

**ALASKA MEDICAID  
PHARMACY AND THERAPEUTICS COMMITTEE**

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

**MINUTES OF MEETING  
November 16, 2012, 2012  
8:05 a.m.**

**Committee Members Present:**

Marvin Bergeson, MD  
Richard Brodsky, MD  
Robert Carlson, MD  
Jeffrey Demain, MD  
Vincent Greear, R.Ph.  
Daniel Kiley, DDS, MPH  
Diane Liljegren, MD  
John Pappenheim, MD  
Claudia Phillips, MD  
Jill Reid, R.Ph. (telephonic)  
Trish White, R.Ph. (telephonic)

**Committee Members Absent:**

Dharma Begich, MD  
Amber Briggs, Pharm.D.  
Mary Elizabeth Gardner, ANP  
John Riley, PA

**Others Present:**

Erin Narus, Magellen Medicaid Administration  
Chad Hope, Pharm.D.  
CJ Kim, R.Ph.

**1. Call to Order – Chair**

Dr. Brodsky called the meeting to order at 8:05 a.m.

**2. Roll Call**

A quorum was present.

**3. Public Comments - Local Public/Health Practitioners**

**Dr. Norvin Perez**, a general practitioner in Juneau, Alaska, discussed an email that he sent in July concerning treatment with Butrans patches, which is the only scale three narcotic patch available in the marketplace and is a tier two medication. His frustration, email and participation in the meeting were based on his staff's inability to overcome the prior authorization process. He encouraged the committee to review their internal numbers and evaluate if their percentage of approved prior authorizations for Butrans patches was lower than other tier two medication. He also encouraged the

committee to review his email where he outlined his concerns, including the need to relieve pain in very specific patient populations. He asked the committee to consider making Butrans patches a peer one medication.

Dr. Hope noted that both Dr. Perez and Dr. Trescott had submitted letters, which were included in the public comment portion of the informational packet. Their one and tier two prior authorization requirement are considered by the Drug Utilization Review Committee, not the Pharmacy and Therapeutics Committee.

**Dr. A. Trescott** discussed Butrans and Nucynta. Butrans is a partial agonist that is used to link between non-opioids, very low opioids, and very high opioids. The preauthorization requires the patient failure on new agonists before being prescribed Butrans, which defeats the purpose of the Butrans patch as a lower alternative. Once a patient is on full new agonists, there is no way to bring them down to a partial agonist without causing withdrawal. She encouraged the committee to consider reversing the process and requiring Butrans before new agonists were prescribed. She then discussed Nucynta. Most opioids require the body to metabolize opioids to the active form. Ten percent of Caucasians are deficient in 2D6, but majorities of the medications used for pain are 2D6 inhibitors and prevent the metabolism of these medications to their active form. There is also an issue with opioids not working well on neuropathic pain. Nucynta gives you the capability of using new agonists, which are not metabolized by 2D6, providing a norepinephrine effect. Nucynta is effective through a wide range of pain problems and has the ability to be easily titrated to get a patient up to the appropriate dose before transitioning them from a short-acting to the long-acting formulation. Nucynta has some unique capabilities that are not available elsewhere, which were reviewed.

Dr. Hope provided an update. Bill McCormick has moved out of state and Paul Michaud reached the end of his term, so those members are no longer on the committee. The preferred drug listed has gone through the regulation process and has been updated. It will be effective as of December 2, 2012. The market shift reports reflect the December 2, 2012, updated preferred products. The annual conflict of interest disclosures will be distributed to the committee members.

#### **4. Re-review of Anticonvulsants, Oral (1st and 2nd Generation) (Red Category)**

**BRIAN STRENG:** A representative of GlaxoSmithKline discussed Potigo (Ezogabine), a schedule-five oral tablet indicated in adults for adjunctive treatment of partial onset seizures, which is the most common type of seizures in adults. Potigo has a unique mechanism of action as a potassium channel opener. It works through the potassium channels and stabilizes the resting membrane potential, thus reducing brain excitability. Between 20 to 30 percent of patients with newly diagnosed epilepsy will continue to experience seizures despite the many drugs available. Several studies and their outcomes were reviewed. Due to the risk of urinary retention with about 2 percent of the patients, there is a Communication REMS Program in place, which is mailed out to clinicians annually. Warning and precautions include dizziness, somnolence, neuropsychiatric symptoms, QT monitoring for patients with existing QT interval prolongation or medications unknown to prolong the QT interval, and the standard class AED warning for suicidality ideation and behavior.

