ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE

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

MINUTES OF MEETING
April 19, 2013
8:00 a.m.

Committee Members Present:
Dharma Begich, MD
Marvin Bergeson, MD
Robert Carlson, MD
Jeffrey Demain, MD
Vincent Greear, R.Ph.
Diane Liljegren, MD (telephonic)
Jenny Love, MD
John Pappenheim, MD
Claudia Phillips, MD
Maggi Rader, MD
Jill Reid, R.Ph. (telephonic)
John Riley, MD
Chuck Semling, MD
Trish White, R.Ph. (telephonic)

Committee Members Absent:
Amber Briggs, Pharm.D.

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

1. Call to Order – Chair

Dr. Demain called the meeting to order at 8:00 a.m.

2. Roll Call

A quorum was present. Dr. Demain recognized the service of two long-term committee members. Dr. Kiley, who served for six years, still works with Medicaid, but in a different capacity. Dr. Brodsky, the former chair, has retired and is moving to Oregon.

3. Public Comments - Local Public/Health Practitioners

There were no public comments.

Dr. Hope noted that while many of the categories may not be considered new, they are being treated as such since Magellen has been reworking the packets, adding products or expanding classes to make the preferred and non-preferred products more comprehensive.

4. Re-review of Antibiotics, Gastrointestinal (Red Category)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Antibiotics, Gastrointestinal. The drugs in this category have varied indications and mechanisms of action. Some of the agents are bacteria static in nature whereas Dificid (Fidaxomicin) is a Macrolide antibacterial agent. Metronidazole has a black box warning related to carcinogenicity. Tinidazole has a similar warning. Alcohol should be avoided during therapy with this adjunct. Nausea is common with this agent, but Nitazoxanide and Tinidazole rates are less than the others in the group. In February 2013, there were 259 claims: 238 claims for Metronidazole tablet, 16 claims for Xifaxan, 4 claims for Neomycin, and 1 claim for Tindamax. There were no specific discussions within this group due to the expansion.

In response to Dr. Demain, Ms. Narus said the currently preferred agent is Metronidazole.

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

5. Re-Review of Beta$_2$ Adrenergic Agents, Long Acting (Red Category)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Beta$_2$ Adrenergic Agents, Long Acting. Long-acting Beta agonists are used in the treatment and prevention of asthma, exercise induced bronchospasm, and COPD to reduce the frequency and severity of exacerbations and improve health status and exercise tolerance. They exhibit activity by increasing cyclic AMP levels, which relax the bronchial smooth muscle. The onset of action for all four drugs is under 60 minutes. The duration of action is 12 hours, except for Arcapta, whose longer half-life allows for once daily dosing. These long-acting beta agonist agents are for controller purposes and are not meant to replace inhalers for rescue therapy. The 2011 GINA guidelines advise against using these agents as monotherapy in asthma. Serevent is contraindicated in individuals with sever milk protein hypersensitivity. Indacaterol is not indicated for the treatment of asthma. In February 2013, there were 5 claims: 3 for Serevent, 1 for Foradil, and 1 for Perforomist. At the last review, a motion for therapeutic alternatives passed unanimously. Significant changes include additional warnings including cautions with use in patients with convulsive disorders, erotaxicosis, diabetes, ketoacidosis, and fetal chromocytoma.

In response to Dr. Carlson's comment about the low number of prescriptions in the class, Dr. Demain said the PR3 guidelines and the FDA recommendation is that you cannot use a monotherapy long-acting bronchodilator for asthma. In children, the recommendation is to use only a combined agent.

Ms. Narus said the agents Dr. Demain were talking about, combination inhaled corticosteroids and long-acting beta agonists, would be covered under tab 6 later in the meeting. The committee discussed why the single and combination agents were separated into different categories.

DR. LILJEGREN MOVED THAT ALL OF THE AGENTS IN THE CLASS BE NON-PREFERRED. THE MOTION FAILED DUE TO LACK OF A SECOND.

Dr. Liljegren did not feel this class should be used as monotherapy in any patients.

Dr. Hope said this was a difficult class, because the financial and therapeutic decisions may be different. From the financial side, there would be an advantage to having this class go out for bid.

DR. GREEAR MOVED A CLASS EFFECT. SECONDED BY DR. BERGESON. THE MOTION PASSED WITH TWO OPPOSED.

Dr. Carlson asked if the DUR Committee should review this class. Dr. Hope said this class was already on prior authorization due to concerns about using single agents, which may be leading to the low utilization of the single-agent products.

6. Re-Review of Intranasal Rhinitis Agents (Blue Category)

DR. PROFANT: Discussed Qnasl, a non-aqueous intranasal steroid. Qnasl is indicated for the treatment of nasal symptoms associated with both seasonal and perennial allergic rhinitis in adults and adolescents 12 years of age and older. Many patients with allergies report side effects with nasal sprays and they prefer to switch medications. Qnasl, a non-aqueous dry aerosol, would be an option for these patients. Unlike the wet nasal sprays, Qnasl has a built-in counter that tracks every spray in an increment of one so patients can be aware of their doses. Using a Medicaid data analysis, dry allergic rhinitis treatments were associated with higher medication possession ratio and lower total pharmacy costs than the wet nasal treatments. The safety information is contained in the package insert.

