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## **Nevada Medicaid Pharmacy and Therapeutics Meeting Minutes**

The Division of Health Care Financing and Policy (DHCFP) Pharmacy and Therapeutics Committee held a public meeting on **December 3, 2015**, beginning at **1:00 p.m.** at the following location:

**JW Marriott – Las Vegas  
Marbella Room  
221 N Rampart Blvd  
Las Vegas, NV 89145  
702-869-7777**

### **Board Members Present:**

Mark Decerbo, Pharm.D.; Shamim Nagy, MD; Weldon Havins, MD; Joseph Adashek, MD; Adam Zold, Pharm.D. Evelyn Chu, Pharm.D.; David Fluitt, RPh

### **Board Members Absent:**

Bill Evans, MD; Mike Hautekeet, RPh

### **Others Present:**

#### **DHCFP:**

Mary Griffith, RN, Pharmacy Services Specialist; Gabe Lither, Deputy Attorney General;

#### **HPES:**

Beth Slamowitz, Pharm.D.

#### **Optum:**

Carl Jeffery, Pharm.D., Kevin Whittington, RPh; Daniel Medina (via teleconference)

#### **Others:**

Sandy Sierawsky, Pfizer; Bret Ferguson, Pfizer; Gina Soto, Alkermes; Gergg Gittus, Alkermes; Yumi Yamamoto, Alkermes; Corinne Glock, Relypsa; Kerry Kostman Bonilla, AstraZeneca; Jin Yun, AsterZeneca;

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Bob Gustafson, Lundbeck; David Kogan, Jennifer Lauper, BMS; Chriss Conner, BMS; Phil Walsh, Sunovian; Samantha Min, Otsuka; Krystal Joy, Otsuka; Melissa Walsh, Novartis; Charissa Anne, J&J; Marykay Queener, J&J; Lovel Robinson, Abbvie; Sal Lofaso, Horizon; Sean McGarr, Allergan; Aimee Redhair, UCB

**Others via teleconference:**

Lori Howarth, Bayer; Jean Ritter, VCG; Ron Dunbar, Prescription Alliance; Rebecca Vernon-Ritter, DHCFP; David Large, Supernus; Jeff Cameron, Dyax; Jeanette Belz; Lea Cartwright; Lisa Wilson, Biogen

**AGENDA**

**1. Call to Order and Roll Call**

Meeting called to order at 1:02 PM.

Roll Call:

David Fluitt

Evelyn Chu

Weldon Havins

Mark Decerbo

Gabe Lither, Deputy Attorney General

Shamim Nagy, Chairwoman

Mary Griffith, DHCFP

Beth Slamowitz, HPE

Adam Zold

Kevin Whittington, Optum

Carl Jeffery, Optum

**2. Public Comment**

Shamim Nagy, Chairwoman: Public Comment?

None.

### 3. Administrative

- A. **For Possible Action:** Review and Approve Meeting Minutes from September 23, 2015.

Shamim Nagy, Chairwoman: We need a motion to approve the minutes from September.

David Fluitt: I make a motion to accept the minutes.

Weldon Havins: Second.

Voting: Ayes across the board – motion carries.

- B. Status Update by DHCFP

1. Public Comment.

Shamim Nagy, Chairwoman: Comment from DHCFP.

Mary Griffith: We are doing this by WebEx, so more people can listen to the meeting and participate. We will be sure to mention them during our public comments. For new business, we started with the NADAC price on November 1, 2015. We are doing this because of the Affordable Care Act. We are required to reference an actual acquisition cost. This comes from CMS and we are one of the first states to use the NADAC. The dispensing fee is increased to \$10.17 and the WAC price is decreased from plus 2% to plus 0%.

Shamim Nagy, Chairwoman: Any public comment?

David Fluitt: I have a question, in September we talked about changing to ICD-10.

Mary Griffith: That was effective as of October 1, 2015. It has been pretty smooth so far. Claims are denying if the claim requires a diagnosis and the ICD-9 is sent.

### 4. Established Drug Classes

- A. Antidepressants - Other

Shamim Nagy, Chairwoman: The annual review for drug classes from September, we are going to move that to the end of the meeting.

Established drug classes, Antidepressants, Other.

Is there any public comment? None.