**DAVID GROSS:** A representative of Pfizer discussed Lyrica (Pregabalin) and its newest indication for the neuropathic pain associated with spinal cord injury. Lyrica is an Alpha 2 Delta calcium channel modulator that is indicated for the adjunct treatment of partial onset seizures, post herpetic neuralgia,

painful diabetic peripheral neuropathy, and fibromyalgia. In addition, as of June of this year, it is indicated for the treatment of neuropathic pain associated with spinal cord injury, making it the first and only medication to receive this indication. Several studies and their outcomes on the new indication were reviewed. Most common adverse events include dizziness, somnolence, dry mouth, edema, weight gain, constipation, and it has the same boxed warning as the other anti-epileptic drugs.

**JEANNETTE GRASTO (ph):** A member of NAMI Fairbanks discussed the preferred drug list. She has two adult children with mental illness who are on Medicaid. Both are currently taking medications that are effective. However, two of those drugs are on the non-preferred drug list. She described the process they had to go through for the preauthorization, which often delayed receipt of the medications for several days. When dealing with serious mental illness, it is difficult to know which drugs will work for an individual. She felt open access to all of the drugs should be available so patients did not have to be transitioned to other drugs that may not be as effective.

Dr. Brodsky said the program had been very carefully crafted so that all medications were available if the physician utilized the medically necessary clause.

Dr. Hope pointed out that drugs requiring prior authorization were reviewed by the Drug Utilization Review Committee and were outside of the Pharmacy and Therapeutics Committee's scope.

Ms. Narus gave the Magellen presentation on Anticonvulsants, Oral (1st and 2nd Generation). Medications in the anticonvulsant class have various indications including use in epilepsy, fibromyalgia, neuropathic pain, bipolar disorder, and migraine. They have varied warnings, contraindications, and interactions. The majority of the agents in this class is part of the REMS Program and requires medication guides. Pregnancy categories vary between categories D and C among most of the products. Selection of products is based on indication. Very little direct comparison of efficacy is available. Metabolism and elimination of the products vary and may impact selection based on drug interaction and/or renal or hepatic impairment. The tolerability and treatment emergent side effects may also impact selection. The utilization statistics that are listed reflect all claims and do not specify the indications for which the individual products were prescribed. There are three subcategories within this overall class. For October, there were 607 claims for the Carbamazepine Derivatives: 47% for Oxcarbazepine tablets, 16% for Carbamazepine tablets, 7% for Carbamazepine XR, and down from there. There were 871 claims for the 1st Generation agents: 29% for Divalproex ER, 27% for Divalproex sodium, 19% for (indiscernible) sodium ER, 6% for Divalproex sprinkles, and down from there. There were 2,845 claims for the 2nd Generation agents: 30% for Gabapentin, 20% for Lamotrigine tablets, 16% for Topiramate, 12% for Levetiracetam, 11% for Lyrica, and down from there. Significant changes include that Onfi (Clobazam) has been released since the last review. It is indicated for use in Lennox-Gastaut Syndrome. It does go through the 2D6 and 2C19 pathway. Concomitant use of alcohol increases its availability in the body by 50 percent. Somnolence is the greatest adverse effect noted for Onfi. Efficacy and safety has not been established in children less than age 2. Dosage adjustment is not required in mild to moderate renal impairment, but it has not been studied in end-stage renal disease. Use in eosinophilia has been seen with Zarontin. At the last review, a motion for therapeutic alternatives passed unanimously.

**DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. DEMAIN. THE MOTION PASSED UNANIMOUSLY.**

## 5. Re-Review of Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) (Red Category)

There were no public testimonies.

Dr. Brodsky explained why this class was listed as a red class, although there was no new information. Magellen redid the COX-2 Inhibitor class as a NSAIDs class to provide a more complete list of products available.

Ms. Narus gave the Magellen presentation on Nonsteroidal Anti-Inflammatory Drugs (NSAIDs). This group now includes selective COX-2 inhibitors, non-selective products, and topical nonsteroidals. These agents are used to treat rheumatoid arthritis, osteoarthritis, and pain from various etiologies. They exert their effect through both anti-inflammatory and analgesic mechanisms. Despite the selective focus of the COX-2 inhibitors, they share cardiovascular concerns with the non-selective products. The American Heart Association's scientific statement on the use of NSAIDs reiterates the reservation of COX-2 inhibitor use in patients with a history of, or at risk of, cardiovascular disease, and suggests that COX-2 selective agents be used as a last resort with prior steps being on pharmacologic treatments, followed by a step pharmacologic approach. In April 2005, the FDA asked the manufacturers of all marketed products to revise the labeling to include the black box warning stating that NSAIDs may cause an increased risk of potentially fatal cardiovascular thrombotic events, myocardial infarction, and stroke. All NSAIDs may have a similar risk, which increases with a longer duration of use. Patients with cardiovascular disease or cardiovascular risk factors may be at greater risk. Within this class, the topical NSAIDs are indicated for the treatment of acute pain conditions including strains and sprains, as well as chronic pain conditions like osteoarthritis. Topical administration of Diclofenac formulations provides an alternative method of drug delivery, but it does not eliminate the possibility of GI effects. In October, there were 2,616 claims within the total class: 49% for Ibuprofen tablets, 13% for Naproxen, 7% for Meloxicam, 7% for Celebrex, 2% for Voltaren topical, and down from there. Originally, the topical products and the COX-2 inhibitors were referenced against each other and the other agents were not specifically reviewed. They are all now combined in a single basket. At the last review, specific to the COX-2 inhibitors, a motion for class effect to include at least one COX-2 selective drug passed with one opposed. For the NSAID topical, a motion for class effect passed unanimously.

