March 1st, 2006

The next North Dakota Drug Utilization Review (DUR) Board Meeting will be held May 1st, 2006 at 1:00pm

Pioneer Room
State Capital
612 East Blvd
Bismarck, ND

Please remember to silence all pagers and cell phones prior to the start of the meeting.

North Dakota Medicaid
DUR Board Meeting
Agenda
Pioneer Room
May 1st, 2006
1pm

1. Administrative items
   - Travel vouchers
   - Board Members Sign In

2. Old Business

• Review and approval of minutes of 02/13/06 meeting	Chairman
• Budget update	Brendan Joyce
• 2nd Review for Sedative/Hypnotic Agents	HID
• 2nd Review for Growth Hormone and Related Products	HID
• Yearly review of ARBs and ACE-Is	HID
• Update on SROA mailing	HID

3. New Business

• Criteria Recommendations	Brendan Joyce
• Upcoming meeting date/agenda August 7th, 2006	Chairman
• Executive Session	Chairman

4. Adjourn — Chairman

Please remember to turn all cellular phones and pagers to silent mode during the meeting.

Drug Utilization Review (DUR) Meeting Minutes
February 13th, 2006

Members Present: Albert Samuelson, Greg Pfister, John Savageau, Patricia Churchill, Carrie Sorenson, Cheryl Huber, Leann Ness, Norman Byers, Scott Setzepfandt, Gary Betting, Bob Treitline

Medicaid Pharmacy Department: Brendan Joyce

HID Staff Present: Candace Rieth

Members Absent: Jay Huber

Chair J. Savageau called the meeting to order at 1:00pm and asked for a motion to approve the minutes from the November 7th, 2005 meeting. N. Byers moved that the minutes be approved and C. Huber seconded the motion. The chair called for a voice vote to approve the minutes, which passed with no audible dissent.

Budget Update:
B. Joyce reported the appropriations as of 12/31/05 were $20,712,942. Actual expenditures were $20,564,342.

Review of Acto*plus* met:
C. Rieth reviewed Acto*plus* met. The board approved to place this medication on prior authorization in November and this is the 2nd review. Actos alone is a once a day dose; in combination with metformin, there is concern that Actos will become a twice a day dosed medication to ensure appropriate metformin dose. There was no public comment on Acto*plus* met. N. Byers made a motion to place Acto*plus* met on prior authorization. A. Samuelson seconded the motion; the motion was approved by voice vote with no audible dissent.

Yearly review of Prior Authorization
Legislation requires a yearly review of the status of prior authorization. C. Rieth reviewed 3 classes, Antihistamines, COXII/NSAIDs, and Proton Pump Inhibitors. Cost avoidance numbers, market share reports and prior authorization forms and criteria were reviewed. Savings through November 2005 were approximately 2.9 million dollars.

SROA Physician Survey:
At the November DUR meeting, the board voted to send SROA letters and surveys to physicians prescribing these opioids on what appeared to be a prn basis. C. Rieth gave the board an update on the mailing. The first week of January, 132 letters were mailed and as of February 10th, 116 surveys were returned. These surveys will be reviewed and the information will be presented at the May meeting.

'I Confirm' Effect on Prior Authorization
B. Joyce reviewed the 'I Confirm' statement that is currently on the prior authorization request forms. A graph shows that the number of PAs approved based on the 'I Confirm' statement have progressively grown over the last 6 months. Chair J. Savageau made a statement that the ARB percentages had increased to greater than 50% in the short time that the class has been on PA. The chair made the statement that this contradicts what is shown in the literature. J. Savageau recommended that the Department watch the progression closely and suggested that the Department act upon the increased growth.

Review Sedative/Hypnotic Agents
C. Rieth reviewed the Sedative/Hypnotic class of medications. The suggested criteria for PA would require a failure of Ambien (Zolpidem) before other single source Sedative/Hypnotics would be covered. A. Samuelson requested more information be provided at the May meeting regarding usage of this class. Market share information will also be provided. There was public comment by Tim Butler, Account and Leadership Development Director for Sepracor. He spoke against the board implementing a prior authorization of Sedative/Hypnotics. Janet Raddatz spoke, representing Sanofi Aventis. She reviewed Ambien related information with the board. Gary Dawson, representing Takeda, reviewed Rozerem related information with the board. N. Byers made a motion to proceed with the PA form and criteria included in the review. A. Samuelson seconded the motion. This topic will be brought up again at the next board meeting for finalization.

Review of Growth Hormone and Related Products
C. Rieth reviewed growth hormone and related products. Placing growth hormone products and IGF-1 products on prior authorization would allow the Department to review each claim for clinical appropriateness. There was no public comment on Growth Hormone and Related Products.
G. Pfister made a motion to place growth hormone and related products on the prior authorization program. C. Huber seconded the motion. This topic will be brought up again at the next board meeting for finalization.

Review of Recommended Criteria:
B. Joyce advised the board that the enclosed recommended RDUR criteria are developed from product information provided by the manufacturers and usually are consistent with new indications, new drugs added, new warnings, etc. These criteria will be added to the current set of criteria, and will be used in future RDUR cycles. C. Huber moved to approve the new criteria and P. Churchill seconded the motion. The motion was approved by voice vote with no audible dissent

The next DUR board meeting will be May 1st, 2006. A. Samuelson made a motion to adjourn the meeting. C. Huber seconded. Chair J. Savageau adjourned the meeting at 2:40 pm.

