KENNY C. GUINN
Governor

STATE OF NEVADA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID

MICHAEL J. WILLDEN
Director

CHARLES DUARTE
Administrator

Nevada Medicaid
Drug Use Review (DUR) Board Meeting

Location of Meeting
401 South Carson Street Room 3137
Carson City, NV

Videoconferencing
555 E. Washington, Room V4412
Las Vegas, NV

MINUTES OF
June 24, 2004
1:00pm

Committee Members Carson City
David England, Chairman
Amy Schwartz
Keith Macdonald
Dr. Johnson-Called in at 2:20pm
Dr. Parker-Called in at 2:20pm
Lori Winchell-Called in at 2:20pm

Absent:
Dr. Uhalde

Others Present:
Carson City:
Coleen Lawrence DHCFP, Jeff Monaghan, FHSC, Dawn Daly FHSC, Joe Tyler Advisory Committee, Bert Jones GSK, Marv Orrck GSK, Jesse Deaver Aventis, Steve Schaereer AZ, James Driver AZ, Reta Harris MD NV Psychiatric Association, Jean Cromin AZ, Sheri Doss Janssen, Darrel Smith Janssen, Patty Hescock Janssen, Tracy Davies Lilly, Mark Arondering MD NV Psychiatric Association, Slater Sparks Mylan-Bertek, Tiger Pope DHCFP, Alan Slaon Purdue, Jeanette Belz NV Psychiatric Association

Las Vegas:
Jamie Wyels FHSC, Carla Sloan Advisory Board, C. Stiles BMS, Joe Duarte Cephalon, MaryAnne Phillips M.D., Charlie Speranos Novartis, Claire Boutin NAMI, Maurice Boutin NAMI, Duar Darsheid GSK

I. Call to Order and Roll Call
David England called the meeting to order at 2:00pm. Roll call was taken. Since they were waiting for other members to call in Dr. England went to item IV.

II. Discussion and Approval of March 18th Minutes
Keith Macdonald asked about the step therapy discussion from the previous meeting. Coleen Lawrence stated that DHCFP did not facilitate a meeting to discuss this as DHCFP is waiting for an official opinion from the deputy attorney general based on language contained in AB384. Dr. Parker asked if there were any decisions the committee can act upon. Ms. Lawrence stated the committee does have the authority to make decisions regarding drug usage criteria but decisions on drugs excluded from the PDL based on AB384 are on hold until the AG's office renders an opinion.

Motion: Dr. Johnson motioned to accept the minutes.
Seconded: Lori Winchell
Votes: Unanimous
Motion carried.

III. Clinical Edits Discussion & Recommendations

A. Standard Preferred Drug List (PDL) Exception Criteria

Dr. Monaghan gave an overview of the criteria. Ms. Winchell asked about the rationale for the criteria. Dr. Monaghan stated the proposal will form the basis for gaining access to non-preferred drugs. Ms. Winchell asked where the criteria originated. Dr. Monaghan stated the criteria are based on PDL criteria used in successfully in other states. . Mr. Macdonald asked how the criteria would be applied. Dr. Monaghan explained if a recipient needed a non-preferred drug the provider would call First Health Services clinical call center and get authorization. The maximum time the process would take would be 24 hours. The pharmacist would also have the option of supplying the patient with a 72- hour emergency supply.

Motion: Dr. Macdonald motioned to accept the criteria.
Second: Dr. Schwartz
Vote: Unanimous
Motion carried

B. New or Updated Clinical Edits for Specific Drugs or Therapeutic Classes

1. Oncychomycosis Antifungals

Dr. Monaghan stated this issue was referred to the DUR board from the Pharmacy and Therapeutics committee. Dr. Parker asked if pain was a prerequisite in all cases. . Dr. Monaghan stated this portion of the edit could be modified.

Dr. Parker stated he wanted the same criteria for Lamisil® and Sporanox®. Keith Macdonald asked how another course of therapy could be provided. Dr. Monaghan stated the prescriber could request a continuation of therapy.

