Connecticut Medical Assistance Pharmacy Program
Drug Utilization Review (DUR) Program
DUR Board Meeting

June 2009 DUR Board Meeting Minutes

Thursday, June 18, 2009 at 6:30 PM
Connecticut Pharmacists Association Office
Rocky Hill, CT

ATTENDEES

Board Members Present: Dennis Chapron, M.S.; Richard Gannon, Pharm.D.; Keith Lyke R.Ph., Bhupesh Mangla, M.D., Ram Illindala, M.D.; Angela Moemeka, M.D., F.A.A.P, Lori Jane Duntz, R.Ph

Ex-Officio Non-Voting Member Present: Heather L. Kissinger, Pharm. D. (HID – DUR Board Coordinator and Secretary), James Zakszewski, R.Ph.

Guests: Robert Zavoski, MD (DSS), Ellen Arce, R.Ph. (EDS), Terence Lee (Gilead); Cory Stewart (Endo), Daniel Martin (Amgen), Craig Lemley (Amylin)

INTRODUCTORY BUSINESS

- Keith Lyke called the meeting to order at 6:36 p.m.
- Heather Kissinger stated Keith Lyke would be acting as chair for the June 2009 DUR Board meeting due to Ken Fisher's absence.

OLD BUSINESS

A. Previous Meeting Minutes

- The March 2009 DUR Board meeting minutes were approved by all members as submitted.

B. Follow-up from Previous Meeting

- The Board reviewed the section titled "Follow-up from the March 2009 DUR Board Meeting." Follow-up 1. A request was made to create a new criterion regarding the interaction between fluvoxamine and the select statins due to fluvoxamine's strong inhibition of 3A4.
- Heather Kissinger stated that a new criterion will be presented during the September 2009 DUR meeting for this purpose.
- Follow-up 2, a request was made to know how many patients received cephalexin between 8/15/08 and 11/21/08. The Board then wanted to compare that number to the 44 patients who were found to have been prescribed cephalexin with a subsequent prescription for metronidazole or oral vancomycin (or both) within a six week period.

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- Heather Kissinger stated that 9458 patients received a prescription for cephalexin between 8/15/08 and 11/21/08. 44 of those patients subsequently received a prescription for metronidazole or oral vancomycin (or both) within a six week period. Therefore, 0.5% of patients who received cephalexin between 5/15/08 and 11/21/08 received possible treatment for C. *diff* infection.
- Follow-up 3, a request was made to know how many patients received sulfamethoxazole/trimethoprim between 8/15/08 and 11/21/08. Compare that to the 86 patients who were found to have been prescribed sulfamethoxazole/trimethoprim with a subsequent prescription for metronidazole or oral vancomycin (or both) within a six week period.
- Heather Kissinger stated that 9626 patients received a prescription for sulfamethoxazole/trimethoprim between 8/15/08 and 11/21/08. 86 of those patients subsequently received a prescription for metronidazole or oral vancomycin (or both) within a six week period. Therefore, 0.9% of patients who received sulfamethoxazole/trimethoprim between 5/15/08 and 11/21/08 received possible treatment for C. *diff* infection.
- Follow-up 4, a request was made for the total prescription claims cost for 2008.
- Heather Kissinger stated that Total Rx claims cost for 2008 was$546,666,410.94
- Follow-up 5, a request was made know what specific diuretics, antihyperuricemia medications, and diagnoses make criteria 113 hit (alert message: Diuretic agents may cause or exacerbate hyperuricemia.).
- Heather Kissinger stated that the specific diuretics were the potassium wasting diuretics, the specific antihyperuricemia medications were Allopurinol, Colchicine, Probenecid, Sulfinpyrazone, and Febuxostat, and no specific diagnosis makes this criteria hit. This is a DC – drug inferred criteria however it negates for heart failure, usually the patient only needs to be on a diuretic.
- Follow-up 6, a request for a list of the specific diagnoses that make criteria 443 hit so that we may specify the criteria to alert for patients with class III and IV HF only (alert message: Congestive heart failure may cause tissue hypoxia and increase the risk for lactic acidosis in patients treated with metformin).
- Heather Kissinger stated the criterion hits for diagnoses beginning with 428, Congestive Heart Failure unspecified. There are no specific icd-9 codes for the classes of heart failure therefore HID cannot make the criteria specific to the class of heart failure a patient may have. Heather Kissinger explained that she found this information on the 2009 icd-9 web page: http://www.icd9data.com/2009/Volume1/390-459/420-429/default.htm

