

**Drug Utilization Review Board
Meeting Minutes, Open Session
July 11, 2012**

<p>Drug Utilization Review Board Meeting Minutes, Open Session HP Enterprise Services / Forbes Field Capital Room Topeka, KS</p>	<p>Members Present: Dennis Grauer, PhD Daniel Sutherland, RPh Judy McDaniel Dowd, PA-C Tim Heston, DO Roger Unruh, D.O. Kevin Waite, Pharm.D. John Kollhoff, Pharm.D. Member Absent DHCF Staff Present: Kelley Melton, Pharm.D. Shea Robinson Shelly Liby HP Enterprise Services Staff Present: Deb Quintanilla, R.N. Lisa Todd, R.Ph. Karen Kluczykowski, RPh HID Staff Present Nicole Churchwell, Pharm.D. ACS Staff Present Bethany Noble, C.Ph.T Larry Dent, Pharm.D.</p>	<p>Representatives: James Stryker, Amerigroup Sumar Bieda, Purdue Sam Smothers, MedImmune, Drew Bernstein, MedImmune Scott Edelhauser, Alcon Berend Koops, Merck Chuck Gillespie, Merck Russ Wilson, J&J Jeff Himmelberg, GSK Dave Sproat, BMS Susan Zalenski, J&J Mike Ketcher, Novo Nordisk Joe Summers, Novo Nordisk Eric Gardner, Vertex Lisa Borland, Vertex Don Larsen, Forest</p>
TOPIC	DISCUSSION	DECISION AND/OR ACTION
I. Call to Order	Dr. Waite called the meeting to order at 10:02 a.m.	
II. Announcements	Dr. Churchwell advised the attendees that the parking spaces in the front of the building (east side) are available for the Board members and that there is additional parking on the west side of the HP office for visitors. Dr. Melton announced that any members of the public should sign in and a public disclosure of interest forms will need to be completed and returned if they wish to speak on any particular agent during the meeting.	
<p>III. Old Business</p> <p>A. Review and Approval of 04/11/12 Meeting Minutes</p> <p>B. Update on Implementation of New Limits</p>	<p>No changes were made. The minutes were approved.</p> <p>Updates on previous board medications that require PAs. This includes the dose optimization on long-acting opioid agents, PAs on agents taken to the Joint Committee on Administrative Rules & Regulations in January, limitations on carisoprodol-containing</p>	<p>Dr. Kollhoff moved to approve the minutes.</p> <p>Ms. Dowd seconded motion and it carried with a unanimous vote.</p>

	<p>products, and limitations on methadone. The state hopes to have more updates for the October meeting.</p> <p>New DUR Board Member Dr. Timothy Heston, DO was introduced at this time.</p>	
<p>IV. New Business</p> <p>A. Topical Acne Medication (Fabior® tazarotene))</p> <p>i. Revised Prior Authorization Criteria ii. *Public Comment iii. Board Discussion</p>	<p><u>Background</u> Fabior® Foam 0.1% is a new formulation of tazarotene, a topical retinoid, indicated for the topical treatment of acne vulgaris in patients 12 years of age or older. The prior authorization for acne medications were last approved by the DUR board in June 2011. It is recommended that Fabior® be added to the current criteria.</p> <p><u>Public Comments:</u> No public comments.</p> <p><u>Board Discussion</u> Ms. Dowd questioned whether Tazorac® had been on the list for plaque psoriasis as well as occasionally acne.</p> <p>Dr. Churchwell explained that all agents listed have criteria for acne, but that Tazorac® also had specific criteria for plaque psoriasis.</p> <p>Ms. Dowd thinks that the criteria should be made more clear to indicate that Tazorac can be approved for acne as well as plaque psoriasis.</p>	<p>Dr Kollhoff made a motion to add Fabior® to the prior authorization criteria and to approve proposed changes</p> <p>? seconded the motion</p> <p>The motion passed unanimously.</p>
<p>B. Synagis® (palivizumab)</p> <p>i. Revised Prior Authorization Criteria ii. *Public Comment iii. Board Discussion</p>	<p><u>Background</u> Synagis® is a synthetic antibody indicated for prophylaxis of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in children at high risk of RSV disease. The Synagis® prior authorization criteria were last updated by the DUR board in July 2009, before the 2009 – 2010 RSV season. To reflect recommendations from the American Academy of Pediatrics (AAP) and CDC information on the RSV season in Kansas and Region 7, it is recommended that Synagis® prior authorization criteria be revised to include the current recommendations.</p> <p><u>Public Comments:</u> Dr. Andrew Bernstein, Board Certified Pediatrician and Medical Science Director for MedImmune, discussed the epidemiology of RSV and stated that exposure will occur within the first one to two years of life. He stated that RSV is the largest cause for hospitalizations in the first year of life and that there is no effective treatment or vaccine, with approximately 400 infants dying each year from RSV infection. Dr. Bernstein added that palivizumab has been shown to be safe and effective and that pre-licensure clinical trials have shown that palivizumab has reduced the RSV-documented hospitalization rate by 55 to 82%.</p> <p>Dr. Bernstein acknowledged, however, that the problem remains that palivizumab is seen as</p>	<p>Dr. Kollhoff made a motion to approve the revised Synagis criteria.</p> <p>Dr. Unruh seconded the motion.</p> <p>The motion passed unanimously.</p>