Public Comment:
None

Motion: Dr. Parker moved to accept the criteria with the modification that the criteria be the same for Lamisil® and Sporanox®.
Seconded: Ms. Winchell
Vote: Unanimous
Motion carried

2. Duragesic Patches

Dr. Monaghan gave an overview of the criteria. Ms. Winchell stated certain drug rehab programs such as Choices require the use of Duragesic® versus the oral agents. She stated this was based on abuse potential. Dr. Parker asked about pain management doctors who use two long-acting narcotics. Dr. England stated that in his practice setting prescribers ordering two long-acting narcotics are contacted and questioned. . He stated with two long-acting narcotics on board it is difficult to manage the patient's and adjust the medications. Dr. England asked Mr. Macdonald if the Narcotic Task Force was seeing any problems with this issue. Mr. Macdonald responded yes, and there were many cases. He advocated incorporating language to address this in the

criteria. If a patient is in a rehab program requiring the use of a Durgesic patch, there could be an exception granted. Ms. Winchell accepted this alternative.

Public Comment:
Shari Dodd, Janssen. She stated oxycontin is second highest in terms of overall drug expense. She stated Nevada is one of only two states that has restrictions on Duragesic. She requested to have the criteria standardized for all long-acting
narcotics. Dr. Monaghan stated failure on or inability to tolerate oral narcotics constitute the current restrictions on Duragesic.

Motion: Dr. Johnson motioned to accept the criteria as written
Seconded: Ms. Winchell
Vote: Unanimous
Motion carried.

3. Altace

Dr. Monaghan gave an overview of the criteria. Dr. England stated if you are treating run-of-the-mill hypertension, Altace® would not be your first choice. If these criteria are met, then Altace® would be indicated.

Public Comment: None
Motion: Dr. Johnson motioned to accept the criteria as written.
Seconded: Keith Macdonald
Vote: Unanimous
Motion carried

4. Oxycontin

Dr. Monaghan gave an overview of the criteria. Dr. England stated that although there is no dosage ceiling, similar to morphine, we are seeing escalating doses with no rhyme or reason. He stated there is a true concern as to whether this is pain management or potential abuse and/or dependency. Dr. Johnson stated he felt the comments were timely and wise. Keith Macdonald described a case where a recipient received the following on March 12, 2004: 960ml of oxycodone liquid (20mg/ml), 10 fentanyl patches, 480 morphine sulfate 30mg, and 1080 Oxycontin® 80mg tablets (2800mg/day). His recommendation after talking with pain management prescribers would be that Oxycontin could be dosed three times a day. Dr. England stated he has seen it ordered every 6 hours and every six hours as needed and has called the prescriber. He stated unless the patient has GI hyper mobility this is a real concern. Dr. England stated as needed dosing is irrational. Dr. Johnson states he does not have the experience with this but asked it the patient was selling it. Mr. Macdonald responded that all he had was the data and asked if it was reasonable to assume Medicaid had some process to investigate this. He stated he would like to know the procedure when cases like this occur. Ms. Winchell asked it they were writing letters to these providers.

Ms. Lawrence stated there are multiple avenues available. One is to look at the provider trends and turn suspicious cases over to SURS for investigation. The DUR board also has the authority to send letters to the providers and implement physician profiling. The recipient lock-in program is another option. Dr. Johnson stated he liked that option. Dr. England stated although the letters are sent out, there is no requirement that provider's respond to the letter. Ms. Winchell stated it is the committee's responsibility to educate the provider and refer the

suspicious cases over for others to investigate. Mr. Macdonald stated the Controlled Substance Task Force has hired an intervention officer to contact patients that appear to be doctor-hopping. The case he stated earlier was one provider and one pharmacy and the officer would probably not intervene. The case, however, is certainly questionable. . The intervention officer is located in Clark county. Ms. Lawrence stated there is a draft of the lock-in policy and she will bring that back to the committee at the next meeting. This would involve no cost.

