State and Public School Life and Health Insurance Board
Clinical and Fiscal Drug Utilization and Evaluation Committee

Minutes

August 6, 2007 – 1:00 p.m.

The State and Public Life and Health Insurance Board, Joint Clinical and Fiscal Drug Utilization and Evaluation Committee met on Monday, August 6, 2007 at 1:00 p.m., in the EBD Board Room, 501 Woodlane, Little Rock, AR.

Members present:	**Members absent:**
Dr. William Golden	Dr. Joe Stallings
Dr. Roberta Monson	Robert Watson
Mark McGrew	Dr. Hank Simmons
Matthew Hadley	Dr. James Bethea
Kat Neill	
Larry Dickerson	

Sharon Dickerson, Executive Director, Employee Benefits Division of DFA

Others Present

Barry Fielder, NMHC; Jill Johnson, UAMS; Walt Morrison, College of Pharmacy/EBD; Jason Lee, Connie Diggs, Shannon Roberts, George Platt, Cathy Harris, EBD; Bryan Meldrum, NovaSys; Mark Helm, UAMS; Aaron Walker, Schering-Plough; Kristi Clark, ABA; Addie Bundy, Nancy Mikhail, Bryan Person,

Call to Order

Meeting was called to order by Dr. Golden. Dr. Monson joined the meeting via-teleconference.

Approval of Minutes

The request was made by Dr. Golden to approve the minutes of the prior meeting. Minutes were approved without objection.

Plan Performance Update *by Barry Fielder*

The Committee reviewed a report of the trend analysis of the Plan over the last three years. Fielder talked about the key parameters used for tracking (PMPM, average Rx cost, average member paid and Rx PMPM). Fielder explained that the "average member paid" is down because of an increase in generic rate which has a lower copayment. The "Average Rx cost "has remained relatively flat therefore the "PMPM" cost is tracking along with utilization.

The Committee also reviewed a graph of the generic dispensing rate trend for the State of Arkansas over the last 11 quarters. Fielder said it is continuing to rise because a lot of high profile drugs have become available generically over the last couple of years and the utilization is good. There is a 14% increase from the 4thQ of 2004 to 2ndQ of 2007 in

the generic rate. Fielder said it is important to give DUEC an update because they have an impact in controlling cost.

The Committee also reviewed a comparison of the top therapeutic category for January - June 2006 vs. January - June of 2007. Fielder reported that the PMPM cost is down in a number of categories. The two categories that are up and highly utilized are Antidiabetic and Antiasthmatic.

Dr. Golden commented that the data is often contaminated by people with COPD because COPD is sometimes coded as Asthma. The guidelines for the use of inhaled steroids in COPD are not the strongest and are for only severe cases. Dr. Golden suggested that Fielder look at the Retiree group that use asthma drugs because there maybe some potential for better formulary or disease management.

Fielder presented another graph which illustrated the breakdown of the membership prescriptions, the total plan paid amount and the per-member-per-month (PMPM) cost by groups. The PMPM cost for the ASE actives and PSE actives is very similar (less than $1 difference). The two groups account for 87% of the membership but 77% of the total plan paid. The ASE ARHealth group accounts for 8% of the total membership but 18% of the total plan paid amount. This equates to a PMPM cost for this group of over $145 dollars.

Dickerson reminded the Committee that the Plan does not provide pharmacy benefit for the PSE Retirees over the age of 65.

Fertility Medication Review *by Jill Johnson/Barry Fielder*

Johnson reported on a request that was made in the last DUEC meeting, whereupon, individuals had concerns that some of the fertility drugs that have different indications are being used for infertility. Johnson said there was not a lot of utilization of the infertility drugs; therefore it is not an issue.

Dickerson said that was good to know because treatment for infertility is not a covered benefit therefore they did not want to cover it on the pharmacy side either.

Xolair *by Jill Johnson/Barry Fielder*

Johnson told the Committee that Xolair is a subcutaneous injection for allergic asthma. It is indicated as add on therapy for moderate to severe symptoms of persistent asthmatics that can not be controlled on inhaled steroids and optimal therapy but is not meant as a substitution.