### **MOTION: DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE ONE COX-2 INHIBITOR.**

Dr. Bergeson said a COX-2 inhibitor should be included in the motion for aspirin sensitive patients, which includes up to 40 percent of adults with asthma and about 5 percent of all patients. Dr. Carlson suggested a motion of class effect and the utilization of the medically necessary clause for anything else. The committee discussed the buying power of including a COX-2 inhibitor on the PDL. Dr. Hope explained why the motion would not directly relate to the buying power. Dr. Phillips discussed the trend of combining medications into a single category, which made it difficult to ensure everything was covered. Dr. Hope explained that by combining categories, the expensive brand name products had to compete with more generics, which could result in reduced prices.

### **SECONDED BY DR. LILJEGREN. THE MOTION PASSED WITH ONE OPPOSED.**

## 6. Re-Review of Sedative/Hypnotics (Blue Category)

**RUPA SHA:** A representative of Purdue Pharma discussed Intermezzo (Zolpidem). Intermezzo is available as a sublingual tablet and is indicated for use in the treatment of insomnia or middle of the night awakening followed by difficulty returning to sleep, if at least four hours of bedtime are remaining. This is the only FDA approved treatment for this specific indication. Historically, patients with insomnia who experience middle of the night awakening followed by difficulty returning to sleep needed to medicate at bedtime. If patients medicated at bedtime, they needed at least seven to eight hours of bedtime. With the availability Intermezzo, patients can target treatment at the time of the prolonged middle of the night awakening as long as four hours of bedtime remain. Intermezzo is contraindicated in patients with known hypersensitivity to Zolpidem. Anaphylaxis and angioedema have been reported with Zolpidem. Intermezzo has gender specific dosing, which was reviewed. We encourage the committee to review all of the warnings and precautions in the full prescribing information. Zolpidem is a schedule four controlled substance. Co-administration of Intermezzo with other CNS depressants increases the risk of CNS depression. It is not recommended to use Intermezzo with other sedative hypnotics at bedtime or middle of the night. The failure of insomnia to remit after seven to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Abnormal thinking and complex behaviors have been reported in patients treated with sedative hypnotics, including Zolpidem. Several studies and their outcomes on the efficacy and safety of Intermezzo were reviewed. Patients should wait at least four hours after dosing, and until they feel fully awake, before driving or engaging in other activities requiring full mental alertness. We request that you consider Intermezzo for the Alaska PDL.

Ms. Narus gave the Magellen presentation on Sedative/Hypnotics. Insomnia is divided into three types based on duration: transient, short-term, and chronic. The agents in this class have different mechanisms of action, but the 2008 Treatment Guidelines do not distinguish among these agents. Drug selection should be individualized based on co-morbid conditions, side effect tolerance, and whether the insomnia results from initiation or maintenance of sleep. Doxepin, Rozerem, and Zolpidem products participate in the REMS Program with associated medication guides. Use of other CNS depressants is cautioned with all agents in this class. Specialized formulations of Zolpidem do not specifically have a significant clinical advantage over tablets. Short-term memory impairment is possible with each of these agents. In October, there were 1,156 claims: 51% for Zolpidem tartrate, 17% for Temazepam, 11% for Zolpidem CR, 9% for Lunesta, 6% for Triazolam, 2% for Rozerem, and down from there. Significant changes have been presented on the Intermezzo tablet. At the last review, a motion for therapeutic alternatives passed unanimously.

The committee discussed other anti-hypnotics that should probably be included in this class but were classified under Other Antidepressants. Ms. Narus explained that some anti-hypnotics were listed under Other Antidepressants based on their mechanism of action.