NDC USAGE for nd_sedhyp from 01/01/05 to 12/27/05 for Program ndu				
Rx Num	**Qty Dispensed**	**Total Price**	**Label Name**	**Market Share**
3378	93015	$270,980.36	AMBIEN	77.61
92	2378	$7,364.20	AMBIEN CR	2.11
40	1320	$826.09	ESTAZOLAM	0.24
28	1027	$242.12	FLURAZEPAM	0.07
526	14199	$47,120.16	LUNESTA	13.50
19	551	$1,526.61	RESTORIL 7.5 MG CAPSULE	0.44
33	879	$2,174.94	ROZEREM	0.62
155	5026	$14,460.90	SONATA	4.14
364	11015	$3,254.73	TEMAZEPAM	0.93
81	2828	$1,193.25	TRIAZOLAM	0.34
4716	132238	$349,143.36		

Totals:

- **Patients 1281**
- **Physicians 494**
- **Pharmacies 187**

Health Information
Designs, Inc.
334-502-3262

North Dakota Medicaid
Recipients Receiving 2 Or More Sedative/Hypnotics overlapping each other for at least 28 days
01/01/05 - 12/31/05

2/24/2006

Non Duals
Recipient Total: 32

Health Information
Designs, Inc.
334-502-3262

North Dakota Medicaid
Recipients Receiving Consecutive Therapy Of Sedative/Hypnotics
Over the Year 2005
01/01/05 - 12/31/05

2/24/2006

Non Duals
Recipient Total: 45

Sedative/Hypnotic PRIOR AUTHORIZATION
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving a new prescription for a name brand Sedative/Hypnotic must use Ambien® (zolpidem) as first line therapy.

****Note:***

- **The PA will be approved if there is a failed trial of Ambien® (zolpidem)**
- **Estazolam, flurazepam, temazepam, triazolam, quazepam and Ambien® (zolpidem) do not require a PA**

Part I: TO BE COMPLETED BY PHYSICIAN

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG:	**Requested Dosage:** (must be completed)

Qualifications for coverage:

❑ Failed Ambien® (zolpidem)	Start Date:	Dose:
	End Date:	Frequency:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Physician Signature: Date:

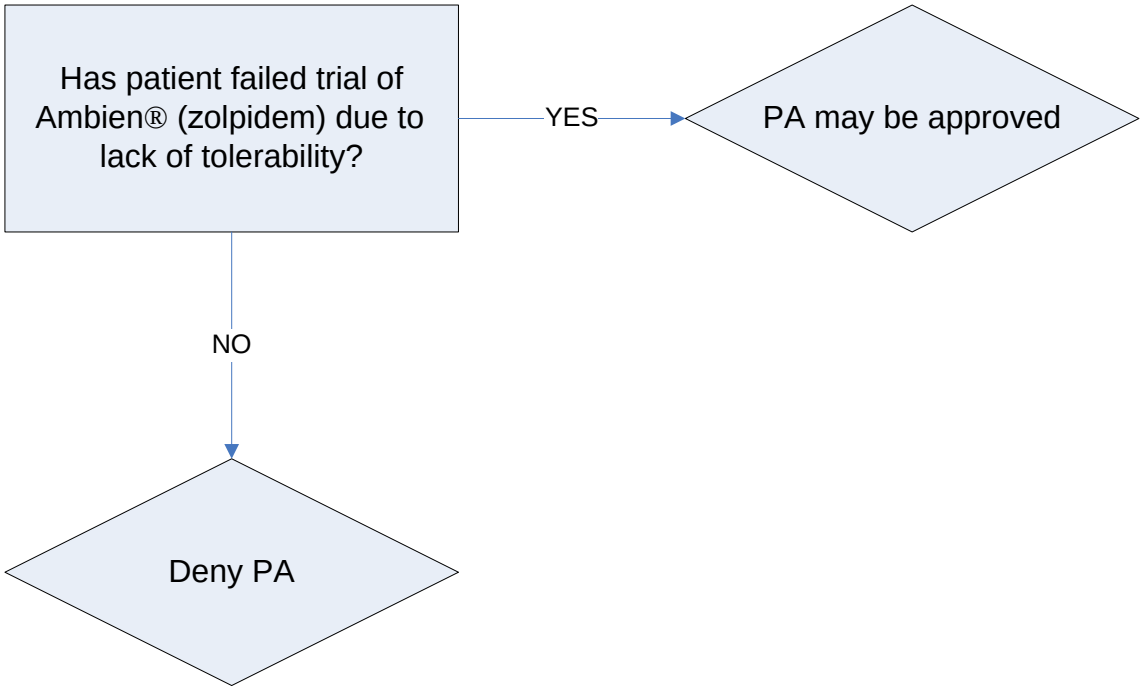
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Sedative/Hypnotic Authorization Algorithm