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- Follow-up 7, a request was made to add rifampin to criteria 797 as a medication that can induce liver enzymes and speed the metabolism of oral, transdermal and vaginal contraceptives (alert message: Certain medications can cause induction of liver enzymes and speed the metabolism of oral, transdermal and vaginal contraceptives. A partial list includes: barbiturates, phenytoin, carbamazepine, felbamate, oxcarbazepine, and St John's Wort. Use caution when using these drugs concomitantly as they may decrease effectiveness of the contraceptives. An alternative method of\contraception may be necessary.).
- Heather Kissinger stated since the alert message states this is a partial list, HID has not included the full list of medications that are considered enzyme inducers in the alert message. Rifampin is an enzyme inducer and does make this criteria hit although not part of the alert message. HID will be adding rifampin to the alert message for future claims.
- Dennis Chapron commented that this would be a good change since rifampin is one of the strongest enzyme inducers.
- Follow-up 8, a question was asked if oxcarbazepine was a medication that can induce liver enzymes to the extent that it should be considered a risk of speeding up the metabolism of oral, transdermal and vaginal contraceptives.
- Charlie Caley had sent an e-mail out to everyone after the March 2009 DUR Board Meeting and stated he was in favor of keeping oxcarbazepine on the list of enzyme inducers due to the following excerpts from the prescribing information:
- "Oxcarbazepine can inhibit CYP2C19 and induce CYP3A4/5 with potentially important effects on plasma concentrations of other drugs." and "In addition, oxcarbazepine and MHD induce a subgroup of the cytochrome P450 3A family (CYP3A4 and CYP3A5) responsible for the metabolism of dihydropyridine calcium antagonists and oral contraceptive, resulting in a lower plasma concentration of these drugs."
- All Board Members agreed with Charlie Caley's e-mail and were in favor of keeping oxcarbazepine on the list.
- Follow-up 9, a request was made to know if a patient's previous use of gabapentin would be a negating factor for criterion 2790 (alert message: Clinical trials have not shown Lyrica (pregabalin) to be superior to gabapentin for the treatment of neuropathic pain associated with diabetic peripheral neuropathy, postherpetic neuralgia or partial-onset seizures in adults. If no contraindications are present consider prescribing the less expensive generic agent, gabapentin, as first-line therapy).

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- Heather Kissinger stated that a patient's previous use of gabapentin is a negating factor for criterion 2790.
- Follow-up 10, a request that zolpidem be added to the list of generic sedative/hypnotics used to treat insomnia in criteria 2793 (alert message: Clinical trials have not shown Lunesta (eszopiclone) to be superior to other sedative/hypnotics for the treatment of insomnia. If no contraindications are present consider prescribing a less expensive generic sedative hypnotic agent before prescribing a brand name product. Generic sedative hypnotic options include estazolam, flurazepam, temazepam, and triazolam). It was further requested that zolpidem be the first generic sedative/hypnotic listed in the alert message prior to all other options.
- Heather Kissinger stated that change was made.
- Heather Kissinger asked the board members if they wanted that same change made to criteria 2792 (alert message: Clinical trials have not shown Ambien CR (zolpidem controlled-release) to be superior to other sedative/hypnotics for the treatment of insomnia. If no contraindications are present consider prescribing a less expensive generic sedative/hypnotic agent before prescribing a brand name product. Generic sedative/hypnotic options include zolpidem, estazolam, flurazepam, temazepam, and triazolam.)
- The Board Members were all in favor of this change.
- Follow-up 11, a request was made to know how many patients were receiving a prescription for a dopaminergic agent and also receiving a prescription for long term high dose metoclopramide.
- Heather Kissinger stated there were **1748** patients who hit on the metoclopramide / black box warning criteria during the 5/5/09 ICER. There were **1901** patients who received a dopaminergic agent between 2/24/09 and 4/24/09. A cross reference search was conducted between the metoclopramide patients and patients who received a dopaminergic agent between 4/1/09 and 6/1/09. **39** patients were found to have received both a dopaminergic agent in conjunction with chronic high dose metoclopramide.
- Dennis Chapron requested to know how many patients out of the 39 who received both a dopaminergic agent and chronic high dose metoclopramide had received metoclopramide first, prior to receiving a dopaminergic agent.
- Heather Kissinger stated she would research this request.
- Follow-up 12, a request was made to know how many patients had a diagnosis of a movement disorder and had received a prescription for long term high dose metoclopramide.