**DR. GREAR MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.**

## 6. Re-Review of Long-Acting Narcotic Analgesics (Blue Class)

**RUPA SHA:** A representative of Purdue Pharma discussed Butrans (Buprenorphine) transdermal systems, a schedule three drug; and OxyContin (Oxycodone controlled release), a schedule two drug. Butrans, transdermal system that delivers Buprenorphine over seven days, and OxyContin, a controlled released tablet dosed every 12 hours, are both indicated for the management of moderate to severe pain when an around-the-clock opioid analgesic is needed for an extended period. While the indications and usages are similar, Butrans may not be appropriate for patients who require greater than 80 milligrams per day of oral Morphine equivalent. The committee should review the full prescribing information and the boxed warnings, precautions, and limitations of use for each product. In July 2012, the FDA required opioid analgesic companies to implement a single, shared risk evaluation and mitigation strategy for all extended release and long-acting opioid analgesics, which was reviewed. Complimentary to the shared ERLA opioid analgesic REMS effort, the FDA has required that the full prescribing information for this class be standardized to include common opioid language and formatting. Butrans and OxyContin are subject to the requirements of the single, shared REMS, which can be viewed at [www.ER-LA-opiodREMS.com](http://www.ER-LA-opiodREMS.com).

**DR. CHANDLER:** A physician discussed Butrans and OxyContin, which he felt were very helpful. Butrans is not as aggressive and has fewer side effects than OxyContin. He discussed the loss of local representation and aggressive support from the DEA within Alaska. The DEA now sends representatives up from the Lower '48 to conduct reviews. With the problems we have experienced with OxyContin and other long-acting, high-level narcotics, he encouraged the committee to work to get improved DEA representation in the state. The Alaska State Troopers provide local support, but due to the problems with medication abuse and marijuana issues, this lack of DEA support needs to be addressed at the committee level. OxyContin and Butrans are both effective drugs and should remain available.

In response to Dr. Hope, Dr. Chandler said he had no information on the State Medical Board or Pharmacy Board expressing interest in addressing over prescribing or over dispensing of pain medications, which is a concern due to the risks involved in prescribing medications.

Ms. Narus gave the Magellen presentation on Long-Acting Narcotic Analgesics. When properly used, long-acting opioids can decrease dosing frequency and adverse effects, and increase consistent pain control. The agents in this class are used for moderate to severe pain. Serious respiratory depression can occur at anytime during use of these medications, but often occurs within the first 44 to 72 hours after initiation or an increase in dose. Doses should be tapered gradually to prevent withdrawal signs and symptoms. All of the medications are a part of the REMS Program. In October, there were 696 claims: 33% for OxyContin, 22% for Morphine SA, 18% for Methadone, 12% for Fentanyl, 4% for Morphine ER (the generic of Kadian), 4% for Tramadol SR, and down from there. Significant changes have been noted. In October 2012, the FDA issued a safety warning that thrombocytopenic purpura appears to occur with the use of Oxymorphone ER when it is abused and injected intravenously and kidney failure requiring dialysis. Oxymorphone ER should only be taken orally. The REMS was revised in July 2012. Safety has not been established for Exalgo (Hydromorphone ER) for patients younger than 17 years of age. Safety has not been established for Ryzolt (Tramadol ER) for patients younger than 16 years of age. At the last review, a motion for class effect to include one transdermal preparation passed with four opposed.

In response to Dr. Bergeson, Dr. Hope said the entire class was subjected to prior authorization. However, there was a 12 percent increase in claims from last month so the prior authorization may not be effective.

Dr. Hope said Buprenorphine is being widely abused nationwide. Drugs to treat opioids addiction are becoming the drugs of choice for opioids addiction. Buprenorphine is also a once-a-week patch that can fall off easily. Since it is indicated for pain, there are no requirements to have the XDEA number in the training. Other states that have reduced the restrictions are seeing mid-level practitioners using it in the office for opioid addiction.

Dr. Carlson said poisoning deaths are now exceeding traffic deaths in many states, including Alaska. All of these drugs have an appropriate use as a lone drug, not as part of a cocktail. Many of the deaths are a result of cocktail use. Methadone is the only drug that has been shown to be more dangerous. About 10 years ago, the state of Washington P&T Committee encouraged Methadone over the other drugs and now they are backtracking due to the number of deaths related to Methadone.

Dr. Chandler talked about Methadone. Recent studies have shown that the combination of Methadone with Benzodiazepine can cause severe central apnea and can cause otherwise healthy people to die at night due to the combination treatment. The other agents disappear with rapid detox within eight hours, but Methadone metabolites are held in the bone and can remain for up to eight weeks.

Dr. Brodsky said Methadone was inexpensive, effective, and long-acting. It was especially useful in patients with terminal cancer. However, practitioners need to be careful when prescribing Methadone. The Prescription Drug Monitoring Program can be used to see where patients are getting their drugs and look for abuse patterns.

Dr. Bergeson discussed the withdrawal process that babies had to endure when the mothers used Methadone.

