ALASKA MEDICAID
PHARMACY AND THERAPEUTICS COMMITTEE

Location of Meeting
Frontier Building, 3601 C Street, Room 880-890

MINUTES OF
March 19, 2004
8:00 a.m.
as approved on October 29, 2004

Committee Members Present:
Terry K. Babb
Michael Boothe (late arrival)
Heidi Brainerd
Richard E. Brodsky
Kelly C. Conright
Traci Gale (telephonic)
Arthur S. Hansen
R. Duane Hopson
Thomas C. Hunt (late arrival)
Diane Liljegren (telephonic)
Ronald J. Miller
Gregory R. Polston
Richard C. Reem
Janice L. Stables
Alexander H. vonHafften
Trish D. White (telephonic)

Committee Members Absent:
Robert H. Carlson
Nathaniel Haddock
Charlene M. Hampton
Michael C. Norman
Sherrie D. Richey
George Stransky

Others Present
Dave Campana
Sandy Kapur
Dr. Jeffrey Demain

I. CALL TO ORDER:

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

II. INTRODUCE NEW MEMBERS:

This item not addressed.

III. ROLL CALL:

The roll call was taken and a quorum was present.

Terry Babb said he would be resigning his position on the Pharmacy and Therapeutics Committee, because he recently accepted a position with First Health and wanted to avoid any conflicts of interest.

Chairman Brodsky thanked Terry Babb for his participation on the committee and wished him good luck in his new position.

IV. PUBLIC COMMENTS:

Roy Palmer, Pfizer Pharmaceuticals, a Ph.D. holder in cardiovascular physiology who worked on cardiovascular products for Pfizer Pharmaceuticals, discussed Lipitor. When choosing a statin agent, one must consider the most effective at lowering LDL. The data indicates there is a linear relationship between LDL reduction and risk reduction. The latest trials indicate that lowering LDL reduces strokes, heart attacks and other cardiovascular events. Epidemiological data indicates that increasing LDLs is a good thing, but the majority of the data shows LDL reduction leads to risk reduction. The PROVE IT trial on ACS patients by Bristol Myers compared an aggressive regimen of 80 milligrams of Lipitor and a moderate regimen of 40 milligrams of Pravachol. It found there was a 16% decrease in the primary end point, which included all-cause mortality or major CV events, in Lipitor as compared to Pravachol. Even though the patients in the Pravachol arm actually reached their insert guidelines, more aggressive treatment with a high dose of Lipitor reduced events by 16% within the first 30 days. The REVERSAL trial measured the plaque burden within an artery and showed that aggressive treatment with 80 milligrams of Lipitor actually stopped the progression of atherosclerosis, which none of the other drugs in this classification demonstrated. The ASCOT trial was a primary prevention trial with an average of 3.3 years of treatment on 10 milligrams of atorvastatin and showed a 36% reduction in non-fatal MI and fatal CHD. The trials have proven Lipitor to be superior. Lipitor has a flexible starting dose of 10, 20 or 40 milligrams, which helps quickly get the LDLs down. The results of the PROVE IT trial indicates it is vital to quickly get below the goal. Nationally, 50% of Medicaid patients taking a statin are taking Lipitor. Changing that medication would take a great deal of effort and a liver test would have to be done before and after changing the medication.

Mike Bennett, regional account manager for Aventis Pharmaceuticals, said he covered the managed care plans in Washington, Alaska and Montana as well as Medicaid. He discussed Nasacort AQ, Aventis' inhaled nasal corticosteroid. The health plans he works with usually covers anywhere from three to five of the advanced generation inhaled nasal steroids. All these drugs, when dosed appropriately, are effective and relatively safe. However, their individual characteristics make them different and cause unique patient reactions. Patient preference is important in this classification, which suffers from poor patient compliance. Nasacort AQ has demonstrated long-term efficacy and improvement in symptoms maintained throughout one year of continuous use at the starting dose and then at the maintenance dose. Nasacort AQ was compared head-to-head with Flonase, the current market leader, for relief of symptoms, safety, sensory attributes and quality of life. The overall findings were both Nasacort AQ and Flonase were equal in efficacy, which supports findings from other studies indicating that higher molecular potency does not translate into superior clinical efficacy. Both Nasacort AQ and Flonase significantly and equally improved individual and overall quality of life scores after three weeks of treatment. The sensory attribute results, while statistically similar, showed that patients reported significantly higher odor scores for Flonase than Nasacort AQ. Both products were safe and well tolerated and should be on the preferred drug list. The significantly higher odor scores for Flonase might cause some patients to stop taking the drug. In fact, the author of the trial suggested that with similarities in safety and efficacy, physicians might need to choose an inhaled nasal steroid based on

patient preference. In a double blind clinical study, Nasacort AQ was preferred two to one over Flonase and Nasonex based on sensory perceptions, including amount of irritation, strength of taste and odor strength. The trial found 54.7% of the patients preferred Nasacort AQ over Flonase at 21.2% or Nasonex at 24.2%. Intranasal corticosteroid agents are important, because they treat the underlying inflammation causing most of the allergic symptoms and the relative costs of other treatments. The least effective drug is that which is not taken. To give Medicaid patients the best chance to comply with their nasal steroid therapy, he urged the committee to give strong consideration to including Nasacort AQ to the preferred drug list.

Thad Woodard, a private pediatrician caring for asthma patients for over 20 years, discussed Advair. Asthma is one of the most common and costly illnesses treated in Alaska. To judge the effectiveness of an outcome, we need compliance from both the patients and the providers. A patient needs something that is quick, easy and demonstrates benefits quickly. The physician needs something that can be demonstrated easily and effectively and demonstrates good feedback very quickly. Advair combines the best medication available, an inhaled corticosteroid with an effective and long acting symptom reliever, for bronchial constriction. Advair is extremely beneficial for all outcomes. Even though Advair is not cheap, it is cost effective for patients with asthma over four years of age. He stressed the importance of compliance. In order to save money or have positive outcomes, the patient and the physician have to use the products.

Chipp Leibach, a Glaxo Smith Kline representative responsible for promoting respiratory products in Alaska, discussed Flonase and Advair. Flonase is the only nasal steroid that has a FDA approved non-allergic rhinitis indication and has been approved to be effective when used on an as needed basis and gives the providers more flexibility. For the past three years, one out of every two prescriptions written for a nasal steroid in Alaska has been Flonase. The Flonase patent expires in May of 2004 and there has been three amended new drug applications filed with the FDA. It is unknown when a generic will be available, but it seems likely to be in the near future. The unique indications of Flonase, combined with its current level of use and the impending generic status, supports inclusion of Flonase on the preferred drug list. He referenced a number of letters written by Alaskan providers, including four of the six pulmonologists, supporting Advair and Flonase.

Andrew Pulliam (telephonic), a physician who has practiced for 20 years in and out of Alaska, discussed three products that have been helpful in his clinical usage. Floxin or Ofloxacin, an ear drop, is non-odor toxic and treats pseudomonas. He encouraged the inclusion of Floxin or Ofloxacin on the preferred drug list. He felt they would be severely handicapped if they did not have Augmentin for treatment of ear infections, sinusitis, soar throats and tonsillitis, because not all of the infections would respond to straight Amoxicillin. The odor difference between Nasonex and Flonase had already been discussed. He had very few patients that complained about the odor, but they did not want to use anything intranasal and had to be coaxed through that. Mometasone and Flonase were slightly more potent, tends to be absorbed less into the bloodstream and immediately eliminated from any gastric absorption by passing through the liver. Both are approved for children.

