BRIAN SANDOVAL
Governor

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William Street, Suite 101
Carson City, Nevada 89701
(775) 684-3676 • Fax (775) 687-3893

RICHARD WHITLEY, MS
Director

MARTA JENSEN
Acting Administrator

Nevada Medicaid

PHARMACY AND THERAPEUTICS COMMITTEE

DRAFT MINUTES

The Division of Health Care Financing and Policy (DHCFP) Pharmacy and Therapeutics Committee held a public meeting on September 22, 2016 beginning at **1:00 p.m.** at the following location:

Canyon Gate Country Club
2001 Canyon Gate Drive
Las Vegas, NV 89117
Phone: (702) 363-0303

Committee Members Present:
Mark Decerbo, Pharm.D.; Shamim Nagy, MD; Adam Zold, Pharm.D.; Evelyn Chu, Pharm.D.; Mike Hautekeet, Pharm.D.; Joseph Adashek, MD; Nikki Beck, Pharm.D.; Christopher Highley, MD

Committee Members Absent:
Weldon Havins, MD

Others Present:
DHCFP:
Mary Griffith, RN, Pharmacy Services Specialist; Gabe Lither, Deputy Attorney General; Shannon Sprout, DHCFP

HPES:
Beth Slamowitz, Pharm.D.

Optum:
Carl Jeffery, Pharm.D., Kevin Whittington, RPh; Daniel Medina (via teleconference), Rob Earnest, Pharm.D., JD

Others:
Christy Heiner, Viking HCS; Michelle Mui, UCB; Alan Kaska, Abbott; Rob Bigham, Shire; Brian Landberg, Arkray; Joe Gilhoudy; Scott Black, Daiichi Sankyo; Michael Sans, Daiichi Sankyo; Charlotte Polhemus, Daiichi Sankyo; Jesse Hong, Purdue; James Kotusky, Gilead; Deron Grothe, Teva; Sandy Sierawski, Pfizer; Contessa Fincher, Teva; Bruce Smith, Glaxo Smith Kline; Tammy Rogers, Purdue; Aida Maxsaur, Purdue; Sarica Klein, Mylan; Ann Nelson, Vertex; Mark Schwartz, GSK; Efrain Alton, Merck; Krystal Joy, Otsuka; Christy Lemons, Onexo; Natalie Cardens, UCB; Jill Suad, UCB; Elaine Defelice, UCB; Kathryn Munoz, Sanofi-Genzyme; Thu-Mai Duorg, Sanofi-Genzyme; Jennifer Lauper, BMS; Chris Conner, BMS; Phil Walsh, Sunovian; Robert Jaramillo, Sunovion; Aimee Doran, United Therapeutics; Richard Arnoto, UCB; David Abraham, MRR; Samantha Sweeney, Otsuka; Colin Carey, Lilly; Kathy Moore, Otsuka; Kaysen Bala, Novo Nordisk; Lovell Robinson, Abbvie; Alyssa Nguyen, Walgreens; Laura Hill, Abbvie; Laura Litzenberger, Janssen; Charissa Anne, J&J; Danielle Marano, Epilepsy Foundation; William O'Neill, BI; Steve Fuchs, Pfizer; Dan Tubridy, BI; Nick Casale, Indiviar; Georgette Dzwileski, Indiviar; Chris Anstead, Amgen; Sally Berry, Tris; David Crosby, BMS; Leon Ravin, DPBH; Tom O'Connor, Novartis; Kat McPherson, Novartis; Jeff Rose; Lisa Wilson, Biogen

Others On-line:
Chris Stanfield; Nick Lourenco; Brent Fushimi; Dominick Vanore; Michelle Giddings; Kim Jacoby; Charlene Knutila; Connie Yuen; Lee Barron; Lisa Wilson; Rob Bigham; Scott Black; Jeanette Belz

AGENDA

1. Call to Order and Roll Call

Meeting called to order at 1:01 PM

Beth Slamowitz, Hewlett Packard Enterprises
Christopher Highley
Nikki Beck
Evelyn Chu
Gabe Lither
Shamim Nagy, Chair
Adam Zold
Mark Decerbo
Michael Hautekeet
Kevin Whittington, OptumRx
Carl Jeffery, OptumRx

2. Public Comment

3.