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- Heather Kissinger stated there were **1748** patients who hit on the metoclopramide / black box warning criteria during the 5/5/09 ICER. There were **51,050** patients who have received a diagnosis for a movement disorder from 1/1/07 through 4/24/09. Movement disorders such as ataxias, dystonias, essential tremor, Huntington's disease, myoclonus, Parkinson's disease, Restless Leg Syndrome, spacticity, tardive dyskinesia, torticollis, Tourette's syndrome, and Wilson's disease were considered for this query. Most disorders fell under diagnosis codes 330-370, Hereditary and Degenerative Diseases of the Central Nervous System. A cross reference search was conducted between the patients who received chronic high dose metoclopramide, and patients who were diagnosed with a movement disorder (1/1/07 - 6/1/09). **393** patients were found to have a diagnosis of a movement disorder and also received a chronic high dose metoclopramide prescription.
- Rich Ganon requested to know how many patients with Parkinson's disease and Tardive Dyskinesia had received chronic high dose metoclopramide. If there were a large number of patients Rich suggested we run an intervention. If there were a small number of patients Rich requested that Heather Kissinger review their profiles and report back to the Board.
- Heather Kissinger stated she would research this request.
- Follow-up 13, a request was made that the June newsletter have a statement regarding negating categories for the lock-in criteria to remind prescribers that certain diagnoses and medications make certain patients exempt from being evaluated for the lock-in program.
- Heather Kissinger stated that due to the amount of information included in the June newsletter regarding GERD, possibly a separate newsletter be written focusing a few issues for the September 2009 edition. A review on the lock-in program could be one topic and recently there has been an update on the RSV guidelines. EDS/HID are beginning to work on putting together a PA for Synagis ® so this could also be discussed.
- Robert Zavoski suggested including anti-influenza medications and the influenza vaccine.
- Follow-up 14, a request was made to know if HID had a criterion pertaining to the interaction between Amiodarone and simvastatin.
- Heather Kissinger stated that criterion 1203 exists for this purpose. (Alert message: Concurrent use of amiodarone and simvastatin may increase the risk of myopathy/rhabdomyolysis, particularly with simvastatin doses greater than 20 mg daily. Doses of simvastatin greater than 20 mg per day in patients taking amiodarone should be avoided unless the clinical benefit outweighs the increased risk of myopathy/rhabdomyolysis. Consider using an alternative statin (i.e., pravastatin, fluvastatin, or rosuvastatin) which is not metabolized by CYP3A4).

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C. Criteria Trend Summary

- Heather Kissinger directed the Board to section 4 to review the Criteria Trend Summary
- Heather Kissinger stated that this was a new addition to the DUR Board packets that began at the March 2009 Board Meeting.
- The purpose of this report is to review criteria previously reviewed 180 days after an intervention is performed to evaluate if that intervention had an impact on the population.