Ms. Narus gave the Magellen presentation on Intranasal Rhinitis Agents. This group contains three categories, antihistamines, steroids, and anticholinergic agents. The antihistamines, such Azelastine and Olopatadine, have demonstrated efficacy as effective or superior to oral second generation products for relief of seasonal allergic rhinitis symptoms. Olopatadine is a selective H1 receptor antagonist. Both products may cause CNS depression, which could alter alertness, and are dosed at one to two sprays in each nostril twice daily. Nasal steroids are considered the most effective products for treatment allergic rhinitis. There is a slight delay in the onset of efficacy. They are also used to treat symptoms of non-allergic rhinitis. The differences between the products are the number of sprays and frequency of dosing. Tapering may be advised when discontinuing. Of the anticholinergic agents, Ipratropium reduces the hyper secretion from nasal glands. It has minimal absorption and thus decreases the risk for systemic side effects. In February 2013, there were 643 combined claims: 611 claims for the nasal steroids, 10 claims for the antihistamines, and 22 claims for the others. Topping off the group was 265 claims for Nasonex, 239 claims for Fluticasone, 48 claims for Flunisolide, 21

claims for Ipratropium, 18 for Veramyst, 16 for Triamcinolone, 9 for Rhinocort Aqua, and down from there. At the last review, a motion for class effect passed unanimously when they were broken out in different subgroups. Significant changes include the addition of Dymista, which is a corticosteroid antihistamine combination. It is approved for patients 12 years of age and older.

Dr. Carlson said that combining these agents and not separating them by class makes the committee's decision more complicated and the formatting is more confusing. His suggestion was to take each class separately and make them therapeutic equivalents based on class.

Ms. Narus explained that the classes were combined for the bidding process, but she would let the group know about Dr. Carlson's concern with the groupings.

Dr. Demain said nasal steroids were the most effective long-term medication for treating allergic rhinitis, but they were not very effective for as needed. For as needed, topical antihistamines work rapidly and are better for patients who want to feel better quickly. Anticholinergic drugs are not used to treat allergies, but to treat different types of non-allergic rhinitis. The agents are actually used for three different reasons, as well as being three different types of drugs.

DR. PAPPENHEIM MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE FROM EACH SUBCLASS. SECONDED BY DR. SEMLING.

Dr. Demain said Flunisolide was poorly tolerated, caused irritation, stings and burns, and is not used very often. He suggested excluding Flunisolide so it would not be the only agent within its subclass.

Dr. Hope said he would be very surprised if Flunisolide was the only agent on the PDL, especially since Fluticasone is generic.

The committee further discussed Flunisolide. Dr. Carlson noted that the medically necessary clause could be utilized. Dr. Demain said it would be expensive to pay retail for the 600 claims in that subclass. Flunisolide is currently non-preferred, yet it has 48 claims a month.

The committee discussed the high number of claims for Nasonex. Dr. Demain said Nasonex was an aqueous-based product with no fragrance that is approved for children above 2 years of age. Children like it. Fluticasone, the generic, is an alcohol-based product that causes more nasal drying and irritation. It also has a rose fragrance that patients with allergies or rhinitis do not like.

THE MOTION PASSED UNANIMOUSLY.

Dr. Liljegren left the meeting due to the phone problems and the difficulty hearing the discussions.

6. Re-Review of Otic Antibiotics (Blue Class)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Otic Antibiotics. Topical treatment of Fluoroquinolones is used in cases of otitis externa, acute otitis media, and chronic superlative otitis media. These agents

act by inhibiting DNA gyrase, an enzyme needed for DNA repair, replication, transcription, and etcetera. Drops are generally administered for 7 to 10 days. Indicated ages vary among the products. Cipro HC is non-sterile and should not be used in cases of perforated tympanic membrane. Safety and efficacy of Otic Quinolones is well documented. These agents are within pregnancy category C. In February 2013, there were 250 claims: 142 claims for Ciprodex, 104 for Ofloxacin, and 4 for Cipro HC. At the last review, a motion for class effect passed unanimously. Significant changes include Cetraxal, which is Ciprofloxacin 0.2%, is now available as a generic product.

The committee discussed the drugs being reviewed compared to utilization reports. Other otic external titus drugs are still within the class, but had no claims reported on the utilization report. Dr. Greear found it hard to believe that no one Medicaid patients used these drugs, because he used them frequently in his practice. Dr. Hope said there might have been a reporting issue on the utilization report. The committee discussed what they would be voting on within this class, which are all of the drugs listed in the front of tab 4 of the informational material provided.

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

Dr. White left the meeting due to the phone problems and the difficulty hearing the discussions.

7. Re-Review of Antiemetic/Antivertigo Agents (Blue Class)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Antiemetic/Antivertigo Agents. The Antiemetic group contains 5-HT_3 antagonists, NK_1 antagonists, Anticopaminergic agents, Antihistamines, Phenothiazines, Anticholinergics and Cannabinoids. The 5-HT_3 antagonists continue to be the first line drugs for the treatment and prevention of nausea and vomiting associated with cancer chemotherapy or radiation. Only the Antihistamines, Phenothiazines, and Anticholinergics contain indications for treatment of motion sickness. Approved drugs for pregnancy category 3 and pediatric utilization were reviewed. As this was a new review with the expansion of the class, the utilization report only shows the 5-HT. In February 2013, there were 637 claims: 375 for Ondansetron ODT, 243 for Ondansetron tablets, and 24 for Ondansetron solution. At the last review, looking at the 5-HT_3 and the NK_1 receptor antagonists, a motion for therapeutic alternatives passed unanimously. With the expansion of this group, there may be discussion on how to evaluate this particular grouping.