Dr. Jeremy Gitomer, a private practice pediatric and adult nephralogist, said he took care of most of the pediatric hypertension cases in the state, many of which were children and Medicaid patients. Seventy percent of his patients are on Norvasc. Norvasc has a 54-hour half-life, which means a juvenile delinquent 13-year-old patient can miss two doses without ending up in the emergency room with a blood pressure of 190. Norvasc has been studied in children and used in infants. Norvasc is crushable, which is very important not only for pediatrics, but adult patients as well. Most of his patients were on

multiple antihypertensives. Norvasc is not the first line medication, but is often a second or third line agent for its effectiveness in dropping the blood pressure by 15 points. The other medications have to be given twice a day and would decrease compliance for severely hypertensive patients from 80% down to 50%. HMG-COA reductase inhibitors should include Zocor and Lipitor. Zocor has the primary prevention data that the other drugs do not. Lipitor reduces proteinuria, which is the single best predictor of coronary events. There is also evidence with Lipitor, beyond the other drugs, showing a reduction in regression of cholesterol via ultrasound in coronary arteries. This is very important for his patients that have established disease, because any drug that can regress a disease is great. We really have to be careful when we are prescribing HMB-COA reductase inhibitors to patients with known coronary disease and give them drugs that are proven to be beneficial.

Roger Westensee, Bristol-Myers Squibb district business manager for the northwest, discussed Tequin. Tequin is available on many hospital formularies including Providence Anchorage, the Providence Alaska System, Fairbanks Memorial, Chief Andrew Isaac's and the Department of Defense. Tequin is one of two of the fluoroquinolones that is unique. It appears to contribute to enhanced in vitro activity and lower selection of resistance of gram-positive bacteria. When it comes to the different indications, Tequin can make things simpler for your patient populations because of its indications for both RTI and UTI. Tequin has indications for acute sinusitis, bronchitis, community acquired pneumonia, uncomplicated skin infections, complicated and uncomplicated UTI. Of the statins, Bristol-Myers Squibb makes Pravachol and has conducted the majority of the studies in this classification. Pravachol provides proven safety for patients, which is unique in this classification. Pravachol should be available for patients that have drug interaction issues such as transplant patients, AIDS patients or patients on multiple drugs that may have interactions. He asked the committee to consider the cost and implications of LFT testing. Pravachol is unique in its labeling in that is has LFT testing only at the baseline and when there is a dosage change. Every other statin on the market requires LFT testing at the baseline, 6-12 weeks after the baseline and periodically thereafter for the remainder of the patient's therapy.

David Beeman, a medical information scientist for Astra Zeneca, discussed four products. Pulmicort Turbuhaler has the longest term studies in the inhaled corticosteroid classification that shows no long-term effects in children. There is no difference in their predicted and actual adult achievements. Pulmicort Respules is the only nebulized inhaled corticosteroid on the market and the only inhaled corticosteroid approved in patients down to 12 months old. Rhinocort AQ is the only inhaled nasal corticosteroid dosed once daily. It has no alcohol or fragrance and has a very high patient compliance rate. The same size distributed is a 30-day supply and the prescription is a 60-day supply. Crestor (Rouvastatin) is one of the newest statins on the market. The FDA approved it in August of 2003. The surveillance included 12,500 patients in the pre-approval clinic process, which is three times as many as any other statins' pre-approval process. We have continued to expand the clinical experience to more than 40,000 patients in the current clinical trial. We have proven the safety and efficacy of Crestor. We came to the market with head-to-head trials with Pravastatin, Simvastatin and Atorvastatin. We currently have more than 2,000,000 prescriptions filled for Rouvastatin in 51 countries. We have proven our increased ability to lower LDL relative to the other statins. We have also proven that we increase HDL consistently and to a greater extent than the other statins on the market. We wanted to look at getting patients to goal, especially with ATP-3 guidelines now showing that more than 50% of the patients that require therapy are in the high risk category and need to have their LDLs lowered below 100. Compared to the other products, we are looking at a 10 milligram starting dose and how well we can get patients to goal without titration. At the starting dose of 10 milligrams, we are getting patients to goal 85% of the time according to the STELLER trial. Even in high risk patients, three times as many patients reach their goal with Rouvastatin compared to Atorvastatin and Simvastatin, and twelve times

that of Pravastatin. Rouvastatin has no issues that cause us alarm or would cause the FDA to change the package inserts.

David Henry, a practicing allergist in Anchorage since 1974, discussed nasal steroids. He knew the committee was governed primarily by cost considerations, but as a practitioner he was compelled by pharmacological and practical considerations. If you look at the pharmacology of the drugs, you can derive a therapeutic index by comparing a variety of their characteristics including availability, half-life, potency and other issues. When you do this, you end up with three tiers of drugs. The top three are Fluticasone, Budesonide and Mometasone. Triamcinolone would follow slightly below that. The dinosaur of the group would be Beclomethasone. They all work to a comparable degree. The practical considerations include side effects, comfort issues and the smell issue. All the drugs have comparable side effects. Comfort issues include stinging and burning caused in some patients. Some patients were concerned with the smell of the product. Fluticasone and Mometasone products are in an alcohol solvent that has a very strong floral smell. Some patients appreciate the smell as it insures that they are getting their dosage, whereas other patients are nauseated by the smell. He preferred a choice of an odorless and an aromatic drug on the preferred drug list. If he had to select a single drug, he would choose Budesonide (Rhinocort AQ).

Chairman Brodsky noted that the committee was not driven by financial considerations. They were looking for drugs that worked and they wanted to insure that there were drugs available that met the needs of the patients.

Jim Hoover, regional manager for state government affairs for the Bayer Corporation for the five northwest states, discussed second and third generation quinolones. Bayer makes Ciprofloxacin, which has multiple generic equivalents coming out in June that will have very attractive prices. Normally the quinolone class of drugs is used in patients who have failed at least one prior therapy. The patients tend to be fairly ill and require relatively acute care that often may be the last step before they are admitted into the hospital. In the five northwest states he covers in the Medicaid arena, four of them have chosen not to limit these drugs, because they are acute care medications. By the time the physicians get to this classification, they tend to have a good idea of what bacteria is involved, what antibiotic is the most potent for the bacteria and which penetrates that particular body side the best. The relatively minor cost saving that may be achieved by going from one brand to another can be offset by the time the patient has to spend at the pharmacy waiting for the physician to either approve or override the preferred drug prescribed. These drugs are often the last step before admission into the hospital and the patient may end up in the emergency room if they have to wait for their medication. That would only have to happen a couple of times a semester to significantly offset any potential cost savings gained from going from one brand to another. He encouraged the committee to carefully consider the real benefits to limiting the quinolone classification verses the downsides to having the patient wind up in the hospital. Moxifloxacin (Avelox) is only indicated for respiratory tract infections and skin and skin structure. For the most part it is used in sinusitis infections, pneumonia and bronchitis. Bayer believes that appropriate promotion of these drugs, both for potential development of resistance and appropriate use guidelines, is very important. Bayer follows the Infectious Disease Society of America guidelines for community acquired pneumonia and promotes within the Otonlaragology Acute Sinusitis guidelines. Bayer recognizes appropriate step care therapy and promotes it products accordingly.

Heather Giese, Glaxo Smith Kline, said physicians around the state had asked when the committee was going to discuss Augmentin XR and Augmentin ES 600. She quoted a portion of a letter submitted by Dr. William Feld. “Chronic sinusitis in adult and children is a very difficult problem to resolve. I find

many of my patients do not improve unless Augmentin XR or ES are utilized. This is also true for those cases of pediatric otitis media that do not resolve with alternative antibiotics and thus having the option to use Augmentin XR or ES for my Medicaid patients." She quoted a portion of a letter from Dr. Thad Woodard. "I'm writing to request the inclusion of Augmentin ES600 on the Medicaid preferred drug list. This medication is a preferred second line antibiotic on virtually all national guidelines for the treatment of acute chronic otitis media and sinusitis. It is available in a convenient twice daily suspension for children and not associated with significant side effects when used appropriately. Without this option, the treatment of children needing outpatient treatment for otitis and sinusitis would be significantly compromised." She noted that the 2003 Stanford Guide recommended Augmentin ES600 first line after Amoxicillin.

