State and Public School Life and Health Insurance Board Clinical and Fiscal Drug Utilization and Evaluation Committee
Minutes
July 6, 2009

The State and Public Life and Health Insurance Board, Drug Utilization and Evaluation Committee (DUEC) met on Monday, July 6, 2009 at 1:00p.m., in the EBD Board Room, 501 Woodlane, Little Rock, AR.

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

Jason Lee, Executive Director, Employee Benefits Division of DFA.

OTHERS PRESENT
Barry Fielder, NMHC; Jill Johnson, Mark Helm, Clay Patrick, UAMS College of Pharmacy/EBRx; George Platt, Leigh Ann Chrouch, Sherri Saxby, Stella Greene, Shannon Roberts, Donna Cook, Sherry Bryant, Cathy Harris, EBD; Bryan Meldrum, Novasys; Barbara Melugin, Health Advantage; Shonda Rocke, Informed Rx; Ronda Walthall, Wayne Whitley, AHTD; Dwight Davis

CALL TO ORDER
Meeting was called to order by Dr. Golden.

APPROVAL OF MINUTES
The motion was made by Dr Golden to approve the March 30, 2009 minutes. Minutes were approved by consensus.

PRISTIQ PRESENTATION *by Wyeth Pharmaceuticals*
Pristiq was excluded from the prescription drug program effective July 1, 2008. Pristiq is an antidepressant in the selective serotonin & norepinephrine reuptake inhibitor (SNRI) class. The committee agreed to review the drug in the future to determine if any new data is available that might warrant a change in coverage status.

Liza Takiya with Wyeth Pharmaceutical presented the committee with a clinical overview conducted by Wyeth research. Takiya conducted a 10 minute presentation about Pristiq.

Takiya answered questions from the committee members.

No action was taken by the committee.

SKELETAL MUSCLE RELAXANTS *by Barry Fielder & Jill Johnson*
Johnson provided the committee with data for skeletal muscle relaxant which included information about the drug names, utilization numbers, quantity and plan cost. Johnson said at some point the idea came up to potentially reference price all the muscle relaxants. Skelaxin (Metaxalone) is the highest price one and its brand only but most of the utilization is for Cyclobenzaprine.

Johnson said there is not a lot of comparative data available and then Johnson referred to the reference material. Johnson said it is the only comparative data she was able to find and so it is hard to make a case to reference price when there is not good data. Johnson said currently Skelaxin is covered at tier 2 with no known advantage but it has not been compared head to head in observational studies.

The committee reviewed the data and discussed.

Dr. Golden suggested they move the drug to tier 3 to preserve access. Dr. Golden said there are multiple generic alternatives.

Simmons made the motion to move to tier 3. Dickerson seconded. All were in favor. Motion carried.

Dr. Golden said the committee may want to consider reviewing the drug Carisoprodol in the future. Dr. Golden said it is a popular drug but it has some safety issues compared to the others.

Neill referenced the utilization numbers for brand name Flexeril. Neill commented that there is a well proven alternative generic product that has been out there for a long time. Neill said this may be one of the situations where they should consider having a brand penalty.

Johnson explained the members can opt for skips and more latitude because the plan doesn't have a mandatory generic policy. Johnson said she would be in favor of a "brand penalty" because the margin of difference of expense is so great for a really old drug for which the generic has been in the market place forever.

Fielder suggested the Benefits Subcommittee should review" brand penalty" policy because it is a benefit plan design issue.

Dr. Golden suggested he bring the issue to the Board and explain to them that there are concerns with the continued use of brand with available generic.

Neill suggested they give the Board some specific examples and include the reference pricing decisions made by the DUEC in the past regarding generic and brand product.

Lee said he would like a fully well defined tier with an aggressive coinsurance or maximum cost that the plan is willing to pay for the drug so that they can at a later point move Flexeril and other drugs into that define tier rather than saying tier 4 is just a network discount.

The DUEC agreed by consensus that Dr. Golden will bring the issue to the Board and provide some examples.

INFLAMMATORY BOWEL AGENTS *by Barry Fielder & Jill Johnson*
Johnson explained the Inflammatory Bowel issue came up because several new drugs made of Mesalamine have come in as new drug. Johnson said Apriso was tabled at the last DUEC meeting and so they want to revisit the issue. There is a $15 dollar difference in price for sulfasalazine vs. all of the mesalamine products.

The DUEC viewed a list of Inflammatory Bowel Agents from March 1, 2009 - May 1, 2009, the utilization numbers and the plan cost associated with them.

Johnson presented references from studies and then talked about a proposed step therapy. Should we require the patients to have a sulfur allergy in order to go to Mesalamine first line? Should everyone be required to try sulfasalazine if they don't have an allergy?

A discussion ensued.

The committee agreed by consensus to put together a proposed policy / PA and send out to GI Community to sees what responses they receive.

