ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE

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

MINUTES OF MEETING
January 18, 2013
8:01 a.m.

Committee Members Present:
Marvin Bergeson, MD
Richard Brodsky, MD
Robert Carlson, MD (telephonic)
Jeffrey Demain, MD
Vincent Greear, R.Ph.
Daniel Kiley, DDS, MPH
Diane Liljegren, MD (telephonic)
Jenny Love, MD
John Pappenheim, MD
Maggie Rader, MD
Jill Reid, R.Ph. (telephonic)
John Riley, MD
Chuck Semling, MD
Trish White, R.Ph. (telephonic)

Committee Members Absent:
Dharma Begich, MD
Amber Briggs, Pharm.D.
Claudia Phillips, MD

Others Present:
Erin Narus, Magellen Medicaid Administration
Chad Hope, Pharm.D.
Todd Paulson
Steve Hall (telephonic)

1. Call to Order – Chair

Dr. Brodsky called the meeting to order at 8:01 a.m.

2. Roll Call

A quorum was present. The following new committee members were introduced: Jenny Love, Maggie Rader, and Chuck Semling.

3. Public Comments - Local Public/Health Practitioners

There were no public comments.

4. Re-review of Angiotensin Modulators (Angiotensin II Receptor Blockers) (Red Category)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Angiotensin Modulators. Angiotensin II receptor blockers share an indication for hypertension. Some agents hold additional indications for nephropathy or heart failure, although ACE Inhibitors remain the mainstay. ARBs block the vasoconstrictive and aldosterone-secreting effects of angiotensin II by selectively blocking the binding of angiotensin II to the AT1 receptors found in tissues such as the vascular smooth muscle and the adrenal gland. JNC7 indicates that they may be used as first line for hypertension. All ARBs reduce blood pressure to a similar degree based on prescribing information. Limited information suggests higher doses of Candesartan, Valsartan, and Irbesartan may decrease blood pressure more than Losartan. In November 2012, there were 603 claims: 46% for Losartan, 29% for Diovan, and 9% for Micardis. For the combination products: 40.6% for Valsartan/Hydrochlorothiazide, 27% for Losartan/Hydrochlorothiazide, and 14.1% for Benicar/Hydrochlorothiazide. Significant changes include that the FDA has added fetal toxicity boxed warnings to all ACE Inhibitors, ARBs, and Aliskiren containing products. Most products are now listed as pregnancy category D in all three trimesters. At the last review, a motion for class effect passed unanimously.

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

5. Re-Review of Neuropathic Pain (previously "Topical Anesthetics" and "Fibromyalgia") (Red Category)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Neuropathic Pain. This new group combines the previous classes Topical Anesthetics and Fibromyalgia. This group includes agents for indications for post-herpetic neuralgia, diabetic peripheral neuropath, fibromyalgia, and general neuropathic pain. The drugs in this class have varied mechanism. Administration varies from topical to oral. Systemic absorption of the topical agents is low. Health care professionals are advised to closely monitor all patients currently taking or starting any anti-epileptic drug such as Gabapentin, including the brand-name drugs Neurotin, Gralise, and Horizant, for changes in behavior that could indicate the emergence or worsening of suicidal thoughts, behavior, or depression. Gralise and Horizant are not interchangeable with other Gabapentin products due to differing pharmacokinetic profiles that affect the frequency of administration. The safety and effectiveness of Gabapentin in the management of post-herpetic neuralgia in patients less than 18 years of age has not been studied. Gabapentin has not been evaluated for use during pregnancy. In November 2012, there were 1,726 claims: 47.3% for generic Gabapentin, 33.5% for Cymbalta, 16.3% for Lyrica, and 2.4% for Savella tablets. Significant changes include an increased warning during the discontinuation of Cymbalta to include a gradual dose

reduction to limit withdrawal symptoms. The indication for Lyrica has been expanded to include neuropathic pain associated with spinal cord injury. In 2011, Gralise, Neurontin, and Lyrica were released from the REMS requirement. As this is a new class, there was no previous discussion.

Dr. Hope said the drugs in this class were previously included in other classes, but they have been combined into a single class. These drugs are not indication specific. If specific drugs are used for specific indications, the claims are included in the utilization report, but we do not know if they were prescribed for neuropathic pain, as there is no prior authorization requirement.