Heidi Swartz, a regional medical scientist for Glaxo Smith Kline, said her background was physiologist and a doctor of pharmacy. She worked in the respiratory product division for Glaxo Smith Kline and in disease state awareness. From an INS standpoint, Fluticasone, Mometasone and Budesonide are not created equally. From a systemic bioavailability standpoint, Mometasone and Fluticasone are very low at 1%-2% and thereby would reduce any potential systemic adverse events that might be associated with a corticosteroid. Budesonide is in the range of 30-40%, so from a systemic bioavailability there is a clear dichotomy between these medications. From a safety perspective, Fluticasone has been evaluated in a long-term growth study in pediatric patients and has been found not to impact growth and height velocity. The floral scent associated with Fluticasone can be handled by appropriate counseling of the patients to spray the drug to the side to reduce the potential smell. Advair is supported in the asthma arena by the NIH guidelines that were updated in 2002. Combination therapy, a long-acting beta agonist plus an inhaled corticosteroid, are the preferred treatment recommendations for asthma in all ages. We have data that demonstrates that when given in combination, there is greater refill persistence across the board. Advair has greater refill persistence statistically significantly greater than Fluticasone (indiscernible) on two separate inhalers as well as inhaled corticosteroids alone. Advair also has the same refill rate compared to Singular. Advair is also supported by the Global Chronic Obstructive Lung Disease Committee guidelines of what to recommend for preferred treatment in COPD. The use of an inhaled corticosteroid, a long acting broncho dilator, is highly recommended for the severe and very severe COPD patients.

Kyle Kilchrist, Schering Pharmaceuticals, presented information on Nasonex. The prevalence of asthma and allergic rhinitis continues to be on an increase, specifically with children and adolescents. The prevalence rate in Alaska is twice that of the national average for allergic rhinitis within children. Nasonex has an indication down to the age of two. Clinicians are obligated to treat patients with medications that work safely, although convenience plays a part in the clinical aspects of patient treatment. Nasonex is indicated for the treatment of nasal symptoms related to seasonal and perennial allergic rhinitis in adults and children over two years of age. It is the only agent that has a prophylaxis indication down to 12 years of age, specifically when it applies to patients that suffer from seasonal allergic rhinitis. A study examined 46 patients in 12 months of treatment for allergic rhinitis and found no evidence of atrophy and a marked reduction in intra epithelia eosinophilia as well as inflammation and cell infiltration. There was no HPA axis suppression in allergic rhinitis patients down to the age of two. The dose was increased to 40 times the dose limit for adults and they found no HPA axis suppression in that patient population. The study provides safety reassurance for the Medicaid population including children, women and adults. In clinical trials most of the commonly adverse events were benign in relation to placebo.

Barry Benson, the national account executive for Merck, provided information on Zocor. Zocor is a high efficacy statin with an excellent history of evidence based outcome studies as demonstrated in the 4-S study and the recently published Heart Protection Study with Zocor at 40 milligrams. Zocor is the only statin with significant proven risk reductions in major coronary and vascular events in CHD in diabetic patients regardless of baseline, LDLC, CHD status, gender and age. It is the only statin currently indicated for diabetes patients. He discussed continuity in care in Alaska, specifically the cross over in Medicaid patients. Zocor is available at the VA, military and Alaska Native medical centers. It is available statewide at the Native Health and Anchorage Neighborhood Health Indigent facilities. It is available through Aetna, Premiere and all the hospital formularies in the state.

Elana Jandourick, an infectious disease physician for Ortho McNeil Pharmaceuticals, discussed Levofloxacin. When comparing compounds in a class, the following should be considered: efficacy, safety, clinical experience, in vitro data and the roles those play in the formulary. There is a lot of talk from the CDC, the World Health Organization and local public health departments about resistance. In Alaska and nationwide, pneumococcal resistance is less than 1% to the quinolones, 26% to penicillin and 26% to macrolides. In terms of focusing on appropriate use, Ortho McNeil believes in appropriate use of their products. For respiratory indications, Levofloxacin should be placed where the (indiscernible) guidelines for the community acquired pneumonia places it. Levofloxacin has wide clinical experience. It has indications for community acquired pneumonia, serious pneumonia, skin and soft tissue infections, complicated and uncomplicated urinary infections and peritonitis. Levofloxacin has had over 300,000,000 prescriptions worldwide. There have been no new safety concerns since the initial package labeling in 1997. In terms of other safety issues in the quinolones classification, the issue of QT prolongation is a concern throughout the class. If you look at the different drugs, there are drugs that have fewer incidents to QT prolongation, such as Levofloxacin and Ciprofloxacin. Gatifloxacin and Moxifloxacin have been shown to prolong QT a little bit more, but not necessarily to levels that may be clinically significant. All the quinolones have had reports of hyper and hypoglycemia. There has been a labeling change with Gatifloxacin regarding hyperglycemia non-ketotic coma. Moxifloxacin and Levofloxacin have not had any labeling changes. People are comfortable with our product. Providence Alaska has recently put Levofloxacin on their formulary and they feel very comfortable with the product. Levofloxacin is on many formularies in other states. Levofloxacin has unmatched clinical efficacy and has a solid safety record. Levofloxacin offers a five-day course for community acquired pneumonia, which provides better patient compliance with fewer pills to take, economic benefits with shorter treatment courses and fewer days of hospital stays due to the shorter length of the treatment.

Chairman Brodsky noted that the rules for the public comment section stated that manufacturers or interest groups would only have one speaker per meeting, which would be adhered to at future meetings.

V. P&T QUESTIONS AND COMMENTS FOR PUBLIC:

There were no questions from the Pharmacy and Therapeutics Committee for any of the public speakers.

VI. PRESIDENT OF ALASKA STATE MEDICAL ASSOCIATION:

Chairman Brodsky introduced Alex Malter, President of the Alaska State Medical Association.

Alex Malter said the Alaska State Medical Association represented physicians statewide and their primary interest was insuring that patients had access to good care. At the request of Mr. Peoples, Dr. Malter expressed concern on behalf of the Alaska State Medical Association with the way the Preferred

Drug Program had been implemented. A legislative forum had been called to discuss this and they raised concerns not only about the way the program had been implemented, but also about some of the medical necessity override issues. The Alaska State Medical Association has not taken a formal position on whether they supported the concept of a preferred drug list, but many of the members were supportive due to the fact that the committee was working together to help the patients in Alaska. In a legislative meeting, the pharmaceutical industry and the doctors were concerned that the program was put together in a rush and was inconsistent with the due process rules of the state. The due process regulations exist to insure a public comment period before the state makes any big decisions, but this process was bypassed in the implementation of the preferred drug list. Some physicians were concerned that the state was trying to strong-arm the way the committee thought about medical necessity issues. They were also concerned with liability issues. The doctors felt that if the state was going to dictate which drugs were prescribed, then they should accept liability for any adverse patient outcomes. The packet contains a draft letter that includes four options for overriding the preferred drug list: allergies, contraindications, multiple indications and an ineffective treatment clause. The Medical Association would prefer something like "ineffective treatment" or "medical necessity". The prescriber should make the final decision on what medications are necessary for their patients. Commissioner Gilbertson indicated that the primary reason for developing the preferred drug list was encourage the physicians to consider cost-effective issues when prescribing. We feel the program will be just as effective without a strict override process. Physicians are trainable and will gradually prescribe the preferred medications when appropriate. Several years ago, Medicaid put through some onerous rules on audits and many physicians dropped out of the Medicaid Program. If physicians stopped seeing Medicaid patient, it would be a bigger disaster than the state not realizing its 10% cost improvement goal in the first two years. Many physicians in Anchorage were unwilling to see Medicare patients due to the reimbursement rates. There is a shortage of physicians and they can afford to be picky about who they see. Some physicians might pull out of the program if it is too difficult to override the preferred drug list.

Gregory Polston asked if the Alaska State Medical Association had been polled to see what the physicians thought about the preferred drug list.

