



Washington State Health Care Authority
Prescription Drug Program

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UNOFFICIAL TRANSCRIPT*
WASHINGTON STATE
PHARMACY AND THERAPEUTICS COMMITTEE MEETING

April 15, 2009
Sea Tac Marriott Hotel
9:00am – 4:00pm

- Carol Cordy: Why don't we go ahead with introductions? Maybe start over here.
- Ray Hanley: Ray Hanley, Health Care Authority.
- Duane Thurman: Duane Thurman, Health Care Authority.
- Donna Sullivan: Donna Sullivan, Health Care Authority.
- Regina Chacon: Regina Chacon, Health Care Authority.
- Bob Bray: Bob Bray, P&T Committee Member.
- Jason Iltz: Jason Iltz, P&T Committee Member.
- Angelo Ballasiotes: Angelo Ballasiotes, P&T Committee Member.
- Carol Cordy: Carol Cordy, P&T Committee Member.
- Barak Gaster: Barak Gaster, P&T Committee Member.
- Patti Varley: Patti Varley, P&T Committee Member.
- Janet Kelly: Janet Kelly, P&T Committee Member.

* For copies of the official audio taped record of this meeting,
please contact Regina Chacon at (206)521-2027 pdp@hca.wa.gov.

Jeff Graham: Jeff Graham, Health Care Authority.

Doug Tuman: Doug Tuman, Labor and Industries.

Jaymie Mai: Jaymie Mai, Labor and Industries.

Siri Childs: Siri Childs, HRSA.

Jeff Thompson: Jeff Thompson, Medicaid.

Chuck Agti: Chuck Agti, HRSA.

Cathy Williams: Cathy Williams, Board of Pharmacy.

Carol Cordy: Thank you. Jeff, did you have anything you wanted to say?

Jeff Graham: No announcements today. Has somebody called in yet? Is Marian there?

Carol Cordy: Not that I know of. There will be a slight change in the agenda.

Regina Chacon: We're going to be swapping the ADHD and macrolides on the schedule. They are both scan reviews so it will be a minimal change. But that's to accommodate the presenters.

Carol Cordy: Is Marian there?

Jeff Graham: Well, we're usually not so on time. I'll check. Here she is. Marian, is that you?

Marian McDonagh: Yes, it is.

Jeff Graham: Okay. We're ready for the review of the newer drugs for insomnia.

Marian McDonagh: Great. All right. All right. So then on slide 1 this is the second update of this report and we finished this in October of last year.

If we go to slide 2 these are the list of the drugs that are included in this report.

And then go to slide 3. We completed the searches through January of '08 and we did receive dossiers from two companies for this update. Overall what we found is there were no new head-to-head trials for update 2. We found 12 new placebo-controlled trials so we had adequate evidence based on that to attempt an adjusted indirect meta-analysis and I'll tell you about that in just a minute. We found only one new observational study for adverse events and we did find several new case reports of adverse events and no new systematic reviews.

On the next slide, slide 4, this just summarizes the type of evidence we have at this point with seven fair quality head-to-head trials and one poor and then that just itemizes those.

So if we go to the next slide, slide 5, so we have...this is eszopiclone compared to zolpidem and we found that based on polysomnography evidence in sleep labs...so not the subjective evidence that we prefer taken by patient diary at home, but there is similar efficacy between these two drugs based on this small head-to-head trial. Our own analysis of the data from the FDA review indicates no statistically significant difference. There was no published direct comparison made between these two drugs in the study so we undertook an analysis of our own. The subjective measures were also reported but the standard deviations were not reported so we were not able to calculate the mean difference for the subjective outcome measures. So what's listed on the slide are the objective measures from the sleep lab.

If we go to slide 6 looking at the direct comparisons for zaleplon and zolpidem and here we actually have four studies and they were the 10 mg zaleplon compared to zolpidem 10 mg. They were similar responses in the subjective sleep latency in both older patients and those under 65. So no differences at similar doses. But sleep quality zolpidem was better on sleep quality versus zolpidem in a pooled analysis of three trials. Zaleplon was reported to have...less likely to cause rebound insomnia and that's measured the first night after drug discontinuation only. So just the one night.

If we go to slide 7 this is zolpidem compared with zopiclone. So here there's only one trial and the drugs were similar for both investigator and patient global assessments of improvement. And subjective sleep outcomes were compared directly only to placebo in a statistical way. But

they looked similar compared to placebo. There was more rebound insomnia with zopiclone compared to zolpidem however. And this was measured in a different way to the previous study that we just talked about. This was follow up, up to a week after the two-week trial ended. For rebound insomnia to have been reported patients had to have sleep onset latency increased by one grade or more. So it was a little bit of a different way of measuring rebound insomnia.

If we go to the next slide. So in this slide because of the very limited amount of direct evidence available we conducted an exploratory meta-analysis using the adjusted indirect method. So here we do think that some caution ought to be used in interpreting these results. This incident is an indirect analysis using the placebo-controlled trials to compare the drugs. So we had no data to add to the meta-analysis for trials of zolpidem extended release, but I will tell you about those studies later. So in this there are 22 studies in this analysis – 4 trials of eszopiclone, 4 from ramelteon, 4 of zaleplon, 7 of zolpidem and 4 of zopiclone. We also did some sub group analysis later looking at the five trials that included only older adults compared to the rest of the evidence. The same sizes here ranged from as small as 14 to 848 patients in an individual trial. The studies ranged from a two-night trial to six months in duration.

So if we go to slide 9 this is the results of the indirect meta-analysis and the doses here were combined for this analysis. There were very few significant differences between the drugs on any of these outcomes. The exceptions were significantly shorter sleep latency and longer sleep duration with eszopiclone compared to ramelteon. On average the sleep latency was 11 minutes shorter with eszopiclone compared to ramelteon and sleep duration was an average of 37 minutes longer. Patients taking eszopiclone also had significantly fewer awakenings than those taking zolpidem. And patients taking zolpidem had significantly more awakenings compared to zopiclone. However, for both of those the difference was less than one time per night with the mean difference 0.6 for eszopiclone compared to zolpidem and 0.8 for zolpidem compared to eszopiclone.

If we move to the next slide, slide 10...so this is again looking at our indirect meta-analysis but comparing the results in older patients compared to the younger adult patients. Here elderly patients' sleep duration was longer with eszopiclone than with either ramelteon or

zolpidem. And those are mean differences in sleep duration of approximately 30 minutes and 33 minutes. And so there was no difference found in the younger patient population for these two comparisons. The difference in sleep latency between eszopiclone and ramelteon was found in the combined analysis and previously is no longer found in the sub-group analysis. So it's an interesting analysis but again reminding you that this is...because this is a sub group analysis we should interpret those cautiously.

On the next slide, slide 11, looking at only studies that used the manufacturer's recommended doses, so not those that used higher doses; we found that sleep duration was longer with eszopiclone 2 mg compared to ramelteon 8 mg and no differences between any other drugs on any other outcomes. And the difference in sleep duration there was again...it was 29 minutes.

On the next slide this is looking at the quality of the studies in the indirect meta-analysis so exclusion of poor quality studies did not change the results of the analysis. For sleep latency the WASO, which is wake time after sleep onset, or the number of awakenings. However, in fair quality studies eszopiclone was significantly...had significantly increased sleep duration compared to zolpidem. So it changed in the finding for that comparison with a mean difference of 37.1 minutes.

Now on the next slide moving on to the evidence for zolpidem extended release again we have no head-to-head trials and we were unable to include the data from these studies in the meta-analysis because they didn't report the mean at end point. The mean either went time after sleep onset or so on any of the outcomes measures we were looking at there. So we have just these three placebo-controlled trials. One in younger adults, one in older adults—those are short-term trials, and then a six-month study looking at intermittent treatment. So we'll talk about the first two studies. They are quite similar to each other. So in the first study zolpidem extended release 12.5 mg was used. Primary outcome measure here was the polysomnography recorded wake time after sleep onset in the first eight hours. And this was recorded on nights 1 and 2 and then again on nights 15 and 16. So the WASO was significantly shorter with zolpidem extended release than placebo in nights 1 and 2 but not on nights 15 and 16. A post-hoc analysis found that the WASO was significantly better than placebo through hour six, but not during hours seven and eight

suggesting that the affects of zolpidem extended release did not persist beyond six hours. The publication from this trial reports only the six-hour results, but the eight-hour results are reported in the FDA review of the original data. Results for the subjects WASO subjective number of sleep awakenings, sleep durations, subjective sleep latency were more mixed. Zolpidem extended release was superior to placebo on some but not all of these assessment points. So the study number two had an identical design but including only patients over 65 years of age. And in this trial the primary outcome measure was the polysomnography measured WASO in the first six hours. So they changed the duration of the study; examination time in the sleep lab that is. And this time the drug was significantly better than placebo both on nights 1 and 2 and nights 15 and 16. There's a rebound effect in both of these studies after discontinuation on the first night after discontinuation...on the first night, sorry, on the first night, night 22, but not on the second night, night 23. So then the third study is the six-month intermittent study where the patients could take the drug or placebo three to seven times per week and the primary outcome measure here was the patient's opinion of whether the treatment had helped them sleep and here clearly the drug had a higher rate of patients reporting an improvement in their ability to sleep.

On the next slide, slide 14, looking at direct comparative evidence for harms no differences were found in adverse events or in withdrawals due to adverse events in the short-term trials and there was no new evidence to add from this report.

If we move to the next slide, slide 15, this is looking at the...trying to make comparisons from indirect evidence. Here we have some new evidence added at the bottom of the slide. Overall, long-term evidence is limited to a few open label extension studies and two placebo-controlled trials. The duration of these studies is six months to a year, but because they are reporting things in very different ways no indirect comparisons were possible from those longer term studies. So we're limited to what we have here. Eszopiclone, zaleplon, zolpidem and zopiclone showed no difference in the withdrawal rate due to adverse events compared to placebo in short-term trials although zolpidem extended release did have a higher rate of withdrawal due to adverse events with an odds ratio of 2.02 with a pooled analysis of three trials compared to placebo. In our adjusted indirect meta-analysis looking at withdrawals due to adverse events we found no differences between any of the drugs.

Moving on to slide 16 looking at subgroups. Here we have, again, adding some new information from our indirect meta-analysis for older patients. So to recap the evidence in the subgroup of patients over 65. Subjective efficacy zaleplon is similar to zolpidem. For daytime somnolence zolpidem has higher rates than zaleplon, but withdrawals due to adverse events were not different and in the adjusted indirect analysis eszopiclone increased sleep duration compared to zolpidem or ramelteon. In addition I wanted to just briefly tell you about some other evidence that's in the report for some subgroups. So eszopiclone, ramelteon, and zolpidem have all been studied in short-term placebo-controlled trials in patients with obstructive sleep apnea or upper obstructed sleep apnea, upper airway resistance syndrome, or symptoms of inadequate sleep associated with those. In mild to moderate sleep apnea the sleep laboratory outcomes were better with eszopiclone than placebo but not with ramelteon compared to placebo. And in severe sleep apnea zolpidem was significantly better than placebo. In overweight patients with upper airway resistance syndrome zopiclone was also superior to placebo in laboratory measures.

So on slide 17 that just provides a summary...some summary statements of what we just talked about. So that really concludes the quick review of what we found in this new update.

I'd be happy to take any questions.

Carol Cordy: Any questions? Can you stay on the line for just a minute?

Marian McDonagh: Sure.

Carol Cordy: I don't have any requests for speakers. Is that...

Jeff Graham: Do you have the...

Carol Cordy: She has it.

Jeff Graham: Are there no...

Carol Cordy: There's no...

Jeff Graham: Okay.

Carol Cordy: Okay. Any discussion? Is this a scan or a new...

Jeff Graham: No. This is an update.

Carol Cordy: This is an update. Okay. So does somebody want to make a motion since this is an update rather than just a scan?

Man: And it looks like there's nothing really...

Duane Thurman: Just a reminder to speak into the mics for the record.

Man: Looks like there's nothing new in terms of new agents that were studied such that the motion from June 20, 2007 probably reads exactly the way we would still want it to read.

Bob Bray: This is Bob Bray. The only addition is the eszopiclone that was not included on the 2007 motion.

Patti Varley: No. It's available in Canada I thought.

Man: I've never heard of that drug. Is that available in the U.S.?

Jeff Graham: This is Jeff Graham. Marian, did you hear that? Isn't that only available in Canada?

Marian McDonagh: Oh yes, I think that's right.

Jeff Graham: Okay. That's probably why we didn't include it.

Marian McDonagh: Yeah.

Man: The only new data that we have was this indirect meta-analysis data from the placebo-controlled trials that found really very little significant differences and the few that were found I think we need to look at pretty...very cautiously given that the idiosyncratic effects of these drugs is going to vary so much from group to group and from the environment the studies were conducted in that I think it's tricky to put too much weight on comparing placebo-controlled agents studied in different

settings. So I guess I would move that we would put forward the wording from our motion from June 20, 2007 exactly as it was stated.

Bob Bray: This is Bob Bray. I second it.

Carol Cordy: All in favor?

Group: Aye.

Carol Cordy: Opposed? The motion passes.

Jeff Graham: Marian, this is Jeff again. You're presenting the macrolides this morning?

Marian McDonagh: That's right.

Jeff Graham: Okay. We have a little shift in our schedule here. So if you can wait just a minute we're going to put up our slides that we have.

Marian McDonagh: Okay. Just let me know when you're ready.

Jeff Graham: Marian, we have them up now. Do you have a copy of these?

Marian McDonagh: I do. So I will just use your slides and walk through those.

Jeff Graham: Okay. Good. Thank you.

Marian McDonagh: Okay. So this is the...it's a preliminary update scan for this report on macrolides. If we go to slide 2 you can see we completed the original report in August of '06 and the electronic searches for literature for that report were completed in March of '06.

If you go to the third slide you see some of the inclusion criteria. The report was limited to either children or adults with the six infectious diseases listed on this slide.

And on the next slide you can see the three macrolides that are included in the report and there are multiple formulations for each of these drugs that are included.

If we go to the next slide, slide 5, that's really a repeat of one of the previous slides. So let's go on.

Slide 6 is the outcome measures. So primarily we found, and we're looking for a clinical or biological cure rate. We were interested in some of these other outcome measures but often didn't find those.

So if we go to slide 7. Again, we were looking for adverse events.

Go to slide 8. We were including the usual designs of RCTs for efficacy or effectiveness and for safety we were including observational studies.

Now for results of the scan on slide 9. So using med line and limiting to RCTs we found 13 studies that could potentially be included in an update of this report. However, only two of these were head-to-head studies. So the direct comparison studies were of clarithromycin extended release compared to azithromycin microspheres in adults, and clarithromycin versus erythromycin in children. And both of those are community-acquired pneumonia. One study directly compared the older immediate release of clarithromycin to the extended release form in children and adolescents with various different infectious diseases including pharyngitis, sinusitis and pneumonia. And the other 10 studies made comparisons of these drugs to various other antibiotics. That's really the new literature.

So if we move on to slide 10 we found no new macrolides on the market, no new indications for the ones that are currently on the market. We did find a few safety alerts.

So going to slide 11 for erythromycin ethylsuccinate the PCE dispersible tablets we found a new FDA warning about potential hearing loss in older people taking this form.

And then the next few slides are about clostridium difficile associated diarrhea. And so the first slide is a warning from the FDA about clarithromycin added to the list of antibiotics that are known to be associated with CDAD.

On the next slide, slide 13, we have the same warning that was added for erythromycin ethylsuccinate in different formulations.

And on the next slide we have the same warning but for erythromycin delayed-release.

And then on slide 15 we have a reporting from the FDA that erythromycin ethylsuccinate, again, Ery-Ped is the name for this dispersible formulation and that is associated with myasthenia gravis or exacerbating the symptoms of myasthenia gravis. So it's a new...at least added for these particular formulations. So that really is all we found in the update scan.

Carol Cordy: Any questions? Again, there's no speakers. Any discussion? So do we have a motion to accept this scan?

Bob Bray: This is Bob Bray. I move that we accept the scan as an adequate scan.

Carol Cordy: Do I have a second?

Jason Iltz: Second. This is Jason.

Carol Cordy: All in favor?

Group: Aye.

Carol Cordy: Opposed? This scan...the motion passes to accept this scan. Now Marian, is Marian also doing ADHD?

Marian McDonagh: That will be Kim Peterson.

Jeff Graham: Is she...we're kind of running way ahead here.

Marian McDonagh: Yeah, you are. I'm sure she's just down the hall. I can just give her a ring and I'm sure it will just take a couple seconds to call in.

Jeff Graham: Okay. Thank you.

Marian McDonagh: Okay. Bye, bye.

Carol Cordy: Thank you.

Marian McDonagh: Thanks.

Man: Do we re-approve our motion from 2006 on macrolides?

Carol Cordy: Even though it's just a scan?

Jeff Graham: Yeah, yeah.

Barak Gaster: This is Barak Gaster. I would move that we accept the previous motion from August 16, 2006 as it was written on that date with no changes.

Bob Bray: This is Bob Bray. I second that motion.

Carol Cordy: All in favor?

Group: Aye.

Carol Cordy: Opposed? So the motion passes.

Kim Peterson: Hello, this is Kim Peterson.

Carol Cordy: Hi Kim. We've got your slides up.

Kim Peterson: For ADHD?

Carol Cordy: Yes.

Kim Peterson: Okay, great. Well, I'm going to be presenting results from the preliminary update scan for...the first preliminary update scan for update 3 of pharmacologic treatments for ADHD.

So let's go to the next slide. We completed the last full update, which was update number 2 in November of 2007 with searches going through March of 2007. Next slide.

And the next few slides provide an outline of the scope of the review starting with population. This review focuses on the full spectrum of patients with ADHD—so pediatrics, adolescents and adult out-patients. Next slide.

Here is a list of the included interventions, which covers all the stimulants and atomoxetine as well. Next slide.

The next two slides list the included outcomes with effectiveness and harms outcomes mixed together. For effectiveness outcomes we included different measures of symptom response, functional capacity, caregiver satisfaction, quality of life and also time to effectiveness and duration of effectiveness, which are on the next slide.

For harms on this slide we included overall adverse effects, withdrawals due to adverse effects, and then continued on the next slide. Also for harms we included serious adverse events, specific adverse events, and misuse/diversion outcomes.

Next slide, 7. Here's the methods of our literature search. Using terms for included drugs and limits for humans, English language and trial design. We searched MEDLINE from the end date for the searches for update 2, which was March 2007 and went through October 2008. And we also searched the FDA and Health Canada websites for identification of new drugs, indications and safety alerts. Next slide.

