

**ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE**

**Location of Meeting
Frontier Building, 3601 C Street, Room 890/896**

**MINUTES OF MEETING
September 21, 2012
8:00 a.m.**

Committee Members Present:

Dharma Begich, Pharm.D.
Marvin Bergeson, MD
Amber L. Briggs, Pharm.D.
Robert H. Carlson, MD
Jeffrey G. Demain, MD
Mary Elizabeth Gardner, ANP
Daniel P. Kiley, DDS MPH
Diane Liljegren, MD (telephonic)
William McCormick, Pharm.D.
John Pappenheim, MD
Claudia Phillips, MD
Jill Reid, R.Ph. (telephonic)
John Riley, PA

Committee Members Absent:

Richard Brodsky, MD
Vincent Greear, R.Ph.
Paul Michaud, Pharm.D.
Trish White, R.Ph.

Others Present:

Erin Narus, Magellen Medicaid Administration
Chad Hope, Pharm.D.

1. Call to Order – Chair

Dr. Demain called the meeting to order at 8:00 a.m. Erin Narus, the new representative from Magellen Medicaid Administration, was introduced.

2. Roll Call

A quorum was present.

3. Public Comments - Local Public/Health Practitioners

There were no public comments.

4. Re-review of Erythropoiesis Stimulating Proteins (Red Category)

CLAIRE MARINER: A representative of Amgen discussed Aranesp and Epogen. Epogen is approved for the treatment of anemia associated with CKD in patients on dialysis. It is used by the majority of chronic dialysis patients. The dosing regimen, which was reviewed, allows for timely intervention to manage changes in hemoglobin as patients on dialysis experience hemoglobin variability due to a number of factors. Aranesp has an FDA approval for the treatment of anemia associated with CKD for patients both on and not on dialysis. The key benefit of Aranesp in CKD patients not on dialysis was reviewed. During 2011, in collaboration with the FDA, Amgen modified the label for ESAs to communicate a revised benefit-risk profile that applies to all ESAs, which was reviewed. Aranesp is approved for the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy. The dosing regimen, which was reviewed, means Aranesp can be synchronized with common chemotherapy schedules. This flexible dosing regimen is unique to Aranesp and allows a physician to consider which treatment best meets the needs of an individual patient, as well as reduces the number of ESA injections needed for anemia therapy. When used in accordance with the ESA prescribing information, ESA therapy provides an important clinical benefit for patients with CIA and CKD by reducing the need for red blood cell transfusions and exposure to their associated risks. Aranesp and Epogen have been approved therapies for more than 10 and 20 years, respectively, and the extensive clinical experience has helped to inform the safety profile of ESAs in the management of anemia. We respectfully ask the committee to maintain both on the Alaska PDL.

Dr. Hope reviewed the letters of support received from several providers on various classifications, which were included in a summary provided to the committee.

Ms. Narus gave the Magellen presentation on Erythropoiesis Stimulating Proteins. ESAs are indicated for use in patients with anemia with chronic renal failure or anemia resulting from chemotherapy for a palliative intent only, and should be discontinued when there is less than one- to two-gram per deciliters increase in hemoglobin. Non-responders should be checked for tumor progression and a deficiency or other etiologies for anemia. Epogen and Procrit can be used in pediatric patients. They are also indicated for use in those patients with zidovudine therapy induced anemia. A single dose vial should be used for pregnant women to avoid benzyl alcohol issues. Significant changes include Omontys, or Peginesatide, was approved for the treatment of anemia due to CKD in adult patients on dialysis only and offers a once-monthly dosing regimen. There is a decreased risk of pure red cell aplasia due likely to it being chemically unlike erythropoietin, but it acts to stimulate erythropoiesis by activating the human erythropoietin receptor. It can be administered either by IV or subcutaneously. Omontys has a REMS program requirement, including provider communication and education on the indication of serious associated risks of cardiac and embolic events. Use in pediatrics has not been established. It exhibits similar safety and efficacy maintaining hemoglobin when compared to the other ESAs.

Dr. Hope reviewed the market shift report, which specifies the preferred products. The Alaska Preferred Drug List is adopted into reference and regulation through a lengthy and formalized process, which takes time to update. Public comments for the update were held last week. A revision reflecting last year's motions and the new generic products available should be out in the near future.

Dr. Demain noted that there is a medically necessary clause that allows medications that are not on the PDL to be prescribed by physicians as long as there is reasonable justification.

Ms. Narus reviewed the utilization. From June to August, there were 48 claims for this class: 25% for Aranesp, 2% for Epogen, and 73% for Procrit. At the last review, a motion for class effect passed unanimously.

DR. LILJEGREN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. BERGESON. THE MOTION PASSED WITH ONE OPPOSED.