NDC USAGE for nd-growthhormone from 01/01/05 to 12/27/05 for Program ndu						
NDC Code	**Rx Num**	**Total Price**	**Label Name**	**Patient Count**	**Patient Age**	**Providers**
13264681	24	$24,300.11	GENOTROPIN 13.8 MG CARTRIDGE	2	17 and 7	2
13264694	6	$5,331.21	GENOTROPIN 13.8 MG CARTRIDGE	1	15	1
13265002	9	$4,739.25	GENOTROPIN MINIQUICK 0.4 MG	1	1	1
13265102	1	$791.73	GENOTROPIN MINIQUICK 0.6 MG	1	1	1
44087108801	5	$366.33	SAIZEN 8.8 MG VIAL	1	7	1
50242002220	8	$1,112.43	NUTROPIN AQ 5 MG/ML VIAL	1	3	1
50242003235	3	$3,435.02	NUTROPIN DEPOT 13.5 MG KIT	1	11	1
50242004314	10	$11,482.90	NUTROPIN AQ PEN CARTRIDGE	2	18 and 11	1
TOTAL	**66**	**$51,558.98**		**8 individual patients**		**3 individual providers**

Growth Hormone PRIOR AUTHORIZATION
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving Growth Hormone meet one of the criteria below:

- **GHD in children and adults with a history of hypothalamic pituitary disease**
- **Short stature associated with chronic renal insufficiency before renal transplantation**
- **Short stature in patients with Turners Syndrome (TS) or Prader-Willi Syndrome (PWS)**
- **Infants born small for gestational age (SGA) who have not caught up in height**
- **Human Immunodeficiency Virus (HIV) associated wasting in adults**

Part I: TO BE COMPLETED BY PHYSICIAN

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG:	**Requested Dosage:** (must be completed)

Qualifications for coverage:

Criteria met:	Diagnosis Date: Drug:	Dose: Frequency:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Physician Signature: Date:

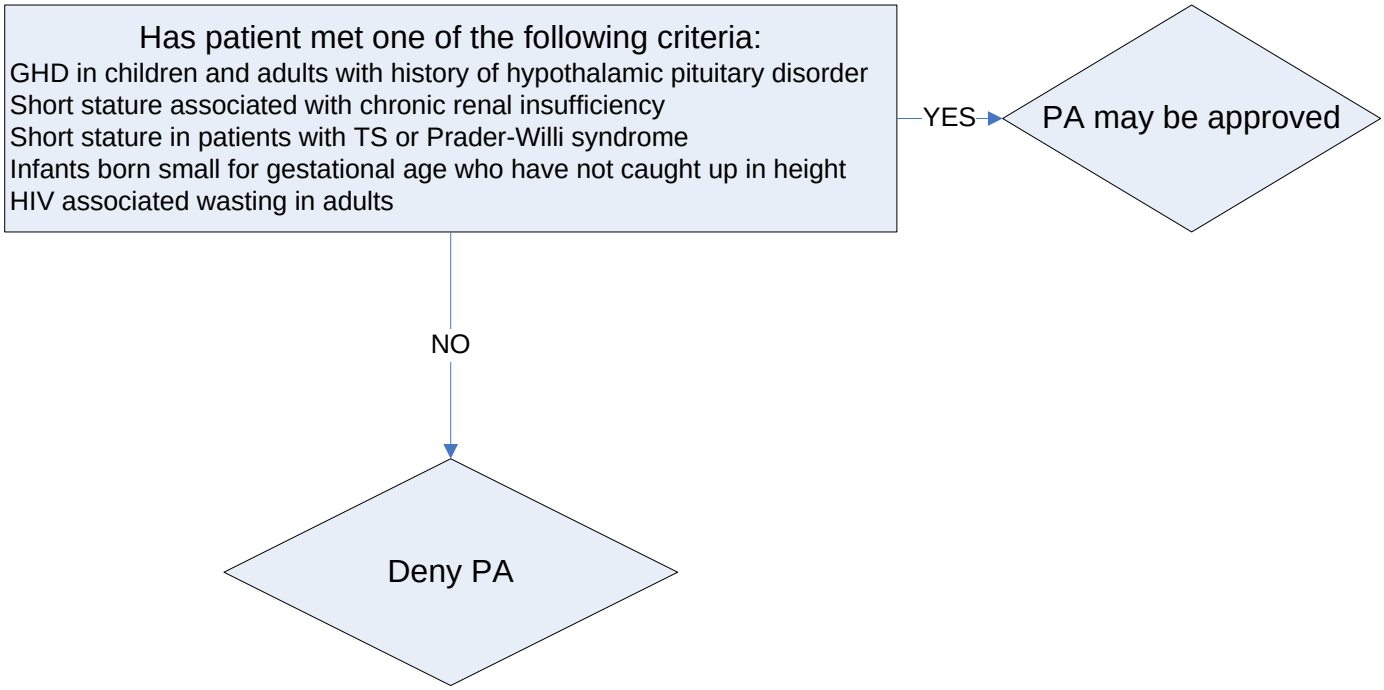
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services
Growth Hormone Authorization Algorithm



IGF-1 PRIOR AUTHORIZATION
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving IGF-1 must meet the following criteria:

- **Growth failure in children with severe primary IGF-1 deficiency or with growth hormone gene deletion who have developed neutralizing antibodies to growth hormone.**

Part I: TO BE COMPLETED BY PHYSICIAN

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG:	**Requested Dosage:** (must be completed)

Qualifications for coverage:

Criteria met:	Diagnosis Date: Drug:	Dose: Frequency:

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Physician Signature: Date:

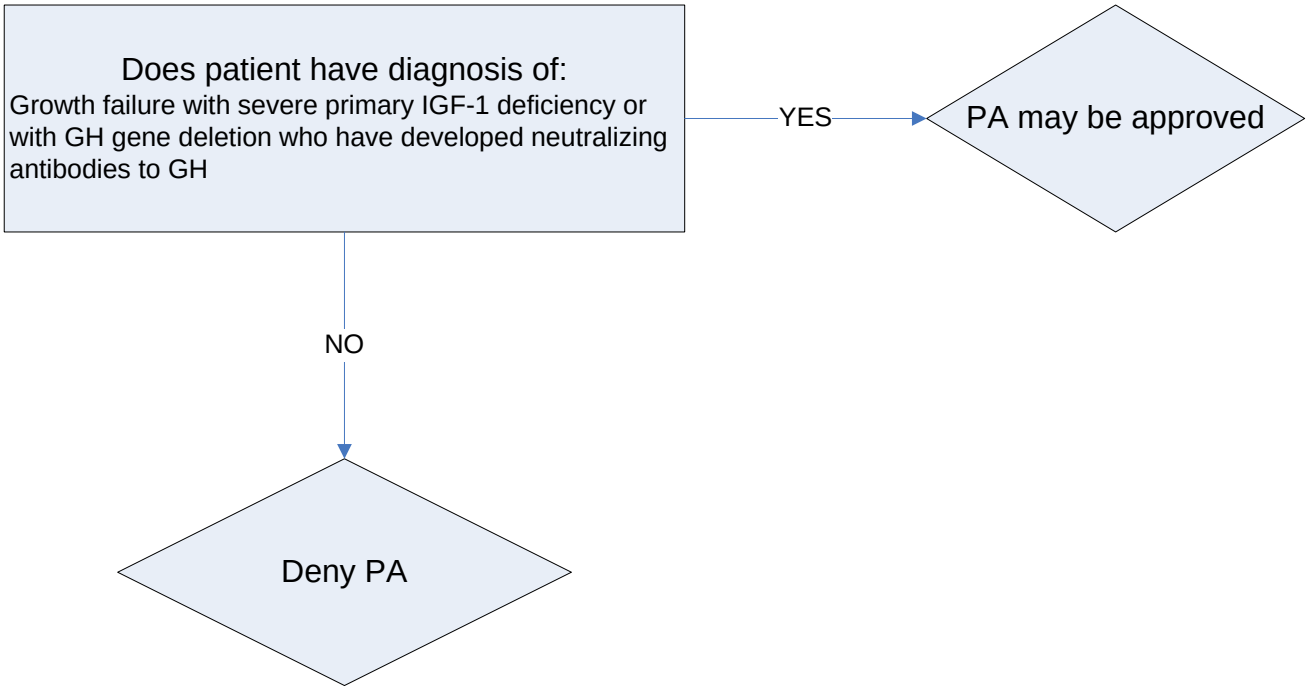
Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /		Initials: _____
Approved - Effective dates of PA:	From: / /	To: / /
Denied: (Reasons)		

North Dakota Department of Human Services
IGF-1 Authorization Algorithm



NORTH DAKOTA MEDICAID
Cost Avoidance Review

PA Class	Implementation Date	Cost Avoidance* Through November 2005
Antihistamine	Mar-04	$577,179
Proton Pump Inhibitors	Mar-04	$2,215,988
NSAIDS/COXII	Mar-05	$173,037
ACE Inhibitors	May-05	-$7,697
ARBS	Sep-05	$34,495
All Classes		$2,993,002

***Cost Avoidance through November 2005 was calculated as follows: 1) Pre PA Actual Costs were projected using a linear trend line based on the actual cost for the most recent 12 months prior to the implementation of the PA; 2) Post PA Actual Costs were subtracted from the projection in (1) for each month after the implementation of the PA; 3) Cost Avoidance through November 2005 is the sum of the differences calculated in (2) for the months after PA implementation.**

NORTH DAKOTA MEDICAID
Percentage Market Share Within Sub-Classes
ACE Inhibitors

	FEB 04	APR 05	NOV 05
All ACE Inhibitors(No Subclass)			
ACCUPRIL	8.39	0.46	0.07
ACCURETIC	0.33	0.11	0.07
ACEON	0.33	0.42	0.16
ALTACE	7.61	8.63	8.48
BENAZEPRIL HCL	0.29	5.28	4.14
BENAZEPRIL HCL-HCTZ	0.00	0.99	1.04
CAPOTEN	0.00	0.00	0.00
CAPOZIDE	0.00	0.00	0.00
CAPTOPRIL	1.99	1.62	1.53
CAPTOPRIL/HYDROCHLOROTHIAZIDE	0.00	0.00	0.00
ENALAPRIL MALEATE	18.87	18.17	16.38
ENALAPRIL MALEATE-HCTZ	0.00	0.00	0.00
ENALAPRIL MALEATE/HCTZ	0.81	0.74	0.88
FOSINOPRIL SODIUM	1.77	2.57	2.54
FOSINOPRIL-HYDROCHLOROTHIAZIDE	0.00	0.18	0.23
LEXXEL	0.00	0.04	0.03
LISINOPRIL	37.70	41.62	45.58
LISINOPRIL-HCTZ	3.64	4.44	5.25
LISINOPRIL-HYDROCHLOROTHIAZIDE	0.00	0.00	0.00
LOTENSIN	5.22	0.04	0.03
LOTENSIN HCT	1.36	0.07	0.16
LOTREL	4.38	3.98	3.75
MAVIK	0.37	0.60	0.13
MOEXIPRIL HCL	2.83	0.14	0.07
MONOPRIL	1.58	0.07	0.00
MONOPRIL HCT	0.40	0.11	0.10
PRINIVIL	0.11	0.04	0.03
PRINZIDE	0.00	0.00	0.00
QUINAPRIL	0.00	1.30	0.33
QUINAPRIL HCL	0.00	4.54	5.25
QUINARETIC	0.00	0.18	0.16
TARKA	0.15	0.25	0.20
UNIRETIC	1.58	1.30	1.31
UNIVASC	0.00	2.01	2.06
VASERETIC	0.00	0.00	0.03
VASOTEC	0.07	0.00	0.00
VASOTEC I.V.	0.00	0.00	0.00
ZESTORETIC	0.18	0.11	0.00
ZESTRIL	0.04	0.04	0.00