Dr. England asked about the process for having cases investigated. Ms. Winchell again stated she thought it was the DUR Board's job to educate and refer the suspicious cases to others for investigation. Ms. Lawrence stated there was a SURS unit within Medicaid that looks into fraud and abuse by providers. Dr. England stated that once the criteria were in place and the education piece was done, they would like to see the enforcement piece occur. Dr. Parker stated the process could take over one year before anything was done. Ms. Lawrence stated the lock-in process could be put in very quickly. Dr. Parker wants to know at the next meeting how the process works once glaring misuse is identified. He asked if there is a tiered letter response and how quickly the process is initiated and how long the process takes. He stated the time from detection to action should be three months or less. Dr. Johnson referred back to the case cited and stated if something happened to that patient the family could sue for malpractice. He stated if they see something this flagrant there should be an obligation to involve the Board of Medical Examiners. Mr. Macdonald stated he is working with an epidemiologist and the deaths from opiod and methadone use has doubled in the last three years in Nevada. The reason he has an interest is because of dosing like this. He suggested the committee should have a report on how recipients are identified, the action taken by the agency and the results. Dr. England stated he would like Dr. Monaghan and Ms. Lawrence to report back to the committee with this information.

Public Comment: None

Motion: Dr. Parker motioned to accept the criteria with the inclusion of intractable pain as justification for dosing three times a day.
Seconded: Ms. Winchell
Vote: Unanimous
Motion carried.

5. Actiq

Dr. Monaghan gave an overview of the proposed criteria. Dr. England stated in the hospital this dosage form is occasionally used for pediatric oncology patients. He also stated it has become a hot item on the street, going for $25 a pop. Dr. Johnson asked what if a patient is going downhill and does not see his oncologist anymore and the family doctor writes for it. Dr. Monaghan stated that scenario could be accommodated through the prior authorization process.

Public Comment:
Maryanne Phillips, MD, pain management specialist. She stated pain is pain, regardless of etiology. She stated she agreed with the limit of 4 units per day. She asked the committee to reconsider the diagnostic criteria.

Dr. Parker stated he uses it in his AIDS patients. Dr. Monaghan stated that to his knowledge, there is not a regulatory body in Nevada that

qualifies physicians to be considered pain specialists. Dr. Johnson stated there is national certification but any doctor can write for pain medication.

Motion: Dr. Parker motioned to change the criteria by removing cancer from the criteria and removing the requirement that the agent can only be ordered by an oncologist or pain specialist.
Seconded: Dr. Johnson
Dr. Schwartz questioned the fourth bullet point. Dr. England suggested an amendment to the motion.

Motion: Dr. Johnson amended the motion to include as criteria the following: pain unresponsive to other therapy, and limit of 4 units per day.
Seconded: Ms. Winchell
Vote: Unanimous
Motion carried.

6. Coreg

Dr. Monaghan asked to table this item at this time as there does not seem to be a large amount of inappropriate utilization.

7. Neurontin

Dr. Monaghan gave an overview of the criteria. Dr. Johnson asked if they could take any action on this because it is a psychiatric medication. Dr. Monaghan stated this drug is actually classified as an anticonvulsant and there are it has no approved indications for the treatment of psychiatric conditions, including bipolar disease. Dr. England stated he was at a continuing education program on anti epileptic drugs and it was pointed out that many drugs in this class are being used for psychiatric conditions. He stated most of the psychiatric studies involving these agents are not blinded or controlled, which is the accepted standard for evaluating drug efficacy. Keith Macdonald recommended a revision on the fourth bullet point of the bipolar criteria. He recommended that it be changed to read “tried and failed”.

Public Comment:
None

Motion: Dr. Johnson motioned to accept the criteria with the statement tried and failed to be included on the bipolar criteria.
Seconded: Dr. Parker
Vote: Unanimous
Motion carried.

8. Zelnorm

Dr. Monaghan gave an overview of the criteria. Novartis gave a handout-attached. Dr. England stated if therapy needed to go beyond 12 weeks, the prior authorization process could be employed.

Public Comment: **None**

Motion: Keith Macdonald motioned to accept the criteria as written.
Seconded: Dr. Parker
Vote: Ayes: Unanimous
Motion carried.

9. Herpetic Antivirals

Dr. Monaghan gave an overview of the criteria. Dr. England asked Dr. Parker if there was an issue with resistance among this group. Dr. Parker

responded most people who become resistant will be resistant to all. Compliance is the only issue with acyclovir.

Public Comment:
Jim Szabo, GSK gave an overview of Valtrex®. Attachment. Dr. England asked Mr. Szabo for his recommendation. He stated Valtrex® is indicated to decrease the chance of transmission. Dr. Parker stated acyclovir was used for a lot of these indications. He stated valacyclovir is more potent and easier to take.