Alex Malter said there were no current plans to poll the physicians, but he would consider it. The congressional delegation received numerous phone calls about the Medicaid issue a year and a half ago, which is why they increased the rates for Alaskan physicians. Senator Stevens and Murkowski's office received so many complaints that it was immaterial how many doctors were not accepting Medicare patients. Most of the Alaska State Medical Association was generally supportive of the preferred drug list, but he encouraged the committee to be sensitive to the fact that some physicians might be unwilling to see Medicaid patients if the process was too difficult.

Chairman Brodsky pointed out that Medicare had been a reimbursement issue and Medicaid rates in Alaska had an excellent rate of reimbursement. He doubted physicians would refuse to see Medicaid patients just because of the preferred drug list.

Alex Malter noted that some physicians refused to see Medicare patients over the audit issue, because they were primarily upset about the way the state did the audits.

Janice Stables reminded the Alaska State Medical Association that there were other groups of providers who could take care of the Medicaid patients regardless of the reimbursement issues.

Thomas Hunt said physicians might refuse to see Medicaid patients over reimbursement rates, but not over a medical override on a prescription. If Medicaid did not save some money then all clinicians would be reimbursed at a lower rate.

Chairman Brodsky pointed out that this was not a formulary, but a preferred drug list. All drugs are available and a physician can override the preferred drug list if he feels his patient needs a non-preferred drug. The committee wanted to work with the providers prescribing drugs for Medicaid patients in a partnership to insure they get the best care in the most economical way so we can deliver the most care to the people who need it.

Alexander vonHafften said the Psychiatric Association was also concerned about the development and implementation of the preferred drug list, cost of care and access to care. Even under the best circumstances, the implementation of the plan can be problematic. The psychiatrists in the state are concerned about how this is going to effect their ability to evaluate and treat patients in the community.

Alex Malter felt most of the doctors in the state would be comfortable with the preferred drug list as long as they have the ability to override it when they felt it was medically necessary.

Chairman Brodsky noted that the override process would be discussed later in the meeting and they would be sensitive to the issues discussed. When a physician feels a patient needs a certain drug, they can give the patient the opportunity to purchase that drug regardless of the position of the insurance company.

Alex Malter said he understood that governments had certain protections from liability. However, recently HMOs have been found to legally be responsible for the administrative decisions they make that influence patient care. Private practice physicians are very concerned with liability issues and this is the type of things that makes some of our members very nervous.

Chairman Brodsky noted that HMOs were different in that it was a contract between two people.

Alex Malter said people had recently started suing Divisions of Health Care Services, because of the decisions they were making. He was not indicating that this would become an issue, but it was a concern of the membership.

Thomas Hunt questioned if it was appropriate for the Pharmacy and Therapeutics Committee to seek legal advice on liability issues in the future.

Chairman Brodsky said the Commissioner's office would handle the legal issues. The committee's job was to develop the preferred drug list.

Alexander vonHafften said part of their professional commitment was to do no harm, which they needed to remember when developing and implementing the preferred drug list.

VII. REVIEW OF LETTERS REGARDING OVERRIDE CRITERIA:

David Campana reviewed the draft letters regarding the wording of overriding the preferred drug list.

Chairman Brodsky discussed the original criteria: allergy to the drug, side effect or interaction with the drug, special indications of the drug, or the preferred drug was ineffective. He overviewed some of the other proposals and called for a discussion of the process by the committee. The criteria could be changed in the future as necessary. The easier we make it on the physicians, the more likely we are to be successful.

David Campana said this issue needed to be resolved today. The letter would be mailed out by April 19, the soft edits would begin on May 19, 2004 and the providers needed a 30-day notice. The criteria developed would be effective until the first meeting next fall. Changes could be made at that time, but it would be difficult to make changes once they were in place.

Sandy Kapur explained the difference between soft and hard edits. Soft edits are messages that come back to the pharmacist at the point of sale that alerts them that it is a non-preferred drug and can be overridden if the prescriptions states it is medically necessary. During the soft edit phase, the claims will still be paid. It is an educational component to encourage people to comply with the preferred drug list. During the hard edit phase, the claims will be denied at point of sale without an override. There are provisions for emergency overrides in special cases.

In response to Janice Stables, David Campana said the criteria might be audited on a retrospective basis. The easiest thing for the pharmacists would be for the physician to note on the prescription that the non-preferred drug was medically necessary. Currently there is no way to capture the data as to why the non-preferred drug was medically necessary, but that should be in the patient's chart.

Janice Stables did not feel it was necessary for the physicians to write four or five possibilities if the data was only going to be collected in one way.

Heidi Brainerd felt this was an opportunity that they were choosing to miss in favor of simplicity. We have an opportunity to improve clinical communication between the prescribers and pharmacy, which directly impacts patient care. If the physician would take 30 seconds to write on the prescription what the drug was with the allergy and what happened with the interaction that could be coded into the pharmacy database and may save a potential drug interaction that would be missed later. It takes a little more work, but it is important that the right and left hand both know what is happening. Dispensing pharmacists are also at a shortage in the state and they are being placed in the unenviable position of being police for the preferred drug list. If there is no intent of the State Medical Association to adhere to the preferred drug list then that needs to be discussed, because you are going to be getting a lot of calls from people who are trying to manage a very stressed system of delivery.

Janice Stables felt they would have a reason for asking the providers to write additional information on the prescriptions if they were monitoring the criteria and using the data. She questioned how important that process was and how it would effect the cost of the medications.

David Campana agreed with Heidi Brainerd that it was a good idea to have the patient's allergy information in the pharmacy software to prevent future events, assist in the patient's overall care and further communication.

In response to Thomas Hunt, David Campana said the information gathered from #8 would let the Medicaid Program know that it was medically necessary to override the edit and supply the non-preferred drug. When the pharmacy sends that with a claim, Medicaid will know that the doctor had

noted on the prescription that the non-preferred drug was medically necessary and then the pharmacy would be given the authority to override the preferred drug list and dispense the medication.

Chairman Brodsky said there would be profiling of physicians to see who was following the preferred drug list, as well as educational efforts directed at those who were not.

David Campana said starting May 1, 2004, a letter would be sent out to any physicians who had at least five patients taking non-preferred drugs. The physician should make a notation in the patient's chart to change the medication or note the medical necessity of the non-preferred drug on future prescriptions. We will retrospectively look at the pharmacies noting the #8 on the prescriptions during the soft edit phase. Once the hard edits are implemented, a prescription for a non-preferred drug will be denied at the pharmacy level. Once the pharmacist receives a new prescription or the doctor's statement of medical necessity, the prescription can be filled.

Chairman Brodsky said there would probably be more phone calls during the hard edit phase, because filled prescriptions without an override would not be reimbursed.

David Campana said they were developing a fax form that pharmacists could use to obtain more information from the physicians without having to make a phone call. The form would be distributed with the letter.

In response to Heidi Brainerd, David Campana said physician assistants did not have a Medicaid prescriber ID and the letter would go to the collaborating physician who writes the actual prescription.

In response to Kelly Conright, David Campana said it would probably happen that a pharmacist would tell a patient that the prescribed medication was not on the preferred drug list and he needed to go back and talk to his doctor. He asked the pharmacists for their support at the Pharmacy Convention, but they are busy and may just tell the patient that they cannot fill the prescription.

Kelly Conright said nursing home patients were supposed to be exempt, but one of their contracted pharmacies was telling the patients that their medications were not authorized. She questioned the possible ramifications from the Medicaid population if they were told they had to go back to their doctor before a prescription could be filled.

David Campana said they were trying to educate the pharmacists to assist them with the program, which was the best way the had for cost containment.

David Campana agreed with Kelly Conright's idea of producing a patient preferred drug list booklet. He was working on a consumer friendly list so the patients knew what individual drugs were for.

Janice Stables suggested running articles in the newspapers telling Medicaid patients that the pharmacy should contact their doctor if there is a problem with their prescriptions.

Heidi Brainerd said the pharmacist did not want to be put in the position of having a compromised relationship with the patient or the prescriber. The patient should have a clear understanding of what to do if there is a problem at the pharmacy.

Janice Stables said the pharmacy fax forms would be one option to resolve the problem.