Class added to PA May 2005

NORTH DAKOTA MEDICAID
Percentage Market Share Within Sub-Classes
ARBS

	FEB 04	AUG 05	NOV 05
All ARBS(No Subclass)			
ATACAND	12.11	11.96	12.52
ATACAND HCT	1.93	2.45	2.04
AVALIDE	1.68	2.04	2.18
AVAPRO	7.86	8.28	9.52
BENICAR	7.09	9.00	8.84
BENICAR HCT	1.16	4.19	3.54
COZAAR	26.80	24.54	22.45
DIOVAN	21.39	20.86	20.27
DIOVAN HCT	8.63	7.98	9.25
HYZAAR	9.66	5.83	6.12
MICARDIS	1.16	1.43	1.50
MICARDIS HCT	0.13	1.02	1.22
TEVETEN	0.26	0.41	0.54
TEVETEN HCT	0.13	0.00	0.00

Class added to PA Sep 2005

ACE INHIBITOR PRIOR AUTHORIZATION
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving an ACE Inhibitor, must use at least two generics as first line.
__Note:__

- **Captopril, Lisinopril, Moexipril, Benazepril, Fosinopril or Ramipril do not require a PA**
- **If the patient has not failed two generics but has subsequently had a successful trial of a brand drug the PA will be approved.**
- **Altace will only be aproved for a recipient who is > 55 years old with previous CV disease or diabetes plus one other risk factor for CV disease.**

Part I: TO BE COMPLETED BY PHYSICIAN

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG:	**Requested Dosage:** (must be completed) **Diagnosis for this request:** **Other CV Risk Factors:**

Qualifications for coverage:

☐ Failed generic drug	Start Date: End Date:	Dose: Frequency:
☐ Failed generic drug		

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Physician Signature: Date:

Part II: TO BE COMPLETED BY PHARMACY

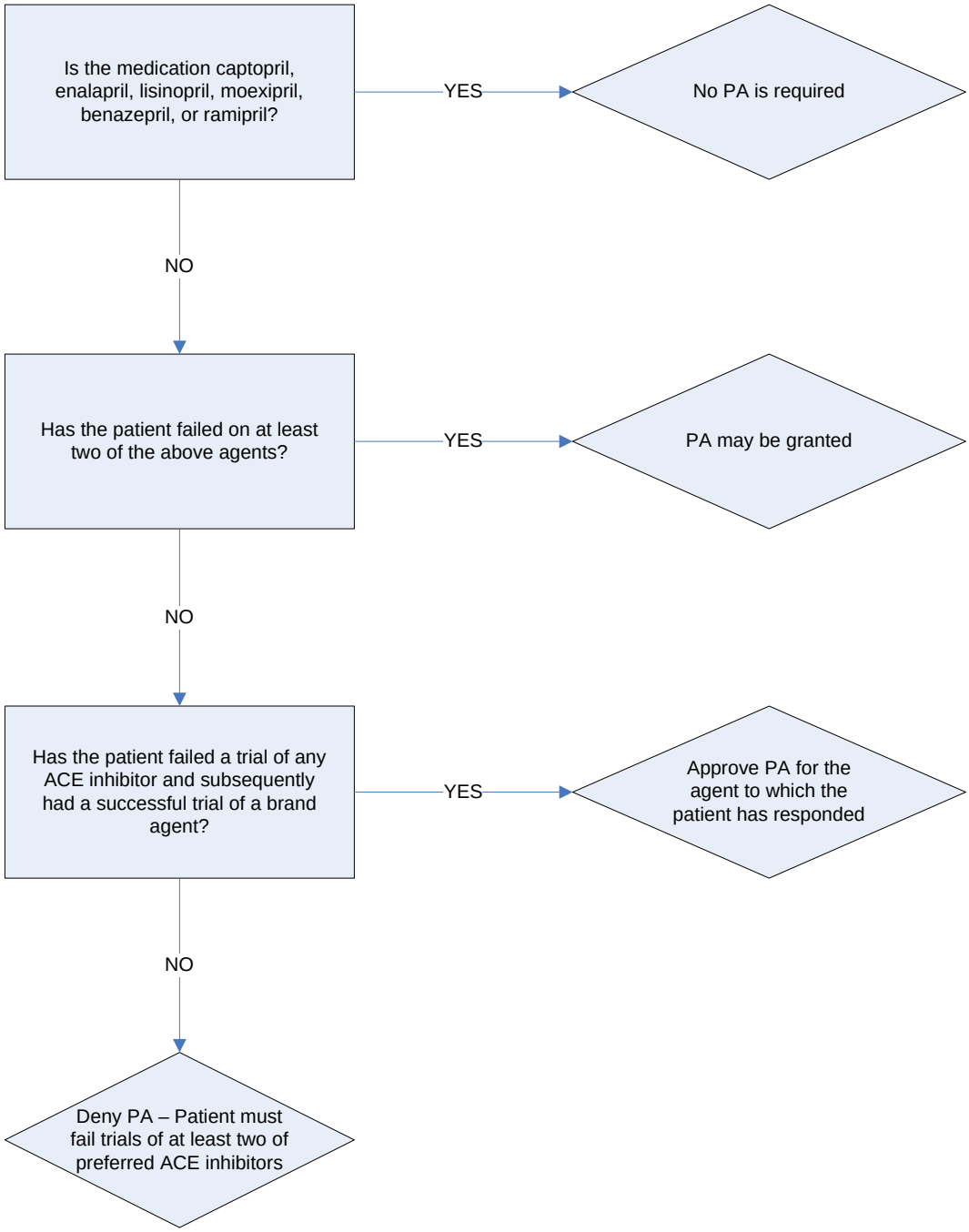
PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