Shamim Nagy, Chair: Any Public Comment?
Gabe Lither: This is the time for any public comment on any topic, otherwise we will take comment as the agenda items come up.

4. Administrative

A. **For Possible Action:** Review and Approve Meeting Minutes from March 24, 2016.

Shamim Nagy, Chair: We need a motion to approve the minutes from the March meeting.
Michael Hautekeet: Move.
Evelyn Chu: Second.
Voting: Ayes across the board, the motion carries.

B. Status Update by DHCFP

Shamim Nagy, Chair: Status update from DHCFP.

Mary Griffith: My name is Mary Griffith. State staff attended the Governor's Conference on Prescription Drug Abuse. There was a lot of good information and input presented at the meeting.
The DHCFP will be hosting our Annual Provider Workshop on October 4th in Reno and October 6 in Las Vegas. There will be speakers and break-out session so providers can talk one-on-one with HP and DHCFP staff to get any billing problems addressed or help with prior authorizations.
The DHCFP will hold a public workshop on October 20 to take public comment on prescription opioid use in Nevada. It will be held in Carson City and video-conferenced to Las Vegas and Elko.
We are also having a public workshop on the 20th for prescription opioid drug abuse.
Our next Drug Use Review Board meeting will be October 27th in Reno.
We have two new members, Dr. Chris Highley, and Dr. Nikki Beck.
Christopher Highley: I'm Chris Highley, I work for Carson Medical Group.
Nikki Beck: I'm Nikki Beck and I work in a Federally Qualified Health Center in Reno.
Mary Griffith: There are some ground rules for this meeting. This is Fee For Service only, not for MCOs. We are going to limit public comment to 5 minutes because of the long meeting agenda. Optum will display the recommendations for the PDL on the screen by drug class. If your drug is recommended to be preferred, you don't have to testify. Please check the screen before proceeding to the microphone. If testimony has already been presented on your drug, we don't need to hear it again. We'd like to hear new information. Please state your name and who you represent.
Gabe Lither: Gabe Lither from the Attorney General's office, we don't discuss cost by statute. Cost is considered behind the scenes, but your job is to decide based on your clinical knowledge of the drugs.
Shamim Nagy, Chair: Public comment?
Christian Stone: Hi my name is Christian Stone, I am a gastroenterologist, I have been practicing for 16 years, representing myself and my patients. I'm here to discuss Cimzia, an antiTNF agent. Cimzia is used for Crohn's disease. I want to

remind the panel of the advantages of Cimzia. I encourage the Committee to make it preferred so it is available to all patients.
Shamim Nagy, Chair: Thank you, we will take this into consideration when we discuss the class. Do we have any other public comments? We are taking drug classes out of order.
Carl Jeffery: We are starting with the ADHD medications, it is section G under Established Drug Classes.
Shamim Nagy, Chair: We will start with G, Established Drug Classes.
Gabe Lither: We taking items out of order Section 5-G – psychotropic agents – ADHD.
Shamim Nagy, Chair: Do we have any public comment?
Christy Hiner: My name is Christy Hiner, for Viking Healthcare Solution, I represent Nelis Pharmaceuticals. Please consider adding Adzenys XR to the preferred drug list. Adzenys is a long-acting amphetamine orally disintegrating tablet. Pharmacokinetic information and the benefits of ODT in youth and adults was presented.
Shamim Nagy, Chair: Any questions?
Gabe Lither: Do you see the medication on the list on the screen?
Christy Hiner: I do, it is highlighted in yellow.
Carl Jeffery: I just want to take a minute to introduce and give an overview of the meeting. For the new people, I'm Carl Jeffery, we are responsible for getting the room and hosting this meeting. The proposed list on the screen is what Optum is recommending as preferred or non-preferred, it mirrors what is on the web. On the left is what is recommended as preferred. The right is the recommended as non-preferred. The yellow highlighted area is the new or proposed changes from the previous list. The center column is just like the published PDL, it lists any PA criteria or restrictions that we may have for the class.
Shamim Nagy, Chair: Any other public comment for ADHD? None?
Carl Jeffery: We have six new agents, we heard about the Adzenys already. The other new medications are all established drugs but with new dosage forms. An overview of the new products and the drug class is presented. Guidelines do not favor one agent over another. No head-to-head studies showing one is better. Optum recommends the class be considered clinically and therapeutically equivalent.
Shamim Nagy, Chair: Any discussion? I need a motion.
Adam Zold: Motion they are therapeutically equivalent.
Joseph Adashek: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: We recommend keeping the class the same, making Adzenys, Dyanavel and Quilichew as preferred to offer more dosing options for children. Aptensio XR and Evekeo and Zenzedi as non-preferred.
Michael Hautekeet: I make a motion to accept the recommendations.
Evelyn Chu: Second.
Voting: Ayes across the board, the motion carries.
Shamim Nagy, Chair: Antipsychotics: Atypical. Any public comment?

