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Meeting Minutes – June 28, 2012 P&T Committee

Las Vegas Chamber of Commerce
6671 Las Vegas Blvd. S., Suite 300
Las Vegas, NV 89119

Committee Members Present

Las Vegas: Adam Zold, Pharm.D.; Eveyln Chu, Pharm.D.; Shamim Nagy, MD; Weldon Havins, MD; Joseph Adashek, MD; Constance Kalinowski, MD; Ronald Shockley, MD

Carson City: Kevin Desmond, RPh; Michael Hautekeet, RPh

Absent: David Chan, RPh;

Others Present

DHCFP:

Las Vegas: Gabriel Lither, Deputy Attorney General

Carson City: Coleen Lawrence, Chief Program Services; Mary Griffith, RN, Social Services Program Specialist

SXC Health Solutions

Las Vegas: Carl Jeffery, Pharm.D., Kevin Whittington, RPh

Carson City: Rob Earnest, Pharm.D., JD; Mariellen Rich, RPh, Irene Tobarak

HPES:

Carson City: Ed Arnold, PBM Liaison

Others:

Las Vegas: John Stockton, Astellas; Don Powell, Forrest; Efrain Alton, Merck; Fred Meister, Merck; Bret Ferguson, Pfizer; Roy Palmer, Pfizer; Deborah Profant, Teva; Deron Grothe, Teva; Jeanne A VanderZander, Lundbeck; Glenna W, Eisie; Brooks Hubbard, BIPI; Bill O'Neill, IPI; John Brokers, Lilly; Helen Liao, Lilly; Ben Skoog, Abbott; Carol Ricciltiolti, Sunovion; Steve Fox, GSK; Gregg Polacek, Nephron; Brian Streng, GSK; Tim Willson, Astra Zeneca; Ryan G, Pfizer; Nick Honaclik, Merck

Carson City: Mylan Hawkins, NV Diabetes; Chase Freeman, P&E; Jeff Scherman, P&E; Ben White, DHCFP

I. Call to Order and Roll Call

The meeting was called to order at 1:05 PM.

CHAIRWOMAN SHAMIN NAGY, MD: Shamim Nagy.

GABE LITHER: Gabe Lither with the Attorney General's Office.

EVELYN CHU, PHARM.D: Evelyn Chu.

RONALD SHOCKLEY, MD: Ron Shockley.

JOSEPH ADASHEK, MD: Joseph Adashek.

CONSTANCE KALINOWSKI, MD: Connie Kalinowski.

CHAIRWOMAN NAGY: Up in Reno please?

MICHAEL HAUTEKEET, RPH: Mike Hautekeet.

KEVIN DESMOND, RPH: Kevin Desmond.

II. Public Comment

COLEEN LAWRENCE: This is Coleen up in the north. I would like to give the Committee members some informational items. This last week, the Sunset Committee that was directed by the Legislative Committee had agreed to allow the Pharmacy and Therapeutic Committee to go forward, to continue. So, that was good news for the Pharmacy and Therapeutic Committee. There was a Subcommittee from the Legislative Committee to review all of the committees that were in the Nevada Revised Statutes, including the P&T, so that was good news for this Committee. I think that is a direct reflection on all of the hard work that has come out of this Committee... on behalf of the division and the department, we do fully appreciate all of the volunteer time that each Committee member does put into this Preferred Drug List. For our public, I would like to make the announcement. We have been talking about this for several quarters now. Medicare and Medicaid services did approve our state plan for supplemental rebates. We did send out several announcements, but I just wanted to let everybody know that it was approved and it is effective January 1 of this year. And also, we are continuing to recruit new members or volunteers, both physicians and pharmacists, for both for the Pharmacy and Therapeutic Committee and the Drug Use Review Board. If you are interested, please contact my assistant, Crystal Johnson. Her phone number is (775) 684-3722 ... but we do solicit applications and we ask NACDS, we ask the Board Of Examiners, we ask PHARMA for active community members who are physicians and pharmacists. You must be practicing in the State of Nevada. You must be licensed in Nevada to serve on these boards. That is one of the key issues ... so please, at all times, we are looking for members. We will be having... one of our board members will be resigning after this Committee meeting today and so this Committee will be short a member after today's meeting. That is all of the announcements for today, Madam Chair.

CHAIRWOMAN NAGY: Public comments?

None.

III. Review and Approval of the March 22, 2012 Meeting Minutes

WELDON HAVINS: I move we approve the minutes of the March 22, 2012 meeting.

ADAM ZOLD: I second.

CHAIRWOMAN: For approval voting.

CHAIRWOMAN NAGY: We will take the voting down here.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.
JOSEPH ADASHEK, MD: Aye.
CONSTANCE KALINOWSKI, MD: Aye.
MICHAEL HAUTEKEET, RPH: Mike Aye.
KEVIN DESMOND, RPH: Desmond Aye.
CHAIRWOMAN NAGY: The motion is approved.

IV. Proposed New Drug Classes

A. Agents for Restless Leg Syndrome

1. Public Comment

BRIAN STRAIN: Thank you, my name is Brian Strain, Medical Science Liaison, with GlaxoSmithKline and I just wanted to make a few comments about one of our newer products, Horizant, which is gabapentin enacarbil that fits into this class. As you are aware, the drug review packet has indicated in adult patients with Restless Legs Syndrome primary (RLS). Three key things: Number one, again, for FDA approved indication, this was the first agent that is a non-dopaminergic approved in this category. Pivotal trials set up very similar to the dopamine agonist, if you will, showing response over 12 week trials. One was trialed up to 52 weeks. The second key point is within this drug category, especially for Restless Legs Syndrome, I think you are aware there are two phenomenon that have been reported, both augmentation and early morning rebound, so basically a worsening of disease on drug treatment if you will for augmentation and sometimes in some patients a wearing off effect over time known as early morning rebound. Within the clinical trial program, again, within the data for gabapentin enacarbil, Horizant, looking at patient diaries and so on, there were no reports of augmentation or early morning rebound. In the final point, I wanted to point out is when you look at the drug category, there is a lot of different options in there. But, why gabapentin, a compound that has been around for a long time? What gabapentin enacarbil really is taking that molecule of gabapentin and putting it together with this enacarbil, what makes it a nutrient mimic. So, instead of the absorption in just that limited region of the upper small intestine, it basically takes advantage now of various nutrient transporters allowing full absorption throughout the entire gut. And so, because of that, you get a very wide range dose proportional so now you have got a compound, which you increase the dose proportionally to increase the gabapentin bioavailability. Once it is absorbed into the bloodstream, it behaves as gabapentin. And so, those are the key things and again why enacarbil is different than the immediate release gabapentin. Thank you very much.

CHAIRWOMAN NAGY: Any questions? What is the half life of this?

BRIAN STRAIN: The half life on this too, again, once it is absorbed... it is an extended release compound as well; but once it is absorbed, again it behaves as regular gabapentin once it is into the bloodstream. But, again, it allows for that once daily dose 600 mg about 5 p.m. in the evening. And, one other key point with that studied higher doses and the labeling is really no additional benefit. So, it really locks it into one tablet once a day.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: The gabapentin works the same way once it is absorbed. It is just that with this new formulation with the Horizant, it is a little bit different the way that it gets into the body. It has a different delivery mechanism that has better bioavailability. Because it is similar to gabapentin, it is absorbed... it is metabolized the same way, has the same drug interactions as all of the other gabapentin products, the generics that are on the market. The other options with this, and I think have been out for a long time and I am not going to spend a lot of time with the other, like the Requip and the other medications that are indicated for this as well. But there is also the Mirapex and the Requip. Also, the extended release formulation of an anticonvulsant that we are talking about now. So, overall, the

treatment with the gabapentin, the ER, significantly decreased the restless legs' symptoms total score compared to placebo and significantly in greater proportions the patients receiving the gabapentin enacarbil were rated as clinician and patient reported clinical global impression improvement responders. The key point with this medication class is that the dopamine agonists are still the number one preferred agents. They are the drug of choice for most patients for Restless Legs Syndrome. The pramipexole and ropinirole are associated with fewer side effects. Therefore, they are preferred over the pergolide. Gabapentin is considered an alternative to the dopamine agonist, especially in patients with neurotic.... neuropathic pain. Other anticonvulsants that are likely to affect the RLS include carbamazepine and valproic acid. Final things to consider; both pramipexole and ropinirole are available generically while gabapentin, the ER form, is only available as a brand product. Generic formulations of gabapentin are available for various strengths, but they require dosing more frequently is the downside of that, and then the gabapentin, the Horizant brand, is the only one that is indicated for Restless Legs Syndrome. That is all I have for the product reviews.

3. Committee Discussion and Action

WELDON HAVINS, MD: I move that we consider the three drugs therapeutically equivalent.

CONSTANCE KALINOWSKI: Second.

CHAIRWOMAN NAGY: All in favor?

WELDON HAVINS: Aye.

ADAM ZOLD: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

CHAIRWOMAN NAGY: That is approved.

4. Presentation of Recommendations for Preferred Drug List (PDL)

CARL JEFFERY, PHARM.D: The recommendation for the PDL we have is the generic pramipexole, the brand name Requip XL and the generic ropinirole making Horizant, Mirapex, brand Mirapex, brand Mirapex ER and brand Requip as non-PDL. Those aren't anywhere near, newer material. Do you need me to read the pattern?

CHAIRWOMAN NAGY: Yes please.

CARL JEFFERY, PHARM.D: Okay. As PDL, SXC recommends the generic, the pramipexole, Requip XL, ropinirole and then... so those are preferred agents and non-preferred would be the Horizant, Mirapex brand, Mirapex ER brand and Requip brand.

5. Committee Discussion and Approval of Drugs for inclusion on the PDL

WELDON HAVINS, MD: Move to approve as suggested.

JOSEPH ADASHEK, MD: Second Adashek Aye.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.
KEVIN DESMOND, RPH: Aye.

CHAIRWOMAN NAGY: So the motion is approved.