CMS Report

- The Board began reviewing the FFY 2008 CMS report.
- Heather Kissinger stated the Executive Summary could be found on pages 3-6 and the CMS Survey could be found on page 7-11.
- The Board reviewed the Executive Summary and the CMS Survey and had no questions, changes, or comments.
- The Board members reviewed ProDUR Table 1 on pages 12-16.
- Heather Kissinger stated there are 8 ProDUR criteria which existed prior to 1/25/08 and include Early Refill, Therapeutic Duplication Drug-Drug interaction, High Dose, Pregnancy, Drug-Age Pediatric, Low Dose, and Late Refill. Low Dose and Late Refill are informational alerts only and do not require and override by the pharmacy. On 1/25/08 5 new alerts were added to the ProDUR criteria and include Drug-Age Geriatric, Ingredient Duplication, Drug Disease, Minimum Duration and Maximum Duration. Minimum Duration and Maximum Duration are also informational in nature.
- Keith Lyke commented that he recognized there were a few new alerts being utilized and that some alerts may not be necessary after the first fill of a medication. Keith used the example of when a patient has a prescription for both albuterol and metoprolol EDS requires an override. Keith stated that if the patient has been on the two medications long term that it would be useful if the alert could be turned off.
- Keith Lyke gave another example of a patient who has been taking fioricet chronically and hits on the Drug-Age Geriatric alert. Keith stated that this alert does not need to hit every time this patient has a fioricet prescription if they have been taking it chronically.
- Ellen Arce stated that ProDUR alerts can be modified by the DUR Board and maybe certain alerts don't need to occur every time a prescription is filled.

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- Bhupesh Mangla suggested that the Board could utilize some of the RDUR queries to assess where the problems are and build up more ProDUR alerts based on those findings.
- Lori Jane Duntz asked why the alert that states a patient has diabetes come up when you try to fill a prescription for Metformin. Lori also asked about the alert that states "This person has been in the hospital" means. Lori also wanted to know how many days the system does back to retrieve diagnosis data for a patient.
- Ellen Arce stated that the system goes back 180 days from the date of service of a claim when analyzing diagnosis data. Ellen also stated she would follow up with Lori's other questions.
- Jim Zakszewski requested that Ellen Arce follow-up on Inferred Disease to make sure that the alert was not active as the Department requested that alert be inactive.
- Ellen Arce stated she would follow-up with Jim.
- Heather Kissinger reported that table 2 of the CMS report could be found on pages 18-20 and included Retrospective DUR criteria used during FFY 2008 submitted by ACS and HID.
- The Board reviewed table 2 and had no questions, changes, or comments.
- Heather Kissinger reported that Attachment 1 of the CMS report could be found on pages 21-23. Attachment 1 is a report on the monitoring of pharmacy compliance with all prospective DUR requirements performed by the State Medicaid agency and the State Board of Pharmacy.
- The Board reviewed Attachment 1 and had no questions, changes, or comments.
- Heather Kissinger reported that Attachment 2 of the CMS report could be found on pages 24-55 and is the year end summary report on prospective DUR screening using the on-line POS system.
- Heather Kissinger stated that pages 27-55 show each ProDUR alert that is reported. Each alert has a 3 page section that includes a table and a bar graph to illustrate the top 10 therapeutic categories by GC3 class that made each alert hit. The alerts that require an override have an additional page displaying a bar graph of the % overrides versus the % cancelled and no response.
- Keith Lyke stated that there was a discrepancy between the amount of prescriptions that were cancelled in 2008 versus 2007 and 2006 and wanted to know why it seemed as though providers were overriding more alerts than years prior.
- Ellen Arce stated that this discrepancy was due to the difference in interchange and there was also extensive training on how to override the alerts in the pharmacy community.
- Keith Lyke stated that there was also a discrepancy between the Early Refill alert in 2008 when compared to 2007 and 2006.

