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# MENTAL HEALTH DRUG ADVISORS GROUP MEETING SUMMARY
## Thursday, Nov. 3, 2011

**Members Present:** Joyce Allen, Joanne Berman, Dr. Clarence Chou, Molly Cisco, Ted Collins, Brett Davis, Dr. Ron Diamond, Shel Gross, Linda Harris, Dr. Harsch, Dr. Hugh Johnston, Catherine Kunze, Jenny Lowenberg, Angie McAlister, Kevin Moore, Michelle Thoma, James Vavra, Dr. Witkovsky

**Staff Present:** Kenya Bright, Rachel Currans-Henry, Brian Groeschel, Sola Millard, Lynn Radmer, Kimberly Smithers, Kim Wohler

**Others Present**: Charmayne Brewster, Naomi Dewitt, Todd Kailas, George Klaetsch, Eric Knox, Erin Kruger, Christina Kropp, Dennis Majeskie, Gina Metelica, Shane Reddemann, NalidiYaucher

## Welcome/Introductions

Kevin Moore, Executive Assistant, Office of the Secretary; Linda Harris, Administrator, DMHSAS; and Brett Davis; Medicaid Director, DHCAA, opened the Mental Health Drug Advisory Group (MHDAG) meeting. Members introduced themselves.

## Prior Authorization Committee's (PAC) Preliminary Recommendations

J. Vavra, Director, Bureau of Benefits Management discussed the Preliminary Recommendations Document. J. Vavra stated that the preference is to have the Preferred Drug List (PDL) be generic drugs, if possible. He said there are instances where the preliminary recommendation is to prefer a brand name over its generic equivalent. These choices are made considering the lower cost with rebates. The group agreed grandfathering does not need to occur, when the brand name drug is preferred over the generic equivalent, in circumstances where federal rebates make the brand name drug less expensive.

## Alzheimer's Agents

T. Collins asked if the Department of Health Care Access and Accountability (DHCAA) would consider making Rivastigmine (Exelon) preferred in the future if the cost goes down and wondered if federal rebates are factored into costs. J. Vavra responded that DHCAA looks at the net price and rebates when factoring in costs, and this is considered when giving

a drug preferred status. The group agreed grandfathering should occur for generic galantamine, due to the recommended non-preferred status.

**Anticonvulsants**

Dr. Witkovsky asked if pharmacies dispense the brand name drug (on the PDL) if the prescription is written for the generic. L. Radmer responded that when prescriptions are written as a generic, the pharmacist can dispense the brand name product. Pharmacies are informed by DHCAA which brand names can be dispensed.

Dr. Witkovsky asked if co-payment would be the same as the generic if the brand name is dispensed. L. Radmer replied it would in some instances. J. Berman asked if receiving a generic prescription and receiving the brand name medication is a concern for consumers. Several members said that the brand name would be equivalent to the generic form.

**Antidepressants-Other**

Dr. Harsch asked if Cymbalta is the only preferred drug for fibromyalgia. J. Vavra reported that there are medications recommended for fibromyalgia besides Cymbalta in the fibromyalgia class. Cymbalta has multiple indications and is not reviewed in the Antidepressants, Other drug class, but instead in the Fibromyalgia drug class. Cymbalta is being recommended to remain non-preferred on the PDL. Dr. Chou stated that it is better to give one medication and not two if a person has both fibromyalgia and depression. C. Kunze asked whether people often get denied for Cymbalta if it is used for both conditions. L. Radmer responded that if it goes through PA, then these issues will be considered.

J. Vavra reported that Wellbutrin XL is more affordable than the generic. C. Kunze stated that her opinion that the brand Wellbutrin XL is more effective than the generic bupropion XL. J. Vavra replied that even when a brand name drug is non-preferred or requires Brand Name Medically necessary prior authorization, coverage is still available through the prior authorization process. T. Collins asked how decisions are made when choosing to prefer a brand name drug over the generic equivalent. J. Vavra responded that several factors are considered, and cost is an important one. T. Collins stated that we want to be careful not to send the message that the brand name is always the preferred agent by now selecting brand medications versus generic.