The committee felt this was a tough class to read, because there were so many categories. Ms. Narus explained how the new grouping and reporting system would work.

Dr. Greear said he found this process hard to support. The committee members are being asked to make good decisions that will help this population, but drugs are being lumped together that do not belong together. Several groupings that did not make sense were reviewed.

The committee discussed how to word the motion considering the grouping of the drugs. Ms. Narus said the committee's motion could address separate subclasses within the group. Dr. Hope said he also had a lot of difficulty with this class.

DR. PAPPENHEIM MOVED TO SEND THE CLASS BACK TO HAVE IT RE-CATEGORIZED AND BROUGHT BACK AT THE NEXT MEETING. SECONDED BY DR. BERGESON.

Dr. Love said she was not comfortable voting on such a large classed based on the reports of only four agents. The committee discussed the report and agreed it did not work for their purposes.

THE MOTION PASSED UNANIMOUSLY.

8. Re-review of Glucocorticoids, Inhaled (Blue Class)

DR. PIZZI: A representative of AstraZeneca discussed Symbicort, which are Budesconide and Formoterol. Symbicort is indicated for the treatment of asthma in patients 12 years of age and older. Several studies and their outcomes were reviewed. Symbicort 160/4.5 is approved for the twice-daily maintenance treatment of airflow obstruction in patients with COPD, including chronic bronchitis and emphysema. Its prescribing information also contains a boxed warning stating long-acting beta agonists such as Formoterol increases the risk of asthma related death. The most common adverse events for asthma were reviewed. Please refer to the Symbicort package insert for the boxed warnings and precautions. Based on today's testimony, we request that Symbicort be maintained on the PDL.

Ms. Narus gave the Magellen presentation on Glucocorticoids, Inhaled. Current guidelines maintain that inhaled corticoids steroids are currently the most effective anti-inflammatory medications for the treatment of persistent asthma. Some patients may require higher doses within their therapy or adjunctive therapy with agents from another class. Some agents require twice a day dosing while others can be administered daily. Products containing Salmeterol and Formoterol should be used with caution with those patients on MAOIs, tricyclic antidepressants and other QT-prolonging drugs. As of April 2011, the FDA is requiring manufacturers of long-acting beta agonists to conduct randomized double-blind control trials to further evaluate the safety of long-acting beta agonists when used in combination with inhaled corticosteroids in comparison to inhaled corticosteroids alone. These results are expected to be available in 2017. As for 2012, the combination products of Symbicort, Advair, and Dulera had their REMS requirement released. In February 2013, there were 968 claims: 491 for the combination products and 70 for the nebulized products. At the top of the list was 319 for the Advair Diskus, 239 for Flovent HFA, 91 for QVAR, 81 for Symbicort, 71 for Dulera, 59 for Asmanex, 51 for Budesconide Respules, and down from there. At the last review, a motion to include one high-potency product, one low- to medium-potency product, one combination product, and nebulized Budesconide passed with one opposed. Significant changes include the MDIs with CFCs are no longer marketed. QVAR FHA has been released in the marketplace. QVAR has had some post-marketing side effects released in terms of psychiatric events and behavioral changes such as aggression, depression, sleep disorders, and psychomotor hyperactivity. Suicidal ideation has been report primarily in pediatric patients.

DR. BERGESON MOVED TO INCLUDE ONE HIGH-POTENCY PRODUCT, ONE LOW- TO MEDIUM-POTENCY PRODUCT, ONE COMBINATION PRODUCT, AND NEBULIZED BUDESCONIDE ON THE PDL. SECONDED BY (NOT NOTED). THE MOTION PASSED UNANIMOUSLY.

9. Re-Review of Ophthalmic Antibiotics (Blue Class)

Ms. Narus gave the Magellen presentation on Ophthalmic Antibiotics. The composition of the group, which was previously reviewed as Ophthalmic Quinolones and Ophthalmic Macrolides, now includes Fluoroquinolones, Macrolides, Aminoglycosides, and others. Indications for Fluoroquinolones and Azithromycin include bacterial conjunctivitis, corneal ulcers. Pediatric ages range slightly, but several are indicated for use down to 1 year of age, Levofloxacin is restricted to patients 6 years or older, and Moxifloxacin can be used down to 4 months. Erythromycin is indicated for newborns and is used for ophthalmia neonatorum due to Chlamydia and as prophylaxis of ophthalmia neonatorum due to Neisseria gonorrhea. The Aminoglycosides are indicated for superficial ocular infections including the conjunctiva or cornea. Tobramycin ointment is used for the treatment of external infections of the eye and its adnexa. Aminoglycosides may be used down to 2 months of age, although there are precautions again neonatal usages. Fluoroquinolones exert their action on the DNA gyrase by inhibiting it. Macrolines and Aminoglycosides inhibit protein synthesis by binding the 50S and 30S ribosomal subunit respectively. All of the products are available in solution form. Ciprofloxacin, Tobramycin and Gentamicin are also available as an ointment. AzaSite (Azithromycin) and Besivance (Besifloxacin) have a unique mucoadhesive delivery system called Durasit. In February 2013, for the Fluoroquinolones and Macrolides, there were 281 claims: 128 for Erythromycin, 59 for Ofloxacin, 48 for Vigamox, 30 for Ciprofloxacin, and down from there. At the last review, when these two groups were in separate classes, motions for class effect, to include Erythromycin ointment, passed unanimously.