Here's an overview of our search results. We found a total of 262 new citations and of those there were 29 that appeared to meet all of our inclusion criteria. Next slide.

So of the 29 trials 9 of them were head-to-head trials and their details are listed in this slide. Among those a majority of them addressed comparisons that have been previously lacking in head-to-head trials. So for example previously we had no head-to-head trials involving a comparison to modafinil, the patch form of methylphenidate, or an extended release form of methylphenidate that is available in Canada. And now there's at least one head-to-head trial for each of those comparisons. And also previously we only had two head-to-head trials involving comparisons to atomoxetine and now it looks like three more have been published since our last update. Next slide.

Here's a summary of the new placebo controlled trials we identified in our scan. For the preschool population the one new study looks like it's actually a companion publication to the PATs trial, which is a trial of immediate release methylphenidate that we've already included. Then in

school age children most of the new placebo controlled trials relate to atomoxetine and are relevant to key question 3 in that they evaluate the efficacy in subpopulations of patients with ADHD with other comorbidities such as oppositional defiant disorder and then the same thing for adults. Most of the new placebo controlled trials relate to atomoxetine and are relevant to key question three. Next slide.

And then here's the results of our searches of the FDA and Health Canada websites. We actually found quite a bit of new information this time. As for new drugs as of January 2008 three new dosage forms were approved for lisdexamfetamine. As for new indications a couple more stimulants that were previously only FDA approved for use in children got FDA approval for use in adults as well. And also atomoxetine got specific approval for use in adults and children with comorbid anxiety disorder. Next slide.

And then the new safety alerts. First one is for dextroamphetamine and it was the announcement of a national voluntary recall of products as a precautionary measure because apparently they had found a few lots that had been manufactured as oversized tablets that delivered higher than labeled doses. Second warning for modafinil and comes from post-marketing surveillance data and involved the addition to the warning section of the product label. Some additional information about risks of life threatening rashes and angioedema and the psychiatric adverse events of hallucination, anxiety and suicidal ideation. For methamphetamine, again, based on post-marketing surveillance data the FDA requested additional information be added to the warning section on risks of serious cardiovascular events, psychiatric adverse events, long-term suppression of growth, seizures and visual disturbances. And then in February 2007 the FDA directed all ADHD drug manufacturers to add to their patient medication guides information on cardiovascular risks and psychiatric adverse events in patients with underlying conditions in certain risk factors that might pre-dispose them to these risks. So taken together all this new information from trials and new drug information led that DERP participating organizations to vote in favor of a full update of this topic and that's currently underway and we are doing full reviews of the new evidence that I just summarized and we're expecting to be completed with that full update by early September of this year. So I can go ahead and take your questions.

Carol Cordy: Do we have a motion to accept the scan?

Patti Varley: Patti Varley. I'll make a motion to accept the scan.

Carol Cordy: Second?

Barak Gaster: This is Barak Gaster. I move to second.

Carol Cordy: All in favor?

Group: Aye.

Carol Cordy: Opposed? The motion passes to accept the scan as a review of ADHD drugs. We have three speakers. I just want to ask you to limit your remarks to three minutes. The first speaker is Dr. Carl...and identify who you're speaking for. First speaker is Dr. Carl Plonsky.

Jeff Graham: Carol, this is Jeff Graham. I also will be timing you so make sure that your comments are limited to three minutes. I also want to say that we don't have modafinil in this drug class. I just want to remind you folks of that.

Carl Plonsky: I'll limit my comments to three minutes. Thank you. First of all I'm Carl Plonsky, a pediatrician, development pediatrics, Tacoma, Washington and I'm here to represent the children and adolescents for whom I care. A lot of these children have ADHD with comorbid conditions and I'd like to thank you for the past support that you've been able to provide the physicians who care for these kids in the state. Approximately a third of the children that we care for in the adolescents are healthy options—Molina and DSHS. And so they have a need for state support medications. Most children would not need medicine who have ADD if their world really could provide increased exercise, breakfast, better sleep and a world of high interest, one-on-one and high structure with immediate and consistent consequences where fear was a factor. Unfortunately, the brain is more complex and we don't have that ability to go ahead and control human beings and so because of those demands we really need to have...a child begin to have insight and to pay attention on a consistent way that's prolonged.

With regards to the weak link as to medicines – because we have to use medications the weak link really turns out to be compliance. That’s really why long-acting medicines really were developed. And this has got the potential to reduce the risk of the inequality and variance with regards to poor attention. Evidence-based studies right now are not helping us to go ahead and support what we’re trying to do simply because the evidence-based studies that are coming across in MEDLIT and with regards to the ones that will be quoted in September really are short-term. They are closely regulated, they’re observed, children are observed, the complex comorbid conditions are excluded automatically because they confound the picture. But however this is the real world of the people that we’re really treating. Being able to individualize and to tailor meds to meet individual needs of a child is analogous to an endocrinologist using his tools to manage a brittle diabetic. His job’s easier. He can go ahead and use blood sugar, hemoglobin H1C, key tones and a BMI. I have to look at performance, temperament, task completion, impulsiveness, dysfunctionality in the family, effort behavior and a whole of different variables. And the child has to assume some of that responsibility on his own and be able to make good judgments and he can’t do that with poor attention.

Gastric absorption varies, C-MACs varies, T-MACs vary, long-acting meds have given us a whole lot more time to counsel, educate and to structure and to help children with self-structure. As a result with long-acting medicines we need less visits, less consults, and less referrals to mental health centers. Studies really are available that we can provide you to show that long-acting medicines use...have decreased incidents of drug use, motor vehicle accidents, hospitalizations and failure. As a result what I’d like to do is to go ahead and use all the tools that we have available.

Jeff Graham: Please complete your remarks.

Carl Plonsky: Thank you. Some of the long-acting medicines that we use don’t work for everybody but will work for some. So we have to individualize. Thank you for your attention.

Carol Cordy: Thank you, Dr. Plonsky. The second speaker is Dr. Diana Orentas-Lein.

Diana Orentas-Lein: Hi. My name is Diana Orentas-Lein and I am a Regional Scientific Director for Novartis Pharmaceuticals and I want to thank you for the

opportunity to present some new information to the committee that was not included in the latest update. Since the last drug class review, Update 3, from...that went up into October of '08 there was a label change to Focalin XR. This information was made available in November. The U.S. Food and Drug Administration approved a 30-minute onset of action for Focalin XR extended release capsules for the treatment of ADHD bringing potential benefits to the young children and their families in those critical early morning hours as they prepare for and they begin their school day. The new labeling is based on clinical study data involving 86 children with ADHD between the ages of 6 and 12. This demonstrated that Focalin XR provided significant improvements 30 minutes post-dose compared to placebo in measures of attention, deportment and academic productivity. The study published by Matthew Broms in the Journal CNS Drugs was a randomized multi-center double-blind cross-over study comparing 20 mg of Focalin XR to placebo for seven days. The final dose was administered in a laboratory classroom setting. Primary efficacy was measured by change from pre-dose in the Swanson, Kotkin, Aglner, M-Flynn and Pelham or SKAMP rating scale combined score at 30 minutes. The SKAMP rating scale is a standard assessment tool used in the laboratory classroom clinical trials to evaluate attention and behavior. Focalin XR extended release capsules deliver 50% of the dose immediately upon ingestion. 50% approximately four hours later. So in addition to an onset of action at 30 minutes it continues to be effective for up to 12 hours. So in closing, Focalin XR is indicated for the treatment of ADHD in patients 6 years and older, as you already know. It's the only methylphenidate stimulant given once daily with an approved indication in adults, adolescents, and children with a temporary established onset of action at 30 minutes. In addition, Focalin XR can be opened and sprinkled on food or applause for the patients who can't take pills or capsules.

I want to thank you for your time and for your attention.

Carol Cordy: Thank you, Dr. Lein.

Diana Orentas-Lein: You're welcome.

Carol Cordy: The next speaker is Dr. Chet Robachinski.

Chet Robachinski: I am Chet Robachinski. I'm a psychiatrist in private practice who treats children, adolescents and adults. But I'm here actually today as an

advocate for my Medicaid patients most of whom I see at the Bailey Boushay House. I'm the Psychiatric Director there and have been there 16 years. Most of them have their insurance through Medicaid.

The reason that I'm here today is to thank the State of Washington for allowing access to long-acting stimulants for my Medicaid patients. I feel that I represent those of us in clinical practice that see a wide variety of patients and have first-hand knowledge from them of how these medications affect their lives. There's a stark contrast in the outcomes between those who have access to the longer acting stimulants treatments for their ADHD symptoms and those who don't. There are three main reasons why the longer acting medications improve outcomes: (1) is improved adherence, which leads to much better efficacy. We all know the research data on once daily dosing. That it improves adherence and therefore clinical outcomes. This is vitally important in HIV as well. This is vitally important also in ADHD compared to TID or sometimes QID dosing that's required for short-acting stimulants. The second is fluctuating blood levels that occur with multiple dosing throughout the day. This can lead to more side effects when blood levels reach their peaks and poorer clinical response when blood levels are at their troughs. Any medication that can flatten out the curve in blood levels and allow for a more consistent steady state of drug will improve clinical response. This is what I witness time and time again when my patients come back to me with their individual stories of response to medication. I find this to be especially true of Vyvanse, which has a novel delivery system that allows very consistent blood levels and a duration of effect that is sufficient enough to seldom require augmentation. I would estimate that 85 to 90% of my patients on this medication report for the first time in their treatment of ADHD that they "feel themselves" and use words like transparent to describe their response meaning they feel the beneficial effects without any of the negative physical or emotional effects they have experienced in the past on other stimulant medication. The third reason is most important to me in the population I serve at Bailey Boushay House—concern for abuse. The vast majority of my patients there have histories of chemical dependency and I once again need to thank you for allowing me to utilize medications in that population that have less potential for abuse. I could thank you specifically, Jeff, for allowing me to use Provigil on one of my patients there who's been on it for about two years now.

When it comes to this concern as well Vyvanse is a standout. As I've been told by a few of my patients who have been honest in reporting to me that they have tried to get high from it they are unable to do so. This is consistent with what was reported in the clinical trials on that agent. Before I conclude I'd like to briefly describe to you a case that highlights the above advantages of the longer acting stimulant medications.

This patient is someone I see in the adult day health program at Bailey Boushay House. He's a 36-year-old man with a history of ADHD since childhood medicated with Ritalin from age 7 to age 17. Unfortunately, he turned to crystal methamphetamines in his 20s, he became quite addicted and [inaudible] converted to being HIV positive. He was then unable to work or function productively in society. He had been clean and sober for two years prior to my seeing him...

Jeff Graham: Dr. Robachinski, would you conclude your remarks?

Chet Robachinski: Yes, thank you. ...but remained on disability because of his severe ADHD symptoms. He had gone untreated by prior providers for fear of inducing a relapse. I first tried him on non-stimulant options but he found no efficacy in them. After getting to know him and trust him as well as receiving collaborative information from his parents who live in the area I cautiously moved forward with the trial of a long-acting stimulant, Vyvanse, feeling it was the safest of all the stimulant options and I'm happy to report that he has thrived for the past eight months able to enter a DVR program and proceed with his life. Thank you again for your time.

Carol Cordy: Thank you, Dr. Robachinski. Any questions from the speakers? Discussion? It looks like we have two motions—one for the methylphenidate and amphetamine based agents and a separate one for the atomoxetine.

Jeff Graham: Carol...Kim, we probably could let you go for a while and I'll let you know when we're ready to have you come back on. Is that all right?

Kim Peterson: Yeah, that's fine.

Jeff Graham: Okay. Good. Thanks. Bye now.

Kim Peterson: Thanks.

Carol Cordy: Thank you.

Patti Varley: Carol, for point of clarification do we just have to say that because it was a scan, right, do we have to re-do him? Or do you just say that the old ones are okay?

Carol Cordy: That's what we did on the previous one.

Jeff Graham: You can say they're okay.

Patti Varley: Yeah. This is Patti Varley. I move that our previous motion from February 20, 2008 are still appropriate.

Carol Cordy: So since there were two motions you can just put an S on it?

Patti Varley: Yes. I'll be fine with that amendment.

Carol Cordy: Do we have a second?

Man: I'll second it.

Carol Cordy: All in favor?

Group: Aye.

Carol Cordy: Opposed? The approval of the previous two motions passes.

Jeff Graham: Since we're running so much ahead maybe we should take a break until 11:15 so we can...

Carol Cordy: 10:15.

Jeff Graham: 10:15, I'm sorry, 10:15. And then we'll have Kim come back on the line then. All right?

Carol Cordy: Okay. So we'll break until 10:15.

Carol Cordy: It's almost 10:15 so let's reconvene.

Jeff Graham: Kim, is that you?

Kim Peterson: Yes.

Jeff Graham: We're just about ready to go.

Kim Peterson: Great.

Carol Cordy: Okay, Kim, we've got the slides up for drug class review for newer anti-emetics.

Kim Peterson: Okay. Well, I'm going to be presenting the new evidence from the first update of the drug class review on newer anti-emetics. Next slide.

So the first three slides provide an overview of inclusion criteria. And for this update there were no changes to our list of included populations. But for interventions we did add the new IV form of aprepitant...fosaprepitant. Also I wanted to mention we are aware of the new patch form of granisetron, which was approved by the FDA in September of 2008, but at that time it was quite late in the timeline for this update and so we deferred its addition to this review until the next update. So no evidence on that new patch form of granisetron appears in the Update 1 Report and won't be discussed in this presentation. Next slide.

Eligibility criteria for efficacy outcomes and there were no changes to the criteria for this update. So let's go on to the next slide. Here's the inclusion criteria for safety outcomes and for study designs. Again, no changes to the update. So really the only change to the inclusion criteria was the addition of fosaprepitant. Next slide.

So here's the details of the search strategy. As for bibliographic databases searches for the original report left off at March of 2005. So for this update we started there and then searched through October of 2008. And also for this update we received submissions from the manufacturers of aprepitant, dolasetron and palonosetron. Next slide.

Here are the details of our study selection process. Our updates are [inaudible] a total of 380 new citations and among those a total of 34 new studies met inclusion criteria and were added for this update. Next slide.

Here's a quick overview of the nature of the evidence overall. Nothing new here. For update 1 I'll point out that we still didn't find any studies of anti-emetic efficacy when used for pregnancy induced nausea and vomiting, as used for preventing radiation therapy induced nausea and vomiting in children overall, or specifically for the use of aprepitant and fosaprepitant in children. Next slide.

Results. The largest body of evidence in this review involved direct comparisons in head-to-head trials between dolasetron, granisetron and ondansetron. So we'll start with that body of evidence. This slide shows the overall numbers of head-to-head trials for each comparison involving those three drugs stratified by population and the numbers in brackets represent those that are new to Update 1. The most noteworthy among the new head-to-head trials is that whereas previously we had no head-to-head trials that compared the newer orally disintegrating tablet form of ondansetron to other 5-HT3 antagonists. Now we have three head-to-head trials of its comparison to the standard form of ondansetron. And previously we had no head-to-head trials of dolasetron versus granisetron for prevention of post-operative nausea and vomiting in adults. But we found two trials with that comparison for this update. And finally, previously we had no head-to-head trials for the treatment of established post-operative nausea and vomiting in adults but we added two for this update. Let's go on to the next slide.

This slide shows the ranges of rates of complete response from head-to-head trials of dolasetron, granisetron and ondansetron across all the populations. For the head-to-head trials we added for this update that compared dolasetron to granisetron to ondansetron for prevention of chemotherapy induced or prevention of post-operative nausea and vomiting. They reported rates of complete response that were in the same ranges as in the trials included in our previous review. And also they were consistent in finding no significant differences between dolasetron, granisetron and ondansetron. So there's no changes to those ranges of rates in the first two columns and the last column in this table. But we highlighted, with underlining the complete response rates from the one new trial that compared granisetron and ondansetron for the treatment of established nausea and vomiting because previously there was no head-to-head trial evidence for this population. But again the complete response rates are similar to those in the other populations and again the differences between granisetron and ondansetron were not statistically significant.

This was a somewhat small trial. And so although they are numerically different they were not statistically different. Next slide.

This slide summarizes the evidence from head-to-head involving comparisons of dolasetron, granisetron and ondansetron in subgroups based on demographics, concomitant medication use, and predisposition to nausea and vomiting. And in the original review the only difference related to subgroups came from a small subgroup analysis showing granisetron but not ondansetron as not working as well in patients with a history of motion sickness. Otherwise no differences in drug effects were reported in subgroups based on demographics or use of other medications. And for this update we found no new subgroup analyses involving any of these three drugs. So there were no changes made relative to this body of evidence for this update. Next slide.

In the original review health outcomes and serious adverse event outcomes were underreported in head-to-head trials and this was also the case for the head-to-head trials we added for this update. So we used evidence from placebo-controlled trials and observational studies to try to fill these gaps. And the only thing we added for this update in this regard was an observational study of adverse events and findings from that are highlighted at the bottom of the slide there. So this was a study that compared the effects of ondansetron and droperidol on ECG related outcomes when used to prevent post-operative nausea and vomiting in 85 consecutive adults. And it found that compared with baseline both ondansetron and droperidol were associated with statistically significant mean maximal lengthening of 2DC intervals, but that the difference between drugs was not significant. Next slide.

So now we're on to the evidence from five head-to-head trials that directly compared aprepitant and fosaprepitant to ondansetron, which are all new to this update. Previously for aprepitant were some placebo-controlled trials of aprepitant evaluating its use as an add on to ondansetron. Next slide.

On this slide we have the main efficacy findings from the three trials of oral aprepitant compared to ondansetron, which for some outcomes suggests that aprepitant may be superior to ondansetron. So two of the new head-to-head trials evaluated the effects of aprepitant compared to ondansetron in preventing post-operative nausea and vomiting in adults.

Both trials were originally developed to test the superiority of aprepitant over ondansetron on the primary efficacy end point of 24-hour complete response, which was defined in this case as no vomiting and no use of rescue therapy. But at some point the design of the second trial with change to have co-primary endpoints...testing aprepitant for non-inferiority on complete response and superiority on no vomiting. And we listed the range of rates for aprepitant and ondansetron for both outcomes on this slide. So the bottom line in these trials is that aprepitant and ondansetron are similar in increasing complete response rates, but for the outcome of no vomiting aprepitant is superior to ondansetron. And then the other head-to-head trial of aprepitant versus ondansetron compared their use in preventing chemotherapy related nausea and vomiting and the main findings here are that compared with ondansetron significantly more patients taking aprepitant had a complete response over five days and greater improvements in quality of life. Next slide.

