



STATE MEDICAID DUR BOARD MEETING
THURSDAY, April 14, 2005
7:00 a.m. to 8:30 a.m.
Cannon Health Building
Room 125



MINUTES

Board Members Present:

Lowry Bushnell, M.D.
Derek G. Christensen, R.Ph.
Dominic DeRose, R.Ph.
Bradford D. Hare, M.D.
Jeff Jones, R.Ph.

Wilhelm T. Lehmann, M.D.
Joseph K. Miner, M.D.
Bradley Pace, PA-C
Colin B. VanOrman, M.D.

Board Members Excused:

Charles M. Arena, M.D.

Karen Gunning, Pharm. D.

Dept. of Health/Div. of Health Care Financing Staff Present:

RaeDell Ashley
Merelynn Berrett
Richard Sorenson
Duane Parke
Nanette Waters

Suzanne Allgaier
Tim Morley
Darlene Benson
Ross Martin
F. Blake Anderson

Other Individuals Present:

Jeff Buel, J&J
Craig Boody, Lilly
Alex Robanis, Eyetech
Jim Rogers, Merck
Tarsa Keane, Purdue
Rich Heddens, MedImmune
Pat Teegarden, Shering-Plough
Troy Benavidez, AstraZeneca
Jane Beatty, MedImmune

Matt Johnson, Takeda
Katie Sill, EyeTech
Oscar Fuller, CMS
Tim Smith, Pfizer
Alan Sloan, Purdue
Barbara Boner, Novartis
Doug Poulsen, BMS
David Stewart, CEC
Laura Hill, Takeda

Meeting conducted by: Lowry Bushnell, Chairman

1. Minutes for March 2005 were reviewed, and approved without correction. Lowry read in the new preamble stating date, purpose and access to the DUR Board meeting and agenda. Duane noted that HB-263 (2005) now requires all new agenda items be posted 30 days in advance of the DUR Board meeting. Duane reviewed the federal, state, and division laws, rules, policies and procedures that define the DUR Board and

Board processes. He noted that the DUR Board must use cost considerations when discussing access and quality of drug delivery since the division is held to that responsibility.

2. As a matter of old business, Dr. Hare did receive an unpublished study on Palladone (hydromorphone SA) cost issues as supplied by the manufacturer Purdue. He noted that on average, most clinicians use a dosing regimen that is more costly than the dosing and subsequent cost cited in the manufacturer's materials. He also noted that a copy of recent Medical Letter shows a conversion factor from other narcotics to hydromorphone SA similar to what the Red Butte Pain clinic uses which has the net effect of showing a higher cost for the Palladone formulations. He notes that his original statement about Palladone being more expensive and not offering any clear cut advantage still holds. He recommends that this drug be available only on prior approval. Duane said that the prior approval criteria for Palladone will require an ICD.9 for cancer and a prior approval to have un-contested access to higher doses. The prior approval will be the same for cancer or chronic non-malignant pain. The client will have had to have failed on three other long acting narcotics including methadone. Failure is to be based solely on adverse drug events, not on clinical efficacy. Chronic non-malignant pain is to be limited to 30 tablets in 30 days, in any combination of strengths. The DUR Board moved to accept the prior approval criteria.

Brad noted that the transdermal fentanyl does not appear to be bioequivalent to Duragesic in regards to the 72 hour dosing. Brad has had several patients that require changing the patch every 48 hours. Derek noted that he has experienced a therapeutic failure as well. Derek noted that the Sandoz generic formulation is the same as the Jannson formulation while the Mylan is not. The generic formulations are AB rated. RaeDell noted that she has had several complaints on the glue, so that the patches fall off. Rick noted that the effective time span is the biggest single complaint that the prior approval team has logged. The DUR Board requested that the utilization history be reviewed and presented next month.

3. Macugen, the new drug for ophthalmic macular degeneration, was discussed. Alex Robanis, Eyetech, noted that the discussion will be focused on tab one of the handout which discusses utilization studies for a 1-2 year period. Alex introduced Paul Bernstein, M.D., associate professor of Ophthalmology and Visual Sciences at the Moran Eye Center and a principle investigator for phase three studies of Macugen (pegaptanib sodium, a selective vascular endothelial growth factor antagonist). Paul noted that a trial macular degeneration is the leading cause of blindness in the U.S. and a major portion of his practice at the Moran Eye Center. The treatments, until recently, have been very limited. The approval of Macugen has been a major advance in terms of a bio-chemical approach in treating the wet form of age-related macular degeneration (AMD). There is continual vision loss with AMD and treatment with Macugen can slow down the loss in a significant manner. Paul discussed the studies performed at the Moran Eye Center. At least one of the studies continued on for a two year period. With treatment with Macugen there was a 47% less vision loss than controls. One of the studies actually showed vision improvement to some degree although AMD is a progressive disease. Paul will send the Moran Eye Center criteria to the Board. Colin asked if there is some way to determine if the patient is non-responsive to Macugen. Paul noted that the patient is constantly being evaluated for drug efficacy and if there is no response then the treatment is discontinued. Brad asked if treatment with Macugen is the primary treatment when AMD presents.

Paul noted that there are 3 ways of treating wet AMD: thermal radiation which is now used rarely; Visudyne, the photo-dynamic treatment approved in 2000, which was the primary treatment until the advent of Macugen; and Macugen which has a much broader application for either of the other two. So, Macugen is now the primary treatment for over 50% of Paul's patients. The DUR Board moved to support the use of Macugen.

4. Duane discussed his findings at the National Drug Utilization Review conference regarding restrictions being applied to the muscle relaxants and specifically carisoprodol. He noted that Utah has a cumulative limit of 120/30 days, but many states are only covering carisoprodol for one month each year for chronic non-malignant pain. Brad said that muscle relaxants are used in his field extensively. He noted that all of these are not indicated for long term use. Carisoprodol is converted to meprobamate which is an early anxiolytic used similarly to the benzodiazepine group. There is no indication for long term use of these products in chronic non-malignant pain, excepting for use in spasticity from spinal cord injury and other neurologic disorders that have chronic spasticity. Typically, the muscle relaxants are not the drugs used for spasticity rather than baclofen and the benzodiazepines. Lowry noted that since most of these agents are centrally acting, long term use actually results in impairment with an overall decrease in life function.

Brad noted that other drugs with chronic use could be looked at such as butalbital combinations. Duane noted that the APAP found in the butalbital combinations probably should be restricted same as the narc/APAP combinations. The DUR Board request that butalbital combinations be reviewed for further action.

Next meeting set for May 12, 2005
Meeting adjourned.

The DUR Board Prior Approval Subcommittee convened and considered nine petitions.

