Iowa Medicaid Pharmaceutical and Therapeutics Committee
Minutes

Date: September 11, 2008

Chair: Susan Purcell, R.Ph.

Time: 9:30 a.m. to 12:12 p.m.

Location: Capitol Room 116, Des Moines, Iowa

Committee Members Present: Bruce Alexander, R.Ph., Pharm.D., BCPP; Matthew Osterhaus, R.Ph; Carole A. Frier, D.O.; Priscilla Ruhe, M.D.; Susan Purcell, R.Ph, CGP; Hayley L. Harvey, DDS, MS; Dallas Sanders, PA-C; Mary Larew, M.D.; and Charles Wadle, D.O.

Iowa DHS Staff Present: Susan Parker, Pharm.D., Pharmacy Consultant; and Brad Horn, Assistant Attorney General.

Iowa Medicaid Enterprise (IME) Staff Present: Thomas Kline, D.O., Iowa Medicaid Medical Director; Tim Clifford, M.D.; John Grotton, R.Ph.; Sandy Pranger, R.Ph.; Erin Halverson, R.Ph.; and Melissa Biddle.

Chairperson Sue Purcell called the meeting to order.

I. Sue Purcell asked that each committee member, DHS staff, and IME staff introduce themselves to the public. The June 12th, 2008 open session minutes were reviewed. Bruce Alexander made the motion to approve the minutes. Matt Osterhaus seconded the motion. The motion passed with no objections.

II. Annual Elections: Dr. Frier nominated Sue Purcell to remain as chairperson, Bruce Alexander seconded, and the motion passed unanimously. Dr. Frier also nominated Matt Osterhaus to remain as vice-chairperson, Dr. Larew seconded, and this also passed with no objections.

III. Legislative Report – Diabetic Review: The Committee reviewed the draft of the letter regarding the diabetic PDL class that will be sent to the legislature by December 15th. Savings were summarized at an aggregate level to protect confidentiality. If the PDL had not been in effect from 2005 to 2007, the State would have spent an additional $1.9 million in state-fund expenses for diabetic drugs. In addition, Federal savings were almost twice this much. It was agreed a disclaimer would be added to explain that some denied PAs might later be approved. Susan Parker commented that a paragraph explaining appeal rights and the exception to policy process needed to be added. Bruce Alexander moved to accept the letter as written. The Committee agreed that no further changes or additions were needed. The final draft of the letter will be reviewed at the November meeting.

IV. PDL (Dr. Clifford): Dr. Clifford reviewed charts outlining Triptan users and generic drug rates. Despite the effects of supplemental rebates, generic utilization is at 66.3%. Dr. Clifford projected this percentage could be over 70% in 2009, with the addition of several

new generics onto the market. Some of the classes could be reconfigured to accentuate the generic utilization rate. The majority (69.2%) of migraine sufferers in the Iowa Medicaid population use only an oral triptan. However, 22.2% of people do take an oral triptan and NSAID concurrently. Bruce Alexander mentioned that the DUR Commission was currently doing a focus study involving triptan use. He suggested that the information included in the chart be cross-referenced with prophylactic use, also taking diagnosis data into account, and then subtracting out the hypertensive patients. Dr. Clifford will bring follow-up data to the next meeting.

V. PA Criteria/Pro-DUR Edits (Susan Parker): Susan Parker summarized Informational Letter 728, which listed PDL status changes following the last P&T meeting, as well as PA criteria changes including OxyContin. It is now non-preferred except for members being treated for cancer related pain. Sandy Pranger said that the letters sent to physicians in advance of this change have helped ease the transition. This informational letter also informed of PA criteria changes to extended release formulations and new ProDUR quantity limits. Informational Letter 724 outlined reimbursement rate changes to several Medicaid provider types. Susan Parker also mentioned the letter written from the P&T Committee to the DUR Commission, wherein the Commission was asked to consider placing quantity limits on Pristiq, as well as the DUR recommendation letter that stated the Commission had agreed to the limits.

