DIVISION OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

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MENTAL HEALTH DRUG ADVISORS GROUP MEETING SUMMARY
Friday, October 19, 2012

Members Present: Joyce Allen, Joanne Berman, Dr. Clarence Chou, Molly Cisco, Ted Collins, Hugh Davis, Shel Gross, Linda Harris, Dr. Harold Harsch, Dr. Hugh Johnston, Richard Kilmer, Dr. Susanne Seeger, Dr. Michael Witkovsky

Staff Present: Kenya Bright, Sarah Coyle, Rachel Currans-Henry, Brett Davis, Sola Millard, Kevin Moore, Lynn Radmer, Kimberly Smithers, Kim Wohler

Others Present: Chris Beal, Tom Erickson, Jan Holcomb, Teai Hoover, Todd Kailas, Recine Lampe, Gina Metelica, Shane Reddemann, Faith Russell, Claudia Stewart, Nadidi Yaucher

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

Rachel Currans-Henry, Deputy Director of Bureau of Benefits Management (BBM), reviewed both the current preliminary recommendations document and highlights from last year's PDL implementation in the Mental Health Drug Classes. R. Currans-Henry reported some medications were recommended to be preferred last year because rebates received from manufacturers; made the brand drug less expensive than the generic equivalent. R. Currans-Henry stated that only preliminary recommendations and expenditure data will be presented at this meeting.

Alzheimer's Agents

R. Currans-Henry reported that there are no recommended status changes to this class. Last year, brand Exelon capsules were preferred over the generic rivastigmine capsules and the recommendation this year is to remain with this status. Galantamine was recommended as non-preferred last year but members were grandfathered. The recommendation this year is to continue with non-preferring galantamine.

There were no additional MHDA recommendations for this class.

Anticonvulsants

R. Currans-Henry reported that there is only the recommendation to add generic Carbatrol (carbamazepine ER) as a preferred drug to this class. Last year, brand Depakote Sprinkles and Tegretol XR were preferred over their generic equivalents (divalproex sprinkles and carbamazepine XR). This recommendation remains the same for this year's cycle. The cost effectiveness of preferring these brands will continue to be monitored going forward. The addition of a new PDL class for neuropathic pain is recommended. Lyrica and gabapentin will be preferred drugs in this new class, as well as in the Anticonvulsants drug class. Lynn Radmer stated generally a drug is represented in only one PDL class. Dr. Suzanne Seeger stated it is strange to see clonazepam in this category as most people use it for sleep or anxiety. L. Radmer replied clonazepam is considered primarily as an anti-anxiety medication, but this drug class is not included on the PDL, so it is added under the anticonvulsants drug class.

There were no additional MHDA recommendations for this class.

Antidepressants-Other

R. Currans-Henry stated that there are two recommended changes. It is recommended to add brand Cymbalta as a preferred drug. It is also recommended to add generic phenelzine as preferred and keep the brand Nardil preferred. There are multiple PDL classes where Cymbalta will be preferred. Brett Davis stated that Dr. Chou pointed out at the last meeting that it is easier to take one medication if a person has depression and fibromyalgia. Dr. Michael Witkovsky stated the generic bupropion XL had been discussed two years ago but is not on the current recommendations list. The FDA has stated that generic bupropion XL 300 mg under the trade name of Budeprion XL fails to demonstrate therapeutic equivalence to brand Wellbutrin XL 300 mg. L. Radmer stated it would not show as a separate line on the recommendations document from the other generic bupropion XL products and that coverage of a product by the Medicaid program is often determined by federal rebate requirements. However, even if a drug is available for Medicaid coverage, providers don't have to use that particular manufacturer's product.

There were no additional MHDA recommendations for this class.

Antidepressants, SSRI

R. Currans-Henry reported there were no recommended status changes last year and there are no recommended status changes at this time. Paxil Suspension is the only one in the class that is not a generic. The department will continue to monitor the cost of generic escitalopram. L. Radmer replied that it is not cost effective compared to others in the class. The department will consider moving it to a preferred status when it is cost effective compared to other generics available in the class. Shel Gross clarified that when the group talks about cost effectiveness, then we are talking about drug cost not drug efficacy.

There were no additional MHDA recommendations for this class.

Antiparkinson's Agents

R. Currans-Henry reported that there are no recommended status changes for this class.

There were no additional MHDA recommendations for this class.

Antipsychotics

R. Currans-Henry stated that there are two recommended changes. It is recommended to add generic loxapine as a preferred drug. It is also recommended to add generic olanzapine as preferred and the brand Zyprexa will continue to require Brand Medically Necessary (BMN) prior authorization. Many generic medications are now available in this class. Seroquel, for example, was preferred and now the generic quetiapine is the preferred agent. R. Currans-Henry reported that the department did have offers from the drug manufacturers of Fanapt, Saphris and Latuda to add their brand product as preferred while allowing a step therapy edit for trial and failure of one generic first. It is recommended to continue the strategy of keeping this a generic class. This is one of the higher cost drug classes.