And then here we have the main efficacy findings for the two new head-to-head trials comparing the anti-emetic effects of IV fosaprepitant and ondansetron in adults undergoing chemotherapy. I should note that both of these trials used a formulation and dose of fosaprepitant that is not currently available in the U.S. So the dosage of fosaprepitant in these trials is slightly lower than the...so it was 100 mg, which is slightly lower than the 115 mg dosage that is used in the United States. With regard to outcome in the first 24 hours both trials showed higher rates of complete response for ondansetron. But the difference only reached statistical significance in the larger of the two trials, which evaluated 177 adults undergoing moderately emetogenic chemotherapy whereas the other trial only evaluated 53 patients who were undergoing highly emetogenic chemotherapy. But these trials also looked at patient outcomes during days 2 through 5 and found that compared to ondansetron as given on day 1 only there were superior complete response rates for fosaprepitant regardless of whether it was given just on day 1 as was the case in one of the trials or whether it was also given as oral aprepitant on days 2 through 5. But again a reminder that this evidence does not allow us to draw conclusions about how this form of fosaprepitant available in the U.S. directly compares to ondansetron since we found no trials for that comparison. Next slide.

So for aprepitant we also found some evidence on its effects in gender and racial subgroups. One source of evidence was from a manufacturer-

funded study where they pulled data from two out of six available placebo-controlled trials to evaluate the potential effects of gender and found that aprepitant was superior to placebo in both women and men. So the gender...there was no differential effects in gender. However, there you have to keep in mind that there are also four other placebo-controlled trials that weren't included at the time that the analysis was done. Maybe they weren't published yet or maybe the data was not yet available, but in any case it's unclear as to how the results might change or if they might change at all if data from those trials were added. Then the other source of evidence was submitted by the manufacturers of aprepitant as part of their dossier and they provided complete response rates for aprepitant and ondansetron stratified by age and race; both of which did not appear in published reports of the associated trials. However, because the same sizes in these subgroups were too small to provide meaningful results they wisely did not in fact perform any statistical analyses to actually compare aprepitant and ondansetron in these subgroups. So although when you look at the data differences based on subgroups aren't obvious, if you just eyeball the rates but still no conclusions could be drawn from this evidence because the sample sizes are just too small. Next slide.

So now we're up to the evidence from head-to-head trials involving palonosetron. Previously we had two head-to-head trials directly comparing palonosetron to either dolasetron or ondansetron in adults undergoing moderately emetogenic chemotherapy and then for this update we added two more trials of palonosetron both involving comparisons to ondansetron in patients undergoing highly emetogenic chemotherapy—so one in adult and one in children. Next slide.

This slide summarizes the main efficacy findings from the trials of palonosetron in adults. So far patients undergoing moderately emetogenic chemotherapy in the original review we included two trials which separately reported that the .25 and .75 mg dosages of [inaudible] palonosetron were both non-inferior to both ondansetron and dolasetron. However, for this update we pulled data from those trials and looked at the combined results which actually suggest that palonosetron may be superior in complete response both within the first 24 hours and over days two through five. And so we've listed the relative risks, 95% confidence intervals in numbers needed to treat from our supplemental analyses on this side. So whereas the original trials were not designed to measure superiority we thought by pooling the data from them that might increase

the power to be able to measure superiority. So for this update also there was one new trial that directly compared palonosetron to ondansetron in adults undergoing highly emetogenic chemotherapy and it too reported that palonosetron was non-inferior to ondansetron in complete response rates. Next slide.

As I mentioned we also found a new head-to-head trial that directly compared palonosetron and ondansetron in children undergoing highly emetogenic chemotherapy and on this slide we've listed the complete response rates for days 1, 2 and 3. There were significantly greater numbers of children with complete response in the palonosetron group compared with the ondansetron groups in all three days. There's a few caveats to this finding, though. First, this was a relatively small study of 100 children conducted at a single center in Mexico City. So already there's questions about the strength and the generalizability of the findings. We would look for findings to be confirmed in a second study that would strengthen this result. And secondly the results of this study must be considered in light of a significant between groups baseline difference in terms of the rate of under nourishment. So at baseline there were significantly more under nourished children in the palonosetron group than in the ondansetron group. And it's not clear what the clinical ramifications of that might be, but any time there's a between groups difference at baseline there's always a question about how well...it indicates...it's an indicator that the randomization method may not have been successful and also this was a difference that was not adjusted for in the efficacy analysis. Next slide.

Now on to adverse effects. This is the only slide we have on adverse effects and it addresses the adverse event rates across all the head-to-head trials. As in the original review adverse events were under reported in the head-to-head trials that we added in this update and most of those were limited to the trials that were focusing on using these drugs in patients that are going through chemotherapy. As in the original review there was no evidence of consistent significant differences between any of the drugs on any adverse event and this didn't change for this update. We listed rates of the most common adverse events and rates of overall adverse events but didn't...but didn't really find these data to be very meaningful in this case since, as you can see, the rates vary so widely across the trials. For example, for any of the drugs as few as 2% up to as many as 53% of patients had headaches across the trials, which makes it hard to reliably

predict the risk of headache for any given patient taking an anti-emetic. But we're keeping in mind that this may just be the nature of this patient population. In patients with cancer it's hard to tell whether...if they are having adverse events it could be being caused by the cancer itself, the chemotherapy or radiation, or other medications that they may be taking as well as the anti-emetic. But the bottom line is that we didn't find any consistent significant differences between the different 5-HT3 antagonists. Next slide.

So this is the last slide and it's a recap of the main findings overall. For dolasetron, granisetron and ondansetron no changes to our previous conclusions that there's good quality evidence that there are no consistent significant differences in efficacy or harms among dolasetron, granisetron and ondansetron. For aprepitant, fosaprepitant and palonosetron though there were some changes in our conclusions for this update, for aprepitant previously there were no head-to-head trials but now we have fair to good quality evidence that aprepitant is at least non-inferior to ondansetron in improving complete response and may be superior in reducing vomiting. For fosaprepitant, previously there were no head-to-head trials but now there's fair quality evidence that at a slightly lower dose than is available in the U.S., when compared with ondansetron it's inferior during the first 24 hours, but superior on days two through five. And then for palonosetron previously there was fair quality evidence that it was non-inferior to dolasetron and ondansetron in patients undergoing moderately emetogenic chemotherapy and then for this update based on our pulled analysis may not even be considered superior. Also for this update we have evidence that palonosetron is at least non-inferior to ondansetron in patients undergoing highly emetogenic chemotherapy and may be superior in children. That's the last slide. Now I can take your questions.

Carol Cordy: Thanks, Kim. Any questions? And you're staying on for the next one on NSAIDs, right?

Kim Peterson: Yes, that's correct.

Carol Cordy: We have one speaker, Mr. Peter Wack.

Peter Wack: Good morning. My name is Peter Wack and I'm actually reimbursement specialist for Merck Oncology. I really just want to make a few comments—one being that Emend or aprepitant is not a competitor to the

5-HT3 antagonists that were reviewed today. So just so the panel is clear Emend is promoted and indicated to be used in combination with a 5-HT3 antagonist. You pick your one. All guidelines say you can pick any one of the four available 5-HT3 antagonists but the standard therapy to prevent chemotherapy-induced nausea and vomiting is a three drug regimen that includes a 5-HT3 antagonist Emend or aprepitant and dexamethasone. So I just wanted to...in the USP pharmacopeia did change in 2008 to list NK1 antagonists as a separate class and I realize the panel knows that we're not a 5-HT3 antagonist, but I also want everyone to understand that we're not out there to say, "Use us in place of a 5-HT3 antagonist." We tried to take what was at the time standard therapy and show that by adding Emend more patients are protected for chemotherapy-induced nausea and vomiting and the majority of that improvement occurs in the delayed phase of chemo-induced nausea and vomiting. That's why you see that superiority on days two through five.

The other addition we came out with an IV formulation. It is 115 mg. It is fosaprepitant and it's a pro drug that's converted to aprepitant as soon as it hits the circulation. And it actually is not indicated to be used alone, as well it's used in combination. You just give that first IV dose at the time of chemotherapy but the patient still, per our label, would take two 80 mg capsules on days two and three, but again have protection for the five full days. The 5-HT3 antagonists usually protect the patient for that first 24 hours. It's after they go home and are at home that they have another emetic response that's called the delayed response and that's where the NK1 receptor like aprepitant locks substance P from binding to that receptor and reduces nausea and vomiting in that delayed phase. So I just wanted to make sure that everyone was clear on that and also that both the National Comprehensive Cancer Network and American Society of Clinical Oncology has aprepitant on their national guidelines up front on the first cycle for prevention of chemotherapy induced nausea and vomiting in both highly emetogenic and moderately emetogenic chemotherapy regimens. That's all I wanted to say today and we'd like to maintain our status as a separate class that, you know, we continue to have access to patients whether it's the three drug oral or the IV followed by the two oral capsules. Thank you.

Carol Cordy:

Thank you. Any questions or discussion?

Janet Kelly: Janet Kelly. I have a question for Kim about the studies with palonosetron versus the 5-HT...the ondansetron or dolasetron. Did they just give a single dose of the dolasetron or ondansetron? Are those just single-dose studies or...

Kim Peterson: Let me have a look. Yes, single doses.

Janet Kelly: Okay. Then we get right back to the same issue there is that palonosetron is more...it has the delayed aspect and it's sort of not comparing adequately. If you only give one dose of ondansetron and one dose of palonosetron you can expect to have more delayed nausea with the ondansetron.

Carol Cordy: Any other discussion or questions? Does somebody want to make a motion?

Ken Wiscomb: This is Ken Wiscomb. I move we accept the scan as an adequate update.

Carol Cordy: This an update.

Ken Wiscomb: Oh, this is an update.

Jason Iltz: This is Jason. So in terms of how these medications are being used now are we seeing that the aprepitant is being used, you know, appropriately as an add on therapy? Is there an expedited prior auth in place for that? Is it fairly straight forward? Is it working just to say we're not going to put it in this class?

Siri Childs: This is Siri Childs from Medicaid and, yes, Emend is separately on our drug list and I believe that it's covered without restrictions. So people have access to Emend.

Janet Kelly: This is Janet Kelly. Another question that I had. I was looking into the palonosetron. It's approved in an oral form but I'm not aware that it is marketed in the oral form yet. I called a couple of weeks ago and it still wasn't marketed. Do you know if it is?

Siri Childs: This is Siri. I do not know.

Janet Kelly: I don't think it is. It's approved it's just not available.

Carol Cordy: So do you want to go ahead and make a motion?

Ken Wiscomb: Do we want to redo the whole thing?

Carol Cordy: If you think it needs to be redone. Why don't we read through the motion from June 20, 2007, which was reinstated on June 18, 2008, unless we want to make any changes.

Jason Iltz: This is Jason. As I read through that I think a lot of the components are applicable now. I'm trying to think back though why we made the statement as to a couple of them saying they should be non-preferred. I'm thinking it was the fact that we didn't have some head-to-head data. We just didn't have all the information we were hoping for. So I think if we could make an amendment to the previous motion and just say...and take that statement out of there that say they should be non-preferred and then it falls out how it may when the medication is reviewed from a contractual standpoint. But I think it's good still to say that we should have both an oral intravenous route approved therapy on...as a preferred drug list option. Does that make sense to the committee?

Carol Cordy: Yeah, I think that's a good idea. Do you want to go ahead and read that since there's a change?

Jason Iltz: Has that been updated now to reflect?

Barak Gaster: This is Barak Gaster. I have a question about aprepitant. So it says there that it's not to be included in the 5-HT3 antagonist class. But then it looks like on the preferred list that we have in our packets it is. Or it is but it says, "excluded from class". So it's listed there but it's...

Woman: It's listed by itself.

Barak Gaster: Sorry. It's confusing. Okay.

Carol Cordy: Jason, do you want to go ahead?

Jason Iltz: Okay. After considering the evidence of safety, efficacy and special populations for the treatment of nausea and vomiting related to chemotherapy, radiation therapy, and post operatively, I move that

granisetron, ondansetron, dolasetron and palonosetron are safe and efficacious. No single 5-HT3 antagonist medication is associated with fewer adverse events in special populations. The preferred drug list must include at least one medication that has both oral and intravenous routes approved in both adults and children. Dolasetron and granisetron, ondansetron and palonosetron can be subject to therapeutic interchange within their routes of administration in the Washington Preferred Drug List. Aprepitant and fosaprepitant are not to be included in the 5-HT3 antagonist class.

Carol Cordy: Is there a second?

Bob Bray: This is Bob Bray. I'll second it.

Janet Kelly: Okay. This is Janet Kelly and I have just one question I think we have to address first. With the palonosetron the regimens are very different and I'm a little concerned about the therapeutic interchange. Currently, as I said, there's the IV. So it's kind of a mute issue. I don't know. But if the oral comes out how do we...I'm not really sure about how that therapeutic interchange would go.

Patti Varley: This is Patti Varley. If the recommendation for how it's used is different than the others than they would have to figure out the therapeutic equivalencies, correct?

Woman: Nobody asked me.

[laughter]

Carol Cordy: Any other comments from our pharmacists on the committee?

Jason Iltz: This is Jason. I guess my thought is that I think it can be done. I think what people have to realize is not necessarily from the dosing standpoint, but from the standpoint of, you know, why one may be a little bit better than the other in terms of a little more delayed chemotherapy induced vomiting versus preventing some of the earlier phase emesis. So I don't know if it's a dosing conversion standpoint. I think it's just realizing when one may be a little more efficacious than the other. And let's see how it pans out. They may not all end up as preferred and so from that standpoint then it may make it easy to be able to switch to the preferred

agents. So I guess my standpoint would be let's not put restrictions on it now. Let's see how it falls out and if it becomes a problem then we can make an edit or a change.

Carol Cordy: Any more discussion? Do you want to comment on that Siri?

Siri Childs: This is Siri Childs. The only comment that I would add is that all of these drugs, even the preferred drugs, are on EPA for their appropriate indications. So we don't have them being used just for any old nausea or vomiting.

Carol Cordy: Okay. It looks like we have the motion and a second. All in favor?

Group: Aye.

Carol Cordy: Opposed? The motion passes. So should we move on to NSAIDs? Okay, Kim, we've got the first slide up.

Kim Peterson: Okay. This is the second preliminary scan of the literature of consideration of the fourth update of this review on NSAIDs. Next slide.

The status of the review is that it hasn't been fully updated since November of 2006. In October of 2007 we did the first preliminary update scan of the literature but then the participating organizations of DERP elected not to pursue a full update at that time. Next slide.

So now we're going to take...we've scanned the literature a second time to consider a full update. So the next slide provided an outline of the eligibility criteria for this review as a reminder of the scope. As for population we've been focusing on adults with chronic pain from osteoarthritis, rheumatoid arthritis, soft-tissue pain, back pain or ankylosing spondylitis. Next slide.

The main efficacy measures are pain, functional status and then discontinuations due to lack of efficacy. Next slide.

For harms the main outcomes are rates of overall adverse events, withdrawals due to adverse events and individual adverse events. Especially there's been a focus on the rates of serious gastrointestinal adverse events and cardiovascular adverse events. Next slide.

The next three slides list all the drugs one by one. They are quite numerous as you know. I probably don't need to read all of them to you. Celecoxib COX-2 inhibitor and then the rest are NSAIDs. So let's go ahead and skip to slide 9.

Okay. So slide 9 provides the details of the search methods that we used for the preliminary update scan. Using terms for included drugs and limits for humans, English language and trial design. We searched Medline going back to the cutoff date from our last scan, which was October 2007 and then searched through September...the first week of September in 2008. And then we also searched the FDA and Health Canada websites for information about new drugs, new indications and new safety alerts. Next slide.

So here's an overview of what we found in our preliminary scan this time. We found a total of 267 new citations and among those only 3 appeared to meet all of our inclusion criteria at the level of title and abstract. Then taken together with the two new trials identified in the first preliminary update scan now there's a total of five trials likely to be added in the full update of this topic. This has not been a very active topic in terms of research since our last full update. Next slide.

So this slide lists the details of three new trials found in this most recent scan. The first trial compared the gastrointestinal safety of celecoxib and naproxen + lansoprazole both in combination with low dose aspirin. But only looking at GI safety over 12 weeks and only reporting rates of endoscopically confirmed ulcers and didn't appear from the abstract to be looking at bleeding rates, which is what we're really interested in. And then the other two trials mainly focused on efficacy over 12 weeks in patients with ankylosing spondylitis in Sieper 2008 and then over just two weeks in patients with osteoarthritis in the Wagentiz 2007 trial. Next slide.

Also for this preliminary update scan we did something a little different in that although the focus of the review has always only been on oral formulations of NSAIDs some of our participating organizations from DERP expressed some interest in the future if they elect to pursue a full update possibly expanding the scope to include topical NSAIDs as well. So we did a little exploratory searching for what trials might be out there

on topical NSAIDs just to get a feel for the volume of literature that we would be adding. First, the only topical NSAIDs that we found to be FDA approved at all were three different forms of diclofenac and then using that information in our searching. Then we only found a few trials comparing topical diclofenac to other NSAIDs. So not...the volume of literature would be quite small. And again there's been no change in the scope. This was just an idea that the...at least one of the participating organizations wanted to consider in the event that this topic was fully updated. Let's go to the next slide.

So now for the results of our searches of the FDA and Health Canada websites. As for new drugs we didn't find any that have actually received FDA approval since our last update, but we were made aware that at least one new yet-to-be-named COX-2 inhibitor is in development by GSK. And we did find a few listings of some trials that have been conducted, but we couldn't find any information about where things are at with regard to the approval process. In the future we would keep an eye out for...if this or any other COX-2 inhibitors were newly approved and we would add those in the event of a full update. Next slide.

So we didn't find any new information about any new indications for NSAIDs or any new safety alerts when we were searching the FDA and Health Canada websites. So overall considering the various sparse new data that would be eligible to be added in a full update would be participating organizations of DERP, again voted against a full update of the topic. So the next time that we'll scan this topic has not yet been determined, but likely would be done in October of this year. So that can always be, again, considering whether or not we should pursue a full update of this topic, but until then the most recent report is from 2006. So that's the last slide. I can go ahead and take your questions.

Carol Cordy: Any questions or discussion? So this is a scan. Is there a...we have three speakers. Do we accept the scan first? Is there a motion to accept this scan?

Ken Wiscomb: This is Ken Wiscomb. I move we accept this scan of NSAIDs as an adequate update.

Carol Cordy: Is there a second?