There was group discussion about PA forms.C. Kunze asked if Cymbalta has its own PA form. L. Radmer responded that there are several prior authorization forms for Cymbalta. Dr. Witkovsky asked if there is an algorithm in the forms. Radmer stated there was not because the form goes across multiple drug classes. There are several Cymbalta forms and for those, there are individual clinical criteria for the different indications of use. M. Witkovsky stated that it would be useful to have user-friendly PA forms.

M. Thoma discussed difficulties pharmacies have when they have to maintain two products (generic and brand) on the shelf. J. Vavra responded that DHCAA staff seeks to get the pharmacy communities' input when making PDL recommendations. S. Gross asked if

pharmacies have a choice not to carry certain medications. M. Thoma replied that some pharmacies feel forced to buy brand names and some pharmacies may choose not to do this. She stated that it is important to communicate PDL changes with the pharmacy community.

**Antidepressants, SSRI**

R. Currans-Henry reported that Lexapro's generic release date is March 2012 and DHCAA will monitor the cost-effectiveness of the generic in deciding whether to give the generic preferred status. Dr. Harsch commented that Lexapro is a safer medication than Citalopram and some organizations have switched consumers to Lexapro from Citalopram. Dr. Diamond stated he has tried to follow this issue since the FDA released warnings about Lexapro but more data on the two drugs' safety is needed. Dr. Harsch stated there were two large clinical trials comparing the drugs and results showed Lexapro fared better in both studies. Dr. Johnston reported that the overdose potential with Citalopram is higher than with Lexapro. He said that in the outcome data, it is hard to find real clinical problems but overdose is a different story.

J. Berman stated that when Lexapro turns generic, people will use it more and will need to know the warnings. J. Vavra stated that information is sent to prescribers to inform them of drug warnings. There is currently no warning for Citalopram. C. Kunze asked if Lexapro is a long-term release pill. M. Thoma responded it was not.

Consideration was made as to whether Lexapro should become a preferred drug, once it is available as a generic. DHCAA staff stated they will revisit this issue when the generic comes out in 2012. The group determined that safety issues for Lexapro and Citalopram should be monitored as more data comes out.

**Antiparkinson's Agents**

No recommendations.

**Antipsychotics**

Dr. Harsch asked how Fanapt was chosen to be recommended as preferred on the PDL. J. Vavra replied that it was chosen, in part, due to the price. S. Gross asked the group what their experience has been with using Fanapt. Many of the group members stated that is rarely prescribed. Several members agreed Fanapt can be difficult to prescribe due to dose titration. Some group members indicated their first choice for additional preferred brand drugs would be Saphris and/or Latuda, instead of Fanapt .Some group members were concerned that new drugs should not receive preferred status when little clinical information is available.

C. Kunze asked if Abilify is non-preferred because of the price. J. Vavra replied affirmatively. C. Kunze stated that she has heard from consumers that they have had wonderful results with Abilify. Dr. Diamond expressed concern about the increased advertisements for Seroquel XR and Abilify. He said many providers are feeling pressure

from their patients to prescribe these. Some group members expressed support for the prior authorization requirement on Abilify and Seroquel XR. It was suggested that without the prior authorization requirement, consumer pressure on providers would increase prescribing of these medications. .

The group discussed the idea of making certain drugs preferred only for psychiatrists. Several group members stated that this idea has been discussed by the group before and there is concern that there are not enough psychiatrists in Wisconsin, especially in rural areas, to make this work.

The committee discussed side effects and health problems associated with atypical drugs. The group expressed concern about the increased healthcare costs due to metabolic side effects with some atypical antipsychotics. J. Lowenberg stated that people with mental illness die much earlier than the regular population and consumers need to be monitored by their provider, have lab work, and be treated holistically. Dr. Johnston stated that this will be the first time the generic drug Olanzapine (Zyprexa) will not be on the Department of Corrections preferred drug list because of the metabolic problems associated with the drug. Dr. Witkovsky expressed concern about long-term risks, weight gain, and increased triglycerides on these drugs. S. Gross stated that Zyprexa is not used very often and it is not critical that it be preferred. Dr. Harsch stated that hospitals often prescribe Zyprexa to in-patients and he could foresee a problem if people could not obtain Zyprexa from the pharmacy after they leave the hospital.