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

In response to Dr. Demain question about why the preferred agent Savella, which was touted for its use in chronic fatigue and fibromyalgia, was not utilized, Dr. Hope said Savella has not been widely utilized on a nationwide basis.

THE MOTION PASSED UNANIMOUSLY.

6. Re-Review of Beta Blockers (Blue Category)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Beta Blockers. This class has various indications. All have the indication for hypertension with similar efficacy. Other indications vary by drug. The 2011 National Institute for Health and Clinical Excellence Guidelines no longer prefer beta-blockers as routine initial therapy for hypertension, however they can be considered in younger patients with contraindications to ACE Inhibitors or ARBs, such as those who have childbearing potential or intolerance. They suggest initiation with ACE Inhibitors or ARBs in patients less than 55 years of age. The JNC8 Guidelines are still in development. In November 2012, there were 1,871 claims: 23.6% for Atenolol, 21% for Metoprolol Succinate, 14.3% for Carvedilol, and 13.3% for Metoprolol Tartrate. Within the combination class, which includes beta-blockers with a diuretic combination: 75.9% for Atenolol/Chlorthalidone, 20.7% for Bisoprolol/Hydrochlorothiazide, and 3.4% for Metoprolol/Hydrochlorothiazide. There were no significant changes within this class. At the last review, a motion for class effect passed with one abstention.

DR. KILEY MOVED A CLASS EFFECT.

Dr. Kiley explained that he moved a class effect, rather than therapeutic alternatives, because some of the drugs include diarrhetic and some do not.

Dr. Liljegren felt the motion should include either a Carvedilol or Metoprolol Succinate product, which are crucial to the treatment of coronary artery disease and cariomyopathy.

DR. LILJEGREN MOVED A CLASS EFFECT, TO INCLUDE EITHER A CARVEDILOL OR METOPROLOL SUCCINATE PRODUCT. SECONDED BY DR. BERGESON. THE MOTION PASSED WITH ONE ABSTENTION.

6. Re-Review of Hypoglycemics, Incretin Enhancers/Mimetics (Blue Class)

TODD PAULSON: A representative Novo Nordisk discussed Victoza. Victoza is a GLP-1 agonist indicated as adjunct to diet and exercise in adults with type 2 diabetes. It is not for patients with type 1 diabetes, MEN 2, medullary thyroid carcinoma, and caution should be used for patients with a history of pancreatitis or renal insufficiency. Victoza is a GLP-1 analog and it carries the characteristics of human GLP-1 in the fact that it works in a glucose-dependent nature. The modifications have extended the duration of action so it can be dosed once daily, irrespective of meals, in a simple device that has a small pen needle. An analog to native GLP-1 is that it is degraded systemically like GLP-1 so there is no dosing adjustment in renal insufficiency or hepatic insufficiency and no accumulation in such disorders. Several clinical trials and their outcomes were reviewed. Based upon the attributes and the demonstration of superiority versus currently used products, we request that Victoza be added to the Alaska PDL.

STEVE HALL: A representative of Boehringer Ingelheim discussed Tradjenta, a DPP-4 inhibitor. Tradjenta is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. It should not be used for patients with type 1 diabetes or for the treatment of diabetic ketoacidosis. It is approved at one dose for patients with type 2 diabetes. The recommended dose is 5 milligrams once a day and can be taken with or without food. No dosage adjustment is recommended for patients with renal or hepatic impairment. It can now be used as monotherapy or in combination with Metformin, Sulfonylurea, Pioglitazone or Insulin. Several studies and their outcomes were reviewed. Adverse reactions and drug-to-drug interactions were reviewed. There are no adequate controlled studies in pregnant women so it should be used only if clearly needed. It is unknown if it is excreted in human milk so caution should be used. The safety and effectiveness of Tradjenta in patients below the age of 18 has not been established. We request that Tradjenta be added to the Alaska PDL.

Ms. Narus gave the Magellen presentation on Hypoglycemics, Incretin Enhancers/Mimetics. There are three subcategories within this group: GLP-1, DPP-4 enzymes, and Amylin analogs.

