

ODJFS P&T Committee Meeting Minutes

July 13, 2005

30 E. Broad St., Lobby Hearing Room

Committee members present: Michael Alexander, DO; Tammie Armeni, RPh; Susan K. Baker, APN; Suzanne Eastman, R.Ph.; Ruth E. Purdy, DO; Robert P. Reid, RPh (chair); Mary Jo Welker, MD.

ODJFS staff present: Margaret Scott, RPh, BHPP pharmacist.

First Health Services Corporation staff present: Alan Daniels, RPh, Account Manager; Karen Parker, RPh, Clinical Manager.

Approximately 80 stakeholders were present, most representing pharmaceutical manufacturers.

The meeting was called to order at 9:10 AM by Mr. Reid, chair, who made opening remarks. He announced that the recently passed budget bill includes a provision to add an additional pharmacist to the P&T Committee, so the department will recruit a new member. He also mentioned that the department has been working with the Ohio Chapter of the American Academy of Pediatrics to fill the current vacancy.

Mr. Reid introduced Ms. Parker to present the department's recommendations for the PDL.

The following are discussion points for certain therapeutic classes. Classes not listed did not generate any discussion from the committee.

Non-sedating antihistamines:

Ms. Baker asked how many PA requests have been received for non-loratadine products. Mr. Reid responded that while he did not have the numbers in front of him, he believed the numbers to be small.

Quinolones:

Dr. Alexander is still concerned about Levaquin's status, since it is on most hospital formularies and has better coverage of staph and strep organisms.

Ms. Eastman added that LTC providers are concerned, especially that in the elderly population more hospitalizations may be required since Levaquin requires PA.

Dr. Welker said that Avelox is the preferred agent on the Ohio State University Medical Center formulary because of concerns about abuse and development of resistance to Levaquin.

Ms. Parker indicated that she recalled this was a difficult decision last year, but she had not seen much backlash since the implementation.

Mr. Reid echoed Ms. Parker's comment, and said he does not recall receiving any phone calls about Levaquin since last October.

Ms. Baker asked for confirmation that the drug does not need to be changed if it is initiated in the hospital (PA is required).

Dr. Alexander asked if the criteria would be the same this year, that the PA would be granted if the drug had been started in the hospital.

Mr. Reid said the department will continue with the same criteria for hospital-initiated therapy.

Dr. Alexander expressed concern that a physician PA is troublesome, since the PCP may not receive a hospital summary until several days after the patient is discharged. He suggested that a pharmacist should be able to request the PA.

Ms. Baker suggested that the hospital physician should request the PA when the patient is discharged.

Mr. Reid asked Ms. Parker if a pharmacist PA request could be handled by First Health.

Ms. Parker agreed that the issue could be explored, and that other states do allow some pharmacist PA requests.

Ms. Eastman inquired whether the department has studied whether courses of treatment are the same for both Avelox and Levaquin, i.e. whether Avelox requires more courses of treatment.

Mr. Reid indicated that the department considered total cost per claim, not claims per consumer.

Migraine:

Ms. Eastman inquired why the decision to add Frova was made.

Mr. Reid and Ms. Parker indicated that the drug had low utilization, and the department saw no reason to exclude it.

ACE Inhibitors:

Dr. Alexander indicated that in his practice, 70-80% of Altace PA requests were denied even though they were requested to reduce risk of heart attack and stroke as indicated in the PA criteria.

Ms. Parker indicated that this concern had been communicated to First Health by the department, and the call center staff had been re-educated to emphasize that the diagnosis should be the first consideration, and that it was not necessary for the prescriber to indicate the HOPE study was the reason for the request.

Mr. Reid suggested that if the situation arises again, to notify the department and it will intervene again to re-educate call center staff.

Caduet:

Dr. Alexander said that he would expect a cost savings for Caduet vs. Norvasc and Lipitor separately.

Ms. Eastman inquired whether a PA would be approved for a patient who is already stable on both Norvasc and Lipitor.

Ms. Parker said that the patient's best interest is the first priority, and that if compliance with taking two separate drugs is questioned, the combination product would be approved.

Dr. Welker asked the cost difference between the combination and separate products.

Mr. Reid indicated that the manufacturer is willing to provide detailed cost savings. He inquired whether the recommendation of the committee is to place the combination product on the preferred side to increase compliance.

Ms. Eastman and Dr. Welker responded affirmatively.

Mr. Reid said the department would consider the change.

Lipotropics:

Ms. Eastman expressed concern that Vytorin and Caduet are presented in the same category, lipotropics combination, since they have different indications.

Ms. Parker agreed that listing combination drugs is difficult because they have different indications.

Ms. Eastman said she thought it would be better to separate the categories.

Ms. Parker agreed to make the change.

Endocrine – Diabetes

Dr. Alexander asked if renal patients and patients who are tube-fed would be able to receive liquids such as Riomet.

Ms. Parker said that both are approvable indications.

Dr. Alexander asked if patients with feeding tubes could be exempted from the PA requirement.