Any public comments?

None.

Next: Pediculocides/Scabicides. Public comments. Public comment up in Reno.

B. Pediculocides/Scabicides

1. Public Comment

None

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: The scabies and pediculocides are infestations of the scaby past by pediculocidal parasites. All of the agents that we will be reviewing are approved for the treatment of head lice with the exception of the crotamiton, or Eurax is the brand. It is only indicated for the treatment of scabies. The pediculocidal effects of these agents result from the neurotoxic effects on the lice. Scabies cause periods of central nervous system hyperexcitation, resulting in paralysis and multiple death of the lice. Benzyl alcohol, the Ulesfia, is unique in that it disables the breathing structure of the lice resulting in asphyxiation rather than neuroexcitation. Neurotoxic insecticides rely on the nervous system to exert their effect. Therefore, newborn larvae are not susceptible to these agents since they do not develop a nervous system for several days after hatching. This presents a challenge for eliminating lice in single treatment because the infestation typically includes lice from all stages of the lifecycle, including newly hatched eggs. Getting specifically into the agents, the malathion is both pediculicidal and ovacidal, but it smells bad and requires 8-12 hours of application and is highly flammable. Lindane has been long past kind of the gold standard, that it is very neurotoxic and has been shown to have several side effects and is not really the first treatment option any more. So new drugs are available; the Ivermectin, which is brand name Sklice, and Spinosad, which is brand name Natroba. Spinosad and Ivermectin are pediculicidal, but not ovacidal because they don't kill the eggs. According to the manufacturer, Spinosad does not require nit combing treatment. This is because it has such a slow metabolism that it is still lingers on the surface, so it is still effective. Topical Ivermectin is proved as a single application product as well. There is a black box warning on Lindane. It talks about the neurotoxic effects, especially with children.

3. Committee Discussion and Action

WELDON HAVINS, MD: Are these neurotoxic orally or are these neurotoxic just

CARL JEFFERY, PHARM.D: I don't know the toxic effects of them if you took them orally, but yeah... well they are neurotoxic to the lice themselves. But they are also neurotoxic, I think, if you were to take them orally.

WELDON HAVINS, MD: So when you are talking about neurotoxic, you are talking about to the lice?

CARL JEFFERY, PHARM.D: Right. Yeah.

UNKNOWN VOICE: But also, probably they can be neurotoxic to the patient.

CARL JEFFERY, PHARM.D: Yeah, and there are certain circumstances if you don't follow the application procedures exactly, you risk absorbing more than you should.

CHAIRWOMAN NAGY: Skin absorption?

CARL JEFFERY, PHARM.D: Yeah.

RONALD SHOCKLEY, MD: At least you won't have lice.

CARL JEFFERY, PHARM.D: So, in conclusion, Permethrin products are recommended as first line therapy for treatment of scabies and lice despite increasing resistance in the United States. Permethrin products include Nix. It is over-the-counter. Lindane, a well-known older agent, is reserved for second line therapy as it carries a black box warning described with the risk of neurotoxicity associated with its use. Overall, the comparative success rates with topical pediculicides have been shown to be approximately 57%, 99% permethrin and 45-95% with the piperonyl butoxide, which is RID, which is also available over-the-counter, 60-88% with Lindane and 78% with malathion. The newer agents, which include Benzyl alcohol, Ivermectin and Spinosad have shown cure rates of 75%, 71-75% and 93-94% respectively, although there is limited published literature confirming these results. The CDC recommends permethrin, or the combination of piperonyl buoxide and permethrin, as equivalent therapies for pediculosis pubis. That concludes by clinical review.

WELDON HAVINS, MD: I have a question. Do you consider all of these therapeutically equivalent?

CARL JEFFERY, PHARM.D: As far as being effective, they are. I believe they are all relatively equally effective. As far as being safe is another... I would not consider Lindane to be safe, but I think the other ones are in the same field.

CHAIRWOMAN NAGY: Are they available over-the-counter?

CARL JEFFERY, PHARM.D: The Nix and RID is available over-the-counter, which is... that is the permethrin and the piperonyl butoxide.

CHAIRWOMAN NAGY: Any more questions?

WELDON HAVINS, MD: Just one. Is there any advantage to Lindane?

CARL JEFFERY, PHARM.D: It is very effective. You know, 60-88% for Lindane is effective but I think there are other ones that are more effective as that one.

RONALD SHOCKLEY, MD: And also, even though they may have similar cure rates, the neurotoxicity is really

CARL JEFFERY, PHARM.D: Right.

EVELYN CHU, PHARM.D: Other ones, if they are used according to the insert directions are safe. Isn't that right?

CARL JEFFERY, PHARM.D: Correct.

CHAIRWOMAN NAGY: There is no other question or discussion, so I motion to consider clinically therapeutic this class of medication.

WELDON HAVINS, MD: I move that we consider this list of medications therapeutically equivalent with the exception of Lindane.

JOSEPH ADASHEK: Second Adashek.
CHAIRWOMAN NAGY: All in favor?
WELDON HAVINS, MD: Aye.
ADAM ZOLD, PHARM D: Aye.
CHAIRWOMAN NAGY: Aye.
EVELYN CHU, PHARM.D: Aye.
RONALD SCHOCKLEY: Aye.
JOSEPH ADASHEK, MD: Aye.
CONSTANCE KALINOWSKI, MD: Aye.
MICHAEL HAUTEKEET, RPH: Aye.
KEVIN DESMOND, RPH: Aye.
CHAIRWOMAN NAGY: So it is approved.

4. Presentation of Recommendations for Preferred Drug List (PDL) inclusion

CARL JEFFERY, PHARM.D: So, we recommend Natroba and the over-the-counter Nix, which is permethrin, and just the generic permethrin as PDL. Leading as non-PDL the Eurax, which is the crotamiton, the malathion, the Ovide, which is the brand name for the malathion, benzyl alcohol and Lindane as all non-preferred. So, I will repeat that again. So as PDL, Natroba, Nix, which is an OTC permethrin and then the generic permethrin as those are all considered preferred. As considered non-preferred, the Eurax, which is crotamiton, malathion, Ovide, which is the brand name malathion, the Ulesfia, which is benzyl alcohol and Lindane as non-preferred.

5. Committee Discussion and Approval of Drugs for Inclusion on the PDL

WELDON HAVINS, MD: I move that we approve for the PDL the permethrin, Nix and Natroba.
ADAM ZOLD, PHARM D: I second that, Zold.
CHAIRWOMAN NAGY: All in favor say aye, starting now.
WELDON HAVINS, MD: Aye.
ADAM ZOLD, PHARM D: Aye.
CHAIRWOMAN NAGY: Aye.
EVELYN CHU, PHARM.D: Aye.
RONALD SHOCKLEY, MD: Aye.
JOSEPH ADASHEK, MD: Aye.
CONSTANCE KALINOWSKI, MD: Aye.
MICHAEL HAUTEKEET, RPH: Aye.
KEVIN DESIMOND: Aye.
CHAIRWOMAN NAGY: Motion approved.

So, we move onto Agents for Neuropathic Pain.

C. Agents for Neuropathic Pain

1. Public Comment

PFIZER PHD: Good afternoon. My name is Dr. (inaudible), I am a regional medical director, Ph.D. with Pfizer and I just wanted to say a few words about Lyrica, which is pregabalin. So, the first thing I wanted to make sure you are aware of is that a week ago, Lyrica received a new indication for neuropathic pain and that was based upon an FDA priority review and the indication was for the management of neuropathic pain associated with a spinal cord injury and this was based upon two pivotal efficacy and safety studies with 357 patients with neuropathic pain following spinal cord injury. Lyrica

is the first agent to have received an indication for spinal cord injury, neuropathy and I think this is important in our patient population. I don't know whether or not at this level you had indications to the DUR board level but I wanted to make sure that you are aware of that and the package insert has been updated, which is available now, or I have a copy of it if you need it. So, this is in addition to the two other neuropathic pain indications we have for diabetic peripheral neuropathy and postherpetic neuralgia and we have a lot of evidence to support that, which is also in the package insert. If I lost you here, the American Academy of Neurology rated pregabalin as the only agent to receive Level A rating of the quality of evidence to support its efficacy in DPN. So, currently in Nevada, you are managing through prior authorization the utilization of Lyrica according to those FDA indications and so I would like to ask you if you would continue to do that and consider adding the newest indication for Lyrica to enable access for this and for patient population and that was everything I wanted to say.

MYLAN HAWKINS: Yes, thank you very much. My name is Mylan Hawkins. I am the State Executive Director for the Nevada Diabetes Association. Thank you for allowing me to speak to you today. As you are aware, people with diabetes are at extreme risk of developing painful diabetes peripheral neuropathies and our whole goal is to see that the physician have no undue draws put on his recommendation or her recommendation for what will be the best medication to meet their patients' needs with regard to this very difficult comorbidity. So, we would ask you to consider not putting any of the neuropathic medicines in a class where prior authorization is needed. We are aware that turn-around time for Medicaid may be as little as 24 hours, but our experience with dealing with many of these patients is that they find when they go to a pharmacy, that is the first time they know that they will require prior auth and many times it will take several weeks for them to get the right medication to meet their needs. So, I thank you for your consideration on this.