Dr. Demain expressed concern with the lack of availability of Erythromycin ointment in the past year. Dr. Hope said there was a New England sterile compounding crackdown nationwide last year due to many quasi-compounding/manufacturers shipping low-cost and questionable quality product around the country, which may have led to a lack of availability.

DR. CARLSON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE FROM EACH CLASS AND ERYTHROMYCIN OINTMENT. SECONDED BY DR. PAPPENHEIM. THE MOTION PASSED UNANIMOUSLY.

Break from 9:19 a.m. to 9:30 a.m.

10. Re-Review of Cephalosporins and Related Antibiotics (Blue Class)

Ms. Narus gave the Magellen presentation on Cephalosporins and Related Antibiotics. This class includes second generation and third generation oral Cephalosporins, as well as Penicillin/Beta-Lactamase combinations. The second generation Cephalosporins is active against gram-positive and gram-negative organisms with indications ranging from pharyngitis to uncomplicated skin infections. Cefuroxime has an additional indication for Gonorrhea. It is primarily renally excreted and these agents require a renal dose adjustment. Third generation oral Cephalosporins have broad-spectrum gram-negative coverage, as well as coverage of penicillin susceptible S. pneumonia, thus gaining most agents in this class an indication for CAP. Cephalosporins lack activity against Enterococcus and Atypical pathogens as a group. The Augmentin (Amoxicillin/Clavulanate) grouping is a broad spectrum antibiotic. ADR profiles for these agents include renal dosing needs, drug interactions, and

etcetera. Cefuroxime suspension has higher bioavailability than tablets, which prohibits therapeutic interchange. Otitis media should be treated with the suspension or the chewable tablets. In February 2013, for previously reviewed agents within this class, there 502 claims: 340 for Cefdinir suspension, 55 for Cefdinir capsule, 36 for Cefprozil suspension, 26 for Cefprozil tablets, 25 for Cefuroxime tablets, 11 for Cefpodoxime, and down from there. At the last review, a motion for class effect to include at least one good-tasting product and to exclude Ceclor for the second-generation products passed unanimously. For the third generation agents, a motion for class effect passed unanimously. Significant changes were reviewed.

In response to Dr. Demain, Ms. Narus said the Amoxicillin/Clavulante group was not reviewed last year and did not appear on the utilization report.

DR. CARLSON MOVED DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE FROM EACH CATEGORY AND ONE GOOD-TASTING AGENT. SECONDED BY DR. RILEY.

In response to Dr. Demain, Dr. Hope said Cefdinir was a good-tasting agent.

THE MOTION PASSED UNANIMOUSLY.

11. Re-Review of Hepatitis C Agents (Green Class)

Ms. Narus gave the Magellen presentation on Hepatitis C Agents. This group includes the Pegylated Alpha Interferons, the Ribavirins, and the Oral Protease Inhibitors. A significant update to the AASLD 2011 Guidelines recommends that patients with genotype 1 hepatitis C viral infection be treated for 24 to 48 weeks with triple therapy containing Beceprevir or Telaprevir in combination with Peginterferon Alfa and weight-based Ribavirin. The recommendation is to not use protease inhibitors alone due to the risk of resistance developing. The Pegylated Alpha Interferons act to inhibit viral replication in side infected cells via complex cascade. Within this class, renal dosing is required. Monotherapy is not recommended unless a patient has a contraindication to, or significant intolerance to, Ribavirin. The combination therapy provides substantially better rates than monotherapy. Safety and efficacy has not been demonstrated for treatment longer than 48 weeks. Safety and efficacy have not been established in liver or other organ transplant recipients. The Ribavirins are nucleoside analogs which disrupt cellular metabolic processes and act as potent RNA virus mutagens. Ribavirins should never be used as monotherapy within HCV. Two forms of contraception should be used during therapy and for the six months following therapy. Safety and efficacy have not been demonstrated with treatment longer than 48 weeks for Copegus or Ribasphere, and no longer than one year with Rebetol. Renal dosing is required for Copegus. Oral Protease Inhibitors are used in combination with the Peginterferon Alfas and Ribavirin as part of the triple therapy program regimen and should not be used as monotherapy. Telaprevir resistance has been observed. Treatment of patients with genotype one infections utilizing the triple therapy approach has shown higher rates of sustained virologic response. Telaprevir must always be taken with food. Boceprevir may be taken independent of food. Both agents are contraindicated in patients who are concurrent drug therapy. Other warnings and risks were reviewed. In February 2013, there were 11 claims: 4 for PEGASYS syringe, 3 for Ribavirin tablet, 2 for PEGASYS Pro-Click, 1 for Incivek, and 1 for Ribavirin capsule. At the last review, a motion for therapeutic alternatives with at least one agent from the Interferons, the Ribavirins, and the Oral Protease Inhibitors passed unanimously. Significant changes were reviewed.

DR. CARLSON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES WITH AT LEAST ONE AGENT FROM EACH SUBCLASS. SECONDED BY DR. SEMLING.

Dr. Carlson said that in a year or two there would be a new set of drugs available in the class that has greater efficacy and fewer side effects if the preliminary literature is accurate.

