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

March 2010 DUR Board Meeting Minutes

Thursday, March 11, 2010 at 6:30 PM
Connecticut Pharmacists Association Office
Rocky Hill, CT

ATTENDEES

Board Members Present: Kenneth Fisher, R.Ph. (Chair), Keith Lyke R.Ph., Dennis Chapron, M.S., Richard Gannon, Pharm.D., Bhupesh Mangla, M.D., Ram Illindala, M.D., Charles Caley, Pharm. D., Angela Moemeka, M.D., F.A.A.P

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

Guests: Fran Kochman (GlaxoSmithKline), Wendy Pollinger (Eli-Lilly); Daniel Martin (Amgen)

INTRODUCTORY BUSINESS

- Ken Fisher called the meeting to order at 6:30 p.m.

OLD BUSINESS

A. Previous Meeting Minutes

- The December 2009 DUR Board meeting minutes were approved by all members with the following changes:
    - Page 1, guest James Kokoszy (Allergan) should be spelled James Kokoszyna
    - Page 6, DUR Board ByLaws Review, bullet 6, change loose to lose.

B. Follow-up from Previous Meeting

- The Board reviewed the section titled "Follow-up from the December 2009 DUR Board Meeting."
- Follow-up 1. Within the Institute for Safe Medication Practices (ISMP) newsletter quetiapine was ranked in the top 15 medications for most frequent drugs involved in serious, disabling, and fatal events in 2008 3Q. During the June 2009 DUR Board meeting, it was requested to know what the serious, disabling and fatal events were specifically.
- After the December 2009 Board meeting Heather Kissinger contacted Pamela Prue from the Freedom of Information Act Department (FOIA) to determine the cost of obtaining the information from them. The total cost would be $72.00 for the information and it would be sent

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on a CD that is not importable into excel easily. It would not be possible for the FOIA to report only the serious, disabling, and fatal events linked to quetiapine during 3rd QTR 2008, they would have to send all ADEs reported to the FDA during that time period. Also, there would be no description of the MedWatch report, only an ADE would be listed. If more information was desired we would have to request information for each ADE, which there would be an additional cost. Unfortunately at this time, there is no budget for this information. Heather then contacted the information center at AstraZeneca (1-800-236-9933) directly to obtain any information relating to quetiapine ranking 15 in the QuarterWatch Report published in the ISMP newsletter (2008 Q3). The nurse she spoke with directed her back to ISMP to obtain that information. The nurse said that any information pertaining to serious, disabling, and fatal events caused by quetiapine that AstraZeneca could divulge would be listed in the prescribing information. To know what specific events ISMP were considering for ranking quetiapine # 15 would have to come from them.

- Follow-up 2, a request was made to update the ByLaws with all changes made during the December 2009 Board Meeting.
- Heather Kissinger stated that all changes were made and the updated ByLaws could be found in section 4 of the DUR Board handouts.
- Follow-up 3, a request was made to know how HID's other states compared to Connecticut's average prescription cost and if the other states' costs are rising per prescription.
- Heather Kissinger stated the cost comparison could be found as attachment 1. 9 states' Program Summaries (including Connecticut) were provided in attachment 1 and Connecticut fell in the middle of the 9 states for average prescription cost per RX, however, Ram Illindala pointed out that the cost per recipient per month for Connecticut was second most costly, only slightly lower than New York.
- Follow-up 4, a request was made to know how the refill rate or the possession ratio is calculated for underutilization or non-adherence criteria.
  Heather Kissinger stated the patient has to get a 70 day supply or less in 90 days. The HIV underutilization criteria hit on 80 day supply or less in 90 days.
- Follow-up 5, a request was made for more information regarding the new criteria Asenapine/Fluvoxamine. It was tabled until the March 2010 meeting.

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10. Asenapine / Fluvoxamine **TABLE UNTIL 03-2010**

Alert Message: Caution should be exercised when co-administering Saphris (asenapine), a CYP1A2 substrate, with the potent CYP1A2 inhibitor fluvoxamine. Concurrent therapy with the agents may result in elevated asenapine plasma concentrations and risk of adverse effects.

Drugs/Disease:

Util A	Util B	Util C
Asenapine	Fluvoxamine	

References:
Saphris Prescribing Information, August 2009, Schering-Plough.

