Psychopharmacology NEWSLETTER

Volume 4, Issue 3 September, 2001

From the Editor:

Douglas Del Paggio, Pharm.D., MPA

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Welcome to our Fall 2001 issue of the Bay Area Psychopharmacology Newsletter! Our look has changed but not our goal to bridge the gap between research and practice in psychiatric pharmacology. Although drug companies generously support this newsletter through unrestricted educational grants, they provide no editorial input or control.

We now have an online version of our newsletter available:

http://www.psychiatricnewsletters.com

This version includes past issues, both an article and author index and article/topic links.

For over three years, the content of our newsletter has been progressive work from the four major Bay Area counties (Alameda, San Francisco, San Mateo and Santa Clara). We hope to continue to bring you the best in psychopharmacology for many years to come.

Consumer Advertising of Prescription Drugs

Gary L. Viale, Pharm D, BCPP, FCSHP

It seems you can't browse a magazine or watch a television program without exposure to "Direct to Consumer Advertising" (DTC).[10,8] From a commercial depicting a woman's overactive bladder to a cancer patient's lack of energy, DTC advertising affects almost all of us. Whether for or against it, most of us either think it has improved access to medical information, or we're against it because the quality of information is questionable.

Every day our patients are confronted with these advertisements in magazines, radio and television programs, now with advertising directly via the internet.[10,8] In particular, our patients in Mental Health are confronted with advertisements on depression, PMDD and Social Anxiety Disorder just to name a few.

One author worried that DTC advertising in the United States might create a drain on healthcare dollars by increasing the number of unnecessary prescriptions, while negatively affecting physician-patient relationships.[1] Hollan (1999) reported in JAMA that while consumer advocates of DTC marketing believe that this practice will give patients a greater control over their health care, in actuality the outcome of DTC marketing is really an increased consumer demand, pointing out that many of the consumers do not know if they are being misled or not by the advertisements themselves.[5]

About thirty years ago the FDA (under the 1962 Kefauver-Harris Amendments to the Federal Food, Drug, and Cosmetic Act), advised that DTC advertising must have 4 basic attributes: (1) they cannot be false or misleading; (2) they must present a "fair balance" of information about the risks and benefits of using the drug; (3) they must contain "facts" that are "material" to the product's advertised uses; and (4) in general, the advertisement's "brief summary" of the drug must include every risk from the product's approved labeling.[9]

The pharmaceutical companies are not required to submit the advertisements before publishing them, however the FDA does routinely examine DTC ads after they have been aired. Pharmaceutical companies have been improving, shown by the decline in the number of violations seen.[9]

In recent surveys by the FDA, patients reported that the advertisements have helped remind them to get their medications refilled and helped them to adhere to their regimen. This survey also reported that some patients complained that the advertisements "make the drugs seem better than they really are."[9]

Additionally, Hollan reported that "more than one third of patients have asked their physicians for information on drugs they have seen in a DTC ad, and nearly one fourth have asked for the drug itself… three quarters of the patients requesting drug prescriptions received them from their physicians". It is obvious that marketing of medications to the consumer is big business.[5]

In the year 2000, pharmaceutical companies spent over $2 billion on DTC advertising, compared to $55 million in 1991.[10] It is projected that $7.5 billion will be spent by 2005.[10]

DTC advertising may affect how our patients present initially to their clinicians. One random phone survey of 329 patients conducted in the Sacramento area discovered that "a sizeable fraction of patients believed that they would react negatively if their physician refused to provide a prescription for a drug advertised in the general media." [3] The survey reported that one fourth of the respondents would resort to persuasion, or seeking the prescription elsewhere, and concluded that avenues for dealing effectively with patient's requests for medications by DTC

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Meeting the Challenges of Recruiting Psychiatrists to the Bay Area

Susan Brekhus

In recent years, the public sector has been faced with the challenge of attracting psychiatrists to work in the Bay Area. With the advent of the "dot commers," soaring costs of housing, and the inability of public hospitals/agencies to pay competitive salaries, many psychiatrists have been hesitant to pursue work in the Bay Area public sector. The good news is that rental and house prices are now on the decline, but will this alone encourage psychiatrists to work here? The majority of individuals who depend upon the public sector for care and treatment often suffer from severe mental illnesses, complicated by substance use and severe psychosocial needs.

