

Pharmacy and Therapeutics (P&T) Committee Meeting Record

Date: October 21, 2011 **Time:** 9:00 a.m. – 2:30 p.m. **Location:** Idaho Medicaid, 3232 Elder Street, Conference Room D

Moderator: Phil Petersen, M.D.

Committee Members Present: Phil Petersen, M.D.-Chair; Perry Brown, M.D.; William Woodhouse, M.D.; Dennis Tofteland, RPh; John Mahan, M.D.; Catherine Hitt-Piechowski, Pharm.D; Mark Johnston, RPh; Tami Eide, Pharm.D; Mark Turner, M.D.

Others Present: Steve Liles, Pharm.D of Provider Synergies; Mark England Pharm.D and Bill Milne, RPh of Magellan Medicaid Administration; Jane Gennrich, Pharm.D, Cody Scrivner, CPhT and Rachel Strutton of Division of Medicaid

Committee Members Excused: Elaine Ladd, Pharm.D;

AGENDA ITEMS	PRESENTER	OUTCOME/ACTIONS
CALL TO ORDER	Phil Petersen, M.D.	Dr. Petersen called the meeting to order.
Committee Business		
➤ <i>Roll Call</i>	Phil Petersen, M.D.	Dr. Petersen completed the roll call, welcomed the P&T Committee members and called the meeting to order.
➤ <i>Reading of Mission Statement</i>	Phil Petersen, M.D.	Dr. Petersen read the Mission Statement.
➤ <i>Approval of Minutes from the May 20, 2011 Meeting</i>		There were no corrections. The May 20, 2011 meeting minutes were accepted as proposed. The committee discussed next year’s meeting schedule. The 2012 meeting schedule will be April 20, May 11, October 19 and November 16.
➤ <i>DERP Update</i>	Tami Eide, Pharm.D	<p>DERP is in its ninth year and is currently DERP 3, with only 11 states currently enrolled (previously 18). Recent budgetary restraints have had an effect on the ability to conduct review studies and there will not be any new reports in the last year of DERP 3. Budgetary constraints and the maturity of preferred drug lists and different program needs have necessitated a redesign of the program for DERP 4. DERP is considering several options for DERP 4.</p> <ul style="list-style-type: none"> ➤ <i>Making final reports proprietary.</i> ➤ <i>Possibly charging fees for reports with a possibility of subscription opportunities for non-member states and outside entities.</i> ➤ <i>Redesigning current products to streamline reporting.</i> ➤ <i>Consideration of derivative products.</i> ➤ <i>Shortening the report production time.</i> <p>DERP 4 will begin July 2012. The committee held some conversation around these proposed changes.</p>

<p>➤ <i>Children’s Asthma Quality Improvement Initiative</i></p>	<p>Perry Brown, M.D.</p>	<p>Children’s Asthma Quality Improvement Initiative Dr. Brown discussed the Children’s Asthma Quality Improvement Initiative which started in September 2011 as part of the Children’s Healthcare Improvement Collaborative (CHIC) project, a grant funded project involving both Idaho and Utah. It is a multi-practice; multi-location collaborative group whose goal is to raise the awareness of children’s asthma. Practices are receiving tools and strategies for quality improvement of care outcomes for children with asthma in their practices. Chart audits have begun to look at a variety of measures over a nine month period time. Boise, Pocatello, Idaho Falls and Twin Falls are being targeted as the piloted areas for this new initiative. The contact person is Natalie Bodine at DHW. There is an opportunity for the P&T Committee to work collaborative with the initiative through its PDL and appropriate drug use recommendations.</p>
<p>Public Comment Period</p>	<p>Phil Petersen, M.D. Cody Scrivner, CPhT</p>	<p>Public Comment Period No speakers signed up to speak during the public comment period. Public testimony was not received.</p>
<p>Drug Class Reviews and Committee Recommendations</p>		<p>Drug Class Reviews and Committee Recommendations</p>
<p>Controller Medications for Asthma (audiotape)</p>	<p>Roberta (Candy) Wines, MPH RTI-UNC EPC</p>	<p><u>Controller Medications for Asthma</u> An audiotape presentation and slides of the most recent DERP update was reviewed by the Committee. Tiotropium and ciclesonide (Alvesco) were added to update as well as new literature since the last review. The report concluded that individual inhaled corticosteroids do not differ in their ability to control asthma symptoms. Inhaled corticosteroids are better than leukotriene modifiers for monotherapy. Results from large trials support greater efficacy with the addition of a long acting beta agonist to an inhaled corticosteroid than with a higher dose of an inhaled corticosteroid or the addition of a leukotriene modifier to inhaled corticosteroid therapy. Dr. Petersen expressed the value of this type of DERP review.</p>
<p>Bronchodilators, Beta Agonists Short-Acting</p>	<p>Steve Liles, PharmD Provider Synergies</p>	<p><u>Bronchodilators, Beta Agonists Short-Acting</u> Dr. Liles presented one clinical trial for acute exacerbation of asthma. Committee Recommendations The committee recommended that all oral albuterol products be designated non- preferred agents. Oral terbutaline was recommended to also be non–preferred, but should be allowed with a diagnosis of pregnancy when other alternatives could not be used and/or the benefit overrode the risk. Prescribers on the committee currently write prescriptions generically for albuterol inhalers and not for name branded agents. Dr. Brown did indicate though that some Electronic Medical Record (EMR) prescribing packages force prescribers to prescribe by branded names because the system forces you to choose a specific</p>

