

DRAFT Minutes—Indiana Medicaid DUR Board  
Meeting of September 4, 2009—Meeting No. 153

**In attendance:**

**Brian Musial, R.Ph. - Chair**  
**John Wernert, M.D. - Vice-Chair**  
**Patricia Treadwell, M.D.**  
**Terry D. Lindstrom, Ph.D.**  
**Kent Summers, R.Ph., Ph.D.**  
**Jeff Brown, R.Ph., MS, BCPS**

**Also present:**

Michael Sharp, R.Ph. - OMPP  
Marc Shirley, R.Ph. - OMPP  
Medina Lee, R.Ph. - OMPP  
Kristin Baldock - OMPP

Jeannine M. Murray, R.Ph. - Anthem  
Chris Johnson, R.Ph. - MDwise  
Katasha Butler, PharmD - Managed Health Services  
James V. Berger, R.Ph. - EDS  
Karen Powell, PharmD - ACS (via conference phone)  
John Stancil, R.Ph. - ACS  
Randall Renshaw, PharmD, BCPS - ACS

**MEETING CALLED TO ORDER:** Mr. Brian Musial, Board chairman, called the meeting of the Indiana Medicaid DUR Board to order.

**APPROVAL OF MINUTES:** Approval of the minutes from the July and August meetings was moved, seconded, and carried with a unanimous vote.

**REMARKS FROM THE CHAIR:** None

**OPENING COMMENTS:** Mr. Marc Shirley thanked everyone for changing their schedules to be at the meeting this morning, necessitated by the need to allow providers sufficient notice regarding matters that may be approved by the Board today. He also stated that the Board would not be meeting on the 25<sup>th</sup> of this month and reminded everyone that the next DUR Board meeting will be held on October 16<sup>th</sup>, 2009.

**THERAPEUTICS COMMITTEE LIAISON REPORT:** Before the Therapeutics Committee (T Committee) recommendations were presented, Mr. Musial read the following statement: The Board accepts the recommendations of the T Committee with the understanding that all applicable agreements will be executed within the time frame defined by ACS and the Office of Medicaid Policy and Planning (OMPP). This time frame is not negotiable. If a manufacturer does not submit the signed agreement to ACS within the specified time frame, then their drug(s) that would have been approved in accordance with the agreement will be moved to non-preferred status.

Dr. Randall Renshaw, Executive Account Manager, ACS presented the T Committee's recommendations from the Committee's August 7, 2009 meetings. He stated that – as always – the three primary drivers behind those recommendations were clinical implications, drug costs, and total program costs. The T Committee reviewed seven therapeutic classes, the Synagis® and Suboxone®/Subutex® prior authorization (PA) criteria, the Over-the-Counter (OTC) Drug Formulary and seven new proposed therapeutic classes; the Committee offered the recommendations listed below. The Board discussed and acted on each class individually.

**1. Respiratory Agents**

- ◆ β-agonist – No changes recommended
- ◆ Leukotriene inhibitors

- Maintain preferred status of Singulair®, but modify step edit to the following: patients 18 years of age and older must have had one of the following medications within the past 6 months: methylxanthine, beta agonist and/or oral inhaled corticosteroid
- Maintain current status of all other agents
- ◆ Nasal preparation
  - Move Astepro™ to preferred status
  - Maintain current status of all other agents
- ◆ Non-sedating antihistamines – No changes recommended
- ◆ Beta adrenergic and corticosteroid combinations – No changes recommended
- ◆ Oral inhaled corticosteroids – No changes recommended
- ◆ Agents to treat COPD
  - Move ipratropium/ albuterol solution (generic Duoneb®) to preferred
  - Maintain current status of all other agents

**Public Comment:** None

**Board Discussion:** None

**Board Action:** It was moved and seconded that the recommendations for respiratory agents be approved. The motion passed unanimously.

