Minutes of the September 29, 2006
Pharmacy & Therapeutics (P&T) Committee Meeting
SD Department of Social Services, Medical Services Division

Members present
Verdayne Brandenburg, MD; Richard Holm, MD; William Ladwig, RPh; Dana Darger, RPh; Dennis Hedge, PharmD; James Engelbrecht, MD.

DSS staff present
Mark Petersen, RPh; Jill Wellhouse.

HID staff present
Christina Daniels, PharmD; Candace Rieth, PharmD.

Administrative Business
The P&T meeting was called to order at approximately 12:30 pm. Bill Ladwig, chairman, directed the meeting. The minutes of the July 7, 2006 meeting were presented and Mr. Darger made a motion to approve as written, with a second by Dr. Engelbrecht. The motion was approved unanimously. Ms. Daniels presented an overview of the prior authorization (PA) activity for July and August 2006. There were a total of 1,078 PA's processed in the month of July, with 95.65% of those requests responded to in under 8 hours. There were 923 (86%) requests received electronically and 155 (14%) received by fax. Overall, there was a 30% approval rating for the month of July.

In August 2006, there were a total of 2,147 PA requests received, with 98.26% responded to in under 8 hours. Of those 2,147 requests, there were 1,892 (87%) electronic requests and 293 (13%) faxed requests. The approval rating for June was 19%. Noting the increase in PA requests, Ms. Daniels reminded the committee that the maximum units prior authorization started in the month of August. While all claims are submitted for an electronic PA check, only those claims with a cancer diagnosis will go through automatically. Ms. Daniels told the committee that the call center had taken many calls when the maximum units PA started and most providers just needed education on the drugs on the maximum units list. The committee requested that Ms. Daniels look into those requests and see what drugs the providers are requesting and how many were solved with educational intervention. Ms. Daniels said that HID can and will provide the information to the committee members.

In response to a question raised at the previous meeting, Ms. Daniels reviewed the number of unique approvals following an electronic denial for the months of June and July. For the antihistamine class, there were 772 total electronic denials, 166 manual reviews of electronic denials, and 86 unique approvals after electronic denial. For the ARBs, it was 68, 35, and 20, respectively. For the PPI class, it was 510, 114, and 60.

Analysis of the Top 15 Therapeutic Classes

Ms. Daniels presented a brief overview of the top 15 therapeutic classes of drugs. The top five classes for the 2nd quarter 2006 are as follows: Antipsychotic agents, Anticonvulsants, Amphetamines, Antidepressants, and Beta-Adrenergic Agonists. Dr. Brandenburg asked that HID research the number of unique patients on amphetamines. The committee also asked that HID research what diagnoses the anticonvulsants are being used for. Mr. Petersen stated that 52.8% of prescriptions were transferred over to Medicare Part D. He also told the committee that South Dakota Medicaid had approximately 100,000 patients with drug coverage and of those 30,000 were using their coverage. January 1, 2006, approximately 14,000 patients shifted to Medicare Part D. These 14,000 patients accounted for 51.6% of the dollars spent.

Analysis of the Top 25 Drugs

Ms. Daniels presented an overview of the top 25 drugs by number of claims and by claims cost. The top five drugs based on total claims cost for the 2nd quarter 2006 are as follows: Seroquel®, Concerta®, Singulair®, Adderall XR®, and Abilify®. The top five drugs based on number of claims are as follows: Singulair®, Amoxicillin, Zyrtec®, Concerta®, and Lorazepam. After reviewing the information, the committee asked HID to look into what diagnoses Singulair® is being used for. Ms. Daniels agreed to bring back the requested data to the next meeting.

Update on Tablet Splitting

Ms. Daniels provided some updated information to the committee regarding tablet splitting. She reviewed the ICD-9 codes which would exempt a patient from being asked to split a tablet. The committee then reviewed the drugs proposed for the tablet splitting edit. Those drugs proposed were Crestor®, Lipitor®, Zocor®/Simvastatin, Zoloft®, Lexapro®, Zyrtec®, and Provigil®. Zoloft®, Lexapro®, and Zyrtec® were drugs taken from the top 25 drugs by claims cost, something the committee felt was important. Ms. Daniels reviewed the annualized cost savings information if a tablet splitting edit were initiated.

The committee discussed the need to provide patient incentive when asking them to participate in the tablet splitting program. Mr. Petersen was asked if an NDC could be set up so that providers could provide the patients with a tablet splitting device. Dr. Engelbrecht also suggested that perhaps patients who join in the tablet splitting program should not have to pay a copay. Jill Wellhouse said that the copay is mandated by the federal government and would be very difficult to change. The committee asked Ms. Daniels to research other states that have implemented tablet splitting as a cost savings measure and bring that information back to the committee.

Mr. Darger made a motion to launch a pilot program with the HMGCoA class where the patient is provided with a tablet splitting device while the committee researches the possibility of changing the copay rule for the participants. Dr. Brandenburg seconded the motion. All members were in favor of implementing this edit. There were none opposed in a voice vote.

Update on Dose Optimization and Atypical Antipsychotic Agents

Responding to a request from the July meeting, Ms. Daniels provided the committee members with information regarding patients taking multiple antipsychotic agents. The first report looked at the number of patients taking three or more antipsychotics (the drugs overlapping each other for at least sixty days) over six months worth of data. There were 13 patients receiving three antipsychotic agents and 2 patients taking four or more.