Barak Gaster: This is Barak Gaster. I second.

Carol Cordy: All in favor?

Group: Aye.

Carol Cordy: Opposed? The motion passes. We have three speakers and again if you could identify who you're representing and limit your remarks to three minutes. First is Dr. Ann Hartry.

Ann Hartry: Thank you. My name is Dr. Ann Hartry. I'm with Clinical Affairs within Medical Affairs at Endo Pharmaceuticals. I wanted to provide a little bit of information today about voltaren gel. Voltaren gel is a topical diclofenac that was approved by the FDA in fall of 2007 for the relief of the pain from osteoarthritis in joints that are amenable to topical treatment and you didn't see it in the scan. It is a recent approval and the pivotal trials are in press as we speak. So those will be coming out in the very near future.

I just wanted to review a little bit of that data for you just for your background so when the next scan comes up it will be vaguely familiar. The active ingredient in voltaren gel is as you expect diclofenac. This is of course a well known NSAID that's available in multiple formulations. This is the only gel topical NSAID that's approved in the U.S. Voltaren gel is approved in a bioequivalent form overseas called voltaren emul gel, but this is the only version approved here in the U.S. The pivotal studies that you'll find in the labeling on voltaren gel, there's two primary ones, one's in a study of osteoarthritis of the knee. It's a 12-week randomized control trial and in that trial there were significant improvements in the voltaren gel trial...or in the voltaren gel population in both pain, physical function and in global rating of disease.

There was another study that evaluated the efficacy of voltaren gel in the treatment of pain from OA in the hands and again this was measured at four and six weeks and again with significant improvements in the patients receiving the voltaren gel as opposed to the vehicle. In addition to the evidence of voltaren gels efficacy it's important to look at the safety and tolerability. A pharmacokinetic evaluation of the gel shows that it has a much lower systemic absorption than for instance a comparable oral dose of diclofenac. So for instance the area under the curve is less than 6% and

the mean plasma concentrations are less than 1%. And then that has the concomitant safety features. For instance in a...well, first I do have to point out that regardless of the systemic absorption this is an NSAID and so it carries the same labeling as all NSAIDs as required by the FDA. And so it does warn of the increased risk of cardiovascular and gastrointestinal effects. However, during our clinical development over 900 patients were exposed to voltaren gel in the randomized double-blind controlled trials and in all of these studies the only adverse events that were seen in greater than 1% of patients and that were different between voltaren gel and placebo were site application reactions. And then this result was further seen in a one-year safety trial...

Jeff Graham: Dr. Hartry, would you please conclude your remarks?

Ann Hartry: The final statement is that this represents an opportunity to get the pain relief of an NSAID without the adverse events of the...with the lower systemic exposure. Thank you.

Carol Cordy: Dr. Peter Kinehan? Not here. Dr. Paul Brown?

Paul Brown: I'm speaking as an advocate for Celebrex. I'm Dr. Paul Brown. I'm a board certified rheumatologist and clinical professor of medicine at the University of Washington. So why Celebrex and for what type of patient? First, the FDA has determined that patients receiving Celebrex do not have an increased incident of cardiac events compared to patients receiving other NSAIDs. Patients who require aspirin for cardio protection as well as another NSAID for relief of pain and inflammation can safely use Celebrex since it alone does not displace aspirin from the COX-1 receptor and platelets. Thus aspirin is still effective in patients taking Celebrex in contrast to patients taking other NSAIDs such as ibuprofen. Celebrex is also the NSAID of choice for patients with prior GI events who require an NSAID since Celebrex alone has been proven to provide the same degree of GI protection as other NSAIDs combined with a proton pump inhibitor. Also Celebrex is the NSAID of choice for patients on coumadin who require an NSAID since Celebrex does not interfere with platelet aggregation and also as a favorable GI profile compared to other NSAIDs. Finally, Celebrex is the only NSAID which can be used safely for patients undergoing surgery since it does not interfere with platelet aggregation. In the 1980s the agencies administering Medicare and other government health insurance programs were concerned about the costs of boutique

NSAIDs such as feldene. High dose aspirin was recommended instead for relief of pain and inflammation. This remedy proved much more expensive than even brand name NSAIDs when the costs of hospitalization for GI bleeds was taken into account. Thus, the apparently cheapest solution doesn't always cost less. Thus, Celebrex is the NSAID of choice for anyone with chronic symptoms of pain or inflammation. In the long run it will prove far less costly and safer than other reportedly cheaper NSAIDS. If you still believe it shouldn't be available for use by all of the medical community then at least consider its approval for use by specialists such as rheumatologists and orthopedists. Thank you.

Carol Cordy: Thank you. Any questions or discussion? So this is...

Jeff Graham: Carol, this is Jeff. Could we let Kim go at this time?

Carol Cordy: Oh, yeah. Kim, thank you very much.

Kim Peterson: You're very welcome. Bye.

Carol Cordy: We'll talk to you next time.

Kim Peterson: Okay. Bye, bye.

Carol Cordy: So I think we do need to have a motion. It looks like the last one was February 20, 2008. I think if there's no changes in the wording why don't we read through this. We can just have a motion to accept the wording in this previous motion.

Barak Gaster: This is Barak Gaster. So after reviewing the wording of our motion dated February 20, 2008, I would move that we re-instate that motion as it was worded on that date.

Carol Cordy: Do we have a second?

Man: Discussion?

Carol Cordy: More discussion?

Man: Are we going to assume then that diclofenac includes the topical route as well as oral route?

Group: No.

Man: Okay.

Man: The current preferred drug list has a little note next to each of the available agents saying that DAW1 does not override EPA. Can you explain what that means to me?

Siri Childs: This is Siri Childs. I'm representing Medicaid and actually based on a recommendation from you all, the DUR board, we have had a criteria in place probably since 1999 that for any NSAID and for any COX-2 we would require that they do not have a history of a GI bleed. That is what that EPA asterisk on the list refers to. I should add that because it's patient safety their DAW does not override that.

Jason Iltz: This is Jason. That's what I was hoping that that meant was that we were making sure that there was no previous history of GI bleed before these folks receive any of these medications. Thank you.

Carol Cordy: More discussion?

Jason Iltz: This is Jason. I'll second the...

Ken Wiscomb: This is Kent...sorry, Jason, go ahead. Go ahead.

Jason Iltz: I'll second the previous motion if there's no more discussion.

Ken Wiscomb: This is Ken Wiscomb. The only comment I was going to make is whether or not we need to address the gel issue. As the motion is here it doesn't state whether the oral medications or IV medications or how that's applied. If our intent is to not have the gels as first line I'm wondering if we need to address that.

Jeff Graham: This is Jeff Graham. The agencies have a...we do not consider those drugs when we look at them because they are not fully reviewed by OHSU by the EPC. So generally we never include those. It's just a matter of policy if they are not fully reviewed by the...I mean you can state that, but we wouldn't consider it because it's not in it. It's mentioned in the review but there's no [inaudible] or anything.

Ken Wiscomb: I just wanted to make sure we didn't need to address that.

Carol Cordy: More discussion or questions, comments? So we have a motion that's seconded. All in favor?

Group: Aye.

Carol Cordy: Opposed? The motion passes. And we are about 50 minutes early for lunch. I'm sure we can't get lunch served earlier.

Woman: Yes, you can.

Carol Cordy: Oh, it's ready.

Jeff Graham: Jeff, when could we start the DUR board?

Siri Childs: I'm sorry but we cannot start until 1:00 because we have about five folks coming from HRSA.

Carol Cordy: Okay. So we'll reconvene at 1:00. Have a nice, long lunch.

Jason Iltz: This is Jason. One of the things that if we finish up a little early from a committee standpoint and I noticed that the last transcription has a lot of...towards the end of man, woman, and so, you know, I'm just thinking when we do our end-of-the-year DUR stuff sometimes it's a lot easier if there's someone whose name is attached to that. So maybe if we have time we could read through that as a committee member individually and try to assign some of the comments in there. If they're yours write your name down and then we could give those to Siri to update the transcript and we don't have to take the time to do it right at 1:00 then when we reconvene.

Siri Childs: Yeah, that would be great.

Ken Wiscomb: What if it says woman and it's mine?

Duane Thurman: Just in general it would be helpful to state your names before you say everything. If we can get into that habit it makes the transcript a lot clearer.

Carol Cordy: Thank you.

Duane Thurman: Like I just didn't do.

Jeff Thompson: That was Duane Thurman for the record. This is Jeff Thompson for the record, record.

Carol Cordy: ...I am the woman in that warning. So we'll reconvene as the drug utilization review committee, and there's new people here if you want to introduce...well, I guess we'll introduce everybody, so we know who we are. Want to start? Let's start this way this time.

Scott Best: I'm Scott Best. I work for HRSA in the PRC Program.

David Albert: David Albert, senior planner and policy analyst for the Division of Alcohol and Substance Abuse.

Phyllis Coolen: I'm Phyllis Coolen, and I manage the Patient Review and Coordination Program under HRSA.

Chuck Agte: Chuck Agte. HRSA.

Jeff Thompson: Jeff Thompson, Medicaid.

Siri Childs: Siri Childs, Medicaid.

Jaymie Mai: Jaymie Mai, L&I.

Doug Tuman: Doug Tuman, L&I.

Jeff Graham: Jeff Graham, Healthcare Authority.

Kenneth Wiscomb: Ken Wiscomb.

Janet Kelly: Janet Kelly.

Patti Varley: Patti Varley.

Angelo Ballasiotes: Angelo Ballosiotes.

Jason Iltz: Jason Iltz.

Robert Bray: Bob Bray.

Cathy Williams: Cathy Williams, Board of Pharmacy.

Regina Chacon: Regina Chacon, Healthcare Authority.

Donna Sullivan: Donna Sullivan. I'm the director of Pharmacy Services for the Washington Healthcare Authority.

Duane Thurman: Duane Thurman, Healthcare Authority.

Deb Cummins: Deb Cummins with the Division of Alcohol and Substance Abuse.

Linda Casten: Linda Casten with [inaudible].

Andre Rossi: Andre Rossi with DOC.

Carol Cordy: So if everybody's read the minutes from February 18, 2009, I ask that we approve those minutes. We do have a lot of unidentified people in the minutes. How did you want to figure those out or we'll just get back to you.

Siri Childs: This is Siri Childs. Jason has already given me his copy with his name written in, in the appropriate spots; so if any of the rest of you would like to do the same thing, I can add those to the master copy.

Carol Cordy: So does somebody want to make a motion to approve the minutes?

Jason Iltz: With those amendments, I move to approve the previous DUR board meeting minutes from February 18, 2009.

Carol Cordy: Do we need to...

Robert Bray: I second it.

Carol Cordy: Everybody in favor, Aye.

Robert Bray: Aye.

Carol Cordy: So the minutes are approved from February 18, 2009.

Siri Childs: This is Siri Childs again, and for the program today, we have two parts, and the first part is bringing back to you the utilization data for Washington Medicaid on the short-acting and long-acting Albuterol. If you remember last time when we studied the drugs for asthma, the rescue drugs, and the controllers, we had a question about should we be looking at the excessive use of short-acting, beta agonists without any type of a controller med. And when we discussed that, you all said it would be really great for this discussion if we could have some idea of what the utilization shows. So today, we have Chuck Agte who is our Medicaid pharmacy program manager here who has pulled the data, and he's here to describe what you're seeing there.

Chuck Agte: Okay. So as Siri has indicated, we've brought back the data that was requested in your last DUR board meeting, and could we go ahead and move to the first slide here. It came out kind of small in the notebook here, so hopefully, you can get a better read up there. If we need to, we can supply larger copies. What we've done is we've pulled all of our beta agonists utilization data, both the short-acting and the long-acting, but you see on the left is the short-acting medications that were found to be being used in conjunction with an inhaled corticosteroid, and on the right, are those claims for clients that we could not find an indication that they were using a controller medication. We have indicated...the drugs, of course, are on the left-hand side. Our second column indicates the number of inhalations in that particular inhaler, and there are some other size variations that we did not find in our own data. For example, the Maxair Autohaler we have listed as 400 inhalations. There is an AD inhalation size, but we didn't find any utilization on that for our clients, so we've only listed what we have utilization for. We then have average inhalers per month which is rounded up to the nearest whole number, and then we give you the number of clients, and then there's a column titled number of clients with diagnosis. We went ahead and included data that's basically the number of clients who were found to have a diagnosis in their history of chronic bronchitis, emphysema, chronic airway obstruction, or bronchitis not specified as chronic or acute, and we've included that information because those are clients that, due to their diagnosis, it may be appropriate for them to only be using a beta agonist and not a controller

medication. So we put that there to kind of inform the numbers and that number is out of the number of total clients that we list. Then of course, we have total number of claims for those clients and total dollars paid, and that's kind of at the high level what we've put together here. Generally, we found that the majority of our clients fall into the two inhalers per month or less. In fact, the majority of clients are using one inhaler or less per month and with another good chunk in the one to two range, and we actually have very few clients who are receiving more than average of two inhalers per month. If we can go to the next slide, at kind of a broad level, what we found is there's a total, at least for the calendar year 2008 utilization data, we had about 48,000 clients who were receiving short-acting beta agonists. Seventy-one percent of those clients were not receiving any controller medication when they were filling the beta agonists. And only 89 clients of that 48,000 are averaging more than 2 inhalers per month. Fifty-eight of those clients did have a concurrent controller medication; thirty one did not. Then we have about 27 percent of the clients who had a diagnosis which indicated that it may be appropriate that they're not receiving a controller medication. So based on what we've found and part of what was discussed in your last meeting, we would like to present a proposed provider notification education piece that we can follow up on this data with, and we would...if we can go to the next slide, our proposed process is that we first...we identify those clients who are exceeding a specified threshold for number of inhalers over a period of time, and we identify that using claim data, and we're hoping that you will give us feedback on what would be appropriate threshold per time period. And then once those clients are identified using the claim data, we would send out notification to the prescriber, and we're trying to design a real-time process; so as this happens, you know, a client gets a fill that day that puts them over the threshold, we would send out notification that day to their prescriber. Based on that, it's purely educational. We would not do any further follow-up, no restricting of their rescue medication. It would just be notification to the prescriber to give them an opportunity to follow up on whether the client does need some additional, either medication or therapy, in regard to their treatment.

If we can go to the next slide. This is a sample of the notification that we've put together, and unless someone wants me to, I'm not going to read through it. It's basically high level, both FDA indications and the recommendations from the National Asthma education and prevention program expert panel. It's essentially just high-level educational material,

informs the prescriber that their client did receive a short-acting beta agonist that exceeded the threshold for the time period. And accompanying this notification, if we can go to the next slide, is an example of a profile that we would provide, along with the notification so that the prescriber could see an active history of how often and how many inhalers their client was filling and as well as...although it's labeled beta agonist drug profile, we have included the controller medications that the client may or may not be receiving as well. So you see Flovent on there as an example of a client having filled controller medications and then several successive fills of Albuterol, you know, outside of having the Flovent filled. And that is, at a very high level, what we're proposing as a process to engage the physician in seeing if their client does need more control, and we're looking for your feedback on both the process and what that threshold should look like that might trigger this communication.

Carol Cordy: This is Carol Cordy. I had one question...two questions. On the second slide or third slide, the summ... that one, is that 26.8 percent a subset of the 71.6 percent, or might some of those people also be on a controller?

Chuck Agte: No. That does cross over, both with a controller and without controllers. That 26.8 percent is of the total clients, not of the ones who didn't have a controller. So that's...

Carol Cordy: Do we know what percentage of the 71.6 have?

Chuck Agte: No. I did not calculate that, but I could with a calculator. We can figure that out for you.

Carol Cordy: Here. I have a calculator. And the other question on sending out this form, it sounds like those are going to be limited just to those people that are getting more than whatever number of inhalers per month.

Chuck Agte: Yes.

Carol Cordy: And why would those be limited?

Chuck Agte: Because of the sheer volume, because we have 48,000 clients...

Carol Cordy: Okay.

Chuck Agte: ...in order to send out notification by hand on all the clients that we believe may be having a problem. We don't want to send it out on all 48,000, because we don't have the resources to do that on a regular basis, so we're looking to identify a subset that is potentially in danger or needing more control for their therapy.

Carol Cordy: Okay, and so do you know what that number is?

Chuck Agte: The number?

Carol Cordy: The number of letters you're going to send out.

Chuck Agte: No. That would depend on the feedback that you provide, based on the discussion. In the last DUR board meeting, it looked like there was an inclination towards a threshold around two or three per month which is why I've identified that we did only have eight-nine clients exceeding an average of two per month.

Carol Cordy: So if we put two per month, it would just be...

Chuck Agte: Eight-nine...

Carol Cordy: ...eight-nine [inaudible]

Chuck Agte: ...and so the number of providers would be something less than 89. They're probably duplicate providers within that client group.

Man: And we'd probably end up reaching out to more than those 89 clients, because if did, for example, use the figure of two per month, the data we're looking at is averaged over a year. So there may be months in which a lot of these clients who aren't averaging more than two per month over a year, they may have the month where they get four, because they're filling two for at home and two for at camp for a child or something like that. So we would probably be sending more than that 89 notices, because we would want to do this on an ongoing basis as we saw clients passing that threshold. The number who would be contacted would be higher than that 89, simply because we'd be looking at a shorter time period.

Carol Cordy: Okay, because it seems like that's so few. I mean, I agree that tens of thousands is too many, but...because it's a helpful...I mean, I think it's a helpful thing to get people on controllers, more than 89.

Barak Gaster: This is Barak Gaster, and I agree that we have to strike some balance between sort of what's logistically possible versus what we would ideally want to do for safety. I mean, it occurs to me that if somebody is using two inhalers per month, then that's 400 inhalations per month, which is more than 10 inhalations per day which is more than 2 puffs 4 times a day. And so that clearly there would be some threshold way below two inhalers per month where they're using too much, and that we could probably even say, if it's on average more than one inhaler or even one inhaler per month over the course of six months or a year that those people should get letters as well, because they're probably using two to three times still as much Albuterol as they should be using. So I would be interested in figuring out what a number of letters to send would be if it was going to be all clients who are getting more than one per month averaged out over the course of six months or a year.

Chuck Agte: Okay. This is Chuck Agte again. To answer the previous question, looking at only those clients who have a diagnosis that would potentially need only the beta agonists, the percentage comes out about the same. When you look at just the clients who are not receiving one, it came out to 26.6 percent of those clients.