- Heather Kissinger stated that information regarding fluvoxamine inhibiting the metabolism of asenapine through fluvoxamine's inhibition of CYP 1A2 could be found in asenapine's package insert. The Board was directed to review the information and to vote on the tabled criteria once the criteria section was reviewed later in the meeting.

Taken Directly from Saphris's PI

Potential for Other Drugs to Affect SAPHRIS

Asenapine is cleared primarily through direct glucuronidation by UGT1A4 and oxidative metabolism by cytochrome P450isoenzymes (predominantly CYP1A2). The potential effects of inhibitors of several of these enzyme pathways on asenapine clearance were studied.

TABLE 4: Summary of Effect of Coadministered Drugs on Exposure to Asenapine in Healthy Volunteers

Coadministered drug (Postulated effect on CYP450/UGT)	Dose schedules		Effect on asenapine pharmacokinetics		Recommendation
	Coadministered drug	Asenapine	C_{max}	$AUC_{0-\infty}$	
Fluvoxamine (CYP1A2 inhibitor)	25 mg twice daily for 8 days	5 mg Single Dose	+13%	+29%	Coadminister with caution*
Paroxetine (CYP2D6 inhibitor)	20 mg once daily for 9 days	5 mg Single Dose	–13%	–9%	No SAPHRIS dose adjustment required *[see Drug Interactions (7.2)]*

*The full therapeutic dose of fluvoxamine would be expected to cause a greater increase in asenapine plasma concentrations. AUC: Area under the curve.

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TABLE 4: Summary of Effect of Coadministered Drugs on Exposure to Asenapine in Healthy Volunteers *(cont)*

Coadministered drug (Postulated effect on CYP450/UGT)	Dose schedules		Effect on asenapine pharmacokinetics		Recommendation
	Coadministered drug	Asenapine	C_{max}	$AUC_{0-\infty}$	
Imipramine (CYP1A2/2C19/3A4 inhibitor)	75 mg Single Dose	5 mg Single Dose	+17%	+10%	No SAPHRIS dose adjustment required
Cimetidine (CYP3A4/2D6/1A2 inhibitor)	800 mg twice daily for 8 days	5 mg Single Dose	–13%	+1%	No SAPHRIS dose adjustment required
Carbamazepine (CYP3A4 inducer)	400 mg twice daily for 15 days	5 mg Single Dose	–16%	–16%	No SAPHRIS dose adjustment required
Valproate (UGT1A4 inhibitor)	500 mg twice daily for 9 days	5 mg Single Dose	2%	–1%	No SAPHRIS dose adjustment required

*The full therapeutic dose of fluvoxamine would be expected to cause a greater increase in asenapine plasma concentrations. AUC: Area under the curve.

- Follow-up 6, the Board requested criteria Asenapine / QT Prolongation (ICD-9s) and criteria Asenapine / QT Prolongation Drugs be combined into one criterion, if possible.

Asenapine / QT Prolongation (ICD-9s)
Alert Message: Saphris (asenapine) has been shown to cause a 2 to 5 msec increase in the QTc interval. Asenapine use should be avoided in patients with congenital long QT syndrome, a history of cardiac arrhythmias, bradycardia, hypokalemia or hypomagnesemia, and in patients receiving any drug that prolongs the QTc interval (e.g., Class IA & III antiarrhythmics, antipsychotics, macrolides and fluoroquinolones).

Drugs/Disease:
Approved as amended with the deletion of cardiac arrhythmia from Util B

Util A	Util B	Util C
Asenapine	QT Prolongation	
	Hypokalemia	
	Hypomagnesemia	

References:
Saphris Prescribing Information, August 2009, Schering-Plough.

Asenapine / QT Prolongation Drugs
Alert Message: Saphris (asenapine) has been shown to cause a 2 to 5 msec increase in the QTc interval. Asenapine use should be avoided in patients with congenital long QT syndrome, a history of cardiac arrhythmias, bradycardia, hypokalemia or hypomagnesemia, and in patients receiving any drug that prolongs

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the QTc interval (e.g., Class IA & III antiarrhythmics, antipsychotics, macrolides and fluoroquinolones).