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Carl Jeffery: This class is up for review because of the generic Cymbalta, duloxetine, we changed the fibromyalgia and neuropathic pain agents. We bring this to the Committee to make it consistent. We recommend the Committee consider these clinically and therapeutically equivalent.

David Fluitt: I make a motion that these be considered clinically and therapeutically equivalent.

Adam Zold: Second.

Mark Decerbo: Just a quick question before we vote, did the DUR Board make any changes with removing the requirement for any diagnosis?

Carl Jeffery: No, there is still a requirement for the diagnosis for the Cymbalta. It is an ICD-10 diagnosis. It should be coming up on a future meeting for the DUR Board.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: The changes are presented, we are moving the generic duloxetine to preferred and the brand Cymbalta to non-preferred.

David Fluitt: I make a motion to accept the recommendation to move the duloxetine to preferred and brand Cymbalta to non-preferred.

Weldon Havins: Second.

Voting: Ayes across the board, the motion carries.

## B. Nasal Antihistamines

Shamim Nagy, Chairwoman: The next class, Nasal Antihistamines.

Is there any public comment?

Carl Jeffery: This is the nasal antihistamines. There is a new generic for the Patanase, olopatadine. This class is really second line after the nasal steroids. They have all been shown safe and effective, and head-to-head studies have not shown one product to be superior. Optum recommends these products be considered clinically and therapeutically equivalent.

Evelyn Chu: I make a motion that these be considered clinically and therapeutically equivalent

David Fluitt: Second.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: Optum recommends the generic olopatadine be considered non-preferred.

Joseph Adashek: Is that something that is ever used? Why make a generic non-preferred?

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Carl Jeffery: There wasn't a whole lot of usage any way. It just barely came on the market, so there are not a lot of people on it now.

Joseph Adashek: I move we accept the recommendation.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

### C. Nasal Calcitonins

Shamim Nagy, Chairwoman: The next class is Nasal Calcitonins.

Any public comment? None.

Carl Jeffery: This is another class where a generic is available, but has never been listed on the PDL. We brought this up so all the products can be listed on the PDL. The Miacalcin is synthetic where the Fortical is biological. All have been shown to build bone mass for osteoporosis. There are not any head-to-head studies. Optum recommends these be considered clinically and therapeutically equivalent.

David Fluitt: I move these be considered clinically and therapeutically equivalent.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: We are listing the two products that have been available for a long time as non-preferred on the PDL. Fortical and the generic calcitonin would be non-preferred and Miacalcin preferred.

David Fluitt: Is there any difference in the dosing between the Fortical and Miacalcin?

Carl Jeffery: No, they are the same, just different manufacturers.

David Fluitt: I make the motion to accept the recommendation.

Weldon Havins: Second.

Voting: Ayes across the board, the motion carries.

### D. Platelet Inhibitors

Shamim Nagy, Chairwoman: The next item is Platelet Inhibitors.

Any Public comment? None.

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Carl Jeffery: We have a couple things here. There is a new generic for Aggrenox, there is a new extended release aspirin product, Durlaza and ticlopidine is no longer on the market. Durlaza is an extended release aspirin product. The Pharmacist Letter had a nice write up on this product. The studies available are the studies for aspirin. There is nothing in the literature that supports the use of the product over a regular release product. Optum recommends these be considered clinically and therapeutically equivalent.

David Fluitt: Were there clinical studies that supported the extended release product with clinical outcomes?

Carl Jeffery: The only studies I saw were pharmacokinetic studies. It had a longer half-life, absorbed over 8 hours instead of the normal 2 hours, but there were no clinical outcomes.

David Fluitt: No decrease in GI bleed?

Carl Jeffery: I didn't see any studies for outcomes or side effects.

David Fluitt: I make a motion these products be considered clinically and therapeutically equivalent.

Adam Zold: Second.

Voting: Ayes across the board. The motion carries.

Carl Jeffery: Our recommendation is to make the aspirin/dipyridamole and the Durlaza as non-preferred and remove the ticlopidine from the list since it is no longer available.

Adam Zold: I make a motion to accept Optum's recommendation.

Weldon Havins: Second.

Voting: Ayes across the board, the motion carries..

#### E. Bladder Antispasmodics

Shamim Nagy, Chairwoman: Bladder antispasmodics.

Any public comment? None.