R. Currans-Henry reported that the clinical information for the new drugs show some advantages with the metabolic impact over Zyprexa, but there is still not sufficient data. Some members suggested looking at the effects in the prescribing communities and see how people are doing on these new medications.

There were various recommendations from the group. Some members suggested adding Fanapt, Latuda, and Saphris to the PDL; some only suggested adding Fanapt to the PDL; and others did not want add any of them. The committee was mixed about whether Zyprexa, once it becomes generic, should be put on the PDL as preferred. Some members did not think it should be on the PDL as preferred because of metabolic problems associated with it, while others supported putting Zyprexa on the PDL because hospitals often prescribe it.

**Sedative Hypnotics**

No recommendations.

**Stimulants and related agents**

The group discussed market supplies of Adderall XR, Amphetamine salt-combo ER, and Amphetamine salt-combo. There are problems with supply and pharmacies being able to access these drugs.

M. Thoma stated that the additional paperwork for pharmacies to stock another Scheduled II medication will be time consuming. She recommended that Adderall XR remain preferred. L. Radmer stated that Schedule II medications do require additional paperwork and dispensing considerations for pharmacies.

Group members discussed concerns about the potential for abuse of Adderall and over-prescribing by providers. Dr. Chou stated that he feels more comfortable prescribing Adderall if he can see the patient's medical history and school reports. Dr. Witkovsky stated he is concerned about the Academy of Pediatrics new guidelines for recommending the use of Methylin chewable tablets for preschool age children who have ADHD.
The group discussed medications for narcolepsy. Dr. Harsch stated that Nuvigil and Provigil are cheaper and are not on the PDL. L. Radmer responded that Provigil is cheaper, needs PA, and sleep study data. This PA form is very detailed.

Group recommended monitoring the potential for abuse and overprescribing of Adderall.

**Antipsychotic Medication in Children**

L. Radmer discussed the targeted Drug Utilization Review (DUR) letter mailed in March 2011 to prescribers. Information was obtained from prescribers related to the number of youth (children 7 and under and youth 8-16 years old) prescribed antipsychotic medication in their practice. She reported the plan is to move to requiring prior authorization when prescribing antipsychotic medication to children 6 years of age and younger. This age group was chosen first because the use of antipsychotics in children this young should be monitored closely. The timeline for implementation is targeted for March 2012.

There will be a new prior authorization form for children 6 years of age and younger. R. Diamond stated that pediatricians in rural areas struggle with prescribing for children because there are very few child psychiatrists. L. Radmer responded that DHCAA will have child psychiatrist consultants involved in the PA process and they will be available to discuss member specific concerns, regarding antipsychotic PA requests for children 6 years of age and younger.

**Proposed Generic Antidepressant 3 Month Supply**

R. Currans-Henry asked the group for their feedback regarding the appropriateness of requiring consumers to get a 3 month supply, after a 90 day stabilization period, of generic antidepressants. Dr. Diamond stated that he does not think it should be required, but allowing a prescriber a choice is preferable. Other members agreed.

Dr. Diamond stated that he would recommend adding Risperdone to the 3 month supply list. There was group discussion about the overdose potential of Citalopram. Several members agreed the risk is small unless a person is on other medications that could interact with Citalopram.

## Next Steps and Adjourn

The group discussed when they would like to meet again. Typically, the MHDAG group meets before the Prior Authorization Committee meeting in order to make recommendations. Although the Prior Authorization Committee will not be discussing the Mental Health drug classes at their next meeting, some members of the group expressed interest in meeting in the first half of 2012, to further discuss mental health drugs and related issues.