North Dakota Department of Human Services

Ace Inhibitor Authorization Criteria Algorithm



PLEASE NOTE: ramilpril (Altace) is considerably more expensive than other preferred ACE inhibitors. DHS recommends that the use of ramipril be reserved for patients 55 years of age or older with previous cardiovascular (CV) disease or diabetes plus one other risk factor for CV disease.

ARB PRIOR AUTHORIZATION
ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

ND Medicaid requires that patients receiving an ARB, must use and fail one ACE Inhibitor.

- Angiotensin II receptor antagonists:
- Atacand, Atacand/HCT, Avapro, Avalide, Benicar, Benicar/HCT, Cozaar, Diovan, Diovan/HCT
- Hyzaar, Micardis, Micardis/HCT, Teveten, Teveten/HCT

Part I: TO BE COMPLETED BY PHYSICIAN

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PHYSICIAN NAME:	PHYSICIAN MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG:	**Requested Dosage:** (must be completed)
	Diagnosis for this request:

Qualifications for coverage:

☐ Failed ACE Inhibitor	Start Date:	Dose:
	End Date:	Frequency:

☐ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Physician Signature: Date:

Part II: TO BE COMPLETED BY PHARMACY

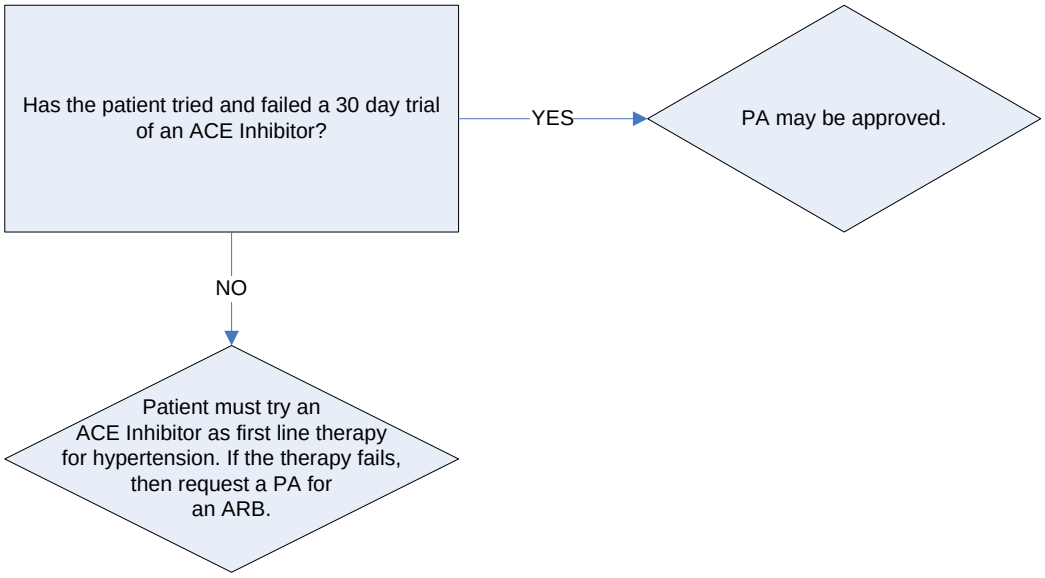
PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

ARB AUTHORIZATION CRITERIA ALGORITHM



NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

Medical Services

John Hoeven, Governor
Carol K. Olson, Executive Director

(701) 328-2321
Fax (701) 328-1544
Toll Free 1-800-755-2604
Provider Relations (701) 328-4030

[TODAY]

[adrs1]
[adrs2]
[adrs3]
[adrs4]

DEAR [tadrs1]:

In compliance with the OBRA '90 federal legislation, state Medicaid agencies are mandated to have an operating Drug Use Review (DUR) Board. One large part of the DUR Board's duties is to facilitate appropriate physician education. Part of this process is to help assure that Medicaid beneficiaries receive appropriate medications in the most cost-effective manner, thus conserving state expenditures for drugs whenever possible.