THE MOTION PASSED UNANIMOUSLY.

12. Re-Review of Ophthalmics for Allergic Conjunctivitis (Green Class)

Ms. Narus gave the Magellen presentation on Ophthalmics for Allergic Conjunctivitis. These agents are used to treat symptoms of perennial and seasonal allergies. All but three products have some systemic absorption. These products should not be used to treat contact lens irritation as the Benzalkonium chloride may be absorbed by the contacts. All products are in solution and dosed as one drop, but the frequency of dosing varies among the agents. In February 2013, there were 88 claims: 38 for Pataday, 37 for Patanol, 9 for Alrex, 3 for Lastacraft, and 1 for Crolom. At the last review, a motion for class effect passed unanimously.

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

13. Re-Review of Antimigraine Agents (Green Class)

Ms. Narus gave the Magellen presentation on Antimigraine Agents. These agents come in a variety of forms. Triptan products include a warning regarding the possibility of serotonin syndrome when used in conjunction with SSRIs. Diclofenac and the combination product of Sumatriptan/Naproxen (Treximet) contain a blacked box warning for a possibility of GI ulceration, perforation, and inflammation. Each drug has a maximum of 24 hour defined dose that should not be exceeded. In February 2013, there were 150 claims: 75 for Sumatriptan, 22 for Maxalt, 11 for Relpax, 10 for Sumatriptan kit, 6 for Treximet, 5 for Maxalt, and down from there. At the last review, a motion for class effect passed unanimously. There had been a discussion on amending the motion to add different dosage forms, but the amendment failed. Significant changes include Rizatriptan has been given approval for pediatric patients between the ages of 6 and 17 years of age after a clear diagnosis of migraine has been establish, and it is a weight-based dosing. Treximet, due to the Naproxen, is contraindicated for patients with a cretin clearance of less than 30, as well as hepatic impairment.

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

14. Re-Review of Ophthalmic Cyclosporine Emulsion (Green Class)

Ms. Narus gave the Magellen presentation on Ophthalmic Cyclosporine Emulsion. Restasis (Cyclosporine Ophthalmic) is indicated to increase tear production of patients whose tear production is presumed to be suppressed due to ocular inflammation associated with Kertoconjunctivitis sicca, which may decrease tear volume or cause poor tear quality. Artificial tears and ointments continue to

be part of the symptomatic treatment of dry eye. In February 2013, there were 33 claims for Restasis. At the last review, a motion for class effect passed unanimously.

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

15. Re-Review of Leukotriene Modifiers (Green Class)

Ms. Narus gave the Magellen presentation on Leukotriene Modifiers. This class of medications is used as add-on therapy in asthma patients with mild persistent symptoms or aspirin-sensitive asthma. They can also be used in patients utilizing inhaled Glucocorticoids to reduce the steroid dose. The Leukotriene mediated effects include airway edema, smooth muscle contraction, mucous secretion, and micro vascular permeability. Accolate has to be dosed on an empty stomach. Singulair is approved for use in children down to 1 year of age for asthma and 2 years of age for allergic rhinitis. In February 2013, there were 809 claims: 459 for Montelukast, 326 for Montelukast tablets, 15 for Singulair chewable tablets, 14 for Singular regular tablets, and down from there. At the last review, a motion for therapeutic alternatives to include all forms of Singulair passed unanimously.

Dr. Demain noted that Singulair went generic in the last year and the chewable tablet no longer tastes good. According to the EPR-3 Guidelines, this class should be used as monotherapy in mild asthma or add-on therapy in moderate asthma. It is also therapeutic in the treatment of allergic rhinitis. It is used in the treatment of virticaria, although it does not have that indication. It is the drug of choice as a component of therapy for patients with aspirin-sensitive asthma. A brief description of each of the drugs was provided.

DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ALL FORMS OF MONTELUKAST. SECONDED BY DR. CARLSON. THE MOTION PASSED UNANIMOUSLY.

16. Re-Review of $Beta_2$ Adrenergic, Short-Acting Agents (Green Class)

Ms. Narus gave the Magellen presentation $Beta_2$ Adrenergic, Short-Acting Agents. Agents in this class are available in meter dose inhaler form or nebulized solution form. These drugs are categorized as reliever medications and used to treat acute exacerbation of asthma. Due to their quick onset of action, they are the primary agent for that. They are not to be used as a controller medication. In February 2013, there were 2,358 claims, with 586 for nebulized products: 762 for ProAir HFA, 493 for Albuterol solution, 485 for Proventil HFA, 444 for Ventolin HFA, 76 for Xopenex HFA, and down from there. At the last review, a motion for class effect to include at least one Albuterol agent passed unanimously. Significant changes include ProAir started to be marketed with a new dose counter.

In response to Dr. Demain, Ms. Narus said the oral agents were not currently reviewed. There may have been some claims, but were not pulled for this utilization since they had not been previously reviewed. Dr. Hope said there were very few oral agents prescribed.