5. Re-Review of Antihyperuricemics (Red Category)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Antihyperuricemics. Gout is managed in three stages: acute treatment, prophylaxis to prevent acute flares, and lowering excess stores of urate to prevent flares of gouty arthritis and prevent tissue deposition of urate crystals. Colcrys is the only FDA approved branded Colchicine. It is indicated for both the treatment and prevention of gout flares. Xantine oxidase inhibitor therapy should not be initiated until four to six weeks after an acute episode. Patients using Uloric or Allopurinol should not stop therapy. After starting Uloric, an increase in gout flares is common due to mobilization of urate from the tissues. Significant changes were reviewed. Krystexxa, an IV agent for gout, is indicated for the treatment of chronic gout in adult patients. It is not recommended for the treatment of asymptomatic hyperuricemia. The pharmacology and dosing regimen of Krystexxa was reviewed. It should not be used in patients with G6PD deficiency due to the increased risk of hemolysis and methomoglobinemia. Therefore, patients of Mediterranean or African ancestry should be screen for this deficiency prior to initiation. Administration is required to occur in a health care setting to manage anaphylaxis, which has a rate of 6.5 percent. Other adverse reactions were reviewed. Caution should be exercised in CHF. Additional drug-drug interactions have not established at this time. From June to August there were 84 claims for the oral agents: 93% for Colcrys and 6% for Probenecid. For the xanthine oxidase: 92% for Allopurinol and 8% for Uloric. At the last review, a motion for therapeutic alternatives passed unanimously.

In response to Dr. Carlson, Ms. Narus said there did not seem to be a causal relationship to cardiovascular or liver enzyme elevations events in patients using Uloric.

DR. LILJEGREN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE XANTHINE OXIDASE INHIBITOR, COLCHICINE PRODUCT, AND URICOSURIC PRODUCT. SECONDED BY DR. BRIGGS. THE MOTION PASSED UNANIMOUSLY.

Break from 8:24 a.m. to 8:32 a.m.

6. Re-Review of Benign Prostatic Hyperplasia Treatments (Red Category)

There were no public comments.

Ms. Narus gave the Magellen presentation on Benign Prostatic Hyperplasia Treatments. This class includes alpha-adrenergic blockers Uroxatral, Flomax, Hytrin, and Rapaflo; 5-alpha reductase

inhibitors Avodart and Proscar; the combination product Jalyn; as well as a new class of phosphodiesterase 5 inhibitors. The significant changes were reviewed. Cialis has been approved for the treatment of BPH and showed a statistical benefit over placebo in BPH symptom improvement. It is a PDE5 inhibitor. The mechanism for reducing BPH symptoms has not been established. It is metabolized through the CYP450 system. CYP3A4 inhibitors may increase Tadalafil exposure while inducers such as Rifampin may decrease exposure. Tadalafil can potentiate the hypertensive effects of nitrates and alpha-blockers. There is insufficient information on use in patients with hepatic impairment. It is not recommended for patients with creatinine clearance less than 30 milligrams for patients on hemodialysis. From June to August, there were 203 claims: 78% for Doxazosin and 22% for Terazosin. For the 5-alpha reductase inhibitors there were 244 claims: 48% for Avodart and 48% for Finasteride. The 5-alpha reductase inhibitors had 472 claims for Tamsulosin. In addition, there were three claims for Cialis. At the last review, a motion for alpha-adrenergic blockers of a class effect, to include at least one alpha-1 selective agent, passed unanimously. A motion for the 5-alpha reductase inhibitors, a motion for class effect passed unanimously.

DR. LILJEGREN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE ALPHA BLOCKER AND ONE 5-ALPHA REDUCTASE INHIBITOR. SECONDED BY DR. CARLSON.

Dr. Carlson suggested that Cialis could be prescribed using the medically necessary clause. Dr. Hope suggested including at least one HI in the motion.

THE MOTION FAILED WITH 11 OPPOSED.

In response to Dr. Carlson, Dr. Demain explained the difference between therapeutic alternatives and therapeutic equivalents, which is basically the same. The PDE5s require a prior authorization so it will be under strict scrutiny even if it is on the preferred list.

DR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE ALPHA-BLOCKER AND ANDROGEN HORMONE INHIBITOR. SECONDED BY DR. GARDNER. THE MOTION PASSED UNANIMOUSLY.

6. Re-Review of Anticoagulants (Blue Class)

JONATHAN MEDSCHER: Spoke in favor of adding Rivaroxaban to the PDL. It has an oral administration versus a subcutaneous injection, which increases patient adherence. There is no need to adjust for age or weight. (Indiscernible -- recording problems.)

