



**MaineCare Services**  
 An Office of the  
 Department of Health and Human Services

John E. Baldacci, Governor

Brenda M. Harvey, Commissioner

Department of Health and Human Services  
 MaineCare Services  
 442 Civic Center Drive  
 # 11 State House Station  
 Augusta, Maine 04333-0011  
 Tel: 1-866-796-2463; Fax: (207) 287-8601  
 TTY: 1-800-423-4331

TO: Maine Drug Utilization Review Board  
 FROM: Sally Griffith-Onnen  
 DATE: November 11, 2009  
 RE: Maine DUR Board meeting minutes from November 10, 2009

<b>ATTENDANCE</b>	<b>PRESENT</b>	<b>ABSENT</b>	<b>EXCUSED</b>
<i>Jeffrey Barkin, MD Psychiatrist, Chair</i>	X		
<i>Lisa Wendler, Pharm. D., Clinical Pharmacy Specialist, Maine Medical CTR, Vice-Chair</i>	X		
<i>William Alto, M.D., Family Practice, Dartmouth Family Practice Faculty</i>	X		
<i>Laureen Biczak D.O., Infectious Disease, GHS</i>			X
<i>Mark Braun, M.D., FACP, Internist/Geriatrician</i>	X		
<i>Timothy Clifford, M.D., Family Practice, GHS</i>	X		
<i>Amy Enos, Pharm. D. Waltz LTC Pharmacy</i>			X
<i>Jack Forbush, D.O., Family Medicine</i>		X	
<i>Stevan Gressit, M.D., Psychiatrist, DHHS Mental Health Medical Director</i>	X		
<i>Steven Meister MD, Pediatrician, Maine CDC, Division Family Health Medical Director</i>			X
<i>Mike Ouellette, R.Ph. GHS</i>	X		
<i>Laurie Roscoe, R.Ph. Martin's Point</i>	X		
<i>Robert Weiss M.D., Cardiologist</i>	X		
<b>Non - Voting</b>			
<i>Jennifer Palow, Pharmacy Manager, OMS</i>	X		
<i>Brenda McCormick, Director OMS</i>	X		
<i>Rod Prior MD, Medical Director OMS</i>	X		

**Call to order**

Dr. Jeffery Barkin (Chair) called the meeting to order at 6 pm.

**DUR Minutes from October**

*Caring..Responsive..Well-Managed..We are DHHS.*

Dr Barkin asked members to review the draft DUR meeting notes for October 13 2009.

- A motion was made to accept the minutes as written, with two spelling corrections for names. The motion was seconded and passed.

## New Business

### **Review/revise Prior Authorization Criteria for CY2010 Preferred Drug List**

#### *Veramyst Nasal Spray*

Bill Beaver from GSK asked to speak to the board regarding Veramyst's inclusion on the PDL. He requested that the board consider aligning any age exclusion on the PDL with the indication for Veramyst (ages 2-11) to avoid confusion for providers. He also stated that he had heard anecdotal evidence that scripts written for one spray per nostril per day have been denied; this is the starting dose for Veramyst and if this dosage is maintained a bottle will last for two months. He concluded by stating that he hoped the board would consider keeping Veramyst on the PDL.

The board reviewed letters received in favor of having Veramyst on the PDL. It was noted that the letters came from a broad base and did not appear to be industry formulated, although they were most likely triggered by industry information. Dr Clifford informed the board of an analysis done on Maine Care claims. Patients were divided into age groups, with 20% of users 8 or under. It would be affordable to the State to allow patients up to the age of 8 to use Veramyst but the State would start to lose substantial savings if Veramyst was provided to other patients without there being a supplemental rebate. Savings for other drug areas were also looked at, included antihistamine and ocular antihistamine use; however there were no savings in using Veramyst rather than Fluticasone.

There was discussion regarding whether the anecdotal evidence was enough to incline the board to recommend that Veramyst be on the PDL. It was also noted that the issue was mainly one of preference rather than clinical outcomes, and that usual practice if a patient had difficulties with one drug that they would return to the provider and get a different one. A more detailed analysis on compliance between Fluticasone, Nasonex and Veramyst will be performed for the February 2010 meeting..

- A motion was made and seconded to add Veramyst to the formulary with a preferred age range of 2-8; the motion was opposed.
- A motion was made and seconded to allow an automated PA for Veramyst if a patient has tried the two drugs on the PDL; the motion was passed.

#### *Zetia*

Motion 9 from the October 13 meeting to allow Zetia splitting without a PA was felt to be ambiguous (this motion had been unanimously opposed). It was proposed that the vote be carried out again to clarify the matter.

- A motion was made and seconded to keep Zetia non-preferred and not do pill splitting. The motion passed unanimously.

The criteria that will apply is: Zetia will be available without a PA as addition to the highest doses of the potent statins. Zetia will also be approved with a PA as an add on for patients at maximally tolerated doses of statins.