## 2. Anti-infective Agents

- ◆ Antiviral (anti-herpetic) agents – No changes recommended
- ◆ Antiviral (anti-influenza agents) – No changes recommended
- ◆ Cephalosporin (1<sup>st</sup> and 3<sup>rd</sup> generations)
  - Move cefdinir capsules & suspension (generic Omnicef®) to preferred
  - Move Omnicef® capsules & suspension to non-preferred
  - Maintain current status of all other agents
- ◆ Macrolides – No changes recommended
- ◆ Fluoroquinolones – No changes recommended
- ◆ Ketolides – No changes recommended
- ◆ Topical antifungals – No changes recommended
- ◆ Systemic antifungals – No changes recommended
- ◆ Ophthalmic antibiotics
  - Add Besivance™ to non-preferred
  - Maintain current status of all other agents
- ◆ Otic antibiotics
  - Add Cetraxal™ to non-preferred
  - Maintain current status of all other agents
- ◆ Vaginal anti-microbial – No changes recommended
- ◆ Hepatitis C agents
  - Move Rebetol® to non-preferred
  - Maintain current status of all other agents
- ◆ Topical antiviral agents
  - Move Denavir® to preferred
  - Move Zovirax® ointment to non-preferred
  - Maintain current status of all other agents

**Public Comment:** None

**Board Discussion:** None

**Board Action:** It was moved and seconded that the recommendations for anti-infective agents be approved. The motion passed unanimously.

## 3. Cardiovascular Agents

- ◆ ACE inhibitors – No changes recommended

- ◆ ACE / Calcium Channel Blockers (CCBs) – No changes recommended
- ◆ ACE inhibitors with diuretics – No changes recommended
- ◆ Angiotensin II Receptor Blockers (ARBs) – No changes recommended
- ◆ ARBs with diuretics – No changes recommended
- ◆ ARBs with CCBs – No changes recommended
- ◆ ARBs with diuretics and CCBs
  - Add Exforge HCT
- ◆  $\alpha$  -  $\beta$  blockers,  $\beta$ -blockers – No changes recommended
- ◆  $\beta$ -blockers with diuretics
  - Add generics to preferred
  - Add brand meds to non-preferred
- ◆ CCBs – No changes recommended
- ◆ CCBs with HMG CoA reductase inhibitors – No changes recommended
- ◆ Selective aldosterone receptor antagonist
  - Move generic Inspra® to preferred with the following step edit - trial of an ARB, CCB, or diuretic within the past 90 days
  - Move brand Inspra® to non-preferred while maintaining step edit
- ◆ Direct renin inhibitor – No changes recommended
- ◆ Direct renin inhibitor and diuretic combination – No changes recommended

**Public Comment:** None

**Board Discussion:** Dr. John Wernert asked if any of the agents in this class caused discussion among the T Committee members. Mr. Musial responded by indicating the T Committee discussed Exforge HCT to make sure this agent was not used as a first-line agent. Dr. Wernert was thinking the beta-blockers with diuretics were already reviewed and asked why these agents were being reviewed again. Dr. Randall Renshaw informed the Board that the beta-blockers with diuretics have never been reviewed for Preferred Drug List (PDL) inclusion. Mr. Musial added that these drugs would have been covered but were never part of the PDL.

**Board Action:** It was moved and seconded that the recommendations for cardiovascular agents be approved. The motion passed unanimously.

#### 4. Lipotropics Agents

- ◆ Bile acid sequestrants – No changes recommended
- ◆ Fibric acid derivatives
  - Add Fenoglide™ to non-preferred
  - Add Trilipix™ to preferred
  - Maintain current status of all other agents
- ◆ HMG CoA reductase inhibitors
  - Move Crestor® to preferred
  - Maintain current status of all other agents
- ◆ Other Lipotropics
  - Move Vytorin® to non-preferred with step edit - trial of an HMG-CoA reductase inhibitor within the past 90 days
  - Maintain current status of all other agents

**Public Comment:** None

**Board Discussion:** Dr. Wernert asked if the reason for moving Crestor® was related to clinical evidence or increased number of claims. Mr. Musial responded by saying that moving Crestor® to preferred status had to do with both clinical evidence and the increased number of claims. He went on to say that there was a financial component to this issue as well.

**Board Action:** It was moved and seconded that the recommendations for lipotropics agents be approved. The motion passed unanimously.

#### 5. Triptans

- ◆ Triptans

- Move Amerge® to non-preferred while maintaining current quantity limit
- Move Frova® to preferred while maintaining current quantity limit
- Maintain current status of all other agents

**Public Comment:** None

**Board Discussion:** None

**Board Action:** It was moved and seconded that the recommendations for triptans be approved. The motion passed unanimously.

#### 6. Electrolyte Depletter Agents

- ◆ Electrolyte depletter agents
  - Add Eliphos™ to non-preferred
  - Add Renvela™ to non-preferred
  - Maintain current status of all other agents.

