DCF Psychotropic Medication Advisory Committee
Monthly Meeting Notes
September 4, 2009, 1:00PM
Riverview Hospital for Children and Youth
Middletown, CT.

PRESENT: See enclosed attendance record.

1. Call to order: Dr. Siegel called the meeting to order at 1:10 pm.

2. Set date/time of next meeting: **The next meeting is scheduled for October 9, 2009 from 1-3PM; RHCY AB Conference Room.**

3. Minutes: The minutes of the July 2009 PMAC meeting were reviewed and approved.

4. Announcements:
   - Changes to DSS Optimal Dosing Program: The Department of Social Services Medical Assistance Program Provider Bulletin (PB 2009-24) dated June 2009 was distributed and discussed: There was some confusion as to the methodology to be used to realize drug cost savings:
     - Possibility 1:Require dispensing of a higher strength of medication when it can then be broken in 2 to provide the needed dose: Example Celexa 20mg would be dispensed as 40mg tablets and then the patient would be instructed to break each tablet in half.
     - Possibility 2: A medication is ordered for example 10mg bid when a once a day 20mg dose would be appropriate.
     - PMAC endorses possibility 2 as long as the logistics involved will not hold up therapy.
   - E-prescribing: The Department of Social Services Medical Assistance Program Provider Bulletin (PB 2009-32) dated August 2009 was distributed and discussed. No action required by PMAC.

5. Presentation of Medicaid Pharmacy Data Report :
   - Dr. Laurie Vander Heide led the discussion: A report covering the period 2/1/2008 thru 6/30/2008 was distributed.
   - Each section of the report was reviewed and discussed in detail. Issues included:
     - The attempt to segregate DCF children was not successful. The data is sorted by behavioral vs. non-behavioral medications.
     - Some medications may be used for medical or behavioral conditions. (clonidine, seizure medications). This report assumes the medications are used for behavioral conditions.
     - The report was able to delineate DCF involved patients. This would include ANY DCF involvement.
     - Some possible discrepancies in some of the graphs were discussed.

- More detail is needed regarding what medications are in each category (stimulants, mood stabilizers, etc.). Also some classes of medications may be used in more than one category: Benzodiazepines may be anti-anxiety or mood stabilizers. More details will be provided on this.
- There was discussion regarding abuse of Quetiapine (Seroquel) as it has been used as a substitute for cannabis.
- It was noted that on the Most Frequently Prescribed" list Depakote is #5 and Lamictal is #10 despite the questionable efficacy of these medications.
- Instituting a project to determine if the prescribing practitioner is a behavioral health provider was discussed.
- The prescribing of brand vs generic was discussed.
- Prescribing profiles were discussed as to what they show and/or compare and what the indicators are. (Such as state-wide average vs. individual prescriber)
- A recommendation was made to have the PMAC set up criteria to identify potential outliers. It was suggested to start with data involving children and compare DCF vs non-DCF data.

- The Sub-Committee will evaluate the report and PMAC feedback. The Sub-Committee will meet (most likely via conference call) consider the information and bring recommendations to the full PMAC.

6. <u>Monitoring Protocol:</u>
   - Invega and Rozerem: Each of these medications were discussed in detail regarding safety and efficacy to determine if either or both should be added to the PMAC Preferred Drug List. Relating to Rozerem: Melatonin was discussed in some detail. It was also noted that a study is underway regarding the pharmacokinetics, dosing, efficacy, and safety of Rozerem use in children. Results should be available in Feb 2010. The committee recommends NOT adding these medications to the preferred drug list. Rozerem will again be considered once the study data is available.
   - guanfacine XR (Tenex XR): A recommendation was made to review this medication for possible addition to the PMAC Preferred Drug List. A monograph will be prepared and presented by the Pharmacist consultants at the next PMAC meeting.
   - Maximum Dosing case data:
     - Atenolol: research indicates that the maximum daily dose for this medication should be 100mg. After further discussion it was recommended that this medication be removed from the PMAC Preferred Drug List due to a lack of data regarding safety and a lack of experience with the use of this medication.
     - Metoprolol: research indicates that the maximum daily dose for this medication should be 200mg. After further discussion it was recommended that this medication be removed from the PMAC Preferred Drug List due to a lack of data regarding safety and a lack of experience with the use of this medication.

- Molindone: research indicates that the maximum daily dose for this medication should be 140mg. Approved by the PMAC.
- Inderal: the current maximum dose is listed as 120mg. After some discussion it was recommended that no change be made at this time.
- Fluoxetine: the maximum recommended daily dose is corrected to 60mg for children and 80mg for adolescents.

7. Adjournment: Dr. Williams adjourned the Committee at 3PM.

Respectfully Submitted:

David S. Aresco