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- Heather Kissinger directed the Board to review the Early Refill Alert, page 27. During FFY 2008 the % of ER alerts that were overridden was 99.82% with 0.16% of the ER alerts being canceled or no response, however in FFY 2007 27.58% were overridden and 72.42% were canceled or no response. This discrepancy is because of interchange. Interchange now counts ER alerts that are overridden with a PA; prior to interchange the PA overridden ER alerts were not counted, making the % of alerts overridden for ER prior to FFY 2008 much less than they are now.
- Ellen Arce added that prior to interchange ER alerts were edits whereas now they are counted.
- Dennis Chapron asked insulin-lispro/insulin glargine and insulin aspart/insulin glargine were in the top 10 therapeutic categories that made the therapeutic duplication alert hit since those medications are supposed to be used together when treating a diabetic patient.
- Ellen Arce stated that if there were certain alerts or medications that made alerts hit that didn't seem logical the Board can modify the ProDUR criteria.
- Dennis Chapron commented that he would like to see more serious interactions rather than the top 10 therapeutic categories that make each alert hit.
- Rich Gannon gave the example of the top Drug-Drug interaction therapeutic category of FFY 2008 was fluoxetine-clonazepam. Rich stated that those two medications are given in conjunction all the time and maybe the alert should be modified to hit only upon initiation of the medications.
- Keith Lyke agreed and also gave the example of the Drug-Drug interaction warfarin-levothyroxine and stated he thought this would be useful upon initiation of therapy but to turn the alert off after the first fill.
- Ellen Arce suggested to the Board to work within the drug-drug interaction alert type first to have a focus area on reducing the illogical therapeutic categories. Ellen also suggested that it may be useful to put together a team of pharmacists to decide which alerts to modify.
- Dennis Chapron requested to see the more serious interactions for Drug-Drug interaction within class I and II high severity.
- Ellen Arce stated that she would follow-up with the request.
- Keith Lyke pointed out that on page 42 the percent of claims overridden during FFY 2008 was input as the wrong number and requested that prior to submitting the report to change the number to 97.96%.
- Heather Kissinger stated this change would be made prior to submitting the report to CMS.

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- The Board had no further questions, changes, or comments regarding Attachment 2.
- Heather Kissinger stated Attachment 3 could be found on pages 56-71 and is a year end summary report on retrospective screening and interventions.
- Heather stated that attachment 3a is the summary of the Therapeutic Class Exceptions (TCEs) submitted by HID and summarizes the total number of patients who hit on a TCE within each AHFS drug class during FFY 2008. Attachment 3b is the summary of the interventions performed during FFY 2008 by HID summarized by AHFS class.
- Heather stated the Attachment 3c is the summary of the patient profiling performed for DUR and Lock-In during FFY 2008. During January, February, and March of 2008 no interventions were performed du to a lack of data due to the implementation of the MMIS Interchange System at EDS. November and December 2007 interventions were performed by ACS and the remainder of the FFY 2008 interventions were performed by HID.
- Heather Kissinger stated she was not sure why the total number of claims reviewed by ACS was much higher that the total number of claims reviewed by HID each month.
- Allen Arce stated that ACS probably counted all claims, pharmacy and medical, when they reported how many claims reviewed.
- Heather Kissinger reported that Attachment 4 of the CMS report could be found on pages 72-100 and is a brief descriptive report on the DUR Board activities during the FFY 2008.
- It was stated that attachment 4 includes the FFY 2008 DUR Board meeting minutes, criteria selections, and quarterly provider newsletters.
- The Board reviewed Attachment 4 and had no questions, changes, or comments.
- Heather Kissinger reported that Attachment 5 of the CMS report could be found on pages 101-103 and describes and policies in place to encourage the use of therapeutically equivalent generic drugs.
- Jim Zakszewski requested that the statement at the bottom of page 101 be changed to read: “Preferred Drug List with nearly all generics preferred” rather than stating that all generics were preferred.
- Heather Kissinger stated this change would be made prior to submitting the report to CMS.
- Heather stated the Generic Dispensing Rate (GDR) for FFY 2008 was 57.99%.
- Rich Gannon asked how CT compared to other states with regarding to GDR.
- Keith Lyke stated that it could be hard to say due to the reporting methods each state has.

