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Indiana Medicaid Drug Utilization Review Board Newsletter

Clinical Topic 1:

Common Cold and Flu

Each year millions of Americans present symptoms of the common cold or flu at the physician's office and receive antibiotic treatment. However, viruses are the cause of the common cold and flu. The usage of antibiotics, in most cases, provides more psychological comfort for patients than actual effects against the disease. In fact, over-the-counter medications and/or vaccination are sufficient to combat the cold and flu.

Based on statistics from the American Lung Association, children have about 6-8 colds a year, and adults average 2-4 colds a year. There are more than 200 different viruses known to cause symptoms of the common cold. Rhinoviruses are responsible for more than half of the colds, but they seldom produce serious illnesses. Other viruses, such as parainfluenza and respiratory syncytial virus, may produce mild infections in adults and more severe lower respiratory infections in young children. The general principle in treating common colds is symptom relief, which can be achieved by antihistamines for sneezing and runny nose (such as chlorpheniramine tablets and syrup, diphenhydramine capsules and elixir), analgesics for aches and fever (acetaminophen, ibuprofen), decongestants for stuffy nose (pseudoephedrine), or cough suppressants (guaifenesin with dextromethorphan).

Flu is a more severe illness than the common cold. Unlike the common cold, influenza typically causes fever, muscle aches, and a more severe cough. However, symptoms of mild cases of influenza are similar to colds. Each year,

influenza affects 10 to 20% of the U.S. population. Vaccination is the primary measure for preventing morbidity and mortality from influenza. The American Academy of Family Physicians and American Academy of Pediatrics recommended that adults aged 50 years or older and children aged 6 to 18 months receive an annual influenza vaccination. High risk individuals aged 19 to 49 years should also receive the immunization. High-risk individuals include, but are not limited to, asthma patients, patients with chronic disorders requiring frequent medical follow-up (such as diabetes mellitus, renal dysfunction, hemoglobinopathies, or immunosuppression), women who are in the second or third trimester of pregnancy during the influenza season, and health care workers. The vaccines are available as an injection as well as the recently approved intranasal spray, FluMist. Antiviral treatments such as amantadine, rimantadine and neuraminidase inhibitors (Relenza and Tamiflu) are additional tools to treat influenza. However, for these drugs to be effective the diagnosis must be made and treatment must be initiated within 48 hours of symptom onset.

Despite the lack of evidence supporting the efficacy of antibiotic agents in treating cold and flu, antibiotics are still frequently prescribed for patients presenting such symptoms. Far from being a harmless practice, prescribing antibiotics for conditions that have no proven benefit of such therapy contributes to serious consequences: the development of antimicrobial resistance and an unnecessary cost to patients and health care system. Today, avoidance of inappropriate antibiotic use and prevention of antibiotic resistance are among the top concerns of public health officials. After decades of antibiotic research and development, we are still engaged in the very same battle with

bacteria. Many bacterial infections in the United States and throughout the world are becoming resistant to antibiotic therapy. The Center for Disease Control and Prevention (CDC) has launched a campaign to fight antibiotic resistance. The following websites provide information for the CDC program and practice guidelines:

- Promoting Appropriate Antibiotic Use in the Community
<http://www.cdc.gov/drugresistance/community/>
- Active Bacterial Core Surveillance (ABCs)
<http://www.cdc.gov/abcs>
- National Immunization Program
<http://www.cdc.gov/nip>
- Principles of Judicious Use of Antimicrobial Agents for Pediatric Upper Respiratory Tract Infections
<http://pediatrics.aappublications.org/cgi/content/full/101/1/S1/163?ijkey=r6Ue0Ru4MrG/Q&keytype=ref&siteid=pediatrics>
- Principles of Appropriate Antibiotic Use for Treatment of Acute Respiratory Tract Infections in Adults: Background, Specific Aims, and Methods
<http://www.annals.org/cgi/content/full/134/6/479>

Clinical Topic 2:

Appropriate Use of Skeletal Muscle Relaxants

Skeletal muscle relaxants (SMRs) are indicated for the treatment of muscle spasm and spasticity. The mechanisms of action of the agents in this class are widely varied, and many are not thoroughly understood. One method by which SMRs exert an effect is interneuronal blockade at the level of the spinal cord. Additionally, these agents have CNS depressant properties that may contribute to, or are mainly responsible for, the skeletal muscle relaxant activity. The CNS depressive mechanism also limits this class' use due to a high incidence of sedation.

Baclofen, carisoprodol, chlorzoxazone, cyclobenzaprine, metaxalone, methocarbamol and orphenadrine all have the indication to treat muscle spasm. For most of the agents, treatment of muscle spasm should be limited to two or three weeks. It is important to encourage proper utilization of these agents because skeletal muscle relaxants, such as carisoprodol and methocarbamol, have been associated with abuse and addiction; therefore, patients should adhere to the suggested dosages for these agents (Table 1). Baclofen, dantrolene and tizanidine have the indication to treat spasticity. These agents may be used for longer periods of time and may play a role in improving the functional status of patients as well as managing the symptoms associated with spasticity. More evidence is warranted to establish whether these agents consistently modify overall disability or improve quality of life.

Although some of these agents (e.g., metaxalone) are presumed to have less pronounced sedative effects than others, all of the SMRs are capable of producing some degree of CNS depression. Potentially hazardous tasks and tasks requiring alertness and/or coordination (such as driving and athletics) should be avoided by patients who are using these drugs. Concomitant use of alcohol or other CNS depressants should be avoided when taking any of these medications.