<p>Bronchodilators, Beta Agonists Long-Acting</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p>product. The committee recommended that the Department choose the most cost effective brands of albuterol inhalers and work with pharmacies to have those brands stocked.</p> <p><u>Bronchodilators, Beta Agonists Long-Acting</u> Dr. Liles provided a review of a new agent Arcapta (indacaterol). The committee reviewed the indications, contradictions, drug interactions and common adverse effects.</p> <p>Committee Recommendations The committee recommended the new agent Arcapta (indacaterol) be made a non preferred agent and hold the same prior authorization (PA) requirements as the other agents in this class.</p>
<p>Leukotriene Modifiers</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Leukotriene Modifiers</u> Singulair (montelukast) will become available generically August 2012. There was no other new clinical data to share with the committee.</p> <p>Committee Recommendations The committee concluded that there were no evidence based differences to support preferring any agent over another in this class.</p>
<p>Glucocorticoids, Inhaled</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Glucocorticoids, Inhaled</u> Dr. Liles provided a review of FDA actions requiring manufacturers to conduct clinical trials to evaluate the safety of inhaled corticosteroids alone compared to combinations with beta agonists. . He also provided a review of one new combination agent Dulera (mometasone/formoterol) including the indications, contra-indications/warnings and two clinical trials. He also reviewed the NHLBI (National Heart, Lung and Blood Institute) clinical trial on exacerbations of asthma in children.</p> <p>Committee Recommendations The committee recommended simplifying the diagnosis requirement for combination agents to persistent asthma. They recommended that Dulera have the same PA criteria as the other combination agents. The committee concluded that there were no evidence based differences to support preferring one agent over another and felt it was more important to have PA criteria for appropriate use than to have one agent preferred over another..</p>
<p>COPD Agents</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>COPD Agents</u> Dr. Liles provided a review of one new agent Daliresp (roflumilast), the indications, contraindications, drug interactions, adverse events and the results of two double blind randomized controlled trials.</p> <p>Committee Recommendations The committee felt that Daliresp was a necessary, but niche drug. The committee recommended that Daliresp be a non preferred, secondary agent. They recommended a PA requirement of its labeled</p>

<p>Intranasal Rhinitis Agents</p>	<p>Steve Liles, Pharm.D. Provider Synergies</p>	<p>indication of a diagnosis of severe COPD associated with chronic bronchitis and a history of two or more exacerbations in the last year. They felt exacerbations should be defined as the need for systemic steroids and/or hospitalization with documented use of other designated COPD agents. The committee concluded that there were no evidence based differences to support preferring any of the remaining agents over another.</p> <p><u>Intranasal Rhinitis Agents</u> Dr. Liles provided information on which medications to choose for specific symptoms of allergic rhinitis based on the most recent guidelines on diagnosis and treatment of respiratory illness in children and adults from the Institute for Clinical Systems Improvement. (ICSI).</p> <p>Committee Recommendations The committee suggested for future reviews grouping the agents by the drug class groups as in done on the written PDL for comparison purposes. The committee felt utilization appeared to be appropriate. The committee concluded that there were no evidence based differences to support preferring any agent over another in any of the specific drug classes.</p>
<p>Antihistamines, minimally sedating</p>	<p>Steve Liles, Pharm.D. Provider Synergies</p>	<p><u>Antihistamines, minimally sedating</u> There was no new clinical data to share with the committee.</p> <p>Committee Recommendations The committee concluded that there was no evidence based differences in efficacy or safety to prefer one agent over another in this class.</p>
<p>Immunomodulators, Atopic Dermatitis</p>	<p>Steve Liles, Pharm.D. Provider Synergies</p>	<p><u>Immunomodulators, Atopic Dermatitis</u> Dr. Liles provided a review of one Meta-Analysis comparing response rates and adverse events between tacrolimus (0.1% only), hydrocortisone and pimecrolimus.</p> <p>Committee Recommendations The committee requested a DUR on this drug class to include patterns of use, presence or absence of step up therapy from steroids, specialty of prescribers and geographic region differences of prescribing patterns. The DUR should include an educational piece on risks of these agents compared to risks from steroids since many practitioners seem to be using these agents to spare patients from steroid exposure.</p>
<p>Cough and Cold</p>	<p>Steve Liles, Pharm.D. Provider Synergies</p>	<p><u>Cough and Cold</u> Dr. Liles walked the committee through the <i>Cough and Cold Therapeutic Class Review (TCR)</i>.</p> <p>Committee Recommendations The committee requested that Medicaid develop a limited list of appropriate agents to be available that would cover the specific symptoms needed to treat coughs and colds. The development of the list should include an analysis of utilization patterns, chronic use and a comparison of utilization to other states using</p>