BOB SNEDIKER: A representative of Janssen discussed Xarelto. It is indicated for the prevention of DBT in patients undergoing hip and knee replacement. It has demonstrated superiority to the low molecular weight heparins. In December, it received approval for treatment of nonvalvular atrial fibrillation. Several studies and their outcomes were reviewed. The bleeding rates for Warfarin and Xarelto are generally considered similar. Although there may be some differences in GI bleed or two unit drops in hemoglobin, the benefits of the hemorrhagic stroke outweigh the risks. Advantages include no monitoring requirements for patients being treated with Xarelto and once-a-day dosing.

In response to Dr. Demain, Mr. Snediker discussed hemorrhaging patients who needed to have anticoagulation reversed and the use of Xarelto in elderly patients.

STEVE HALL: A representative of Boehringer Ingelhem discussed Pradaxa, which is a novel oral anticoagulant that has been on the market since FDA approval in 2010. A recent label change was reviewed. Pradaxa is indicated to reduce the risk of stroke and systemic embolism in patients with nonvalvular atrial fibrillation. Several studies and their outcomes were reviewed. Pradaxa has a similar risk of major bleed relative to Warfarin. Primary efficacy endpoints were generally consistent across all major subgroups in the study with the exception of a trend in patients over 75 years of age to a higher incidence of major bleeds. The risk of stroke and bleeding increases with age, but the label indicates that the risk/benefit profile is favorable in all age groups. It also showed less total bleeds, less life-threatening bleeds, and less intracranial hemorrhages, but increased rates of GI and major GI bleeds relative to Warfarin. Pradaxa is contraindicated in patients with active pathological bleeds and patients with a history of hypersensitivity reactions to the drug. Blood levels are impacted by PGP inducers and inhibitors, as well as renal function. Pradaxa is superior in reducing strokes relative to Warfarin and has similar rates of major bleeding. With the new label, it is the first and only anticoagulant to show superiority in reducing both ischemic and hemorrhagic strokes relative to Warfarin in patients with nonvalvular atrial fibrillation.

In response to Dr. Demain, Mr. Hall discussed the use of Pradaxa in elderly patients. Risks increase with age. Patients over 75 years of age should have ongoing monitoring. Patients who are older than 30 can have a dosage of 150 milligrams, twice a day. Patients between 15 and 30 years of age should be given 75 milligrams, twice a day.

Ms. Narus gave the Magellen presentation on Anticoagulants. Within this category, there are injectable and oral agents, which were reviewed. Most of the significant changes were noted in previous testimony. From June to August, there were 600 claims for the oral agents: 85% for Warfarin, 7% for Coumadin brand, 6% for Pradaxa, and 1% for Xarelto. There were 137 claims for the low molecular weight heparins: 79% for generic Enoxaparin, 4% for Fondaparinux, 4% for Fragmin, and 13% for Lovenox. At the last review, a motion for therapeutic alternatives passed unanimously.

Dr. Hope suggested having the motion reflect one each of the injectable and oral product if that is the intent of the committee.

DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE ORAL AGENT, ONE INJECTABLE AGENT, AND WARFARIN. SECONDED BY DR. LILJEGREN. THE MOTION PASSED UNANIMOUSLY.

7. Re-Review of Platelet Aggregation Inhibitors (Blue Class)

JAMIE HURST: A representative of AstraZeneca discussed Brilinta. It is indicated to reduce the rate of thrombotic cardiovascular events in patients with acute coronary syndromes, including unstable angina and long ST-elevation myocardial infarction when given with aspirin 100 milligrams or less. Brilinta has been shown to reduce the rate of a combined endpoint of CV death, MI, or strokes. It also reduces the rate of stent thrombosis in patients treated with percutaneous intervention. It is contraindicated in patients with a history of intracranial hemorrhage, active pathological bleeding, or

severe hepatic impairment. Several guideline updates, which suggest the use of Brilinta over Clopidogrel, were reviewed. They include a class one recommendation for the use of Brilinta for the management of patients with ACS undergoing PCI for at least 12 months, Brilinta for the management of ACS in patients not undergoing PCI, and Brilinta plus low-dose aspirin as a treatment option for the first year following an ACS event with all about PCI. Several studies and their outcomes were reviewed. There are boxed warnings for increased risk of bleeding and for use of maintenance doses of aspirin less than 100 milligrams per day. Please refer to the Brilinta's prescribing information for complete product information, boxed warnings, and precautions.

In response to Dr. Demain, Mr. Hurst said Brilinta could be used in combination with less than 100 milligrams of aspirin per day.

LINDA KRUEGER: A representative of Lilly discussed Effient, a thienopyridine P2Y₁₂ platelet inhibitor that is converted to an active metabolite primarily by CPY3A4 and CYP2B6. It inhibits platelet action by irreversibly binding to the platelet ADP receptor. The dosage information was reviewed. Patients should also take aspirin at 75 milligrams to 325 milligrams per day. It is indicated for the reduction of thrombotic CV events in patients with acute coronary syndrome who are to be managed with percutaneous coronary intervention as follows: patients with unstable angina or non-ST elevation myocardial infarction, or patients with ST-elevation myocardial infarction when managed with either primary or delayed PCI. Several studies and their outcomes were reviewed. Please refer to the complete prescribing information for the safety data and boxed warnings.

