



STATE MEDICAID DUR BOARD MEETING  
 THURSDAY, January 12, 2006  
 7:00 a.m. to 8:30 a.m.  
 Cannon Health Building  
 Room 125



## MINUTES

**Board Members Present:**

Derek G. Christensen, R.Ph.  
 Dominic DeRose, R.Ph.  
 Colin B. VanOrman, M.D.

Bradford D. Hare, M.D.  
 Jeff Jones, R.Ph.  
 Wilhlem T. Lehmann, M.D.  
 Joseph K. Miner, M.D.

**Board Members Excused:**

Karen Gunning, Pharm D.  
 Lowry Bushnell, M.D.  
 Charles M. Arena, M.D.  
 Bradley Pace, PA-C

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

Rae Dell Ashley, R.Ph.  
 Tim Morley, R.Ph.  
 Richard Sorenson, R.N.  
 Brenda Strain

Suzanne Allgaier, R.N.  
 Merelynn Berrett, R.N.  
 Nanette Waters

**Other Individuals Present:**

Craig Boody, Lilly  
 Sharon H. Kern, GSK  
 David Harper, Sanofi Aventis  
 Jeff Buel, J&J  
 Pierre Thoumsin, Amgen Jason Bott, (?)  
 Tim Smith, Pfizer  
 Deanne Calvert, Sanofi-Aventis

Cap Ferry  
 Shannon Beatty- MedImmune  
 Richard Heddens, MedImmune  
 Bart Watts, TAP  
 Paul Pereira, TAP  
 Lisa Martin, MHAU

Meeting conducted by: Tim Morley

1. Minutes for December 8, 2005 were reviewed, corrected and approved.
2. Business Carried Forward:
  - a. Cymbalta- Two ICD-9 codes, 311 for depressive disorder NOS, and 729. 2 for neuralgia, neuritis unspecified were presented for Board consideration and approval. These are to be used by the pharmacists when adjudicating claims for Cymbalta. The pharmacist must enter one or the other depending on the patients use for the med. Motion to pass- approved

b. Coverage of Cough and cold Preps- The list of covered legend items presented to the Board for its consideration includes guaifenesin w DM 600/30 tabs, guaifenesin w hydrocodone 100/5 liquid, promethazine, and hydroxyzine. The list of covered OTC items includes diphenhydramine, chlorpheniramine, loratidine (single agent), diabetic cough syrup, doxylamine, pseudoephedrine 30 & 60 mg tabs, and guaifenesin with/without DM. The Board suggested deleting hydroxyzine and changing the promethazine to promethazine w codeine. The board approved the OTC list as presented.

c. Anti-depressant/anti-convulsant Dx codes- Four general Dx codes were presented to the Board for its consideration and approval- 311 depressive disorder NOS, 729.2 neuralgia, neuritis unspecified, 345 epilepsy and recurrent seizures, and 780.5 sleep disturbances. It was decided to wait and see how this works with Cymbalta before expanding to other categories. Motion was passed to approve to go into effect in three months – 1<sup>st</sup> of April- if results are positive with the Cymbalta.

d. Acne preparations- The list of covered agents for acne preparations presented to the Board included all but the following exclusions which would not be covered: benzoyl peroxide preparations, tretinoin acne preps, topical acne anti-biotics including those with benzoyl peroxide, and isotretinoin. States have the option to exclude coverage for acne preparations. Derek noted that the expensive products aren't included on this list. Jeff noted that a patient would then be able to come in with a cheap script for benzoyl and they will end up getting expensive differin. Dr. Lehman said that a cost analysis approach, staying with coverage for cheaper agents and cross off the more expensive ones. Jeff suggested a step therapy for the category. It was agreed that we would bring this item back to the Board with more info and recommendation.

e. Methadone usage- Data was presented showing usage of methadone, combined usage with benzodiazepines and anticonvulsants and other opiates and death rates among methadone users. Some data also presented from the medical examiners office speaking to overdose deaths. Dr. Hare stated that the data lacks some correlation with how it is being used as well as prescribed. This data really doesn't tell us anything. The Medical examiner needs to look at toxicity screens and look at prescription records and put in a meaningful form. The data doesn't say much and is not well correlated. It was noted that current policy as practiced by the system with regard to methadone and the long acting opioids is not in accordance with the guidelines the Board understood to be in place. Methadone should not be dispensed concurrently with any long acting opioid medication. This correction will be made.

f. Nausea and vomiting of pregnancy review criteria- 5-HT anti-nausea medications are increasingly being requested as first choice for nausea and vomiting of pregnancy. A differentiation between nausea and vomiting of pregnancy and hyperemesis gravidarum is needed. Derek suggested circulating the treatment algorithm available from the Up to Date website in conjunction with the American College of Obstetricians and Gynecologists. He notes that patients will switch themselves to lesser cost alternatives with other insurance plans when co-pays are higher. Dr. Lehman noted that information from grand rounds indicates that the nausea and vomiting of pregnancy is comparable to, if not worse than, that associated with cancer chemotherapy. He feels that step therapy is very reasonable if it follows guidelines that all can agree to, but doesn't feel that we should be too restrictive to the point that women frequent ER's for fluids. Dominic pointed out that other HMO's are using some form of step therapy and that should be a guide. No action was taken on this item.

g. Low molecular weight heparins- Some shift in standard of care has been noted for this category. Dr. Jones with the Department of Health has verified that the standard of care in pregnancy for the use of LMWH's seems to have shifted away from heparin to the fragmented forms. David Harper, PharmD from Sanofi-Aventis, manufacturer of Lovenox, addressed the

board. He referred to the American Academy of Chest physicians 2004 guidelines three areas of concern with pregnancy: 1) acute thromboembolism needing a heparin agent because warfarins cannot be used in pregnancy; 2) prevention of venous thromboembolism in patients who have had previous episodes; 3) patients that are thrombophilic.

Two treatment regimens are recommended by the AACP 1) Unfractionated heparin continuous infusion with constant ptt monitoring; 2) Sub Q LMWH. The AACP endorses the second alternative because of greater bioavailability, better safety profile (less thrombocytopenia, less osteoporosis), and less monitoring required. For active thromboemboli, treatment is needed throughout pregnancy, and continuing treatment for 6 weeks postpartum. Warfarin is the option of choice postpartum. For prophylaxis treatment the same regimens are recommended, but dosing requirements are less. RaeDell asked about the other LMWH that are available. Dr. Harper said that Daltaparin is indicated similarly except for knee surgery or non-surgical patients. Tinzaparin is only approved for treatment of active thromboembolism. Enoxaparin is indicated for prophylaxis.

Standard of care reflected in the community as exemplified by the University of Utah now uses the LMWH's bypassing the heparin option due to the associated inconvenience and expense of monitoring. Dr. Miner states that this is not an area subject to great over-use and abuse and recommended that standard of care be adopted, and that policy not require fail first with heparin. He noted that no distinction is necessary between treatment and prophylaxis. Dr. Lehman agreed with that position. Motion was made and passed to that effect.

Remaining items were tabled for the next DUR Board meeting.

Next meeting set for February 9,2006

Meeting adjourned.

The DUR Board Prior approval sub-committee convened and considered 4 petitions.

