State and Public School Life and Health Insurance Board
Clinical and Fiscal Drug Utilization and Evaluation Committee

Minutes
May 5, 2008

The State and Public Life and Health Insurance Board, Joint Clinical and Fiscal Drug Utilization and Evaluation Committee met on Monday, May 5, 2008 at 1:00 p.m., in the EBD Board Room, 501 Woodlane, Little Rock, AR.

Members Present:
Dr. William Golden
Dr. Hank Simmons
Kat Neill
Larry Dickerson
Dr. James Bethea
Mark McGrew

Members Absent:
Dr. Joe Stallings
Robert Watson
Matthew Hadley

George Platt, Chief Operating Officer, Employee Benefits Division of DFA

Others Present:
Barry Fielder, NMHC; Jill Johnson, College of Pharmacy, UAMS; George Platt, Patricia Schafer, Marty Usrey, Kim Wilmot, Shannon Roberts, Randi Porter, Sherry Bryant, Kristi Cox, Stella Greene, Faith Houston, Marilyn Jersild, Ellen Justus, Sharon McDonald, Cathy Harris, EBD; Bryan Meldrum, Novasys; Ronda Walthall, Wayne Whitley, AHTD; Barbara Melugin, BCBS/HA; Dawn Clemence, Logan Kersey, Pfizer; Katherine Hall, ADFA; Clay Patrick, UAMS

Call to Order
Meeting was called to order by Dr. Golden.

Approval Of Minutes
The request was made by Dr. Golden to approve the February 4, 2008 minutes. Minutes were approved without objection.

Antiasthmatic Agents (LTRA's) Update *by Jill Johnson*
Johnson reported The Leukotriene Receptor Antagonists (LTRA) PA Criteria for patients 12 and under became in effect April 1, 2008. Johnson said the intent was to prevent monotherapy from happening in kids 12 and under. However, upon review, it was discovered that the set-up was perhaps not consistent with the original intent of the DUEC.

The initial setup as of 4/1/08 provided for step therapy criteria to include all members age 13 and older and a straight prior authorization requirement for members 12 and under. Johnson said they've since realized that the prior authorization requirement (and the supporting criteria) was designed for only those members 12 and under on monotherapy.

Subsequently, the plan set up was changed to apply the same step therapy criteria of a lookback for an inhaled/oral steroid. This will result in only those members with a LTRA claim without a corticosteroid in their immediate history experiencing a rejected claim requiring a prior authorization.

Johnson provided the Committee with a report of Asthma Edits that became effective 04/01/08 that summarized the criteria for Advair, Symbicort and single entity drugs. Johnson also provided the committee with several pages of the Asthma guidelines and a summary of the Leukotriene Receptor blockers.

Johnson reported the 2007 Asthma guidelines support the use of a LABA/ICS combination or a LTRA/ICS combination for certain patients, but do not support combination therapy with LABA/ICS/LTRA. Johnson said she could not find any data while searching PUBMED 5/5/08 that assess any benefit or detriment with the three drug combination; therefore, with no known benefit and with extra cost, the use of the three drugs concurrently should be deterred.

Johnson reported they are in the process of running a report to see what sort of combination therapy they are dealing with and will provide the results in the next meeting. Dr. Golden suggested they look at dosage also.

Dr. Golden stated they will consider maximization of one therapy before adding another drug when all the data has been reviewed.

Chantix Review by Corphealth

Sharon Marcum informed the Committee they contacted EBD when the U.S Food and Drug Administration (FDA) reported on the connection between Pfizer's anti-smoking drug Chantix and serious psychiatric problems. Marcum provided the Committee with the script used by Corphealth coaches regarding Chantix and an activity chart for pharmacotherapy. Marcum explained the chart indicated a sharp decrease in nicotine replacement therapies (NRT) usage as well as Bupropion, since the committee approved coverage for Chantix in 2006. Marcum said they would like the committee's input on the script.

The Committee had no questions or comments during the meeting.

Dr. Golden suggested any comments or suggestions be directed to Corphealth as appropriate by members of the Committee.

Vyvanse Utilization Review *by Jill Johnson*
Vyvanse is a prodrug for dextroamphetamine. It was originally approved for use in the treatment of Attention Deficit/Hyperactivity Disorder (ADHD) in children, 6-12 years of age. Vyvanse recently received FDA approval for the treatment of attention deficit hyperactivity disorder in adults.

The Committee reviewed utilization data from 1Q08 and cost comparison data with other products to treat ADHD. Johnson stated before Vyvanse was approved for the treatment of ADHD in adults, the adult member population had already received a prescription for it; with the majority being 20 or under. Johnson reported the drug is more expensive than dextroamphetamine; and at this point, with their being no known advantages, the drug is converted to dextroamphetamine.

Johnson recommended they send letters to Vyvanse users and stop covering Vyvanse at the beginning of the next quarter because it offers no benefit.

Neill explained the prodrug was marketed particularly for adults that there would be less potential for abuse because it takes longer to get into the system and a lot of prescribers want to prescribe it because they believe it's true. Neill said she did not know of any data for this.

Dr. Simmons stated there are people who believe there is less potential for abuse; however, there isn't data to justify that conclusion. Dr. Simmons commented there certainly are people in the medical community that have advanced the idea.