Ms. Narus gave the Magellen presentation on Platelet Aggregation Inhibitors. Indications and mechanisms of action vary within the platelet inhibitor class. The primary role is the prevention of thrombotic events. In October 2010, the FDA reiterated its warning of the Clopidogrel combination causing decreased anti-platelet activity. Plavix, Effient and Brilinta are contraindicated in patients with active bleeds. Both Brilinta and Effient have REMS requirements that medication guides be given at dispensing. Plavix has been released from REMS. Significant changes have been outlined in previous discussions. The 2012 ACCB Guidelines no longer include Ticlopidine. From June to August, there were 765 claims: 4% for Aggrenox, 84% for generic Clopidogrel, 4% for Effient, 9% for Plavix, and no utilization for the other agents. At the last review, a motion for therapeutic alternatives, with Clopidogrel or Prasugrel being preferentially included, passed unanimously.

Dr. Hope noted that Plavix had gone generic again.

Dr. Demain questioned if any of these agents were indicated as a primary prophylaxis in aspirin-sensitive patients with no previous MI or stroke event. Ms. Krueger said Effient did not have that indication, and Mr. Hurst said Brilinta did not have that indication, either.

DR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, WITH AT LEAST ONE OF CLOPIDOGREL (PLAVIX) OR PRASUGREL (EFFIENT) BEING PREFERENTIALLY INCLUDED, AND EXCLUDING TICLOPIDINE. SECONDED BY DR. GARDNER. THE MOTION PASSED WITH ONE OPPOSED.

8. Re-review of Pancreatic Enzymes (Blue Class)

WILLIAM LAM: A representative of Abbott discussed Creon. The committee is encouraged to review the full package insert for comprehensive safety and efficacy data. Nutritional status is vital to the long-term survival of patients with CF. Creon is the first FDA-approved, delayed-released pancreatic enzyme to be marketed in the U.S. and the only one to be indicated to treat pancreatic insufficiency due to pancreatectomy or chronic pancreatitis. It is not interchangeable and product substitution is not recommended. The CF Foundation recommends that prevention of malnutrition be a primary goal in the management of these patients. Studies show a strong correlation between higher BMI and improved lung function in the survival of CF patients. Several studies and their outcomes were reviewed. Dosing regimens were reviewed. Creon should be initiated in patients at the lowest recommended dose and gradually increased. Pancreatic enzyme products are not absorbed in the gastrointestinal tract in any appreciable amount. In April 2004, the FDA announced that all pancreatic enzyme products are new drugs and require approval. In April 2009, Creon became the first pancreatic enzyme to be approved under this process. It is the number one prescribed pancreatic enzyme in the U.S. We urge the committee to maintain the preferred status of Creon on the Alaska PDL.

Dr. Hope said Dr. Roberts, who provided public comments last year, said the agents were not necessarily interchangeable.

DR. KILEY MOVED THAT THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. LILJEGREN.

Dr. Demain noted that these products were not interchangeable. Physicians can continue to prescribe patients the agents they are currently using with the medically necessary clause.

THE MOTION PASSED UNANIMOUSLY.

9. Re-Review of Topical Psoriasis Agents (Blue Class)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Topical Psoriasis Agents. Psoriasis is a chronic autoimmune disease that appears on the skin, but psoriasis can also affect the joints and connective tissue. Topical corticosteroids are the cornerstone of treatment. These agents have different mechanisms of action, but the affect is to normalize skin cell production and reduce inflammation. Taclonex should not be used in patients with calcium metabolism disorders as hypocalcaemia and hypercalciuria have occurred. In June to August, there were 54 claims: 7% for Calcitrene ointment, 6% for Calcitrene solution, 4% for Calcitriol, 19% for Dovonex, 6% for Taclonex, 15% for Vectical, and 39% for Tazorac cream. Significant changes were reviewed. It has been demonstrated that Calcitrene ointment can be unstable when mixed with other topical preparation. At the last review, a motion for class effect passed unanimously.

Dr. Demain said he found Dovonex to be effective. Using a high-potency topical steroid can often exacerbate psoriasis, but combining it with a low-potency topical steroid can be beneficial. The class is interchangeable, but it should not be limited to the product that is in combination with Betamethozone.

DR. BRIGGS MOVED A CLASS EFFECT. SECONDED BY DR. KILEY.

Dr. Carlson noted that there were only 21 patients receiving these agents so the medically necessary clause could be utilized. The committee discussed whether both a skin and scalp formulations should be included in the motion.