JOHN ROJAS: Hi. I am John Rojas with Eli Lilly and Company. Nice to see you all. I am going to speak today about Cymbalta, or duloxetine, which is indicated amongst other things for neuropathic pain related to diabetic neuropathies. It is indicated at 60 mg. It has also indications for major depressive disorder, chronic musculoskeletal back pain, fibromyalgia, angina with anxiety disorder. The efficacy in neuropathic pain for diabetic patients was established in three clinical trials, which were not part of your clinical packet. 60 mg and 120 mg were statistically significant of our placebo in the control trial of 1-24 hour average pain severity. One in 50% of the patients in these trials had a greater than 50% reduction in their pain. There was also a 26 week maintenance study that was published and it is important to note that in these studies, any one with major depressive disorder was not allowed in this study. So, this is a depression independent treatment effect. We are also established as first line treatment along with the UK 2010 guidelines of neuropathic pain and so are the European affiliated guidelines. There is an opioid utilization to account for cost and retrospective cohort study, those with diabetic peripheral neuropathic pain who initiated duloxetine versus a standard of care. Results demonstrated that duloxetine treated patients were significantly less likely than any to use opioids rather than the standard of care patients, and that was statistically significant. We also had significantly lower direct healthcare costs over this time period, which to the order of the duloxetine patients had an average cost of \$25,400 versus \$37,500 and that is statistically equal, statistically significant. It is apparently driven by less outpatient costs. There are limitations, of course, through retrospective data. I welcome any discussions. We ask for continuation of Cymbalta's access using the ICD9 code 250.6.

CHAIRWOMAN NAGY: I have a question. Is it used in spinal cord injuries?

JOHN ROJAS: It isn't studied in that and we don't have any indication. I can say that for Pfizer's new pre-guideline indication. We don't have that study or evidence to support that is.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: So, we briefly just discussed the agents for neuropathic pain. It is a new drug category for us but because we already have Cymbalta and the Lyrica as considered preferred in other classes, my focus is really going to be on this new, another gabapentin agent, Gralise, if I am pronouncing it right. I don't know if there is any representative here to correct me on it, but there is a new gabapentin extended release product that I will spend most of my time on. As stated earlier, I will briefly cover the other agents that are available for the neuropathic pain. So, we have the duloxetine or Cymbalta as we have just discussed, the gabapentin, which has been out for a long time and has been the long mainstay for this treatment, now the new gabapentin extended release, Gralise, and also the gabapentin we discussed for Restless Legs Syndrome was just approved not even a month ago for... also for neuropathic pain. So, there are two different brand name gabapentin products involved in this now; lidocaine patches and then the pregabalin, the Lyrica, which was discussed a little bit earlier. And all of these agents are FDA approved for the treatment of postherpetic neuralgia, with the exception of duloxetine, which is indicated for neuropathic pain associated with diabetic neuropathy. So, that is why it has got the other ICD-9 associated with it. Not too many head to head studies. One study, the postherpetic neuralgia were transitioned from gabapentin to the pregabalin. No significant difference was reported between the treatments with regard to pain based on a visual analog scale. Some patients required an increase in pregabalin dosage to improve the analgesic effect after transitioning from gabapentin. Moving on to discuss the gabapentin brand Gralise, which was recently approved for neuropathic pain. It is a new once a day formulation, similar to the Horizant. It is an antiepileptic drug in theory, but is approved for the management of postherpetic neuralgia. This new formulation of gabapentin is a gastroretentive tablet. Therefore, it swells in the gastric fluid in the upper gastrointestinal tract. It is not interchangeable with the other gabapentin products, so that the doses do not convert back and forth. FDA approval for this, for the Gralise, was based on an 11 week placebo control trial evaluating gabapentin 1800 mg once daily in 452 patients with diabetic peripheral neuropathy for at least six months. Results demonstrated that patients receiving gabapentin had significantly greater improvement in pain scales compared to placebo. No head-to-head trials with this formulation of gabapentin have been conducted. Current clinical guidelines recommend tricyclic antidepressants, gabapentin and pregabalin as first line of management. Other recommended second line therapies include topical lidocaine, particularly in the elderly, opioids and capsaicin. Guidelines do not distinguish or give preference to one specific formulation of gabapentin over another. The only black box warning is on Cymbalta and it relates to suicidal ideation. So, Cymbalta does have a black box warning. So, in conclusion, I think we find these therapeutically equivalent and that can be from the guidelines, I think they are all equivalent from a treatment standpoint.

3. Committee Discussion and Action

JOSEPH ADASHEK: I move we accept the guidelines and the therapeutic alternatives.

ADAM ZOLD, PHARM.D: I second.

CHAIRWOMAN NAGY: All in favor.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM.D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

CHAIRWOMAN NAGY: Motion approved.

4. Presentation of Recommendations for Preferred Drug List (PDL) inclusion

CARL JEFFERY, PHARM.D: So, our recommendation for the Preferred Drug List would include Cymbalta, Lyrica and generic regular release gabapentin. Considered non-preferred would be the new formulation of gabapentin, Gralise, the new formulation Horizant, Lidoderm and I will repeat those again. So considered preferred...

WELDON HAVINS, MD: Why don't you just give us the ones you suggest.

CARL JEFFERY, PHARM.D: Okay. So, consider preferred Cymbalta, Lyrica and the regular release gabapentin.

5. Committee Discussion and Approval of Drugs for Inclusion on the PDL

JOSEPH ADASHEK, MD: I move we accept the recommendations.

WELDON HAVINS, MD: Second.

CHAIRWOMAN NAGY: All in favor.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM.D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

KEVIN DESMOND, RPH: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

CHAIRWOMAN NAGY: Motion approved.

Moving on to diabetic agents now.

D. Diabetic Agent: DPP-4 Inhibitors and Combinations

1. Public Comment

BILL O'NEILL: Good afternoon. My name is Bill O'Neill. I am a pharmacist with Boehringer-Ingelheim. I just have a few public comments on Tradjenta and the combination of Metformin and Juentaducto. Just first, I want to compliment the P&T Meeting on a very thorough class review and the first statement I would just like to make is just one out of page 1, paragraph 2 of the review, which says that in general, the DPP-4 inhibitors are associated with a favorable side effect profile. We also have a weight neutral effect compared to other diabetic agents commonly used in the management of type II diabetes. The risk of hypoglycemia associated with DPP-4 inhibitors is low. In addition, the DPP-4 inhibitors have not been associated with the same increased risk of cardiovascular disease. So our first request is that we just continue to offer DPP-4s as an alternative for type II diabetes. There is a lot of literature, current literature, and specifically the article that was in the Clinical Journal of American Society of Nephrology that was published in 2010 entitled The Prevalence of Chronic Kidney Disease in US Adults with Undiagnosed Diabetes and Pre-Diabetes, and that study had suggested that 40% of patients with type II diabetes have some degree of renal impairment and so we think that is a pretty significant subcategory of your diabetic patients, and so I just wanted to direct you to another piece of your review in terms of paragraph 3 on the first page that says that single-entity linagliptin, which is Tradjenta is the only agent within the class that does not require renal or hepatic dosing. So, it has a simple 5 mg once a day dosing you can take regardless of meals and we do not have to adjust for any hepatic or renal issues. And so, we would recommend that if you are going to make any limitations in this class that you would consider that those products as one of the choices for that subpopulation. The only other request is that you notice on the PDL on Chapter 1 it was not there and I would hope that you would add that as Camille suggested as well. And, with that, unless there are any other questions.

MYLAN HAWKINS: Thank you. Again, this is Mylan Hawkins, State Executive Director of Nevada Diabetes Association. New medications have been showing to be greatly improving quality of life of people with diabetes, so we would urge you to take into consideration these new medications to help improve the quality of life, prevent the comorbidities and better control people who have diabetes. Thank you.

FRED MEISTER: Good afternoon. My name is Fred Meister. I am a Pharm.D. I am one of the regional medical directors for Merck, Sharp and Doehm and I would like to bring up a couple of the points to substantiate the efficacy and safety of our drug, Januvia, with or without Metformin. Seeing that this has already been reviewed very thoroughly and is already available on your primary drug formulary, I thought I would just hit a couple of points that I think would be worthy of mention today. One is it is indicated in type II diabetes only. It is not a first line drug, as are none of the drugs in this category. It is an add-on drug in those individuals who aren't therapeutic who have not achieved their goal for A1c. That typical first drug is by the way Metformin. When you look at the indications for this particular drug, it can be used in patients who are on insulin, type II diabetics on insulin. It can be used in conjunction with insulin. It can be used in conjunction with essentially every other category of anti-diabetic drug. Once again, it is add-on. It is not first line therapy but it is an adjunct to first line therapy. Obviously, this includes diet and exercise. The safety aspect of the drug; it has been brought up that some drugs don't require renal adjustment and other drugs do. Januvia has been used and studied in patients with impaired renal function. A study of 99 patients with mild, moderate and severe renal function all the way to the point of being on dialysis has been demonstrated and therefore the drug is appropriately used or not contraindicated in the comorbidity of renal impairment. Because the drug is excreted by way of kidneys like many other drugs are, it does have to be adjusted for varying degrees of renal insufficiency. This is a function of its pharmacokinetics and not a function of its toxicity to drugs. As we know, diabetics are the leading contributor to renal failure in the country and therefore, it wouldn't be a surprise then to say that patients on any of these drugs go on to develop renal failure all the way up to the point of dialysis. Another area that has been brought up is pancreatitis. Januvia has not been studied in pancreatitis as I believe most of the other drugs in this category have not either. There are reports of pancreatitis during therapy with Januvia with or without Metformin, which is not surprising seeing that in the normal population of diabetic type II patients, they frequently develop pancreatitis independent of the drug therapy, but the association has been made that most of these drugs have been associated with patients that develop pancreatitis that have not really demonstrated one way or the other that they are the contributing primary or just an incident bystander. In looking at the powerability of the drug, in most of the studies with each and every one of the other types of antihyperglycemic agents, there are only two of the other agents that have shown an increased incidence of hypoglycemia when Januvia is added and that is insulin and glipizide. It is sulfonylurea. None of the other drugs that have been tested with Januvia have had an increased incidence of the hypoglycemia no more so than the placebo, or the baseline therapy that the patient was already on. So, to emphasize the points above and beyond what you have seen in our review, I think it is important to know that Januvia has been the longest studied drug in this category. It has a very good safety profile. No drug is safe. They're all... they all have side effects and toxicities, but those have been covered in your review. The problem with renal impairment is not a function of the drug per se, but a function of adjusting the dose of the drug. With regard to pancreatitis, no one is really sure it is drug- related or just an associated factor. Powerability; patients have been able to tolerate it quite nicely considering the disease that they are being treated for. As I mentioned, there are only two situations in which these other individuals that have a slight increase and adverse effect and that is typically hypoglycemia when used in conjunction with insulin or used in conjunction with a sulfonylurea. For now, I thank you very much for giving me the opportunity to present this. If you have any questions, I will be happy to address them.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: I will continue on with the DPP-4 inhibitors, which we... were just discussed here, which include linagliptin, saxagliptin and sitagliptin, which are all available as single entity products as well as in combination usually with metformin except that when it has the simvastatin, the Juvisync. DPP-4 inhibitors are FDA approved indications as adjunct to diet and exercise, improved glycemic control in adult patients with type II diabetes. Overall, the medication class is significantly more effective compared to placebos in reducing glycosylated hemoglobin A1C, plasma