**DR. KILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE NON-CLASS TWO PREPARATION AND ONE EXTENDED RELEASE PREPARATION. THE MOTION FAILED DUE TO LACK OF A SECOND.**

**DR. PHILLIPS MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE TRANSDERMAL PREPARATION. SECONDED BY DR. PAPPENHEIM.**

In response to Dr. Demain, Dr. Brodsky said the transdermal patch would still require prior authorization through the DUR Committee. The committee further discussed the motion. Dr. Greear reviewed the advantages of the transdermal preparation, including cancer patients who could not swallow pills. Dr. Hope discussed the abuse potential of the transdermal preparations, including the fact that Fentanyl does not show up on standard drug tests and the patches can be worn under the clothes and does not have to be taken orally. Dr. Chandler discussed the uses of Fentanyl as well as various other ways it can be abused.

**THE MOTION PASSED UNANIMOUSLY.**

## 7. Re-Review of Restless Leg Syndrome Agents (Blue Class)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Restless Leg Syndrome Agents. Restless Leg Syndrome is a neurological sensory disorder in which patients experience irrepressible sensations in the legs or arms while sitting or laying still that causes them to move their arms or legs. When non-pharmacologic medications like sleep hygiene, avoiding medications that provoke RLS, and lifestyle adjustments are ineffective, pharmacologic therapies should be considered. The American Journal of Medicine RLS Guidelines report that dopaminergic therapy appears to be the most effective and relieves symptoms rapidly. In October, there were 182 claims: 62% for Pramipexole, 37% for Ropinirole, 1% for Mirapex ER, and none for the rest. Significant changes include there is an ongoing safety review by the FDA of Mirapex for possible risk of CHF. Neupro came back on the market as well. At the last review, a motion for class effect passed unanimously.

Dr. Hope said there was not a prior authorization on these products so the list would apply to either Restless Leg Syndrome or Parkinson's disease. To have it only apply to one or the other, we would need to apply a prior authorization requirement. Prescriptions would be filled utilizing the medically necessary clause.

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

*Break from 9:28 a.m. to 9:46 a.m.*

## 8. Re-review of Atypical (2nd Generation) Antipsychotics (Green Class)

Ms. Narus gave the Magellen presentation on Atypical (2nd Generation) Antipsychotics. Indications for agents in the class vary and include schizophrenia, bipolar disorder, psychotic disorders, treatment resistant depression, and irritability associated with autistic disorder. First generation antipsychotics work by blocking the dopamine D2 receptors and the mesolimbic dopamine pathway, thereby decreasing the positive symptoms associated with psychosis. Second generation agents are serotonin-dopamine antagonists. They have reduced incidents of EPS, lesser impact on prolactin levels with an increased efficacy on negative symptoms. Their higher affinity for certain receptors is not without adverse effects such as those occurring with metabolic changes. Clozapine and Lurasidone are pregnancy category B. All others are category C. Medication guides must be dispensed with Aripiprazole, Quetiapine, and Olanzapine products. In addition to a medication guide, injectable Olanzapine requires the prescriber, pharmacy and patient to be enrolled in the Zyprexa/Relprevv Patient Care Program. In October, there were 3,367 claims for the oral products: 26% for Risperidone tablets, 20% for Abilify, 17% for Quetiapine, 14% for Olanzapine, 6% for Ziprasidone, and down from there. There were 68 claims for the long-acting injectable antipsychotics: 54% for Risperdal Consta, 29% for Haloperidol Deckanoit, 9% for Fluphenazine Deckanoit, and down from there. Significant changes include approvals have been given to Aripiprazole and Risperidone for monotherapy treatment of bipolar maintenance. Approvals have also been given to Quetiapine, Quetiapine XR, and Ziprasidone when used in combination with Lithium in maintenance therapy. At the last review, a

motion for therapeutic alternatives for the oral preparations, and one 1st and one 2nd generation injectables should also be included on the PDL, passed unanimously.

**DR. PHILLIPS MOVED THAT THE DRUGS IN THE ORAL PREPARATION CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. PAPPENHEIM. THE MOTION PASSED UNANIMOUSLY.**

The committee discussed the long-acting injectable antipsychotics. Ms. Narus said the long-acting injectables included both the 1st and 2nd generation drugs. In response to Dr. Brodsky, Ms. Narus said she did not know why Envega, which was a fancy Risperidone, was not included on the list, but would be included in the review.

**DR. PHILLIPS MOVED THAT THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE ONE 1ST AND ONE 2ND GENERATION INJECTABLE. SECONDED BY DR. PAPPENHEIM. THE MOTION PASSED UNANIMOUSLY.**