THE MOTION PASSED WITH ONE OPPOSED.

Break from 9:26 a.m. to 9:38 a.m.

Dr. Demain discussed the medically necessary clause. The medications that have high abuse or inappropriate use potential are monitored through the Drug Utilization Committee and not this committee. Our goal is to ensure that there are appropriate choices for Alaskan patients so physicians can provide good standard care.

10. Re-Review of Alzheimer's Agents (Green Class)

Ms. Narus gave the Magellen presentation on Alzheimer's Agents. There are two subsections within this group: the acetyl cholinesterase inhibitors and NMDA receptor antagonists. Namenda has a unique mechanism of action and acts as an NMDA receptor antagonist, which was described. There have been medication errors resulting from not removing old Exelon patches. Patients need to be educated on proper dose and administration. From June to August, there were 202 claims for the acetyl cholinesterase inhibitors: 79% for Donepezil tabs, 7% for Donepezil ODT, 1% for Aricept, 6% for Exelon patches, and 6% for Rivastigmine capsules. For the NMDA receptor antagonists, there were 160 claims for Namenda tablets. At the last review, a motion for therapeutic alternatives passed unanimously.

In response to Dr. McCormick, Dr. Hope said the bids could be based on either a specific drug or a specific dosage formulation.

In response to Dr. Riley, Dr. Hope explained that both generic and brand name drugs were listed on the utilization report. If the brand name appears, the prescription was filled with the brand name drug. If the brand name appears and then suddenly the generic is listed, it may indicate that there was a new generic market approval. The market often shifts to the generic products before the list is updated.

Dr. Demain said there were some medications where the generic was not a reasonable substitution due to formulation or therapeutic range. He questioned if that was applicable to any of these medications. Dr. Hope said that he did not feel that brand name drugs were superior to generics. He was not aware of any of the drugs in this class being a source of controversy.

DR. PAPPENHEIM MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

11. Re-Review of Lipotropics, Other (Green Class)

Ms. Narus gave the Magellen presentation on Lipotropics, Other. This class includes Niacin, omega-3 fatty acids, fibric acids, cholesterol absorption inhibitors, and bile acid sequestrants. Clinical studies have repeatedly shown that high levels of LDL are a major risk factor for coronary heart disease. Lowering these levels reduces the risks. Although accomplished by different mechanisms of action, the

common goal of these agents is to lower the serum LDL. The 2011 recommendations for fasting triglycerides are now less than 100 milligrams per deciliter. The goals for LDL were reviewed. From June to August, there were 821 claims for the fibric acids group: 21% for Gemfibrozil, 42% for Tricor, 17% for Trilipix, and 5% for Fenofibrate. In the Niacin group, there were 211 claims: 98% for Niaspan and 2% for Simcor. For the cholesterol absorption inhibitors, Zetia had 352 claims. For the omega-3 fatty acids, Lovaza had 127 claims. For the bile acid sequestrants, there were 48 claims: 27% for Cholestyramine, 4% for Cholestyramine Light, 46% for Colestipol tablets, 10% for Colestipol Light, and 14% for WelChol. At the last review, these agents were broken out into the various groups. For the fibric acid, omega-3 fatty acid, and bile acid sequestrants, a motion for therapeutic equivalence passed unanimously. For Niacin, a motion for class effect passed unanimously. For the cholesterol absorption inhibitors, a motion for Zetia as a class effect passed unanimously. For the bile acid sequestrants, a motion for class effect passed unanimously.

Dr. Carlson felt there were several efficacy problems within this class. Fish oil tablets do not parallel the efficacy of a fish-rich diet and have no value. Niacin and Zetia studies were discussed.

Dr. Hope said that would play into handling the drugs as a single category. If they are split, then the categories with only one drug will include that drug whether or not the efficacy is there. With a specific motion, you can eliminate the drugs that you do not want to include on the PDL.

Dr. Demain pointed out that Lovaza was being purchased, but fish oil was probably equally effective or ineffective and cost pennies on the dollar.

DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE TRIGLYCERIDE LOWER AGENT AND ONE BILE ACID SEQUESTRANTS. SECONDED BY DR. KILEY.

The committee discussed eliminating Lovaza from the PDL. Dr. Hope explained that the motion would need to specifically state which drugs were excluded from the PDL.

Dr. Phillips said that last year a physician testified that there was a place for Niacin in his particular population. Dr. Hope reviewed two letters that was provided by Dr. Maciejewski and Dr. Scalia, both advocating for Niaspan. The committee further discussed the motion. It was noted that the medically necessary clause could be utilized.

THE MOTION PASSED UNANIMOUSLY.