### **Analysis of H1N1/ Tamiflu Compounding**

The Office of MaineCare Services (OMS) is working closely with Maine Center for Disease Control

*Caring..Responsive..Well-Managed.. We are DHHS.*

and Prevention (CDC) regarding the H1N1 flu virus. The CDC recommended increasing timely access to anti-influenza treatments and give timely feedback regarding what is going on with treatments that CDC can use. CDC is now receiving a claims report on a weekly basis. Data was presented to the committee, showing the great increase in the number of scripts for Tamiflu which presumably had to do with H1N1 cases as seasonal flu peaks later. Because of this, a number of stores have run out of Tamiflu suspension, requiring compounding of the capsules. The State underpays for compounding compared to private insurers and some pharmacies are refusing to compound; the State will bring their payment into line with others, but only when the suspension is unavailable. Mr. Ouellette said that a comparison of which scripts are prophylactic and which are treatment could be done but the data is dependent on the pharmacies reporting correctly.

### Old business

#### **WIC Medicaid Formula Coverage Update**

This will be discussed at the next meeting as Dr. Meister was absent.

#### **Chronic Narcotic Use Prior Authorization/Promotion of Standard of Care**

Rebecca Colwell, president of the Maine Hospice Council, asked to speak to the board regarding the Chronic Narcotic Use PA. She wished to convey to the Board the concern of Hospice providers that patients with end of life diseases other than cancer and HIV/AIDS may require this PA. Dr Clifford replied that based on initial input the Guideline had been revised, and a PA would not be required for hospice patients or for those members being actively treated for a life threatening illness such as AIDS or cancer. This has been approved by the State and is currently posted to the Maine Medical Association and will go out to the listserve and be included in the winter newsletter coming out at the end of November.

Robert McElwain, practice manager from Northeast Neurosurgery in Bangor asked to speak to the board regarding the Chronic Narcotic Use PA. He said he was concerned that the PA could make things difficult for the practice and for its patients. The practice manages patients from Waterville and north, with some patients coming from many hours away. There would be difficulty for them to travel so far for drug screening or counseling. He asked if there was anything in the guidelines that spoke to surgical pain, as individuals may have three to four months of medication. Dr Clifford responded by saying that the PA requirement would be for opioids, and that the requirement was aimed at looking at doctors who start patients on narcotics without pursuing other options such as surgery. For those patients who may require narcotics long term it would make sense to partner with local doctors or to hand over prescribing responsibility where possible and to communicate with them the need for tapering. Dr Clifford said that there would be clarification, but until they had real cases coming through they did not want to lock into a rigidly predefined plan. Dr Clifford will bring this up again with the committee at that stage.

#### **Psych Work Group Monthly Update**

Dr Barkin said that there was some desire to make Wellbutrin easy to get to for kids with ADD by bypassing the PA requirement. Dr Clifford said this made sense to cut down on PA volume; Mr. Ouellette said that it would be ready in January.

#### **Savella and Fibromyalgia**

There was a discussion as to whether there should be a class for fibromyalgia to allow Savella to be

*Caring..Responsive..Well-Managed.. We are DHHS.*

more easily compared with Lyrica to encourage Savella use. As Savella is classified as an anti-depressant, this would mean double listing it. Another difficulty is that the PDL is used to generate a lot of reports which double listing would interfere with. Further, other disease states also have issues with drugs used for them being in another class. No decision was made to change the status quo.

### **Abilify Pill Splitting Analysis**

Abilify is an antipsychotic which for the right patient type requires less metabolic monitoring but is very expensive. It was decided to make low doses available by splitting pills. Analysis was done to look at compliance rates for Abilify patients with split and non split tablet dosing. Data was presented to the board, first showing confirmation that splitting is occurring and the corresponding savings. The first comparison of patients using split and non split pills was done after three months and showed no significant difference. The current analysis compared compliance with a baseline and used two different adherence measures; days late for refill and medication possession ratio. These show different aspects of the adherence.

The data so far is not conclusive; looking at the days late for refill measure, splitters had a higher compliance rate for ages 19-64; but looking at the medication possession ratio (MPR) there was no significant difference. Adherence in both cases was low; psych drugs have poor adherence in general (as do other drugs). Differences in adherence between patients using split and non-split pills may have something to do with doctors selecting patients who have been on Abilify longer to use split pills or some other factor that is not presented in the data.

There was discussion on possible interventions; Ms. McCormick spoke of interventions done with HIV drugs and how the results were not simply a straightforward issue of not taking the drugs. It was agreed that the data was not yet robust enough to use for intervention; further analysis will be done on specific cases, and calibration of the two adherence measures is needed. Further analysis will be presented at the February meeting.

### **Adjournment**

- A motion was made and seconded that the meeting be adjourned. All were in favor.

The meeting concluded at 8:10. The next meeting, focusing on new drug reviews, will be held January 12, 2010 as there is no meeting in December.

*Caring..Responsive..Well-Managed.. We are DHHS.*