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- Ellen Arce stated sometimes GDR can be quite low in states that have no incentive for the client to choose a generic product over the brand.
- The Board hypothesized the reason for the GDR being so high during FFY 2008 could have been due to the release of many generic products through the year.
- The Board had no further questions, changes, or comments regarding Attachment 5.
- Heather Kissinger reported that attachment 6 of the CMS report could be found on pages 104-123 and is the program evaluations/cost savings estimates prepared by HID, ACS, and EDS.
- RetroDUR and Lock-In cost savings during FFY 2008 reported by HID was $1,971,201. This amount only accounts for the time period April 2008 through September 30, 2008, due to the lack of claims from EDS beginning January 25, 2008 through March 2008.
- No cost savings was reported by ACS due to the fact that they did not receive any data beyond 12/23/07 therefore no outcome analysis was performed. If they had reported on cost savings they would have covered October 1, 2007 through January 25, 2008.
- ProDUR cost savings in FFY 2008 was estimated to be a total of $7,184,600 on 57,748 prescriptions. Early Refill and Ingredient Duplication are the top two cost savings alerts
- The Board reviewed Attachment 6 and had no questions, changes, or comments.
- The Board approved the CMS report contingent upon Heather Kissinger making the few minor changes that were requested.

A. Program Summary Review

- The Board reviewed the program summary review for 1st quarter 2009.
- Heather Kissinger stated that the prescription claims cost for 1st quarter 2009 was $154,083,959.42
- The average prescription cost decreased by $8.04 compared to 4th quarter 2008.
- The Board hypothesized the decrease in average paid per RX could have decreased due to an increase in generic drug release, specifically the release of topiramate to the market.

B. Intervention Activity Report

- The Board reviewed the Intervention Activity report for 1st quarter 2009.
- It was stated that the Intervention Activity Report is a monthly summary of the distribution of letters mailed to prescribers and also summarizes the main criteria that were reviewed each month.

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- In January 2009, 1795 letters were sent. The main intervention reviewed was Lidoderm (transdermal lidocaine) is FDA approved only for the relief of pain associated with postherpetic neuralgia. Our records do not indicate a supporting diagnosis for the use of this medication. The long-term safety and efficacy of this agent in treating other disease states is unknown (878 letters), and the lock-in criteria (535 letters).
- In February 2009, 1362 letters were sent. The main interventions reviewed were: Tussionex overutilization, venlafaxine overutilization, fentanyl overutilization, and Flector overutilization (358 letters), and the lock-in criteria (369 letters).
- In March 2009, 1503 letters were sent. The main intervention reviewed was: Clinical trials have not shown Lyrica (pregabalin) to be superior to gabapentin for the treatment of neuropathic pain associated with diabetic peripheral neuropathy, postherpetic neuralgia or partial-onset seizures in adults. If no contraindications are present consider prescribing the less expensive generic agent, gabapentin, as first-line therapy (807 letters) and the lock-in criteria (358 letters).

C. Therapeutic Criteria Exception Report: ICER Date 5-5-09

- The Board reviewed the Therapeutic Criteria Exception Report that was created using the ICER ran on 5-5-09.
- Heather Kissinger stated this report is meant to help guide which interventions the Board decides to use.
- Bhupesh Mangla commented that he had read an article in the past that stated ACEI controlled blood pressure better for Type I diabetics and ARBs controlled blood pressure better for Type II diabetics when used for renal protection and management of congestive heart failure in these patients.
- Heather Kissinger stated that criteria 547, lipid lowering agents may be underutilized resulting in subtherapeutic effects, was recently reviewed.
- Dennis Chapron gave Heather Kissinger a copy of the Institute for Safe Medication Practices (ISMP) newsletter and pointed out that quetiapine was ranked in the top 15 medications for most frequent drugs involved in serious, disabling, and fatal events in 2008 3Q. Dennis commented that it would be interesting to know what the serious, disabling, and fatal events were specifically.
- Heather Kissinger stated she would look into the request and follow-up.
- Keith Lyke stated that an intervention regarding use of PPIs post hospitalization would be a good intervention to perform.