Jason Iltz: Chuck, this is Jason Iltz. As a follow-up to what you just said, so you had the slide up there that had with controller or without controller. If we can go back to that, there was the one column that you just referred to that says, number of clients with diagnosis double asterisks, and down below you read off what those were. So what I don't see on there is reactive airway disease, and so is that what you're saying, the difference between those number of clients, and I guess, it's column 3 versus column 4 that that 3,800 or whatever that is minus 1,100, that the difference there, those people have a diagnosis of reactive airway disease?

Chuck Agte: Those...that would be a safe assumption. We did not pull diagnosis for everyone. We identified those diagnoses associated with COPD and...is that it? Just COPD. So we pulled those diagnoses associated with COPD and pulled them out. So the presumption would be that the remainder of those clients do, in fact, have reactive airway disease, but we didn't pull

the data at that level. We just tried to eliminate the ones who might be appropriate for just a beta agonist.

Jason Iltz: Okay. So then the next part as a follow-up to that then is when we identified the threshold and we have letters that go out...and I know we didn't read the wording on the utilization letter, but I think we have an opportunity to also say to the physician and the client at this point in time to say, maybe we need to reevaluate whether or not you would benefit from a controller medication based on the discrepancy there of how many people are actually without controller meds versus how many are. And so if we can maybe add that to the letter, that may be helpful. Really not telling them they have to do it, but it's a point of time when they could reevaluate. And then you refer to the expert guidelines, the recent report. If we could put a Web site or something in there that they could go to access that report, I think that would a valued addition as well.

Chuck Agte: Thank you.

Robert Bray: This is Bob Bray. I hate to be a naysayer, but I'm just picturing busy physicians opening one more letter that takes their attention to something else, and I really...and just for ease of use of the letter, I like the Web site idea where it gives you one more resource. But even just separating that out a little bit more and highlighting, here's the guideline...here's what the guideline says, here's what the FDA labeling says, so that someone could scan that very quickly and realize how it's organized. It's kind of in one...in several paragraphs that you really have to go through and kind of pick out where's the detail for me. So I think if it was organized and highlighted that way, the same information, it would just...I think it would reach more people, because they'd actually read it with a little more understanding.

Barak Gaster: This is Barak Gaster.

Jeff Thompson: Doctor's don't read. They just scan. This is Jeff Thompson making that remark.

Robert Bray: You're right. Bob Bray.

Barak Gaster: This is Barak Gaster. I would completely agree with that, that if our goals is really to educate, then the educational material needs to have way fewer

words in it and just more focus in terms of exactly the message that we're trying to convey. I mean, so as it reads now, it sounds more like it's a sort of written guideline which is not nearly the kind of level of education that most people need. And so, I mean, I would just try to make it a lot less wordy; and so rather than saying this may be a marker of destabilization of asthma and requires reevaluation of the plan, of the patient and treatment regime, I think just more clearly say that this person is probably using too much short-acting and probably should be on more of a controller medication, and rather even saying controller medication say, should be on an inhaled steroid. You know, just to be as direct as possible, because just like Bob said, the time of day when I'm going through my mail is always the most sort of harried and frustrated time of the day, where every second that I'm sort of opening envelopes and reading the junk that gets sent to, the more frustrated I am. And if I opened this and looked at that, I would not sit down and take and time to piece through what it was trying to say to me.

Chuck Agte: And this is Chuck Agte. Just to clarify, not that it affects anything being said, but based on the way we normally put these programs together, and not that it makes a difference as far as having to go through correspondence, but this would actually be going to providers via fax. They would receive it as a fax.

Kenneth Wiscomb: This is Ken Wiscomb. I think I would add on there too a mechanism for us to return that fax to you if this patient's no longer ours. I mean, you may have our name down as a last prescriber, but I know in my system, you know, and I'm sure most hospital-based systems are like this. If there's multiple clinics, I may have written a prescription that had three refills on it four months ago, and they've already switched to some other provider. So if you just added one line and put a fax number, and you know, we could check off a little box that said...

Patti Varley: This is Patti Varley, and as I...and I would defer to the people who might use this more, but when I read that title, it sounds like a survey, like utilization, and I'm just wondering in the realm of paperwork amounts that everybody gets, a survey doesn't really hold high priority. It's probably one of those round files if I don't think it's clinically significant and it's just somebody wanting to know my utilization. So would, again, just for the matter of the bullet points and making this seem like more of a priority, you might give thought to that.

Barak Gaster: Barak Gaster. I mean the title could be, you're patient may be using too much Albuterol. You know, that...

Patti Varley: You're patient...

Robert Bray: Just add the word, warning on the end of it.

Jeff Thompson: Don't you love editing by group?

Patti Varley: Yeah.

Carol Cordy: I wanted to go back...this is Carol Cordy...to what you said about that the number of letters is limited by staff. This is kind of backwards way of doing it, but what is your limit? How many years can you...

Patti Varley: Zero right now.

Carol Cordy: What, zero?

Patti Varley: Zero.

Carol Cordy: Zero to eighty-nine.

Patti Varley: Yeah.

Carol Cordy: Just because it's kind of a random thing. As Barak said, is it one? Is it one and a half? Is it two? You can go the other way and say, how many? You know, can we send out 300? See what the 300 gets us.

Patti Varley: And this is Patti Varley, and I guess I'll take the other side of the coin which is in this time of budget crunch and having to prioritize what we do with our time. I actually would rather do the highest slice of the pie first. Risk first, and then go down from there as outcome data and resources might change. I just feel like that's probably more doable and more realistic in this current environment.

Barak Gaster: This is Barak Gaster, and I guess one of the other, I think, or maybe even the trigger for all of this was our discussion last time about using long-acting without controller medications. And actually reassured by this data

is in that if it looks that's the bottom right-hand corner of this slide, where it's long-acting without controller medications. The number of clients is 47. The number of those who have a diagnosis of COPD is 33. And so we're looking at an N of 14 in the entire medicated populations, say, Washington, are using a long-acting without a controller medication which is a really small number, and so I would say that I'm reassured by this data and thank you for bringing it to us.

Siri Childs: This is Siri Childs, and I would have to echo what Patti Varley said, on our resources are practically nonexistent, so in order for us to take this project under our wing, we would have to do it probably taking the most at risk; and then, you know, in the event that we would ever have more resources, we could take more on. So with that in mind, I am looking for a recommendation from the committee.

Patti Varley: This is Patti Varley again. And as you were speaking, Siri, it made me think that, you know, you're...many of the clinicians are going to be treating more than one patient. So even though we are taking that slice of the highest risk patients, I guess I would assume that if it came to my attention about patient A, I would then in my own practice start to think about it as it applied to other patients. So I think even by doing that because you have prescribers that are going to have more than one client, they may only get a form on one or two, but it would make them also aware so that they might look differently at their others.

Siri Childs: Right.

Carol Cordy: This is Carol Cordy. Can't it be sorted by prescriber? I mean, of those 89 patients, you were saying there may be 40 prescribers.

Man: We could potentially look at it by prescriber. That would make it less a...because part of what we tried to look at and design was something that was kind of a real-time intervention, where when a client, based on because pharmacy data is daily at the time a prescription is filled, to give the opportunity to intervene at the time the client was getting additional inhalers. We could do it at a prescriber level, but that would take more of the nature of a retrospective review of every month, every couple months, because there is no way on a prescription by prescription basis to have the system determine, you know, does this prescriber have enough clients that we need to send him a letter. So it would depend on the nature of the way

we want to look at the intervention. If you're looking at client intervention at the time of fill, you sort of have to do it at the client level, but...

Carol Cordy: So that was the plan is that the patient is filling that second prescription, and that's when the letter goes out?

Man: Yes.

Patti Varley: And this is Patti Varley. I mean, I assume, just like myself, even though I don't treat patients with this, that what that would pick up on, rather than targeting prescribers and looking at that from the patient, is the example here is that there was someone else filling prescriptions. And if I'm not aware of that, this system allows me to know that someone else is prescribing similar or the same medications for my patient, and I don't think...I think there's times where you wouldn't be aware of that if you did it just prescriber. If the patient's data is sent to you and it shows that they're getting it from their specialty person and their primary care, that may be information one or both prescribers didn't have.

Barak Gaster: This is Barak Gaster. And so going back to Siri's request for input on how this might be structured if we had more resources. And so I would first say that breaking it down by number of inhalers per month is probably too crude of a measure, and that we probably would want data that was by average number of inhalers over the past 12 months. Because if you were to look at what the guidelines are...so I just sort of scratched this out, so that if maybe an ideal use of Albuterol is 5 to 10 uses per week, and so let's call it sort of the upper limit of that, 10 uses per week at 2 puffs per week...or 2 puffs per use...that would be 20 puffs per week, and then times 50 weeks for the year, so it'd be a 1,000 puffs per year. And then at 200 puffs per inhaler. So on average, a well-controlled patient with asthma should be using about 5, no more than 5 inhalers per a 12-month period. And so then if you were going to sort of give them a few extra to have in the car and at the gym, so then maybe 7 or 8 is sort of a target for a 12-month period, and so that rather than rounding all those people up to 1 inhaler per month, that you'd want data that was 8, 9, 10, 11, 12 inhalers per year. And then that would also kind of allow you to sort of more find the number of letters that you had the resources to send and figure that out.

Chuck Agte: This is Chuck Agte. To answer one of the questions asked earlier when we do...I just took it down to the level on the data that is here, and presuming I'm adding correctly on the fly, it looks like we've got only about 1,200 patients who are averaging more than one per month. So the more than 2 per month was the 89, and the more than 1 per month on average was a little over 1,200.

Patti Varley: This is Patti Varley. That was 1 per month for 12 months?

Chuck Agte: Yes. All of this data is based on...

Patti Varley: A year?

Chuck Agte: ...average of calendar year 2008.

Patti Varley: Yeah. This is Patti Varley, and I have no idea if this applies in this current environment or not, but I'll just say there are some of my patients who because of the economy and their insurance coverages, are trying to get extras while they're insured, and I don't know if that ever is a variable that would apply here or not to someone, for instance, who's going to camp this summer who also isn't going to have the same coverage, because there's a change. And I don't know how often you guys see that and if you see that as being more of an issue lately?

Chuck Agte: On these particular beds, it is more possible; because since there aren't any specific controls or limits and asthma is hard to quantify, it's not something like, you know, if you know a med is generally b.i.d. use and you see somebody getting 1,200 for a month, yeah, maybe they're stocking up. It's hard to tell with these meds, and in general, we haven't been seeing that. I don't have hard data for that, but in general, because of the nature of the Medicaid client base, you're not really going on and off coverage that often. I mean, you maybe going from fee for service to managed care, but the coverage is approximately the same either way, so we don't usually see that kind of behavior.

Jeff Thompson: This is Jeff Thompson. I could tell you what's happening right now. Our caseloads are growing remarkably so it's more likely that people are coming off of their commercial insurance and coming on Medicaid. So for us, it's not an issue. I think you have an anxious asthma clinician over there that wants to make a comment.

Greg Ledewood:
(spelling?)

My name is Greg Ledewood, and I'm the co-chairman of the Washington Asthma Initiative Provider Support Committee. I think it needs to be made clear that the guidelines actually support far less rescue therapy than you're proposing. In fact, that this is a scientific-based decision, we as the Washington Asthma Initiative have currently...are producing a document that recommends no more than two, I repeat two, Albuterol rescue inhalers per year, not per month, and we would say, and the guidelines would support us as does the scientific data, that anyone that is using that much Albuterol per month is totally out of control. Now, granted there are people, in fact, that need two inhalers, one at home...maybe three, one at school, one in the car. I don't have a way of capturing that. But if in fact, patients are...if clinicians are writing for three and five refills at each contact with the patient, that's wrong. We're trying to discourage that. I would like to see the committee, if they make recommendations, have it somewhat at least parallel what we're trying to do with the Washington Asthma Initiative to make sure that we recognize...and this data is really quite clear. In fact, our data suggests that 70 percent of our asthmatics in this state are not controlled, based on what you have learned and what we have seen in other managed care organizations on refill medications. So I would encourage you if you're going to make a recommendation, to be a lot more conservative than you currently have proposed. Twelve hundred clients using one per month is too many. And if you ratchet that down to, let's say, 4 per year, then you're going to have a whole lot more of this 48,000 people that are going to be identified as not controlled. Thank you.

Carol Cordy:

Thank you. So if it was...Carol Cordy...it feels like we're kind of back to can we do 48,000 or can we do 89 or how many can we do? And even 1,200 is a bump up from 89. If we went to the four or even five a year, do you have the quick numbers there of how many?

Chuck Agte:

No, not divided down to that. I mean, we have the data, but not in what I've brought today.

Jason Iltz:

This is Jason. So I mean, what you have up on the board up there, that's average per month, right?

Chuck Agte:

Average per month over a year.

Jason Iltz: And I would guess that you weren't rounding something that when you divided it out was .2 or something like that. I'm guessing that that's probably outside of the norm. That maybe you're rounding .78 or something like that. So even four or five, if I'm thinking about the numbers per year, four or five per year, I think that includes everybody you see up there. Is that...I mean, based on the numbers that I'm looking, it looks like we'd have to identify and send a letter on every one of those patients.

Chuck Agte: Yes, and so the numbers there are, in fact, just rounded up to the nearest whole number. So if somebody came out showing .1, they're going to be in that one category that's up there. But you're right. If we took it down...without it in front of me, I can't say exactly how many, but...

Jason Iltz: From your recollection, though?

Chuck Agte: ...if we took it down to four or five per year, we would be talking in, you know, probably the tens of thousands of that forty some thousand.

Jason Iltz: This is Jason. We're back at balancing that number, how many can we do? Who are the patients right now that are at the most highest risk for problems due to this? And don't get me wrong. They're all at risk, but we need to find that happy medium. And to the points that Patti made earlier and this gentleman up here made, we need to change the behavior, but that's not going to happen over night. And so what I hear on the frontline is when you ask the question, how many inhalers would you like, they pose a question right back to you, and that's how many can I get? And so that's the behavior and the thought process that we need to change in starting to make the restrictions so that you could only get so many. That's...that will help; but I think if you go from some of these people that are getting an average of one a month and say they can't even get one a month, it's going to be a huge mess when we start.

Jeff Thompson: This is Jeff Thompson. What we'll do is we'll take on as much as we can. We'll just start from the 89 and then work down. If we can take on more, we will. We'll be more than happy to work with the Asthma Coalition in just start working it. But right now with all the efforts that we have with our budget cuts, our staffing cuts, it's 89. I think it's the [inaudible].

Patti Varley: This is Patti Varley. And maybe what we could do is in the bulleted form, you might be able to say that what the recommendation is so that we are targeting the highest risk patients, but please look at your other clients and see whether they're following the recommended protocol or not. Again, I think it's an educational opportunity for them; and I would assume as you do those 89, you'll have a better sense of prescribers that are also prescribing for some of the others. So to me, with limited resources, you could use this resource for an additional educational support of, although we're just asking you about the highest utilizers, it's come to our attention that most people in the state are above what's recommended. So I think you could add that as an [inaudible].

Kenneth Wiscomb: Yeah, and this is Ken Wiscomb. I mean, I think we all understand the budget constraints, but I sort of agree with the gentleman from the Asthma Coalition. I mean, if we're going to do this, even realizing that we can't do it in total of we'd like to, those step points that we make seems to me they ought to be based on science and what the standard of care is. And so I mean, it would be interesting to me to know that if you have that data, if you can rerun it and throw out a group that's less than one inhaler per month and see how many people that is, just out of curiosity. But if you have to limit to 89, you have to limit to 89, but I would agree that we ought at some point be reflecting what we feel the standard of care is as a point of [inaudible].

Carol Cordy: This is Carol Cordy. Is there any way, and I realize again without staff it's hard to do this, but to do something to find out whether this works, I mean, with field [inaudible].

Jeff Thompson: I think that would be part of the goal of targeting a small group upfront is that that allows you...you know, if you are engaging in a process that doesn't turn out to work, you're not using lots of resources to send thousands of letters. If you start small, look at the impact on the utilization for those clients, we can determine where the process might need to be fine tuned.

Carol Cordy: Okay. Because I think if we did a 100 and had some follow-up to see if it worked and it was a great thing and we got all these people on rescue inhalers, I mean, on control inhalers, off the rescue inhalers, then there'd be some incentive to do the next 100.

Patti Varley: Right. And this is Patti Varley. And just to play the other side of the field and devil's advocate, being a pediatric person and also having lived with a geriatric person who had inhalers, both those populations tend to lose them a lot. So I just...

Man: You called Chris geriatric.

Patti Varley: No, he's not...so I just would want to make sure that as we do this, we understand that sometimes it's due to the fact that life happens, and my ADHD children with asthma are losing their inhalers. They're not necessarily using them. But again, I think we still need to pursue this, and I think it's still something that needs to be done, but I want to make sure we at least make sure we understand that sometimes it is these other issues that are affecting them.

Siri Childs: Please...this is Siri Childs, and please know that this is not an Albuterol limitation. This is identifying a marker for education. And at this point in time, I think that the recommendation that I'm hearing from the committee is that we'll do this to the extent that we can, but right now the way the data looks is that those clients receiving more than two per month will be our target, and in six months we'll bring you back some data that shows what happened to those 89 patients.

Patti Varley: Great. Sounds good.

Jason Iltz: This is Jason Iltz. The other thing that may be helpful the next time we look at this data to get more towards the science side would be, rather than looking at average per month, is just to look at total number over the period of time that we're looking at or maybe add a second column that one is average and one is just strictly the number over that period. Then we may be able to par it down to get to those numbers that we're talking here that Barak was talking about and what the Asthma Coalition will be recommending as well.

Patti Varley: And this is Patti Varley. I'm assuming your data can go beyond the 89? Because again, my assumption, and maybe it's wishful thinking would be that some prescribers would change prescribing for other clients not in that 89 target if this information is understood by them, and they apply it then to other clients. So would it include data about the others?

Chuck Agte: Yes. This is Chuck Agte. And yes, we could bring the data back to you in that form. We can look at the specific clients targeted and also look and see if we can show if there was a pattern across the board of any sort of shift as well and maybe specific to the prescribers who received contact.

Patti Varley: That'd be great.

Robert Bray: This is Bob Bray. And I mean, maybe a step further would be the other consequences of improvement, you know, can you also show in those targeted patients, a reduction of ER visits for asthma exacerbation? Because ultimately, if they're controlling them, they're not just changing their utilization of the medication, but they're decreasing other expenses and consequences as well. That'd be interesting to see if it reduces that, because that would certainly give an impetus to move forward. I mean, that would bring a new benefit that currently the utilization isn't really seeing all of.

Chuck Agte: Yes. We can include ER data when we bring it back and hospitalization.