Skeletal muscle relaxants are a class of drugs whose place in therapy is disputed due to their adverse effect profile and lack of well-designed studies to demonstrate consistent improvement in patients' functional status. These medications can be efficacious when used judiciously. They should not be a substitute for rest, exercise, physical therapy or proper doses of effective analgesics, but rather serve as adjunctive, short-term therapy. Additionally, there is little evidence that demonstrates additional benefit of combination SMR therapy; therefore, concurrent use of multiple muscle relaxants should be avoided. Providers should monitor for adverse effects, abuse, and tolerance in patients.

Table 1. Appropriate dosage and administration of skeletal muscle relaxants

Drug	Adult Dosage and Administration
Baclofen	Titrate slowly up to 40-80 mg/day po given in 3-4 divided doses.
Carisoprodol	350 mg 3 or 4 times daily; take the last dose at bedtime.
Chlorzoxazone	250-500 mg given TID-QID; doses up to 750 mg TID-QID may be given for severe muscle spasm.
Cyclobenzaprine HCl	5-10 mg TID; do not exceed 60 mg/day. Do not use longer than 2 or 3 weeks.
Dantrolene sodium	25-100 mg BID-QID; maximum dosage is 400 mg/day.
Metaxalone	800 mg TID-QID
Methocarbamol	1.5 g QID for 2-3 days
Orphenadrine citrate	100 mg QAM and QPM
Tizanidine HCl	8 mg TID-QID; maximum dosage is 36 mg/day.

Preferred Drug List Review

PDL Re-Review Schedule

A complete re-review of the Indiana Preferred Drug List by the Therapeutics Committee is scheduled to take place on the following dates:

- November 7, 2003
- February 4, 2004

Questions About the PDL

Providers who wish to know more about the PDL are encouraged to refer to the Indiana PBM Web site, www.indianapbm.com. The Indiana PBM website contains specific information about the PDL and the PDL process.

Also, PDL bulletins can be found at www.indianamedicaid.com. For questions about the PDL, please call the ACS – State Health Care Clinical Call Center at 1-866-879-0106.

information pertaining to bulletins and the latest news involving the IHCP pharmacy benefit, as well as DUR Board information, by clicking the appropriate listing from the menu.

DUR Board Members

The 2003 DUR Board members are as follows:

Terry Lindstrom, Ph.D.
Chairperson, Pharmacologist

John J. Wernert, M.D.
Vice-Chairperson, Physician

Patricia Treadwell, M.D.
Physician

Marc Shirley, R.Ph.
OMPP Representative-Ex Officio

Neil Irick, M.D.
Physician

Philip N. Eskew, Jr., M.D.
Physician

G. Thomas Wilson, B.S. Pharm., J.D.
Pharmacist

Thomas A. Smith, P.D., M.S.
Pharmacist

Paula J. Ceh, Pharm.D.
Pharmacist

Brian Musial, R.Ph.
Pharmacist

Marko Mychaskiw, R.Ph., Ph.D.
Health Economist

Vicki Perry
HMO Representative

The DUR Board meets once a month. Dates, locations, and agendas for upcoming meetings are published on the DUR Board Web site. The Web site also allows readers to submit comments to the Board via e-mail. To access the DUR Board Web site, go to the IHCP Web site at www.indianamedicaid.com. Position the cursor to the Pharmacy Services button, found on the top bar of the IHCP’s homepage, to highlight menu selections. Readers can access

Top 25 Drugs Third Quarter 2003

The following table lists the drugs ranked by total amount paid for the first quarter of 2003 for prescriptions dispensed to non-risk based IHCP members.

Top 25 Drugs by Total Amount Paid

DRUG	TOTAL PAID	TOTAL CLAIMS
ZYPREXA	\$10,376,406.67	35,174
RISPERDAL	\$6,443,106.13	36,362
PROTONIX	\$4,724,572.60	49,078
SEROQUEL	\$4,644,219.16	24,700
DEPAKOTE (AND GENERIC)	\$3,491,265.32	30,813
NEURONTIN (AND GENERIC)	\$3,244,837.12	27,306
ZOLOFT	\$3,015,944.19	35,383
LIPITOR	\$2,970,871.37	35,475
ALLEGRA	\$2,550,612.66	41,425
DURAGESIC	\$2,502,204.01	13,507
OXYCODONE (OXYCONTIN AND OTHERS)	\$2,462,446.84	12,537
PAXIL	\$2,180,490.70	25,263
PLAVIX	\$2,138,503.73	19,362
NOVOSEVEN	\$2,086,110.79	115
ZOCOR	\$2,062,319.73	17,624
TOPAMAX	\$2,021,046.30	10,921
EFFEXOR (AND XR)	\$1,920,779.03	17,694
ABILIFY	\$1,864,999.89	6,603
ACTOS	\$1,700,458.22	9,661
ADVAIR	\$1,633,398.97	11,826
SINGULAIR	\$1,624,695.69	20,291
WELLBUTRIN (AND SR, XL)	\$1,536,368.37	16,374
ARICEPT	\$1,410,486.65	11,194
METHYLEPHENIDATE (CONCERTA AND OTHERS)	\$1,386,265.50	21,633
PROZAC (AND GENERICS)	\$1,337,509.60	23,261