Chairman Brodsky said the preferred drug lists would be provided to the prescribers and the pharmacists. The pharmacists are being educated about the program through letters.

Alexander vonHafften said they wanted to have this system within the patient care stream without the physicians having to call a 1-800 number, but they had to decided how the system would work for everyone.

Arthur Hansen felt they should just have the physicians note "medical necessity" on the prescriptions. Since they were not actually collecting the data on the reasons for the medical necessity, no other information needed to be supplied.

Diane Liljegren felt the allergy information was necessary for the pharmacist to provide good patient care.

Chairman Brodsky said the allergy information should be in the pharmacy database so the information would be available if the patient saw another prescriber or went to a different pharmacy.

RONALD HUNT MOVED THAT THE TERMINOLOGY BE MADE SIMPLE. THE LANGUAGE SHOULD READ: THE PRESCRIBER WHO DESIRES A DEVIATION FROM THE PREFERRED DRUG LIST SHOULD STATE MEDICALLY NECESSARY OR AN ALLERGY TO THE MEDICATION. SECONDED BY ARTHUR HANSEN.

David Campana said the pharmacists and physicians would ask if there were any criteria that defined medical necessity.

Chairman Brodsky said the phrase "medically necessary, failed preferred drug" would satisfy that language.

Arthur Hansen felt that there was no reason to have that since they were not collecting the data.

Richard Reem suggested the following language: option 1 "allergy", option 2 "everything else."

Janice Stables suggested sending the providers examples of medical necessity in the educational letters that would be sent out.

David Campana said the criteria included patient allergy, contraindication, FDA approved and ineffective treatment.

Gregory Polston said they should encourage the physicians to provide as much information as possible.

Alexander vonHafften asked about situations where there were multiple preferred medications on the preferred drug list, but the physician still prescribe a non-preferred medication.

Chairman Brodsky pointed out that there were several preferred drugs in most of the classifications. They wanted to simplify the override process for the physicians. The first thing we need to do is put the system into place and try to get the physicians to use the preferred drug list. Afterwards, we can evaluate the performance and decide whether or not it is successful. If there is little success and

everyone writes "medically necessity" for everything, then we need to review the system to find another way to achieve our goals.

Arthur Hansen was concerned about Medicaid going back and doing audits of records to see if further notations of the medical necessity were in the patient's chart. He would like the system to be as simple as possible for the prescriber. The prescriber has a reason for prescribing non-preferred drugs. He did not feel it was up to the pharmacy to keep records on the patient's allergies. The past Medicaid audits had negative effects and there are very few dentists who now accept Medicaid.

Thomas Hunt pointed out that no one had talked about chart reviews.

David Campana said it was not their function to do chart reviews, but there might be some reviews of prescriptions.

Gregory Polston said it was the physician's responsibility to document why he prescribed a patient a certain medication.

Chairman Brodsky said the physician documented why he prescribed a patient a certain medication in the charts, but he would not justify why he varied from the Medicaid preferred drug list in the chart.

Sandy Kapur said she was unfamiliar with what happened in the past with the Medicaid audits, but there was nothing in this program that would hinder or prevent payment to the physicians. They were only asking the physician to note "medical necessity" when prescribing non-preferred drugs. There would be a collection of data of high percentage physicians who did not prescribe to the preferred drug list. Any "auditing" that would be done would be more along the lines of someone speaking to the physician to find out why he was not following the preferred drug list. The physicians who are not adhering to the preferred drug list may have valid reasons that the committee needs to review.

Arthur Hansen said the past problem with the Medicaid audits was still a concern. He did not want this program to be involved in something like that, so he would prefer to keep it simple and have the physicians simply note "medically necessary." If they needed to add more information later to satisfy the pharmacies or help with statistic gathering then that could be discussed at a later date.

Heidi Brainerd said the pharmacists only wanted to call the physicians if there were clinical concerns or if they had information that would affect clinical care. The pharmacists do not want to call the physicians for record keeping items or things that could be dealt with at a different level. The pharmacists are in this position because they are at the point of dispensing the medications and not because they have a desire to harass the physicians about which drug they have prescribed.

Diane Liljegren said there was some miscommunication and misunderstandings between physicians and pharmacists and she felt it was very important to clarify that.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED WITH TWO OPPOSING.

David Campana said the new criteria would be added to the preferred drug list provider letters that would be mailed out on May 12, 2004. The prescriber would also be sent a list of the preferred

medications. The pharmacists would receive the fax form and the current preferred drug list. Comments on the letters could be sent to David Campana via e-mail.

VIII. REVIEW/APPROVE MINUTES FROM EARLIER MEETINGS

Chairman Brodsky said the meeting minutes of January 16, 2004 and February 13, 2004 needed to be reviewed and approved.

David Campana had a correction to the February 13, 2004 meeting minutes. Dr. Woodard's and Dr. Roberts' specialties on page 9 needed to be correct. Dr. Roberts is a pediatric pulmonologist and Dr. Woodard is a pediatrician.

Alexander vonHafften referenced the February 13, 2004 meeting minutes, page 5, last paragraph, which read: "Mr. vonHafften felt that would be saying that the P&T Committee failed in their duty to provide equivalent drugs." That was actually a direct quote from the October 10, 2003 minutes and not his personal beliefs. Arthur Hansen felt "Mr. vonHafften" should be changed to "Dr. vonHafften."

Alexander vonHafften noted that a motion in the February 13, 2004 meeting minutes had failed, but the record did not indicate who had voted for or against the motion. He felt it would be helpful to show a break down of the votes.

ALEXANDER vonHAFFTEN MOVED TO APPROVE THE MEETING MINUTES OF JANUARY 16, 2004 AND FEBRUARY 13, 2004. SECONDED BY GREGORY POLSTON. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

IX. INHALED AND NEBULIZED CORTICOSTEROIDS:

Sandy Kapur reviewed the inhaled corticosteroid agents. There are currently five inhaled corticosteroid agents available as single source brand name products including Pulmicort, Azmacort, Aerobid, Aerobid-M, Flovent and QVAR. We also include Advair, which is a combination product of Flovent and long-acting Serivent. It is well known that this class of agents is equal in potency and efficacy when used in used in equal potent dosages. The major issue that comes with using equal potent dosages is compliance in patient use, taste, tolerability and other patient compliance issues. Efficacy wise, they are equivalent when used in equal potent dosages. Steroids are one of the first line agents in the treatment of asthma. They are a controller medication used as a second line after a beta agonist has been used or exhausted for the treatment of asthma.

Sandy Kapur reviewed QVAR, which is the only HFA product available and is more environmentally tolerable. QVAR, as the only HFA product available, has greater lung deposition. It is exceptional in that it is a HFA product in a solution, not a suspension, and allows for greater deposition into the pulmonary area. QVAR is able to deliver a higher proportion of smaller particles to the lung vasculature. The active product has a higher receptor binding infinity to the lung, which prolongs its

duration of action. Anything that is prolonged in the pulmonary tree is also prolonged elsewhere in the body and there is a high degree of systemic absorption. With QVAR, less than 10% is systemically absorbed. In addition to systemic absorption, you have to look at plasma protein binding. QVAR is greater than 87% plasma protein binding, so what does get absorbed into the systemic circulation is bound to plasma proteins and is not actually circulated to the rest of the body to cause adverse reactions. It also has a high degree of clearance, which indicates it is liver metabolized and cleared by other organs in the body as well.

Dr. Demain said QVAR was a new form of the older drug Beclomethasone. QVAR has several advantages. It is a low to mid potency, so it is a nice start medication for mild persistent asthmatics. It is very well tolerated by patients, especially those prone to thrush or oral mucosititis. A spacer is not necessary with QVAR, because of the fact that it is in solution and has a high delivery to the lungs. It has a very high delivery to lungs, allowing us to use lower doses. Beclomethasone is also one of the drugs preferred during pregnancy.