Johnson reported that there are 28 members on Xolair and in reviewing the medication history of the 28 utilizing members for January 2007 through June 2007, it was noted that 11 of the 28 showed inconsistent or no evidence of concurrent inhaled corticosteroid use. Johnson said she also reviewed a report about the member's medical claims and there were several that did not have a diagnosis of asthma but a diagnosis of allergic rhinitis. Johnson said it appears that people are using the drug for allergic rhinitis.

Johnson said the existing prior authorization (PA) criteria are a little tough for the call center pharmacist to follow. Johnson said she wanted to provide a better guideline and had the following recommendation.

Recommendation: Xolair® (omalizumab) PA Criteria

1. Is the patient 12 years of age or older?
   If yes, go on to next question. If no, stop and deny coverage.

2. Does the patient have a diagnosis of moderate or severe persistent asthma with either a positive skin test or with in vitro reactivity to a perennial aeroallergen?
   If yes, go on to next question. If no, stop and deny coverage.

3. Has the patient been prescribed and had filled inhaled corticosteroids for a minimum of the past 3 of 4 months prior to this request or has the patient been determined to be dependent on systemic steroids to prevent serious asthma exacerbations?
   If yes, go on to next question. If no, stop and deny coverage.

4. Has the patient been in the ER or hospitalized, due to an asthma exacerbation, twice in the past 6 months? List the place and dates of ER visits or hospitalizations:
   If yes, go on to next question. If no, stop and deny coverage.

    - If approved for coverage, PA is good for 3 months. Re-authorization for a PA will require the patient to be compliant with optimal asthma drug therapy as per the current NHLBI Asthma guidelines.

Mark Helm, UAMS College of Pharmacy talked about the Medicaid guidelines for Xolair.

The Committee conducted an in-depth discussion about compliance and adds on therapy.

Dr. Golden restated the motion. Motion approved without objection.

Oral Antifungal Agents Review: *by Jill Johnson/Barry Fielder*
Fielder recommended the Committee place a PA criteria on oral antifungal agents prescribed for diagnosis of onychomycosis. Fielder said they want to control cosmetic usage.

Drug Name
Lamisil 250mg tab*
Itraconazole 100mg cap
Sporanox 100mg cap
* Generic Lamisil (terbinafine) tablets just became available in early July 2007

Recommendation: Proposed PA Criteria for diagnosis of onychomycosis

1. Is patient immunocompromised?
2. Does patient have diabetes?
3. Is patient's disease severe enough to cause significant pain that limits normal activities of daily living or interference with work?
4. Does the patient experience repeat ingrown toenails requiring surgery?
5. Site of infection? Fingernails or Toenails
6. Infection Documented by: Positive KOH test or other lab test?

Neill suggested they include the steps for progression in the PA Criteria for diagnosis of onychomycosis, similar to those in the PA Criteria for Xolair. Johnson said she would make the changes to the format.

The Motion was approved without objections.

Narcotic Analgesic Review *by Jill Johnson/Barry Fielder*

Fielder talked about dosing guidelines and proposed the following quantity limits for the Committee's consideration.

Kadian (morphine sulfate extended release capsules) – product available in 20mg, 30mg, 50mg, 60mg, 80mg, 100mg, and 200mg capsules. Kadian is dosed either once or twice daily. **Recommend quantity limits of 2/ day.**

Avinza (morphine sulfate extended release capsules) – product available in 30mg, 60mg, 90mg, and 120mg capsules. Avinza is dosed once daily. **Recommend quantity limits of 1/day.**

Opana ER (oxymorphone extended-release tablets) – product available in 5mg, 10mg, 20mg, and 40mg tablets. Opana ER is generally dosed every 12 hours. **Recommend quantity limits of 2/day.**

OxyContin (oxycodone extended-release tabs) – product available in 10mg, 20mg, 40mg and 80mg tablets. OxyContin is generally dosed every 12 hours. **Recommend quantity limits of 3/day.**

MS Contin (morphine sulfate controlled-release tablets) – product available in 15mg, 30mg, 60mg, and 100mg tablets. MS Contin is generally dosed 2-3 times per day. **Recommend quantity limits of 3/day.**

The Committee conducted an in-depth discussion about dosage guidelines and quantity limits.