**Public Comment:** None

**Board Discussion:** None

**Board Action:** It was moved and seconded that the recommendations for electrolyte depletter agents be approved. The motion passed unanimously.

#### 7. Multiple Sclerosis Agents

- ◆ Multiple sclerosis agents – No changes recommended

**Public Comment:** None

**Board Discussion:** None

**Board Action:** It was moved and seconded that the recommendations for multiple sclerosis agents be approved. The motion passed unanimously.

#### 8. Synagis® PA Criteria Review

- ◆ Synagis®
  - Maintain Synagis® as non-preferred
  - Maintain current Synagis® criteria

**Public Comment:** None

**Board Discussion:** Dr. Renshaw stated that there are differences between the Food and Drug Administration (FDA) approved indications and the new American Academy of Pediatrics (AAP) recommendations. Additionally, Dr. Renshaw stated that due to the unavailability of supporting literature for these new recommendations, the T Committee suggested waiting until the supporting medical literature is available so that it could be critically reviewed to make an informed decision about these PA criteria. He went on to say that the T Committee wanted a compilation of Synagis® criteria from other states to establish a trend and to enhance their decision making. Dr. Renshaw added that the T Committee would like for Synagis® to be reviewed again in November of this year to see if medical literature supporting the new AAP recommendations is available. There was much discussion among the Board members about when this agent should be reviewed and the current weight of the medical literature for this agent.

**Board Action:** It was moved and seconded that Synagis® be maintained as non-preferred and to maintain the current Synagis® PA criteria. Also, it was moved and seconded that this agent be re-reviewed in November 2009 to see if the aforementioned AAP medical literature is available. The motion passed unanimously.

#### 9. Subutex/Suboxone® PA Criteria Review

- ◆ Subutex/Suboxone®
- ◆ Subutex®/Suboxone® to non-preferred
- ◆ With the following PA criteria requirements
  - Approval will be granted if all criteria below are met. The physician must provide explanations for all unmet criteria and indicate the reason treatment with Suboxone or Subutex is medically necessary in order to obtain approval
    - The prescriber must request the PA
    - Subutex will be approved up to a total of 34 days for induction therapy depending upon the request of the physician. Concurrent use of other opioids will be allowed during this 34-day induction period only for the purpose of tapering off other opioids. If treatment with Subutex is needed for a period longer than 34 days, the physician must provide an explanation. Approval of Suboxone will be granted for 6 months. Suboxone may be dispensed as a 34-day supply at a time only.
    - Patient must be 16 years of age or older
    - Physician must meet all qualifications to prescribe Suboxone/Subutex (Federal, State, and Local)
    - Patient must have a diagnosis of opiate dependence/addiction (at prescriber’s office or verified from prior rehab/detox)
    - Physician must verify that the risks of using Suboxone with alcohol or benzodiazepines have been explained to the patient
    - Physician must verify that there are no untreated or unstable psychiatric conditions that would interfere with Suboxone/Subutex compliance
    - If patient is pregnant, physician must explain choice of Suboxone/Subutex over alternatives or submit OB office documentation supporting patient is unable to use an alternative medication
    - Physician must provide documentation of the patient’s referral to or active involvement in formal counseling with a licensed behavioral health provider; must also indicate the name of the behavioral health provider and where the patient is receiving counseling
  - PA renewal requests will be granted if all criteria below are met. If any of the below criteria are not met, the physician must provide explanations for all unmet criteria and indicate the reason treatment with Suboxone is medically necessary in order to obtain re-approval
    - Patient must demonstrate consistent use of Suboxone during the prior 6 months (this will be verified with pharmacy data; if inconsistent use is noted upon database search, then written explanation indicating the reason Suboxone should be continued despite apparent non-compliance would be needed)
    - Physician must provide documentation of two urine tests in 6 months that are negative for opiates since previous authorization; must also provide the date of each urine test
    - Physician must provide documentation supporting patient’s consistent participation in formal counseling with a licensed behavioral health provider since previous authorization; must also indicate when counseling took place
    - Physician must provide documentation indicating patient is receiving ongoing behavioral health care for coexisting behavioral health disorders
    - Physician must provide justification for prescribing other controlled substances concurrently
  - Patients who are currently taking either Suboxone or Subutex will be “grandfathered” and these patients will not be required to obtain a PA for these medications
  - Of note, Suboxone and Subutex are not reimbursable for use in pain management