#### **9. Re-Review of Stimulants and Related Agents (Green Class)**

Ms. Narus gave the Magellen presentation on Stimulants and Related Agents. Agents in this class have been used to treat ADHD, hyper somnolence, and obesity, specifically Desoxyn. Stimulants act by blocking the reuptake of norepinephrine and dopamine in the presynaptic neuron. Amphetamines tend to release newly synthesized dopamine while Methylphenidate causes the release of stored dopamine. Both types are available as racemic and single isomer products. Provigil and Nuvigil participate in REMS with medication guides and communication plans. Kapvay (Clonidine ER) and Intuniv (Guanfacine ER) have FDA indications for the treatment of ADHD as an adjunct to stimulants. Both act as alpha 2-A adrenergic receptor agonists. Both have dose dependent decreases of blood pressure and heart rate. Patients should not become dehydrated or overheated. It is important not to abruptly discontinue and to taper down slower to avoid effects in blood pressure. There are two different brand names of Methylphenidate products, Ritalin and Concerta. In October, there were 2,836 claims: 17% for generic Concerta, 17% for Intuniv, 13% for Dextroamphetamine salt 24-hour, 10% for Focalin XR, and down from there. At the last review, a motion for therapeutic alternatives to include at least one extended release and one non-stimulant formulation passed unanimously.

**DR. PHILLIPS MOVED THAT THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE EXTENDED RELEASE AND ONE NON-STIMULANT FORMULATION. SECONDED BY DR. BERGESON. THE MOTION PASSED UNANIMOUSLY.**

#### **10. Re-Review of Progestins for Cachexia (Green Class)**

Ms. Narus gave the Magellen presentation on Progestins for Cachexia. Megestrol is used for Cachexia resulting from many conditions, even though the FDA indication is for Anorexia and Cachexia for those patients with AIDS. Megestrol is a synthetic derivative of Progesterone. The mechanism of action is not completely known. Both products are pregnancy category X. In chronic use, it can precipitate glucose intolerance. In October, there were 7 claims: 57% for the generic Megestrol Acetate and 43% for Megace ES. At the last review, a motion for class effect passed unanimously.

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

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

Ms. Narus gave the Magellen presentation on Antidepressants, Other. The drugs in this class either inhibit the reuptake of or block the receptors of one or more neurotransmitters such as dopamine, serotonin, and norepinephrine. All agents are indicated for the treatment of MDD. Other indications vary among the agents. The FDA requires that a medication guide be dispensed with all drugs in this class, with the exception of Trazodone and Nefazodone. None of the drugs in this class has a current REMS requirement. SNRIs may be as effective as SSRIs, but tend to have additional adverse effects that are of concern. The 2010 American Psychiatric Association Treatment Guidelines for patients with MDD recommend an SSRI, SNRI, Mirtazapine or Bupropion as appropriate for initial treatment in most patients. Data showing superiority in efficacy of one or another class of drug are not robust. They do differ in their adverse event profiles and safety, and these characteristics should be considered when choosing an initial therapy. Other factors to consider include drug interaction profiles, pharmacokinetics, patient preference, and historical patient response. In October, there were 2,713 claims between Other and SNRIs: 47% for Trazodone, 14% for Bupropion XL 150-milligram, 13% for Bupropion XL 300-milligram tablets, 12% for Ritazopine, 8% for generic Bupropion SA, and down from there. For the SNRIs: 57% for Cymbalta, 29% for (indiscernible) ER, 6% for Pristiq, and down from there. At the last review, a motion for therapeutic alternatives passed with one opposed. A 2011 study by the Agency for Healthcare Research and Quality looking at comparative effectiveness of 2nd generation antidepressants in the pharmacological treatment of adult depression showed no substantial differences in efficacy or effectiveness were identified between the different drugs within the study.

In response to Dr. Bergeson, Ms. Narus said the FDA recently removed generic Wellbutrin from the marketplace.

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

**12. Re-Review of Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRI) (Green Class)**

Ms. Narus gave the Magellen presentation on Antidepressants, Selective Serotonin Reuptake Inhibitors (SSRI). Drugs in this class have varying FDA approved indications. Overall, these drugs are classified as antidepressants although the indications include OCD, panic disorder, and bulimia. In October, there were 3,070: 29% for Sertraline, 23% for Fluoxetine, 17% for Escitalopram, 16% for Citalopram, 10% for Paroxetine, and down from there. At the last review, a motion for class effect passed with one opposed.

**DR. PHILLIPS MOVED A CLASS EFFECT. SECONDED BY DR. PAPPENHEIM. THE MOTION PASSED UNANIMOUSLY.**

**13. Re-Review of Bladder Relaxant Preparations (Green Class)**

Ms. Narus gave the Magellen presentation on Bladder Relaxant Preparations. Overactive bladder is a chronic syndrome characterized by urinary urgency and frequency. It occurs at about the same rate for women and men, but females experience urgent continence generally at a higher incidence than men do. These medications exert their effect by their antagonistic effects and muscarinic receptors, thereby depressing both voluntary and involuntary bladder contractions. In October, there were 337 claims: 35% for Detrol LA, 18% for VESicare, 14% for Oxybutynin, 9% for Enablex, 8% for Oxybutynin ER, and down from there. Tolterodine, a generic for Detrol, is now available. At the last review, a motion for class effect passed unanimously.