NEW DRUGS *by Jill Johnson*

Drug	**Tier**
Vectical Ointment	T3
Vimpat tabs	T3 w/PA -Revisit upon request
Loseasonique	T3 / Review reference price option in future
Inova Kit	Exclude
Afinitor	T3 w/PA
Savella	T3 w/ QL of 100m
Nuvigil	T2 w/QL. 250mg
Simponi Inj	T3 w/PA

Coartem Tab	Tabled
Exforge HCT	T3
Asacol HD	Tabled /Consult with GI Doctors
Lamictal ODT kit and tab	Exclude / Monitor feedback from providers and members
Besivance Susp.	Exclude
Momexin Kit	Exclude
Samsca Tab	Tabled / Pending more information
Ulesfia Lotion	Exclude
BenzaClin Kit Care	Exclude
Cetraxal Sol	Exclude
Lamictal XR Kit and tab	Exclude / Monitor feedback from providers and members
Salvax Duo Kit	Exclude

MEDICATION MANAGEMENT PROGRAM (CINRYZE) *by Jason Lee*
Lee explained the drug Cinryze was presented in the last DUEC meeting. The recommendation was to place it in T3 w/PA but the issue was tabled.

Lee informed the committee that EBD has an in-house health services team staffed with nurses and they would like to create a medication management program for the members that are on certain medications after the prescription is filled. Lee said the plan does not have anything in place to help the member and they would like to be able to create a program to address some of the "after the prescription" issues.

Lee said he would like to add one more step to the previous recommendation to place the drug Cinryze in T3 w/PA. Lee presented the DUEC members with a proposal of the Medication Management Program.

Recommendation: In addition to the previous recommendation; Cinryze is only available if the member participates in the in our in-house nurse managed health enhancement program..

Lee said this will give them the opportunity to be involved in the members care and give them the opportunity to intervene if the drug is not being prescribed or administered in the right way. Lee said this will give them the ability to stay involved and if the medical condition worsens they can go into more aggressive case management and ensure that the other physicians and specialists are being consulted.

Lee said it is a step that they have never taken before but that it is important for them to make plans to stay involved. Lee said they really don't have any other way to encourage the member to be involved in the management program and this is an aggressive way to manage the incredibly expensive cost for this drug and will also give them the opportunity to have a management program in place for the other more expensive drug that will come down to the pipe line under the speciality heading as well.

Hadley said it is a good idea and then informed the committee that they are doing something similar with the UAMS system. Hadley said they have nurses that follow some of the speciality drugs to make sure patients understand how to use them appropriately and that there is no waste. Hadley said he believes it is the coming thing because they are going to see more and more expensive speciality drugs so they are going to have to look for some assistance to help make sure they are used effectively.

Dr. Golden said his only concern is that 80% of the issue is how to structure the coverage for Cinryze as opposed to the patient compliance. Dr. Golden said there is still a huge conundrum about when the drug is indicated and so the program probably won't' make a big difference.

Lee explained that this drug would have been automatically covered until the Board approved the coverage policy for new drugs in April 2009 and then explained how the medication management process differs from the current case management program. Lee said they will not have a role in how to manage the drug and the case nurses will not have the authority to effect the change in therapy. Lee said they want to give the member some additional resources because right they don't have any ongoing clinical resources for the member

Dr. Golden said he is currently dealing with Cinryze on the Medicaid program and the literature is just abysmal. Dr. Golden said there is really no clear understanding as to when the drug is appropriate.

Johnson said that the prior authorization (PA) process is similar to what Lee is proposing. The PA would just need to be shortened and the protocol written in a way that the pharmacist at EBrx would be able to tell if the criteria are being met.

Neill said a PA may be more cost effective than an individualize strategy. Neill said a lot of time specialty type products are required through specialty pharmacies and so there is the possibility that the criteria the plan has are not necessarily the same or may overlap with a specialty pharmacy protocol. Neill said it could get very confusing for the member.

Dr. Stallings said the doctor and the patient relationship is the way it usually works. The case manager is really just managing their cost under the guise of doing something different. Stallings talked about health conditions for which the correct specialist may not be available in the rural areas and so the member's primary care doctor may oversee the management of the problem and the medication as time goes on. Stallings committed that some time people use speciality drugs for other non indicated additions and maybe they have success.

Dr. Golden and Dr. Stallings discussed the cost for Cinryze. Dr. Golden said at some point you want to have a master plan for managing the drug regardless of the specialty of the physician taking care of the patient.

Dr. Stallings said he is not sure that a case manger is going to have the expertise to be able to say that this is the right thing to do or the wrong thing to do. Stallings said it may be that a physician may need some academic education or credentialing or some kind of academic detailing; something that would be beneficial or just to limit.

Simmons said he has been involved in a number of cases with immune modulators and there are times when the decisions are not straight forward. Simmons said he would appreciate anything the plan can do to make decisions more straight forward and more data based.

Hadley suggested Lee check with other drug plan to get an idea of how they are dealing with this particular medication.

The committee continued to discuss.

No action was taken by the committee.

Lee will present a skeleton of the medical management program at the next meeting.

OLD BUSINESS *by Jason Lee*
The DUEC reviewed previously excluded drugs; Vyvanse and Toviaz.

No action taken by the committee

Meeting adjourned.