glucose and postprandial glucose with no major effect on body weight. Head to head trials with other antidiabetic agents are limited and not consistent in terms of superiority. Combination therapy with DPP-4 inhibitors and metformin consistently demonstrate superiority in improving glycemic outcomes over monotherapy with either the DPP-4 inhibitors or metformin. With regards to specific DPP-4 inhibitor agents, all single entity products are available for once daily dosing. Two fixed dose combination products contain metformin immediate release. That is the jentadueto and the sitagliptin, which is the Janumet, which are available for twice daily dosing. Two other fixed dose combinations have the extended release metformin as the Kombiglyze XR as well as the Janumet XR. According to current clinical guidelines for the management of type II diabetes, metformin remains the cornerstone for most anti-diabetic treatment regimens. Additionally, patients with high A1C will likely require triple therapy in order to achieve goals. The DPP-4 inhibitors are recommended as potential second line treatment options to be added to or in combination with metformin in patients not achieving glycemic goals. In some instances, they can be used as monotherapy, but again, metformin is usually the most appropriate choice. As far as safety, all the combination products with the metformin carry a black box warning because of the metformin... because of lactic acidosis. Whether or not that is clinically relevant or not, we can discuss. We have concluded that all of these products are therapeutically equivalent and all provide the same benefit clinically to the recipients.

3. Committee Discussion and Action

CHAIRWOMAN NAGY: Any comments? Questions? So, we need a motion for approval for this new drug classification.

WELDON HAVINS, MD: I move that all the drugs in this classification be considered therapeutically equivalent.

MICHAEL HAUTEKEET, RPH: Second.

CHAIRWOMAN NAGY: All in favor?

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM.D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Mike Aye.

CHAIRWOMAN NAGY: The motion is approved.

4. Presentation of Recommendations for Preferred Drug List (PDL)

CARL JEFFERY, PHARM.D: SXC recommends that we include all of these agents as preferred.

5. Committee Discussion and Approval of Drugs for Inclusion on the PDL

WELDON HAVINS, MD: I move that all of the agents be placed on the Preferred Drug List.

CONSTANCE KALINOWSKI, MD: Second.

CHAIRWOMAN NAGY: All in favor.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.
MICHAEL HAUTEKEET, RPH: Aye.
KEVIN DESMOND, RPH: Aye.
CHAIRWOMAN NAGY: Motion approved.

Moving on to established drug classes.

V. Established Drug Classes

A. Respiratory: Inhaled Corticosteroid/Beta-Adrenergic Combinations

1. Public Comment

FRED MEISTER: You may recognize me. I think I have been here before. I'm Fred Meister. I am one of the regional medical directors from Merck and I would like to discuss the aspects of Dulera, a combination beta 2 agonist and inhalation corticosteroid. The name of the drug is Dulera. It is indicated for individuals with asthma four years of age or over. The first thing I want to point out is that right under the name package insert is the black box warning. The black box warning has to do with an increased potential for asthma-related deaths associated with mometasone long-acting. It is a long-acting beta agonist, beta 2 agonist. This is extrapolated from a study done with the salbutamol in which there was a U.S. study in which there was an increased incidence. It was also stated that in children and adolescence, there was an increased incidence of hospitalizations in that particular age group. Like I stated, the black label warning, the black box warning is due to one study and one drug and the FDA considers all of these drugs to be equivalent in nature with regard to this adverse effect. According to the recent guidelines, the use of inhalational corticosteroids and beta 2 agonists while very well established, we know it is not first line therapy. First line therapy consists of inhalational corticosteroids. Individuals who need rescue from that typically will receive a short acting beta 2 agonist. So, when the individual needs more sustained activity, then that is when we will look at the combination of longer acting beta 2 agonists in combination with the corticosteroid. Studies have been done with Dulera in several... actually two studies are FDA approved. These individuals were studied for 12 weeks. At 26 weeks, a total of somewhat over 1,500 patients and both of these particular studies were a combination on the Dulera increased the ability of the individual to have FEV1 first expiratory volume greater than baseline and the incidence of adverse effect was no greater than in any of the other agents against which are studied and those other agents were drugs such as Advair. A single head to head comparison without Advair demonstrated not inferiority and therefore was accepted by the FDA as prudent. The actual Dulera patients in this particular study found a more rapid attainment of FEV1 when look at erroring under the curve for the first 12 hours, which showed that there was greater significance, quickness in the duration of efficacy in looking at FEV1 compared to that of Dulera. There is no one drug in this category that is preferred over any of the others according to the guidelines. There are no generic drugs that fall into this category. So, with that, I think that our ability, the safety and the efficacy has been shown to be at least comparable if not a little higher than or +/- than some of the other drugs that they have used in these particular studies. Now, I would like to ask you to consider adding this to your formula and I thank you for your time.

GREG PANCHO: Hi, my name is Greg Pancho. I am with Medline Pharmaceuticals. Thank you for letting me speak today. We just wanted to respectfully request if the Board would consider putting all strengths of generic albuterol onto the Nevada Medicaid PDL. Currently, only the full strength 2.5 mg albuterol is on the PDL, which is indicated for patients 12 years on up and there are two lower strength generic albuterol that is indicated for patients under 12 years of age and so, we would like to see if that could be added to the PDL please. Thanks.

CARL JEFFERY, PHARM.D: I think that is outside of the scope of discussion. Right now, we are discussing inhaled corticosteroid, beta adrenergic combinations, so I think in September, I think is when we will be talking about that.

GREG PANCHO: Okay, all right, thank you.

MARIA PEPPAGABBY: Hello. My name is Maria Peppagabby and I am a scientific manager with AstraZeneca and we have presented before the studies on Symbicort. Symbicort is already on the PDL and we just ask that you keep it on the PDL and just as a reminder, it is approved for both asthma and COPD. It also has a box warning and I just wanted to open it up for any questions that you may have on the product.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: As you may recall, this is a carry-over from last meeting, so it's a request for what kind of PA numbers we get for the Dulera and, you know, it is very few. We have a total of eight requests for this medication. That's quarter. So that is 90 days. So, not a great demand for this product. I can review real briefly. I think the previous presenters probably presented it as well for the Dulera, so I don't feel like reading that much since we presented it last month. But, again, it is the same recommendation as we feel these are all therapeutically equivalent.

3. Committee Discussion and Action

ADAM ZOLD, PHARM D: I motion that the three products are therapeutically equivalent.

WELDON HAVINS, MD: Second.

CHAIRWOMAN NAGY: All in favor?

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

CHAIRWOMAN NAGY: Motion approved.

4. Presentation of Recommendations for Preferred Drug List (PDL)

CARL JEFFERY, PHARM.D: So, our recommendation is to make them all considered preferred.

CHAIRWOMAN NAGY: Including Dulera?

CARL JEFFERY, PHARM.D: Dulera, Advair and Symbicort, all preferred.

5. Committee Discussion and Approval of Drugs for inclusion on the PDL

ADAM ZOLD, PHARM D: I motion to go with the approval for all three products.

WELDON HAVINS, MD: Second.

CHAIRWOMAN NAGY: Vote for approval. Reno.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

CHAIRWOMAN NAGY: Next: Respiratory: Intranasal Steroid Rhinitis Agents. Public comment?

B. Respiratory: Intranasal Steroid Rhinitis Agents

1. Public Comment

DEBORAH PROFANT: Good afternoon. I am Deborah Profant, one of the Medical Science Liaisons with Teva Pharmaceuticals. I did bring a sample in of the device, but I didn't realize there were people video-conferencing in. But, if you don't mind, I will pass this to the ones in this row. I don't know if that is allowed, or...Okay. So, I will just make a few quick comments. I am presenting on behalf of Teva Respiratory to introduce QNASL as a non-aqueous intranasal steroid with aero-stabilized HFA delivery. QNASL is indicated for treatment of nasal symptoms associated with seasonal and perennial allergic rhinitis in adults and adolescents 12 years or older. There was a recent allergy survey that revealed that many patients switched due to bothersome side effects and two-thirds of allergists surveyed indicated that patients asked to be switched from their current aqueous nasal spray due to these side effects such as a taste or dripping down the throat. So, QNASL is non-aqueous. It is based in ethanol. It may be a viable alternative for these patients that are dissatisfied with mainly the aqueous side effects. It is recognized that all of the intranasal steroids are considered kind of equally efficacious, so Teva's product here is just really based on product feature that it is a non-aqueous aerosol for patients. We have done three randomized double-blind placebo controlled clinical trials on over a thousand seasonal and perennial allergic rhinitis patients. The QNASL groups experienced statistically significant and clinically meaningful improvements and the patient reported total nasal symptom scores as well as quality of life scores as well as physician-rated scores. Additionally, the device does include a dose counter so the patient can keep track of their daily dosing. In terms of safety and tolerability, we have four of the placebo-controlled clinical trials on over 1,300 seasonal and perennial allergic rhinitis patients. Incidence of adverse events in the short-term studies was similar to a placebo and the most common adverse events are nasal discomfort, headache and nose bleed. Finally, you may recall that there were dry non-aerosol sprays available in the 1990's. These all were chlorofluorocarbon based and because of the ozone depletion controversy of those products, they were all removed from the market. So, this year, now, there are two nasal and one other product that is the dry aerosol for allergic rhinitis. So, we would just like you to consider the addition of QNASL for other non-aqueous patients so that allergists have the option to add this when a patient is not tolerating a wet aqueous nasal spray. Thank you.