The North Dakota DUR Board requested that Medicaid Pharmacy claims be scanned to identify patients who received a one-time fill of Sustained Release Opioid Analgesics (SROA's) during a 7-month window. For example, the review would identify a patient who had received Oxycontin 20 mg during the month of August, but not before or after August. As these medications are intended for the management of chronic pain, the patient would generally be expected to continue receiving the medication in a continuous or long-term fashion.

You are receiving this notice because Department records indicate a patient(s), in your care, that **appears** to have received a single fill of a Sustained Release Opioid Analgesic during the 7-month review window. As part of the educational process, the DUR Board reminds you that prescribing an SROA in this manner is contrary to the manufacturer's recommendation, and other short-term pain medications may be more suitable for this condition/diagnosis.

In presenting this information to you, the Department recognizes that the management of each patient's drug therapy depends upon an assessment of the patient's entire clinical situation about which we are not fully aware. Enclosed is a survey to fill out based on your individual treatment plan with each patient(s) listed asking for the rationale for prn (as needed) use, **if** SROA's were prescribed in this manner. Please return the survey to the Department in the enclosed envelope within 20 business days. All information received will be used for Department purposes only and will remain confidential.

Thank you for your professional consideration.

Sincerely,

Brendan K. Joyce, PharmD
Administrator, Pharmacy Services

ND DEPARTMENT OF HUMAN SERVICES REQUEST FOR INFORMATION:
SUSTAINED RELEASE OPIOID ANALGESICS

PRESCRIBER RESPONSE:

All information used to generate the enclosed letter, including Prescriber identification, was obtained from ND Medicaid Pharmacy Claims Data. If there appears to be an error in the information provided, please note the discrepancy. Thank you for your cooperation.

1. This patient was under my care during the time frame identified:
_____ Yes
_____ No (If No, stop here but please return this response.)

2. This patient has a diagnosis of:

3. The directions given for use on the patient's prescription:

4. Do you currently have a narcotic/pain management contract with this patient?
_____ Yes
_____ No

5. Rationale for prn (as needed) use, **if applicable**:

6. Please check here if you wish to receive reference information on identified patient___.
(Please provide a fax number if available_____-_____-_____.)
Comments: _____
_____
_____

[adrs1] Case# [case_no]
Letter Type [letter_type]
[alert_msg]
[criteria]

130 Responses to ND SROA Mailing

Is this your patient	Diagnosis	Contract	Deceased
Y	aspiration pneumonia	N	
Y			Y
Y	compression fractures	N	
Y	compression fractures	N	
blank			
Y	CHF	N	
N	saw once-prescribed 16 tabs	N	
Y	PVD		Y
N			
N			
Y	chronic pain syndrome	Y	
Y	low back pain	N	
Y	PVD	N	Y
Y	fibromyalgia	Y	
Y			
N			
Y	GI tumor	N	
Y	myeloma		Y
Y	chronic tonsillitis	N	
N			
Y	fibromyalgia, chronic arthritis	N	
N	suspect fraud		
Y	fracture	N	
Y	chronic back pain	N	
Y		N	
Y		N	
N			
Y	multiple trauma, ARDS		
Y	spinal stenosis		
Y	multiple trauma	N	
Y	malignant melanoma	N	Y
Y	lupus	Y	
Y	ligament rupture	Y	Y
Y	shoulder pain	Y	
Y	shoulder pain	Y	
blank			
blank			
Y	pain syndrome	Y	
Y	lower back pain	N	
Y			Y
Y	lymphoma	N	
Y	back pain	N	Y
Y	osteoporosis with fracture	N	Y
blank			
Y	lung cancer	N	Y
Y	chronic low back pain	Y	
Y	chest pain	N	
blank			
Y	cyst of wrist	N	
Y	cancer	N	Y

130 Responses to ND SROA Mailing

Y	lung cancer	N	Y
Y	colon cancer	N	Y
Y	back pain, neuropathic pain	Y	
Y	lower back pain	N	
Y	abdominal pain	Y	
Y	degenerative disc disease	Y	
Y	fibromyalgia, deg disc disease	Y	
Y	chronic pain	N	
Y	lower back pain	N	
Y	CVA		Y
Y	hip pain	N	
Y	abdominal pain	N	Y
Y			Y
Y	herniated disc	N	
Y	lumbar backache	Y	
Y	joint pain	Y	
Y	vertebral collapse fracture	N	
Y	lung cancer	N	Y
Y	hip fracture	N	
Y	endometriosis	Y	
Y	back pain	Y	
Y	lupus	Y	
Y	chronic lower back pain	Y	
Y	degenerative disc disease	Y	
Y	chronic drug abuse	N	
Y	vertebral compression fracture	N	
Y	chronic pain	N	
N			
Y	trauma from fall	N	Y
Y	lower back pain	N	
Y			Y
Y			Y
Y	ankle fracture	N	
Y	cancer	N	
Y	cancer	N	Y
Y	chronic pain	N	
Y	PVD	N	
Y	dementia		
Y	carcinoid tumor	N	
Y	fibromyalgia, back pain	N	
Y			
Y	post op c-section	N	
Y	shoulder pain	N	
Y			Y
Y			Y
blank			
Y	knee pain	N	
Y	chronic pain syndrome	Y	
Y	headaches	N	
Y	maxillary sinusitis	N	
Y			Y

