



STATE MEDICAID DUR BOARD MEETING
THURSDAY, March 12, 2009
7:00 a.m. to 8:30 a.m.
Cannon Health Building
Room 125

MINUTES

Board Members Present:

Neal Catalano, R.Ph.
Tony Dalpiaz, PharmD.
Wilhelm Lehmann, M.D.
Joseph Yau, M.D.

Derek Christensen, R.Ph.
Brad Hare, M.D.
Colin VanOrman, M.D.

Board Members Excused:

Mark Balk, PharmD.
Peter Knudson, D.D.S.
Dominic DeRose, R.Ph.

Joseph Miner, M.D.
Bradley Pace, PA-C

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

Lisa Hulbert, R.Ph.
Merelynn Berrett, RN
Duane Parke, R.Ph.
Debbie Harrington, RN

Rick Sorenson, RN
Tim Morley, R.Ph.
Carol Runia

Other Individuals Present:

Chris Beckwith, U of U
Barbara Boner, Novartis
Alan Bailey, Pfizer
Jeff Buel, J&J
Mark Crosby, IHC Home Care

Susan Bagley, APRN
Ann Gustafson, GSK
Dennis Quist, Steiffel
Roy Lindfield, Schering

Ben Campbell, DRRC
Lori Howarth, Bayer
Sue Heineman, Pfizer
Cary Green, Merck

Meeting conducted by: Colin VanOrman, M.D., DUR Board Chairman

1. Housekeeping: Manufacturers were asked to provide information to the DUR Board in writing through Medicaid, and to refrain from paging, calling, or visiting them during their work time.
2. P&T Committee Update: Duane Parke addressed the Board. Medicaid is in the process of rolling over new PDL Contracts for 2009, and continuing to add new drug classes.
3. Topical Acne Preps: Christina Beckwith addressed the Board and presented information on acne medication prepared by the University of Utah Drug Information Service.

The Board asked how to handle therapy for patients who have had acne for years. It would be reasonable to bring the condition under control, and then continue maintenance therapy with a topical retinoid or a combination of topical retinoids and benzoil peroxide.

The Board asked how long the patient should be placed on antibiotic therapy. It would be reasonable to treat for 8-12 weeks, and possibly continue for up to 18 weeks if the patient is showing response. Continuing it any longer would create the risk of resistance.

Lisa Hulbert addressed the Board. The reason that this came up is because by federal law Medicaid can exclude treatments for cosmetic conditions. Many state Medicaid programs exclude products for acne. Medicaid currently has age limitations on many products. The question is whether or not to limit coverage on acne products further.

Dr. Yau asked if the Board is expected to define what is cosmetic. Also, is the Board expected to develop a treatment algorithm? Tim Morley stated that he had originally placed this topic on the agenda in order to ensure that Medicaid is not covering cosmetic products. Based on the presentation given by Dr. Beckwith, there are situations in which acne is not just a cosmetic condition. Should Medicaid have a rational treatment approach for the instances in which acne is determined to not be cosmetic?

Lisa Hulbert asked if the Board wanted proposed treatment criteria for the May meeting.

Dr. Lehmann stated that he does not believe that the Medicaid clients that he has treated for acne appear to have just a cosmetic condition. In particular, he felt that the age limitations are unfair, because acne is even more stigmatizing for adults than children. However, it would be nice to have some guidelines to discuss since the presentation by Dr. Beckwith was rather complex.

Dr. Hare asked the other Board members if they were in agreement that acne was not a cosmetic condition. The Board members agreed with Dr. Hare.

Tim Morley asked Dr. Beckwith if there was any data about usage for tretinoin for wrinkles. That was not the focus of this review. However, tretinoin can be used for wrinkles, and that would be a strictly cosmetic use.

Dr. VanOrman stated that he felt that it would be extremely difficult to formulate guidelines, due to the complexity of the treatment algorithm provided by the University of Utah Drug Information Service. He also felt that the subjectivity of "moderate to severe" would make any PA difficult to enforce. He suggested that if Medicaid wanted to bring this topic back to the DUR Board, the focus should be on products that have been shown to be clearly not effective or inappropriately utilized.

Dr. Hare stated that he has difficulty sorting through the utilization data that was provided by Medicaid. He asked Dr. Beckwith if the numbers indicate that there may be any problems that the DUR Board needs to address.

Dr. Beckwith stated that as far as efficacy, all of the agents reduce the number of lesions. That has been clearly shown. There are some combination products that are more expensive that are not necessarily more effective. The class could be examined for the best use of State dollars.

Dr. Yau asked if cost could be an up-front reason to look at the class. Tim stated that the class could be looked at as cosmetic versus non-cosmetic use, and for providing a rational and logical treatment approach. However, cost cannot be discussed specifically.

Dr. Beckwith stated that she is willing to return with specific guidelines.