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

#### **14. Re-Review of Opiate Dependence Treatments (Green Class)**

Ms. Narus gave the Magellen presentation on Opiate Dependence Treatments. These agents are used for opioid abuse. All agents exert their actions at the mu receptor. Buprenorphine as an agonist and the other two are antagonists. Both of the combination products participate in the REMS Program with medication guides to be given at the time of dispensing. All three are pregnancy category C. The brand name Subutex was listed as manufacturer obsolete as of February in April of this year. Significant changes include the combination of Buprenorphine and Benzodiazepines have resulted in reports of coma and death in post-marketing reports. In many of these cases, it was due to the misuse by self-injection of the medication. In October, there were 388 claims: 46% for Suboxone Sublingual Film, 28% for Suboxone Sublingual Tab, 23% for Buprenorphine (the generic for Subutex Sublingual), and 2% for Vivitrol. At the last review, a motion for therapeutic alternatives passed with three opposed.

Dr. Hope said the manufacturer of Suboxone tablets is now on a campaign to have the FDA restrict or discontinue the tablet and move everything to the film. The claim is that the film is safer than the tablet, but it is important to note that the tablet version is off-patent and the film is not.

The discussion around last year's motion included a debate on whether Maltraxzone should be considered a therapeutic alternative or if there should be both an injectable and an oral formulation.

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

#### **15. Re-Review of Short-Acting Narcotic Analgesics (Green Class)**

Ms. Narus gave the Magellen presentation on Short-Acting Narcotic Analgesics. Drugs in this class produce super spinal analgesia, resulting in respiratory depression, euphoria, and physical dependence. In general, opioids are contraindicated in patients with acute or severe bronchial asthma or paralytic ileus. Caution is to be used when using the other agents in this class in those with severe bronchial asthma. Dose adjustment is important for patients with renal or hepatic impairment when using any of the agents in this class. Use of opioids should be used in caution with seizure patients. Tramadol agents used in the presence of SSRIs and other agents affecting the serotonin pathway can increase risk of seizures and serotonin syndromes. Abrupt discontinuation of these drugs can result in withdrawal symptoms and tapering down is highly advised. In October, there were 5,869 claims: 52% for the

combination Hydrocodone/Acetaminophen, 16% for Oxycodone/Acetaminophen, 12% for Tramadol, 7% for Acetaminophen with Codeine, 5% for straight Oxycodone, and down from there. Significant changes include that due to the risk of abuse and addiction for the transmucosal Fentanyl formulations; these agents are only available through a restricted access program called Transmucosal Immediate Release Fentanyl Risk Evaluation and Mitigation Strategy Access Program. Outpatient health providers, including prescribers, pharmacies, and distributors, must enroll in this program. Outpatients must sign a patient/prescriber agreement to ensure they understand the risks and benefits of this therapy. At the last review, a motion for class effect passed with one opposed.

**DR. GREAR MOVED A CLASS EFFECT. SECONDED BY DR. BERGESON. THE MOTION PASSED UNANIMOUSLY.**

#### **16. Re-Review of Skeletal Muscle Relaxants (Green Class)**

Ms. Narus gave the Magellen presentation on Skeletal Muscle Relaxants. Skeletal muscle relaxants consist of antispasticity and antispasmodic agents. The antispasticity agents, such as Baclofen, Tizanidine, and Dantrolene, aid in reducing muscle hypertonicity and involuntary jerks. Antispasmodic agents, such as Carisoprodol, Cyclobenzaprine, Metaxalone, and Methocarbamol, are primarily used to treat musculoskeletal conditions. Mechanism of action, ADR profiles and efficacy varies among the agents. In October, there were 1,630 claims: 47% for Cyclobenzaprine, 25% for Tizanidine, 18% for Baclofen, 7% for Methocarbamol, and down from there. Amrix (Cyclobenzaprine) ER is now available as a generic. At the last review, a motion for therapeutic alternatives passed unanimously.

In response to Dr. Liljegren, Dr. Hope said the committee discussed excluding Carisoprodol last year due to its habit forming potential. Dr. Liljegren said she would like to exclude it this year. Dr. Pappenheim said Methocarbamol also had potential for abuse and dependence. In response to Dr. Brodsky, Dr. Liljegren said that although abuse and dependence had been a reason to exclude drugs in other categories today, there were good alternatives available in this class. Dr. Hope noted that Carisoprodol had a prior authorization requirement and the maximum quantity that will be authorized per claim was a 14-day supply or 56 tablets.