not being cost-effective. He noted that there is a cost effectiveness study by Weiner, et al. that is specific to a Medicaid population and uses Medicaid-specific costs. This study was published in the Journal of Medical Economics in March and evaluated using full season dosing versus no dosing of palivizumab in four different birth cohorts based on gestational age and risk factors specific for RSV hospitalization. Using an ultra-conservative model, palivizumab was shown to either be cost-saving or cost-effective, especially in high-risk patients less than 32 weeks gestational age. For each pre-term high-risk infant, a cost-savings of about \$2,400 could be recognized using full-season dosing. Dr. Bernstein further stated that using the current AAP recommended pre-screening criteria from the 2009 Red Book for 32-34 week gestation, but dosing these infants for the entire season (as supported by the FDA-approved labeling), resulted in an Incremental Cost Effective Ratio (ICER) of about \$16,000 per Quality-Adjusted Life Year (QALY). If previous AAP guidelines from the 2006 Red Book were used, the cost per QALY was \$38,000. In all cases, the results were far below the accepted benchmark of \$50,000 per QALY, regularly regarded by medical economists as the threshold for cost effectiveness.

Dr. Bernstein reported that a second study looked at the effect of compliance with palivizumab and its impact on hospitalizations. This study looked at over 8,400 premature Medicaid infants in 12 states over 6 RSV seasons and compared the rate of hospitalization for RSV bronchiolitis in high risk premature infants who received full-season dosing with those who were non-compliant. The result was that non-compliance was identified in over 2/3 of Medicaid patients, minority populations, and children enrolled in capitated plans. Non-compliant infants showed a 62% relative increase in hospitalizations related to RSV. Non-compliant patients with Chronic Heart Disease (CHD) or Chronic Lung Disease (CLD) had an 83% higher relative risk for hospitalization.

Dr. Bernstein summarized by saying that palivizumab was shown to be cost-saving in high-risk patients who are less than 32 weeks gestation and cost-effective in premature infants 32-35 weeks using full season dosing and not an abbreviated or truncated pattern that is currently recommended by the AAP. The majority of Medicaid patients appeared not to be compliant with full recommended doses, and this non-compliance significantly increases their risk for RSV bronchiolitis. These studies suggest that by targeting the most appropriate patients for RSV prophylaxis and by improving overall compliance, full season dosing would result in reduced hospitalizations for the highest risk infants in Kansas. He requested that the board consider allowing full season dosing for all 32-34 week infants that meet current PA criteria for RSV prophylaxis.

Dr. Bernstein also suggested that the board, when presented with the option to change the season from November to March, would review both CDC virology data and RSV alert, which collects laboratory data from hospitals within Kansas to see what the season actually is. He stated that over the past 3 years, the RSV season in Kansas and the Kansas City metro area lasts into April. Dr. Bernstein stated that ending dosing by March 31 may leave kids

unprotected for the season into April.