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- Heather Kissinger stated she would verify that HID had a criteria for this purpose and run an intervention based on Keith's request.
- Keith Lyke requested to know how each criterion is categorized into major, moderate or severe.
- Heather Kissinger stated she would follow-up with the request.

C. RetroDUR New Criteria Selections

- Criteria 1, Silodosin/ Over-utilization was approved as written by the Board.
- Criteria 2, Silodosin / Over-utilization – Renal Impairment was approved as written by the Board.
- Criteria 3, Silodosin / Contraindication was approved as written by the Board.
- Criteria 4, Silodosin/ Potent CYP 3A4 Inhibitors - Contraindication was approved as written by the Board.
- Criteria 5, Silodosin/ Moderate CYP 3A4 Inhibitors - Contraindication was approved as written by the Board.
- Criteria 6, Silodosin/ Alpha-Blockers was approved as written by the Board.
- Criteria 7, Silodosin/ Potent P-glycoprotein Inhibitors was approved as written by the Board.
- Criteria 8, Silodosin/ Other Antihypertensive Agents was approved as written by the Board.
- Criteria 9, Silodosin/ PDE-5 Inhibitors was approved as written by the Board.
- Criteria 10, Milnacipran/ Over-utilization was approved as written by the Board.
- Criteria 11, Milnacipran/ Nonadherence was approved as written by the Board.
- Criteria 12, Milnacipran/ Monoamine Oxidase Inhibitors was approved as written by the Board.
- Criteria 13, Milnacipran/ Risk of Suicide was approved as written by the Board.
- Keith Lyke requested to know what the cutoff age was for criteria 13 prior to activation.
- Criteria 14, Milnacipran/ Uncontrolled Narrow Angle Glaucoma was approved as written by the Board.
- Criteria 15, Milnacipran/ Serotonergic Drugs was approved as written by the Board.
- Criteria 16, Milnacipran/ Clonidine was approved as written by the Board.
- Criteria 17, Milnacipran/ Seizures was approved as written by the Board.
- Criteria 18, Milnacipran/ Hypertension was approved as written by the Board.
- Criteria 19, Febuxostat/ Over-utilization was approved as written by the Board.
- Criteria 20, Febuxostat/ Nonadherence was approved as written by the Board.
- Criteria 21, Febuxostat/ Azathioprine, Mercaptopurine & Theophylline was approved as written by the Board.

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- Criteria 22, Febuxostat/ Cardiovascular Events (Warning) was rejected by the Board.
- Criteria 23, Febuxostat/ Liver Enzyme Elevation (Warning) was approved as written by the Board.
- Criteria 24, Zonisamide/ Therapeutic Appropriateness was approved as written by the Board.
- Criteria 25, Clopidogrel/ Proton Pump Inhibitors was tabled by the Board indefinitely until further investigation could be performed.
- Dennis Chapron requested that Heather Kissinger remind him to forward the Medscape Medco study article to her.
- Criteria 26, Quetiapine/ Low Dose for Sedation was approved as written by the Board.

D. Newsletter

- The Board approved the June 2009 DUR Newsletter with the following modifications:
    - On the second page, second column, under IV. Promotility Therapy, remove: bethanechol, tegaserod, and baclofen. Change sentence to read: Currently available FDA approved promotility agent is metoclopramide and is not ideal monotherapy for most patients with GERD.
    - On the second page in the table add the dosing information for the new PPI, dexlansoprasole.
- The Board agreed that once those changes were made to the newsletter, Heather Kissinger would begin the mailings.
- The topic of the September 2009 DUR newsletter was agreed upon by the Board to cover the updated RSV Guidelines, anti-influenza medications/vaccines, and an overview of the Lock-In program.

NEW BUSINESS

- The date for the September 2009 DUR Board meeting was confirmed as Thursday September 10, 2009.
- The dates for the remaining 2009 DUR Board meetings are:
    - Thursday September 10, 2009
    - Thursday December 10, 2009
- The meeting was adjourned at 8:30 pm.

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