CAROL ROSATI: Good afternoon. My name is Carol Rosati. I am the management market's area director for Sunovion Pharmaceuticals and I am here to ask you to consider another dry INS from your formulary. I want to thank Teva for providing an insight into the unmet need and also the fact that these were available prior to the Montreal Protocol and about 35% of the utilization before the Montreal Protocol was in a dry type INS formulation. So, Zetonna is the name of the product. It is indicated for treatment of symptoms associated with PAR and SAR. The reason why I say symptoms and not nasal symptoms is in our label we do have the ocular symptom indications. We did do studies in ocular SAR. Zetonna is the first and only dry preparation. It is once a day, one spray per nostril per day. So, that makes us very unique in that space. In summary, I just wanted to give you a few facts regarding the product and then if you have any additional questions, we do have information that can be forwarded to the panel and I would like to point out that all ISI important safety information in the class and with this drug are available on our website, Zetonna.com. So, basically, in summary, Zetonna through the clinical trials shows efficacy in SAR and PAR. We also show in studies the fact that it does work for the full 24 hours being once a day, one spray per nostril. We demonstrate improvement in ocular symptom scores and ocular symptom improvement as a part of our label. Adverse reactions for Zetonna were comparable to placebo in both short-term and long-term trials and we do also have patient satisfaction surveys where

Zetonna did report a high level of patient satisfaction with the dry type formulation. In addition, it is a low volume of spray and it is also in a dose counter. Ours is unique. We have both numbers and basically a stop light; red, yellow, green indicating when the medication is getting close to being out. There are 60 actuations per container and we also have some additional studies that we did that shows that 98% of the ciclesonide remains in the nasal cavity two minutes post administration and we took that out further at 10 minutes and it was about 81%, so you know that the medication is getting to where it needs to be. Zetonna also joins Omnaris. Omnaris is another INS agent, which is a dry. So, we have both the wet and dry in our product portfolio. If you have any additional questions, I could answer them now. Since we were just actually... we are being shipped to the wholesalers over the next two weeks, so we are not... we will be in the market very soon. We were approved last January. We are just getting to the market right now, but I would really like you to consider this as a dry option for your patients that need an INS.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: Okay, I am going to get going. With apologies to my last presenter, we actually don't have any clinical information on the Zetonna included in our review because we usually only include products that are commercially available at the time when we publicize these. So, I apologize. But it is still... I believe it is still up for the Committee to consider as preferred if that is your desire. I will quickly cover some of the intranasal corticosteroids. This is our existing class review already. So, I am not going to spend a lot of time on the new ones or on the old agents, but they all are indicated for the treatment of the allergic rhinitis, seasonal allergic rhinitis and some of the other ones are indicated for nasal polyps and some of the other... there are a few other indications. The new one that I will kind of focus on is the QNASL that we heard from the Teva manufacturer. It is the new beclomethasone product similar to some of the other beclomethasone products except it is a dry powder inhaler. It was recently approved by the FDA as the first intranasal corticosteroid formulated as a dry nasal aerosol. So, the head to head trials evaluating efficacy and safety of fluticasone, propionate demonstrated these agents are comparable with the other agents. One study in the treatment of fluticasone resulted in significantly less needs of blockage, nasal discharge and eye water and irritation compared to the treatment with beclomethasone. In the second study of fluticasone, patient rated nasal symptoms scored significantly better than beclomethasone in all times when measured; however, additional results of these studies reinforced that all of the intranasal corticosteroids should be considered equally efficacious. Sorry, technical difficulties. So, in conclusion with this class, intranasal corticosteroids are considered first line agents for the treatment of allergic rhinitis, especially for the patients with moderate to severe symptoms. Consensus guidelines do not recommend use of one intranasal corticosteroid product over another. All available intranasal corticosteroids have demonstrated safety and efficacy for their respective indications. Head to head trials have not consistently demonstrated clinically significant differences between the products. So, we consider them all equally effective. Now, I will remind the panel again too that we have not reviewed this because I don't have the documentation to show that it is equally effective as well.

WELDON HAVINS, MD: Do you have any objections to including them in the therapeutically equivalent?

CARL JEFFERY, PHARM.D: I honestly don't know enough other than what we just learned. I don't know enough about the product to make that judgment.

CHAIRWOMAN NAGY: So, when would next we review this?

GABE LITHER: It would be in the September meeting.

CHAIRWOMAN NAGY: September meeting. Any questions or discussion? Do I have a motion for equivalency clinical and therapeutic about this class of medication? A motion to approve.

3. Committee Discussion and Action

CONSTANCE KALINOWSKI, MD: I move to approve all of these meds therapeutically equivalent.
WELDON HAVINS, MD: Second.
CHAIRWOMAN: Motion vote for approval. Motion for approval.
WELDON HAVINS, MD: Aye.
ADAM ZOLD, PHARM D: Aye.
CHAIRWOMAN NAGY: Aye.
EVELYN CHU, PHARM.D: Aye.
RONALD SHOCKLEY, MD: Aye.
JOSEPH ADASHEK, MD: Aye.
CONSTANCE KALINOWSKI, MD: Aye.
MICHAEL HAUTEKEET, RPH: Aye.
KEVIN DESMOND, RPH: Aye.
CHAIRWOMAN NAGY: Motion approved.

4. Presentation of Recommendations for Preferred Drug List (PDL)

CARL JEFFERY, PHARM.D: Currently, the PDL lists fluticasone and Nasonex as preferred and we recommend to keep that as just the fluticasone and Nasonex as preferred.

5. Committee Discussion and Approval of Drugs for Inclusion on the PDL

WELDON HAVINS, MD: I vote that we consider, that we approve the two recommended drugs for the PDL.
ADAM ZOLD: I second.
CHAIRWOMAN NAGY: Motion for approval.
WELDON HAVINS, MD: Aye.
ADAM ZOLD, PHARM D: Aye.
CHAIRWOMAN NAGY: Aye.
EVELYN CHU, PHARM.D: Aye.
RONALD SHOCKLEY, MD: Aye.
JOSEPH ADASHEK, MD: Aye.
CONSTANCE KALINOWSKI, MD: Aye.
MICHAEL HAUTEKEET, RPH: Aye.
KEVIN DESMOND, RPH: Aye.
CHAIRWOMAN NAGY: Motion approved.

Moving to the next drug classification: Topical Androgenic Agents.

C. Topical Androgenic Agents

1. Public Comment

JOHN ROJAS: John Rojas with Eli Lilly speaking to you today about Axiron, which is topical testosterone. It sits in with a class of other topical testosterone, so the need is never... maybe not so much in the Medicaid space. I would say with knowledge it is a limited market of patients since Medicaid's typically have women and children. The 2010 guidelines recommend that testosterone is provided in as safe a way as possible. Each one of the topical testosterone carries with it a black box warning for the risk of transference between the agent to children or women who should not be receiving it. Axiron was established. Its clinical efficacy was established in a patient population of 155 patients over the course of

a 120 days. Patients were enrolled. They were started on the recommended dose of 60 mg. They came back after 15 days. They were assessed for whether or not they were below 350 ng/dL, which defines low and if they were, they increased the dose and if they were above 1,050 ng/dL, which is considered high, they were lowered. At the end of the study, 75% of patients on Axiron were at the 60 mg dose or two pump actuations a day. This is a very similar design and outcome that you have seen in other clinical testosterone. The pump goes into the top, which is a cup and the cup is a no-touch cup. It goes under the underarms. That is one difference. Testosterone has been around since 1953. The expectation of agents being different from one another is low. You would expect testosterone to do what it does, so the method and delivery is different in most agents. What may be different is something called equi-affected dosing. In our trial, we had 75% at the two pump actuations, or 60 mg a day. AndroGel 1.62%, 75% of those patients required... in order to get to normal levels required three pump actuations or four. And so the dosing per day can differ because they differ in solution and so you see that true with the packets for AndroGel 1% solution. It's according to their clinical trial 1-1/2 packets is the average weighted dose that is used, not the recommended the dose. So, the modal dose is not the story. It's this equi-affected dose that can be managed and investigated in terms of how to evaluate a commodity markets based off this. How much you need a day to get a patient to normal levels and I think you will see some differences there.

CHAIRWOMAN NAGY: Any comments?

RONALD SHOCKLEY, MD: I have a question. Is there any difference as that is a solution...

JOHN ROJAS: This is a solution. Milliliters is the unit of measurement.

RONALD SHOCKLEY, MD: Is there any difference as far as absorption compared to the gels?

JOHN ROJAS: So, It is not necessarily different. It is just in a little different location, underarm and axilla. Especially, if there is hair there. It can have different levels of absorption than the chest and arms, which is where AndroGel will go. If we are testing, we will have a different level of absorption on the legs and the thighs. So, it is difficult to say because they all work different... If it is not effective by its user is important to know.