Dr. Leon Ivan: I am Dr. Leon Ivan, I am the statewide Psychiatric Medical Director for the Division of Public and Behavioral Health and Clinical Professor for the Department of Psychiatry at the University of Nevada School of Medicine. I would like to talk about Rexulti, brexpiprazole. I would like to request all the atypical antipsychotics including Rexulti be available for patients diagnosed with schizophrenia and other psychotic disorders. This allows the choice for the most effective medication. Delays in treatment can lead to further impairment and several other issues. The benefits of antipsychotics and how some are different is presented. Each patient is unique and responds differently based on side effects and efficacy. First exposure to medication has an impact on further treatment. Non-adherence leads to further complications. For the School of Medicine, having access for the medical residents will allow them to learn about these agents.
Shamim Nagy, Chair: Any questions?
Christopher Highley: Can you specify the benefits of Rexulti over aripiprazole? Is the formulation the same? Any compliance difference?
Dr. Leon Ivan: Both are oral tablets. The difference comes in the receptor binding, Rexulti provides more affinity to 5HT-2 1a and D2 partial agonist. Which has been described as the most beneficial for an atypical antipsychotic, published in 2008 before this medication was introduced on the market.
Shamim Nagy, Chair: Any other questions? Next public comment?
Dr. Horne: I request to have Rexulti on the preferred list because in my experience some patients do much better on this and have failed others.
Carl Jeffery: The Statute requires a trial of one agent in this class before moving to a non-preferred agent
Dr. Horne: But it doesn't have to be that it is paid for by Medicaid?
Carl Jeffery: No, just an attestation from the prescriber that a preferred agent has been tried.
Shamim Nagy, Chair: Any other comments?
Samantha Sweeny: I am Samantha Sweeny with Managed Market Liaison with Otsuka. I'm here to talk about Rexulti or brexpiprazole. An overview and new studies of Rexulti is presented. Otsuka requests Rexulti be made preferred for Nevada Medicaid.
Shamim Nagy, Chair: Any questions? No. Any other comments?
[Inaudible Name]: I use Rexulti in a lot of patients and see improvements in the symptoms. Thank you.
Shamim Nagy, Chair: Any other comment? No, Carl.
Carl Jeffery: I wanted to call out Chapter 1200 the exception criteria. On the bottom line, antipsychotics only demonstrate therapeutic failure on one preferred agent. Just keep that in mind. I want to call out the different diagnoses for each product. Calling out the new medications, Vraylar and Nuplazid. Vraylar has an indication for bipolar and schizophrenia, the only indication for Nuplazid is Parkinson's related hallucinations and psychosis. Vraylar has lots of studies showing it is effective. Nuplazid for Parkinson's disease also has some good data showing it is effective. I threw in Rexulti even though it has been out for a while. The Committee has a packet of letters from the provider community. We heard from a few other providers. From my pharmacist point of view, on paper the