GLP-1 is part of the system involved in the regulation of glucose homeostasis, which increases insulin synthesis, insulin release, decreases glucagon secretion and slows gastric emptying. Byetta and Victoza have added indications of add-on therapy to insulin glargine. Some patients may develop anti-Exenatide antibodies; therefore, an attenuation of glycemic response could occur. Significant changes include Bydureon has been added since the last review. Bydureon is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes. Several safety issues were brought up during the public testimony related to Multiple Endocrine Neoplasia syndrome type 2 and acute pancreatitis. Bydureon is subject to a communication plan and post-marketing reports have indicated serious hypersensitivity reactions in some of these agents. In November 2012, there were 31 claims: 48.4% for Byetta, 48.4% for Victoza, and 3.2% for Bydureon.

The DPP-4 enzyme inactivates the GLP-1 incretin molecule, thus by inhibiting the DPP-4 enzyme; these agents slow the inactivation of the incretins and prolong their action. The 2011 AACE Guidelines indicate that these drugs can be used as monotherapy or in combination with other anti-hyper glycemics for patients with type 2 diabetes. Since insulin secretion is increased and glucagon secretion

reduced, the result is a lowering of glucose levels. In 2011, the REMS for Byetta, Januvia, and Janumet were removed. A significant change is that renal function must be monitored with acidic-lipton containing agents. Janumet XR and Jentadueto have been added since the last review. There have been post-marketing reports of serious hypersensitivity reactions in Januvia and Janumet. In November 2012, there were 127 claims: 75.6% for Januvia, 18.9% for Janumet, 3.9% for Onglyza, and down from there.

The Amylin analogs were reviewed. Symlin is indicated for patients with type 1 or type 2 diabetes that is using insulin but fail to achieve glycemic control. Persons with the hemoglobin A1C of greater than 9 are not candidates for this drug, nor are those patients who require drugs to stimulate gastric motility. There were no significant changes within this class. In November 2012, there were 3 claims: 100% for the Symlin pen.

At the last review, there was significant discussion on this class regarding separating the GLP-1s and DPP-4s. There were two motions. A motion to consider the GLP-1 categories a class effect passed unanimously. A motion to consider the DPP-4 category a class effect passed unanimously.

In response to Dr. Demain, Dr. Brodsky said that no letters of support had been received for any of the categories being reviewed during this meeting.

The committee discussed the best way to word the motion to include one drug from each category. Dr. Liljegren supported leaving them as two separate groups according to their class.

DR. GREEAR MOVED THE GLP-1s AND DPP-4s WERE SEPARATE CATEGORIES AND BOTH WERE A CLASS EFFECT. AT LEAST ONE AGENT FROM EACH CATEGORY SHOULD BE INCLUDED ON THE PDL. SECONDED BY DR. LILJEGREN. THE MOTION PASSED UNANIMOUSLY.

7. Re-Review of Ulcerative Colitis Agents (Blue Class)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Ulcerative Colitis Agents. The 2010 Practice Guidelines of the American College of Gastroenterology state differences in treatment based on disease severity. The combination of oral and topical mesalamine is more effective than either alone. Patients with active disease should be started with an oral Sulfasalazine or an alternate Aminosalicylate. Asacol and Asacol HD should be used in pregnancy only if the benefits outweigh the risks. Dibutyl phthalate, an inactive ingredient in the enteric coating of these branded products, have been associated with external and skeletal malformations and adverse effects on the male reproductive system in animal studies when given at doses 80 times that of the human dose. Special populations include that Apriso is a concern in patients with PKU due to the presence of aspartame. Colazal and Sulfasalazine are the only agents approved in pediatrics. Colazal is approved for patients five years of age and older. Sulfasalazine is approved for patients six years of age and older. In November 2011, there were 83 claims: 42.2% for Asacol, 21.7% for Sulfasalazine immediate release, 14.5% for Pentasa, and down from there. Significant changes include that Giazo (Balsalazide) is new since the last review. It is indicated for male patients 18 years of age and older. Lialda (Mesalamine MMX tablets) has gained an

added indication of maintenance of remission. In geriatric patients, reports suggest that a higher incidence of blood dyscrasias within this group and caution should be taken to closely monitor blood cell counts during therapy. At the last review, a motion for therapeutic alternatives passed unanimously.

