco C, Liu L, Moreno C, Laje G: National trends in the outpatient treatment of children and adolescents with antipsychotic drugs. Arch Gen Psychiatry 2006; 63:679–685.
Patel NC, Crismon ML, Hoagwood K, Johnsruud MT, Rascati KL, Wilson JP, Jensen PS: Trends in the use of typical and atypical antipsychotics in children and adolescents. J Am Acad Child Adolesc Psychiatry 2005; 44:548–556.
Correll CU, Carlson HE, Endocrine and metabolic adverse effects of psychotropic medications in children and adolescents, J Am Acad Child Adolesc Psychiatry (2006)45:771-791.

Recommendations

Approved Approved Rejected
As
Amended

6. Desvenlafaxine / High Dose

_____✓_____

Alert Message: Pristiq (desvenlafaxine) may be over-utilized. The manufacturer's recommended maximum daily dose is 50 mg. Doses of 50 to 400 mg per day were shown to be effective but there is no evidence that doses greater than 50 mg per day confer any additional benefit.

Conflict Code: HD – High Dose

Drugs/Diseases:

Util A Util B Util C

Desvenlafaxine

Max Dose: > 50 mg/day

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

7. Desvenlafaxine / Nonadherence

_____✓_____

Alert Message: Pristiq (desvenlafaxine) may be under-utilized. Non-adherence to the dosing regimen may result in sub-therapeutic effects which may lead to decreased patient outcomes and additional medical cost.

Conflict Code: LR – Non-adherence

Drugs/Diseases:

Util A Util B Util C

Desvenlafaxine

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

8. Desvenlafaxine / Renal Impairment Dose

_____✓_____

Alert Message: The recommended maximum dose of Pristiq (desvenlafaxine) in patients with severe renal impairment or end-stage renal disease (ESRD) is 50 mg every other day. Patients with moderate renal impairment should receive a maximum daily dose of 50 mg. The dose should not be escalated in patients with moderate or severe renal impairment or ESRD.

Conflict Code: HD – High Dose

Drugs/Diseases:

Util A Util B Util C (Inclusive)
Desvenlafaxine ESRD
Renal Disease Stage III, IV, V
PhosLo
Renagel
Zemplar
Fosrenol

Max Dose: 50 mg QOD

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

Recommendations

**Approved Approved Rejected
As
Amended**

9. Desvenlafaxine / MAO Inhibitors

____✓____

Alert Message: Pristiq (desvenlafaxine) is contraindicated in patients taking a Monoamine Oxidase Inhibitor (MAOI) or in patients who have taken a MAOI within the preceding 14 days because serious, sometimes fatal, interactions may occur. Symptoms may include but are not limited to: tremor, seizures, hyperthermia with features resembling neuroleptic malignant syndrome and mental status changes. At least 7 days should be allowed after stopping desvenlafaxine before starting a MAOI.

Conflict Code: DD – Drug/Drug Interaction

Drugs/Diseases:

<u>Util A</u>	<u>Util B</u>	<u>Util C</u>
Desvenlafaxine	Phenelzine	
	Isocarboxazid	
	Tranylcypromine	

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

10. Desvenlafaxine / Venlafaxine

____✓____

Alert Message: Pristiq (desvenlafaxine) should not be used concurrently with venlafaxine (Effexor/Effexor XR). Desvenlafaxine is the major active metabolite of venlafaxine and concomitant use with venlafaxine may result in elevated plasma concentrations of desvenlafaxine and risk of adverse effects including serotonin syndrome.

Conflict Code: DD – Therapeutic Duplication

Drugs/Diseases:

<u>Util A</u>	<u>Util B</u>	<u>Util C</u>
Desvenlafaxine	Venlafaxine	

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

11. Desvenlafaxine / Serotonergic Agents

____✓____

Alert Message: Caution is advised if Pristiq (desvenlafaxine) is co-administered with other serotonergic agents (SSRIs, SNRIs, triptans). Concurrent use of serotonergic agents may result in a potentially life-threatening serotonin syndrome (e.g., agitation, hallucinations, tachycardia, hyperthermia, hyperreflexia, nausea, vomiting). If concomitant therapy is warranted, observe patient closely for adverse effects, particularly during initiation or dose increases.