12. Re-Review of Bile Acid Salts (Green Class)

Ms. Narus gave the Magellen presentation on Bile Acid Salts. These agents are used to dissolve gallstones as an alternative. Not all patients experience complete dissolution of gallstones and recurrences has been observed in almost 50 percent of patients within five years of bile acid therapy. From June to August, there were 131 claims: 92% for Ursodiol and 8% for Forte. At the last review, a motion for therapeutic alternatives passed unanimously.

Dr. Carlson said there were a number of patients with primary biliary cirrhosis in the state, which may account for the major use in this category. I doubt that very many patients with gallstones are being advised by their surgeons to take a medicine rather than having a procedure.

Dr. Hope noted that none of these drugs was currently listed as preferred agents. This class was reviewed for the first time last year and the PDL has not yet been updated. Dr. Briggs asked for clarification on the timeline for the committee's decisions to take effect. Dr. Hope said it did not always take a year, but there were challenges last year that significantly slowed down the process.

DR. GARDNER MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY UNIDENTIFIED FEMALE. THE MOTION PASSED UNANIMOUSLY.

13. Re-Review of Topical Antiviral Agents (Green Class)

Ms. Narus gave the Magellen presentation on Topical Antiviral Agents. These products are used for cold sores occurring from either an HSV-1 or HSV-2 infection. Recurrences resulting from HSV-2 are rare. Approximately 80 percent of the adult population is infected. Abreva is the only FDA approved over the counter medication. Systemic absorption of topical antivirals is low. Topical therapy should be started during the pro-derma period and used for acute outbreaks only. Xerese is a combination product. It is available for treatment in patients 12 years of age and older. From June to August, there were 81 claims: 10% for Denavir, 47% for Zovirax cream, 43% for Zovirax ointment, and none for Xerese. At the last review, a motion for class effect passed unanimously.

DR. BERGESON MOVED A CLASS EFFECT. SECONDED BY DR. CARLSON.

Dr. Carlson noted that the Zovirax ointment was a preferred agent, but not Zovirax cream, yet the utilization was split between the two. Dr. Hope said the package sizes between the two agents were significantly different so it was not one-for-one, but many prescribers do not necessarily consider those.

Dr. Gardner questioned if this class needed to be included on the PDL, because they do not work very well. Dr. Hope said the state looks to capture the best price, but he agreed that the efficacy of the class was questionable. Dr. Demain questioned why half of the prescriptions were not on the preferred list. Dr. Hope said that was a function of physicians taking advantage of the medically necessary clause.

THE MOTION PASSED UNANIMOUSLY.

14. Re-Review of Multiple Sclerosis Agents (Green Class)

Ms. Narus gave the Magellen presentation on Multiple Sclerosis Agents. Multiple Sclerosis is an autoimmune-type inflammatory disease that can result in sensory disturbances, ataxia, fatigue and partial or full paralysis, and cognitive impairment. MS is divided into four clinical courses: relapse and remitting, primary progressive, secondary progressive, and progressive relaxing. There are a number of different medications within this class, which were reviewed. Ampyra is a broad-spectrum potassium channel blocker indicated to improve walking as demonstrated by an increase in walking speed, but it is not considered a treatment for MS. Ampyra is an oral agent with contraindications of moderate to

severe renal impairment. Gilenya is also an oral agent. Its mechanism of action is thought to involve the reduction of lymphocyte migration into the CNS. The first dose can result in a decrease in heart rate and AB conduction. These are usually asymptomatic, but patients should be observed six hours after the first administration. Due to the drug's effect on lymphocytes, the patient may be at a higher risk for infection. Baseline CBC and LFTs are recommended, as is an optometric examine as macular edema can occur. Avoiding live vaccines during treatment is advised and for two months after discontinuation of therapy. It is taken once daily. Gilenya, Ampyra, and Extavia have REMS requirements, which require medication guides at the time of dispensing. Significant changes include that Ampyra is contraindicated in patients with a history of seizure and in patients with moderate to severe renal impairment. Fingolimod causes lymphocyte suppression, which may continue for two months after discontinuation. It is advised to monitor LFTs and contraception should be used up to two months following discontinuation to decrease risk of fetal harm. Recently approved Abosio will not be reviewed during this meeting. From June to August, there were 63 claims: 38% for Copaxone, 30% for Rebif, 11% for Avonex, 10% for Betaseron, and 11% for Gilenya. Ampyra had two claims. At the last review, a motion for therapeutic alternatives, including at least one drug besides Ampyra, passed with one opposed.

Dr. Demain pointed out that the only difference between Rebif and Avonex was the mode of delivery.

Dr. Hope said the DUR Committee placed a prior authorization on Ampyra to ensure that it is not accidentally prescribed when a provider who intends to prescribe an oral MS treatment, but inadvertently prescribes the drug that increases walking speeds. The prior authorization requirement will be maintained whether or not it is a preferred agent.