Board Discussion

Ms. Dowd asked Dr. Bernstein if the studies he cited were based on dosing starting October 1 or November 1 in this area. Dr. Bernstein stated that if you look at the data specifically, the season has been pushed back slightly since 2009, possibly due to some relationship with H1N1. However, the season is roughly stable from November to April. Dr. Bernstein cited a study published in the journal Pediatrics in 2010 by Palazzo et al. that found that if your local virology varies from the November-March period, it is recommended to start prophylaxis 30 days prior to the start of the historical season, and then to stop this prophylaxis 30 days prior to the end of the historical season. In our area, this appears to be November-April.

Dr. Melton discussed information that Dr. Churchwell had included for the members, which showed charted CDC data for the region that Kansas is in. Dr. Bernstein noted that the season starts late in November or early December and goes late into April or May. He mentioned that data more specific to certain metropolitan areas may be available, and that the 10% threshold seen on the chart is usually considered the start of the season. This standard depends on testing, however, which may not be done if it does not have an impact on patient care.

Dr. Kolhoff asked how many claims the program has for Synagis annually. Dr. Churchwell reported that for the last season we had just over 700 claims for 190 beneficiaries for this vaccine. Dr. Kolhoff asked if this should essentially be 5 claims per beneficiaries, and Dr. Churchwell explained that this should be the case except for those infants born from 32-35 weeks gestation, who are only approved to receive 3 doses.

Dr. Kolhoff asked if there is any possibility for infants to receive the medication outside of this time period. Dr. Melton stated that, in preparing for the meeting with Dr. Waite, we had discussions about how they had seen the season extending. She stated that if we have infants that have not yet met their 5 doses, and the season seems to be lasting longer, we are able to review on each beneficiary on a case-by-case basis. Dr. Kolhoff asked if this makes the guidelines in the criteria arbitrary. Dr. Melton stated that the state thinks this sets a better guideline for our physicians to lean on, and to plan to get an infant's 5 doses within this window. We are willing to review exceptional cases, but we would like to have beneficiaries within the window in the criteria because this is when the highest rates of RSV are seen. Dr. Churchwell also mentioned that part of the problem with the October start date is that a baby's last dose ends up being in February, which can be problematic if there is an extended season. She also mentioned that if you review the CDC data, the season really begins to increase in late December, so a November 1 start date leaves the recommended 30-day period prior to season start.

Dr. Grauer expressed his concern that if the patient needs 5 doses, they must have started by December. Ms. Dowd agreed, stating that she is concerned about cutting two months off of the season. She stated that November 1 seemed to be an appropriate start date, but that we should potentially extend the season to April 30 due to the literature reviewed.

Dr. Kolhoff asked if any cost-effectiveness data is available for Kansas specifically. Dr. Melton stated that the study Dr. Bernstein cited had cited another study that Dr. Theresa Shireman from KU had done specific to Kansas. However, this study was done in 2002 and did not take a number of economic factors into account. Dr. Melton also said she had concerns about how the actual study Dr. Bernstein cited applied to Kansas, noting that this study assumed 100% compliance with the Synagis dosing regimen, and as he mentioned, 2/3 of Medicaid patients are not fully compliant with this regimen. She stated that the state could look at our own data in terms of compliances and outcomes, but that a national study may not be generalizable to Kansas. Dr. Churchwell also mentioned that in this study, the season was November 1-March 31.

Dr. Waite commented that, when looking at the data, even though the season continues into the early part of April, the season is clearly on the decline at that point. He stated that the risk for infection after full dosing is unknown, and asked Dr. Bernstein if he had any information available on this. Dr. Bernstein stated that the half-life of the product was found to be about 20 days in laboratory settings. However, in an individual child, assuming they get 5 doses, there will be a peak in dosing seen after a dose, but these levels may dip below a threshold level about the time the next dose should occur. Dr. Bernstein recommended that if there is still a concern of a community risk of RSV a patient should continue to receive Synagis.

Dr. Unruh stated that he agreed with the move to November 1, but mentioned that there have been years when it may have been helpful to have the season go through April. Dr. Kolhoff stated that provided administrative staff is willing to handle circumstances outside of the typical season, he was willing to accept the shortened season.