Conflict Code: DD – Drug/Drug Interaction

Drugs/Diseases:

<u>Util A</u>	<u>Util B</u>	<u>Util C</u>
Desvenlafaxine	SSRIs	
	Duloxetine	
	Triptans	

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

Recommendations

Approved Approved Rejected
As
Amended

12. Desvenlafaxine / Aspirin & NSAIDS

_____ ✓ _____ _____

Alert Message: The concurrent use of Pristiq (desvenlafaxine) and aspirin or NSAIDs may increase the risk of GI bleeding due to alterations in platelet hemostasis. Drugs which inhibit the reuptake of serotonin cause decreased serotonin uptake by platelets, decreasing serotonin stores and increasing bleeding time.

Conflict Code: DD – Drug/Drug Interaction

Drugs/Diseases:

<u>Util A</u>	<u>Util B</u>	<u>Util C</u>
Desvenlafaxine	Aspirin	
	NSAIDS	

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

13. Desvenlafaxine / Warfarin

_____ ✓ _____ _____

Alert Message: The concurrent use of Pristiq (desvenlafaxine) and warfarin may alter the anticoagulant effects of warfarin and increase the risk of bleeding. Drugs which inhibit the reuptake of serotonin cause decreased serotonin uptake by platelets, decreasing serotonin stores and increasing bleeding time. Monitor patients who are receiving warfarin therapy when desvenlafaxine is initiated or discontinued.

Conflict Code: DD – Drug/Drug Interaction

Drugs/Diseases:

<u>Util A</u>	<u>Util B</u>	<u>Util C</u>
Desvenlafaxine	Warfarin	

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

14. Desvenlafaxine / Potent CYP 3A4 Inhibitors

_____ ✓ _____ _____

Alert Message: Concomitant use of Pristiq (desvenlafaxine), a CYP3A4 substrate, with potent 3A4 inhibitors may result in elevated desvenlafaxine plasma concentrations. The patient may be at increased risk for desvenlafaxine adverse effects (e.g., anxiety, insomnia, dizziness, headache, and specific male sexual function disorders).

Conflict Code: DD – Drug/Drug Interaction

Drugs/Diseases:

<u>Util A</u>	<u>Util B</u>	<u>Util C</u>
Desvenlafaxine	Ketoconazole	
	Ritonavir	
	Itraconazole	
	Erythromycin	
	Nelfinavir	

References:

Pristiq Prescribing Information, Feb. 2008, Wyeth Pharmaceuticals, Inc.
Facts & Comparisons, 2008 Updates.

Recommendations

Approved Approved Rejected
As
Amended

15. Polypharmacy / Therapeutic Duplication

_____ _____

Alert Message: The patient is receiving multi-class polypharmacy. Review the patient's medication history for any unintended additional therapy and assess adherence to ensure efficacy. Complex drug regimens increase the risk of adverse effects, drug/drug interactions, and non-adherence, which may result in the relapse/recurrence of the disease state.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

<u>Util A</u>	<u>Util B</u>	<u>Util C (Inclusive)</u>
Antipsychotics	Antidepressants	Mood Stabilizers Benzodiazepines Stimulants

**Anticonvulsants and sympatholytic agents will be added to this group of criteria.*

References:

Facts & Comparisons, 2008 Updates.
 Kreyenbuhl JA, McCarthy JF, et al: Long-term Antipsychotic Polypharmacy in the VA Health System: Patient Characteristics and Treatment Patterns. *Psychiatric Services* 58:489-495, 2007.
 Kreyenbuhl JA, Marcus SC, West JC, et al: Adding or Switching Antipsychotic Medications in Treatment-Refractory Schizophrenia. *Psychiatr Serv.* 2007 Jul; 58(7):983-90.
 de las Cuevas C, Sanz EJ, Fuentye JA, et al: Polypharmacy in Psychiatric Patients as an Alternative to Limited Mental Health Resources. *Jrnl Clin Psychopharm.* 2005 Oct; 25(5):510-512.
 NASMHPD Medical Director's Technical Report on Psychiatric Polypharmacy. Oct. 2001
 Available at: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Polypharmacy.PDF

16. Polypharmacy / Therapeutic Duplication

_____ _____

Alert Message: The patient is receiving multi-class polypharmacy. Review the patient's medication history for any unintended additional therapy and assess adherence to ensure efficacy. Complex drug regimens increase the risk of adverse effects, drug/drug interactions, and non-adherence, which may result in the relapse/recurrence of the disease state.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

<u>Util A</u>	<u>Util B</u>	<u>Util C (Inclusive)</u>
Antipsychotics	Mood Stabilizers	Benzodiazepines Stimulants