Drugs/Drug:

Util A	Util B			
Asenapine	Foscarnet	Perphenazine	Pentamidine	Paliperidone
Fosphenytoin	Fluphenazine	Pimozide	Ziprasidone	
Alfuzosin	Granisetron	Quetiapine	Amitriptyline	
	Amantadine	Haloperidol	Quinidine	Amoxapine
	Amiodarone	Ibutilide	Ranolazine	Clomipramine
	Arsenic Trioxide	Indapamide	Risperidone	Desipramine
	Atazanavir	Isradipine	Salmeterol	Doxepin
	Azithromycin	Itraconazole	Sertraline	Imipramine
	Chloral Hydrate	Ketoconazole	Solifenacin	Nortriptyline
	Chlorpromazine	Lapatinib	Sotalol	Protriptyline
	Clozapine	Levofloxacin	Tacrolimus	Trimipramine
	Disopyramide	Lithium	Tamoxifen	Propafenone
	Dofetilide	Methadone	Telithromycin	Procainamide
	Dolasetron	Moexipril/HCTZ	Thioridazine	Gemifloxacin
	Droperidol	Moxifloxacin	Tizanidine	Fluoxetine
	Erythromycin	Nicardipine	Tolterodine	Dronedarone
	Felbamate	Nilotinib	Vardenafil	Mexiletine
	Flecainide	Octreotide	Venlafaxine	Clarithromycin
	Fluconazole	Ondansetron	Voriconazole	Erythromycin
	Gemifloxacin	Norfloxacin	Ciprofloxacin	

References:
Saphris Prescribing Information, August 2009, Schering-Plough.

- Heather Kissinger stated Asenapine / QT Prolongation (ICD-9s) and Asenapine / QT Prolongation Drugs cannot be combined because the first is classified as a drug-disease interaction, and the other is classified as a drug-drug interaction.
- Charlie Caley commented that a change in the QTc interval of 2-5 msec was not that substantial.
- Bhupesh Mangla agreed with Charlie but stated that the change in the QTc interval of 2-5 msec could be substantial for some patients and not for others depending on what other medications some patients are taking, the changes in QTc can be additive, but in isolation, asenapine alone would probably not be substantial.

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C. Review of DUR Board ByLaws

- The DUR Board ByLaws were reviewed and approved as amended with the following additional changes:
  - Page 3, Terms of Membership, it was requested to add in the last sentence of this section to read: If more than one member wishes to resign, the member with the most years of service on the Board may resign first.
  - Page 4, Board Officers, Annual Election, it was requested to have the sentence in this section read: The DUR Boars may elect a Chairperson and Vice-chairperson if so desired, during the first meeting of the DUR Board of each federal fiscal year.
  - Page 5, Election Procedures, it was requested to remove the following sentences: If no one member receives a simple majority of the ballots, the nominee who received the lowest number of ballots is dropped and the members cast written ballots from the remaining nominees. This procedure is repeated until a nominee receives a majority of the votes.

D. Criteria Trend Summary

- Heather Kissinger stated that section 4 is the criteria trend summary, the purpose of this report is to review criteria previously reviewed 6 months after intervention letters are mailed to evaluate if the intervention had an impact on the population.
- 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 zolpidem, estazolam, flurazepam, temazepam, and triazolam) had 756 hits in July 2009 and decreased to 204 hits in January 2010.
- Dennis Chapron requested that flurazepam and triazolam be removed as alternative options from all sedative hypnotic criteria.
- Heather Kissinger stated she would have this done.
- Criteria 1348-1364, 1367-1373, 1530-1533, 1554-1562, 2609-2610 (Alert message: The patient may not be receiving the optimal dosing regimen for this medication. A higher strength exists for this medication, which would allow for a reduced dosing schedule. Utilizing the optimal dosing for this medication would increase patient compliance, decrease Medicaid expenditures,

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and reduce drug diversion.) had 893 hits in August 2009 and decreased to 560 hits in February 2010.