Rexulti and Abilify have very similar profiles as far as what receptors they react with. There are some other minor receptors and different affinities for these and that all leads to the therapeutic effect. Shown below are some of the other agents and the receptors they hit. So on paper, these are similar drugs, but that is why we have the Committee and their clinical experience to offer guidance. Optum recommends this class be considered clinically and therapeutically equivalent. We might call out Nuplazid being a little different, it is technically an antipsychotic, but it does not have the same indications as the others, so maybe add a caveat with that product.
Joseph Adashek: I move they are all clinically and therapeutically equivalent.
Adam Zold: Second.
Christopher Highley: I have a question about the first slide, what is the definition of therapeutic failure?
Carl Jeffery: It would be clinical like side effects or lack of response or contraindication.
Voting: Voting, 7 Ayes, 1 Nay – Motion carries
Carl Jeffery: Optum recommends moving the brand Abilify to non-preferred and the generic aripiprazole to preferred and then the two new agents Nuplazid and Vraylar to non-preferred. To make it clear, Nuplazid would still be available for Parkinson's related dementia because it is a unique indication, it would not require any failure on any agent before getting it approved.
Mark Decerbo: That was one of my concerns, in terms of the unique indication, you could be potentially pushing people to clozapine or quetiapine first, but we could carve out the Nuplazid with an ICD-10 code of Parkinson's?
Carl Jeffery: Yeah, we could do that to allow a Parkinson's disease related diagnosis to override the non-preferred status.
Mark Decerbo: Would that come from us or the DUR Board?
Carl Jeffery: Yes, you would do that here.
Joseph Adashek: I would like to make a motion that we make that medication preferred for a diagnosis of Parkinson's disease.
Mark Decerbo: I second.
Carl Jeffery: Gabe, does this all need to go into one motion?
Gabe Lither: It would be easier if it was all in one motion.
Joseph Adashek: I have other discussion too. I don't use this medication in my practice, but we have lots of doctors from the community say they use Rexulti a lot with good results, I listen to that. My motion would be to also make Rexulti a preferred agent. There are psychiatrists here that know more than me on this, so maybe they can speak too.
Gabe Lither: We can put that all in one motion to see if it works.
Joseph Adashek: Ok, the motion is to make Nuplazid preferred if an ICD-10 diagnosis of Parkinson's is submitted on the claim and to make Rexulti preferred as well.
Adam Zold: Second.
Mark Decerbo: So we have two motions combined.
Carl Jeffery: And for clarification, it would also be to accept the remaining recommended changes.

Joseph Adashek: Yes, to also accept the other recommendations.
Voting: Ayes: 5, Nays: 3 – The motion carries.

5. Annual Review – Established Drug Classes

A. Analgesics: Opiate Agonists

Shamim Nagy, Chair: Going back to Annual Review, established drug classes, Analgesics, Opiate agonists.
Public comment? No comment.

Carl Jeffery: I want to discuss Butrans. With the current state of the opioid abuse in Nevada, we would like to offer some agents that are less abuseable. Butrans is a one a week patch, it is a CIII so it doesn't take the extra CII prescription. It is indicated for the management of pain like the other agents on the list. One of the reasons we have never had it preferred before is because of the dose limit, once you get to 20 micrograms per hour, you need to move to something more potent. Optum recommends these be considered clinically and therapeutically equivalent.
Joseph Adashek: I move they are all therapeutic equivalents.
Adam Zold: Second.
Voting: Ayes across the board.
Carl Jeffery: Optum recommends we move Butrans to preferred and that is our only change. The abuse deterrent opioids are in a different class and will be discussed later.
Adam Zold: I move we go with Optum's recommendations.
Mark Decerbo: Second.
Voting: Ayes across the board, the motion carries.

B. Anti-infective Agents: Antivirals: Anti-hepatitis Agents: Polymerase Inhibitors/Combination

C. Anti-infective Agents: Antivirals: Anti-hepatitis Agents: Protease

Shamim Nagy, Chair: Anti-infective agents, antivirals, anti-hepatitis agents.

Chris Conner: I am Chris Connor with BMS and I am here to talk about Daklinza. An overview, indications, and data for coinfected patients is presented. It is used with Sovaldi for genotype 3. (about 12% of all Hep C patients), they are at a higher risk of progressing to cirrhosis and carcinoma. Daklinza is available in three different doses and is not co-packaged. There are no significant drug interactions with proton pump inhibitors. I ask for you to add Daklinza as preferred on the Nevada Medicaid PDL.
Shamim Nagy, Chair: Thank you, next?
Laura Hill: I am Laura Hill with Medical affairs at Abbvie, I would like the panel to consider moving Viekira and Technivie back to preferred status. There have been updates to the labeling. Indications, contraindications, studies, renal