**Public Comment:** None

**Board Discussion:** Dr. Renshaw stated that the T Committee did take into consideration the Subutex/Suboxone recommendations from the DUR Board such as use for pain management, non-approved FDA indications, grandfathering, and concurrent use with other opioids. Dr. Renshaw further stated that the T Committee recommended that a statement be added to PA criteria indicating that Suboxone or Subutex would not be reimbursable for pain management. He also added that the T Committee recommended not “grandfathering” patients currently taking Suboxone or Subutex. Lastly, Dr. Renshaw stated that 74 patients were taking either Suboxone or Subutex concurrently with other opioids during the second quarter of 2009. Mr. Musial summarized

that the only change from the previously presented Suboxone/Subutex PA criteria is the statement regarding these agents are not reimbursable for pain management. Dr. Wernert pointed out that patients in the induction period may require treatment with concurrent opioids. There was much discussion among the Board members regarding the PA criteria, use in pain management, grandfathering, non-FDA approved indications, and concurrent use of other opioids.

Mr. Mike Sharp stated there is federal statute relating to medically accepted indications. He added that medically accepted indications for any product are those that appear in certain compendia. He gave two examples of these compendia: Micromedex® and the American Hospital Formulary Service (AHFS). Mr. Sharp summarized by stating that Medicaid agencies cannot knowingly reimburse for medications when the use is not for a medically accepted indication. There was much discussion about medically accepted indications among the Board members. Dr. Wernert suggested that concurrent use of opioids be allowed with Subutex for the 34-day induction period.

Both Dr. Wernert and Dr. Lindstrom expressed concern about not “grandfathering” patients who are currently taking either Subutex® or Suboxone®.

**Board Action:** It was moved and seconded that the DUR Board accept the T Committee recommendations and, additionally, allow concurrent use of other opioids during the Subutex® induction period and allow “grandfathering” to those patients currently taking either Suboxone® or Subutex®. The motion passed unanimously.

#### **10. OTC Drug Formulary Review**

- ◆ OTC Drug Formulary Review – No changes recommended

**Public Comment:** None

**Board Discussion:** None

**Board Action:** It was moved and seconded that the “no recommendations” for OTC Drug Formulary changes be approved. The motion passed unanimously.

#### **11. Proposed New Therapeutic Classes for PDL Review**

- ◆ Post-herpetic neuralgia agents (e.g., Lidoderm®)
- ◆ Cannabinoid anti-emetics (e.g., Marinol®)
- ◆ Anti-immunoglobulin E agents (e.g., Xolair®)
- ◆ Pancreatic enzymes
- ◆ Oral contraceptives
- ◆ Prenatal vitamins
- ◆ Topical anti-parasitics

**Public Comment:** None

**Board Discussion:** None

**Board Action:** It was moved and seconded that the classes be included for PDL review. The motion passed unanimously.

**ACS UPDATE:** Dr. Renshaw presented the prior authorization statistics for the month of July 2009. He stated that there were a total of 3,798 prior authorizations.

#### **MENTAL HEALTH QUALITY ADVISORY COMMITTEE (MHQAC) APPROVED SMART PA RULES:**

Mr. John Stancil, Account Manager, of ACS introduced Karen Powell, clinical pharmacist, who was on the conference line. Mr. Stancil added that Dr. Powell was responsible for the development many of these clinical rules. He presented five of the following Smart PA rules approved by the MHQAC.

##### **1. Atypical Antipsychotics Duplicate Therapy Classes**

- ◆ Approval criteria

- Approvable diagnosis – psychosis, bipolar affective disorder, episodic mood disorder, depressed mood disorder (for aripiprazole in conjunction with another antidepressant and olanzapine in conjunction with fluoxetine)
- And both atypical antipsychotics involved in the therapeutic duplication are prescribed by or in consultation with a psychiatrist
- And one of the following
  - There is history of at least 2 weeks of single-drug therapy at an adequate dose of each medication involved in the therapeutic duplication in the past year
  - The medications involved in the therapeutic duplication are being cross tapered (administered by the call center)
- And for call center approvals only – Must meet utilization edits
- ◆ Denial criteria
  - Use of two atypical antipsychotics for more than 60 of the past 70 days and absence of approval criteria
  - Non-psychiatrists unaware of the black box warning for patients  $\geq$  65 years of age