Dr. Golden said he is in favor of quantity limits then requested that Fielder provide distribution numbers and check to see if any members are on more than one Narcotic drug.

The Committee agreed to table the discussion pending more data.

Byetta *by Jill Johnson/Barry Fielder*

Byetta is indicated as adjunctive therapy to improve glycemic control in patients with type 2 diabetes mellitus who are taking metformin, a sulfonylurea, a thiazolidinedione, a combination of metformin and a sulfonylurea, or a combination of metformin and a thiazolidinedione, but have not achieved adequate glycemic control.

Fielder said there was an increase in the utilization of Byetta in the most recent six months period in comparison to last year for antidiabetics. Fielder explained that weight loss associated with Byetta appears to have created a market for patients without diabetes. Numerous reports have demonstrated that the use of Byetta for weight loss in non-diabetic patients is occurring. Fielder reported that 48 out of the 350 utilizing members from January through June 2007 time period were noted to have no concurrent use of any oral antidiabetic agent.

Recommendation – Contingent edit requiring presence of a sulfonylurea, thiazolidinedione, metformin, or any combination of these products over a period of 120 days to ensure use in diabetic patients before Byetta claim are paid.

The Committee conducted an in-depth discussion. Dr. Golden clarified that at this time monotherapy is prohibited with Byetta.

The Motion approved without objections.

Provigil Review *by Jill Johnson/Barry Fielder*

Provigil is indicated to improve wakefulness in patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea/hypopnea syndrome, and shift work sleep disorder.

Fielder explained that the recommended dose of Provigil is 200 mg given once a day. Doses up to 400 mg/day, given as a single dose, have been well tolerated, but there is no consistent evidence that this dose confers additional benefit beyond that of the 200 mg dose.

Recommendation – Considering the significant use of doses > 200mg per day, it is recommended that a quantity limit of 1/ day be placed on both the 100mg and 200mg strengths of Provigil. The 200mg strength is approximately 43% more expensive than the 100mg strength therefore one 200mg tablet is less costly to the plan than two of the 100mg tablets.

Johnson and Neill discussed Adult ADHD disorder and the recommended dosages. Neil said she has seen dosage for 100mg to 300mg for adult ADHD patients. Johnson said she could not find any information on exceeded dosage for Provigil usage.

Dickerson suggested they look at the claims to determine if they have a history of any other diagnosis and that they could also place a cap on the drug. Hadley said he agreed and 400mg is a reasonable cap.

Neill said she has no problem with holding the dosage at 200mg per day and if the member is denied because they do not meet the PA criteria and is an off label indication, it can be handle as a separate issue.

The motion approved without objections.

New Drugs *by Jill Johnson*

Johnson introduced the New Drugs for April, May and June 2007

Drug	Generic Name
Janumet 50/1000 & 50/500	T3
Soliris INJ 300mg vial	T2/PA
Altabax Ointment 1%	T3
Veramyst spray	Excluded
Vyvanse 30mg, 50mg, 70mg	T3
Elestrin Gel	T3
Symbicort Aerosol 160/4.5 & 80/4.5	T3

Supprelin LA Kit	T3/PA
Lybrel tabs	T2
Letairis tablets 5mg & 10mg	T3
Divigel Gel	T3

Committee agreed to review Vyvanse in 6 mos. The motion approved without objections.

Other Business:

Dr. Golden told the Committee about the remarks made by the Board about Simvastatin w/no copays.

Adjournment:

Dr. Golden moved to adjourn the meeting. The motion was approved without objection. The meeting adjourned at 2:10 pm.