BEN STOVALL: Hi, my name is Ben Stovall. I am a pharmacist. I am with clinical evidence and outcomes group at Abbott Labs. I am here today to speak about AndroGel to the Committee and I encourage the Committee to review the full PI for AndroGel for comprehensive safety and efficacy information. AndroGel 1% and 1.62% are FDA approved for replacement therapy in adult males for conditions associated with primary and secondary hypogonadism. Administration for AndroGel 1.62% is different than 1% and the two are not interchangeable. Today, the data I will review is specifically for AndroGel 1.62%. It is an odorless testosterone gel. 1.62% has increased viscosity and provides patients the opportunity to reduce its total mass of the gel by first dosage. The recommended starting dose for AndroGel is two pump actuations applied topically once daily in the morning to clean, dry intact skin of the shoulders and upper arms only. Serum testosterone levels should be measured and dosage adjustments to achieve normal testosterone levels in these patients similar to other agents. A pivotal trial evaluated efficacy for AndroGel on 274 hypogonadal men. All eligible patients received AndroGel or placebo once daily and had periodic withdrawals during the assessment throughout the study period. In patients treated with AndroGel, 82% of the patients had a mean testosterone level within the normal range a day of 112 meeting the primary end point. 191 of these patients continued in the open label treatment for an additional 182 days. And now for safety; AndroGel produced similar box warnings as stated before for secondary exposure as reported in children. The most common side effect reported is increased PSA, emotional liability, hypertension, increased red blood cell count and contact dermatitis. Application site reactions were reported in 1% of patients. None of these discontinuation occurred due to application site reactions. Lastly, I request the Committee to consider the Endocrine Society Guidelines for testosterone therapy, which recommends patient preference, and treatment be taken into consideration when initiating therapy as it may give more opportunity for compliance in this population. In conclusion, AndroGel is FDA approved for testosterone therapy in adult males for primary and secondary hypogonadism. Now, AndroGel 1.62% is available. It is a low volume testosterone gel. The

pivotal study that I talked about before demonstrated normal testosterone levels in 82% of patients have favorable safety profile. After treatment out to one year, application site reactions, abnormal lab tests and prostatic disorder, the most common ADs experienced in patients. AndroGel has demonstrated the ability to manage the symptoms of hypogonadism in males and remains the most widely prescribed treatment. So, we respectfully request the Committee today maintain a preferred status listing for AndroGel 1.62%. I want to thank everybody for their time. Any questions?

CHAIRMAN NAGY: Thank you. Any questions?

UNKNOWN VOICE: I have a question. When do you typically check levels after initiation treatment.

BEN STOVALL: I usually check a couple of weeks after they have been started on a dosage or lower change dose.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: The new drug that is out here that wasn't reviewed before was the Fortesta, which is similar to the other ones. It is another. The testosterone products that we will talk about briefly is the Androderm, AndroGel, the Axiron, the Fortesta and... All of these products are approved by the FDA for testosterone replacement therapy in males with primary hypogonadism, congenital or acquired and hypogonadotropic hypogonadism congenital or acquired. There are a few different factors between the topical testosterone products with the exception of the formulation of the site of administration. So, as we discussed, the Axiron is underarms, the Fortesta is on the thighs and the AndroGel is on the upper chest. All are available in gel preparations and the Axiron is formulation as the topical solution. These products are available as metered dose pumps and single use tubes that are applied once daily. No studies are available to evaluate the Axiron or Fortesta compared to other androgens or topical testosterone products. The studies all showed that they were safe and effective at increasing the level of testosterone in men who were receiving them. To repeat, there is a black box warning with the topical agents for the risk of transference to children or women. We feel they are all therapeutically equivalent.

3. Committee Discussion and Action

JOSEPH ADASHEK, MD: I vote they are all therapeutically equivalent, Adashek.

ADAM ZOLD, PHARM D: I second.

CHAIRWOMAN NAGY: All in favor?

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

The Motion Carries

4. Presentation of Recommendations for Preferred Drug List (PDL) Inclusion

CARL JEFFERY, PHARM.D: So currently, we have Androderm and AndroGel as listed as preferred and we think that it should just be continued that, the same, the Androderm and Androgel as preferred.

5. Committee Discussion and Approval of Drugs for inclusion on the PDL

WELDON HAVINS, MD: I move that we maintain on the PDL list Androderm and AndroGel.

CONSTANCE KALINOWSKI, MD: I second.

CHAIRWOMAN NAGY: All in favor?

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

D. Anticonvulsants – Benzodiazepines

1. Public Comment

DR JANE - SENIOR MEDICAL SCIENCE LIAISON: Good afternoon. I am Dr. Jane (inaudible). I am a senior medical science liaison with Lundbeck and I am here today to share some highlights on the newest benzodiazepine anticonvulsant clobazam, or Onfi. Onfi was approved last year by the FDA for the adjunctive treatment of seizures associated with Lennox-Gastaut Syndrome in patients two years of age or older. As such, it did receive Orphan Drug Designation. LGS is a catastrophic epilepsy that is usually diagnosed early in childhood and is characterized by a triad of symptoms. These include multiple seizure types, which are often refractory to most treatments, developmental delays, mental retardation and a classic EEG pattern with slow spike waves. That EEG pattern changes frequently as patients grow into adulthood and may disappear altogether. Despite that fact, the seizures do persist into adulthood. One 16 year longitudinal study of LGS patients demonstrated that 92% of patients continue to have severe seizures into adulthood and of the LGS patients, only 35% of them are able to work usually in a sheltered workshop or some type of assisted living. Fifty-three percent are in custodial care and are either institutionalized or at home with a supported living situation. Seizure control really correlates well with ability to function for these patients. Of the 12 patients in the study who were actually able to be employed, five of them were completely seizure-free and the rest had sufficient seizure control so that they could manage to function in a normal work situation. Onfi was approved on the basis of the largest ever control trial done in Lennox-Gastaut Syndrome. There were 238 patients in the study ages 2-54 years of age. All of them were on one to three other anti-epileptic drugs and had not had control, and therefore were enrolled in this study. By way of framing this, the average number of seizures per week prior to admission to the study was 86. That is per week. The range was from two up to over a thousand. In this group of patients, the mean reduction in weekly seizure drops seizure frequency was 68%. Now, drop seizures are the ones that cause people to wear helmets... that cause people to fall to hit their heads. Okay, so those are the ones that tend to interfere with quality of life to the greatest extent. Twenty-five percent of the patients in this study in the high dose group had a 100% reduction in the rate of drop seizures. In addition, patients in this study had a 65% reduction in all seizure types. An interim analysis of an open label extension study from this study showed that 80% of patients continued to receive Onfi and continued to receive benefit in terms of seizure control. In fact, about 80% of these patients had a 50% or greater reduction in the number of seizures for a period of up to two years. It did not matter what the age of the patients were. Efficacy was similar across all age groups. Although classified as a benzodiazepine, Onfi is a 15, hence the name Onfi, versus the 14 benzodiazepine. So, it is structurally dissimilar. Although clinical data is somewhat unclear at this time, preclinical data suggests that clobazam may bind to a different site on the GABA receptor. It is a partial agonist and also it is preferential for the alpha2 versus the alpha1 subunit on the GABA receptor. This may account for the observed differences that we see where there is less sedation and less tolerance. So, in conclusion, while we know that Nevada has been very open to

having all anticonvulsants available to the citizens of Nevada, we would like to ask based on the proven efficacy and the orphan drug status that you give strong consideration to add clobazam to the PDL list.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: First I want to point out, the NRS lists, identifies that, and I will read it here, except as otherwise provided in the subsection, a list of preferred prescription drugs established pursuant to the subsection I must include without limitation every therapeutic prescription drug that is classified as an anticonvulsant medication or anti-diabetic medication that was covered by the Medicaid program on June 30, 2010. If a therapeutic prescription drug that is included on the list of preferred prescription drugs, pursuant to this subsection, is prescribed for clinical indication other than the indication for which it was approved as of June 30, 2010, the Committee shall review that new clinical indication for that drug pursuant to the provisions of subsection 5. Essentially, I will let Gabe, the attorney, back me up. Essentially, that means a drug that comes out after June 30, 2010 can be subject to considered not preferred.

GABE LITHER: Right, or that the evidence grandfathered in after that date is subject to the same.

CARL JEFFERY, PHARM.D: Okay, I wanted to get that out so the public hears it and the board members here for that rule. Getting back into...

CHAIRWOMAN NAGY: I have a question? Grandfathered means the drugs which are already on the PDL?

CARL JEFFERY, PHARM.D: The drugs that Medicaid covered on June 30, 2010 must always be considered preferred.

GABE LITHER: Not all the drugs. The drugs classifications, the...

CARL JEFFERY, PHARM.D: For those indications. For example, the Neurontin products. I don't know if we can go into this, but...

CHAIRWOMAN NAGY: As described at that time?

CARL JEFFERY, PHARM.D: Yeah, exactly. So, with the therapeutic class review, the anticonvulsants, the benzodiazepines, the current class has been out for a long time. The new one as talked about before was the Onfi. It has been available in Europe for a long time and was just recently introduced into the US for the indication for the Lennox-Gastaut indication. Currently, that is its only indication. The clobazam, which is Onfi, may be associated with less sedation compared with some of the other benzodiazepines, although it is recommended for various types of seizures with the guidelines. It is used in the United States, limit to the Lennox-Gastaut Syndrome. Also, that is the only indication for the medication. The other medication indicated for the other benzodiazepine indicated for the Lennox-Gastaut is also clonazepam, the Klonopin, which has been available for a long time. Clobazam was compared with placebo on patients two to sixty years of age with Lennox-Gastaut Syndrome. Following 12 weeks of treatment with clobazam, all three doses, 0.25, 0.5 and 1 mg/kg significantly decreased the weekly drop seizure rate compared to placebo. In addition, weekly totals of non-drop seizure rates decreased with clobazam. Patients receiving clobazam also experienced higher responded rate, greater than 50% decrease in average weekly seizure rate compared to patients receiving placebo. Study by "Conroy", the number of drop seizures per week was significantly reduced from baseline for patients receiving low dose and high dose clobazam. The mean drop seizure rate was reduced from baseline in both treatment groups. The clobazam was approved by the FDA in October of 2011 and its only indication is adjunctive treatment for seizure disorder associated with Lennox-Gastaut Syndrome despite being studied throughout Europe for various other forms of epilepsy. Globazam may be associated with less sedation compared to the other benzodiazepines. Globazam is recognized as the effective treatment usually for use in refractory diseases when first line treatments are ineffective or not tolerated. For the treatment of Lennox-Gastaut specifically, sodium valproate should

be offered first line with lamotrigine offered as adjunctive therapy if sodium valproate is ineffective or not tolerated. So given that, we find that not all of the products are equally effective within this class for their approved indications.

CHAIRWOMAN NAGY: Thank you. Discussion? Comments?