## 2. Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) Duplicate Therapy

- ◆ Approval criteria
  - Approvable diagnoses – depression, bulimia nervosa, obsessive-compulsive disorder, panic disorder, Premenstrual Dysphoric Disorder (PMDD), Generalized Anxiety Disorder (GAD), Post Traumatic Stress Disorder (PTSD), Social Anxiety Disorder (SAD)
  - And both SSRIs/SNRIs involved in the therapeutic duplication are prescribed by or in consultation with a psychiatrist
  - And one of the following
    - There is history of at least 4 weeks of single-drug therapy at an adequate dose of each medication involved in the therapeutic duplication in the past year
    - The medications involved in the therapeutic duplication are being cross tapered (administered by the call center)
  - And for call center approvals only
    - Must meet utilization edits
    - Duloxetine (Cymbalta®) claims for patients with a diagnosis of fibromyalgia or diabetic peripheral neuropathic pain do not require PA.
- ◆ Denial criteria
  - Use of two SSRIs/SNRIs for more than 60 of the past 70 days and absence of approval criteria

## 3. Stimulant Duplicate Therapy

- ◆ Approval criteria
  - Approvable diagnoses – Attention Deficit Disorder (ADD)/Attention Deficit Hyperactivity Disorder (ADHD), narcolepsy
  - And both stimulants involved in the therapeutic duplication are prescribed by or in consultation with a psychiatrist
  - And one of the following
    - There is history of at least 2 weeks of single-drug therapy at an adequate dose of each medication involved in the therapeutic duplication in the past year
    - The medications involved in the therapeutic duplication are being cross tapered (administered by the call center)
  - And for call center approvals only
    - Must meet utilization edits
- ◆ Denial criteria
  - Use of two stimulants for more than 60 of the past 70 days and absence of approval criteria

## 4. Typical Antipsychotic Duplicate Therapy

- ◆ Approval criteria
  - Approvable diagnoses – psychosis, bipolar affective disorder, episodic mood disorder
  - And both typical antipsychotics involved in the therapeutic duplication are prescribed by or in consultation with a psychiatrist

- And one of the following
  - There is history of at least 2 weeks of single-drug therapy at an adequate dose of each medication involved in the therapeutic duplication in the past year
  - The medications involved in the therapeutic duplication are being cross tapered (administered by the call center)
- And for call center approvals only
  - Must meet utilization edits
- ◆ Denial criteria
  - Use of two typical antipsychotics for more than 60 of the past 70 days and absence of approval criteria

## 5. Low Dose Atypical Antipsychotic Therapy

- ◆ Approval criteria
  - Approvable diagnoses – psychosis, bipolar affective disorder, unspecified episodic mood disorder, depressed mood disorder (for aripiprazole in conjunction with another antidepressant and olanzapine in conjunction with fluoxetine)
  - And one of the following
    - No claims for the same active ingredient as on the current claim in the past 30 days (new start)
    - The sum of the incoming claim and all current claims with the same active ingredient  $\geq$  the minimum effective dose 7 days from now
    - Prescribed medication being used short-term (administered by the call center)
    - Prescribed medication being tapered with plans to discontinue (administered by the call center)
    - Prescribed medication being cross tapered with another mental health medication (administered by the call center)
  - And for call center approvals only
    - Must meet utilization edits
- ◆ Denial criteria
  - Seroquel® XR 50 mg or Seroquel® 25 mg or 50 mg used for sleep
  - Average daily dose less than the minimum effective dose and absence of approval criteria

**Public Comment:** None

**Board Discussion:** Dr. Wernert asked if diagnosis code ranges were used in the development of these Smart PA rules. Mr. Stancil responded by saying a complete list of diagnosis codes are compiled in Appendix B of each Smart PA rule. There was much discussion among the Board members about what constitutes duplicate therapy. Mr. Stancil explained that duplicate therapy is defined as the use of two similar agents for more than 60 of the past 70 days in the absence of approval criteria. He summarized by providing an example: Drug A must be tried and tapered before Drug B can be tried, and both Drug A and Drug B must be tried before starting both Drug A and B. There was much discussion about when a prescriber would need to call the call center. Mr. Stancil clarified issues such as age restrictions and unclear diagnoses by pointing out the “paper tape” designation in the flow charts; the “paper tape” designations in the flow charts are situations in which a prescriber would need to call the call center. He added that the clinical rules were able to access medical data but sometimes the medical data, e.g., diagnoses, were not always readily available.

