

January 12, 2009

Dear Providers:

As stewards of cost-effective medical care for the Upper Peninsula Health Plan (UPHP) population, we have reviewed our formulary coverage of proton pump inhibitors (PPIs). We are attempting to address their utilization in the treatment of acid-related disorders in a cost-effective manner. The cost of the PPIs varies widely. They range from less than 60¢ to as much as \$10 per day of therapy at usual doses. We have noticed what we consider "excess" utilization of brand PPIs, and we recognize a tremendous opportunity to optimize savings without compromising care. Brand-name PPIs account for 48% of spending in this category. In addition, generic drugs such as pantoprazole offer minimal cost savings over omeprazole. Therefore, we have amended our processes and prior authorizations for PPIs.

Effective March 1, 2009, the UPHP PPI formulary will be:

Formulary Preferred Agent: Omeprazole (Prilosec OTC)

Second-line agent (with required prior authorization):

Pantoprazole (Protonix)

Nonformulary agents:

Lansoprazole (Prevacid)

Esomeprazole (Nexium)

Rabeprazole (Aciphex)

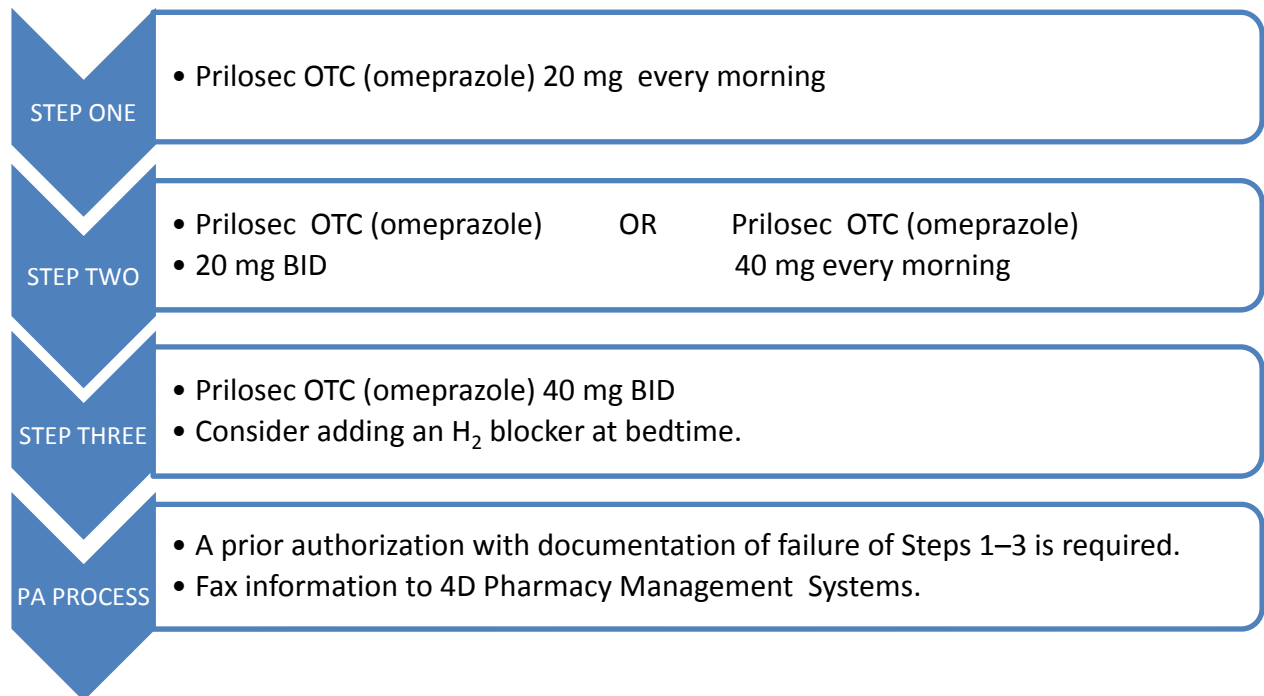
As of March 1, 2009, members using nonformulary proton pump inhibitors will need to switch to omeprazole. Pantoprazole or nonformulary PPIs will only be allowed with very stringent authorization criteria and documentation of medical necessity. No grandfathering will be allowed for this change.

With the education of your patients, this formulary initiative will be successful. We believe that the initiation of this evidence-based change will result in a decrease of \$377,539 in PPI spending during the next year. Thank you for your assistance in providing cost-effective pharmaceutical care to UPHP members. Our evidence-based "Treatment of Acid-Related Disorders" is enclosed. It is also available at www.uphp.com (Pharmacy).

Sincerely,
Pharmacy Department

Enclosure

Upper Peninsula Health Plan Treatment of Acid-Related Disorders



Clinical-Practice and Evidence-Based Protocols

- Proton pump inhibitors (PPIs) are considered pharmacologically equivalent when administered at appropriate doses. Small differences are uncertain, insignificant, and not always consistent from study to study.
- PPIs are most effective when administered before the first meal of the day.
- A second dose should be taken at the evening meal for BID dosing.
- PPI administration should occur 15–30 minutes before a meal to be “activated” by food.
- PPIs can be prescribed with nightly H₂ blockers for breakthrough symptoms; however, they are not to be administered at the same time due to the marked decreased efficacy of the H₂ blockers when given concomitantly.
- Interim PPI usage does not reliably block acid-related symptomatology. Antacids or H₂ blockers are recommended on a PRN basis.
- 10%–15% of patients respond suboptimally to PPIs. The reasons for this are not “clear” but are most commonly related to a failure to follow the optimal administration regimens listed above. Pharmacogenomic differences are present but thought to be rare.

Approaching a patient with refractory gastroesophageal reflux disease symptomatology is a difficult situation. When a patient seems to “fail” on a PPI, the following clinical assessments are necessary.

- Consider the reason for PPI failure.
 - Nocturnal acid breakthrough (which could be solved by the use of an H₂ blocker)
 - Administration issues
 - Dosage interval (increase the frequency)
 - Daily dosage (increase the dosage)
 - Timing of the administration with respect to meals
- Other causes of the patient's symptoms, which may be confused with GERD and for which PPI treatments would not be appropriate
 - esophageal hypersensitivity
 - bowel diseases (IBS, dyspepsia, etc.)