DR. PAPPENHEIM MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE DRUG OTHER THAN AMPYRA. SECONDED BY DR. BRIGGS. THE MOTION PASSED WITH ONE OPPOSED.

15. Re-Review of Bone Resorption Suppression Agents (Green Class)

Ms. Narus gave the Magellen presentation on Bone Resorption Suppression Agents. This class includes Bisphosphonates, Calcitonins, and others drugs. All are indicated for the treatment of osteoporosis in post-menopausal women, except for Etidronate, which is indicated for the treatment of Paget's disease of the bone. The 2010 American Association of Clinic Endocrinologists Guidelines state that Alendronate, Risedronate, Denosumab, and Zoledronic Acid be used as first line agents, Ibandronate as second line, Raloxifen as second or third, and Calcitonins as last line for those with post-menopausal osteoporosis. From June to August, there were 487 claims within the Bisphosphonates: 81% for Alendronate generic, 6% for Actonel, 1% for Atelvia, and 7% for Fosamax Plus D. For the Calcitonins, there were 23 claims: 61% for Calcitonin-Salmon and 39% for Fortical. For the other bone resorption agents, there were 37 claims: 89% for Evista, 11% for Forteo, and none for Prolia. At the last review, a motion for class effect for the Bisphosphonates passed unanimously. A motion for class effect for the Calcitonins passed unanimously.

In response to Dr. Demain, Dr. Hope said he has not seen recent shifts in the usage of Bisphosphonates related to osteoporosis or jaw issues, but there were reductions in 2008 and 2009. Medicare Part D covers many of our elderly patients' prescriptions, so we may not see that.

DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE ONE FROM EACH OF THE THREE CLASSES, EXCLUDING FORMULATIONS ADMINISTERED DAILY. SECONDED BY DR. GARDNER.

Dr. Liljegren felt at least one drug that was not administered on a daily basis should be included on the PDL to address compliance issues. Dr. Hope said Fosamax Daily was the only drug taken daily, but he was not sure if it was still on the market. Alendronate is administered weekly and Boniva administered monthly. The committee discussed whether the motion should exclude drugs dosed daily.

THE MOTION PASSED UNANIMOUSLY.

16. Re-Review of Antiparkinson's Agents (Green Class)

Ms. Narus gave the Magellen presentation on Antiparkinson's Agents. Parkinson's disease is a progressive, neurodegenerative disorder with cardinal motor features of tremor, bradykinesia, and rigidity. It is characterized by striatal dopamine deficiency. Dopamine agonists are used as therapy in early PD. They have a Levodopa sparing effect and can reduce the frequency of off time. Newpro, which was recently reapproved, will not be part of this review. For significant changes, there is a recent FDA communication where the FDA is doing additional safety reviews for Mirapex for possible risk of CHF exacerbations with that agent. From June to August, there were 475 claims: 57% for Pramipexole generic, 42% for Ropinirole, and 1% for Mirapex ER. At the last review, a motion for class effect passed unanimously.

Dr. Pappenheim questioned why there was only a small section of the Antiparkinson's agents up for review. Dr. Hope agreed and suggested postponing this class until the next meeting so an answer could be provided.

Dr. Carlson noted that Parkinson's disease was less common than Alzheimer's, yet there were more claims for these agents. He questioned if these agents were being used off-label for something else. Dr. Demain pointed out that Parkinson's disease affected more young people, whereas Alzheimer has affected more elderly patients who were covered by Medicare.

THIS CLASSIFICATION WAS POSTPONED TO THE NEXT MEETING.

17. Re-Review of Pulmonary Arterial Hypertension Agents (Green Class)

Ms. Narus gave the Magellen presentation on Pulmonary Arterial Hypertension Agents. There are two unique oral and inhalation receptor agents in this class. Both are indicated for the treatment of pulmonary arterial hypertension (PAH). Tracleer is indicated for classes two, three and four. Letairis is indicated for classes two and three. Endothelin receptor subtype specificity is different between agents. Drug selection is complex depending on many factors. Other therapies were reviewed. The boxed warning for potential liver injury with Letairis was removed in March 2011, and monthly testing for serum liver enzymes is no longer required. Letairis and Tracleer are both part of the REMS program. Significant changes were reviewed. For patients undergoing intermittent dialysis, exposures to intravenous Iloprost were nearly five times higher than with subjects with renal failure not requiring dialysis and subjects with normal renal function, which should be taken into account when prescribing

Iloprost. From June to August, there were 13 claims for the PD inhibitors: 77% for Revatio and 23% for Adcirca. There were two claims for Tracleer and one for Letairis. For the inhaled agents, there were three claims for the Tyvaso refill inhalation kit. At the last review, a motion for therapeutic alternatives passed unanimously.