Dr. England asked to table this issue until the next meeting**.**

Motion: Ms. Winchell motioned to table until next meeting.
Seconded: Keith Macdonald
Vote: Unanimous
Motion carried.

10. Clarithromycin for H. Pylori

Dr. Monaghan gave an overview of the criteria. He stated this is being discussed pending the finalization of the PDL. Dr. England suggested it be tabled until the PDL is finalized.

11. Xopenex

Dr. Monaghan gave an overview of the criteria. Dr. England wanted to add to the criteria that the 0.3mg dose and the 0.6mg dose could not be used more than every 6 hours and the 0.125mg dose could not be used more than every 8 hours.

Public Comment: None

Motion: Ms. Winchell motioned for approval with the dosing revisions added.
Seconded: Dr. Parker
Vote: Unanimous
Motion carried.

12. Sonata/Ambien

Dr. Monaghan gave an overview of the criteria. Dr. England recommended extending the criteria to all sedative hypnotics.

Public Comment:
None

Motion: Dr. Schwartz motioned to accept quantity limits of 30 per month and include all sedative hypnotics.
Seconded: Keith Macdonald
Vote: Unanimous
Ms. Lawrence stated the recommendations will be communicated to the Pharmacy & Therapeutics Committee and will be sent to public hearing for addition to Medicaid Chapter 1200.

IV. Presentation of Drug Utilization Review Reports

A. Top 50 Drugs Ranked by Payment Amount
B. Top 10 Therapeutic classes Ranked by Payment Amount
C. Nevada Medicaid Drug Spending Analysis (SFY03 versus SFY04)

Dr. Monaghan, FHSC gave an overview of these reports.

Keith Macdonald asked if the increase was being driven by drug cost or utilization. Dr. Monaghan responded it was primarily due to utilization**.**

Dr. England asked if point-of-sale caused increases in utilization in other states when POS was implemented. Dr. Monaghan responded yes, primarily due to the pharmacy having immediate access to eligibility information, and as a result, being paid more consistently and promptly. Dr. England asked if there was any utilization data concerning brand versus generics. Dr. Monaghan responded Nevada's generic use is approximately 52%, which is very good compared to other states. Dr. England asked about the increase in utilization compared to increase in drug cost. Dr. Monaghan referred him to the fishbone chart in the Nevada Medicaid Drug Spending Analysis. Dr. England asked if we are getting better data since Nevada is now using an electronic system compared to the previous manual system. Dr. Monaghan responded yes, definitely. He also stated that some costs were not showing up at all in the previous system due to the onerous, manual process previously in place. Many times providers would simply get discouraged and not pursue payment.

Coleen Lawrence, DHCFP stated the savings projected from the PDL, MAC, and enhanced edits will simply help reduce the steep increase in drug expenditures now being experienced. She stated there were two significant issues involved in the 26% increase in expenses this past year. One is the transfer of diabetic supplies from DME to pharmacy. This also caused a large increase in the number of utilizers. Another contributor was that transfer of home infusion providers from provider type 37 to type 28, i.e., pharmacy. She stated there will be a need to trend this year versus next year to truly compare the two time periods with the new billing processes in place.

Dr. Monaghan stated that the cost saving initiatives being implemented are meant to "flatten the curve" with regard to the steep increases in expenses experienced over the past few years. The total expenses are not expected to go down.

V. Retrospective Drug Utilization Review (RetroDur)

A. Results of the Duplicate Atypical Antipsychotics DUR

B. Results of the Re-Reviews of Zolpidem (Ambien)

Dr. England stated he will hold the above items until the next meeting.

VI. Schedule next meeting, September 16, 2004 1pm
Motion: Dr. Johnson accepted the time & date of next meeting.
Seconded: Ms. Winchell
Vote: Unanimous
Motion carried.

VII. Public

Dr. Harris offered a consensus statement to enter into the public record. Attachment. Dr. England accepted it.

VIII. Adjourned at 4:00 pm
Motion: Ms. Winchell motioned to adjourn.
Seconded: Dr. Parker
Votes: Unanimous
Motion carried.