DR. KILEY MOVED THE DRUGS IN THIS CLASS WERE THERAPEUTIC ALTERNATIVES.

DR. LILJEGREN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE SHORT-RELEASE, ONE LONG-RELEASE AND ONE RECTAL FORMULATION BE INCLUDED ON THE PDL. SECONDED BY DR. BERGESON.

In response to an unidentified male, Dr. Brodsky said he did not believe that if a Mesalamine oral formulation was approved that the topical formulation would be automatically approved, even though Mesalamine oral and topical should be used together for effectiveness based on the review. Dr. Hope suggested treating each formulation separately or including them specifically in the motion if you want both formulations included on the PDL.

THE MOTION PASSED WITH ONE OPPOSED.

8. Re-review of Ophthalmics, Glaucoma Agents (Blue Class)

There were no public testimonies.

Ms. Narus gave the Magellen presentation on Ophthalmics, Glaucoma Agents. Glaucoma is the second most common cause of blindness in the United States and the most common cause among African Americans. In 2010, the American Academy of Ophthalmology stated prostaglandin analogs are the most efficacious for lowering intraocular pressure and should be considered first line in Primary Open-Angle Glaucoma. Lumigan and Travatan should not be used in patients under 16 years of age due to increased risk of pigmentation. Alphagan P is contraindicated in patients less than 2 years of age. In November 2012, there were 64 claims among all sub-groupings. In the Sympathomimetics agents: 50% for Lopidine, 37.5% for Alphagan P, and 12.5% for the Brimonidines. For the Beta-blockers: 46.7% for Timolol gel, 26.7% for (indiscernible), 20% for Timolol drops, and down from there. For the Carbonic Anhydrase Inhibitors: 50% for Dorzolamide/Timolol, 33% for Azopt, and 16.7% for Dorzolamide. For the Prostaglandin Analogs: 45.7% for Latanoprost, 37.1% for Travatan, 11.4% for Lumigan .01, 5.7% for Lumigan 0.3, and down from there. The new agent in that class, Zioptan, had zero claims. The agents indicated for children less than 2 years of age had zero utilization. Significant changes include that Zioptan (Tafluprost) is new since the last review. It is the only prostaglandin analog preservative-free formulation and is available in single-use containers. Propine has been discontinued. Lumigan 0.03 will no longer be manufactured as of the end of 2012, but Lumigan 0.1 will remain on the market. Cosopt PF is also preservative free, but it is not a prostaglandin analog. At the last review, a motion for therapeutic alternatives to include one agent from each subclass passed unanimously.

Dr. Hope explained that this class seems to have low utilization, but that is due to double coverage between Medicare and Medicaid, which artificially lowers the utilization. The majority of the claims are through Medicare, which the PDL does not affect. Dr. Brodsky noted that the Medicare Part D legislation prohibits the competition and rebate process that Medicaid utilizes.

DR. RILEY MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC EQUIVALENTS, TO INCLUDE ONE DRUG FROM EACH SUBCLASS. SECONDED BY DR. DEMAIN. THE MOTION PASSED UNANIMOUSLY.

9. Re-Review of Angiotensin Modulators (ACE Inhibitors and Renin Inhibitors (Green Class)

Ms. Narus gave the Magellen presentation on Angiotensin Modulators: ACE Inhibitors and Renin Inhibitors. This class includes two subcategories, Direct Renin Inhibitors and ACE Inhibitors.

Direct Renin Inhibitors are approved as anti-hypertensives and work by targeting the renin-angiotensin-aldosterone system at the point of activation, thereby lowering blood pressure by decreasing plasma renin activity. This class if an alternative, but evidence to date does not show a clear advantage over ACE Inhibitors or ARBs. In December 2011, Novartis stopped the Altitude Study due to higher adverse events occurring when direct renin inhibitors were given with ACE inhibitors and ARBs. All Aliskiren-based medications are contraindicated with ACE inhibitors and ARBs at this point. In November 2012, there were 9 claims: 88.9% for Tekturna and 11.1% for Tekturna with Hydrochlorothiazide. The significant change within this subcategory is Novartis voluntarily decided to cease marketing of Alterna as of July 20, 2012, to allow patients to transition to another therapy.

