



John E. Baldacci, Governor Brenda M. Harvey, Commissioner

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TO: Maine DUR Board
 FROM: Shari Martin
 DATE: March 15, 2009

RE: Maine DUR Board meeting minutes from March 10, 2009

Chair, Jeffrey Barkin MD. called the meeting to order at 6:00 p.m. Introductions were made then the floor was opened up for public comments, no public speakers this session.

ATTENDANCE	PRESENT	ABSENT	EXCUSED
William Alto, M.D. Dartmouth Family Practice			X
Robert Carroll, R.Ph., Target Pharmacy	X		
Timothy Clifford, M.D., Family Practice, GHS	X		
Mike Ouellette, R.Ph. GHS	X		
Steven Meiser MD, Pediatrician	X		
Andrew Cook, M.D. Psychiatrist (DBDS)	X		
Amy Enos, Pharm. D. Waltz Pharmacies	X		
Laureen Biczak DO, Infectious Disease, GHS	X		
Lisa Wendler, Pharm. D., Clinical Pharmacy Specialist, Maine Medical CTR, Vice-Chair	X		
Mark Braun, M.D., FACP	X		
Jeffrey Barkin, MD Psychiatrist, Chair	X		
Non -Voting			
Jennifer Cook, Pharmacy Manager, OMS	X		
Brenda McCormick, Director OMS	X		
Jude Walsh, Governor's Office			X
Rod Prior MD, Medical Director OMS	X		

OLD BUSINESS:

Dr Barkin asked members to review the draft meeting notes for February. A motion was made to accept the minutes of the February 10, 2009 DUR Board meeting as written. The motion was seconded and passed unanimously.

Haldol and Typical Utilization trend in children: Dr Clifford outlined the report specifics for this study. The study was broken into two groups: Haloperidol and Phenothiazines. Claims utilization was looked at for period of 2000-2008 by age groups. 0-18 age through age 80. Board asked if rates were adjusted over time, they were not.

Dr Barkin requested that the data be broken into three groups to include Moban utilization in addition to the Haloperidol and the phenothiazines. Dr Clifford took this as an action item to present at next meeting. Report will also show rate adjustments.

Board noted that the elderly population looked like they had decreased utilization over time. Question was raised if decreased utilization for the population could be because of 1st generation drugs Atypical vs 2nd generation Metabolic Rate. In order to determine the reason trends for Medicare Part D would need to be looked at. Psych work group requested a chronological Psych Drug profile analysis.

Dr Barkin requested that the PDL include Trilafon/ Perphenazine (schizophrenia drugs). Dr Meister requested a breakout of the data for Foster children. He stated that this population has a high rate of Atypical utilization treated with psychotropic drugs and he would be interested in seeing the statistics.

Psych Work Group Monthly Update. Group set to meet Thursday the agenda includes Typical utilization data metabolic monitoring initiative for patients on Atypical Antipsychotic.

Abilify pill splitting: 112 scripts went through without prior authorization because of the splitting criteria. The 15 and 30 strength pill splitting doses process without looking for PA. Dr Barkin stated that the psych group was very happy.

Lisa Wendler PharmD, Vice- Chairperson researched the pill splitting and noted that there was not any specific data available. Recommendations for pill splitting were solicited from the manufacturers, no recommendations were submitted. No specific data available but the makers of Zyprexa stated splitting exposes active ingredients. Recommendations to pharmacies would be to split as fresh as possible and store in tight containers.

Board noted that a lot of health plans have criteria in place that require or encourage pill splitting.

Board discussed that compliance data be looked at, once there is enough to report on, to ensure splitting the Abilify doesn't affect compliance measures. Dr Clifford noted that there is mandatory splitting in place for other drugs (such as Zyprexa) and compliance measures are not an issue.

Dr Barkin will bring the question of Abilify noncompliance measures to Psych work group.

New business:

HIV drug interactions (update hard edits) : Dr Clifford introduced the drug interaction document and explained that it was based in Liverpool. Because the compilation was done outside the USA there are drugs on the list that are not currently being used in the United States. The document can be used as a tool for identifying the drug interactions edits that should be in place with HIV drugs.

Dr Biczak explained that the biggest issue she has noticed in her practice is the drug interactions for patients who go to various physicians and the implications of not knowing all of the drugs that a patient is prescribed by other prescribers. Measures are being looked at by electronic meds to check on pt prescriptions. Not uncommon for patients not to report the HIV drugs to other prescribers. There were a number of patients who started Simvastatin and she had to contact their cardiologist to have them change the medication due to the serious drug interactions with the HIV medication. There is a need for harder edits to be put in place for the more dangerous combination drugs. Mike Ouellette stated that we currently have DDI edits in place that are hard blocked. Challenge is people who are on 3, 4 or 5 different meds so co-administration is not always an option. Some statins have edits in place but not necessarily with HIV medications.

Action item of scaling down the list was given to Dr Biczak. Once she scales down the list Lisa will do comparison of edits for those drugs. Lisa will comment back to board on which drugs should be prescribed w/o edits. She will compare against the Maine Medical edits already in place. Once this is completed then prioritization and recommendations will be done for drugs where there is true toxicity while ensuring that it does not affect the HIV providers. Discussed possibility of exempting the HIV docs (15 or 20).

For PPI edit's do not exclude HIV prescribers but narrow down list for live threatening interactions. Erythromycin and protease inhibitors. Dr Clifford recommends looking at HIV profiles and incorporating more safety by putting more edits in place that would hit up against other prescribers

Tobacco Cessation: Dr Clifford introduced the Smoking Cessation utilization chart which showed utilization chart for period of third quarter of 2006 through fourth quarter of 2008. The chart showed that utilization peaked at first quarter of 2008 with almost 4000 people. The fourth quarter showed utilization at approximately 2000. Publicly quoted statistic that 43% of MaineCare members smoke. Current usage of Chantix is three months supply with three months renewal if effective. NRT utilization data shows people do not stay on NRT long. Information was provided by Tobacco helpline for Tobacco Free Maine. Looking at data and efficacy. Rational behind study was indication of efficacy.

Brenda McCormick, Director, stated that cessation will become a department initiative. State needs to come up with ideas to deter tobacco use. Dr Richard Fein asked the board if there can be a link that requires MaineCare patients need to try another drug with the tobacco cessation drugs. Maybe a request that doctors encourage patients to use Wellbutrin in addition to nicotine replacement products.

Tom Algozzine from Pfizer stated that with Chantix prescription patients can also use receive counseling services at no additional cost. Pfizer has a helpline to assist with tobacco cessation counseling services. Board asked if the information is given to patients with prescription at the pharmacy. Tom wasn't sure if it was but stated that pharmacies are aware of the counseling services. Discussion ensued on how to get the information out to more people.

Improving Atypical Adherence- Tabled until May meeting

Closed Session:

WIC/ Baby Formula – Discussions ensued on statistical information presented, clarification needs prior to recommendations of next steps. Prior authorization forms and criteria from other insurers distributed.

Adjournment: A motion was made and seconded that the meeting be adjourned. All were in favor. The meeting was concluded at 8 p.m. The next meeting will be held on April 14, 2009.