Dr. Demain pointed out that the drug being predominantly prescribed was not currently a preferred agent, which the committee discussed. Dr. Hope said although there was a prior authorization process to restrict usage of these drugs for PAH, there are providers using them for heart disease. Therefore, the utilization may not necessarily be reflective of just PAH. This class has a high potential for abuse being that Revatio is Viagra under a different name and Adcirca is Cialis under a different name. The committee discussed their obligation to look at therapeutic issues and not necessarily the other issues.

Dr. Pappenheim said it made him uneasy to have just one medication, because some patients have allergies or intolerances.

DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE ORAL AGENT AND ONE INHALED AGENT. SECONDED BY DR. LILJEGREN. THE MOTION PASSED UNANIMOUSLY.

18. Re-Review of Phosphate Binders (Green Class)

Ms. Narus gave the Magellen presentation on Phosphate Binders. There are four entities in this class. Two are different salts of the same active drug. Calcium and Lanthanum containing products have a propensity to bind other medications. Lanthanum is contraindicated in bowel obstruction, ileus, and fecal impaction. Tablets should be chewed or crushed thoroughly to reduce the risk of GI events. All agents are FDA approved for the treatment of elevated phosphate levels in renal disease. Although Renagel and Renvela have similar adverse event profiles, it was noted that Renvela had a slightly higher incidence of upper GI events. Lanthanum has had reports of hypocalcaemia as well. From June to August, there were 148 claims: 36% for Calcium Acetate, 47% for Renvela tablets, 16% for Renagel, and 1% for the Renvela power pack. At the last review, a motion for therapeutic alternatives passed unanimously.

DR. GARDNER MOVED THAT THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. BRIGGS. THE MOTION PASSED UNANIMOUSLY.

19. Re-Review of Cytokin and CAM Antagonists and Related Agents (Green Class)

Ms. Narus gave the Magellen presentation on Cytokine and CAM Antagonists and Related Agents. Cytokines and solid adhesion molecules are involved in inflammatory processes throughout the body. These agents are indicated for use in rheumatoid arthritis. Some are indicated for treatment and some are indicated for reducing signs and symptoms. Other uses for these agents include psoriatic arthritis, Crohn's disease and ankylosing spondylitis among other indications. There are various drug interactions, contraindications, and warnings within this class. It is important to refer to the PI information specific to each medication. Significant changes were reviewed. The American College of Rheumatology's 2012 Guidelines for the Management of RA were reviewed. From June to August, there were 234 claims: 46% for Enbrel, 44% for Humira, 6% for Cimzia, 2% for Simponi, and 1% for Remicade. At the last review, a motion for therapeutic alternatives passed unanimously.

In response to Dr. Demain, Dr. Hope said physician administered drugs are not currently processed through the pharmacy point of sale system and are not be included on the PDL, except for Remicade which can be processed through that system by home infusion therapy pharmacies.

DR. LILJEGREN MOVED THAT THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. BERGESON.

Dr. Demain suggested including both Enbrel and Humira in the motion due to their high utilization, which the committee further discussed. The committee discussed whether people were being allowed to remain on their existing medications using the grandfathering clause or the medically necessary clause. Dr. Hope explained how each of the clauses worked, as well as the bidding process. The committee discussed whether both Enbrel and Humira should be included in the motion.

THE MOTION PASSED WITH ONE OPPOSED.

20. Re-Review of Antianginal Agents.

Ms. Narus gave the Magellen presentation on Antianginal Agents. Ranexa remains the only drug in this category. It has a first line chronic angina indication and may reduce hemoglobin A1C in those patients with coronary artery disease and diabetes. The dosages were reviewed. There have been no significant changes in this class. From June to August, there were 39 claims for Ranexa. At the last review, a motion for class effect passed unanimously.

DR. CARLSON MOVED A CLASS EFFECT. SECONDED BY DR. KILEY. THE MOTION PASSED UNANIMOUSLY.

21. Review Minutes from April 20, 2012, Meeting

Dr. Demain noted that the minutes reviewed at the last meeting were from January, not April.

DR. KILEY MOVED TO APPROVE THE MEETING MINUTES OF APRIL 20, 2012, AS CHANGED. SECONDED BY DR. PAPPENHEIM. THE MOTION PASSED UNANIMOUSLY.

22. Comments from Committee Members or Chair

Dr. Hope discussed how the meeting information was sent to the committee. The electronic format will be used in the future to reduce staff time and save paper.

Dr. Demain said the next meeting would be held on November 16, 2012.

Dr. Briggs commended Dr. Demain for doing an excellent job of running the meeting. Dr. Carlson pointed out that there has been excellent staff support from the entire department.

23. Adjourn

Without objection, the meeting adjourned at 10:51 a.m.