DIVISION OF MENTAL HEALTH & SUBSTANCE ABUSE SERVICES

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MENTAL HEALTH DRUG ADVISORY GROUP
MEETING SUMMARY
Thursday, October 31, 2013

Members Present: Hugh Davis, Ron Diamond, Shel Gross, Richard Kilmer, Linda Harris, Hugh Johnston, Catherine Kunze, Molli Rolli, William Parke-Sutherland, Susanne Seeger, Michael Witkovsky
Staff Present: Joyce Allen, Marie Danforth, Brett Davis, Rebecca McAtee, Sola Millard, Lynn Radmer, Kimberly Smithers, Kim Wohler
Others Present: Amy Aumann, Nick Boyer, Charlemagne Brewster, Randy Cullen, Teai Czajka, Paul Lebron, Tom Olson, Ramie Zelenkova

Welcome/Introductions
Linda Harris, Administrator, DMHSAS and Brett Davis, Medicaid Director, DHCAA, opened the Mental Health Drug Advisory Group (MHDAG) meeting. Members introduced themselves.

Changes to BadgerCare Plus Program Due to the Affordable Care Act
Brett Davis informed the group that the BadgerCare Plus Core Plan expires Dec. 31, 2013. On January 1, 2014, there will be 82,000 members who will have access to mental health benefits. We currently have 77,000 individuals who are transitioning to qualified health plans. Uninsured people will have access on the first of January. There are 160,000 people on the childless adult waitlist. There are 77,000 people we are attempting to inform about the changes. Division of Health Care Access and Accountability (DHCAA) has sent two letters and made three phone calls and are mailing out applications. We are working with eleven regional enrollment networks. Certified application counselors and navigators are increasing along with the technology improvements.
Dr. Diamond asked if there was concern that some people will not have insurance on January 1, 2014.
Brett Davis replied that this is always a concern and we are making all the efforts we can.
Dr. Cullen asked if people would have access to medications.
Brett Davis replied the current plan is what they will have access to. There are 56,000 individuals in Milwaukee alone. There are currently 14% who are uninsured and the governor would like to cut this to 7%. Please partner with us to get people signed up. The public can call the Member Services Line: 1-800-362-3002 to sign-up. People can sign up until March 31st and there will be some exceptions made. The E4healthwi.org website is the one stop shop led by the Wisconsin Primary Health Care Association. More information can be found on the DHS website: http://www.dhs.wisconsin.gov/health-care/

Preliminary Recommendations
Kimberly Smithers presented the preliminary Preferred Drug List (PDL) recommendations for each Mental Health Drug Class. The market share presented at the meeting is based on the total number of prescriptions for each therapeutic class for months May, 2013-July 2013.

Alzheimer's

- Recommendation to non-prefer generic donepezil 23mg
- Recommendation to non-prefer brand Namenda XR
- Recommendation to non-prefer brand Razadyne solution
- Continue to prefer brand Exelon capsules over generic rivastigmine capsules.

There were no additional MHDA recommendations for this class.

Anticonvulsants

- Brand Lyrica remains preferred in three classes (Anticonvulsants, Fibromyalgia and Neuropathic Pain)
- Generic Gabapentin remains preferred in two classes (Anticonvulsants and Neuropathic Pain).
- Recommendation to prefer generic phenytoin chewable tablet
- Recommendation to non-prefer generic lamotrigine XR
- Recommendation to non-prefer generic tiagabine
- Recommendation to non-prefer brand Oxtellar XR
- Recommendation to non-prefer brand Trokendi XR
- Continue to prefer brand Carbatrol
- Continue to prefer brand Depakote Sprinkles over generic divalproex sprinkle
- Continue to prefer brand Tegretol XR over generic carbamazepine XR

There were no additional MHDA recommendations for this class.

Antidepressant, Other

- Brand Cymbalta is preferred in three classes (Antidepressants, Other; Fibromyalgia, and Neuropathic Pain)
- Brand Cymbalta's generic release is expected by the end of the year.
- Generic Bupropion XL and generic venlafaxine ER capsules utilization increase shown is due to brand Wellbutrin XL and brand Effexor XR shift to BMN status
- No significant market share changes were noted in the Antidepressants, Other class, due to last year's brand Cymbalta's change to preferred status. Market share for Cymbalta is measured in the Neuropathic Pain class and showed an increase of 4.6%
- Recommendation to non-prefer generic desvenlafaxine ER
- Recommendation to non-prefer brand Forfivo XL

Catherine Kunze expressed concern with the department's Brand Medically Necessary (BMN) policy because of previous personal experience with the use of a generic antidepressant drug. She wanted to bring this up as a caution that people may be doing well on the brand name medication and then having to switch to the generic equivalent can be a problem. She stated people should not be required to try and fail on generic Cymbalta and recommended not applying BMN policy.