Carl Jeffery: There is a new drug in this class, Myrbetriq, we'll talk about that more in a minute. Sanctura XR is no longer available on the market, the generic is, but not the brand. And a DUR Board member asked we review bethanechol because it works a little differently than the others. Myrbetriq works a little differently than some of the others in this class, it is a beta-3 adrenergic receptor agonist. It relaxes the detrusor smooth muscle, so it may not have any of the other anticholinergic side effects. It was approved based on three trials. One study was compared with tolteradine as an active comparator. It was shown to be non-inferior to tolteradine. The different indications are shown here. The only one that stands out is the flavoxate, but the others

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are all very similar. Optum recommends these product be considered clinically and therapeutically equivalent.

David Fluitt: I make a motion these be considered clinically and therapeutically equivalent.

Evelyn Chu: Second.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: Optum recommends bethanechol be considered preferred, remove the Sanctura XR and make Myrbetriq non-preferred.

Mark Decerbo: Was bethanechol non-preferred or was it not captured?

Carl Jeffery: It was considered non-preferred.

David Fluitt: The most restrictive aspect of this class is the anticholinergic effects, since Myrbetriq is specific to the beta-3 receptor sites, is there less incidence of dry mouth with this product?

Carl Jeffery: There are, there are some other side effects though. There were fewer anticholinergic side effects.

David Fluitt: Since there are fewer anticholinergic side effects, should the Committee consider making Myrbetriq preferred?

Carl Jeffery: We could, but there is always the argument you could use this product if you have a contraindication to one of the preferred agents. We should encourage some of the other established products first that are shown effective.

Joseph Adashek: I move we accept the recommendations.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

#### F. Angiotensin II Receptor Antagonists

Shamim Nagy, Chairwoman: Angiotensin II receptor antagonists.

Any public comment? None.

Carl Jeffery: We have this class to review again because we have some new generics on the market now. The only ones on the list now are Benicar and Edarbi are the only products on the list without a generic available. The Diovan and Cozaar are higher utilized drugs. Optum recommends these be considered clinically and therapeutically equivalent.

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Mark Decerbo: I make the motion these products be considered clinically and therapeutically equivalent.

Adam Zold: Second

Voting: Ayes across the board, the motion carries.

Carl Jeffery: Optum recommends candesartan, the brand Cozaar, the brand Hyzaar and valsartan be added as non-preferred. We would keep the rest of the class the same.

Adam Zold: Is the usage of the valsartan pretty low?

Carl Jeffery: Kevin, do you remember off the top of your head?

Kevin Whittington: Yes it is all in the brand.

Joseph Adashek: I move we agree with the recommendations.

Weldon Havins: Second.

Voting: Ayes across the board, the motion carries.

#### G. Immunomodulators: Topical

Shamim Nagy, Chairwoman: The next class is immunomodulators, topical.

Any public comment? None.

Carl Jeffery: Another class where we have a new generic on the market, Tacrolimus is the generic for Protopic. The indication is shown here on the slide. They have been shown safe and effective with the exception of the black-box warning with skin cancer possibilities. Optum recommends the products in this class be considered clinically and therapeutically equivalent.

David Fluitt: I make a motion these be considered clinically and therapeutically equivalent.

Weldon Havins: Second.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: Optum recommends tacrolimus be added as non-preferred.

Joseph Adashek: I move we accept the recommendations.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries..

#### H. Ophthalmic Nonsteroidal Antiinflammatory Drugs (NSAIDs)

Shamim Nagy, Chairwoman: Ophthalmic non-steroidal anti-inflammatory drugs.

Public comment? None.

Carl Jeffery: We have a new ketorolac generic on the market, more manufacturers giving us a chance to look at the whole class. These are used before and after surgeries and one for seasonal conjunctivitis. They are all standard NSAIDs. Optum recommends these be considered clinically and therapeutically equivalent.

Weldon Havins: I move we consider these clinically and therapeutically equivalent.

Joseph Adashek: Second.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: We are going to move some things around. The Accular PF is no longer available, so that will be removed from the list. Ketorolac and Ilevro will be added as preferred and Acular and Acular LS will be added as non-preferred.

Weldon Havins: I move we accept the recommendations.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

#### I. Disease-Modifying Antirheumatic Agents

Shamim Nagy, Chairwoman: Disease-modifying antirheumatic agents.

Public comment.

Carl Jeffery: Briefly, we told the Committee we would bring this back because there was some confusion about how it was named, so that is why it is coming back up. We can still open it up for public comment.