CONSTANCE KALINOWSKI, MD: What is the prevalence of Lennox-Gastaut? It is quite rare isn't it.

CARL JEFFERY, PHARM.D: It is quite rare. Yeah... I don't...

CONSTANCE KALINOWSKI: in Nevada.

CARL JEFFERY, PHARM.D: We ran the numbers. We have had... Let me find them again. So, when a drug comes out, it is automatically considered non-preferred and so, we have received in the past 90 days four requests for this medication. So, in all of Nevada, we have received four requests, and they have all been approved.

3. Committee Discussion and Action

CHAIRWOMAN NAGY: Motion to consider these agents therapeutically interchangeable.

WELDON HAVINS, MD: Second.

CHAIRWOMAN NAGY: Vote for approval.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

CHAIRWOMAN NAGY: Motion carried.

4. Presentation of Recommendations for Preferred Drug List (PDL) Inclusion

CARL JEFFERY, PHARM.D: So, currently we have Clonazepam, Diastat, Diazepam, Klonopin and Valium listed as preferred agents and we recommend keep it the same considering Onfi is not first line therapy for most seizure therapy.

5. Committee Discussion and Approval of Drugs for Inclusion on the PDL

WELDON HAVINS, MD: I move that we keep the PDLs in this category the same.

CHAIRWOMAN NAGY: Second. All in favor.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

CHAIRWOMAN NAGY: Motion approved.

Next drug class: Ophthalmic Glaucoma Agents – Prostaglandins.

E. Ophthalmic Glaucoma Agents – Prostaglandins

1. Public Comment

None.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: So, this again is an existing drug class with a new addition of Zioptan. These are the prostaglandin analogs for ophthalmic use to treat glaucoma. There are currently four ophthalmic prostaglandin analogs approved by the FDA, which include bimatoprost (Lumigan), latanoprost (Xalatan), the new one tafluprost (Zioptan) and travoprost (Xalatan Z), none of them easy to pronounce. The tafluprost, the newest of the prostaglandin analogs was approved by the FDA as the only agent in the class that is formulated to be preservative-free. That was before ophthalmic prostaglandin analogs. Bimatoprost appears to be the greatest efficacy in reducing intraocular pressure. However, studies have not consistently demonstrated a difference in intraocular pressure reduction between travoprost and latanoprost. Available studies suggest the newest agent, tafluprost, may have similar efficacy to the latanoprost but may be less effective when compared to travoprost. So that is confusing. In one study, there was no difference in the reduction of intraocular pressure from baseline between the tafluprost and the travoprost following six weeks of treatment. There are a lot of words here that just say that it's equally effective with all of the other ones. So, our recommendation is that they all be considered equally effective.

3. Committee Discussion and Action

WELDON HAVINS, MD: I move they all be considered therapeutically equivalent.

MICHAEL HAUTEKEET, RPH: Second.

CHAIRWOMAN NAGY: Vote for approval.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye.

4. Presentation of Recommendations for Preferred Drug List (PDL) Inclusion

CARL JEFFERY, PHARM.D: We have got the latanoprost and travatan Z as considered preferred and we recommend to add Zioptan, the new prostaglandin, to that list as well in keeping the other two.

WELDON HAVINS: But not Lumigan?

CARL JEFFERY, PHARM.D: Right. Yes.

WELDON HAVINS: And the reason?

CARL JEFFERY, PHARM.D: It is in the best interest of the State.

5. Committee Discussion and Approval of Drugs for inclusion on the PDL

WELDON HAVINS, MD: I move that we include latanoprost, tafluprost and and travoprost, is that Xalatan... Xalatan and Travatan Z in the PDL.

CARL JEFFERY, PHARM.D: Right, the generic form of the Xalatan.

CHAIRWOMAN NAGY: Second. All in favor.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye

F. Platelet Aggregation Inhibitors

1. Public Comment

JOHN ROJAS: Hi, I am John Rojas again for Eli Lilly here to speak about Effient, or prasugrel. Effient carries with it a black box warning for bleed risk in patients who are under 60 kilograms over age 75 or had a prior TIA or stroke. It ends up being a very important triage in terms of how clinicians have guided their care around that black box warning. We are finding that after three years post marketing, they are using that to deal with the risk, the minimum risk. In terms of essential need, clopidogrel in PCI patients, there is a tremendous amount of uncertainty with clopidogrel, about a 30% nonresponse rate. There are several reasons. The first is that only 10-15% of the actual drug becomes active. Our genetic alleles are varied. Patients who have an inability to convert that remaining 10-15% to active drug, that's 30% of Caucasians, 40% of African-Americans and 50% of Asian Americans who have at least one allele that doesn't allow them to use clopidogrel. Also, there have been associations in black box warnings printed about clopidogrel with PPIs including over-the-counter omeprazole. It is very difficult to manage at a playing level. Comorbidities such as diabetes also can reduce your ability to use clopidogrel. The cost of discovering those patients, who they are, who are the 30%, and who are the 70% that respond can be quite burdensome. According to the GRAVITAS Study, lowering the dose of clopidogrel does not overcome these challenges. The PCI space is about 12% of the existing for clinical market space. We currently occupy only 10% of that, which is to say only 1% of current products use is prasugrel, so the risk is known in long-terms of the now generically available clopidogrel. The advocacy of that... the main risks of these two drugs are not equivalent from our clinical trial starting a head-to-head study with Plavix. The adequate dose of Plavix over the course of 15 weeks, 13,600 new patients showing a clear difference in real outcomes. The mean outcomes were cardiovascular death, MI, stroke. The primary end point in this study was in favor of prasugrel, 19% risk production overall and that includes those patients who are now considered high risk and typically do not receive the medicine. NSAID patients, diabetes subcategory patients 30 day, post 30 day and stent thrombosis category. There were relatively risk reductions that were statistically and clinically meaningful in terms of the primary outcome driven again by

myocardial infarction. In the US patient populations, actually the results were identical. The 19% noted risk reduction, with relatively low event, but 2% of patients on clopidogrel have a stent closure and only 1% of prasugrel patients have stent closure. Most recently there was a patient study of 10,000 possible patients. Very few were over the age of 75 or less than 60 kilograms or had a prior TIA or stroke. So, there were a few kinds. We showed actually... the risk of bleed did not manifest in the real world... that there was numerically less bleeding than we have encountered through propensity score matching to make sure that we are talking about apples and apples in both matching through propensity scoring and regression and decided these were the same patient populations in a retrospective very disciplined review showing that there is no difference in bleed. Length of stay was actually lower in the hospital setting with Effient. So, in summary, we have been able to show clinical superiority in clinical trial with real health outcomes showing real world patient differences and failure to manage the risk known and in light of the uncertainly known with existing clopidogrel. We ask that you entertain the current PA status, which is all based on no PA required if you have a certain ICD9 code for the PCI space.

SCOTT ANDERSEN: Good afternoon, everyone. My name is Scott Andersen. I work for Medical Affairs at AstraZeneca and I am going to be giving testimony today on AstraZeneca's Brilinta, or the generic name is ticagrelor. Brilinta is indicated to reduce the rate of thrombotic cardiovascular events in patients with acute coronary syndrome. So, that includes unstable angina. It is important to know that this approval goes as a dual anticoagulate indication with aspirin at doses of less than 100 mg. Brilinta is shown in clinical trials to reduce the rate of a combined end point of CV death, myocardial infarction or stroke with the overall results in those trials being driven by both CV death and myocardial infarction. In patients treated with PCI that were stented, Brilinta is also shown to reduce the rate of stent thrombosis. There are a couple of contraindications; those patients that have a history of intracranial hemorrhage, active pathologic bleeding or severe hepatic impairment. Over the last year, three major cardiovascular associations have updated their guidelines on ACS patient populations. Brilinta has been added as a Class I recommendation for the management of patients that have ACS with stenting. In one of those guidelines, the ACCP guidelines, Brilinta has been added also as a treatment option when given with low dose aspirin in those patients with ACS with or without stenting. So, ACS patients can be followed up with PCI procedures and stenting. They can be medically managed or surgically managed and Brilinta has been studied in all of those different follow-up settings. The ACCP Guidelines have actually suggested the use of Brilinta over clopidogrel. The main clinical trial that led to the approval of Brilinta is the study called PLATO. In the PLATO study, Brilinta was compared directly to clopidogrel in over 18,000 patients and the primary composite end point was timed first occurrence of a CV death, MI or stroke. At 12 months, there was a statistically significant reduction in the composite end points and that was driven by a 16% reduction in myocardial infarction and a 21% reduction in cardiovascular death with no appreciable differences in stroke between the two compounds. Brilinta is currently the only anti-platelet FDA approved that demonstrates significant reductions in CV death versus clopidogrel as a stand alone end point. It is important to know that higher doses of aspirin do not have established benefit in the ACS setting and that there is a strong suggestion that the use of such doses with Brilinta limit its effectiveness. So, again, I will reiterate that if Brilinta is chosen for a patient at a low-dose aspirin, less than 100 mg should be recommended as well. Adverse reactions in the PLATO study: The PLATO defined major bleeding rates were similar amongst the two groups, Brilinta and clopidogrel. If we break that down into different categories, non-CABG related bleeding was higher in the Brilinta group and the most commonly reported adverse reactions in this study were bleeding and dyspnea. So, with that, I would like to request that Brilinta remains as part... I believe it is on a temporary... that it is temporarily available but be added to the PDR on a more permanent basis. I would be happy to entertain any questions.

CHAIRMAN NAGY: It's temporary available.

CARL JEFFERY, PHARM.D: No. When a new drug comes into an established class, it automatically falls to the non-preferred status. So, currently, its... its considered non-preferred. It has not been reviewed. It has not been reviewed yet.

CHAIRMAN NAGY: How long has it been on the market?

SCOTT ANDERSEN: So just under a year here in the U.S. So, eleven months.

CHAIRMAN NAGY: And Europe...

SCOTT ANDERSEN: Europe before that, correct.