R. Currans-Henry asked the group for their thoughts about requiring a failure of two generics before a brand name drug is prescribed. Right now, if a person fails on one generic, then they can be prescribed a brand name. Dr. Witkovsky asked if there is data on the breakdown of age groups and market share. Dr. Witkovsky stated he did not see injectable products on the list. Dr. Witkovsky asked about tracking the use of long-acting injectable medications. L. Radmer replied that the PDL usually only contains the drugs dispensed in pharmacies and not the injectable drugs administered in a physician's office. Dr. Chou stated there is a huge difference in cost with injectable medications. R. Currans-Henry reported Medicaid had offers for Fanapt, Saphris, and Latuda to allow a person to fail on one generic and then go to one of these brand name drugs as a preferred medication to take the rebate offer. Clinically, the drugs are different, so it is hard to determine which product(s) should move to preferred at the last committee meeting, it was discussed that selecting only one brand name drug to be preferred did not make sense. The consensus was to continue to operate with a generics first policy and not pre-select the brand name product. There are a wide range of generics available as preferred drugs; however, providers can request a non-preferred brand name antipsychotic with prior authorization. If a person has been stable outside the Medicaid program on a non-preferred drug, the prior authorization form includes a question to determine if the request is a continuation of treatment. .

R. Currans-Henry reported Abilify and Seroquel XR has been holding constant over the last year. L. Radmer stated DHCAA is looking at Provider Synergies data from other states. T. Collins stated Abilify is advertised often for depression. He wondered how many people have tried other antipsychotics and how many prescriptions are written by psychiatrists versus nurse practitioners. L. Radmer stated she is confident the market share would increase. S. Gross asked if we would know from information in the PA if a person has tried other products before Abilify is approved. L. Radmer responded we would know that a

drug failed, but we would have to look at claims data to see what was billed previously. Last year, the group considered keeping olanzapine non-preferred due to its metabolic effects. L. Radmer stated we have heard Zyprexa is often prescribed in the hospital but there can be issues in continuing treatment at discharge due to the need to get a PA; however, if the generic is preferred, then people can continue it without needing the PA.

Dr. Witkovsky asked if the claim data would be checked if he filled out the prior authorization form reporting a person tried two generics and failed. L. Radmer responded that it depends on the specific PA. If the PA is one that comes in for manual review then the information on the PA form and a person's claim history are compared. Sometimes there are adherence and compliance issues where a person is not taking the medication like the prescriber has indicated. The group members discussed children and antipsychotics. L. Radmer reported DHCAA's focus has been on kids 6 and under, but there is not a lot of data yet. Dr. Hugh Johnston reported at the Department of Corrections (DOC), there is a PA process that parallels Medicaid's. Dr. Johnston stated Abilify is used for psychosis and depression, but the person and their needs are taken into consideration, such as, a person having a history of psychosis but not having tried other drugs.

Joanne Berman stated she has heard from others and seen for herself that the PA process for non-preferred drugs in this class has worked well. J. Berman stated she would lean toward keeping things as they are and not require failure of two generics before going to a non-preferred drug. J. Berman stated she would suggest monitoring Fanapt and Saphris and see what feedback is received as there is not a big market share for these two medications. Dr. Chou reported that he experiences barriers to getting a patient's medication history. Dr. Chou stated that he agrees there should be failures before non-preferred drugs are prescribed. Some group members discussed the issue that some consumers are forced to get off non-preferred drugs because they do not have a history of using drugs on the PDL. L. Radmer stated if a person is stable for 30 days on a non-preferred antipsychotic drug outside the Medicaid Program, then he/she is not forced to change to a preferred drug.

S. Gross indicated he agrees with J. Berman that the PA process is working well right now because people do not have to go through too many hoops to get the non-preferred drugs. Some group members discussed how counseling and therapy can be effective and medications may not be needed but therapy can be more difficult to obtain than medications. Hugh Davis agreed with S. Gross and J. Berman about keeping the process the same. H. Davis stated he is concerned about the fail twice recommendation and the human cost. He would like more data to review.

There were no additional MHDA recommendations for this class.

Sedative Hypnotics

R. Currans-Henry reported that there are no recommended status changes to this class.

There were no additional MHDA recommendations for this class.

Stimulants and Related Agents

R. Currans-Henry stated that there are a few recommended changes. It is recommended to add brands Strattera and Intuniv as preferred drugs. It is also recommended to add generic methylphenidate ER (generic of Concerta) as preferred and keep the brand Concerta preferred. There are several instances in this class where the brand and generic equivalents are both preferred. This is to take advantage of the high federal rebate on the brand product while maintaining product availability, due to recurring drug shortage issues.

There were no additional MHDA recommendations for this class.

Antipsychotic Prior Authorization Activity Update and Feedback from Psychiatrist Consultants

L. Radmer reported there is a PA process for prescribing antipsychotics to children under the age of seven. Medicaid has two psychiatrists that review PAs. Medicaid has not been denying many PAs but typically the PA is sent back to the prescriber for more information and the prescriber may not resubmit the request again. The diagnoses for this age group are similar to what has been seen in the past. Risperidone is the most prescribed drug and Abilify is the second. The bulk of PAs are approved. Psychiatrists are the primary prescribers of these medications. It is hard to know if the prescriber is a child/adolescent or adult psychiatrist because this information is self-reported. Wisconsin has a low number of child/adolescent psychiatrists.