Ms. Parker indicated that there is no way to know which patients have feeding tubes, so a change could not be made to the system.

Mr. Reid suggested that the department could explore allowing a pharmacist to make a PA request in the case of a patient with a feeding tube.

Dr. Welker asked Ms. Eastman if she had heard any problems in the LTC community regarding patients with feeding tubes.

Ms. Eastman said she has not heard any concerns from the LTC community.

Dr. Alexander said he has heard of patients and caregivers crushing metformin tablets for administration through a tube; metformin is not indicated for this type of administration and that this practice is potentially dangerous.

Mr. Reid reiterated that the department will explore allowing a pharmacist to make a PA request for tube-fed patients.

Bisphosphonates:

Dr. Alexander indicated that Fosamax liquid would be better for patients on feeding tubes. He also indicated that the Fosamax Plus D combination may be a less expensive option to providing Actonel with a calcium-vitamin D combination.

Mr. Reid said the department would entertain information from the manufacturer of Fosamax Plus D. He also said that the department currently covers calcium-vitamin D combination.

Proton Pump Inhibitors:

Dr. Welker asked if any changes will be made based on the clinical information presented on July 12.

Mr. Reid indicated that the department is considering allowing Prevacid SoluTab for patients age 6 and under without PA.

Dr. Welker asked if that exemption would include the granules for infants.
Dr. Alexander added that both may be appropriate for patients with PEG tubes.
Dr. Welker indicated that pediatricians at OSU prefer the SoluTab formulation.
Mr. Reid said the department will consider both the SoluTab and granules.
Dr. Alexander asked why Prilosec OTC will now require PA, since it seems that there would be a cost savings with using the OTC product if there are several available.
Ms. Parker indicated that Prilosec OTC is only manufactured by one company. Generic omeprazole is only available by prescription, and that the cost of Prilosec OTC is higher than other products.
Dr. Alexander reiterated his comments made last year that Protonix is the only PPI with no drug-drug interactions, and asked whether a better price could be negotiated.
Mr. Reid agreed that the department would like that, but gave some background that some manufacturers may offer a better price in exchange for exclusivity, so sometimes the department is not able to make a choice that may seem obvious at first glance.
Dr. Welker indicated that the same type of contracting occurs in hospitals as well.
Mr. Reid also commented that PA required for doses of greater than one per day is not uncommon in private plans.

Urinary Antispasmodic Agents:

Ms. Eastman asked if Detrol and Detrol LA were moved to the PA required side due to cost.
Mr. Reid responded that the movement was due to supplemental rebate negotiations.
Ms. Eastman expressed concern that the decision was not clinical, that it was based on cost vs. newer agents.
Mr. Reid and Ms. Parker confirmed that the decision-making process is complex.
Ms. Eastman expressed surprise that the department would include newer drugs with less clinical information available over a drug with more clinical experience.
Ms. Baker noted that a large market share will need to be moved to other agents.
Ms. Eastman expressed concern that patients stabilized on therapy will need to switch.
Mr. Reid said that he expected prescribers would be heavily detailed on the newer products.
Ms. Baker again noted the large population of well-controlled patients.
Mr. Reid indicated that the population had not gone unnoticed.
Dr. Alexander said that a urologist with whom he has spoken indicated that Detrol has a different mechanism of action on the neck of the bladder, and may be more effective especially for male patient.
Mr. Reid said the department will pursue this subject with the pharmaceutical manufacturer.

COPD Anticholinergics:

Dr. Welker expressed support for DuoNeb since mixing two vials may be difficult for some patients; she also acknowledged the significant increased cost of the combination product.
Ms. Eastman echoed Dr. Welker's concerns that measuring incorrectly may cause problems for the patient.

Dr. Welker said she was surprised that the manufacturer of Spiriva could not offer a better price.

Dr. Alexander indicated that Spiriva has better efficacy and that DuoNeb is easier for patients to use.

Mr. Reid said he has received a lot of mail on Spiriva, and that the department would try to negotiate with the manufacturer. He also noted that Atrovent HFA may be moved to the preferred side as the Atrovent MDI supply dries up, probably within the next year. However, the department wants to take advantage of the lower price of the MDI as long as it is available.

Sedative-Hypnotics:

Dr. Alexander expressed concern that all of the preferred agents are benzodiazepines, which carry a risk of addiction. In addition, they are all indicated for short-term therapy.

Mr. Reid added that the sedative-hypnotics as a group are not only used short term.

Dr. Alexander suggested adding Lunesta, which does have a long-term use indication.

Ms. Parker confirmed that Lunesta is the only product with the long-term use indication.

Dr. Alexander hopes the department will be able to negotiate better pricing for Lunesta.

Mr. Reid noted this request.

Muscle Relaxants:

Mr. Reid noted the market share of Skelaxin (15.3%).

In closing, Mr. Reid said that the department will pursue the issues discussed during the meeting, but may not always be successful with negotiations.