The group discussed the quality of generic versus brand medications. Richard Kilmer stated the price of some generics are going up and there have been problems with shortages of some seizure drugs and people remaining on their medications due to cost.
Lynn Radmer responded that the generic structure has been challenging for some drugs. It is a weekly exercise to watch pricing and availability. She explained that the BMN policy requires trial and failure on two manufacturers of a generic equivalent before the brand name equivalent can be approved for use.
William Parke Sutherland stated that "failing" is actually huge for people as it can be significantly disruptive for people.
Kimberly Smithers replied that the discussion will be shared with the Medicaid Prior Authorization Committee, which then gets shared with the Secretary's office.

Antidepressants, SSRI

- Brand Lexapro required BMN prior authorization, effective December 1, 2013
- Generic escitalopram (generic of Lexapro) changed to preferred status on 7/1/2013
- Recommend to non-prefer generic Fluvoxamine ER
- Recommend to non-prefer brand Brisdelle

There were no additional MHDA recommendations for this class.

Antiparkinsons Agents

- Recommendation to prefer brand Lodosyn

There were no additional MHDA recommendations for this class.

Antipsychotics

- Recommendation to prefer brand Latuda
- Latuda claims data shows a slightly larger market share than Fanapt or Saphris.

Kimberly Smithers stated that during the last meeting, the committee did not express a strong need to add brand Fanapt, Saphris, and Latuda as preferred agents. It was also discussed during the last meeting, that there could be a policy change to require trial and failure of two preferred agents before approval of a non-preferred agent. DHCAA did not proceed with this policy requirement and the policy requirement remains a trial and failure of one preferred agent before approval of a non-preferred agent.

There were no additional MHDA recommendations for this class.

Sedative Hypnotics

- Recommend to prefer generic triazolam.

Lynn Radmer stated the dentist community uses triazolam as a pre-procedure agent. It is a low cost medication and dentists asked to make this preferred rather than requiring Prior Authorization (PA).

There were no additional MHDA recommendations for this class.

Stimulants and Related Agents

- Recommendation to add brand Procentra as a preferred product
- Recommendation to add brand Quillivant XR as a preferred product
- Recommendation to non- prefer generic amphetamine salt combo (generic of Adderall) and continue to prefer brand Adderall
- Continue to prefer brand Adderall XR over generic amphetamine salt combo ER
- Recommendation to non- prefer brand Concerta and continue to prefer methylphenidate ER
- Recommendation to non-prefer generic dextroamphetamine capsule ER and generic dextroamphetamine solution and continue to prefer brand Dexedrine Spansule
- Recommendation to non-prefer brand Zenzedi

Kim Wohler stated Adderal XR was the number one ranked drug in both utilization and expenditures for all the PDL drug classes.

There were no additional MHDA recommendations for this class.

Anxiolytics

- This is a brand new class and recommend to add it to the PDL
- Recommend to non-prefer generic alprazolam ODT, diazepam intensolm meprobamate, oxazepam, and brand Niravam

Kimberly Smithers stated the DHCAA looks at cost and therapeutic effect, and makes recommendations based on this.
Dr. Chou commented that meprobamate is not a good drug and would not recommend it. Lynn Radmer replied that its use is limited and it cannot be removed to maintain compliance with federal outpatient drug policy.
William Parke-Sutherland asked why these classes were not grandfathered.
Lynn Radmer replied that this is a new class and the approach has been to allow grandfathering in some mental health drug classes. In specific drug classes there may be concerns about changing medications for certain diagnoses because of how the medications work in people's systems. These types of classes are grandfathered. However, like the Sedative Hypnotics drug class which is not grandfathered, there is not this type of clinical concern with this new class. There is always the PA option available for approval of a non-preferred drug.
William Parke-Sutherland stated anxiety and post-traumatic stress disorder (PTSD) can affect life greatly.
Lynn Radmer replied that should not have a significant affect in this class since the drugs that are most commonly used are being recommended as preferred.
Dr. Cullen stated Valium should be eventually removed as it can cause overdoses and other problems.
Molli Rolli stated that Valium is sometimes used for colonoscopies as a short term anesthetic.

Children's Behavioral Health Initiative Update
Joyce Allen reported the Division of Mental Health and Substance Abuse Services (DMHSAS) is working with other DHS divisions and the Department of Children and Families (DCF) on the initiative. As a result of last year's summit, the group decided to focus on three areas:

- Identify problems and data analysis
- Work across states and with Rutgers University's Medicaid Network for Evidence-based Treatment (MEDNET) consortium on comparing data from other states and interventions in the Medicaid program
- Broaden focus from youth prescribed antipsychotic medication to youth prescribed psychotropic medication. Look at the data and determine which group of youth would be better served with non-pharmaceutical services (e.g., Evidence-based Practices, counseling).