VI. Drug Rebate Contract Issues: There are some particular brands that will, essentially, become free to the Medicaid program. Their CMS rebates are sometimes greater than the acquisition cost to the store, and in some cases, even exceed the average wholesale price. Examples will be mentioned in the confidential session. Iowa has a 40% drug rebate return with its PDL, while the national average for all Medicaid programs is only 26%.

VII. Discussion of Drugs Prescribed for Mental Illness: The Committee discussed Iowa Code 249A.20A, which addresses how to deal with the recommended drugs, stating: "*With the exception of drugs prescribed for the treatment of human immunodeficiency virus or acquired immune deficiency syndrome, transplantation, or cancer and drugs prescribed for mental illness with the exception of drugs and drug compounds that do not have a significant variation in a therapeutic profile or side effect profile within a therapeutic class, prescribing and dispensing of prescription drugs not included on the preferred drug list shall be subject to prior authorization*". Dr. Clifford listed some drugs that could be up for possible PDL status changes: Seroquel, Seroquel XR, Luvox, Luvox CR, Equatro, carbamazapine, Tegretol, Paxil, Paxil CR, Vyvanse, amphetamine, Lexapro, citalopram, Pristiq, venlafaxine, Effexor XR, Concerta, methylphenidate, and methylphenidate ER. When dealing with any product that is an extended release form, an isomer, or a metabolite, of a drug, such as Pristiq, he proposed the following process: 1) after reviewing the evidence and looking at the literature, the committee goes ahead and takes a vote to say if there is a clinically significant difference between this product and other products in its therapeutic profile; 2) potentially take a second vote depending on the outcome of the first, to say it there's a clinically significant difference that's being offered in terms of the side effect profile; and 3) depending on the results of the previous 2 votes, then decide whether or not to place the drug on the PDL or not. This way, the committee could objectively go through any prospective PDL drug profile before making any vote for its placement on the PDL or

RDL. The pertinent information could be included in the drug abstracts so the committee could make an educated decision. Sue Purcell asked if the committee would be discussing these drugs at the November meeting. Dr. Clifford replied that if it was acceptable to the committee, he would like to take the mental health drug examples, try to create new abstracts of them, and specifically deal with those at the meeting. Sue Purcell agrees this needs to be done. Dallas Sanders asked Dr. Wadle his opinion; he concurs that the mental health field should be treated equally to all other medical fields in terms of the PDL. Bruce Alexander said that the Mental Health Sub-Committee had partnered with the Iowa Psychiatric Association to deal with some of these issues. He believes this would be another good topic for conversation for them. Dr. Clifford also proposed, for the sake of making the PDL easier to understand, that if there are drugs that offer significant clinical advantages, even though pricing is not ideal, that the committee go ahead and make them preferred and try to get rid of the other dichotomy with the RDL. Sue Purcell noted that this would probably extend the length of the meetings. She asked whether the November meeting would need a 2-day block of time. Dr. Clifford suggested taking a look at several of the key drugs only, to iron out the process. These would go through the Mental Health Sub-committee first. He thinks they should begin by reviewing the top 4 or 5 drugs. Susan Parker was unsure if this could go to the Mental Health Sub-committee prior to the November P&T meeting. She asked them to clarify their wishes for this process. Did they want these drugs to be reviewed by the sub-committee first, and then the P&T committee, or did they prefer to assess the drugs and provide a recommendation to the sub-committee? Chuck Wadle responded that very soon notification would need to be sent to the parties involved of what the P&T committee is doing, and it could go either way. If they meet and have recommendations before the next P&T meeting, that would be fine. Alternatively, if they are unable to discuss this topic before the November P&T meeting, the P&T committee could provide recommendations that would then be reviewed by the sub-committee. Susan Parker responded that it would depend on whether it would fit into the sub-committee agenda for September 26th. She said that anything that came out of this meeting would definitely be shared with the DUR commission and the Mental Health Sub-Committee as well, as this discussion is running concurrently in all committees, from different perspectives, but with similar endpoints. Chuck Wadle said that if the Mental Health Sub-committee had some insight into which 5 drugs might be chosen before the 26th, then they could be discussed at that time.