County inpatient and outpatient mental health programs aim to provide the highest quality of care to individuals with severe mental illnesses and other mental disorders, with a particular focus on those from ethnic and other minority groups. Unfortunately, well-publicized underfunding is a constant threat to its ability to recruit and retain physicians. What strategies can public hospitals and agencies use to highlight their programs and offer incentives to psychiatrists in order to combat the lower pay and challenges of working with the chronically mentally ill and disadvantaged?

The SFGH Department of Psychiatry, for example, has been successful in attracting an increasing pool of resources to develop new programs and to use capitation to expand rather than restrict services. The most recent achievement of the Department is in receiving funding for a 4-year pilot program to develop a Trauma Recovery Center. The Center will serve as a demonstration project to increase access to services for victims of crime, including victims of hate crimes, domestic violence, and family members of homicide victims.

The County system respects the diverse cultures of its patients and employees, and believes it takes a mixture of all kinds of experience, strengths, and perspectives to make a successful clinical and academic department. A multidisciplinary staff of psychiatrists, pharmacists, psychologists, nurses, therapists, as well as administrators provide services. In addition, teaching is an extremely important component of the mission of many departments and the academic environment is ripe with professional opportunities.

The County strives to blend the best of the academic world with the opportunities and needs of the public sector. In turn, their innovative programs and creative energy attract psychiatrists and other mental health professionals throughout the nation to work with them in an environment that is rich with professional growth and opportunity.

If you are interested in exploring public sector employment opportunities within the Bay Area, you may contact the individuals listed below:

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Celia Moreno, MD.
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(650) 573-2043
cmoreno@co.sanmateo.ca.us

Consumer Advertising

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advertising are needed.[3] The physician-patient relationship has been directly affected as a result of DTC marketing.

How does this focus affect our role as clinicians? We must improve our method of educating patients about various disease states. For example, clinicians should provide screening and education on the signs and symptoms of depression. If confronted by a patient who has seen a DTC advertisement , the clinician should proceed by focusing on issues of that disorder through education. Selection of medication should be based on which is the right one for the current indication and not based on which medication was marketed best. If the patient becomes concerned that the DTC ad medication was not prescribed, the clinician must be armed with the knowledge to explain the rationale for choice of medication.

We all need to be prepared for patients who respond to DTC advertising requesting particular medications for their disorders. Although a recent editorial in the American Journal of Health System Pharmacists described DTC drug advertising as dangerous, commenting that other developed countries have made it illegal, realistically, the practice is probably here to stay. Education of the patient regarding their disease state, along with factual information on medication choices is crucial in today's aggressive medication market. Increasing your understanding of these issues will ultimately help your patient as well.

References available upon request

Alameda County
BEHAVIORAL HEALTH CARE

Behavioral Health Care's MIA Medication Financial Rewards Program

Douglas Del Paggio, PharmD, MPA
Richard P. Singer, MD

It is our pleasure to announce Behavioral Health Care's MIA Medication Financial Rewards Program–an exciting and innovative approach to recognizing the cost-saving efforts of BHCS staff in regards to pharmaceutical expenditures. It is the first such program of its kind in our system and provides for a portion of each clinic's relative savings, developed through their participation in the Medically Indigent Adult Medication programs, to be returned to it for patient care use.

Beginning in 1998, the BHCS MIA Program was initiated. On a large scale, this program works with drug companies indigent care drug programs for clients without third party coverage (usually MediCal). Both short-term medication vouchers, and long-term application programs are utilized.

On a monthly basis, potential clients are identified through our PBM, and applications are initiated. With the cooperation of the client, caseworker and psychiatrists at 12 BHCS clinics, the application is completed and submitted. If approved, the drug company will deliver a supply of medication for the client ranging from 1-3 months. Meanwhile, the client's MediCal eligibility is assessed. If indicated, a MediCal application will be completed. On average, ~65% of our clients become MediCal eligible within 1 year, and no longer are enrolled in this program.

