

WY P&T Committee Meeting Minutes  
Thursday, February 18, 2010  
Cheyenne, WY  
9 a.m. – 3 p.m.

Members present: Steen Goddik, Kurt Hopfensperger, Joe Horam, Scott Johnston, Robert Monger, Scot Schmidt, Dean Winsch

By phone: Becky Drnas, Tonja Woods

Excused: Joe Farrell, Richard Johnson, Kevin Robinett

Ex-officio: Donna Artery, Antoinette Brown, James Bush, Melissa Hunter

Guests: Nikki Yost (GHS), Kerri Powell (GHS) by phone

Dr. Hopfensperger called the meeting to order at 9:06 a.m.

Approval of Minutes

The minutes of the November 19, 2009 meeting were approved as presented.

Department of Health

- A. State pharmacist report: None
- B. Pharmacy Program Manager Report:

The PDL was significantly expanded on January 6. There are some issues with some of the supplemental rebate contracts that may result in a few changes to the PDL. Prevacid life-time PAs will be transitioned to the generic.

It was noted on PAs for the sleep agents that some patients have been on these agents for several years. The Committee felt that there wasn't a great alternative, so they should be approved. Aimee will bring information on long-term use in the Medicaid population to the next meeting.

PAs have been received for use of Nuvigil in ADHD. The Committee agreed that for use in ADHD, stimulants should be pushed to max dose before Nuvigil is approved. The exception is intolerable adverse effects with use of stimulants. There was a motion, second and all were in favor.

The Request for Proposals for DUR services will go out in the next month.

C. Psychiatrist Advisory Board Report: Minutes were included in the packet. The PAB spent most of their time reviewing the chart of antipsychotic doses.

# Wyoming EqualityCare Medication Criteria

(This criteria will be used to review DUR profiles to determine if provider education and/or further action [i.e. psychiatric review] is recommended.)

Drug	FDA Daily Maximum Dose (children)	Pediatric Maximum Dose Thresholds (*zero (0) indicates the need for expert opinion)			High dose and additional information
		≤5 Years <i>All claims for children age 5 or under will be retrospectively reviewed</i>	6-12 Years	13-17 Years	
					Recommended high dose thresholds: claims that hit the 150% threshold or above will require prior authorization (PA)
<b>Risperdal</b> (Risperidone)	3mg Higher doses have been used w/out additional benefit, but w/ more side effects	0	3mg	3mg	150% = 4.5 – round to <b>5mg</b> Dosing recommendations vary for dx and weight. The max recommendation is 3mg, and high dose will base off of that. DUR can pull claims for retrospective review in a more detailed way via dx.
<b>Invega</b> (Paliperidone)	12 mg (adult dosage – not established for children)	0			<b>Already on prior authorization</b>
<b>Saphris</b> (Asenapine)	20 mg (adult dosage, not established in children)	0			150% = 30mg
<b>Fanapt</b> (Iloperidone)	24 mg (adult dosage – not established for children)				150% = 36mg
<b>Zyprexa</b> (Olanzapine)	30 mg	0	10 mg	20 mg	150% = 45mg
<b>Abilify</b> (Aripiprazole)	30 mg	0	15mg	30 mg	150% = 45mg Dosing recommendations vary for dx and weight. The max recommendation is 15mg for Autism, 10mg for schizophrenia, and 30mg for Acute bipolar mania. High dose will base off of 30mg. DUR can pull claims for retrospective review in a more detailed way via dx.
<b>Geodon</b> (Ziprasidone)	120mg (adult dosage, not established in children) Use autism max dose	0	120mg	120mg	150% = 180mg <b>Autism (off-label) - Initial dosage:</b> Initial dose of 20 mg nightly, increased by 10 to 20 mg weekly in a twice-daily regimen. Mean final dose was 59.23 mg (range, 20 to <b>120 mg daily</b> ) for

					a mean of 14.15 weeks (range, 6 to 30 weeks).  <b>Tourette syndrome (off-label) -</b> <b>Initial dosage:</b> Initial dosage was 10 mg twice daily, titrated to <b>30 mg 3 times</b> daily over an 8-week period. Facts & Comparisons
<b>Seroquel</b> (Quetiapine)	800 mg	0	400 mg	600 mg	<b>150% = 1200mg</b> <b>Off-label dosing:</b> <b>Tourette syndrome</b> <b>(children/adolescents) (off-label) -</b> <span style="border: 1px solid black; padding: 2px;">4</span> Dosing ranged from 25 to 175 mg/day for 8 weeks based on treatment evaluations and tolerability. Initiate dose at the low end of the range and titrate based on tolerability and efficacy Facts & Comparisons  Dosing recommendations vary for dx and weight. The max recommendation is for schizophrenia is 400mg-800mg daily (divided in 2 or 3 doses), 10mg for schizophrenia, and 400-600mg for Acute bipolar mania (divided in 2 or 3 doses). High dose will base off of 800mg. DUR can pull claims for retrospective review in a more detailed way via dx.
<b>Clozaril</b> (Clozapine)	900 mg (adult dosage – not established for children)	0			<b>150% = 1350mg</b>

There was a motion, second and all were in favor of requiring prior authorization for 150% of labeled dose of antipsychotics.