<p>Otic Anti-infectives and Anesthetics</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p>Magellan Medicaid Administration support for PDL decisions. It was noted that previous P&T Committee Recommendations for limiting prescription quantities and number of refills for these agents have not been operationalized in the claims adjudication system, but methods to implement these restrictions are still being pursued. The Committee affirmed that decongestants which are not currently covered by Idaho Medicaid should remain excluded from coverage.</p> <p><u>Otic Anti-infectives and Anesthetics</u> Dr. Liles provided a review of one new clinical trial. Dr. Eide discussed an FDA announcement that Auralgan (antipyrine/benzocaine) was seized from the manufacturer by the U.S. Marshalls as it is not FDA approved. The manufacturer had continued to sell it despite multiple warning letters from the FDA. Idaho Medicaid cannot cover medications that have not been approved by the FDA.</p> <p>Committee Recommendations The committee concluded that there were no evidence based differences to support preferring any of the remaining FDA approved agents over any other.</p>
<p>Otic Antibiotics</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Otic Antibiotics</u> There was no new clinical data to share with the committee.</p> <p>Committee Recommendations The Committee recommended that Cortisporin otic suspension be preferred over the solution. They concluded that there was not sufficient evidence to make further recommendations of preferring one agent over another.</p>
<p>Ophthalmic Antibiotics</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Ophthalmic Antibiotics</u> Dr. Liles provided a review of two new drugs- Zymaxid (gatifloxan 0.5%) and Moxeza (moxifloxin 0.5%). The committee reviewed two new clinical trials for this class.</p> <p>Committee Recommendations The committee concluded that there were no evidence based differences to support preferring any agent over another in this class. They recommended having at least one agent from the aminoglycoside drug class and from the flouroquinolone class as preferred.</p>
<p>Ophthalmic Antibiotic/Steroid Combinations</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Ophthalmic Antibiotic/Steroid Combinations</u> This is the first review of this drug class. There was no significant comparative clinical data to share with the committee.</p> <p>Committee Recommendations Because of safety concerns with the steroid component of these agents, the Committee requested a DUR review to evaluate whether the prescribing physicians were specialists (ophthalmologists) , primary care, or ER prescribers.</p>

<p>Ophthalmics, Anti-inflammatory</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Ophthalmics, Anti-inflammatories</u> There was no new clinical data to share with the committee.</p> <p>Committee Recommendations The Committee requested that these agents be added to the above DUR review to determine the main prescribers of these agents. They concluded that there were no significant evidence-based differences to prefer one agent over another.</p>
<p>Ophthalmics for Allergic Conjunctivitis</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Ophthalmics for Allergic Conjunctivitis</u> Dr. Liles provided a review of one new drug Lastacaft (alcaftadine).</p> <p>Committee Recommendations The committee concluded that there were no evidence based differences to support preferring one agent over another in this class.</p>
<p>Ophthalmics, Glaucoma Drugs</p>	<p>Steve Liles, Pharm.D Provider Synergies</p>	<p><u>Ophthalmics, Glaucoma Drugs</u> Dr. Liles provided review of one new clinical trial comparing Cobigan (brimonidine/timolol) and Cosopt (dorzolamide/timolol).</p> <p>Committee Recommendations The committee concluded that there were no evidence based differences to support preferring one agent over another for this class of drugs. They felt that the use of these agents was limited to specialty practice and drug choice should be deferred to the specialist’s discretion.</p>