ACE Inhibitors can be used as first line therapy in the treatment of hypertension. They have shown to slow the progression of diabetic nephropathy, reduce mortality in CFH, and reduce risk of adverse cardiovascular outcomes in high-risk patients. In November 2012, there were 1,891 claims: 94.3% for Lisinopril, 2.4% for Enalapril, and down from there. For ACE Inhibitors with a diuretic combination: 96.9% for Lisinopril/Hydrochlorothiazide and 1.6% for Benazepril/Hydrochlorothiazide. An adverse reaction of psoriasis has been added to Zestril and Zestoretic in their labeling.

At the last review, a motion for therapeutic alternatives to include one agent from each subclass passed unanimously.

In response to Dr. Brodsky, Ms. Narus said there was a notation last year that when the primary drugs were approved, the combination products that were not cost prohibitive would also be included and did not have to be voted on.

DR. DEMAIN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE DRUG FROM EACH SUBCLASS. SECONDED BY DR. RILEY. THE MOTION PASSED UNANIMOUSLY.

10. Re-Review of Calcium Channel Blockers (Green Class)

Ms. Narus gave the Magellen presentation on Calcium Channel Blockers. All agents in this class, except for Nimodipine, Diltiazem ER, and Nifedipine ER, have FDA indications for the treatment of hypertension. There have not been any significant differences noted between these agents. This group consists of Dihydropyridines and Nondihydropyridines calcium channel blockers, as well as combination products. In November 2012, there were 806 claims for the entire class. For the Dihydropyridines: 91.7% for Amlodipine, 2.6% for Nifedipine ER, and down from there. For the Nondihydropyridines: 33.6% for Verapamil, 29.2% for Diltiazem CD, 20.4% for Diltiazem ER, 5.8% for Diltiazem XR, and down from there. Utilization for the combination products was reviewed. Significant changes include rare reports of GI obstructive symptoms in patients with known structures in association with the ingestion of Procardia XL. Cases of tablets adhering to the gastrointestinal wall with ulceration have been reported, some requiring hospitalization and intervention. There has been no utilization within the last three months for that particular drug. At the last review, a motion for therapeutic alternatives, to include at least one Dihydropyridine and one Nondihydropyridine, passed unanimously.

DR. LILJEGREN MOVED THE DRUGS IN THE CLASS WERE THERAPEUTIC ALTERNATIVES, TO INCLUDE AT LEAST ONE DIHYDROPYRIDINE AND ONE NONDIHYDROPYRIDINE. SECONDED BY DR. GREEAR. THE MOTION PASSED UNANIMOUSLY.

11. Re-Review of Topical Acne Agents (Green Class)

Ms. Narus gave the Magellen presentation on Topical Acne Agents. There are four subgroups represented in this class: Dapsone (Aczone), Retinoids, Benzoyl peroxide combination products, and Others.

Dapsone (Aczone) is indicated for the treatment of acne vulgaris. The exact mechanism of action is not known, but thought to work via suppression of neutophil recruitment oxidation. It is believed to have some antibacterial activity. In November 2012, there were 8 claims.

Topical retinoids remain a foundational treatment for acne as they target the microcomedone by decreasing the cohesiveness of follicular epithelial cells. When used early on, retinoids increase the speed of resolution of acne lesions. Retinoid monotherapy, or in combination with Benzoyl peroxide, is generally recommended as maintenance therapy. Tazarotene should be avoided in pregnancy as it is category X. Hyper- or hypopigmentation may be observed with Tretinoin. In November 2012, there were 98 claims: 46.9% for Tretinoin, 12.2% for Epiduo, 10% for Retin-A micro, and 10% for Retin-A micro pump.

Benzoyl peroxide combination products work in concert against acne vulgaris. The combination helps to minimize resistance from the use of Clindamycin alone. Benzoyl peroxide has bactericidal activity against Propionibacterium acnes in addition to a keratolytic and desquamative effect. The combination is useful in decreasing the number of lesions in mild to moderate acne. Clindamycin may enhance the neuromuscular blocking properties of other agents and should be avoided in combination with neuromuscular blockers. In November 2012, there were 54 claims: 75.9% for Clindamycin/Benzoyl Peroxide gel and 24.1% for BenzaClin.