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Y	cancer		
Y	chronic back pain	N	Y
Y	severe osteoarthritis	N	
Y	colon cancer	N	
blank			
Y	terminal pain		Y
Y			Y
Y		Y	
Y			Y
Y		N	Y
Y	severe osteoarthritis	Y	
Y	CVA	N	Y
Y		N	
Y	osteoporosis	N	
N	lower back pain	N	
Y	osteoporosis	N	
Y	chronic back pain	N	
Y	diabetic ulcer	N	
Y	chronic pain	N	Y
Y	development disorder		
Y	osteoporosis		Y
Y	chronic pain	Y	
Y	CHF, COPD	N	Y
Y	orthopedic concerns	N	
Y	cancer		Y
Y	chronic migraine	Y	
N			
Y	phantom pain	N	
Y	chronic pain	N	
112Yes/10No		24Yes/68No	34

NORTH DAKOTA MEDICAID
RETROSPECITVE DRUG UTILIZATION REVIEW
CRITERIA RECOMMENDATIONS
2ND QUARTER 2006

Recommendations ***Approved*** ***Rejected***

1. Tussionex / Overutilization _____ _____

Alert Message: Tussionex (hydrocodone/chlorpheniramine) may be over-utilized. Physical dependence and tolerance may develop upon repeated administration. In treating allergic rhinitis or common cold, it is vital to assess the patient regularly and systematically to ensure continued effectiveness of selected agent and the relative occurrence of side effects.
Conflict Code: ER – Overutilization (Duration)
Drugs/Disease:

Util A	Util B	Util C
Tussionex		

Day Supply: 15 days in 90 days

References:
Micromedex Healthcare Series, Drugdex Drug Evaluations, 2005.
Tussionex Prescribing Information, December 2002, Celltech Pharmaceuticals, Inc.

2. Rosiglitazone / Therapeutic Appropriateness _____ _____

Alert Message: Post-marketing reports suggest that Avandia/Avandamet (rosiglitazone -containing products) may cause new onset and worsening of diabetic macular edema. Concurrent peripheral edema may also occur in these patients. Macular edema resolved or improved, in some cases, following discontinuation of the drug or dose reduction.
Conflict Code: TA – Therapeutic Appropriateness
Drugs/Disease:

Util A	Util B	Util C
Rosiglitazone		

References:
MedWatch: The FDA Safety Information and Adverse Event Reporting Program, 2006.

**Avandaryl (rosiglitazone/glimepiride) will be added to the criteria alert message when/if it becomes available.

3. Avinza / Therapeutic Appropriateness _____ _____

Alert Message: Patients must not consume alcoholic beverages while on Avinza (morphine extended-release) therapy. Additionally, patients must not use prescription or non-prescription medications containing alcohol while on Avinza therapy. Consumption of alcohol while taking Avinza may result in the rapid release and absorption of a potentially fatal dose of morphine.
Conflict Code: TA – Therapeutic Appropriateness
Severity: Major (Black Box Warning)

Util A	Util B	Util C
Avinza	Alcoholism	
	Alcohol Abuse	
	Alcohol-containing Medications	

References:
MedWatch - The FDA Safety Information and Adverse Event Reporting Program, 2005.
Avinza Prescribing Information, Oct. 2005, Ligand Pharmaceuticals Inc.

Recommendations	*Approved*	*Rejected*

4. Lindane / Therapeutic Appropriateness _____ _____

Alert Message: Lindane can be poisonous if not used properly. Seizures and death have been reported following use with repeat or prolonged application, but also in rare cases following a single application. The medication should only be used by patients who cannot tolerate or have failed first-line treatment with safer medications. Infants, children, the elderly, patients with other skin conditions and those who weigh less than 110 lbs (50 kg) may be at greater risk for serious neurotoxicity.
Conflict Code: TA - Therapeutic Appropriateness (Black Box Warning)
Drug/Disease:

Util A	Util B	Util C
Lindane		

References:
FDA Public Health Advisory: Safety of Topical Lindane Products for the Treatment of Scabies and Lice, FDA Center for Drug Evaluation and Research, March 28, 2003.
Lindane Shampoo Prescribing Information, April 2005, Alliant Pharmaceuticals.
Facts & Comparisons, 2005 Updates.

5. Beta Blockers / Therapeutic Appropriateness _____ _____

Alert Message: Non-selective beta-blockers should be used with caution in patients with diabetes. These agents may mask the signs and symptoms of hypoglycemia and delay recovery time. Beta blockade also reduces the release of insulin in response to hyperglycemia; it may be necessary to adjust the dose of antidiabetic drugs. Cardioselective beta-blockers are preferred due to the decreased risk of adverse effects on glucose regulation.
Conflict Code: TA - Therapeutic Appropriateness
Drug/Disease:

Util A	Util B	Util C
Propranolol	Diabetes (Drugs & ICD9s)	
Penbutolol		
Carteolol		
Pindolol		
Timolol		
Nadolol		

References:
Facts & Comparison, 2005 Updates.
Micromedex Healthcare Series, Drugdex Drug Evaluations, 2006.