Carol Cordy: I just wanted to kind of repeat what Jason was asking for...Carol Cordy. Since these are averages, can the next table be number per year?

Chuck Agte: Yes. This is Chuck Agte. We can format the next information that way. The only reason it wasn't that way this time around is honestly because of resource issues, we only had a chance to make a couple passes at the data when we went into it, and we honestly didn't know if we were going to end up with hundreds of clients getting an average of seven or eight per month, then so we kind of did it at this high level to see how it came out, and we can fine tune that and take it down to the next level to present the data next time.

Barak Gaster: This is Barak Gaster. I guess, bringing it back to what is the scientific basis of what we're talking about. I think that the scientific basis is great for the question of using a long-acting beta agonist without a controller medication, and that was the impetus for this review in the first hand and shows that, generally speaking, the Medicaid prescribing providers in the state of Washington are doing a pretty good job in that regard. And that then to come back to how many short acting is somebody using in the course of a month or a year, the exact data on that, I think, is not as clear-cut and that some of the guidelines that have been made that say that

somebody should not be using their rescue inhaler more than once or twice a week is not as well supported by evidence. I mean, there's no question that people who have poorly controlled asthma have poor outcomes, but the drive to get somebody down to using their rescue once a week is, I think, a little bit more than expert opinion than it is an actual evidence-based finding.

Carol Cordy: Any more discussion? Siri, to you want to move on? Are you doing the...

Siri Childs: I would like to move on, but we need to have a formal recommendation from the committee. Or did you all agree with what we said?

Carol Cordy: We all agreed with what you said.

Siri Childs: Okay. Thank you.

Chuck Agte: Thank you.

Patti Varley: Okay. The next thing that we want to talk about is we want to bring to you what you also asked for at the last meeting when we talked about the high utilization of incredibly high doses of Opiate narcotics. And it's my pleasure to have all of these folks from HRSA here that work with these patients on a daily basis. We have folks from DASA (?) here. We have folks from our quality management team. We have folks from our patients requiring coordination, and they are all here to present this next section. So I'm going to turn this over to Scott Best who's going to lead the presentation, and then each one of these folks will be able to elaborate a little more and to answer your questions.

Scott Best: Okay, this first slide...the second slide was a slide that was brought to you at a previous meeting, at the last meeting, where we were talking about the average morphine equivalents by prescriber, and the question was raised, who are these prescribers? And if you hit the next slide, when we...another question that was also asked was, how many of these prescribers of greater than a 1,000 morphine equivalents accounted for the clients in this group that were at greater than a 1,000 morphine equivalents. And so in an effort to answer that question and also to answer...next slide...the question of how many of these prescribers also were prescribing to clients in this group, we put together a data poll. First of all, this was for fiscal year 2008, and I want to point out...next

slide...that because we have calendar year 2008 now, we pulled for a different group, but it's...many of the prescribers are exactly the same prescribers that were prescribing in fiscal year 2008. So the way that we wanted to answer that question of how many of them is we pulled...for calendar year 2008, all prescribers who met all the following criteria: noninstitution prescribers, so we didn't include hospitals, clinics, or pharmacies, and they provided prescriptions to clients with an average of a 1,000 morphine equivalent dosage per day in calendar year 2008. And because we ended up with hundreds and hundreds of providers, they only had one or two that they had provided medications for, we set a limit so that we would just get the ones who had prescribed to at least five clients on that amount of morphine equivalents, and the prescribers were prescribed...had a maximum morphine equivalent dosage per day of at least a 1,000 milligrams per day per client. That way we know that these are the prescribers who actually put the client at greater than 1,000...put at least one client at greater than a 1,000 morphine equivalents. These are not unduplicated client counts, so that if you...we're going to give you a list of actual providers without the names or provider IDs or anything, and the providers who prescribe to clients in the greater than a 1,000, provider A may have prescribed to him in January, and provider B may have prescribed to the same clients at some point during the day. They may share a client, so they're not unduplicated, and the list does include prescribers who consider themselves as pain specialists, even if they are not board certified as well as those prescribers who are board certified in pain medicine.

Next slide. This is the actual breakdown of the providers. You'll notice up here provider A...and it goes down by, based on clients that they had that were at greater than a 1,000 morphine equivalents. So provider A had 91 clients at greater than a 1,000 morphine equivalents during calendar year 2008, and he also was prescribing for a 172 clients at 180 to 999 morphine equivalents. And because I thought I'd go ahead and throw in the third category, he had 108 clients that were at 120 to 179 morphine equivalents. This total is just a total of all the clients in these categories. It doesn't include anybody that got less than 120 morphine equivalents, and the total narcotics scripts is every narcotic script that they wrote, regardless of who is was for, whether it was a client who got any of these, and it has more to do with this next column which is, dispenses written scripts. One of the things that we find is that a lot of the clients in high over utilizing areas they find that the street price for narcotics if it's brand-

name is much higher than it is if it's a generic; and so if they can get a provider to provide them with a narcotic that is dispense as written at the brand-name, then it will end up...it's enabling some of the clients to get more money street value for the medications that they are being given. And so here in this it tells us how many of the prescriptions were dispense as written, and this is a subset of this group right here. And so if somebody has 1,509 total narcotic scripts and only 10 of them of were dispense as written, that might tell you something more about that provider other than just that he had these various things, and so I'm just trying to outlay some of the profiles that these various providers have for the way that they are prescribing their narcotics. Over here, I've included...

Jeff Thompson: So just to be clear...it's Jeff Thompson. We don't know if there's diversion or if this is abuse, misuse or if it's appropriate use. I think Scott is accurate that the street value for the brand is higher than the generics. We do know...I mean, you've looked at the literature. This is no difference between the brand and generics or between the preferred and nonpreferred, yet you can see that there is a particular selection in the preferred and nonpreferred by providers. I will tell you that the first three providers on this list are now closed down by the DEA.

Man: There's how many?

Jeff Thompson: The first three.

Patti Varley: This is Patti Varley. Can you tell us by letter who on this list is a certified pain management specialist? So like, for instance, is A a...

Scott Best: I can...basically, it's everything from the University of Washington, Harborview, down to a primary care provider on [inaudible].

Patti Varley: No, no, I understand. What I'm saying, though, is if we're looking...I'm looking at the percent...this is Patti Varley again...the percent of narcotic DAW, and my...what I'm trying to, in my own mind, is if I look at S, S has 11 percent DAW. Then I look at BB, and they have 10 percent DAW, and those seem higher than the others averages as do a few others. My question is could...I'm just curious...can you match those with people who are the certified pain specialists?

Scott Best: Well, part of the problem with that is what constitutes a certified pain specialist? The top three prescribers here all consider themselves pain specialists, but it doesn't mean that they were certified in any way, and so there are people who are on this list that are used by others as pain specialists. I couldn't tell you exactly which ones they are off the top of my head, and there are some that I recognize. There are others that I don't really recognize whether they've ever claimed to be a pain specialist or ever been trained in any kind of pain specialist training or anything like that. We do know that in the previous meeting where this was originally...where we originally brought this to you, that the vast majority of these are being prescribed for long-acting back pain, neck pain, shoulder pain, knee pain, headaches, things like that that are not noncancer. These aren't sickle cell anemia. These are not people with severe medical problems or trauma, things like that. Most of these are getting this for pain that's long-acting, long-term back pain or neck pain, shoulder pains, headaches, things like that.

Angelo Ballasiotes: This is Angela Ballasiotes. Can you tie the number of deaths of patients per the doctor or the prescriber?

Scott Best: Yeah, we've done...

Angelo Ballasiotes: Does some things...does one prescriber stand out or a couple of prescribers stand out with the number of deaths they are associated with?

Scott Best: This is Scott Best again. One of the things about that is that the death...the opioid death data that I think we brought to you before started...because we are getting our opioid death data from the Department of Health, the latest opioid death data is for 2007. And so we don't have opioid death data for 2008 yet, but when we looked at opioid death data from 2004 to 2006 which was last year's data, there were providers who were on this list who were also on the list of providers who were prescribing to the clients who died of unintentional opioid overdose.

Jeff Thompson: This is Jeff Thompson. Looking at the names, it includes names that are basically all over the spectrum of the state, M.D.s, ARMPs, DOs, PAs, ones from the university, ones from Harborview, ones from rural communities, ones that are basically board certified pain specialists, and others.

Barak Gaster: This is Barak Gaster. A question that came up last time as well was in the very wide prescribing gap between 180 and 999 mg, and that's a five-fold different in dose; and that if we could figure out a way to split that group in half and report a 500 to 999 and split that out from the 180 to 499, then we probably would get more useful information.

Scott Best: I certainly could do that. I didn't know that that was going to be something that you were wanting.

Carol Cordy: This is Carol Cordy. When you figure out the morphine equivalent dose, what are you using for methadone?

Scott Best: Oh, for methadone, because there's a...on the AMDG Web site, they have a calculator that uses three different doses for methadone. When you're doing it in a query format, you can't use three different dosages, and so it's all calculated at the lowest calculation, so it ends up being 4 mg, I think, of methadone equals 30 mg of morphine equivalence.

Carol Cordy: Okay. So that's more an analgesic equivalent?

Scott Best: Yes. It's an analgesic equivalent.

Barak Gaster: This is Barak Gaster again. So I think it's telling that the top three on this list have been shut down which sure leads you to believe that an awfully high percentage of the top 15 probably should be shut down as well. I mean, so I think that this is a really powerful and useful tool that we should be using in the name of patient safety.

Jason Iltz: This is Jason Iltz. So initially my thought was, oh good, you know, A, B, and C are no longer doing this. Where are all the patients going that were being served by those folks?

Scott Best: And therein lies the problem. Just shutting it down doesn't really do anybody any favors to clients or the providers, because right now when B and C were shut down, 800 clients were basically released in the clinic on to the community, and now are flooding the emergency rooms and other clinics throughout.

Jason Iltz: Right.

Scott Best: So there needs to be a much more aggressive but detailed education around this; otherwise...I mean, honestly, we can't let the DDA be doing our credentialing. It's not fair to the clients. It's not fair to the state. It's not fair to you, but we need leadership in how to address this.

Phyllis Coolen: This is Phyllis Coolen, and this is just one strategy, the narcotic review, which I'm going to be talking about. It's just one strategy of many, and we have been collaborating with the Department of Health. They have a committee that is looking at...and Jamie's on that committee and Jeff and Scott and I on the prevention of abuse and deaths related to prescription opiates, and so like I said, just there's a whole number of activities. It's really exciting, actually, to be involved, because we know this is such...this is a public health issue. There's just a lot of things going on, and this is just one effort.

Angelo Ballasiotes: You know, there's also a large... Angelo Ballasiotes...there's also a large cycle social component, and those have to be addressed together. You can't take one without the other, unfortunately, because it's going to make it even more difficult.

Siri Childs: This is Siri Childs, and I think it's time, unless you have more questions, to let you know what is our next step?

Man: And I'm going to turn the time over to Phyllis Coolen who has the rest of the slides.

Phyllis Coolen: Thank you. As I said, this actually a really exciting times, because there's so much activities around pain management or looking at appropriate use of opiates, not only at a state level but also in the national level. I'm just going to run through some stats here real quick, again, to sort of put things in perspective. Even though the U.S. is number 3 in world population, we have 306 million folks, and we're behind China and India, and they have over a billion people, in 2006, the U.S. accounted for 99 percent of global consumption of Hydrocodone, 80 percent of global consumption of oxycodone. And in 2007...and this is data from the International Narcotics Board...in 2007, the board has seen an increase in sales, both in Europe and in North America of Oxycodone which is up 90 percent in sales and Hydrocodone up 70 percent. Also, a significant increase in Sentinol. Unfortunately, the Pacific...there's some stats here that aren't kind of things that we would like to be known for but unfortunately we

are. The Pacific states which is Washington, Oregon, Hawaii, California, and Alaska we rank the highest in life use and for nonmedical use of pain relievers, and that was information from the CDC. In Washington state, the leading cause of unintentional injury death is poisoning, with over 90 percent of those poisoning due to drug overdose. Death, again, related to prescription opiates continue to rise. We just got the analysis of 2007, and unfortunately, Medicaid accounts for 53 percent of the total Washington deaths that are related to prescription opiates. That's a huge problem for all us. It's a huge problem for Medicaid.

As I mentioned, we are on a subcommittee with the Department of Health...I mean, we're on a committee with the Department of Health, and we're also...I'm part of a subcommittee that's looking at physician education, and it's sponsored by WZMA (?), and Jeff is on that committee, Dr. Kohonas (?) who is the new director of the Division of Anesthesiology and Pain Medicine at the University of Washington, he's also on that committee. So we're talking about what is the best way to educate physicians and then be able to use maybe that model to also work with, say, the ARNPs. But this effort...again, this is the one effort that we're hoping to go forward with, and it's called a narcotic review process.

So next slide. And we also wanted some feedback on this form. Initially, and I think you're familiar with a narcotic review project in which when narcotic requests come in, those are looked at and an information or sheet is faxed to the physician that's...and a 12-month profile of the client saying, is this still appropriate? Do you still want us to fill the narcotics? And it's sort of like a yes or no, and then it kind of stops there. And if it's no, then we don't fill it, but there's no further process, you know, there's not an initial process that goes forth that says, what happens to that client then if they don't fit the drug? Are we doing any education with that prescriber, particularly? So this is the next process. Because in talking and looking at all the research and talking with a pain management specialist in our subcommittee, there are at least three initial tools or assessments that a prescriber needs to be asking their client if they're going to be prescribing medication, and we need to know that. One of the number one questions that a prescriber should be asking about clients on narcotics or they're planning to, what is the functional level of that client? Because for some of our clients, they would just say, well, I'm feeling good or this is really working. Okay. We're going to continue to give you some more medication. And as they build up that addiction or they build

up that dependence, they just want more and more. There's not been a real clear assessment that's been going on, an understanding of what exactly is happening with that client. So I know that like Dr. Kohonas and also some of the other pain specialists, they said, they've got to ask that question. What is the functional level? So that's one of the questions that we have here now. If the prescriber say, yeah, you know, I want to continue that drug, we'll continue that drug, but we'll also be sending this form to them and saying, we also need to know what else is going on with this client. And it's to also help to make...to help them think, again, it's sort of like if they do it for one client, is it something they're going to then think about with their other client. We don't just want to know that they're feeling okay. We want to know what is the function level before and after, during; because if they haven't improved in their functional level, well, why would you increase their medication, or continue on a 1,000 mEq of morphine? That doesn't make any sense.

The other key question again is have you done any kind of assessments on the behavior or substance abuse history of a client? Because if an assessment is done, I mean, that should be a red flag. What we see in the patient review and coordination program is we see clients coming out of treatment, and they've done wonderful. They go to the doctor. They've got a back problem, boom, they're back on heavy-duty narcotics, and we'll just see that continue to increase in the medication. So it's like, well, you know, and sometimes clients are honest and sometimes they're not in terms of saying, yeah, I just got out of treatment, and that I don't want to be on narcotics, but that's something again the prescriber should be asking and doing an assessment on. It's really, really, important.

The other piece, let's see, what's the other one here is? I can't read this one.

Barak Gaster: And we can't read it either.

Phyllis Coolen: Best practices. I know Jeff probably has talked about the 120 mEq, just that's the guidelines. And talking with some of the family docs, we've...you know, some of them have used that. They have found that to be very helpful. Some abuse it because...have said, well, the state says, so we don't mind being the bad guys. Again, it's like at there is something out there for them to be able to look at, review, consider, and then what other best practices. Because for a majority of our clients, for Medicaid

clients, they are on multiple medicines, antipsychotics, as well as all the different other narcotics that they're on. So the idea for the narcotic review plus, is what we're calling it, is for the prescriber to consider tapering the opiate medications. If in fact, the client's doing better, or if in fact, the client's is not getting any better, then maybe again it's to try and taper it. Instead of just cutting off the medication, you want to be...we want to make sure that the client is safe, that they get their drugs, and there's a safe way of making sure that the medication is tapered off rather than just cutting them off completely. I think sometimes we certainly have seen that when we've...when a provider has been terminated, not only by the feds, and clients are on high doses of medication, and they're looking to find somebody who will accept them and who will provide them those continued high doses.

Another important thing, and Jamie know this, was Dr. Franklin recently did a survey of physicians asking about chronic pain and the use of opiates. He found that, certainly, that a majority of family docs do prescribe narcotics. They do see chronic care patients, but they're also very, very uncomfortable in prescribing large amounts of narcotics. So that information is helping the committee to also, again, look at various strategies, and this is possible again part of that effort here are some tools, because there is going to be some links to various tools. Here's some tools. Here's some guidelines, again, for you to use. The other important piece to this is there's a care coordination component. There will be two clinicians who will be working with, not only a patient review clients, but also the nonpatient review clients to really reach out to the physician. We want the physician to be able to, the prescribers, to really be engaged in working with that client and looking at the safety access, the appropriate use of opiates, and again, that's what a number of the prescribers...I mean, the number of physicians on that physician education committee has said is they also want to be able to engage the community. That's what they have to do rather than having somebody from the state just say, this is what you need to do. Do this. Do this. In order for anything to be successful, it's the people in the community, the prescribers on the committee who have to be involved in this whole process and understand it and be willing to make, again, in terms of behavior changes. Also, it's...the care coordination includes not only working with the prescriber but also working with the client, and our patient review and coordination program, our program managers as well as our clinicians work on a daily basis with clients. They're doing a lot of education. They're, again, it's

very hard in terms of some of the behavior changes, but it's that connection, it's that building up of relationship that has really helped considerably, so that's another effort on our part.

Next slide. And I think you might have seen something like this, but this is just an example of narcotics utilization in the past 12 months that we would send to the prescriber who's prescribing narcotics and say, again, here's some recent activities for the client that you may not have been aware of. That they're going to different prescribers. You may think you're only prescribing, you know, one narcotic, but in fact, the client is getting all these other prescriptions, and they're getting it from different prescribers.

Barak Gaster: Is that [inaudible]

Phyllis Coolen: It gives them an overall better picture of what's going on.

Barak Gaster: Yes. This is Barak Gaster. So the idea would be that this report would be sent to all narcotic prescribers?

Phyllis Coolen: Actually, it's narcotic prescribers in the review...in the narcotic review program. One thing I forgot to mention is that because there are thousands of...again, it's sort of like the same issue with the asthma drugs, is we found that in looking at how many clients were on 120 mEq. or more...there was like what? Over 10 thousand or...I mean, so there wasn't a way to actually, again, looking at all those 10 thousand folks at once. So again, we wanted to start at the very top, and we're looking at those 1,000. We've identified 1,000...I mean, clients who are on 1,000 mEq. of morphine.