The next report detailed recipients receiving two or more atypical antipsychotic agents, where the drugs overlapped each other for at least sixty days. In looking at six months of data, there were 115 patients taking two and 5 patients taking three or more.

The committee had questions about the use of multiple antipsychotic agents and Mr. Petersen gave a brief overview of the CNS program, which is a DUR program looking at the mental health drugs for adults and children. The CNS program checks for high and low dosages, patients taking five or more psychotropics, and sends educational letters. Mr. Ladwig asked Mr. Petersen if the committee could see the data from the CNS program. Mr. Petersen said that he could not share that information but asked that HID bring similar data to the next meeting for the committee to review.

The committee asked Ms. Daniels to bring back information about the top prescribers of mental health drugs**.**

Cost Shift Data/Medical Analysis of PA Implementation

After putting a prior authorization requirement on the PPI and antihistamine classes in March 2006, the committee wanted to look at cost shift data to ensure that the PA program is saving the state money and not increasing patient medical costs. In the first report, those patients taking a PPI in the four months prior to March 2006 were identified (dual eligible patients were excluded) and split into three groups: 1) those that continued on a PPI after March, 2) those that took neither a PPI nor an H2RA, and 3) those that were changed to an H2RA. The total medical costs relating to those patients were obtained for four months prior to and four months post implementation. The total medical costs did not increase for any of the groups examined. The average cost of a prescription for a PPI decreased by more than fifty dollars in the months following the prior authorization requirement for the PPI class. This resulted in a substantial cost savings to the state of South Dakota.

The second report examined the cost of PPI prescriptions per month and the cost of H2RA prescriptions per month. The cost of PPIs decreased significantly, while the cost of the H2RAs remained the same, lowering overall costs. This report also examined the medicals costs associated with inpatient visits, endoscopies, emergency department visits, and hospitalizations due to different GI diagnoses. The report showed that post-PA costs were very similar to pre-PA costs.

The third report looked at the change in market share. While all PPIs were examined, the most significant change was with Prilosec OTC®, which was at a 13% market share in

February 2006 and rose to a 56% market share following the PPI PA implementation in March 2006.

The fourth report assessed the change in market report for the antihistamine class. From February 2006 to March 2006, the market share of loratadine OTC increased from 4% to 20%. The committee members also wanted to know if putting a prior authorization requirement on antihistamines would affect the market share of Singulair®. It was affected, although not to a great extent. In February 2006 Singulair® had a 33% market share and in March 2006, a 37% market share.

Update on Anxiolytics, Sedatives, and Hypnotics

In the July 2006 P&T committee meeting, the members reviewed the Anxiolytic, Sedative, and Hypnotic class. The costs of the branded agents were discussed. The committee requested that Ms. Daniels do a cost comparison of all agents in this class.

From January 1, 2006 to June 30, 2006, Ambien® had an 8% market share and a 30% dollar share, followed by Ambien CR® with 10% and 3% and Lorazepam with 39% and 19%, respectively. The members requested data on Trazodone, which will be provided at the December 2006 meeting.

Analysis of Asthma and the South Dakota Medicaid Population

A general overview of asthma and the treatment standards were reviewed, with emphasis on a 2005 CDC study that found 10.5% of adults in South Dakota have been told that they have the disease. The Medicaid program pays for approximately 1,500 albuterol prescriptions per month for South Dakota recipients.

The November 2005 FDA Public Health Advisory, regarding long-acting $beta_2$-agonists, was briefly discussed. Ms. Daniels then reviewed information specific to South Dakota Medicaid patients. There were 1,059 unique recipients that filled a prescription for a long-acting $beta_2$-agonist (dual eligible patients excluded) in the last twelve months. Of those, 979 patients did not have a rescue inhaler filled within six months.

There were 17 recipients that used more than one rescue inhaler per month for six out of the last twelve months. Of those patients, 3 were on an inhaled corticosteroid and 8 had a steroid burst for a total of 26 instances.

There were 1,434 recipients that had an ER visit with a diagnosis of asthma. Of those, 299 had a prescription for Advair® and 18 of the 299 had 10 or more prescriptions for Advair® in the last 12 months. 409 patients were taking an inhaled steroid. 20 of the 1,434 patients had, at some point, used more than 1 rescue inhaler per month.

The members asked that HID look at the data again and provide demographic information on the patients with asthma, the pharmacies and providers that these patients are visiting and detail compliance with patients on inhaled steroids. Ms. Daniels agreed to bring the requested data to the next meeting and the board temporarily tabled the issue of asthma medications.

DAW Analysis

The board reviewed the effectiveness of the DAW edit for Duragesic®, Oxycontin®, and Neurontin® and discussed the possibility of implementing a DAW edit across the board. Mr. Darger made a motion to implement a DAW prior authorization for all brand name medications, with the exception of the narrow therapeutic index drugs. Dr. Brandenburg seconded and the motion was approved unanimously.

Other Business

After discussion the next meeting date was set for December 8, 2006.

There were no further comments or questions and the meeting was adjourned at approximately 3:00 pm.

Respectfully submitted,

Christina Daniels, PharmD

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