Since 1998, this program has saved over 1.2 million dollars. In the year 2000 alone, we saved ~$540,000.

The overall cost of medication is reduced with the use of this program. For example the average Zyprexa prescription would cost $250, but ~$105 is saved through this program, resulting in an average cost of $145.

Savings for each clinic will be measured on a calendar year basis and financial rewards will be based on a percentage of savings and be provided to that clinic for patient care use. A clinic's staff and supervisor will determine such use, with final approval given by the Executive or Center Director.

For the initial year of the program, $135,000 (25% of total 2000 savings) has been identified for distribution back to the clinics based on overall MIA program performance. Neither site or staffing size, indigent

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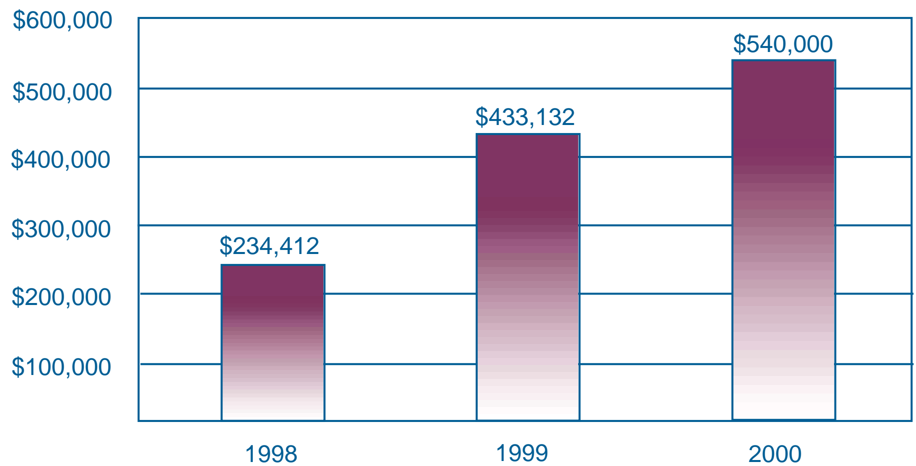