- Criteria 2949, (Alert message: Low dose Seroquel (quetiapine), less than 200 mg, is sometimes used off-label as a sedative agent. Quetiapine is not FDA approved for the treatment of sleep-related problems. The long-term safety and efficacy of this treatment strategy have not been evaluated.) had 485 hits in September 2009 and decreased to 344 hits in March 2010.
- Criteria 2375, (Alert message: Butalbital-containing products may be over-utilized. Patients using these agents more than 3 times a week may develop dependency, tolerance, and rebound headaches. Butalbital is FDA-approved for the treatment of episodic tension-type headaches, but is has not been proven to be clinically effective in migraine headaches. If butalbital is being prescribed for tension-type headache, consider using aspirin, acetaminophen, or an NSAID. If butalbital is being prescribed for migraine headaches, consider using a migraine-specific medication such as a Serotonin 5-HT1 Receptor Agonist.) had 374 hits in September 2009 and decreased to 219 hits in March 2010.
- Dennis Chapron mentioned that some studies have been done investigating whether or not butalbital is a 3A4 inducer similar to Phenobarbital.

Retrospective Drug Utilization Review

A. Program Summary Review

- The Board reviewed the program summary review for 4th quarter 2009.
- Heather Kissinger stated that prescription claims cost, the number of prescriptions, the total number of unique recipients, the cost of recipient per month, and the average paid per prescription decreased when compared to 3rd quarter 2009.
- Keith Lyke stated that it would be interesting to view the 1st quarter 2010 Program Summary during the June 2010 Board meeting to see if the Medicare copay had an impact.

B. Intervention Activity Report

- The Board reviewed the Intervention Activity report for 4th 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 October 2009, 1549 letters were sent. The main interventions reviewed were: Concurrent use of fentanyl products with potent CYP 3A4 inhibitors (e.g., ritonavir, ketoconazole, itraconazole, troleandomycin, clarithromycin, nelfinavir, and nefazodone) may result in an increase in fentanyl plasma concentrations, which could increase or prolong adverse effects and may cause potentially fatal respiratory depression. Patients receiving fentanyl and potent CYP 3A4 inhibitors should be monitored for an extended period of time and dosage adjustments made if warranted (54 letters), The maximum recommended dose of propoxyphene napsylate is 600 mg per day and 390 mg per day for propoxyphene hydrochloride. Exceeding the maximum dose of propoxyphene may result in accumulation of the parent compound and the active metabolite causing an increased risk of adverse reactions and sometimes fatal overdose. Fatalities within the first hour of overdosage are not uncommon (4 letters), Angiotensin-converting enzyme inhibitors (ACEIs) are not recommended during pregnancy due to the possible risk of fetal abnormalities in humans. ACEIs should be used only if the benefits outweigh the risks of harm to the fetus. All ACEIs are FDA pregnancy category C during the first trimester and pregnancy category D during the second and third trimesters (6 letters), Estrogens alone or in combination products should not be used in patients with a history of endometrial carcinoma (3 letters), Thiazolidinediones, alone or in combination with other antidiabetic agents, can cause fluid retention, which may exacerbate or lead to heart failure. Patients should be observed for signs and symptoms of heart failure. Discontinue thiazolidinedione therapy if any deterioration in cardiac status occurs. Rosiglitazone and pioglitazone are contraindicated in patients with NYHA Class 3 and 4 cardiac status (36 letters), Rosiglitazone-containing products may cause or exacerbate congestive heart failure. Their use is contraindicated in patients with NYHA class 3 or 4 heart failure and not recommended in patients with symptomatic heart failure. Patients should be observed for signs and symptoms of heart failure (rapid weight gain, dyspnea, and /or edema). If heart failure develops initiate appropriate therapy and consider alternative antidiabetic therapy (11 letters), Patients with renal impairment or a past history of lactic acidosis\may be at increased risk of developing lactic acidosis when\receiving metformin therapy (186 letters), Thioridazine been shown to prolong the QTc interval in a dose related manner and has been associated with torsade de pointes-type arrhythmias and sudden death. Thioridazine use should be avoided in combination with other drugs that are known to prolong QTc interval or inhibit P450 2D6 and in patients with congenital long QT syndrome, a history of cardiac arrhythmias or reduced activity of P450 2D6 (2 letters), Pioglitazone-containing products may cause or exacerbate congestive heart failure. Their use is contraindicated in patients with NYHA

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class 3 or 4 heart failure and not recommended in patients with symptomatic heart failure. Patients should be observed for signs and symptoms of heart failure (rapid weight gain, dyspnea, and/or edema). If heart failure develops initiate appropriate therapy and consider alternative antidiabetic therapy (225 letters), and the lock-in criteria (504 letters).