Barak Gaster: And so all...Barak Gaster...so all those patients, physicians, would each receive this report?

Siri Childs: This is Siri Childs, and the idea is that when the prescription why one prescriber for an opioid for that identified client hits the computer edit, the first thing that we will do is send a 12-month profile with pin form that asks...that says to the prescriber, please note this 12-month profile. Would you like to continue this particular prescription? And if they say, yes, we go ahead and fill the prescription, and then we turn around and resend this 12-month profile with that pin form that Phyllis just described

that goes into a little bit more depth as to have you done an assessment? Have you done such and such, and Phyllis is going to explain what else goes along with that form, but it's to the prescriber of the medication that has just hit the edit for that targeted patient, and that patient is targeted because they've received more than 1,000 morphine equivalent dose per day.

Phyllis Coolen: This is Phyllis Coolen, and we've identified about 700, 750...

Man: 757.

Phyllis Coolen: ...757 clients who currently are on 1,000 mEq. or more.

Patti Varley: This is Patti Varley. So if you look at this list and you look at the last one that's the PA bond and that's the one who writes the next one, they would get that? Would also all the other previous prescribers be sent this as well or just the current person filling it?

Man: I can address that, because the first part of this process we're talking about is based in our current process for this program, and what we do is once the client has been identified as eligible for this program, then each narcotic prescription they get is acted on. So if, say, the doctor at the top has not prescribed for that client in six, eight months, they're never going to hear from us. Not until or unless they write a prescription for that same client again.

Angelo Ballasiotes: This is Angela again. I guess, I may see some holes in that, or a hole in that, but I think it's very important that you educate the physician or the prescriber of this issue that's going on in this state and the West Coast with regards to the problem we're having, number one. Number two, you know, these people buy it with cash, too. You know, they're not going to go through your system, and I think that's a real caveat. I would like to see something a little bit more assertive. I would like to see something with...if a patient comes up and is receiving 1,000 mEq. of morphine, at that time, that person would need a mandatory assessment for abuse, dependence, and mental health.

Siri Childs: Angelo, Let's table that question...

Angelo Ballasiotes: Okay.

Siri Childs: ...until we have a chance to describe the entire process.

Angelo Ballasiotes: Okay, I'm sorry.

Siri Childs: Okay? You're right with us.

Phyllis Coolen: So as the process continues, if a prescriber says, you know, they fill this out, they've sent in the information. Yes, we want to continue this medication. We've sent this pin form. They've filled it out. It then will go to the drug utilization team, and we'll look the whole process. We'll look at what isn't medically necessary. What exactly is going on here? Is it appropriate information that they're giving us? Do we need more information? Those are the kind of things that we're going to be looking at. And then the other process would be is, is if the client might be appropriate for placement into the patient review and coordination program, then that client would then go to, you know, we would make that referral to the patient review and coordination program.

The other piece is we may decide this client really needs...would probably benefit from a second opinion, and so we are coordinating with the University of Washington in that effort and developing some kind of process. Again, that's part of the teaching mechanism, the coordination that needs to go on. This is very, as you know, very, very complicated situation with these kinds of clients, and so what...that's why it's important to have that second opinion if it's appropriate, and so we'd go through that. Or if in fact, that the client...or realize that the client might be abusing the system, then there is way then that we can direct that client to the patient review and coordination program. The idea, again, is for the clinicians to do care coordination, working with that client closely, working with the provider. Maybe the client would benefit from referral to DASA or to mental health services, because those are the kinds of things we ask that prescriber. You know, has a client...maybe the client has some behavioral issues. You know, what's there on the resources? What's out there in the community? And then we'll be able to provide that linkage within.

Next slide. Because it's just another...again, another tool. This is a drug abuse screening tool to share with the prescribers. These are some questions that, again, would be helpful to ask if you haven't asked these

kinds of questions. Have you used drugs other than those required for medical reasons? So you either do that assess...I mean do that kind of assessment. Again, that's giving them a much broader picture of what's going with a particular client. They can...it's just 28 questions in terms of scoring, it terms of at risk, higher risk of drug abuse, and again, then maybe we need a resource and be able to make that referral to somebody in the committee. One of the things that we hear from prescribers is that they want to be able to...if they want to make a referral to somebody in the community or to DASA or to mental health, they want to be able to pick up that phone and call a person. They don't want to be transferred here and there, or they don't know who the person is in the community. It's been changed. So part of the effort is to make sure that we connect...as part of this care coordination is connect with that prescriber and say, we're here to help you, assist you with the management of this client. Here are some resources. Give me a call. If you need some resources, if you need to know who in DASA you need to call, I can help you with that, and then we will be able to do a lot of that coordination that oftentimes gets...that doesn't get done. So that's part of that...part of the whole process, again, in trying to develop strategies that would help to decrease, again, deaths and abuse of narcotics. Again, just not cut patients off completely off their medications.

The next slide is...

Barak Gaster: This is Barak Gaster. Can I ask a quick question here?

Phyllis Coolen: Sure.

Barak Gaster: And it has to do with DASA, and part of this is my naïveté. So does DASA make referrals to methadone maintenance? Like what is the connection between DASA and methadone maintenance?

Deb Cummins: This is Deb Cummins. I'm with DASA, and we certify the methadone clinics. We are also a federal accreditation body, so we oversee these clinics, both in the counseling portion, but also we have medical peer reviewers that come in with us to oversee those. So any type of referral that's made to a certified agency can be done either through our regional offices, through the 24-hour help line, they can make referrals directly that way, or by calling DASA directly, and we can hook people up that way.

Barak Gaster: I mean, I guess one of the main questions that I have is a patient who has chronic pain and who also has opioid addiction, can they get methadone maintenance treatment?

Deb Cummins: If the patient is opiate addicted, so if they meet the diagnosis DSM4 criteria for opiate addiction, then yes then can.

Barak Gaster: Okay, I mean, I have had patients tell me before that they were turned away from a methadone maintenance program, because they were told that because they have chronic pain and they need opioids for their pain, that they cannot get methadone maintenance from the methadone maintenance program. Is that true or not true?

Deb Cummins: It may be a particular program. Maybe a naive clinician. I would certainly like to know about those. There's a very high focus right now on methadone programs and cardiac issues, deaths due to benzodiazepine, and so there's a real focus on methadone right now, even nationally, and the JOA report just came out I think last week that really looks at methadone mortality nationally. So I think they're very cautious. Each program is being very, very cautious, because we do trainings on issues such as this.

Barak Gaster: Okay.

Jeff Thompson: This is Jeff Thompson. I mean, we do have...I know a number of programs that will treat both, the pain and the addiction. It's very differential, and there are some that are doing it outside of methadone replacement therapies also. We know that for a fact. It was my contention that a best practice is that a physician who's treating or an ARNP who's treating at this level with that type of history is best served by working as a team with a mental health professional, a DASA professional, and their expertise as a medical professional. And if you aren't, I think you put both yourself and the client at risk.

Deb Cummins: This is Deb Cummins again, and I wanted to talk a little bit about the screening form. The State of Washington is just wrapping up a federal grant screening and brief intervention therapy where we have placed chemical dependency professionals in the emergency rooms. I don't know if any of you have heard about it. We called it WasBert (?). What it did basically is identify folks that came into the emergency rooms that were

coming in related to either drug use or alcohol consumption or use, and someone would meet with them and use one of these screening tools, the DAST or the audit tool, to basically look at their use to determine whether they needed to either go into brief therapy or go on to a further assessment. The project has been very successful, and this tool, I think, was originally placed into this project to help physicians, ARNPs, PAs, to have a tool to look at their patients. You know, if you do have a question about misuse or addiction, to be able to have something that would just be easy to score and know that, yeah, this person's at risk, and they need to be referred on.

Phyllis Coolen: Next slide, please. And this is just...I don't know if you've seen this before, but this is a toolkit Web site, sort of a one-stop shop that has information about drug use disorders, chemical dependency treatments, contacts went in there, and I know that actually the site is...I don't know the exact numbers, but I know that the site has actually been used a lot, so people and prescribers use this site quite often. They found it to be very, very helpful. So again, that's some information that a link to that Web site will be part of the whole packet of information that does go to the prescriber. I think that's it, or there's a next slide that says, questions.

Ken Wiscomb: This is Ken Wiscomb. I mean, just to sort of be a devil's advocate, we've learned today that we live in a relatively small geographic area or part of the world where 80 percent of oxycodone...or Hydrocodone and 90 percent of oxycodone is utilized. We're talking about a group of people that use, as I remember, Dr. Franklin's recommendation's 120 mEq. per day is the maximum dose. So we're talking about group of people where they're using more than eight times that dosage per day. And if you look at this list, there's clearly providers that are prescribing this...people writing 300 prescriptions a year, and 11 percent of them are for branded pharmacy...there's clearly diversion. There's clearly abuse. You know, sort of to quote that old TV commercial, where's the beef? I mean, it's like it seems like this is a real, nice, soft approach that's going to be real patient friendly, but you know, looking...backing up and looking at a standpoint, it's like maybe always taking a soft approach is why 80 or 90 percent of the abuse in the world is in our country. I mean, does that make sense to anybody else? I mean, it seems like we ought to be working both ends against the middle maybe, and letting the providers know that somebody's now looking at these things, and they're going to be accountable for this stuff.

Siri Childs: This is Siri Childs, and what we've presented today is a dramatic change from what we did previously or what we are currently doing. What we are asking you for today is to approve this process, where for the first time ever we're putting a medical necessity evaluation into the request for narcotics, and we are going about this by first gathering information from the prescriber and giving that prescriber tools and the same way doing almost subliminal education process. And when the information comes back to us, it comes back to use as a multi disciplinary team. Phyllis mentioned that we have a patient requiring coordination representative. We have a drug utilization review team person. We have someone from DASA. We have someone from mental health working all together for that one patient. When the information comes back to us from a prescriber who's resistant to change, what is the next step? The next step probably is going to be a referral to the University of Washington, and the experts at the University of Washington are going to be working directly with that prescriber, and so it's completely different, our proposal, than what we had done in the past. What we had done in the past is we said, here's a 12-month profile. Do you really want to continue this? And if they said, yes, that was the end of it. So you see it's really quite a dramatic step, and so we are asking for your blessing to go forward with this, and you know, try to put some teeth into the process.

Chuck Agte: This is Chuck Agte, and in response to the question about the providers themselves, again, this is one small piece of the growing set of tactics for tackling narcotics, and this is the piece intended to, as Siri pointed out, focus on the clients and help the clients. We do have other processes through her, so that do in fact focus on the prescriber; and if you want to hear any of that, we do have Linda Casten here from our QMT area who does do provider reviews.

Siri Childs: Good Segue, Linda, if you could just comment.

Linda Casten: I'm the nurse...one of the nurses in the quality review area, and...

Man: I don't think her mike's on.

Siri Childs: A little closer to the mike...

Linda Casten: We get a lot of our referr....

Man: They're not turned on.

Siri Childs: Maybe use a [inaudible].

Linda Casten: Can you hear me now? Our area gets a lot of referrals for physicians who are over prescribing. Just this morning, I was working and I was asked to take a look at two clients who the prescriber is writing exorbitant amounts of methadone. So we take a look at that, and obviously when you're writing 2,400 tablets of 10 mg methadone and you're writing it every 30 days, you have to question the medical necessity. So we take it a step further, and we do request the charts and try to discern whether or not the patient's diagnosis really is justified by this exorbitant amount of narcotics. We have prescribers who are writing well into the 8,000 and 9,000 mEq. per day, and it is as Phyllis indicated for lumbago joint pain and just some very benign other diagnoses. So that is what we do. We try to educate the prescribers. We try to work with them, but I see this as our next step in trying to really limit the amount, not to have the patient not get the pain medication that they truly need. Because as a nurse, I really believe that there are patients who do need that, but do they need that level of narcotics? At what point are we seeing an escalation in the deaths? Because obviously when you're on that amount, if you are taking it, there comes a point where you may be confused and forgot that you took a dose, and then you take the next dose shortly thereafter.

Jeff Thompson: I just want to correct a statement she made. For AMBG guidelines and what Gary and [inaudible] have come up with, 120 is not a maximum. 120 is a stop and take a big, deep breath, and [inaudible]...

Man: Recommended. I'm sorry.

Jeff Thompson: ...and consider a referral to a pain specialist, especially if pain and function are not improving. So we're not about no at 120. This issue is, is that there's no general agreement on what is a maximum dose and how do you document that you are getting medical necessity out of an escalating dose of narcotics, and that's what we're faced with.

Man: And that was Jeff Thompson speaking.

Jeff Thompson: I'm Jeff Thompson. [inaudible]

Patti Varley: This is Patti Varley, and I apologize. I had to step out for a minute, but I am wondering if what you are just describing is similar to the second opinion of kids on high-dose stimulants, which is when they are clearly outliers, which again, this state is more generous than the FDA is even, that so again, the guideline of 120 versus the hard stop. But when they're way up there, is this idea of a second opinion where someone looks carefully and closely and tries to problem solve alternative ways of caring for those patients, is that...am I correct?

Man: Yep.

Barak Gaster: Barak Gaster. I would then question sort of what happens in follow-up after that happens. So then they get sent to the University of Washington. The specialist there says, oh, no, this patient should not be on opiates at all. They are suffering from severe substance abuse. So then the referring doctors gets that message. Okay, I'm going to stop, but then that patient goes down the street and finds a new provider to prescribe.

Jeff Thompson: Well, this is Jeff Thompson. We will recommend taper plans.

Barak Gaster: Okay.

Jeff Thompson: And then at that point we can work with Phyllis's program which is a lock-in program, where it's only one prescriber, one narcotic prescriber, primary care, one hospital, so we can work on processes to make sure that there's the least amount of doctor shopping. If it is a cash trade, there's not much we can do about that.

Patti Varley: And this is Patti Varley. I'm assuming that the recommendation would therefore also include sending them to a treatment program.

Barak Gaster: This is Barak Gaster. When they don't show up for that recommended treatment program, then I guess, the key sort of ultimate sort of final stop has to be the lock-in. I mean, that there has to be a lock-in that in order to make the system work.

Chuck Agte: This is Chuck Agte, and that lock-in is one possibility. We also have because of the referral to UW, whatever recommendations come out of there, or if you just have a client who's completely uncooperative, a

prescriber who's not cooperative, we do have the ability once we have that second opinion, once we have our own clinicians looking at the case in detail, dealing with appropriate referrals, we do have the ability that when all else fails, we can actively limit what we will pay for for this client. So there is a point at which in the process, hopefully, cooperating with a prescriber, cooperating with a client, getting them the appropriate resources, then we get a treatment plan from their prescriber who has come on board with the process and comes up with a treatment plan to taper them, to get them to appropriate doses, or off of a medication. But even if everybody is not cooperative we do ultimately have the ability that based on the feedback our clinical staff get from UW to look at putting together an appropriate taper of what we're willing to pay for. Even if a doctor doesn't come on board with us, we can't find a single physician willing to treat them, we can still say based on clinically established guidelines for tapering a client we're going to let you continue where you are right now, but next month you're getting this much less and that's all we'll pay for. And so that is the least preferable outcome of the program because really the idea would be to try and get a prescriber cooperating with a reasonable treatment plan. But there is ultimately teeth in the process if there is no cooperation along the line.

Ken Wiscomb: This is Ken Wiscomb and I guess...and I realize our primary concern here is the patient. And I'm not trying to suggest it shouldn't be, but my concern is that, you know, I grew up in Chicago where the mafia owned the liquor stores and, you know, nobody had an incentive to do otherwise because booze was cheap. And it seems to me if a provider is making lots of extra dollars off a partnership with a client that he's writing [inaudible] and narcotics to or just off the patient visits from people that he's giving narcotics to he's going to have the ability...he or she is going to have the ability to string this process out for a long, long time before that stops. And there's not going to be any incentive for that provider to drive their patient/clients towards the supportive process that you're describing. In other words the more sort of underhanded they are, you know, the more they're going to be stringing it out.

Jeff Thompson: Well, this is Jeff Thompson. That's why we have the Board of Pharmacy and that's why we need your help. I mean at some point in time, you know, we'll be more than happy to invite them to a closed meeting where you can ask them questions. But at this point in time there is no general agreement about where is a line of too much. There is no abuse/misuse of

narcotics as it relates to a community standard. And that is what we are struggling with and why we need your help is to establish that community standard because it can't just come from DOH and it can't just come from DSHS. And that is the big struggle.

Angelo Ballasiotes: I have two comments. The Center for Disease Control states that in their statistics that 80% of people incarcerated either have a mental illness and/or a substance dependence type problem. I do see that by practice. They are in and out of jail, in and out of prison. The other comment I want to make is I would like to see very much DOSA and Mental Health work together as a team. The word on the street is they might not be doing that. There might be some competition going on and I don't think that benefits the community. Those are my comments.

Jeff Graham: This is Jeff Graham speaking. I'm just sitting here observing and a few things I've observed or I think I'm hearing is that not only are we a country as our Secretary of State Clinton has said that demands illicit drugs and causes a problem within the world that we also demand legal drugs because we have this high rate of utilization of what we call legal drugs in the world. If we have a hammer and we want to slam everybody in the prisons and then we have those kinds of problems. But Jeff is there anything going on nationally? I mean this is being recognized in every state I believe and I know you're doing some other work in other areas. But is there any way to look at this just...I mean instead of just Washington by themselves doing it?

Jeff Thompson: This is Jeff Thompson. What is interesting is, is that this is a unique problem and only a handful of states...states that you would think that would have a problem like New York and California don't have this problem and we don't really know why they don't have this problem. Is it because of triplicates? Is it because of prescription monitoring programs? There really is not a clear understanding and so we're actually in unknown territory. I think there are some best practices like the CASPR program out of Kentucky, but we don't have funding any longer for the prescription monitoring program. The tamper proof prescriptions will be coming online. I guess the governor is going to sign that legislation.

Siri Childs: Oh good.

Jeff Thompson: So everybody will have to use tamper resistant prescription pads. So hopefully that will help, you know, in some of the instances. But I think we're in unknown territory.

Angelo Ballasiotes: Angelo Ballasiotes again. I want to make a comment on methamphetamine. That was more of an issue on the West Coast here and now it's moved to the East Coast and nothing was really done about it and we didn't get much help from the federal government it seems to me until it got to the East Coast. And that was kind of where the population is and then it gets a little bit more exposure across the nation.