Dr. Grauer asked what the threshold for the start of the season was, referring the CDC graph information provided. Dr. Churchwell explained that the start of the season is considered to be 2 consecutive weeks above 10% positive. Dr. Waite noted that around April 7th, it dropped below 10%. Dr. Bernstein added that reviewing one season represents just that one season's worth of data. For this reason, it is important to look at 5 years minimum of data to determine what the season historically is. Dr. Melton asked if the previous season represented an especially long season. Dr. Bernstein stated that the past season went outside of what is typically seen for an RSV season. He stated that for the past 3 years, the season has started in November or December and gone into April.

Dr. Grauer asked Dr. Bernstein how many patients he has given Synagis doses in April. Dr.

	<p>Bernstein stated that in his practice he advocates for complete season dosing, which varies across the country. He stated that in the Mid-Atlantic region where he practices, the RSV season may only last 13 weeks, whereas in Kansas' region the season may last 25 weeks. He stated that in either case, he would err on the side of making sure his patients were covered.</p> <p>Ms. Dowd asked if the state knows how many providers may attempt to obtain a Synagis prior authorization even if their patients may receive a denial. Bethany Noble stated that there was only one request for out-of-season dosing, and it was approved. Dr. Melton added that this patient lived in an area of the state where the season was longer, and was also approved due to patient-specific factors.</p>	
<p>C. Transmucosal Immediate-Release Fentanyl (TIRF) Products (Subsys®(fentanyl sublingual spray))</p> <p>i. Revised Prior Authorization Criteria</p> <p>ii. *Public Comments</p> <p>iii. Board Discussion</p>	<p><u>Background</u></p> <p>Subsys® is a new transmucosal immediate-release fentanyl product indicated for the management of breakthrough pain in patients who are 18 years of age or older, have a diagnosis of malignant cancer, and are already receiving and are tolerant to around-the-clock opioid therapy. Subsys® must be prescribed by an oncologist or pain specialist and the prescriber, patient, and pharmacy must be enrolled in the TIRF REMS Access program. Patients should use no more than 2 units per episode of breakthrough pain and should not exceed 4 episode treatments per day for a maximum of 8 units per day. The DUR board last approved the TIRF prior authorization criteria in October 2011. The recommendation is to add Subsys® to the TIRF prior authorization criteria</p> <p><u>No Public Comments</u></p> <p><u>Board Discussion</u></p> <p>Dr. Waite noted added that Subsys® is a unit dose product (not a multi-dose spray), so units are very easy to define when monitoring this medication.</p> <p>Dr. Churchwell stated that in 2006, before fentanyl PA criteria went in place, there was much more utilization, although Actiq was the only agent on the market at that time. Dr. Churchwell reviewed utilization of all fentanyl products from January 2011 to May 2012, and stated that 23 claims were seen for 3 beneficiaries, so utilization has been greatly reduced since this criteria has gone into place.</p>	<p>Dr. Kolhoff made a motion to add Subsys to the PA criteria</p> <p>Dr. Grauer seconded the motion.</p> <p>The motion passed unanimously.</p>
<p>D. Firazyr® (icatibant)</p> <p>i. Proposed Prior Authorization Criteria</p> <p>ii. *Public Comments</p> <p>iii. Board Discussion</p>	<p><u>Background</u></p> <p>Firazyr® is bradykinin B2 receptor antagonist indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adults 18 years of age and older. Other drugs used for HAE have approved prior authorization criteria, including Kalbitor (a plasma kallikrein inhibitor), Berinert and Cinryze (both C1 esterase inhibitors). It is recommended that prior authorization criteria be approved for Firazyr®. 43:15</p> <p><u>No Public Comments</u></p> <p><u>Board Discussion</u></p>	<p>Dr. Kollhoff made a motion to approve Firazyr® PA criteria.</p> <p>Ms. Dowd seconded the motion.</p> <p>The motion passed unanimously.</p>