**Anticonvulsants and sympatholytic agents will be added to this group of criteria.*

References:

Facts & Comparisons, 2008 Updates.
 Kreyenbuhl JA, McCarthy JF, et al: Long-term Antipsychotic Polypharmacy in the VA Health System: Patient Characteristics and Treatment Patterns. *Psychiatric Services* 58:489-495, 2007.
 Kreyenbuhl JA, Marcus SC, West JC, et al: Adding or Switching Antipsychotic Medications in Treatment-Refractory Schizophrenia. *Psychiatr Serv.* 2007 Jul; 58(7):983-90.
 de las Cuevas C, Sanz EJ, Fuentye JA, et al: Polypharmacy in Psychiatric Patients as an Alternative to Limited Mental Health Resources. *Jrnl Clin Psychopharm.* 2005 Oct; 25(5):510-512.
 NASMHPD Medical Director's Technical Report on Psychiatric Polypharmacy. Oct. 2001
 Available at: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Polypharmacy.PDF

17. Polypharmacy / Therapeutic Duplication

_____ ✓ _____

Alert Message: The patient is receiving multi-class polypharmacy. Review the patient's medication history for any unintended additional therapy and assess adherence to ensure efficacy. Complex drug regimens increase the risk of adverse effects, drug/drug interactions, and non-adherence, which may result in the relapse/recurrence of the disease state.

Conflict Code: TA – Therapeutic Appropriateness
Drugs/Diseases

**Anticonvulsants and sympatholytic agents will be added to this group of criteria.*

<u>Util A</u>	<u>Util B</u>	<u>Util C (Inclusive)</u>
Antidepressants	Mood Stabilizers	Benzodiazepines Stimulants

References:

Facts & Comparisons, 2008 Updates.
 Kreyenbuhl JA, McCarthy JF, et al: Long-term Antipsychotic Polypharmacy in the VA Health System: Patient Characteristics and Treatment Patterns. *Psychiatric Services* 58:489-495, 2007.
 Kreyenbuhl JA, Marcus SC, West JC, et al: Adding or Switching Antipsychotic Medications in Treatment-Refractory Schizophrenia. *Psychiatr Serv.* 2007 Jul; 58(7):983-90.
 de las Cuevas C, Sanz EJ, Fuentye JA, et al: Polypharmacy in Psychiatric Patients as an Alternative to Limited Mental Health Resources. *Jrnl Clin Psychopharm.* 2005 Oct; 25(5):510-512.
 NASMHPD Medical Director's Technical Report on Psychiatric Polypharmacy. Oct. 2001
 Available at: http://www.nasmhpd.org/general_files/publications/med_directors_pubs/Polypharmacy.PDF

18. Glaucoma Medications / Nonadherence

_____ ✓ _____

Alert Message: Nonadherence to prescribed glaucoma/ocular hypertension treatment may result in sub-therapeutic effects and progression to blindness.

Conflict Code: LR – Nonadherence
Drug/Disease:

<u>Util A</u>		<u>Util B</u>	<u>Util C</u>
Brimonidine	Brinzolamide		
Apraclonidine	Latanoprost		
Dipivefrin	Travoprost		
Levobunolol	Bimatoprost		
Betaxolol	Dorzolamide		
Metipranolol	Echothiophate		
Carteolol	Pilocarpine		
Timolol	Carbachol		

References:

Nordstrom BL, Friedman DS, Mozaffari E, et al. Persistence and adherence with topical glaucoma therapy. *Am J Ophthalmol* 2005;140:598-606.
 Reardon G, Schwartz GF, Mozaffari E. Ocular hypotensive therapy in a managed care population. *Am J Ophthalmol* 2004;137:S3-S12.

Recommendations

Approved Approved Rejected
As
Amended

19. Etravirine / Nonadherence

_____ ✓ _____ _____

Alert Message: Nonadherence to antiretroviral therapy may result in insufficient plasma levels and partial suppression of viral load leading to the development of resistance, HIV progression, and increased mortality.