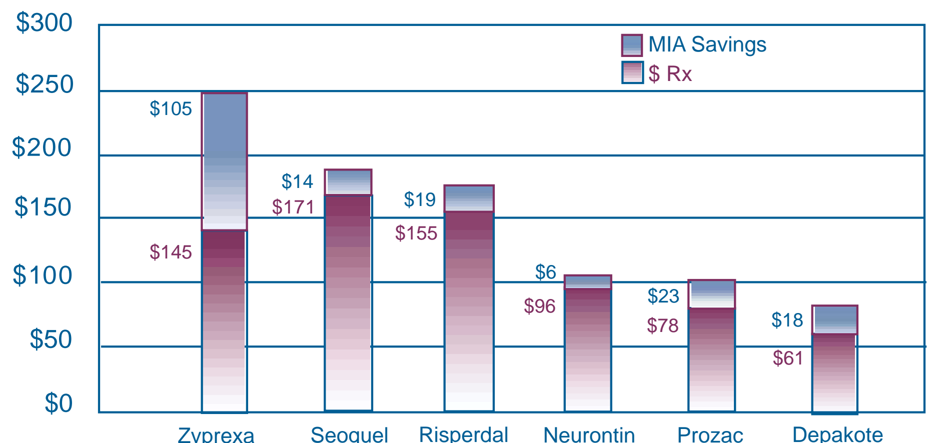

MIA Medication Financial Rewards Program

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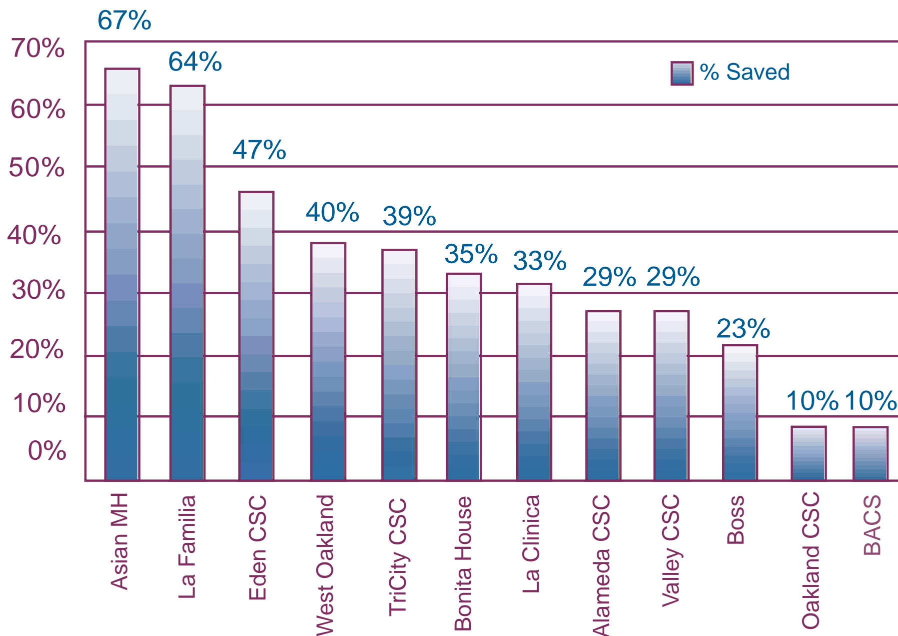
caseload or the total medication expenditure has relevance to the amount of the financial reward earned since it is solely based on the percentage of cost savings generated.

BHCS 2000 MIA Program: % Medication Budget Saved



Atypical Antipsychotics and the Anticholinergic Dilemma

Mark D. Watanabe, PharmD, PhD, BCPP

In determining quality assurance criteria for psychotropic medication monitoring, the question often arises whether the use of concomitant anticholinergic agents to treat antipsychotic-induced movement disorders is warranted in an individual taking an atypical agent such as risperidone, olanzapine, or quetiapine. Historically, the initiation of anticholinergic drugs for prophylaxis against extrapyramidal symptoms (EPS) was once a clear standard of practice, especially in patients taking "high-potency" traditional agents such as fluphenazine or haloperidol. "Low-potency" drugs, e.g., chlorpromazine or thioridazine, had inherent anticholinergic properties that were thought to render them less likely to cause EPS. Yet, even the "low-potency" agents were not completely devoid of the risk of causing movement disorders.

Clinical experience has confirmed that, overall, the atypical antipsychotics have a decreased propensity to cause EPS compared to the older neuroleptic. Does this mean that anticholinergic agents should not be used in individuals on atypical agents? The medical literature does not offer a definitive answer at present. Perhaps, as in the case of the "low-potency" traditional agents, atypical agents with innate anticholinergic properties would be less likely to require concomitant anti-EPS drugs, but this may not always be a given. A study published last year (1) comparing anticholinergic activities among patients receiving standard clinical doses of olanzapine or clozapine demonstrated differences between the two: Olanzapine was shown to have one-fifth the anticholinergic potential of clozapine. Unfortunately, there was no mention of abnormal movement assessments or differences in observed EPS between subject groups. A European meta-analysis of randomized controlled antipsychotic trials (2) included a comparison of antiparkinsonian use in patients taking olanzapine, quetiapine, risperidone, and haloperidol. Not surprisingly, the investigators found that all of the newer agents were associated with less frequent use of anti-EPS medication compared to haloperidol, with risperidone having a slightly less favorable EPS profile among the comparator atypical agents. Each of these recent reports suggest that treatment-emergent EPS is still possible with the newer antipsychotics.

The advantages of not automatically giving more medications to a patient are evident: Compliance is more likely with a simpler regimen, and added side-effect burdens are avoided. In most cases, anticholinergic prophylaxis is not needed in patients taking atypical antipsychotics. However, when there may be clinically justifiable reasons for the combination, those reasons should be clearly documented in the medical record and incorporated in the therapeutic plan. In the absence of consensus guidelines on the issue, such documentation would minimize confusion in any quality assurance process.