	Dr. Waite mentioned that this drug is administered subcutaneously, so you may see more utilization of this drug for that reason.	
<p>E. Kuvan® (sapropterin)</p> <p>i. Proposed Prior Authorization Criteria ii. *Public Comments iii. Board Discussion</p>	<p><u>Background</u> Kuvan® is indicated for treatment of phenylketonuria (PKU) in conjunction with a phenylalanine-restricted diet. PKU is an inborn condition that leads to hyperphenylalaninemia resulting in decreased intelligence and a decreased ability to focus, remember, and organize information. Kuvan® works by replacing tetrahydrobiopterin (BH4), a cofactor for phenylalanine hydroxylase, resulting in decreased phenylalanine levels. Due to off-label use, it is recommended that prior authorization criteria be approved for Kuvan®.</p> <p><u>No Public Comment</u></p> <p><u>Board Discussion :</u> Dr. Grauer asked what the off label uses were. Dr. Dent replied that there are some off label psychiatric uses such as for ADHD, and Dr. Churchwell added that the main off label use was for autism. She also stated that it is believed that BH4 aids in the regulation the neurotransmitters, which may be why it is used for these conditions. She also stated that reviewing Drug Dex shows PKU as the only labeled indication, with no off label uses being supported. Dr. Churchwell also reported that we have seen utilization with no diagnosis of PKU.</p> <p>Dr. Kollhoff asked about how responsiveness to Kuvan will be documented as part of the criteria. Dr. Churchwell stated that the prescriber must document this responsiveness.</p>	<p>Dr. Grauer made a motion to approve Kuvan® prior authorization criteria.</p> <p>Dr. Kollhoff male seconded the motion.</p> <p>The motion passed unanimously.</p>
<p>F. Victrelis® (boceprevir)</p> <p>i. Proposed Prior Authorization Criteria ii. *Public Comments iii. Board Discussion</p>	<p><u>Background</u> Victrelis is a Hepatitis C virus (HCV) NS3/4A protease inhibitor indicated, in combination with peginterferon and ribavirin, for the treatment of chronic hepatitis C genotype 1 infection in patients who are 18 years of age or older with compensated liver disease, including cirrhosis, who are previously untreated or who have failed previous interferon and ribavirin therapy. To ensure safe and appropriate use, it is recommended that prior authorization criteria be approved for Victrelis.</p> <p><u>Public Comments</u> Chuck Gillespie, Medical Science Liaison with Merck, stated that there is data to support use of Victrelis in null responders. He also stated that when looking at both protease inhibitors, when compared to an appropriate control, the Sustained Viral Response (SVR) rates vary within about 1-2%, from about 66% for Victrelis to 79% for telaprevir. Null responders had about a 30% cure rate versus 0% on prior therapy. SVR rates go up to 96% for about half of patient who had negative viral rates at 8 and 24 weeks. He also discussed the advantages of triple therapy with his medication, stating that if patients are unable to tolerate pegylated interferon and ribavirin alone, they do not have to add on Victrelis. He</p>	<p>Dr. Kollhoff made a motion to approve the criteria for Victrelis.</p> <p>The motion was seconded by the Ms. Dowd.</p> <p>The motion passed unanimously.</p>