- In November 2009, 1514 letters were sent. The main interventions reviewed were: The use of propoxyphene-containing products in elderly patients may result in accumulation of the parent compound and the active metabolite leading to cardiotoxicity and CNS toxicity, such as hallucinations, confusion and drowsiness (153 letters), Amitriptyline-containing products should be avoided in elderly patients. Amitriptyline has significant anticholinergic and sedative properties which can increase the incidence of falls and fractures. Consider alternative agents with more favorable adverse effect profiles (155 letters), The use of antihistamines with potent anticholinergic activity is not recommended in elderly patients (82 letters), Benzodiazepine anxiolytic agents with long half-lives should be avoided in the elderly due to their increased sensitivity to these agents. Chronic dosing of these agents may result in accumulation of the parent compound and the active metabolites causing prolonged sedation and increased risk of falls/fractures. Anxiolytics with short to intermediate half-lives such as oxazepam and lorazepam are recommended as alternatives (376 letters), and the lock-in criteria (440 letters)
- In December 2009, 1180 letters were sent. The main interventions reviewed were: Butorphanol may be over-utilized (7 letters), The overuse of beta agonists may signal worsening asthma (93 letters), Meprobamate is usually intended for short-term use because it is highly addictive and sedating (3 letters), Paroxetine may be over-utilized. The manufacturer's recommended maximum daily dose for regular-release paroxetine is 60mg per day (13 letters), Sertraline may be over-utilized. The manufacturer's recommended maximum dose is 200mg per day (15 letters), Fluoxetine may be over-utilized. The manufacturer's recommended maximum dose is 80mg per day (4 letters), Patient has been receiving tizanidine (Zanaflex) for > 90 days. Limited data are available on the long-term use of tizanidine in patients other than those that have a diagnosis for multiple sclerosis, spinal cord injury or stroke. Consider evaluating for therapeutic efficacy and tolerance of adverse effects. Salmeterol doses greater than 100 mcg per day (given in two equally divided doses) have been associated with significant increases in heart rate, reductions in diastolic pressure, and prolongation of QTc interval which may potentially produce life-threatening arrhythmias (14 letters), Salmeterol doses greater than 100 mcg per day (given in two equally divided doses) have been associated with significant increases in heart rate, reductions in diastolic pressure, and prolongation of QTc interval which may\potentially produce life-

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threatening arrhythmias (5 letters), Mobic (meloxicam) may be over-utilized. The manufacturer's recommended maximum dose is 15 mg per day (4 letters), Ultram (tramadol) may be over-utilized. The manufacturer's recommended maximum dose is 400 mg per day (2 letters), The maximum recommended dose of acetaminophen is 4000 mg per day. Exceeding the maximum daily dose of acetaminophen may result in liver toxicity (31 letters), Atorvastatin may be over-utilized. The manufacturer's recommended maximum daily dose is 80mg/day (3 letters), Pravastatin may be over-utilized. The manufacturer's recommended maximum daily dose is 80 mg (2 letters), Simvastatin may be over-utilized. The manufacturer's recommended maximum daily dose is 80 mg (4 letters), Ibuprofen may be over-utilized. The manufacturer's recommended maximum daily dose is 3200mg (1 letter), Cyclobenzaprine may be over-utilized. The manufacturer's recommended maximum daily dose is 30 mg (7 letters), Quetiapine (Seroquel/Seroquel XR) may be over-utilized. The recommended maximum dose is 800 mg per day. The safety of doses above 800 mg per day has not been evaluated in clinical trials (53 letters), Chlorpromazine may be over-utilized. The recommended maximum dose is 800 mg per day for outpatients. Exceeding this dose may increase the risk of adverse effects (e.g., extrapyramidal symptoms, orthostatic hypotension, and sedation) (1 letter), Geodon (ziprasidone) may be over-utilized. The recommended maximum dose is 80 mg twice a day. Exceeding this dose may increase the risk of adverse effects (e.g., QTc prolongation, sedation, and rash). The safety of doses above 100 mg twice daily has not been systematically evaluated in clinical trials (76 letters), While fentanyl is effective in the treatment of acute severe pain, the transmucosal dosage form may not be the most effective choice in the relief of continuous pain. This dosage form may present problems due to: wide patient-to-patient variation to reach maximum blood levels; limitations of only four units or doses per day; short duration of effects; formulation is only indicated for the management of breakthrough cancer pain in opioid tolerant patients. Each of\these characteristics can lead to the inappropriate or overuse of the dosage form (6 letters), Fentanyl transdermal patches may be over-utilized. The majority of patients are adequately maintained with administration every 72 hours. Some patients may not achieve adequate analgesia using this dosing interval and may require systems to be applied every 48 hours rather than every 72 hours. An increase in the transdermal dose should be evaluated before changing dosing intervals in order to maintain patients on a 72-hour regimen (54 letters), Combunox (oxycodone/ibuprofen) may be over-utilized. The manufacturer's recommended maximum dosage is 4 tablets in a 24-hour period, with use not to exceed 7 days (1 letter), Vyvanse (lisdexamfetamine) may be over-utilized. The manufacturer's recommended maximum