Sandy Kapur reviewed Pulmicort Turbuhaler, which is also considered a mid potency drug. Pulmicort is approved for use in pregnancy. The respules have been studied and have an indication for children from 12 months to 8 years of age. The Turbuhaler has a very unique delivery device in that it is a dry-powder formulation and is breath actuated. The patient does not have to coordinate a hand to mouth inhalation delivery system. A disadvantage to Pulmicort is the dry-powder devices sometimes have cohesive and adhesive properties that cause clumping and each individual dose may not be as uniform or equivalent as the other meter dose inhalers or HFA inhalers available. Pulmicort is inhaled in the active form. It has the third highest relative receptor binding infinity, which means it has prolonged action in the lungs. It is moderately lipophilic and undergoes a high degree of first pass metabolism, which means its systemic absorption is very low. Its system absorption is about 10%. It is highly plasma protein bound at 88%, so the actual systemic absorption and potential for side effects is low. Pulmicort has a very well established safety data profile.

Dr. Demain said they had a very well established guideline for therapy in asthma that was developed by the NIH. They look at mild intermittent, mild persistent, moderate and severe asthma, so not all asthma is the same. The guidelines are very clear. The mild intermittent asthma does have some controversy, but for mild persistent asthma it recommended that low to mid potency steroids be started rather than high potency steroids. Pulmicort is preferred during pregnancy and has been awarded a category B. It tends to be very well tolerated by patients with sensitivity to benzalkonium chloride. Many inhalers contain benzalkonium chloride and can potentially worsen asthma. Pulmicort has minimal problems associated with thrush. The delivery device seems to be very well accepted, although it is not something that younger children can easily master. Pulmicort is the only nebulized steroid.

Sandy Kapur reviewed the inhaled corticosteroid agents. Flovent (Fluticasone) is a meter-dosed inhaler in a suspension form. It is a high potency corticosteroid available in three formulations, 44 micrograms, 110 micrograms and the 220 micrograms. Inhaled products allow for easy dosage titration. Fluticasone, as a steroid, has the highest relative receptor binding affinity of 1,800 versus the 935 of Budesonide. It is the most lipophilic, which also associates it with greater pulmonary retention and a longer duration of action. It is cleared by the liver and is 90% plasma protein bound, which means it is relatively devoid of systemic side effects. Flovent also has a very well established safety profile. Aerobid and Aerobid-M (Flunisolide) is considered a very low potency corticosteroid. Of all the inhaled steroids, it has the highest systemic bioavailability and the least plasma protein binding. The plasma protein binding is approximately 80%, which is lower than the other inhaled corticosteroids. It is a less potent

corticosteroid, thus necessitating multiple inhalations to provide an adequate dosage for most patients. It also has a very unpalatable aftertaste that patients find hard to tolerate. Azmacort (Triamcinolone) has a very effective and useful spacer, but it is a less potent corticosteroid that requires multiple puffs to be equivalent to a higher potency inhaled corticosteroid. They spoke to several specialists, including Dr. Roberts, Dr. Woodard and Dr. Demain and they all felt Pulmicort and Flovent should both be on the preferred drug list. They also suggested a lower potency steroid should be made available for patients with a less severe disease and children.

Dr. Demain felt Aerobid was an inferior product and should not be considered for the preferred drug list. He felt Fluticasone was one of the best topical steroids available and he liked the fact that it came in three dosage preparations, which makes it easy to taper the medication down as the patient improves. Pulmicort is useful for patients with less sever asthma and pregnant asthmatics.

Sandy Kapur said one of the specialists said that QVAR may be of greater use in children with croup than the other inhaled corticosteroids due to earlier studies.

In response to Janice Stables, Sandy Kapur said since Pulmicort Respules was the only inhaled corticosteroid and was indicated for children from 12 months to 8 years of age, they would like to allow it for children less than 8 years of age. David Campana said an exception would be added in the system for the Pulmicort Respules.

Diane Liljegren said the Pulmicort Respules were also very useful in demented or developmentally disabled people who just could not figure out how to use an MDI and she would prefer it was not limited to children.

THOMAS HUNT MOVED THAT FLOVENT (FLUTICASONE), PULMICORT TURBUHALER (BUDESONIDE) AND PULMICORT RESPULES (WITHOUT LIMITATION TO AGE) BE ADDED TO THE PREFERRED DRUG LIST. SECONDED BY JANICE STABLES. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

Sandy Kapur reviewed Advair, which is the only combination corticosteroid, long acting beta 2 agonist available. They spoke to Dr. Jeffery Demain, Dr. Owen Hanley, Dr. Dion Roberts and Dr. Woodard. She quoted Dr. Dion Roberts. "Advair is one of the most over-utilized and abused agents in the armetarium. Its ever popular and growing usage as a first line agent in the treatment of asthma and pulmonary lung disease is inappropriate as the beta 2 adrenergic component may contribute to the masking of worsening lung disease, thus incurring more harm. It is strongly recommended that Advair not be a first line therapy, but be used only in patients who are not adequately controlled (or have plateaued) on an inhaled corticosteroid and have an increasing need for rescue medications."

Dr. Demain said Advair was an excellent and useful agent when used in the appropriate population of moderate to severe asthmatics and should be considered for the preferred drug list for patients that meet

the criteria for moderate to severe asthma. He suggested adding to the preferred drug list, but adding "(for moderate to severe asthmatics)" in the description.

David Campana said the committee should not make statements about the use of drugs and should only decided which drugs were preferred and non-preferred.

Janice Stables said some people had better results with Advair than they would with the double inhalers. The diskus were easier to use and had better patient compliance. Some of the more severe COPD asthma patients that would not comply with the multiple doses of steroids were quite happy to comply with the little portable diskus.

Dr. Demain said Advair had been extensively studied in COPD patients. Even though it is difficult to demonstrate significant improvements in their pulmonary function studies, it has demonstrated extraordinary improvement in their quality of life and activity level. He felt Advair was the drug of choice for COPD patients.

In response to Alexander vonHafften, Chairman Brodsky said Advair was used at the Alaska Native Medical Center, but they did not have as many patients on Advair as indicated here.

Sandy Kapur questioned if they would be following the ANC guidelines if Advair was non-preferred with the medical exception, which had to be written on the prescription without a defined reason.

Dr. Demain felt Advair should be placed on the preferred drug list, because 30% of the asthmatic patients used Advair or a combination of Flovent and Salmeterol.

THOMAS HUNT MOVED TO ADD ADVAIR AS AN UNRESTRICTED PREFERRED DRUG. SECONDED BY RICHARD REEM. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

X. INTRANASAL CORTICOSTEROID AGENTS

Sandy Kapur reviewed the intranasal corticosteroid agents. There are currently seven available products that represent six chemical entities. All are FDA approved for the indication on seasonal allergic rhinitis and perennial allergic rhinitis. Flonase, Beconase AQ, and Rhinocort AQ have the additional indication of non-allergic perennial rhinitis. Beconase AQ has the additional indication for the prevention of recurrence in nasal polyps following surgical removal. Beconase AQ is the third most lipophilic agent and potent anti-inflammatory agent. The disadvantages include the fact that it is dosed twice a day, it is the oldest agent in the classification and it has a rosy smell and flavor that is offensive to some patients. All of these agents are equivalent in efficacy when used in equal potent dosages and it really comes down to patient preferences and compliance issues. Rhinocort AQ is a medium potency steroid that has an excellent safety profile. It is fragrance free and benzalkonium chloride free. Benzalkonium chloride is a known irritant that causes toxic reactions in the nose, eyes, ears and lunch and may exacerbate the symptoms of allergic rhinitis. Rhinocort AQ can be dosed once daily. Nasacort AQ (Triamcinolone) is