The other category includes a variety of products including antibiotics to azalyic acid and Benzoyl Peroxide containing agents. In November 2012, there were 133 claims: 27.8% for Clindamycin solution, 19.6% for Clindamycin Phosphate medication swab, 13.5% for Clindamycin Phosphate gel, and 11.3% for Clindamycin lotion.

At the last review, an amended motion for therapeutic alternatives with at least one drug from each subclass passed unanimously.

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

Break from 9:00 a.m. to 9:18 a.m.

12. Re-Review of Immunomodulators, Atopic Dermatitis (Green Class)

Ms. Narus gave the Magellen presentation on Immunomodulators, Atopic Dermatitis. These agents bind to the FKBP-12 protein, which inhibits calcineurin, thus inhibiting T-cell activation through cytokine transcription suppression. Rare cases of malignancies have been reported with both agents. The FDA recommends short-term, intermittent use. Neither product demonstrates one clear advantage over the other. In November 2012, there were 78 claims: 57.7% for Elidel and 42.3% for Protopic. The AAD expects a guideline update for topical pharmacologic agents for use in atopic dermatitis in the spring of 2013. At the last review, a motion for therapeutic alternatives passed unanimously.

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

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

Ms. Narus gave the Magellen presentation on Androgenic Agents. Oral forms of these agents are ineffective due to first pass metabolism so injectable and transdermal formulations are an ideal delivery. All are indicated for testosterone replacement therapy in males with a deficiency or absence of endogenous testosterone. Application sites and dosing recommendations are not interchangeable. Medication guides are required for Androgel, Axiron, Testim and Fortesta. In November 2012, there were 11 claims: 90.9% for Androgel and 9.1% for Testim. At the last review, a motion for class effect passed with one abstention.

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

14. Re-Review of Hypoglycemics, Insulins (Green Class)

Ms. Narus gave the Magellen presentation on Hypoglycemics, Insulins. Exogenous insulin products supplement deficient levels of insulin when the body cannot produce enough. Per the American Association of Clinical Endocrinologists in their 2011 Diabetes Care Plan Guidelines when insulin

therapy is indicated in patients with type 2 diabetes, long-acting basal insulin should be the initial choice in most cases. Insulin analogs, glargine and detemir are preferred over NPH due to lower incidents of hypoglycemia. Rapid or short acting insulin should be considered if postprandial hyperglycemia is present. In November 2012, there were 803 claims. For the long-acting insulins: 48.7% for Lantus SoloStar pen, 43.7% for Lantus vial, 5.2% for Levemir pen, and 2.4% for Levemir vial. For the rapid-acting insulin: 34% for Novolog flex pen, 24.8% for Novolog vial, 21.1% for Humalog vial, and 17% for Humalog log pen. For the insulin mixes: 33.3% for Novolog mix 70/30 flex pen, 22% for the Novolog 75/25 flex pen, and down from there. For the insulin 70/30: 33.3% for Novolog 70/30 flex pen, 40% for the Novolog 70/30 vial, and down from there. For the insulin N group: 67.9% for the Novolog N vial, 25% for the Humulin N vial, and 7.1% for the Humulin N pen. For the insulin R: 48% for the Novolog N vial and 44% for the Humulin R vial. There were no significant changes within this group. At the last review, a motion for class effect to include at least one formulation from the long-acting, rapid-acting, insulin mix, insulin 70/30, insulin N, and insulin R subgroups, and preferentially including Lantus, passed with one opposed.

Dr. Demain said Lantus was preferred because it was the protocol for the local hospitals. Dr. Greear said Lantus was also the only true 24-hour medication. He was disappointed that the Novolog rapid-acting pens were not on the PDL, because they were easier for the patients to use. Dr. Demain said a third of the patients using rapid-acting formulations used the pens although they were not on the PDL.

DR. GREEAR MOVED A CLASS EFFECT TO INCLUDE AT LEAST ONE FORMULATION FROM THE LONG-ACTING, RAPID-ACTING, INSULIN MIX, INSULIN 70/30, INSULIN N, AND INSULIN R SUBGROUPS, AND PREFERENTIALLY INCLUDING LANTUS. SECONDED BY DR. DEMAIN. THE MOTION PASS UNANIMOUSLY.