dose for children is 70 mg daily. Doses greater than 70 mg have not been studied in children (2 letters), Once a successful dose of Fentora (buccal fentanyl) has been established, if the patient experiences greater than 4 breakthrough pain episodes per day, the dose of the maintenance (around-the-clock) opioid used for persistent pain should be re-evaluated (4 letters), and the lock-in criteria (331 letters)

- Heather Kissinger stated the reason there was a decrease in the letters sent for the month of December in comparison to the other months in the 4th quarter was due to the criteria for overutilization being over sensitive. Those particular criteria will flag patients who fill a prescription 5 days before the prescription is due for overutilization, when in actuality, the patient may have just filled the prescription early.
- Dennis Chapron stated he would like to see a targeted intervention for polypharmacy, possibly looking at patients who have received 15 or more chronic medications per month.
- Dennis also requested that a few profiles of patients who are currently taking 15 or more chronic medications be brought in to the next Board meeting for review by the members.
- Heather Kissinger also stated she would bring in a few lock-in profiles to show the members examples of those as well.
- Dennis then requested samples of all lock-in letter types be brought in as well.

C. Therapeutic Criteria Exception Report: ICER Date 2-5-10

- The Board reviewed the Therapeutic Criteria Exception Report that was created using the ICER ran on 2-5-10.
- Heather Kissinger stated this report is meant to help guide which interventions the Board decides to use.
- Heather Kissinger stated that a new section was added to the Therapeutic Criteria Exception Report which categorizes multiple criteria into common problem types or themes. Page 1 of the report displays the major severity criteria, page 2 of the report displays the moderate severity criteria, and page 3-11of the report displays the problem types.
- Heather Kissinger stated that the March intervention was reviewing adverse fetal effects problem category and the pregnancy category.
- Bhupesh Mangla stated that the non adherence to antiretroviral therapy was a very serious topic and if possible, we should send out intervention letters.

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- Jim Zakszewski stated that due to privacy laws, letters regarding HIV and AIDS status cannot be sent to providers.
- Charlie Caley questioned the brand name product Dilantin (phenytoin) has generic equivalents available, and whether the two drugs were interchangeable due to bioavailability.
- The Board suggested that if Heather was to review the cost control problem category that the Dilantin (phenytoin) criteria are left out to due questionable interchangeability.
- Dennis Chapron questioned the indications for Inderal LA since there is a criterion under the cost control problem category regarding the use of brand name Inderal LA when the generic short acting propranolol is available.
- Ram Illindala stated he thought the indications for Inderal LA were different than the indications for short acting propranolol.
- Dennis also stated he thought practitioners don't use Inderal LA for hypertension.
- Ram stated he thought Inderal LA might be used to prophylax against migraines, and also might be used to treat tremors and akathisia.
- Dennis requested Heather Kissinger research the uses of Inderal LA and report back to the Board.
- Heather stated she would follow up.