VIII. The public speakers were:

SPEAKER	SUBJECT
Andrew Zalski from Pfizer, Inc.	Selzentry
Jim Wilson from GlaxoSmithKline	Requip & Treximet

At 11:11, motion to go to closed session was made by Dr. Hayley Harvey and seconded by Matt Osterhaus. The motion passed with unanimous approval (with the exception of Dr. Mary Larew who was out of the room at the time). Open session resumed at 11:56 pm.

IX. PDL Discussion and Deliberation (Dr. Clifford): It was recommended that Amphotericin B change to preferred on the PDL, and Fungizone would be removed since it has been discontinued by the manufacturer. Danocrine, Desquam-E Gel, Prolixin, and Prolixin

Deconate have also been discontinued, and will thus be removed from the PDL. It was also recommended to change the status of Subutex to non-preferred on the PDL per recommendation from the DUR Commission. Treximet was recommended to remain non-preferred on the PDL; however, utilization data will be reviewed further at the November meeting. Dr. Priscilla Ruhe motioned to accept these recommendations. Dallas Sanders seconded, and the motion passed unanimously.

X. Newly Released Drugs (Dr. Kline): Patanase was recommended to be non-preferred on the PDL. To date, no comparative efficacy trials have been conducted. Other antihistamines, which are selective H_1 Receptor antagonists, appear on the Preferred Drug List which are more cost effective, and treat a wider variety of seasonal allergy symptoms. Additionally, some of the oral alternatives are approved for use in patients as young as six months of age. Pylera was also recommended to be non-preferred. There is currently a preferred combination product on the Preferred Drug List used for *H. pylori* that contains a PPI making it more cost effective than Pylera™, since patients using Pylera™ would also have to fill a prescription for a PPI. Selzentry was recommended to be as non-recommended. It is not recommended to be used as first line therapy. It also represents a more costly choice than other anti-retrovirals. To begin with, the drug itself is more expensive than other alternatives in the class. However, the cost differential is compounded even more by the required laboratory testing, as well as the fact that it is recommended to be taken at high dosages in combination with certain other HIV medications. Dr. Frier asked that it be noted that this was non-recommended to protect patients with inexperienced doctors and also from complications of the drug when combined with other drugs that should not be used at the same time. This notation is to assure everyone that this is not primarily a financial decision. Dallas Sanders motioned to accept these recommendations. Dr. Chuck Wadle seconded, and the motioned passed with no objections or abstentions.

XI. Newly Released Generics and New Dosage Forms (Dr. Clifford): Acarbose was recommended to be non-preferred, as the brand is also non-preferred. Divalproex Sodium EC was recommended to be non-preferred, pending SMAC pricing. Paroxetine ER was recommended to be non-preferred, but its status will be re-evaluated at the November meeting. Risperidone was recommended to be non-preferred due to its cost. Risperdal status was recommended to change to preferred. Ropinirole was recommended to become preferred and Requip would become non-preferred. Zaleplon was recommended to be non-preferred with conditions; this is the same status as the brand name Sonata. Lipofen was recommended to be non-preferred. Prezista 600mg was recommended to be recommended. Requip XL and Voltaren Gel were both recommended to be non-preferred. Matt Osterhaus motioned to accept these recommendations. Bruce Alexander seconded, and the motioned passed with no objections or abstentions.

A motion was made by Bruce Alexander to adjourn the meeting. Dr. Hayley Harvey seconded the motion. All in attendance approved. The meeting adjourned at 12:12 p.m. The next scheduled meeting will be November 13, 2008 in Capitol Room 116.