Dr. Hare moved that the Board be given some more specific guidelines to consider at a future meeting. Neal Catalano seconded the motion. The motion passed with unanimous votes by Neal Catalano, Tony Dalpiaz, Dr. Lehmann, Dr. Yau, Derek Christensen, Dr. Hare, and Dr. VanOrman.

4. Barbiturate Combinations Versus Tryptans: Lisa Hulbert addressed the Board. Recently, at the P&T Committee meeting, there was testimony from Susan Bagley from the Migraine Treatment Center that there is no rational place for barbiturates in the treatment of migraines. This prompted Medicaid to place the class on the DUR Board agenda. Dr. Carrie Ann Madden and Dr. Ben Campbell addressed the Board and presented information prepared by the University of Utah Drug Information Service

Dr. Hare stated that the pain center is seeing less of these drugs. Looking at this class of drugs, he wonders where the analgesia is coming from. If anything, barbiturates and benzodiazepines can be said to have an anti-analgesic effect. These are basically sedative combinations that give very little analgesic benefit. Patients with tension headaches would be better served by other therapies, rather than these drugs. He does not have a problem with patients who are taking a small amount of these – maybe a couple of doses per month. He is presently withdrawing a patient who was using up to 12 of these per day, and probably having persistent headaches due to the butalbital. If nothing else, the Board should be able to come up with some very strict limits for occasional rather than daily use. The other thing would be to say that these drugs have no place in therapy, and should not be paid at all.

Susan Bagley, APRN, addressed the Board. The problem is that this is perceived as a very safe and cheap drug, and it is overused. There are a lot of healthcare dollars wasted on withdrawing patients from butalbital with Phenobarbital tapers. This drug was developed in the 1940's when patients were being sedated to manage pain without any real clinical evidence. More specific medications for migraine treatments should be encouraged.

Lisa Hulbert stated that there are currently limits for 30 tablets in 30 days for butalbital containing compounds. Dr. Hare stated that this is not an amount where the Board would have to worry about withdrawals.

The Board members asked about the patients who may be getting excessive quantities and paying cash. Dr. Hare stated that this is not the Board's concern. The Board

should be concerned about appropriate use of state funds for paying for medications.

Lisa stated that the Board could consider a PA for these medications to prevent use for migraines.

Dr. Hare felt that physicians would probably be relieved to have butalbital-containing compounds removed from Medicaid coverage. Dr. Lehmann agreed that most primary care physicians would be relieved to have an excuse to not write prescriptions for it. He also feels that there is a real problem with diagnosing migraines.

The Board asked Susan if there is any type of patient that would have to have this drug. She did not think that any patient would need to have this drug over all other available drugs. It has only been used for historical reasons. This is the type of drug that suppresses the ability to get appropriate prophylaxis on board. The next generation of tryptan drugs will not have the contraindications for people with cardiovascular issues.

Derek asked if, as part of a PA, Medicaid could require prophylaxis for migraines before authorizing butalbital-containing compounds. Duane stated that Medicaid could impose quantity limits in the past. Currently, if the manufacturers are paying rebates, Medicaid has to have a way to pay for it.

Susan Bagley stated that people should not be habitually using barbiturates or, for that matter, tryptans. Patients who have chronic headaches should be on prophylaxis, which is fairly inexpensive, with rescue medications such as tryptans being the “icing on the cake”. The claim of chronic headaches as a disability is not acceptable to her because of the treatments that are available.

Dr. Hare asked, if based on Duane’s comments, Medicaid needs to make a drug available even if it is inefficacious. Dr. Hare stated that there is no evidence that this is a good product, and actually fairly good evidence that it is a harmful product.

Dr. Hare stated that if Medicaid must provide a mechanism to cover these medications, individual requests for butalbital-containing compounds should come before the Board on a case-by-case basis. Medicaid should not have to worry about tapering or withdrawing individuals with the 30 tablet in 30 days cumulative limit.

Dr. Hare moved to have PA for any of the butalbital-containing products as he proposed. Dr. Lehmann seconded the motion. The motion passed with unanimous votes by Neal Catalano, Tony Dalpiaz, Dr. Lehmann, Dr. Yau, Derek Christensen, Dr. Hare, and Dr. VanOrman.

5. The minutes for February 12, 2009 were reviewed, corrected, and approved. Dr. Yau voted to accept the minutes as written. Dr. Lehmann seconded the motion. The motion passed with unanimous votes by Neal Catalano, Tony Dalpiaz, Dr. Lehmann, Dr. Yau, Derek Christensen, Dr. Hare, and Dr. VanOrman.

Next meeting set for April 9, 2009
Meeting adjourned.

The DUR Board Prior Approval Subcommittee considered 0 petitions this month.

Minutes prepared by Jennifer Zeleny