Shamim Nagy, Chairwoman: Any public comment? None.

Carl Jeffery: We did some research on this. All of them are considered DMARDs except for Cosentyx and Stelara. It makes sense to remove these two agents and keep the name the same. We are changing the class because these non-preferred agents will technically be preferred now. Gabe, so we need a vote from the committee?

Gabe Lither: Not for the changes you are proposing, no.

Joseph Adashek: All these drugs need prior authorization anyway.

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Carl Jeffery: So we can just solicit some feedback if this sounds ok, but we don't need an official vote.

Joseph Adashek: So if we wanted one of these preferred for example.

Carl Jeffery: Right, the DUR Board sets the clinical criteria for these products.

Mark Decerbo: Is it one uniform process for preferred vs. non-preferred, is there any difference?

Carl Jeffery: It is essentially the same process, except the recipient must show they have tried or cannot tolerate Enbrel or Humira before getting a non-preferred, or show why they can't take these. If they had an allergy or a unique indication.

Mark Decerbo: I don't have a problem with changing the classes, we have been cleaning up a lot of these lately. The last slide you presented, the classification, is that an AHFS classification?

Carl Jeffery: Yes, exactly.

Shamim Nagy, Chairwoman: There is no vote needed.

Carl Jeffery: Right, we just wanted to let the Committee know what we are doing and solicit feedback.

## **5. Established Drug Classes Being Reviewed Due to the Release of New Drugs**

### **A. Alzheimer's Agents**

Shamim Nagy, Chairwoman: The next class is Alzheimer's Agents.

Any public comment? None.

Carl Jeffery: Namzaric is the new drug, a combo of Aricept and Namenda. Two well-known drugs for moderate to severe Alzheimer's disease. The combination of the two has been used together for a long time. Neither stops nor slow the progression of the disease, but they work for symptom control. The combo should only be used if they are already stabilized on the two individually. Optum recommends these products be considered clinically and therapeutically equivalent.

Joseph Adashek: So moved.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: The new products we recommend be non-preferred, but also switch the brand Namenda to non-preferred and the generic memantine as preferred.

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Mark Decerbo: One question, wasn't there some litigation between Namenda XR and a generic manufacturer? Where they blocking a generic? Is there a memantine XR that is available?

Carl Jeffery: It didn't show on my current product list, but it might show up soon.

David Fluitt: These products are sometimes hard to take. Is there any information showing they stopped the medication less when taking the combination form?

Carl Jeffery: I don't remember seeing anything specifically addressing that.

David Fluitt: That might be the only advantage I can see with this product.

Carl Jeffery: With the criteria from the FDA indication, they have to be stable on the two products separately before moving to the combo, that will qualify them to meet the non-preferred criteria to get the Namzaric.

David Fluitt: I move to accept the recommendations.

Joseph Adashek: Second.

Voting: Ayes across the board, the motion carries.

Gabe Lither: Just to be clear, you can make an alternative motion at any time, you don't have to just accept the recommendation.

## B. Oral Atypical Antipsychotics

Shamim Nagy, Chairwoman: Oral Atypical Antipsychotics, any public comment?

Samantha May: My name is Samantha May, I believe you have all had the chance to read the information about Rexulti. I have a company approved script. Covered indications, mechanism of action, efficacy of medication through studies, details of trial outcomes, and adverse effects. Please refer to the package insert. Please consider adding Rexulti to the PDL.

Carl Jeffery: We just heard about Rexulti, I won't go over all of it again. The pivotal trials were talked about. The secondary outcomes may have been more important to talk about. We have a new treatment option that works a little differently. But over all we recommend this class be considered clinically and therapeutically equivalent.

Joseph Adashek: I move we accept the recommendation that these be considered clinically and therapeutically equivalent.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

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Carl Jeffery: In addition to the new Rexulti, there are a few new generics available, aripirazole and paliperidone. We want to include both new generics and Rexulti as non-preferred.

Joseph Adashek: Are you getting a lot of requests for Rexulti.

Kevin Whittington: We didn't have any utilization.

Weldon Havins: Paliperidone is a generic?

Carl Jeffery: It is a generic for Invega.

Mark Decerbo: What is the PA process for these? We have expanded the list so much and with such a varied response to these agents. If someone is an excellent candidate for Rexulti, how hard is it to get this medication?