Hugh Davis asked for a timeline of the initiative.
Joyce Allen responded there is a timeline and it was presented to the Department of Health Services' (DHS) Secretary's Office.

Stimulant Prescribing
Lynn Radmer discussed the Stimulant Prescribing handout. There is concern that some children are receiving high doses of stimulants. The Drug Utilization Review (DUR) committee had a retrospective review performed. DHCAA worked with Drs. Cullen and Maskel to determine upper dosage limits for children under the age of 15. DHCAA developed a prescriber intervention letter for dosages over 25% of the dosage limits for children under age 15; any prescriber with 3 or more members will get a letter. If a prescriber has two members and the prescriber contributed at least five or more stimulant prescriptions for each member, then they will receive a letter. The high dose stimulant prescribing happens across all prescriber types. In late November, a targeted DUR letter will be mailed out with a response form asking these prescribers to explain the justification for the high dosing of stimulants for youth. There will be follow-up phone calls. Lynn Radmer commented that the letter and phone conversations are meant to be educational.
If significant concerns are identified with a specific provider, this could result in limiting their ability to participate within our program.

Dr. Chou commented that some states have looked at non-child psychiatrist prescribing patterns.
Lynn Radmer responded that we have been tracking prescriber data with antipsychotics and we can consider doing this for stimulants.

Susanne Seeger asked why some prescribers are high dosing.
Lynn Radmer responded that some prescribers treat a patient until they see a response. There are also concerns that the stimulant may not be used appropriately.
Shel Gross stated there is a bill introduced for a children's psychiatrist phone line where prescribers can get more support and be able to ask questions.
Dr. Witkovsky expressed concern about prescribers not getting all the records and collateral information needed to make a diagnosis.

Antipsychotic Prior Authorization (PA) for Children
Lynn Radmer reported that DHCAA created prescriber intervention letters in 2011. In 2012, DHCAA started requiring a prior authorization (PA) for children under age 7. Drs. Cullen and Maskel helped develop the PA and outreach. The data shows we are seeing less use of antipsychotics in this age group. The next steps are to add age 7 to the PA by the first quarter of next year. PAs are generally good for a year. There will be a shorter PA approval period for children with Body Mass Indexes (BMI) of 85% BMI or higher. There will also be more discussion about coordinated care and appropriate monitoring for these children.
Dr. Chou stated he would like to see the prescriber data.

The group discussed the need to reduce the BMI of children.
Dr. Cullen stated that if you go to any playground, 35% of kids will have a BMI 85% or greater. It is an epidemic issue and we need education and stratified interventions.
Lynn Radmer stated that the Children's Behavioral Health Project is looking at improving education and identifying non-pharmaceutical solutions.

Mental Health 2014-2015 Budget Initiatives
Joyce Allen gave an update regarding the Governor's budget initiatives.

- Funding for two new forensic units at the Mendota Mental Health Institute. One will open now and one will open in early December.
- Funding for expansion of in-home counseling for children who have serious emotional disturbances.
- Office of Children's Mental Health should up and running by January 2014. The goal is to ensure integration of services across State agencies. The Governor has received resumes.
- There is 3.7 million for the Coordinated Services Team (CST) expansion. There are currently 44 programs funded. The goal is to expand statewide. The Children Come First Advisory Committee has advised on the expansion plan. There will be a multi-year roll-out approach with the goal to have the same system across state.
- There is 1.3 million available for three Peer Run Respite Centers which will begin in July 2014. The respite centers will be run by peers and will be in residential settings with a small number of beds and a short stay. There is an advisory committee involved in laying out the framework for the Request for Proposal (RFP). The funding is General Purpose Revenue (GPR) funding and is not an MA benefit.
- There is 10.2 million set aside for the Comprehensive Community Services (CCS) Expansion to begin in July 2014. By March 1, DMHSAS must submit a report to the legislature's Joint Finance Committee. CCS is for adults and children who need mental health and/or substance abuse services beyond outpatient services. For counties/tribes that will provide CCS on a regional basis, they will not have to provide the non-federal share as the state will cover that portion.

Mental Health Drug Advisory Group Membership Openings
Linda Harris reviewed the MHDAG current membership and available openings.
The group was asked to email Sola Millard with suggestions of possible members. Bill Orth and Kathi Cauley were suggested to fill the county staff opening.

Next meeting: The MHDAG will meet June 20, 2014.