	<p>also stated that Victrelis has the advantage of response-guided therapy, which can shorten standard therapy from 48 weeks to about 28 weeks. Mr. Gillespie also stated that Victrelis should never be used as monotherapy, and that one of the potential adverse effects is anemia.</p> <p><u>Board Discussion</u> Dr. Melton mentioned that for both this agenda item and the next, the package inserts are much more specific in terms of lab draws, stopping therapy, and timeframes, but to manage these agents exactly in line with these details would have required a new Prior Authorization every month. It was decided that if the state determined the patients were appropriate in terms of age and diagnosis, then the state was comfortable with prescribers managing these drugs.</p>	
<p>G. Incivek® (telaprevir)</p> <p>i. Proposed Prior Authorization Criteria ii. *Public Comments iii. Board Discussion</p>	<p><u>Background</u> Incivek is a Hepatitis C virus (HCV) NS3/4A protease inhibitor indicated, in combination with peginterferon and ribavirin, for the treatment of chronic hepatitis C genotype 1 infection in patients who are 18 years of age or older with compensated liver disease, including cirrhosis, who are treatment-naïve or who have been previously treated with interferon-based treatment, including prior null responders, partial responders, and relapses. To ensure safe and appropriate use, it is recommended that prior authorization criteria be approved for Incivek</p> <p><u>Public Comments</u> Lisa Borland, Managed Care Liaison with Vertex Pharmaceuticals, offered to answer any questions the board may have regarding Incivek.</p> <p><u>Board Discussion</u> Dr. Waite clarified that the 12-week treatment duration of Incivek came from the package insert. Dr. Melton indicated that that it is 12 weeks of Incivek, and based upon the patients response it is then followed by a 12 or 36 weeks of the peg/riba combination.</p> <p>Lisa Borland expanded on the dosing, on this to state that treatment duration for all patient groups is 12 weeks of Incivek with pegylated interferon and ribavirin. The patient will then have an additional 12 or 36 weeks of pegylated interferon and ribavirin alone. The total duration of therapy depends on viral response in weeks 4 and 12, as well as the patient’s prior treatment history.</p>	<p>Dr. Sutherland made a motion to approve the prior authorization criteria for Incivek.</p> <p>Ms. Unruh seconded the motion.</p> <p>The motion passed unanimously.</p>
<p>H. Short-Acting Opioids Quantity Limits</p> <p>i. Proposed Quantity Limit and Prior Authorization Criteria ii. *Public Comment</p>	<p><u>Background</u> When opioid therapy is warranted in patients with chronic pain, it is typically recommended that a long-acting agent be used for baseline analgesia and a short-acting opioid be used for breakthrough or incident pain. Patients using opioid therapy long-term should be monitored closely for efficacy, tolerability, and appropriate use. In an effort to promote appropriate prescribing, monitoring, and utilization of opioid agents, limitations were placed on long-</p>	<p>Dr. Kollhoff made a motion to accept the short acting opioid quantity limits revision.</p> <p>Dr.Sutherland seconded the motion.</p>

<p>iii. Board Discussion</p>	<p>acting opioids to limit the number of units per day a patient can receive without a prior authorization. A quantity limit for patients using long-term short-acting opioids is being proposed to work in conjunction with the current limitations on long-acting opioids. Patients filling prescriptions for more than 180 units of hydrocodone, oxycodone, morphine, and/or oxymorphone-containing products in 45 days (4 units per day) will require a prior authorization. Quantities lower than 180 units in 45 days will not be affected by this limit.</p> <p><u>No Public Comment</u></p> <p><u>Board Discussion</u></p> <p>Dr. Kollhoff asked how many beneficiaries would be affected by this. Dr. Churchwell presented utilization data that showed numerous claims above this limit.</p> <p>Dr. Grauer asked if the criteria asking for only one prescriber or practice would be an issue in implementing this criteria. Dr. Churchwell stated that this criteria is in place in the long-acting opioids criteria.</p> <p>Dr. Kollhoff questioned if the quantity limit would push beneficiaries into using higher-cost alternatives when higher doses of lower cost alternatives might be appropriate. Dr. Waite mentioned that this PA is meant to address chronic pain, not acute pain. Dr. Churchwell stated that the limit will be 180 units over a 45-day period and will not look at the ratio of tablets per day.</p> <p>Dr. Heston stated that a concern of his would be for long term care patients and the documentation required for patients to obtain these medications, and stated that his patients might not even meet the three criteria. Dr. Melton pointed out that we could look at lengthening the PA from 3 months to 6 months. She also stated that we could take a more conservative approach to begin with and give patients a higher limit before requiring PA.</p> <p>Dr. Sutherland stated that in his retail practice he struggles with controlled substances prescriptions and has asked for a diagnosis on every single narcotic prescription. He stated that questionable diagnoses are seen in patients at doses higher than seen in this PA criteria. He agrees that terminally ill and cancer patients are appropriate, but stated that the third criteria piece left open the possibility that a prescriber could work around the PA.</p> <p>Dr. Sutherland also reported that he serves nursing home patients and does not have them bumping up against the maximums proposed here. Dr. Melton asked Lisa Todd if dual eligible patients would even hit these limits, or if we would just pay for their Medicare Part D copays for these prescriptions.</p> <p>Dr. Grauer also mentioned that some patients just pay cash, and that this is not even captured in the utilization data reviewed by the board. Dr. Melton mentioned that the Board</p>	<p>The motion passed unanimously.</p>
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	<p>of Pharmacy and their K-TRACS program received a grant to look at the data of Medicaid’s lock-in beneficiaries to determine if they are following limitations or are paying cash at other pharmacies.</p> <p>Dr. Dent added that the SmartPA program will be automated if the patient is terminally ill or has cancer.</p> <p>Dr. Kollhoff asked if it would be possible to make the PA last a year. Dr. Churchwell stated that once a PA is approved, there are no longer limits on these drugs. Dr. Sutherland mentioned that he would like to look at the third criteria again. He stated that in his experience, narcotic prescribing has been very lax. Dr. Melton asked Ms. Noble if a claim written by a second provider will go through if a patient has a PA in place. Ms. Noble confirmed that it would. Dr. Melton suggested that that this may be a reason to keep the shorter duration, and that this could be reviewed at PA renewal.</p> <p>A discussion was had about prescribers working in the same practice being approved to write for a given patient.</p> <p>Dr. Sutherland asked if there is some way to capture the other reasons, other than terminal illness and cancer, that these drugs would be dispensed in high quantities, as the third criteria point allows for these drugs to be prescribed by a willing provider. Dr. Kollhoff asked how much additional paperwork burden we expected to see from this change. Dr. Melton explained that for the similar long-acting opioids criteria, all information can be collected over the phone. She also discussed how the Soma criteria was implemented in terms of prescriber education. Dr. Heston added that the requirement for a concurrent long-acting opioid will deter some of the abuse in these situations.</p> <p>Dr. Waite stated that by implementing this criteria we will have a subset of data to review on patients who hit the PA requirements and were not able to meet them. Additionally, putting these limitations in will limit the use of state resources for drug seeking behaviors. He also mentioned the importance of the K-TRACS system in reviewing these patients.</p> <p>Dr. Melton mentioned a suggestion from Dr. Churchwell that a review of the K-TRACS system be required by the prescriber prior to PA approval. Ms. Dowd mentioned that a prescriber does not always do this, as they have the ability to designate office staff to run these reports. It was also decided to include the web address for the K-TRACS system on the PA form.</p>	
<p>I. Retro-DUR Intervention Topic Selections</p> <p>i. Retro-DUR Outcomes Report</p> <p>ii. Board Discussion</p>	<p><u>Background</u></p> <p>Each year the board selects five RetroDUR Intervention Topics for prescriber lettering and education. At this meeting, the board will choose 2 or 3 topics from the following, with the remaining chosen at the October meeting:</p> <ol style="list-style-type: none"> 1.) Appropriate lab monitoring of A-typical Anti-Psychotics 2.) The risk of QT prolongation with Quetiapine 	<p>Dr Unruh made a motion to approve the selected topics</p> <p>Dr. Kollhoff seconded the motion.</p>