15. Re-Review of Hypoglycemics, Meglitinides (Green Class)

Ms. Narus gave the Magellen presentation on Hypoglycemics, Meglitinides. These agents are non-sulfonylurea hypoglycemic agents and help to lower glucose levels by stimulating insulin release from the pancreas. Doses are taken 30 minutes prior to the meal. They can be taken two, three, four times a day depending on the agent. In November 2012, there were 7 claims: 85.7% for Nateglinide and 14.3% for Prandin. Significant changes include clinical trials comparing Repaglinide to sulfonylureas. The incidence of total serious cardiovascular adverse events, including ischemia, was higher for Repaglinide at 4% than for sulfonylurea drugs at 3% in one-year controlled trials. However, Repaglinide was not associated with excess mortality rates when compared to observed mortality rates with other oral anti-diabetic drugs. At the last review, a motion for class effect passed unanimously.

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

16. Re-Review of Hypoglycemics, Metformins (Green Class)

Ms. Narus gave the Magellen presentation on Hypoglycemics, Metformins. Metformins have the capability of decreasing hemoglobin A1Cs by 1.5 to 2 percent. They work to act in decreasing hepatic glucose production, decreasing intestinal glucose absorption, and increasing peripheral glucose uptake in utilization, which improves insulin sensitivity. In November 2012, there were 1,032 claims. Within

the hypoglycemic single-agent group: 81.2% for Metformin, 18.7% for Metformin extended release, and 1 claim for Riomet. For the combination products, there were 13 claims: 76.9% for Glyburide/Metformin and 23.1% for Glipizide/Metformin. At the last review, a motion for class effect passed unanimously.

Dr. Hope said reviewing the utilization was not exciting, but going through the motions on a class such as the Metformins helps to keep the utilization where it is at and preventing it from going in a different direction.

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

17. Re-Review of Hypoglycemics, Sulfonylureas (Green Class)

Ms. Narus gave the Magellen presentation on Hypoglycemics, Sulfonylureas. Sulfonylureas enhance the response to beta cells to glucose in the pancreatic islet, resulting in an increasing in the secretion of insulin. In November 2012, there were 327 claims: 30.6% for Glyburide, 28.8% for Glipizide, 21.1% for Glimepiride, 9.8% for Glipizide ER, and down from there. Significant changes include patients with known glucose 6-phosphate dehydrogenase deficiency treated with sulfonylureas had an increased risk of hemolytic anemia in post marketing studies. For this reason, a non-sulfonylurea agent should be considered when treating patients with this deficiency. At the last review, a motion for class effect passed unanimously.

In response to Dr. Brodsky, Ms. Narus said the preferred agents were not listed on the online PDL. The preferred agents last year were reviewed.

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

18. Re-Review of Hypoglycemics, Thiazolidinediones (TZDs) (Green Class)

Ms. Narus gave the Magellen presentation on Hypoglycemics, Thiazolidinediones (TZDs). Thiazolidinediones, of which Rosiglitazone and Pioglitazone are members, both come as single agents and in combination with Metformin or Glimepiride. Significant changes include in 2011 the FDA issued a safety announcement stating that Actos, for longer than one year, may be associated with an increased risk for bladder cancer. Rosiglitazone, which is brand name Avandia, base medications were withdrawn from retail pharmacies in November 2011 and are now under a restricted access program. REMS for Pioglitazone was removed in 2012. However, the medication guide was maintained as part of the product labeling. In November 2012, there were 117 claims. Within the single agents: 72.6% for Pioglitazone, 23.1% for Actos 30 and 45 milligram, and 4.3% for Actos 15 milligram. Avandia had zero utilization. For the combination products, there were 9 claims: 55.6% for Actos/Metformin and 44% for Pioglitazone/Metformin. At the last review, a motion for therapeutic alternatives, excluding Avandia, passed unanimously.

Dr. Brodsky noted that the pricing for the Actos 15, 30, and 45 milligram formulations were very different. Some states have preferentially preferred the 15-milligram formulation in the past. If a physician needed a 45-milligram dose, they used three 15-milligram tablets.