Mr. Stancil also presented statistics relating to the estimated number of prescription claims affected by each Smart PA rule: 1) For the atypical antipsychotic duplicate rule, 14,014 claims would hit the edit per month and 1,771 claims would deny per month; 2) For the SSRIs and SNRIs duplicate rule, 16,375 claims would hit the edit per month and 1,473 claims would deny per month; 3) For the stimulant duplicate rule, 4,263 claims would hit the edit per month and 162 claims would deny per month; 4) For the typical antipsychotic duplicate rule, 845 claims would hit the edit per month and 106 claims would deny per month; and 5) For the low dose atypical antipsychotic rule, 9,429 claims would hit the edit per month and 571 claims would deny per month. Dr. Kent Summers asked if the call center was equipped to handle this increased volume of claims. Mr. Stancil responded by saying each rule would be implemented one at a time.

Dr. Lindstrom asked how these rules function differently from what was done before Smart PA. Mr. Stancil responded by saying Smart PA was able to look at diagnosis codes and psychiatrists’ designation as well as other medical information. He went on to say that PA criteria developed before Smart PA looked only at prescription

claims data; therefore, with Smart PA, many claims would pay at point-of-sale as opposed to the prescriber being directed to the call center for a PA. Mr. Musial asked how long it takes to get a PA that is routed to the call center. Mr. Stancil responded by saying phone authorizations are entered while the caller is on the phone and faxed authorization are acted upon within 24 hours.

Dr. Summers suggested that we look not only at financial savings but also the impact of these rules on the quality of care of the Medicaid recipients. Mr. Sharp stated that the MHQAC is focused on quality and the Committee will be tasked with creating an outcomes-based report at some time in the future. Dr. Patricia Treadwell asked how residents who prescribe behavioral health medications would be handled. Mr. Stancil responded by saying the prescriber's identification number would be compared to a specialty list furnished by EDS. He added that if the prescriber was not on the list, the prescriber would have to phone the call center to obtain an approval. Lastly, Mr. Stancil indicated that the first approval for Smart PA edits will be for six months, and the second approval will be for one year.

Dr. Wernert expressed concern over the perception by some providers that the Medicaid program is always being changed. Mr. Sharp indicated that a listing of Smart PA rules would be published ahead of time along with a phased-in schedule. Dr. Summers suggested the new Smart PA rules be tested in a small geographic area before implementing across the state. Mr. Sharp stated that the idea of testing these rules in a small geographic area or maybe starting with the rule with the least provider impact would be considered in an effort to proceed carefully.

**Board Action:** It was moved and seconded that the MHQAC-approved Smart PA rules be approved. The motion passed with five ayes and one abstention.

**MANAGED CARE ORGANIZATION UPDATE:**

- Proposed PDL Changes—MDwise: Mr. Chris Johnson presented material previously sent to the Board members. It was moved and seconded that the PDL changes be approved. The motion passed with five ayes and one abstention.
- Proposed PDL Changes—Anthem: Ms. Jeannine Murray presented material previously sent to the Board members. It was moved and seconded that the PDL changes be approved. The motion was approved unanimously.
- Proposed PDL Changes—MHS: Dr. Katasha Butler stated that she did not have any updates for the Board

**NEW DRUGS:** None.

**LIAISONS WITH OTHER BOARDS:** None.

**PUBLIC COMMENT:** Mr. Keith Huff, a Medical Liaison representing Sanofi-Aventis, spoke in reference to Plavix®. Mr. Huff detailed the indications for Plavix® and cited various studies supporting the use of Plavix®. He expressed concern over the MDwise drug interaction edit involving Plavix® and omeprazole. Mr. Huff did not think it was appropriate for Plavix® to be denied in patients who already take omeprazole. Mr. Chris Johnson, of MDwise, stated that the intent of this edit is for the prescriber to change proton pump inhibitor therapy. Mr. Johnson went on to say that if an intervention is required at the time of adding Plavix® therapy, he felt it was a reasonable safety measure for MDwise members. Dr. Summers added that the intention of this intervention was not to change Plavix® therapy, but rather to change proton pump inhibitor therapy. Mr. Huff indicated that he simply wanted to ensure that the acute coronary syndrome patient is being treated appropriately.

**OLD BUSINESS:** The Board members and OMPP discussed the progress of adding new Board members.

**NEW BUSINESS:** None.

**MEETING ADJOURNED.**