McGrew explained the metabolic process for prodrug.

Motion: Dr. Simmons made the motions to withdraw Vyvanse from tier 3 and exclude from the prescription drug plan. Mr. Dickerson seconded. All were in favor. Motion carried.

Miscellaneous Formulary Issues *by Barry Fielder*
Fielder provided a list of medications for consideration of movement to tier 3. While the branded medications do not have generic equivalents available today, they are all in drug categories where generic alternatives exist. In fact, for several of them there are multiple generic alternatives available. The products are in classes for which they have not had a specific class review. Fielder provided detailed utilization data for the most recent 3 month period.

Fielder requested the Committee evaluate the products and consider their formulary placement relative to providing the most cost-effective pharmacy benefit.

Dr. Golden suggested keeping Coreg CR at tier 2 due to compliance issues.

An in depth discussion ensued.

Motion: Dr. Simmons made the motion to move the following drugs to tier 3. McGrew seconded. All were in favor. Motion carried.

- InnoPran XL
- Levatol
- Aceon
- Fosamax + D
- Cardizem LA
- Kadian

Motion: Dr. Simmons made the motion to move Coreg to tier 3 as well. Bethea seconded. Motion carried.

Reconsideration Of The Motion: At Neill's request the Committee revisited the drug Fosamax plus D.

Neill posed a question to the committee about the advantages of covering Fosamax plus D. Neil said calcium, plus D can be taken separately, and then referred to the 322 members prescribed Fosamax plus D in the 1Q08. Neil and Fielder discussed the cost implications for generic Fosamax.

McGrew commented calcium with D is very prevalent in the market place and is therefore not a compliance issue. McGrew agreed, take calcium with D and take the generic Fosamax.

Motion: Neil made the motion to exclude Fosamax plus D from the prescription drug program. McGrew seconded. All were in favor. Motion carried.

Oxycontin *by Barry Fielder*
Fielder explained OxyContin (oxycodone ext rel) has been available in generic form for some time. However, due to patent litigation, the generic is no longer available. As a brand with a generic available, OxyContin has defaulted to Tier 3 status. Rebate opportunities do exist if OxyContin is placed in a preferred (Tier 2) position on the formulary.

Fielder suggested the committee discuss tier status of OxyContin going forward since there is no generic equivalent available. Fielder provided detailed utilization data.

Dr. Simmons commented on the other alternatives that are available aside from OxyContin.

Johnson said she and Fielder are going to be doing some work on narcotics for the next meeting. Johnson said they will also bring back a proposal for a one-provider-one pharmacy policy for chronic pain medication users.

The Committee agreed to table the discussion until they review the information for narcotics in the next meeting.

Thiazolidinedione Class Review *by Jill Johnson*
Rosiglitazone (Avandia), Pioglitazone (Actos) are currently on tier 2. Johnson reported Rosiglitazone began receiving some bad press in 2007.

Johnson stated the current best evidence indicates the CV risk issues with TZDs are not resolved. Rosiglitazone showed a detriment in the meta-analysis that included even trials that were not published. By contrast, in the meta-analysis of pioglitazone actually showed a reduction in events including death, MI, or stroke in patients with DM. Heart failure is an adverse effect for both drugs.

Johnson recommended moving Rosiglitazone to T3 and keep Pioglitazone at T2 for now.

Motion: Dr. Bethea made the motion to leave Pioglitazone (Actos) at tier 2. Dr. Simmons seconded. All were in favor. Motion carried.

Neil stated because Rosiglitazone (Avandia) is FDA approved it is hard to defend excluding it completely; but, perhaps take an incentive approach. Neil said she believes it's a bigger issue in terms of disease state management for diabetes and it would probably be a good opportunity to do a general informational letter in terms of the evidence that really supports using metformin first line. Neill said they should also include the information about w/insulin because there is no black box warning for insulin with Actos although there is a statement in the package inserts that there is a risk with it.

Motion: Neill made the motion to move all Avandia products to tier 3. Dr. Simmons seconded. All were in favor. Motion carried.

New Drugs For January – March 2008 *by Jill Johnson*

DRUG	Tier
Bystolic 2.5mg, 5mg, 10mg tablets	T3
Sanctura XR cap 60mg	T3 – Revisit in 1 yr

Intelence tab 100mg	T2 w/ PA
Simcor tabs 500/20, 750/20, & 1000/20	N/C
Omnaris Suspension, intranasal	T3
Pristiq	Exclude – Review in 6 months

The Drug Arcalyst INJ Sterile was referred to EBD Administration for research because the drug may not be applicable on the pharmacy side.

Dr. Golden talked about the recent data about the efficiency of the drug Atenolol. After which, the committee agreed to remove Atenolol after a year's transition period.

Motion: The Committee agreed by concensus to authorize appropriate staff members to communicate with prescribers about the grace period to transition patients off Atenolol, effective Jan 1, 2009 with an educational piece.

Other Business
Sherry Bryant, Pharmacy Coordinator for EBD informed the Committee the Benefits Strategic Planning Workgroup (BSPW) met on April 29, 2008; whereupon, the BSPW received a request to review data for the proton pump inhibitors since the benefit structure change in 2005. Bryant reported the BSPW will be reviewing the impact of the change on the medical side and will provide the DUEC with the results.

Meeting Adjourned.