The committee discussed whether Actos should be excluded due to the risk of bladder cancer after using the drug for one year. Dr. Pappenheim felt that decision should be left to the practitioner.

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

19. Re-Review of Immunosuppressants (Green Class)

Ms. Narus gave the Magellen presentation on Immunosuppressants. Following induction therapy at the time of surgery, transplant recipients are stated on drug regimens that consist of several categories. Antiproliferative agents such as Azathioprine and Mycophenolate are used as adjunctive therapy. Sirolimus and Everolimus are proliferation inhibitors with mechanisms of action different from that of Mycophenolate. They may be used to decrease the doses of calcineurin inhibitors, such as Cyclosporine or Tacrolimus, which are typically included in the regimen but can have serious adverse events at higher therapeutic concentrations. Although Azathioprine has an indication for rheumatoid arthritis, it should be reserved for severe cases where the patient has failed NSAIDs and DMARDs. Cyclosporine has an indication for plaque psoriasis, but again should be used for severe cases where patients have failed standard therapies. Cyclosporine and Mycophenolate are available as different salts, but the products are not interchangeable. In November 2012, there were 124 claims: 24.2% for Azathioprine, 21.8% for Mycophenolate, 21.8% for Tacrolimus, 7.4% for Gengraf capsules, 6.5% for Myfortic, 4.8% for Prograf, 4% for Cyclosporine capsules, 4% for Rapamune tablets, 2.4% for CellCept suspension, and down from there. Significant changes include Zortress has been associated with angioedema, hyperlipidemia, and fluid accumulation. REMS is no longer required as of 2012. Rapamune was also released from the REMS in 2011. 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.

Dr. Demain said a significant number of these medications were used off label for things like immune mechanisms and immune reactions. When physicians are making choices, the drugs are very distinct agents, but the medically necessary clause can always be utilized.

THE MOTION PASSED UNANIMOUSLY.

20. Re-Review of Smoking Cessation Agents (Green Category)

Ms. Narus gave the Magellen presentation on Smoking Cessation Agents. There are generally two types of agents in this class: nicotine replacement products and non-nicotine replacement agents. The 2008 guidelines state that all smokers trying to quit should be offered medication, except where contraindicated. All seven approved therapies are considered first line agents. In November 2012, there

were 211 claims: 33.2% for Bupropion SR, 20.9% for Chantix tablets, 19.4% for Chantix dose pack, 11.8% for Nicotine patch, and down from there. Within this class, the Bupropion SR 150 milligram is capturing all claims for that product regardless of indication.

Dr. Hope said there were two separate categories for Bupropion: Zyban and Wellbutrin. The products are the same, but have different codes, so sometimes the pharmacist grabs the "wrong" bottle from the shelf. He did not believe that most of the claims were actually for smoking cessation.

Ms. Narus resumed. Significant updates include the manufacturer of Chantix is currently conducting a large safety clinical trial to assess neuropsychiatric adverse events as outcomes. The results from this trial are expected in 2017. The Veterans Administration had also done a review of this class as well. At the last review, a motion for therapeutic alternatives passed unanimously.

In response to Dr. Demain, Dr. Hope said there was no prior authorization requirement or step edit for this class. There are quantity limits on Chantix and nicotine replacement therapies, but there is no requirement to use a nicotine replacement product before transitioning to Chantix. There used to be a step edit, but it ended in 2010. There is no quantity limit on Bupropion. The committee discussed whether Chantix had ever been on the PDL and what information patients received when they were prescribed Chantix.

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

In response to Dr. Riley, Dr. Hope said Chantix would either make it onto the PDL or would be available utilizing the medically necessary clause. Some nicotine gums were covered on the PDL while some generics are not, which was based on price. The committee discussed how the electronic cigarettes, which are not FDA regulated, and nicotine inhalers worked.

THE MOTION PASSED UNANIMOUSLY.

21. Review of November 16, 2012, Meeting Minutes.

This item was postponed to the next meeting, as the meeting minutes had not been distributed to the committee.

22. Comments from Committee Members or Chair

Dr. Hope said Dr. Brodsky will be retiring and a new chairperson will need to be appointed at the April meeting, which will be April 19, 2013.

23. Adjourn

Without objection, the meeting adjourned at 9:56 a.m.