DR. GREEAR MOVED A CLASS EFFECT TO INCLUDE AT LEAST ONE ALBUTEROL AGENT. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

17. Re-Review of Low-Sedating Antihistamines (Green Class)

Ms. Narus gave the Magellen presentation Low-Sedating Antihistamines. Minimally sedating antihistamines are selective, competitive, peripherally acting histamine H_1-receptor antagonists with little or no central or autonomic nervous system activity. Although they have similar efficacy, sedation was reported in up to 14 percent of patients using Cetirizine. Leovcetirizine has a lower incidence of sedation at lower doses, but has increased risk at higher doses. Fexofenadine tends to cause the fewest CNS effects. Allegra ODT contains Phenylalanine. In February 2013, there were 298 claims: 220 for Loratadine tablet OTC, 39 for Loratadine solution OTC, 24 for Levocetirizine, 7 for Loratadine D OTC, and down from there. At the last review, a motion for class effect with at least one pediatric preparation being included passed unanimously. Significant changes include Zyrtec OD and Loratadine liquid gels coming to the marketplace. Allegra ODT suspension, which is brand name only, was approved for the treatment of chronic idiopathic urticaria in children 6 months to 11 years of age, but it does require a prescription if used in children less than 6 years of age. Levocetirizine should be used with caution in patients with risk for urinary retention based on post-marketing studies.

In response to Dr. Bergeson, Dr. Hope said he submitted a package to have Medicaid cover more of the over-the-counter medications in this category, but that did not move forward. If a drug undergoes an RX to over-the-counter switch, we have to get special approval from the Centers for Medicaid and Medicare Services to cover it on a case-by-case basis. When Allegra and Zyrtec went over-the-counter, we could not cover it anymore because we did not have federal approval. We have received approval for over-the-counter Claritin. The committee further discussed the issue in terms of utilization, performance of the drugs, and the cost to Medicaid since patients often change from the less expense over-the-counter drug to a more expensive prescription drug that will be covered.

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

18. Re-Review of COPD Agents (Green Class)

Ms. Narus gave the Magellen presentation on COPD Agents. Bronchodilators are central to the management of COPD symptoms. For mild disease, a short acting agent used as needed is available. For moderate to severe disease, scheduled use for bronchodilators is recommended. The anticholinergic agents exert activity by blocking the cholinergic neuron transmission, thereby causing bronchi dilation. The most common adverse event is dry mouth and generally resolves with continued use. In February 2013, there were 404 claims: 151 for Combivent, 142 for Spiriva, 50 for Albuterol/Ipratropium (generic Combivent), 30 for Daliresp oral, 16 for Ipratropium nebulizer, and down from there. At the last review, a motion for therapeutic alternatives to include one long-acting, one combination, and one oral agent passed unanimously. Significant changes include Combivent CFC has been replaced with Combivent Respimat, which is dosed at one inhalation four times daily, not to exceed six doses in 24 hours. Terdorisa PressAir (ph), which was supposed to launch at the end of 2012, is a long-acting dry powder inhaler that has been approved for COPD and has twice daily dosing.

DR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AT LEAST ONE LONG-ACTING, ONE COMBINATION, AND ONE ORAL AGENT. SECONDED BY DR. BERGESON.

Dr. Demain said Tiotropium, although it has not yet received the FDA recommendation, has a lot of very good literature to support its use in moderate to severe asthma.

THE MOTION PASSED UNANIMOUSLY.

19. Re-Review of Tetracyclines, Oral (Green Class)

Ms. Narus gave the Magellen presentation on Tetracyclines, Oral. Tetracyclines are indicated for a wide variety of infections primarily caused by infectious agents, which were listed. You may also see these agents used in the treatment of acne and rosacea. These agents generally are bacteria static in nature. Drug reactions, eosinophilia, systemic symptoms, and Lupus-like symptoms have been reported with Minocycline use. Over sensitivity is a concern with these agents. These agents should be taken on an empty stomach to minimize the decrease in absorption. Tetracyclines are not recommended in children less than 8 years of age due to tooth discoloration, with the exception of use in cases of anthrax post-exposure therapy with Doxycycline. Minocycline ER should not be used in patients less than 12 years of age. In February 2013, there were 313 claims: 147 for Doxycycline Hyclate tablets, 88 for the Doxycycline capsule, 67 for Minocycline, 3 for Doxycycline Monohydrate, and down from there. There was no previous discussion on this class. There have been no significant changes.

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

20. Re-Review of Fluoroquinolones, Oral (Green Category)

Ms. Narus gave the Magellen presentation on Fluoroquinolones, Oral. This group includes second and third generation systemic Quinolones. Second generation agents have stronger gram-negative activity than third generation agents and are primarily used to treat UTIs and abdominal infections. Third generation agents exhibit broader spectrum of activity, picking up some gram-positives, which gains them indications for CAP. Cyclic Quinolones play a role in certain genital urinary and STD infections. They have good bioavailability and are frequently candidates for IV-to-oral therapy conversions. Safety concerns for this class includes tendon rupture in elderly or malnourished individuals, exacerbated muscle weakness in patients with myasthenia gravis, QT prolongations, pseudo membranous colitis, photosensitivity, and glucose tolerance issues. In February 2013, there were 322 claims: 199 for Cipro tablets, 116 for Levofloxacin tablets, 2 for Avelox, 2 for Cipro suspension, 2 for Levaquin tablets, and 1 for Levofloxacin. At the last review, a motion for class effect to include a second and third generation product passed unanimously.

DR. PHILLIPS MOVED A CLASS EFFECT TO INCLUDE AT LEAST ONE SECOND AND THIRD GENERATION PRODUCT. SECONDED BY DR. RADER. THE MOTION PASSED UNANIMOUSLY.