Phyllis Coolen: This is Phyllis Coolen and the CDC is actually...has taken a leave. They recognize that abusive narcotics or opiates is a public health issue and so they've done...like Dr. Palazo has done a number of congressional hearings and has presented his studies, and various studies, at congressional hearings and they have gathered various states together to talk about the issue, what are some strategies, what are some things that all of us can learn from each other in terms of helping each other combat this whole issue. We do know that there are a number of states that do have the Prescription Monitoring Program. Unfortunately for Washington State, we didn't have the funding to continue that program. But that's, you know, that program would allow prescribers to be able to look at either real time or at least maybe a week delay to look at what exactly medications or actually specifically narcotics a person has been provided with and that would help in terms of their overall prescribing methods. So there's a number of studies that are going on in that whole arena. It's, you know, it's just a very complex and long process that as Jeff had said, "We're in unknown territory that we're stepping into." That's why it's kind of an exciting area to be involved with. I know that Caleb is applying for a grant to, again, a big grant to look at the whole issue and maybe develop a prescription monitoring program.

Jaymie Mai: This is Jaymie Mai. I just want to add or answer Jeff's question. Actually, the FDA is at attention now with the CDC working...looking at all the deaths...that a couple months ago the FDA actually sent out notice to manufacturers of Schedule 2 opiates. They are I think under discussion with the manufacturers about possible risk management programs for those drugs. So we'll wait to hear what they come up with but I think that's a positive sign in terms of on a national level that they are starting to

notice that there is an increase in opiate related death and they are starting to look at that.

Jeff Thompson: This is Jeff Thompson. I think there are states we can look at as to how not to do it. West Virginia, you know, where Oxycontin was thought to be safer and now that's the hillbilly heroin, Vermont where suboxone was thought to be the answer and now suboxone is the number one abused and sold drug in Vermont. And so there are a number of programs that we can look to about where not perhaps mistakes were made, but just how to basically stay out of trouble.

Barak Gaster: This is Barak Gaster. So I think coming back to Siri's request I think we, as a committee, can strongly endorse this project. It's a great step in the right direction and I think looking at all of the components of it the piece that I predict would have the highest impact would be the 12-month narcotic utilization report only because my guess is that a lot of the providers who are writing prescriptions for the 700 clients getting more than 1,000 a day are not aware that their patients are seeing other providers as well. And that the simple information that they are will probably lead many of them to cut those patients off. And so I think that is great and I would even advocate for a future step moving down on that cutoff. Rather than the 700 clients getting more than 1,000 that it would be the several thousand clients who are getting more than 500 as also a group of clients who likely have a very high incidents of prescription drug abuse.

Siri Childs: Thank you very much. This is Siri Childs and that is exactly our plan. We would like to start this process. If everything goes well we'd like to start it August 1st. And as we start this we recognize that this is going to go on forever. We will continue our march through these milligrams of opiate dosing until we can get to our goal of, you know, are the folks in Washington state following the opiate guidelines? So it will take us a long, long time, but we want to start August 1st if possible with your blessing.

I have one other document to draw your attention to and that was the handout that I gave you for your binder. This letter is the cover letter for this packet that we're putting together. Remember that we're going to send the 12-month profile, the PIN form asking for medical necessity, and this cover letter that Jeff has written will introduce the process and tell

why we are asking for the information. So I just wanted you to see that and have that be part of the packet that you recommend that we start using.

Patti Varley: This is Patti Varley and one editorial comment would be the last sentence of the first paragraph be in bold dark type.

Barak Gaster: This is Barak Gaster. Another suggestion is the second question, “How do we identify clients for review?” And I would say, “Our clinical staff has identified clients with greater than 1,000 morphine equivalent dosage,” you need per day there to make that clear.

Siri Childs: Thank you.

Bob Bray: This is Bob Bray. Just for clarification the second opinion to University of Washington pain folks is for that population, over 1,000 equivalents per day and that will include travel costs for those folks that are outside the Puget Sound area?

Siri Childs: Uh huh.

Bob Bray: And thank you for doing that. I think that’s a huge stumbling block for people getting second opinions from my end of the state. So the fact that that will be covered is very...appreciate that.

Jeff Thompson: And just to be clear that what we’re anticipating is, is that there will be two levels. There will be a record review with recommendations and a phone consultation and if then necessary then a face-to-face with an intervention that they have to identify, you know, a number of different issues.

Carol Cordy: This is Carol Cordy. I have a couple of just more practical questions. You talked about figuring out the morphine equivalent dose by having methadone 4 mg to 30. But the other part of the guidelines that are...I can’t remember which website that’s on are recommending that you seek a second opinion at 40 mg of methadone. I’m just curious as to why that difference is there? I mean it says 120 equivalents of methadone, but it says 40 rather than 16, which is what the dose would be. Can anybody comment on that?

Jaymie Mai: This is Jaymie Mai. The specialists when we were working on the guideline, the specialists actually had a great discussion, lengthy discussion about whether or not the number of people...I mean essentially you'd be cutting off...the cutoff would be about 20 mg of methadone. That's when you're going to seek a second opinion or a consult. I think they had great discussion about whether or not we have the capacity in the state to be able to handle the number of consults. And so I think they sort of said, "Okay, for methadone let's just start with 40 and see where we go with that." And so that's how that was arrived. But they called that out particularly.

Carol Cordy: Because I would say...I'm in a residency program. That is really confusing to residents to get their head around and they are thinking, "Okay, 40 of methadone is equivalent to 120 of morphine," if I had been at that meeting I might have argued to make it...

Jaymie Mai: This is Jaymie again. The calculator when we developed that had a very difficult time and I think if you look at it carefully it said it is not equivalent.

Carol Cordy: The other question just in light of Jeff what you were saying about Vermont and suboxone. Does the state have any plans to change their suboxone coverage?

Siri Childs: This is Siri Childs and the answer is no.

Jeff Thompson: I will qualify her no. So we...this is Jeff Thompson. We are doing some pilots. So with working with Pat Knox out of King County if somebody wants to get off methadone replacement therapy we are working with her to use suboxone for a more extensive inpatient/outpatient period so that people can transition off of methadone replacement. We are also looking at opportunities where we are transporting clients to and from methadone replacement clinics. It's about \$4 million a year in transportation on a daily basis. We are looking at setting up other suboxone clinics that if you could offset transportation costs and that pencils out that it's less money we'll set up those suboxone clinics. So we are looking at other opportunities but it has to be within the funds that are available and we can't kill ourselves.

Siri Childs: This is Siri Childs adding to Dr. Thompson's statement. In each of those pilots we do expect that the protocol that we have in place will be followed. He agrees.

Barak Gaster: This is Barak Gaster. And so I have three recommendations for going forward and I'm going to put them in order from the easiest to tackle to the most difficult to tackle. And so I think the easiest to tackle recommendation has to do with the toolkit. And so on the toolkit the key to getting this 12-month history is getting the patient's consent and so there's a link on this toolkit page to go to a DSHS release form and my recommendation would be that a specific release form for this program be developed that's quicker and easier to use and more directly...and easier to understand how it relates to this program. But this generic DSHS release form is long and complicated because it needs to serve all the possible functions that DSHS release has to do with. But I would recommend coming up with a more focused release that is specifically just to get a 12-month history of medications.

Chuck Agte: Before you move on this is Chuck Agte. Currently for the narcotic review program just for the profile of the medications we don't need a release and we don't require it for that.

Barak Gaster: I understand. That's only going to capture 700 clients currently whereas I think this toolkit and this 12-month history with the release form is a really powerful tool that will capture many, many more than those 700. And we have started using it at our clinic but have developed a specific release form for use in our clinic because I know that if I just ask the providers in my clinic to download and use that DSHS consent form that they're not going to do it because they're going to look at that complicated release form and then said, "I don't have time to deal with this today." That's my first and easiest to tackle recommendation. Another suggestion would be that...I mean I think that the big elephant in the room is still the Medicaid patients paying cash for their opiates. And so I'm thinking about whether a pharmacist can refer someone to this narcotic review program when they encounter a patient paying cash for a very large prescription for opiates.

Phyllis Coolen: This is Phyllis Coolen and actually the pharmacists have been really extremely helpful and have been our eyes and ears out there in the community. And when patients do come in paying, you know, wanting to

pay them a lot of cash they actually make that referral to the patient review and coordination program. And so we review those and also look at the cash transactions that are going on and will often times place that client on restriction. But we do need...and I know that...

Barak Gaster: What does restriction mean?

Phyllis Coolen: It means that the client is restricted to one primary care provider, one pharmacy, one narcotic prescriber and one hospital for non-emergency use. I know that Siri has discussed a number of times with WISPA(?) regarding accepting cash for a covered service. Often times though what happens is a client will deny that they are on Medicaid. They don't show that they have a coupon or if a pharmacy says no, you know, "I can't fill it." They'll just go down to the next pharmacy. But we do get those referrals. We've been very good about providing those referrals.

Barak Gaster: I guess I can see how you can get sort of the immediate referral into the lock-in, but then...I mean I think you're doing a great job of developing this program that is going to cast a wider net than just those...to me you're trying to funnel more people into that lock-in, which is sort of the final sort of end point to the narcotic review program. And so I guess I would wonder whether if pharmacists had an opportunity to refer someone upstream there. So that rather...or give the government, the state government, an opportunity to...rather than make the tough call so you get a...you get a referral from a pharmacist. Right now without this narcotic review program then Medicaid's only choices are either to lock them in or to sort of file that concern away and not be sure what to do with it. So I guess I would build into this narcotic review program that patients are referred to it if they've got more than 1,000 a day of mil equivalents or if a pharmacist or a provider has referred their name for concern. It would be just a streamline, funneling process for Medicaid to...because of now it sounds like you get a phone call from a pharmacist and then you struggle with whether to lock them in or to file that concern away. And so I guess I would sort of put in a plug for using this narcotic review program as another option for when you get somebody's name. There I'm specifically thinking because if that can then lead to these automatic 12-month narcotic review reports going out...because I think some of the patients who are paying cash for their opiates are probably not always paying cash. They probably sort of have in their minds that they can probably get away with charging Medicaid once a month and then the other times they are

going to pay cash. And so when they do use Medicaid once a month for their high dose opiate that that is going to trigger this report and it will probably capture at least some of the doctor shopping clients.

Phyllis Coolen: This is Phyllis Coolen and I agree. That's also a good...that's another good strategy to encourage those pharmacy...particularly pharmacy providers to make a referral either to this narcotic review and also the patient review program. Just for clarification is that we actually run, from our patient review, we also run monthly algorithms on high narcotic users and high ER users. So often times those clients who are paying cash will actually fall under one of those categories. It's not unusual and so we do see those folks. And then also again in terms of just the whole coordination effort; if we do see that there is a prescriber who's prescribing a lot of the medication. So it's not only the clients paying cash, but you've got a prescriber. We send those prescriber names over to Linda to review. So there's a lot of coordination effort that is going on within HRSA on this whole issue.

Jeff Thompson: So this is Jeff Thompson. If we though increase the roles we also have to increase the number of providers that service Phyllis' program and right now we're having great difficulty. I would say if everyone would just take one then we wouldn't have to have those kind-hearted that would take 10.

Barak Gaster: This is Barak Gaster. Which is why I'm a little bit skeptical about the success of this referral to the expert part of the program just because I have a feeling that if we were to really utilize a narcotic review program to include the number of clients that we probably should be in this state there is no way in heck that you're going to find enough doctors that who are willing to provide all of those consultations, which is why I come back to...in my mind the piece of this program that has the most sort of easy teeth to it is the narcotic utilization report. And so I would circle back to that as being the sort of low hanging fruit which we should be utilizing more. And part of the reason that I'm thinking about pharmacists and providers being able to directly refer somebody to a narcotic review program is that...I mean as I have started to encourage providers in my clinic to use this 12-month history from the toolkit I get struck with...I can think of five patients who we've used it on in the past three months and of those five, three of the five came back sort of with egregious doctor shopping, which made it very easy for us to say, "We're not going to be prescribing opiates for you anymore from this clinic." But the

discomforting feeling was that then it was just going to be very easy for them to go down the street and go somewhere else and there was no way to report that person as somebody who should be...who should at least be sort of monitored more carefully by Medicaid. We used your toolkit, we found somebody who was at a very high risk of inappropriate use and, you know, all we could do is sort of shut our door to them and let them go somewhere else. And so that if providers had a way to refer a patient to a narcotic review program like this I think that would add a lot to increasing the identification of patients who are misusing and I think that it's especially...in that it will lead to these narcotic utilization reports that are...they're a lot cheaper than the consultations and are sort of readily available in that we've got the computer system to do it. Whereas we don't have the large cadre of specialists to provide these consultations.

Bob Bray: Do you have one more coming?

Barak Gaster: No. I actually folded the pharmacist triggering refer and the provider triggering referral is one big suggestion.

Bob Bray: I just wanted some clarification on those patients that get locked down. You mentioned they have one prescriber. In the past that was recognized as one prescriber location. So it would be Family Practice Spokane as opposed to Dr. Bray. There's a huge problem to lock them down to one prescriber because they're not always there when the prescription is being refilled. It would be similar to saying, "You can go to Rite-Aid, but you can only see Frank when you get your prescription." And so are you doing it that way where you're locking them down to one prescriber group? Or are you trying to lock them down to one prescriber for all their narcotics? Because I think that's really hard to do. It came up in my practice where one of the physicians went on sabbatical and the patient was told they can't get their prescriptions because it wouldn't go through.

Phyllis Coolen: This is Phyllis Coolen. Actually we do restrict clients to a clinic, you know, often times in working with that clinic that sometimes the clinic will say, "We want that client to see only Dr. Frank." But we do add into the system that clinic number because we know that there are a number of other prescribers within that clinic who may be seeing the client and we don't want to create barriers for that client to be seen.

Bob Bray: I guess what I would say is that's not always done by all of the Medicaid providers. I can tell you offline about one in particular that's a managed Medicaid provider that was trying to lock down to one individual and it was very difficult to accomplish the task.

Barak Gaster: This is Barak Gaster. I have a question. I think "lock in" is probably better than "lock down". So with going back to this "lock in" program. So if a patient complains to Medicaid and says, "I don't get along with this provider group. I need a different provider group." Then do they get to switch to a different lock in?

Man: When they're locked into the PRC program they're initially locked in for an initial two-year period and if they just don't like their provider then that's not a reason to change providers. If they, however, change to a different location, like they move, or their provider moves then we can change them to a different provider. Otherwise...or if the provider says, "I'm not going to take care of your client anymore." Then of course we can change them. But just because they want a different provider they're locked into that provider for two years initially, three years after that and then six years for each successive period.

Barak Gaster: This is Barak Gaster. What is going to happen is they are going to be locked in. That provider group is saying, "I don't think that chronic opiates are appropriate for you and then they're going..." That client is going to say, "That doctor group I don't like them. I don't get along with them. I need a different doctor group." But they won't have that option for two years.

Man: We have that happen every day. We have 3,000 clients in PRC and we have calls every single day about, "I just can't get along with him. He's not giving me what I need." And we always support the doctors.

Man: That's the way it goes.

Siri Childs: How about wrapping this up with one nice recommendation?

Carol Cordy: Barak, would you like to make one? Well, it looks like what you've asked for is for us to approve HRSA's process to incorporate medical justification into the new narcotic review process.

Siri Childs: That's right.

Carol Cordy: Would everybody agree that we would like that done?

Angelo Ballasiotes: Do we have a timeline for follow-up or any follow-up in there so we can see where progress is made?

Siri Childs: How about if we say that we'll bring it back in a year?

Man: Can we say a year from implementation since the implementation date is in question? There are some budget constraints.

Siri Childs: How about August 2010?

Carol Cordy: Is that good enough? Does everyone agree?

Group: Yes. Yes, we all agree.

Carol Cordy: Okay. So we will adjourn until June...oh, another comment.

Cathy Williams: Yeah. I was waiting until you made your final decision and feedback. I wanted to say that I had a long conversation with Caleb [inaudible]. This is Cathy Williams by the way, yesterday. And he has made an offer to DOH to fund the PMP for four years if he gets the life sciences grant that Jaymie has been talking about. He anticipates a final notification by July 22nd. There's been some delay. He was supposed to find out next month, but because this funding is tied to tobacco settlement money and thus to the state budget there's been a delay. But if he gets the full grant; he's already made the offer. DOH knows, Barry [inaudible], Karen Jensen, Steve Saks, that he will fund it for four years. By statute it has to stay at DOH, but he would pay the software vendor directly, fund it for four years, and because he is such an amazing researcher he's going to look at the outcome data and he wants to maximize the use of the PMP by physicians to best effect their practice. So he's going to do something with the data, patient level analyses, prescriber level analyses, dispenser level analyses that no other state has done, been interested in doing. This is cutting edge work that he's going to be doing and I want you to be aware of it, I want you to push for this and remember it. If he gets the grant he'll fund the PMP for four years. And it won't take much for the PMP to become self-sustaining. Just one small impact on drug utilization,

physician practice patterns has an incredible bang for the buck. So believe me it won't take long for it to become totally self-sustaining. So stay tuned. We're hoping he gets the grant and DOH has not said that they will accept it, but I want everyone else to know that he's made that offer.

Patti Varley: This is Patti Varley. Can you define the acronym?

Man: PMP?

Cathy Williams: Oh, Prescription Monitoring Program. The one that just got cut.

Siri Childs: Which is a great deal.

[applause]

Cathy Williams: So this will give you your data, Barak and Phyllis. You'd have all the data you need to identify patients. There would be no guessing whatsoever.

Barak Gaster: So this is Barak Gaster. One more quick suggestion. This toolkit, again, is awesome. There's lots and lots of useful stuff on it. It is really, really hard to find on the web. So I guess you're mailing this 48-character URL to people for them to type into their browser, but most people are going to want to Google it and I will tell you that trying to find this website is almost impossible. And so I don't know...there are computer tricks to tag your web page to make it findable by Google and right now they are not there.

Carol Cordy: Can you...there's no way to link it the rx.wa.gov?

Man: It is.

Carol Cordy: Oh, it is?

Man: It is on the AMDG guidelines. It is also on rx.wa.gov, but we can...if you're just looking for this it's hard to find it.

Siri Childs: It's going to be on that pen form and it's going to be on Jeff's cover letter too. So it's going to be on two places that go out to each prescriber.

Man: If you're a computer person you want to get it through Google. You don't want to have to read it off a piece of paper.

Man: You remember going to the meeting and hearing about it two months and then you're there with the patient and you want to find it and you can't.

Carol Cordy: Okay. Can I adjourn? We will adjourn until June.

Siri Childs: Thank you all so much.