**DR. LILJEGREN MOVED A CLASS EFFECT. SECONDED BY DR. DEMAIN. THE MOTION PASSED WITH ONE ABSTAINING.**

#### **17. Re-Review of Topical Steroids, Low Potency (Green Class)**

Ms. Narus gave the Magellen presentation on Topical Steroids, Low Potency. These agents are indicated for the relief of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses, mild to moderate atopic dermatitis, seborrheic dermatitis of the scalp, and psoriasis of the scalp. In October, there were 230 claims: 40% for Hydrocortisone cream, 38% for Hydrocortisone ointment, 7% for Desonate gel, and down from there. There were no significant changes. At the last review, a motion for class effect passed unanimously.

**DR. PHILLIPS MOVED A CLASS EFFECT. SECONDED BY DR. DEMAIN. THE MOTION PASSED UNANIMOUSLY.**

#### **18. Re-Review of Topical Steroids, Medium Potency (Green Class)**

Ms. Narus gave the Magellen presentation on Topical Steroids, Medium Potency. There are similar indications as with the low-potency class. They are also indicated for mild to moderate atopic dermatitis in ages 3 months to 18 years of age. In October, there were 127 claims: 20% for Hydrocortisone Valerate cream, 17% for Hydrocortisone ointment, 14% for Fluticasone, 14% for Mometasone, and down from there. At the last review, a motion for class effect passed unanimously.

**DR. DEMAIN MOVED A CLASS EFFECT. SECONDED BY DR. BERGESON. THE MOTION PASSED UNANIMOUSLY.**

**19. Re-Review of Topical Steroids, High Potency (Green Class)**

Ms. Narus gave the Magellen presentation on Topical Steroids, High Potency. In October, there were 492 claims: 50% for Triamcinolone cream, 31% for Triamcinolone ointment, and down from there. At the last review, a motion for class effect passed unanimously.

The committee discussed how these drugs were categorized this year as compared to last year.

**DR. PHILLIPS MOVED A CLASS EFFECT. SECONDED BY DR. GREEAR. THE MOTION PASSED UNANIMOUSLY.**

**20. Re-Review of Topical Steroids, Very High Potency (Green Category)**

Ms. Narus gave the Magellen presentation on Topical Steroids, Very High Potency. In October, there were 85 claims: 34% for Clobetasol cream, 31% for Clobetasol ointment, and 12% for Clobetasol solution. At the last review, a motion for class effect passed unanimously.

**DR. DEMAIN MOVED A CLASS EFFECT. SECONDED BY DR. DEMAIN. THE MOTION PASSED UNANIMOUSLY.**

**21. Re-Review of Growth Hormones (Green Category)**

Ms. Narus gave the Magellen presentation on Growth Hormones. This medication is administered by either IM or subcutaneous injection. Most products are given six to seven times per week. Pediatric patients can be anywhere from three to six times per week. Treatment with growth hormone may decrease insulin sensitivity so it is important to monitor patients with diabetes for hyperglycemia during therapy. These agents are similar in safety and efficacy. Caution should be advised when using these products as they may contain Benzyl alcohol and has been associated with adverse events in pediatric patients. In October, there were 32 claims: 28% for Nutropin AQ, 25% for Nutropin AQ cartridge, 19% for Genotropin cartridge, and down from there. At the last review, a class effect passed unanimously.

In response to Dr. Bergeson, Dr. Hope said there was a group wide prior authorization for this category.

**DR. BERGESON MOVED A CLASS EFFECT. SECONDED BY DR. DEMAIN. THE MOTION PASSED UNANIMOUSLY.**

**22. Review Minutes from September 21, 2012, Meeting**

Dr. Pappenheim noted that Xanthine oxidase was spelled X-A-N-T-H-I-N-E, not X-A-N-T-I-N-E oxidase.

**MOTION: DR. KILEY MOVED TO APPROVE THE MEETING MINUTES OF SEPTEMBER 21, 2012, AS CORRECTED. SECONDED BY DR. GREAR. THE MOTION PASSED UNANIMOUSLY.**

**23. Comments from Committee Members or Chair**

Dr. Hope discussed a program change for Medicaid in which all healthcare providers who bill Medicaid needs to reenroll in the enrollment process that will be starting March 31, 2013.

Dr. Brodsky said two pieces of information would be coming in an envelope marked “Xerox” and should not be discarded. One is the reenrollment information and the other is a request for physicians to provide copies their licenses.

Dr. Hope reiterated that physicians who did not reenroll with Alaska Medicaid would not be eligible for Medicaid reimbursements. As of January 1, 2013, Benzodiazepine and Barbiturates will no longer be excluded from the Medicare Part D Program for Medicare and Medicaid recipients. Those drugs will still be covered, but they will need to be billed to Medicare instead of Medicaid. The “Xerox” envelopes were already mailed out, but not everyone has received them yet. If you have not received the envelopes, you can contact Xerox or visit their website for more information.

Dr. Brodsky said he would be resigning after the next two meetings. Anyone interested in becoming the Chair should contact Dr. Hope.

**23. Adjourn**

Without objection, the meeting adjourned at 10:31 a.m.