21. Re-review of Macrolides - Ketolides

Ms. Narus gave the Magellen presentation on Macrolides - Ketolides. Macrolides have activity against gram-positive cocci and atypical pathogens. Azithromycin and Clarithromycin demonstrate better

tolerability with more convenient dosing regimens and improved activity against H. influenza. These agents bind to the 50S ribosomal subunit of susceptible bacteria inhibiting RNA-dependent protein synthesis. Drug interactions and cautions can vary among these agents. In February 2013, there were 1,431 claims: 754 for Azithromycin tablets, 444 for Azithromycin suspension, 128 for Zithromax suspension, 38 for Clarithromycin tablets, 14 for Azithromycin packets, 11 for EES suspension, and down from there. At the last review, a motion for therapeutic alternative to include Azithromycin and one pediatric formulation passed unanimously. Significant changes include CDC gonorrhea guidelines, which were reviewed. FDA reviewed labeling of Azithromycin and Macrolides, which prompted a new study that found an increased risk of death with Azithromycin versus Amoxicillin or Ciprofloxacin for patients not on an antibiotic. Language regarding QT prolongation has been added to the warning sections of all Azithromycin products. The study also found an increased risk for cardiovascular death and all-cause mortality with a five-day course of Azithromycin.

Dr. Hope asked if physicians were using less Azithromycin after the cardiac update. Dr. Riley said it was being used less for viral infections.

DR. SEMLING MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE AZITHROMYCIN AND ONE PEDIATRIC FORMULATION. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

22. Re-Review of Antivirals, Herpes Simplex Virus (HSV) (Green Category)

Ms. Narus gave the Magellen presentation on Antivirals, Herpes Simplex Virus (HSV). The CDC recommendations for initial recurrent episodes of genital herpes are chronic suppressive therapy and indicate no preference for any of the three oral agents. Valacyclovir is rapidly converted to Acyclovir. Famciclovir is metabolized to its active metabolite Penciclovir. Renal failure is a risk for Acyclovir and Famciclovir as acute chronic failure and even death have occurred. Probenecide has been shown to interact with Acyclovir and Penciclovir. In February 2013, there were 281 claims for the herpes agents: 138 for Valacyclovir, 82 for Acyclovir tablets, 20 for Acyclovir capsules, 19 for Famciclovir, 18 for Acyclovir suspension, and 4 for Valtrex. At the last review, a motion for class effect to include an oral suspension and a capsule or tablet passed unanimously.

In response to Dr. Semling, Dr. Hope said Valtrex branded name was preferred over the Valacyclovir because it had a very large federal rebate, which caused the brand-name product to be less expensive than the generic.

DR. BERGESON MOVED A CLASS EFFECT TO INCLUDE AN ORAL SUSPENSION AND A CAPSULE OR TABLET. SECONDED BY DR. PHILLIPS. THE MOTION PASSED UNANIMOUSLY.

23. Re-Review of Antiviral Agents, Topical (Green Category)

Ms. Narus gave the Magellen presentation on Antiviral Agents, Topical. These products are used for cold sores occurring from either an HSV-1 or HSV-2 infection. Recurrences resulting from HSV-2 are rare. Abreva offers the advantage of being the only FDA approved over-the-counter medication. There were no significant differences noted between the available products. Systemic absorption is low. Topical therapy should be started during the prodrome phase and used for acute outbreaks only. In

February 2013, there were 26 claims: 14 for Zovirax ointment, 9 for Zovirax cream, and 3 for Denavir. At the last review, a motion for class effect passed unanimously.

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

24. Re-Review of Ophthalmic Anti-Inflammatories (Green Category)

Ms. Narus gave the Magellen presentation on Ophthalmic Anti-Inflammatories. The main use of these products is for relief on inflammation and pain associated with ophthalmic surgery. Use for longer than 14 days increases the risk of adverse corneal events. Transient burning, irritation, and corneal edema are the most commonly reported adverse effects. These products have no significant effect on intraocular pressure. After cataract surgery, Diclofenac and Nepafenac have been associated with an elevation of pressure. Frequency and number of drops vary between the agents. Safety and efficacy in pediatric patients has not been established for Bromfenac, Diclofenac, Flurbiprofen, and Ketoralac. Nepafenac (Nevanac) has not been studied in children less than 10 years of age. In February 2013, there were 10 claims: 3 for Flurbiprofen, 3 for Ketoralac, 2 for Diclofenac, 1 for Ketoralac LS, and 1 for Bromday. At the last review, a motion for class effect. After a discussion about patients who had been wearing contact lens, the motion passed unanimously without an amendment.

In response to Dr. Demain, Ms. Narus said last year only the NSAIDs were reviewed.

In response to Dr. Pappenheim questioned of last year's motion of class effect, Dr. Demain said only the NSAIDs were voted on last year. The topical steroids were bundled into the group this year.

DR. BERGESON MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES TO INCLUDE ONE AGENT FROM EACH CLASS. SECONDED BY DR. PAPPENHEIM. THE MOTION PASSED UNANIMOUSLY.