a medium potency agent. It is fragrance free, thus decreasing sensitivity. It does not cause an excessive amount of post-nasal dripping to the degree the other nasal steroids appear to. Nasacort AQ has a large degree of patient acceptance. Nasalide and Nasarel (Flunisolide) are considered low to medium potency corticosteroids. All have significant amounts of side-effects associated with use. Clinically it is not felt that these agents have a significant place in the treatment of allergic rhinitis or rhinosinusitis disease. Nasonex (Mometasone) is considered a medium to high potency corticosteroid. It is approved for children from 2 to 11 years of age. It is very well tolerated and accepted by patients. It has minimal side-effects. It can be used to treat anything from simple hay fever to severe allergic rhinitis, nasal polyposis and chronic sinus disease. Flonase (Fluticasone) is a high potency agent. It is FDA approved for children 4 and older, although there are pediatric studies of use in children 3 years of age and up. It is well tolerated and accepted by patients. Flonase has a strong fragrance and may not be as well tolerated as other agents. Sandy Kapur summarized the intranasal corticosteroid agents. Beconase AQ's disadvantages include a rosy flavor and it is dosed twice a day. Nasalide, Nasarel and Flunisolide are unaccepted by the general prescribing and patient population due to its adverse effects. Rhinocort AQ and Nasacort AQ are considered relatively equivalent in potency. Flonase and Nasonex are of higher potency and are considered relatively equivalent in their ability to treat patients and acceptability within the patient and provider community. Nasonex should be given preference in the pediatric population, which could be done via a systems edit. Otherwise, it was felt that one medium potency agent and one high potency agent should be included on the preferred drug list.

Dr. Demain said Nasonex (Mometasone) is the preferred agent for children under 12 years of age, because Fluticasone is not tolerated well by younger children and other patients due to its tendency to burn. Nasacort AQ has the highest patient acceptance and does not have a fragrance. Rhinocort AQ does not have benzalkonium chloride, which tends to be a preservative that can provoke brachia spasm and can cause contact dermatitis and mucositis in certain patients. Fluticasone is the most potent topical steroid and is the drug of choice when treating patients with nasal polyposis and chronic sinus disease. He recommended adding Nasonex AQ (for children), either Rhinocort AQ or Nasacort AQ and (Flonase) Fluticasone to the preferred drug list.

JANICE STABLES MOVED THAT RHINOCORT AQ AND NASACORT AQ WERE EQUIVALENT. JANICE STABLES ALSO MOVED THAT NASONEX AQ IS ACCEPTED FOR CHILDREN AND FLONASE BE ACCEPTED AS THE PREFERRED DRUG. SECONDED BY RONALD MILLER. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

XI. QUINOLONES: SECOND GENERATION & THIRD GENERATION

Sandy Kapur said that the second generation quinolones had been subdivided into two groups. The first group is second generation quinolones that can be used to treat systemic gram-negative infections: Cipro, Ciprofloxacin (generic of Cipro), Floxin and Ofloxacin (generic of Floxin). The second group includes Maxaquin (Lomefloxacin), Noroxin (Norfloxacin) and Cipro XR. Although Maxaquin is FDA labeled for the treatment of chronic bronchitis and acute bacterial exacerbation of gram negative organisms, it is felt that other agents may provide more adequate coverage. Maxaquin, Norfloxacin and

Ciprofloxacin are pretty much limited to the UTI spectrum and the UTI area of treatment. Dr. Burger, the ID specialist in Fairbanks, said Cipro would be considered the preferred choice in the second generation quinolones. It is a very versatile agent that has a broad spectrum. Restricting Cipro to patients with pseudomonal infections may be too late as resistance is already quite high. The gram negative coverage of Cipro is strong enough that it is a useful agent, particularly in urinary tract infections where cultures may take longer. Dr. Burger had a preference for Ciprofloxacin generic in the immediate release. He did not have a preference between Maxaquin, Noroxin and Cipro XR.

In response to Chairman Brodsky, Sandy Kapur said even though Cipro was available generically, it would not automatically be added to the preferred drug list, because there was only one manufacturer.

Dr. Demain pointed out that a patient often left a hospital on a certain drug and did better if they stayed on the same drug. Ciprofloxacin was included many of the hospital formularies.

THOMAS HUNT MOVED TO ADD CIPRO TO THE PREFERRED DRUG LIST. JANICE STABLES SECONDED THE MOTION.

Chairman Brodsky said other competitively priced drugs, besides the ones chosen, might be included on the preferred drug list. Cipro will be on the preferred drug list if the motion passes, but some of the other second generation quinolones might be preferred as well due to their pricing.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

Sandy Kapur reviewed the third generation quinolones. Of the respiratory quinolones, so named for their enhanced gram positive activity, there are currently three agents that are marketed. The fourth agent, Zagam, has been discontinued. Although not FDA labeled for the treatment of anaerobic infections, there is data to support that both Avelox (Moxifloxacin) and Tequin (Gatifloxacin) have some in vetro activity against anaerobes, but not to the degree of the only fourth generation quinolone, Trovan. In vitro, Tequin and Avelox are similar in activity. Tequin is two to four times and Avelox is four to eight times more active than Levaquin against S. pneumonia, including strains highly resistant to penicillin. The clinical significance of these differences is uncertain. Tequin, Avelox or Levaquin may be chosen in light of clinical equivalency. Sandy Kapur read Dr. Burger's comments into the record. "I think Avelox and Tequin are fairly similar in coverage and overall resistance. I do think Tequin is a bit better with anaerobes coverage, but it is not adequate for serious anaerobic infections. From personal experience, I feel that Avelox is not as well tolerated as Tequin. Tequin tolerance seems almost identical to Cipro. More people have to stop before a course of Avelox is over due to GI distress. So unless there is a big benefit in cost for Avelox, I would favor Tequin. I think Tequin probably has a slight advantage over Levaquin and Avelox for anaerobic coverage, but once again none of these new quinolones are primary treatment for a serious anaerobic infection. I tend to use Tequin when anaerobes are probably a factor in the infection but not the major or critical pathogen. For example, I tend to think that Tequin alone works as well as Cipro and Flagyl together for uncomplicated outpatient diverticulities (and much better tolerated) or a diabetic foot infection with proven gram negative rods and probable

anaerobes. I don't use Tequin in more serious anaerobic infections, such as for postoperative intra-abdominal abscess treatment following appendicitis. In summary, I would say that I favor Cipro for the first group and Tequin for the second. But if there are dramatic cost benefits for one of the other newer quinolones (Levaquin, Avelox or Tequin), I could probably live with one of the others as long as a prior history of drug intolerance is sufficient justification for using a non-preferred drug (e.g. GI intolerance). There are lots of other differences being touted, but I generally think these are minor, theoretical, or clinically insignificant differences. For example, the Qtc questions are probably a class effect and theoretical resistance to developing bacterial resistance is still very theoretical."

Dr. Demain agreed with Dr. Burger's comments. Tequin (Gatifloxacin) has significant benefits in patient tolerance, minimal side effects and possibly a lower risk of Qtc prolongation. He pointed out that many hospital formularies included Tequin.

The committee discussed the doses and duration of treatment of the various third generation "respiratory" quinolones.