D. RetroDUR Criteria

New Criteria

- Criteria 1, Liraglutide / Over-utilization was approved as written by the Board.
- Criteria 2, Liraglutide / Non-adherence was approved by the Board.
- Criteria 3, Liraglutide / Black Box Warning – Thyroid Cancer was approved as written by the Board.
- Criteria 4, Liraglutide / Medullary Thyroid Carcinoma & Multiple Endocrine Neoplasia Syndrome (Black Box Contraindication) was approved as written by the Board.
- Criteria 5, Liraglutide / Type 1 Diabetes & Ketoacidosis was approved as written by the Board.
- Criteria 6, Liraglutide / Insulin Secretagogues was approved as written by the Board.
- Criteria 7, Liraglutide / Pancreatitis was approved as written by the Board.
- Criteria 8, Liraglutide / Pediatric Patients was approved as written by the Board.
- Criteria 9, Liraglutide / Renal Impairment was approved as written by the Board.
- Criteria 10, Liraglutide / Hepatic Impairment was approved as written by the Board.
- Criteria 11, Liraglutide / Gastroparesis was approved as written by the Board.

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- Criteria 12, Liraglutide / Oral Drugs was approved as written by the Board.
- Criteria 13, Saxagliptin / High Dose was approved as written by the Board.
- Criteria 14, Saxagliptin / Renal Impairment was approved as written by the Board.
- Criteria 15, Saxagliptin / Nonadherence was approved as written by the Board.
- Criteria 16, Saxagliptin / Strong 3A4/5 Inhibitors was approved as written by the Board.
- Criteria 17, Saxagliptin / Sulfonylureas was approved as written by the Board.
- Criteria 18, Saxagliptin / Sitagliptin was approved as written by the Board.

Tabled Criteria from December 2009 Meeting

- Asenapine / Fluvoxamine was approved as written by the Board.

E. Newsletter

- The Board approved the March 2010 DUR Newsletter with the following modifications:
    - Page one; Change all "Chronic Inflammation in asthmatics" to "Reversible Inflammation in asthmatics".
    - Page one, column two, third paragraph, third bullet, systemic corticosteroids, add in parenthesis (short course of oral steroids)
    - Page two, column two, first paragraph, third bullet, systemic corticosteroids, add in parenthesis (short course of oral steroids)
    - Add in small box regarding FDA's newest published warning regarding "Long acting beta agonists (LABAs) should never be used alone in the treatment of asthma in children or adults"
- The Board agreed that the newsletter would be approved once those changes were made.
- Charlie Caley suggested we do a newsletter regarding the combination of SSRIs and NSAIDs and the risk of GI bleeds. If too controversial then maybe just a report to the board regarding how many patients received both an SSRI and an NSAID and were subsequently diagnosed with a GI bleed.
- Bhupesh Mangla suggested a newsletter topic of Polypharmacy to coincide with the polypharmacy interventions.
- Also suggested was a newsletter topic of medication use in the elderly.

NEW BUSINESS

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- Heather Kissinger stated that HP and HID will begin a separate review process for the HUSKY A pediatric population in addition to the current reviews on the Medicaid adult population. Once the reviews start there will be 1000 monthly pediatric reviews and 1000 monthly adult reviews with a targeted intervention. The lock in reviews will also be doubled to 800 reviews per month. The start of the extra reviews is projected for April or May 2010.
- Heather Kissinger stated that recently the HP provider relations department had written a newsletter regarding Medicaid patients who abuse prescription medications. The Department had reviewed the informational bulletin and requested that if the DUR Board found the information helpful and wanted to publish it in the DUR Newsletter, they could decide to do so.
- Heather Kissinger handed out the preliminary bulletin and asked the Board members to review the information and discuss it during the next DUR Board meeting in June 2010.
- Heather Kissinger directed the members to review the Certificate of DUR Board servitude created for members who had recently resigned in order to recognize their service.
- The Board voted unanimously on the format of the certificate with one request, to have Ken Fisher sign the document as well as Jim Zakszewski prior to mailing to past members.
- Heather agreed and stated she would bring the certificates for Michael Moore and Lori Jane Duntz in to the June 2010 DUR Board Meeting for signatures prior to mailing them out.
- The date for the June 2010 DUR Board meeting was confirmed as:
    - Thursday June 10, 2010
- The meeting was adjourned at 8:15 pm.

The preparation of this document was financed under an agreement with the Connecticut Department of Social Services.