	<p>3.) Non-adherence to Anti-Psychotic Medications 4.) Appropriate Intuniv utilization 5.) Long term utilization of immediate release opioids 6.) Cost control for Pregabalin, diclofenac transdermal, and Cox 2 Inhibitors</p> <p>Each topic was presented by Dr. Churchwell and reviewed by the board. Topics # 1, 2, 3, & 5 were chosen at this time and the remaining will be selected the October 2012 DUR Meeting.</p>	The motion passed unanimously.
V. KanCare Update	Dr. Melton announced that Amerigroup, Sunflower and United Health Care are the new KanCare providers. By the October meeting there will be a clearer idea of what will be seen for this board.	
VI. *Open Public Comment	Susan Zalenski, Johnson & Johnson, asked if Pharmaceutical benefits will still be handled through the state. Dr. Melton answered that they will. Ms. Zalenski also asked for clarification on supplemental rebates, double rebates, state PDL's and managed care organizations from the state and inquired if she had a Q & A available about Pharmaceutical Expectations. Dr. Melton advised her that she did not at this time, though if she ran into some of the same questions that kept coming up to keep track of them and they could meet about them if necessary.	
VII. Adjourn	<p>The meeting was adjourned at 11: 53 a.m.</p> <p>The next meeting will be on Wednesday October 10, 2012 . It will begin at 10:00 am at the HP Enterprises Services Office.</p> <p>**LUNCH WILL BE PROVIDED FOR DUR BOARD MEMBERS</p>	<p>Dr. Grauer made a motion to adjourn.</p> <p>Dr. Kollhoff seconded the motion.</p> <p>The motion passed unanimously.</p>