More tracking needs to occur to ensure children taking antipsychotics have lipid testing and blood glucose monitoring. The psychiatrist consultants have been contacting providers directly who do not have labs for these patients. There can be systems issue of who is following the child and lack of follow through by the family. The help by the psychiatrist consultants has been well-received. There is a concern about psychotropic medications for kids in general. The data shows Mirtazapine is being used in this age group and the doses seem high; however, this has not been teased through yet but the thought is it is being prescribed for sleep. The number of requests for Cymbalta and Lexapro are surprising. There is use of Namenda in children with autism. Dr. Chou stated having a collection of data about the use of Namenda may help understand how it is being prescribed. J. Berman stated she is hearing about some systemic issues from consumers who have been in acute settings as there are many barriers related to the setting.

Antipsychotic Prescribing in Children Summit Update

J. Allen, Director of the Bureau of Prevention, Treatment and Recovery, gave an update on the September summit. There is a joint effort between divisions to address antipsychotic prescribing in children. The goal of the summit was to reach out to the whole system (prescribers, advocates, and family members) not just prescribers. Stakeholders were brought in to look at data and share thoughts.
Key findings:

- Three percent of children on Medicaid were prescribed antipsychotics in Wisconsin. A study examined 16 other states and found the rates varied from .09 and 4%.
- Seventy percent of psychiatrists initiated prescriptions. There was no difference in the pattern of drug choice by the prescriber.
- The two most common disorders were Bipolar and ADD/ADHD.
- Children in foster care were nine time more likely to receive antipsychotics.
- Less than 50% received blood glucose monitoring and only 24% had a lipid test completed in a year.
- The percent of children prescribed antipsychotics varied by county significantly. This may be due to specialists in the area, hospitals, and residence of a child. This led attendees to ask: What is the culture of prescribing?

Feedback from Interviews by Dr. Liz Feder and Dr. Rick Immler with prescribers:

- Information and support is needed; especially for the primary care providers.
- Telephone access to child psychiatrists.
- Difficulty finding therapists experienced with evidence-based practices (EBP).
- Pressure to prescribe.
- Lack of continuity of care, especially for kids in foster care.
- Inefficient prevention/interventions. Other interventions are often not prescribed.
- More research is needed on kids taking antipsychotic medications and the metabolic side effects.

Other key areas:

- Need to take a holistic look at the child and take into account his/her culture and social life during the assessment. Need to provide non-pharmaceutical alternatives.

J. Allen stated there is a question of whether the state should promote guidelines for prescribing. There is a need for guidelines; however, there is a concern that it could limit providers' discretion of prescribing certain medications and add more hoops and result in fewer providers in the business. Another concern is if providers do not follow the guidelines, then they would be held liable. A second option is for the state to provide decision support tools. The summit attendees discussed there is a huge stress on children's mental health and the need for the availability of more therapeutic interventions. R. Currans-Henry stated there is no one thing we should be doing, but multiple things at different levels of the system.

J. Allen stated the next step is to take the various ideas out there and determine what can be done and in what manner. Some of the ideas include: more data analysis, examine ways we do practice, and identify strategies to build system supports. J. Allen information the group that the review report and slides will be sent out to the group in the next couple months. J. Allen stated she would like the group to weigh in and rank what to do next. B. Davis replied that this does not preclude us to taking action steps now. J. Allen stated there are roles for various groups in this process.

T. Collins stated we could look at the older population's experience with antipsychotics and their push for more appropriate use of the medication. Dr. Wikovsky asked if Wisconsin

has more children in foster care placements then other states. R. Currans-Henry responded that this can be looked into. There is a national group that is gathering data on youth and use of psychotropic medication.

Dr. Chou stated he is concerned about liability if the state has prescribing guidelines. One does not want to be too prescriptive or proscriptive. There are over 7,000 youth in foster care in Milwaukee. Prescribers need to do good assessments of children and families and use the wraparound model. Data tells us what medications are being prescribed but not what other services are being provided. B. Davis responded that the foster care medical home can help look at the larger picture and it is headed in the right direction.

J. Allen stated the summit was a great first step. It is now necessary to take a deeper look and develop better strategies for dealing with challenging behavior. Systems of support need to be built where there is sharing of clinical information across systems. Wisconsin can take a look at initiatives in other states that promote best practices. H. Davis stated the group has not discussed support for parents, such as peer support for parents. Having support can improve the parents' ability to cope with situations and results in better school outcomes. J. Allen replied this subject could be added to the group that will look at non-pharmaceutical interventions. R. Currans-Henry indicated there will be follow-up conversations about these issues. B. Davis stated that the groups' input is valuable to this process.

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 in May, members of the group expressed interest in meeting in the summer of 2013, to further discuss mental health drugs and related issues. As of 12-13-12, the next MHDAG meeting will be on Tuesday, June 18 from 9:00 am-11:30 am in room 751 at the Department of Health Services, 1 West Wilson Street, Madison, WI 53703.