ANTIPSYCHOTIC	EPS RISK
Clozapine	+
Olanzapine	+
Quetiapine	+
Risperidone	+/++*
Haloperidol	+++

* dose-dependent increase
+: low incidence
++: moderate incidence
+++: high incidence

Therapeutic Update of New Formulations – PART I

Kirby Lee, UCSF Pharm.D. Candidate and Renee Spencer, Ph.D.

A number of new formulations and indications of existing psychotropic medications have recently hit the market. It is not clear to what extent these formulations provide additional benefits or therapeutic advantages over existing formulations. Below is a brief description of each drug describing the formulation, indication, efficacy, potential advantages/disadvantages, average wholesale price (AWP), and Medi-Cal status.

Depakote ER (Abbott Laboratories)

Depakote ER is an extended-release tablet indicated for the prevention of migraine headaches in adults. It is supplied as a 500 mg tablet containing divalproex sodium and dosed 500-1000 mg QD. Potential advantages include improved compliance with once-daily dosing and a 10-20% lower fluctuation in plasma concentration compared to Depakote delayed-release tablets given BID. However, many psychiatric patients are placed on a QHS regimen of the existing Depakote formulation. Furthermore, in patients who may be more sensitive to side-effects, it may be easier to titrate the dose using Depakote delayed-release 250 mg tablets. Depakote ER is not bioequivalent to Depakote delayed-release. The total dose of Depakote ER may need to be 10 to 25% higher to achieve equivalent blood levels.The current AWP for Depakote ER 500 mg is $1.72 per tablet. It is priced similarly to standard Depakote but can end up being somewhat more expensive due to the higher dose usually required. It is not on the Medi-Cal formulary.

Prozac Weekly (Eli Lilly & Company)

Prozac Weekly is a new formulation of Prozac indicated for continuation treatment of depression. Patients may be switched to Prozac Weekly after achieving an antidepressant response to treatment with Prozac 20 mg daily. It is supplied as a modified release formulation containing enteric-coated pellets of fluoxetine hydrochloride 90 mg in a capsule and dosed once-weekly. The 90 mg Prozac Weekly formulation is bioequivalent to 90 mg immediate release, only the onset of absorption and Tmax are delayed by 1 to 2 hours compared to the once-daily regimen of Prozac 20 mg/day. Therefore, it is recommended that Prozac Weekly be started one week after stopping Prozac 20 mg/day in order to maintain similar peak concentrations. Administration of Prozac Weekly once-weekly results in increased fluctuations in peak and trough concentrations of fluoxetine and norfluoxetine. According to the package insert, average steady-state fluoxetine concentrations are 50% lower following the once-weekly regimen compared to the 20 mg once-daily regimen. While a potential advantage is improved adherence, it is unclear if this can be achieved in the more severely ill, disorganized population as is seen in community mental health. This formulation should only be used for patients who are stable on a 20 mg daily dose of Prozac. The current AWP for Prozac Weekly 90 mg is $18.90 per capsule providing a cost savings of $1.82/week over daily Prozac. It is not on the Medi-Cal formulary.

Sarafem (Eli Lilly & Company)

Sarafem is indicated for the treatment of premenstrual dysphoric disorder (PMDD). The active ingredient of Sarafem is fluoxetine hydrochloride and its pharmacokinetic parameters and adverse effect profile are identical to Prozac.

It is supplied as 10 mg or 20 mg lavender pulvules containing fluoxetine hydrochloride and dosed 20-80 mg QD. Sarafem 10 and 20 mg are priced similarly to Prozac at $2.89 and $2.97 per pulvule respectively. It is available through Medi-Cal.

Remeron SolTabs (Organon)

Remeron SolTab is a new formulation of oral disintegrating tablets containing mirtazapine indicated for the treatment of depression. It is supplied as 15, 30, or 45 mg tablets with a usual dose of 15-45 mg QD. Remeron SolTab disintegrates on the tongue in less than 30 seconds and produces a peak concentration in 2 hours. It is bioequivalent to Remeron (mirtazapine) tablets with similar pharmacokinetic parameters and adverse effects. This formulation may be advantageous in those patients who have difficulty swallowing tablets or have compliance issues. However, Remeron tablets can be crushed and mixed with food to achieve the same effects. The current AWP for Remeron SolTabs 15 and 30 mg is $2.30 and $2.37 per tablet respectively. Remeron SolTabs are priced similarly to the standard tablets and are available through Medi-Cal.