CHAIRMAN NAGY: How long there?

SCOTT ANDERSEN: Oh, let's see. Uh... January, must be 18-19 months total time from first approval.

DR. : Good afternoon. My name Chris "Myatt". I am a local interventional cardiologist here in Las Vegas. I have been asked by AstraZeneca to be at your disposal if you have any clinical questions on why an interventional cardiologist would choose one or another anti-platelet agent. If you have no questions, I can give you a brief synopsis.

WELDON HAVINS, MD: Yeah, I have a question. Which one would you chose?

DR. MYATT: Brilinta. Brilinta is the only anti-platelet agent that has been shown to reduce absolute mortality in the setting of acute coronary syndrome compared to standard of care products. For the last 12 years, Plavix has been the unrivaled standard of care in acute coronary syndrome since its approval and in the PLATO trial there was an absolute reduction of 1.4% in absolute mortality. That means if you treat 1,000 patients, you will save 14 lives. We see many acute coronary syndrome patients and that is not an unreasonable number to reach a thousand patients in a matter of a couple of months for cardiologists.

CHAIRMAN NAGY: It seems like a very promising drug.

DR. MYATT: Yes. Let me put that into historical perspective for you. The 22% reduction in absolute mortality is of the same magnitude as giving an aspirin for an acute MI and that was data from the ISIS-2 a quarter of a century ago before they gave beta blockers, statins, ACE inhibitors or Plavix. If you given an aspirin for a heart attack, that is the magnitude of benefit you will get. If you give streptokinase for an MI, that is the magnitude of death benefit you will get. If you give a TPA over streptokinase, that is the same magnitude you will get. I believe if you ask most interventional cardiologists what they would want for their own heart attack, they would say they would want direct angioplasty instead of TPA or thrombolysis for their heart attack. Yes, the reduction in the only randomized largest trial for angioplasty versus thrombolysis, the absolute reduction mortality is 1.3% at 30 days. That is a 30 day reduction. That is not as impressive as a 1.4% reduction at 12 months. It would be unheard of to not have this drug available to your Nevada state citizens.

2. Drug Class Review Presentation – SXC Health Solutions

CARL JEFFERY, PHARM.D: Yeah. So, I appreciate it doctor. It was a good review and it is a good thing I agree with him. To give a brief overview of the platelet inhibitors for cardiovascular, cerebrovascular and peripheral vascular diseases. Use of these agents is both monotherapy, combination therapy by national and international clinical guidelines as based on the clinical indications for the patient's risk of thrombotic events. I am going to turn this up. The newest one, which is the Brilinta, which was introduced, it has not been reviewed it. It works in a similar manner as the other ones. What makes it different is it is not a pro drug. It doesn't have to be converted, so it does not require the enzymatic conversion to become pharmacologically active. It is not subject to the potential drug interactions associated with the other platelet inhibitors. Also, it is administered twice a day, so if there is a downfall to it, that's... that would be it. When compared to clopidogrel, Brilinta resulted in lower platelet receptor expression and a greater extent of the incubation of the platelet aggregation suggesting increased potency at the P2Y12 receptor. When you look at the whole class, the only one with the black box warning including the Plavix, is the clopidogrel. Guidelines still recommend as stated the Brilinta by far. It shows it's more effective than the Plavix. Based on that data, I mean we have the options as far as

clinically equivalence, I think the physicians have their options. I think you could make the argument if they are clinically equivalent or not, but for the purpose of this discussion, we all love doing this as equivalent.

3. Committee Discussion and Action

ADAM ZOLD, PHARM D.: I motion to consider all therapeutically equivalent.

WELDON HAVINS, MD: Second.

CHAIRWOMAN NAGY: Approval voting.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye

CHAIRWOMAN NAGY: Motion approved. So, drug for inclusion.

4. Presentation of Recommendations for Preferred Drug List (PDL)

CARL JEFFERY, PHARM.D: So, we are going to recommend some changes here. Currently, Aggrenox, aspirin dipyridamole and Plavix are considered preferred and we would like to in addition keep Aggrenox. We would add Anagrelide, keep aspirin, keep the dipyridamole, add the cilostazol, ticlopidine and clopidogrel, and Brilinta as preferred. So, essentially it is easier to see the nonpreferred list, which is the brand Plavix since the generic is available now and Effient. I am sorry, those are the non-preferred drugs. Do you want me to repeat what we said is preferred. So, as preferred, we are recommending Aggrenox, Anagrelide, aspirin, Dipyridamole, cilostazol, ticlopidine, clopidogrel, and Brilinta.

5. Committee Discussion and Approval of Drugs for Inclusion on the PDL

WELDON HAVINS, MD: I move those be included in the PDL list.

JOSEPH ADASHEK, MD: Second Adashek.

CHAIRWOMAN NAGY: Motion for approval.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye

CHAIRWOMAN NAGY: Motion approved.

VI. Report by SXC on New Drugs to Market, New Generic Drugs to Market, and New Line Extensions

CARL JEFFERY, PHARM.D: Okay. We are on the home stretch. In the back of your binders, there is the... it's got a sheet that lists out some of the new products that are coming to market and indications. I would like to just point out a few of those changes here. I'm going to get my notes out. There are highlights. There is a newer one out from June, but this is a May's report that is out. Some of the changes as we just finished discussing is that clopidogrel is now available generically. I think this will definitely have some impact on the State here. The other one that is going to be available very shortly is the Requip XL, actually 23 on the market now. A couple of other highlight things that may be an impact for the State in the coming months: As you may be aware, the FDA has mandated that there is no acetaminophen containing product that has more than 325 mg of acetaminophen per tablet and that goes into effect January of 2014. As a response to that, Abbott Labs has introduced a Vicodin ES and HP that will have the 5 mg and 300 mg of acetaminophen in the 7.5 and the 300s. So, all of them have the 300 mg of the acetaminophen. I think this will have an impact on the State because I think they will be brand only for a while. So, on the basis...

CHAIRWOMAN NAGY: Did they give a reason for doing this?

CARL JEFFERY, PHARM.D: Toxicity with the acetaminophen. Some of the other new drugs that are coming out is the one I am sure we will talk about shortly is we had a good discussion last month for our last meeting about stroke and the Xarelto competitors, but there is a new one, Eliquis that is coming out by Bristol Myers that is going to be out. It is supposed to be out today according to my list. So, this will be something we discuss in the future and again this will probably be in September's meeting when we discuss this. Just a few more, the Zohydro. There is a new formulation of the hydrocodone alone that is coming out. It is will be a schedule 2 product with no acetaminophen containing products. I think at one point 30 years ago, it was available. But, this will be an extended release version. Just a few more to call out. There is also a... I did not see the note on here but there is also a combination product of morphine/oxycodone that will be coming out shortly that I think may be an impact to the State or ... many of these aren't branded products so they are at cost when there are generic alternatives available. Those as they come out will be reviewed here as well. That is it for my review of what is in the pipeline and what is going to be generic.

VII. Review of Next Meeting Location, Date, and Time

CARL JEFFERY, PHARM.D: So, September and... Right now we are scheduling a new location that won't be here. It will be over... I think it is the Department of Health Building. It is over on Charleston and I can't remember the cross street.

CARL JEFFERY, PHARM.D: I will give you the address so we know where it is. I hope it is okay. I hope the weather is okay then. But, the address is 3111 West Charleston and right now the meeting is scheduled for July 26. I'm sorry, not July. I am looking at the wrong month, September 27.

COLEEN LAWRENCE: September 27. And then Madam Chair I would like to kind of remind everybody about that next meeting, if that is okay?

CHAIRWOMAN NAGY: Yes, of course.

COLEEN LAWRENCE: Thank you. For our public, this is by statute our annual review of the Preferred Drug List and for those of you who have not been with us the last nine years. Oh, that is a long time. The Preferred Drug List, we have a set way that we do this annual review, so when you see this agenda, it will be a little bit different than in our quarterly agendas. We break it down into two main sections. The one section... Excuse me, the second section will be a chunk of classes and those are classes that we will recommend to the Board that we do not need to break down and go through each review of the sections of the drugs. Especially for your new Board members because for example, there will be class and a drug that we just reviewed today and so we don't need to review them in another couple of months. Um... the other section of drugs are classes of drugs that will be re-reviewed and there are three main reasons that we review

them at the annual review. The first reason is because if something, there is a new drug that has come into that class, I mean indication for a drug, new safety reasons have come forward, something has changed within a drug or from that class that needs to be re-reviewed for that class. The second reason is that it is for the best interest of the State for which it is being reviewed. And, the third reason is one of the Committee members has asked for us to review it at the annual review. They could ask us at any time within the year to hold the review and to ask us to review it at the annual review and so we may have reviewed it. Typically, we don't have this list of them. It may... it is only probably the last few months and they ask us to hold it and to review it at the annual review. Okay, so those are the three main reasons why we put those drugs of classes to review on that section of the agenda. So, for those of you who are new and have not ever been through an annual review, schedule lots of time to be with us because it is a very lengthy meeting and our goal is to get it done in one day. Unfortunately, the last time we had to put it off to the second meeting, but our goal is to always have it done in one meeting and that is it.

VIII. Public Comment

IX. Adjournment

CHAIRWOMAN NAGY: Do I have a motion for adjournment.

WELDON HAVINS, MD: Move we adjourn.

UNKNOWN VOICE: Second

CHAIRWOMAN NAGY: All in favor.

WELDON HAVINS, MD: Aye.

ADAM ZOLD, PHARM D: Aye.

CHAIRWOMAN NAGY: Aye.

EVELYN CHU, PHARM.D: Aye.

RONALD SHOCKLEY, MD: Aye.

JOSEPH ADASHEK, MD: Aye.

CONSTANCE KALINOWSKI, MD: Aye.

MICHAEL HAUTEKEET, RPH: Aye.

KEVIN DESMOND, RPH: Aye

CHAIRWOMAN NAGY: Meeting adjourned. Thank you everybody.

Meeting adjourned at 3:14 PM.