Conflict Code: LR – Nonadherence

Drug/Disease:

Util A Util B Util C
Etravirine

References:

Hoffman C, Mulcahy F, Goals and Principles of Therapy, Eradication, Cost, Prevention and Adherence. In: Hoffman C, Rockstroh J, Kamps BS, eds. HIV Medicine, Flying Publishers-Paris, Cagliari, Wuppertal, Sevilla, 2005:167-173.
Cheever LW, Chapter V: Adherence to HIV Therapies. A Guide to Clinical Care of Women with HIV/AIDS, 2005 Edition, HIV/AIDS Bureau, US Department of Health and Human Services.
<http://hab.hrsa.gov/publications/womencare05/WG05chap5.htm>

20. Etravirine / Protease Inhibitors

_____ _____ ✓ _____

Alert Message: Intelence (etravirine) should not be co-administered with protease inhibitors without low-dose ritonavir. Concurrent use of these agents without low-dose ritonavir may cause a significant alteration in the plasma concentrations of the protease inhibitor.

Conflict Code: DD – Drug/Drug Interactions

Drug/Disease:

Util A Util B Util C (Negating)
Etravirine Saquinavir Ritonavir
 Indinavir
 Nelfinavir
 Atazanavir
 Fosamprenavir

References:

Intelence Prescribing Information, Jan. 2008, Tibotec Therapeutics. Facts & Comparisons, 2008 Updates.

21. Etravirine / Tipranavir + Ritonavir

_____ _____ ✓ _____

Alert Message: Intelence (etravirine) should not be co-administered with ritonavir-boosted Aptivus (tipranavir). Concurrent use of these agents may cause a significant decrease in the plasma concentrations of etravirine and loss of therapeutic effect.

Conflict Code: DD – Drug/Drug Interactions

Drug/Disease:

Util A Util B Util C (Inclusive)
Etravirine Tipranavir Ritonavir

References:

Intelence Prescribing Information, Jan. 2008, Tibotec Therapeutics. Facts & Comparisons, 2008 Updates.

Recommendations

Approved Approved Rejected
As
Amended

22. Etravirine / Fosamprenavir + Ritonavir

_____ _____ _____✓_____

Alert Message: Intelence (etravirine) should not be co-administered with ritonavir-boosted Lexiva (fosamprenavir). Concurrent use of these agents may cause a significant increase in the systemic exposure to amprenavir.

Conflict Code: DD – Drug/Drug Interactions

Drug/Disease:

<u>Util A</u>	<u>Util B</u>	<u>Util C (Inclusive)</u>
Etravirine	Fosamprenavir	Ritonavir

References:

Intelence Prescribing Information, Jan. 2008, Tibotec Therapeutics.
Facts & Comparisons, 2008 Updates.

23. Etravirine / Atazanavir + Ritonavir

_____ _____ _____✓_____

Alert Message: Intelence (etravirine) should not be co-administered with ritonavir-boosted Reyataz (atazanavir). Concurrent use of these agents may cause a significant decrease in the plasma concentrations of atazanavir and loss of therapeutic effect. In addition, the systemic exposure of etravirine may be increased as much as 100%.

Conflict Code: DD – Drug/Drug Interactions

Drug/Disease:

<u>Util A</u>	<u>Util B</u>	<u>Util C (Inclusive)</u>
Etravirine	Atazanavir	Ritonavir

References:

Intelence Prescribing Information, Jan. 2008, Tibotec Therapeutics.
Facts & Comparisons, 2008 Updates.

24. NNRTIs / Dual Therapy

_____✓_____ _____ _____

Alert Message: The use of two non-nucleoside reverse transcriptase inhibitors (NNRTIs) is not recommended in any antiretroviral regimen. Patients in the 2NN clinical trial who received dual NNRTI containing regimens had a higher frequency of adverse events leading to treatment discontinuation. The concurrent use of NNRTIs may result in significant alterations in plasma concentrations leading to loss of therapeutic effect and/or adverse effects.

Conflict Code: TD – Duplication

Drug/Disease:

<u>Util A</u>	<u>Util B</u>	<u>Util C</u>
Etravirine		
Delavirdine		
Nevirapine		
Efavirenz		

References:

Intelence Prescribing Information, Jan. 2008, Tibotec Therapeutics.
Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents. Developed by the DHHS Panel on Antiretroviral Guidelines for Adults and Adolescents - A Working Group of the Office of AIDS Research Advisory Council. January 29, 2008.

The minutes of the July 23, 2008 DUR Board Meeting have been reviewed and approved as submitted.

Carol H. Steckel (✓) Approve () Deny 8/27/08
Carol H. Steckel, Commissioner Date

Kathy Hall (✓) Approve () Deny 8/21/08
Kathy Hall, Deputy Commissioner Date

Robert Moon, M.D. (✓) Approve () Deny 8/25/08
Robert Moon, M.D., Medical Director Date