Carl Jeffery: They would need to show trial and failure of two preferred agents or have some good clinical justification as to why they need a non-preferred agent.

Joseph Adashek: So if someone goes to the website, how long does it take someone to answer back?

Carl Jeffery: If they send a fax, our average turnaround time is 5-6 hours for a decision, we are required to have a response back within 24 hours. A phone call is right away.

Gabe Lither: Do you have to show a failure of two?

Carl Jeffery: Unless there is justification for why they can't take two. Failure is a pretty broad term, it could be side effects, or maybe they didn't quite achieve treatment goals.

Joseph Adashek: Do you have any statistics on how many you end up denying the first time around? If someone did try one, what percentage do you have for approving it the first time around?

Carl Jeffery: I don't have those exact numbers, a ballpark, we approve about 90% of requests anyway.

Weldon Havins: Since the response is so variable, why not include the generics in the preferred category?

Carl Jeffery: To have the generics as non-preferred.

Gabe Lither: There are a host of other drugs that meet the State's needs.

Mary Griffith: I need to add, our policy for the standard preferred drug list exception policy, we only require failure of one agent for atypical antipsychotics, anticonvulsants and anti-diabetics. I just wanted to clarify that.

David Fluitt: That falls under the continuity of care that we talked about last time.

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Carl Jeffery: That's right, there is only one failure, thank you.

Joseph Adashek: I move we agree with the recommendations.

Weldon Havins: Second.

Voting: Ayes across the board, the motion carries.

### C. Ophthalmic Antihistamines

Shamim Nagy, Chairwoman: Ophthalmic antihistamines. Any public comment? None.

Weldon Havins: Why are we moving Pataday? For the State interest? It has been on the preferred list.

Carl Jeffery: Right, that's our recommendation. We'll move through this information first. We have a new drug Pazeo. There are three products now with olopatdine with different strengths. Patanol, Pataday and Pazeo. The indications are in line with the other products. There are several over the counter products now for the ketotifen. The prescription product is the only one indicated for allergic conjunctivitis. The Pazeo had two trials showing it was significantly better than placebo. When compared to Pataday, Pazeo was shown to be better at 24 hours. Optum recommends these be considered clinically and therapeutically equivalent.

Adam Zold: I make the motion that these are clinically and therapeutically equivalent.

David Fluitt: Second.

Voting: Ayes across the board, the motion carries.

Carl Jeffery: Optum recommends making Ketotifen and Pazeo preferred and moving Pataday to non-preferred. The other generics that have been on the market for a while will be listed as non-preferred. The reason for moving Pataday away is because there are a lot of other products on the market to treat allergic conjunctivitis. The manufacture of Pazeo is trying to drive use and has been working with use pretty well.

Weldon Havins: I move we accept the recommendations.

Joseph Adashek: Second.

Voting: Ayes across the board, the motion carries.

### D. Short-Acting Respiratory Beta-Agonist

Shamim Nagy, Chairwoman: Short acting respiratory beta agonists, public comment? None

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Carl Jeffery: We have a new product on the market, the Proair Respiclick, another albuterol inhaler. The slide shows what it looks like. It works by breath actuation, a big breath in gives the dose. Good delivery as long as there is good lung function. It hasn't been studied in severe lung disease. It has a dose counter and does not require a spacer. But it is just another albuterol. Optum recommends these be considered clinically and therapeutically equivalent.

Mark Decerbo: I move these products be considered clinically and therapeutically equivalent

Adam Zold: Second

Voting: Ayes across the board, the motion carries.

The same list with the addition of the Proair Respiclick as non-preferred. We still have the Proair and the Proventil as albuterol options as preferred.

Joseph Adashek: With Xopenex and a PA requirement for it. I disagree with needing a PA. I think there is such a difference in the cardiac side effects with the inhaler that I don't think we need a PA for the Xopenex. There is such a difference with side effects, and it is standard of care for the treatment of asthma. I would like the PA be removed from the Xopenex.

Carl Jeffery: It is the DUR Board that makes the clinical criteria for the Xopenex.

Mary Griffith: There are clinical criteria from the DUR Board, but it is for recipients experiencing side effects with other beta-adrenergic agonists or for patient whose cardiovascular status is considered to be in severe deteriorating condition. Those are the quantifications by the DUR Board.

Joseph Adashek: I don't understand this, who is the DUR Board?