25. Re-Review of Topical Antifungals (Green Category)

Ms. Narus gave the Magellen presentation on Topical Antifungals. These agents are indicated for tinea pedis, tinea cruris, tinea versicolor, tinea corporis, and cutaneous candidiasis, as well as onychomycosis. Agents within this class vary in their indication spectrum. Miconazole (Vusion) should not be used to prevent incontinence dermatitis as resistance may develop. All agents are considered either pregnancy category B or C. Ciclopirox is active against many different fungi including dermatophytes and yeast. Its mechanism of action is through inhibition of metal dependent enzymes. It is applied once daily to the effected nails at bedtime for 48 weeks. In February 2013, there were 506 claims: 165 for Nystatin cream, 82 for Nystatin ointment, 51 for Clotrimazole/Betamethasone, 36 for Ketoconazole shampoo, 32 for Ketoconazole cream, 29 for Nystatin powder, 29 for Nystatin/Triamcinolone, 28 for Econazole, 24 for Ketoconazole cream, 14 for Nystatin/Triamcinolone ointment, and less than 6 for the Ciclopriox cream and gel shampoo products. At the last review, a motion for class effect passed unanimously.

Dr. Pappenheim felt the motion should specify several different means of application such as shampoos, creams, and ointments. Dr. Hope cautioned that said some of the designer application styles come with a very large price tag.

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

26. Re-Review of Hepatitis B Agents (Green Category)

Ms. Narus gave the Magellen presentation on Hepatitis B Agents. Prolonged antiviral therapy is needed for the suppression of chronic Hepatitis B infections. Epivir HBV can be used in patients older than 2 years of age. Telbivudine is indicated for compensated liver disease when lab parameters are met. Hepsera is indicated for patients age 12 and older. Baraclude and Tyzeka are indicated for patients age 16 and older. In February 2013, there were 12 claims: 6 for Baraclude, 5 for Hepsera, and 1 for Epivir. At the last review, a motion for therapeutic alternatives passed unanimously. Significant changes include the European Association for the Study of Liver published updated guidelines in 2012. The guidelines continue to support the ASLD's guidelines, which were reviewed. Lamivudine, Telbivudine and Adefovir should only be used for first line if the more potent drugs are not available or appropriate.

DR. LOVE MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. RADER. THE MOTION PASSED UNANIMOUSLY.

27. Re-Review of Ophthalmic Antibiotic-Steroid Agents (Green Category)

Ms. Narus gave the Magellen presentation on Ophthalmic Antibiotic-Steroid Agents. These agents are indicated for corticosteroid responsive inflammatory ocular conditions for which a corticosteroid is indicated and where bacterial infection or a risk or bacterial infection exists. These combinations are contraindicated in most viral diseases of the cornea and conjunctiva during mycobacterial injection of the eye and fungal diseases of ocular structures. Corticosteroids should be used with caution in patients with glaucoma. Prolonged use may warrant evaluation of the intraocular pressure. In February 2013, there were 55 claims: 20 for Pred-G suspension, 15 for Tobramycin/Dexamethasone, 7 for the Neomycin/Polymyxin/Dexamethasone combination, 7 for Tobradex ointment, 3 for Tobradex suspension, and 1 for the remaining products. At the last review, a motion for therapeutic equivalents passed with one opposed.

The committee discussed the currently preferred agents, both of which had utilization in February. In response to Dr. Carlson, Dr. Demain said Neomycin one of the more common contact sensitizers. Once a patient develops contact sensitivity, Amino glycosides cannot be used.

DR. CARLSON MOVED A CLASS EFFECT, TO INCLUDE ONE PRODUCT THAT IS NOT NEOMYCIN-BASED. SECONDED BY DR. GREEAR. THE MOTION PASSED UNANIMOUSLY.

28. Re-Review of Antivirals, Influenza (Green Category)

Ms. Narus gave the Magellen presentation on Antivirals, Influenza. All products within this class should be administered within 48 hours after the onset of symptoms. Amantadine and Rimantadine frequently boasts high rates of resistance. Local susceptibility patterns should be taken into account during the current season. Relenza and Tamiflu are indicated for types A and B. Amantadine and

Rimantadine are only indicated for type A. In February 2013, there were 140 claims: 62 for Tamiflu capsules, 55 for Tamiflu suspension, 11 for Amantadine tablets, 7 for Amantadine capsules, and 5 for Amantadine syrup. Not to discriminate, but there have been discussions about the off-label use of Amantadine for autism, so it is unclear what specific indications for which the Amantadine was prescribed. At the last review, a motion for therapeutic alternatives passed unanimously.

The committee discussed the different uses for Amantadine including antiviral activity, Parkinson's disease and a number of different things.

Dr. Carlson said the BMJ has questioned the effectiveness of Tamiflu. There is unpublished study data that is going to be released in the near future on the efficacy of Tamiflu.

DR. LOVE MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES. SECONDED BY DR. RADER. THE MOTION PASSED UNANIMOUSLY.

29. Election of New Chair and Vice-Chair

This item was addressed in a closed session that included the committee members only.

DR. BERGESON MOVED JEFF DEMAIN AS PRESIDENT. SECONDED BY DR. PAPPENHEIM. THE MOTION PASSED UNANIMOUSLY.

DR. PAPPENHEIM MOVED JENNY LOVE AS VICE PRESIDENT. SECONDED BY DR. BERGESON. THE MOTION PASSED UNANIMOUSLY.

30. Review Minutes of November 16, 2012 meeting and January 18, 2013 meeting

Being no objections, the meeting minutes of November 16, 2012 and January 18, 2013 were approved.

31. Comments from Committee Members or Chair

32. Adjourn

Without objection, the meeting adjourned at 10:47 a.m.