Zyprexa Zydis (Eli Lilly & Company)

Zyprexa Zydis is a new formulation of oral disintegrating tablets containing olanzapine indicated for the treatment of schizophrenia. It is supplied as 5, 10, 15, or 20 mg tablets with a usual dose of 5-10 mg once daily. It is bioequivalent to Zyprexa tablets with similar pharmacokinetic parameters and adverse effects. Buccal absorption does not appear to occur to any measurable extent; therefore, it does not have a faster onset of action than the standard oral tablet. This formulation may be advantageous in those patients who have difficulty swallowing tablets or have compliance issues. However, Zyprexa tablets can be crushed and mixed with food to achieve the same effects. The current AWP for Zyprexa Zydis 5 and 10 mg is $7.03 and $10.08 per tablet respectively. Standard Zyprexa 5 and 10 mg tablets are less expensive costing $5.90 and $8.98 respectively. Zyprexa Zydis is not on the Medi-Cal formulary.

To be continued in next issue

CONTINUING MEDICAL EDUCATION

Social Inept Children
Hernert Schreier, MD
September 11, 2001 – 12:15 pm
San Mateo MHS, 225 West 37th St.
(650) 573-2530

Advancements in Management of Schizophrenia
Seth Cohen, MD
September 12, 2001 – 12:00 pm
Alameda Co. BHCS, 2000 Embarcadero, #400
Oakland (510) 567-8106

Motivational Enhancement Strategies in Schizophrenia
Doug Ziedonis, MD
September 18, 2001 – 8:00-12:00 pm
Alameda Co. BHCS, 2000 Embarcadero, #400
Oakland (510) 567-8106

SSRIs, Dopamine, and Prolactin: What's the Connection?
Paul Barkopoulos, MD
September 21, 2001 – 11:45 pm
SFGH Room #7M30, 1001 Protrero Ave.
(415) 206-4938

Obsessive Compulsive Disorder
Lorrin Koran, MD
September 25, 2001 – 12:15 pm
San Mateo MHS, 225 West 37th St.
(650) 573-2530

Dual Diagnosis Delima
Pablo Stewart, MD
October 5, 2001 – 11:45 pm
SFGH Room #7M30, 1001 Protrero Ave.

Post Traumatic Stress Disorder
Daniel Becker, MD
October 9, 2001 – 12:15 pm
San Mateo MHS, 225 West 37th St.
(650) 573-2530

Bedside Manner
Jeff Kane, MD
October 11, 2001 – 12:00 pm
Alameda Co. BHCS, 2000 Embarcadero, #400
Oakland (510) 567-8106

New Tx for BAD
Mark Frye, MD
October 19, 2001 – 11:45 pm
SFGH Room #7M30, 1001 Protrero Ave.
(415) 206-4938

Psychiatry in Russia
Masha Mednikov, MD
October 23, 2001 – 12:15 pm
San Mateo MHS, 225 West 37th St.
(650) 573-2530

New Treatment Modalities for Mood Disorders
Terrence Ketter, MD
October 24, 2001 – 12:00 pm
Alameda Co. BHCS, 2000 Embarcadero, #400
Oakland (510) 567-8106

Hispanic Cultural Issues
Carmenza Rodriguez, PhD
November 13, 2001 – 12:15 pm
San Mateo MHS, 225 West 37th St.
(650) 573-2530

Defining the Role of Atypcial Antipsychotics
Ron Koshes, MD
November 16, 2001 – 12:00 pm
Strizzi's
1376 E. 14th Street, San Leandro
(510) 567-8106

BAY AREA PSYCHOPHARMACOLOGY NEWSLETTER

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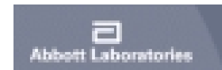

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