THOMAS HUNT MOVED TO ACCEPT ALL THE THIRD GENERATION QUINOLONES AS EQUIVALENT. SECONDED BY ARTHUR HANSEN. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

XII. CALCIUM CHANNEL BLOCKERS:

Sandy Kapur reviewed the calcium channel blockers, which were divided up into the following three classes: dihydropyridine calcium channel blockers, non-dihydropyridine calcium channel blockers, and phenylalkylamine non-dihydropyridine calcium channel blockers. There are six dihydropyridine calcium channel blockers. Nifedipine is available generically as Procardia immediate release, Procardia extended release, Adalat immediate release and Adalat controlled release. Isradipine is available brand name only as DynaCirc immediate release and DynaCirc CR. Nicardipine is the generic of Cardene and Cardene sustained release. Nisoldipine is the generic of Sular and is available brand name only. Amlodipine is brand name Norvasc. Felodipine is the generic for Plendil, which is currently available as brand name only, but a generic should be available in about a year. Nimodipine (Nimotop) is a special dihydropyridine and is only indicated for use in patients within 96 hours of (indiscernible) hemorrhage for 21 days. All dihydropyridines are FDA labeled for the use in hypertension. In addition to hypertension Procardia (Nifedipine), Cardene (Nicardipine) and Norvasc have indications for the treatment of angina. In hypertension, there has not been a trial showing that calcium channel blockers are any better or inferior to any of the other anti-hypertensive agents for the prevention of major cardiac related events. It has not been proven that one dihydropyridine is superior to another in the treatment of hypertension. In the treatment of angina, current ACCHA guidelines state that in the absence of contraindications, beta blockers are actually the preferred agents and are recommended for initial therapy. If a patient has a serious contraindication to a beta blocker or unacceptable side effects, a calcium channel agonist can be used. They state that long-acting dihydropyridines and non-dihydropyridine agents are equally effective as beta blockers, but they do not specify certain agents. The true source of contention is the use of dihydropyridine calcium channel blockers in patients with

heart failure. Although none of the dihydropyridines are used in the actual treatment of CHF, contention is towards whether any of the dihydropyridines are actually safe in the treatment of uncontrolled hypertension in patients with CHF. According to the ACTION HF, which was an advisory council on heart failure, thus far there are two dihydropyridines that have been proven to be safe and effective for the treatment of hypertension in patients with heart failure. Those two agents are Norvasc, as exemplified in the PRAISE trial, and Plendil, which was exemplified in the V-HeFT III trial. All dihydropyridine calcium channel blockers can be dosed once daily, but DynaCirc may be more effective given twice daily. Norvasc is truly the only once daily agent in terms of half-life. All of the other products can be given once daily, but they can be given once daily due to a change in their formulation. Plendil, Sular, Cardene and DynaCirc are all changed to an extended release formulation and they cannot be crushed or chewed and patients have swallowing difficulties. We were not able to talk directly with a cardiologist, but we received an e-mail from Dr. Krause. He said, "With any calcium channel blockers, our patients need access to long-acting formulations." We also spoke to Dr. Maciejewski, a nephrologist. He said Norvasc differs from other currently marketed dihydropyridines by virtue of its long elimination half-life. He felt Plendil and Norvasc both appeared equally effective in lowering blood pressure and in patient acceptance and tolerance. The greatest side effect of both appears to be pedal edema. He felt Sular and DynaCirc were equivalent in their anti-hypertensive efficacy and one agent could be chosen based on comparable efficacy, even though their utilization was not very high. He was impressed by early studies on DynaCirc that said it had a natriuretic or diuretic that might be useful for patient with CHF, but that has not been proven in any long-term outcome study.

Thomas Hunt felt all the dihydropyridine calcium channel blockers were relatively equally efficacious, although Norvasc seemed to be the most tolerated and easiest to use.

THOMAS HUNT MOVED THAT NORVASC (AMLODIPINE) BE ADDED TO THE PREFERRED DRUG LIST. SECONDED BY UNIDENTIFIED PERSON. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

Sandy Kapur reviewed the non-dihydropyridine calcium channel blockers. All the products were available generically with the exception of Cardizem LA. Cardizem LA, when dosed at bedtime, achieves peak plasma levels 11 to 18 hours after dosing, thus peaking in the early morning hours when an increased risk for serious cardiovascular events may occur. Although, it has not been truly established that targeting the peak hours is beneficial. Dr. Maciejewski was impressed with Cardizem LA and felt it was a very good agent and he utilized it in his practice a great deal. He felt Cardizem CD, Dilacor SR and Tiazac were all equivalent in clinical efficacy. The only special agent in this classification is VASCOR (Bepridil Hydrochloride). It is indicated for the treatment of chronic stable angina (class effort-associated angina) for patients who have failed to respond optimally to other agents.

Janice Stables asked if specialists might feel Cardizem LA was medically necessary for a certain patient population. She suggested accepting all the generics with medical necessity guiding the use of Cardizem LA.

AN UNIDENTIFED FEMALE MOVED THAT ALL THE NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS WERE EQUIVALENT. SECONDED BY RICHARD REEM. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

Sandy Kapur reviewed the Phenylalkylamine non-dihydropyridine calcium channel blockers. Verapamil is available in immediate release and extended release as Calan, Isoptin and Verelan, which are all available generically. Verelan PM and Covera-HS are brand name only. These are agents that are designed to be administered at bedtime with anti-hypertensive effects in the early morning hours when there is a variation of blood pressure. Dr. Maciejewski said of the two available chronotropic agents, there does not appear to be a greater efficacy or advantage of either or Cardizem LA. He felt that only the Cardizem LA product would be needed. Dr. Krause said he needed a long-acting Verapamil type agent, which would be available generically with the Calan, Isoptin or Verelan products. According to the manufacturer there is an unspecified problem with Covera HS and it will not be available until May of 2004.

THOMAS HUNT MOVED THAT THE PHENYLALKYLAMINE NON-DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKERS WERE EQUIVALENT. SECONDED BY ALEXANDER von HAFFTEN. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

XII. LIPOTROPICS: FIBRIC ACID DERIVATIVES & STATINS

Sandy Kapur reviewed the fibric acid derivatives. There are two chemical entities and three products available. Gemfibrozil (Lopid) is available brand name and generic. Micromized Fenofibrate is the generic name for the two brand name products, Tricor and Lofibra. In the treatment of hyper-triglyceridemia, the fibric acid derivatives are the drugs of choice. Micromized Fenofibrate has a greater LDL decreasing factor than Lopid. However, in regards to tryglycerides, it seems equivalent. Fenofibrate has a decreased amount of drug interactions. Lopid (Gemfibrozil) has been shown to have significant drug interactions and increases the hypoglycemic effects of those agents. Fenofibrate appears to impair or increase (indiscernible) levels, which is an increased marker or cardiovascular disease. It also appears to increase the (indiscernible) levels or impair renal function. There is also concern about increased (indiscernible) levels that indicate worsening of cardiovascular disease, which does not appear to happen with Gemfibrozil. Neither Gemfibrozil or Fenofibrate is the drug of choice for decreasing LDL, but the fibric acid derivatives are the drug of choice for decreasing tryglycerides.

In response to Alexander vonHafften, David Campana said fibric acid derivatives were commonly prescribed in Alaska.

HEIDI BRAINERD MOVED TO ADD GEMFIBROZIL TO THE PREFERRED DRUG LIST. SECONDED BY THOMAS HUNT.

Diane Liljegren felt both Gemfibrozil and Fenofibrate should be added to the preferred drug list, because they had many differences in their interactions and side effects. (Indiscernible -- telephonic.)

Thomas Hunt said Fenofibrate seemed to be more potent, better tolerated and had fewer interactions. He would prefer to see both the agents on the preferred drug list.

CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. THE MOTION PASSED WITH ONE OPPOSING.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Liljegren, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: Hunt.

The Pharmacy and Therapeutics Committee decided to postpone the discussion on Statins to the next meeting.

XIII. CLASSES FOR NEXT P&T MEETING:

Chairman Brodsky noted that the April meeting had been cancelled. The classification to be reviewed at the May meeting included sedative hypnotics, anti-anxiety drugs, new generation antidepressants, SSRIs, CNS stimulants and long-acting narcotics. The statins, which were postponed from this meeting, would also be reviewed at the May meeting.

XIV. FINAL COMMENTS BY CHAIR OR OTHER MEMBERS:

Chairman Brodsky said the committee had previously felt they needed a broader representation from the mental community when reviewing the mental health drugs. A group of mental health professionals would be assembled before the next meeting to review the process and the materials so they would be prepared to talk at the May meeting.

XV. ADJOURNMENT:

THOMAS HUNT MOVED TO ADJOURN THE MEETING. SECONDED BY RONALD MILLER. CHAIRMAN BRODSKY CALLED FOR A VOTE ON THE MOTION. MOTION PASSED UNANIMOUSLY.

Aye: Brainerd, Brodsky, Conright, Gale, Hansen, Hopson, Hunt, Miller, Polston, Reem, Stables, vonHafften, White.

Nay: None.

The meeting adjourned at 12:23 p.m.