Old Business

A. Proposed PA criteria for Intuniv were reviewed. There was a motion, second, and all were in favor of the following criteria.

**Intuniv**

**Intuniv will be approved with the following criteria:**

- **ADHD Diagnosis required, AND**
- **Must be at least 5 years of age, AND**
- **14 day trial and benefit of guanfacine, AND**
- **14 day trial of stimulant OR 30 day trial of Strattera.**
- **OR**
- **Contraindication to ADHD medications (including stimulants and nonstimulants)**
- **Tic disorder associated with stimulants (trial of nonstimulant required)**

B . Tablet splitting/Dose optimization: After reviewing tablets that can reasonably be split and make sense economically, as well as other states’ experience with similar policies, the Office of Pharmacy Services feels that dose optimization is a more feasible

cost savings intervention than tablet splitting. We will begin working on this, beginning with the antipsychotic medications.

C. Review of the Targeted Immune Modulators. There is a trend to use these medications earlier, however, a trial of methotrexate is still required.

Marc Jensen (UCB) gave public comment on Cimzia. It is the only pegylated TIM. This results in decreased dosing frequency and increased dosing flexibility. It is approved for Chron's and rheumatoid arthritis. There are no head to head trials with the other agents.

Review of DERP Report:

Efficacy: The available evidence does not show significant differences in terms of efficacy.

Safety: There is a paucity of evidence comparing the safety of these medications.

Clinical experience: Choosing a drug is generally based on trial and error. It is hard to determine which one to use. Typically, start with a two to three month trial of methotrexate, then move to a TNF, then switch to another TNF and finally move on to another class. Methotrexate is often continued, but combination TNF agents are not used. All indications should be covered on the PDL.

There was a motion, second and all were in favor of the above recommendations. Cost will be reviewed for determination of preferred drugs.

Two new agents are available in the class: Stelara and Actemra. There is very little information available on these agents. There was a motion, second and all were in favor of the following criteria for the new agents.

#### **Stelara**

**60 day trial of one TNF agent.**

#### **Actemra**

**60 day trial of methotrexate and one TNF agent.**

#### New Business

A. Xolair prescribing information changes were reviewed. Lee Ding (Genentech) gave public comment. The PI was updated to reflect information regarding use in 6 – 12 year olds. The risk/benefit ratio does not support use in this population. The Committee felt that this drug is limited to those who are frequently hospitalized and

should not be restricted. An education letter will be drafted for prescribers using the drug in children under 12.

B. A provider requested that DUR treat antipsychotics similarly to stimulants in terms of maintenance medication designation. Scot gave an overview of how they have worked with a local institution to solve the problems which are detailed by the requesting provider. The Committee felt it was reasonable to ask the provider to work with the dispensing pharmacy to solve any issues as it would prevent wasted doses resulting from dosage changes which are frequent with this class of medications.

C. Fred Amberger (Novartis) gave public comment on Fanapt. He provided an overview of the available information on the drug, indicating that it is very similar to those currently on the market in terms of safety and efficacy. The Committee agreed that it was similar and indicated that the Office of Pharmacy Services should review the cost and make it preferred if there is a cost benefit to doing so.

D. PA Criteria

i. New Drugs were reviewed. There was a motion, second, and all were in favor of the following criteria.

**Ampyra**

**Diagnosis of gait disorder associated with MS required.**

**Initial use will be allowed for eight weeks. After eight weeks, the prescriber will have to certify that the drug is effective for the patient for continued therapy.**

**Lysteda**

**A 90 day trial and failure of NSAIDs AND oral contraceptives will be required prior to use of Lysteda.**

John Brokars (Lilly) gave public comment on Zyprexa Relprevv. It is a long-acting injectable antipsychotic. There is an associated REMS program as a result of post-injection delirium. The Committee did not see any reason to limit this medication any further.

ii. Use of Synagis has been reviewed since the implementation of defined dose and season limits. There remains a significant amount of use that falls outside of the guidelines. As a result, stricter criteria will be necessary beginning with the fall 2010 season. There was a motion, second and all were in favor of the following criteria.

Open Comments:

There were no additional comments.

The Committee met in closed session to review patient profiles. There being no further business, the meeting adjourned at 1:30 p.m.

Respectfully submitted,

Aimee Lewis  
WYDUR Manager