Mary Griffith: There are two different PA's. There is a PA for non-preferred drugs. And then the clinical PA. The clinical PA is decided by the DUR Board and they make the criteria. We can bring this up to the DUR Board. We have three physicians and pharmacists on the Board.

Joseph Adashek: This is the first meeting I have heard that we cannot overrule the DUR Board.

David Fluitt: Can we make the recommendation that this no longer requires a PA?

Joseph Adashek: That is what I would like to do.

Mary Griffith: We would have to bring it back up to the DUR Board.

Gabe Lither: You can ask that the DUR Board review that and we can make sure it is on the next agenda for the meeting. You are welcome to make public comment at the meeting.

Mary Griffith: The DUR Board is a Federal requirement. The P&T is a State requirement. The DUR Board is appointed by the Director and the P&T is appointed by the Governor. The DUR Board is tasked with looking at safety and utilization and putting criteria on specific drugs.

Anyone can suggest a drug to be reviewed. Whereas the P&T Committee, you are doing the preferred vs. non-preferred.

Joseph Adashek: It just seems weird that a Board that is there for safety would have a PA for a drug with less cardiac side effects. So you think it would be the other way around. If that is more clinical.

Gabe Lither: Carl, do you know what the DUR Board was concerned about when they made this criteria?

Carl Jeffery: I think it was recently reviewed, but it is a carryover from a long time ago.

Weldon Havins: Can we make a motion to ask the DUR Board to review this drug?

Gabe Lither: You don't need a motion for that.

Joseph Adashek: How do we ask the DUR Board to review this?

Carl Jeffery: You just did, we'll get it on the next agenda for the DUR Board.

Joseph Adashek: So we have nothing to do with the clinical PA.

Carl Jeffery: Right, they look at the utilization management and this relates when Xopenex first came on the market, they wanted to make sure the utilization was appropriate. Still today, the majority of patients are going to do just fine with albuterol, from their perspective, there really isn't a reason albuterol shouldn't be considered first and then move to Xopenex.

Joseph Adashek: But that is probably because they don't know any better. They take albuterol and they are all shaky and their heart is racing, they don't know there is an alternative that doesn't have these side effects.

Gabe Lither: Can you make sure you send out an email for when the next DUR Board meeting is?

Carl Jeffery: We'll have a WebEx too.

Mary Griffith: The DUR Board is in Reno and in the evening.

Evelyn Chu: At the hospital level, we have removed Xopenex from the formulary. If the physician orders it, we auto-sub for albuterol, and we have done it for years and we have not had any issues. There have not been any difference in outcomes.

Joseph Adashek: I don't think there would be, it is the side effects, the shaky and heart rate. They don't know there is an alternative.

Evelyn Chu: But if the physician does right do not substitute for a patient with Afib or other heart problems, they can get the Xopenex, otherwise they can get albuterol.

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Joseph Adashek: There are patients that just won't take albuterol because they don't like the side effects, but they don't know better that there is a drug that doesn't have the side effects.

Weldon Havins: How do we know by looking at it what kind of PA it requires?

Carl Jeffery: If it says PA on the list, then it is a clinical PA, the only other reason it would require a PA is if it is non-preferred. We added this to the PDL about a year ago to indicate what products on this list requires a PA.

Joseph Adashek: When dealing with pregnant women because it makes them shaky and they're worried about the baby. So this is something you may not see in the hospital. The levalbuterol is non-preferred and it doesn't require a PA?

Carl Jeffery: It would, it is just the nebulizer solution, and they would still need to try two preferred agents. We should have a note by that one too.

Joseph Adashek: I make a motion to agree with the recommendations.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

## **6. Annual Review – Drug Classes Without Proposed Changes From September 23, 2015 Meeting**

Shamim Nagy, Chairwoman: We will go back to the annual review of the September mass approval.

Public comment?

Carl Jeffery: This is here because of a technicality, we didn't have an action item on the agenda, but this is the class list where we do not recommend any changes. Every class that was not reviewed in September is on this list.

Weldon Havins: I move that we approve drugs for inclusion on the PDL as noted in our agenda item 4.C.

Adam Zold: Second.

Voting: Ayes across the board, the motion carries.

## **7. Closing Discussion**

Shamim Nagy, Chairwoman: Any public comment? Date of the next meeting?

Carl Jeffery: March 24, 2016, here again if we can.

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Meeting adjourned.