dysfunction, and efficacy information is presented. New extended release formulation now available.
Shamim Nagy, Chair: Thank you, any questions? No, next person.
James Kotusky: I am James Kotusky with Gilead Sciences, I would like to provide a brief statement for Epclusa. Indications are presented.
Gabe Lither: Sorry to interrupt, you're here for Epclusa. Could you keep it brief since your drug is preferred.
James Kotusky: Trials, lab testing and discontinuation rates information is presented.
Shamim Nagy, Chair: Any other comments or questions? Any other public comments?
Carl Jeffery: There are a few agents in this class. We used to have a separate class for the protease inhibitors. We are combining that class with this class and making it an all-encompassing Hep C class. The list of drugs available are shown here and the genotypes they cover. A quick overview of Zepatier, SVR rates show it is very effective and tolerable. Epclusa, there are high cure rates with all the genotypes. Daklinza has good cure rates, but it has to be given with Sovaldi. Optum recommends the drugs in this class be considered clinically and therapeutically equivalent.
Michael Hautekeet: I make a motion to accept these are clinically and therapeutically equivalent.
Evelyn Chu: Second.
Voting: Ayes across the board, the motion carries.
Shamim Nagy, Chair: Do we need a motion to combine the classes.
Carl Jeffery: I don't think we would, we are recommending the Olysio being moved to this class and the other two agents Incivik and Victrelis are no longer available. Gabe, do you agree?
Gabe Lither: Historically, you guys have handled the drugs classes, so I don't think we need a separate motion.
Carl Jeffery: Optum recommends we include Epclusa and Zepatier as preferred and keep Harvoni and Sovaldi as preferred too. This would make Daklinza, Olysio, Technivie and Viekira Pak as non-preferred.
Adam Zold: I would like to make a motion to include Daklinza as preferred.
Gabe Lither: Your motion is to accept the recommendation but add Daklinza as preferred too.
Carl Jeffery: If that is the direction of the Committee, you might as well make Technivie and Viekira preferred as well.
Adam Zold: We had a good discussion a few years ago, and given the cure rates of these drugs we should make the class all inclusive. I think we should stick with that, we should make all the drugs as preferred.
Gabe Lither: So you are changing the motion to include all drugs?
Adam Zold: Yes, I rescind my previous motion and move to make all drugs preferred.
Joseph Adashek: I don't use these drugs in my practice, what is the reason you recommended these as non-preferred?

Carl Jeffery: Daklinza does have a good cure rate, but it requires the addition of Sovaldi as opposed to a single agent, adding to the complexity of the regimen. That is really the basis of our decision.
Evelyn Chu: So to be clear, the agents recommended as preferred are all single agents that can be used as is, and the ones recommended as non-preferred is that they are more complex regimens and they also require ribavirin. That is the reason you are suggesting non-preferred.
Mark Decerbo: It seems ribavirin has dropped off.
Carl Jeffery: Ribavirin is in its own class and we are not reviewing that class today. To reiterate the motion on the floor is to include all medications as preferred.
Voting: Nay – 5, Aye – 3, the motion fails to pass
Joseph Adashek: I move we accept the recommendations made by Optum.
Nikki Beck: Second.
Voting: Nay – 1, Aye – 7, the motion carries.

D. Biologic Response Modifiers: Multiple Sclerosis Agents: Oral

Shamim Nagy, Chair: The next topic is Biologic Response Modifiers, Multiple Sclerosis Agents, oral.
Comments from the floor? No comments.

Carl Jeffery: No new medications in this class, but we wanted to bring this to the Committee. The medication Gilenya has more side effects compared to the other two. But there are a lot of patients that find value in this medication. Optum recommends these be considered clinically and therapeutically equivalent.
Shamim Nagy, Chair: Any discussion?
Mark Decerbo: I move these be considered clinically and therapeutically equivalent.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Optum recommends just moving Gilenya to preferred to provide more access to patients.
Evelyn Chu: I move we accept the list as presented by Optum.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

E. Dermatological Agents: Topical Anti-infective: Topical Scabicides

Shamim Nagy, Chair: Dermatological Agents, Topical anti-infective, topical scabicides.
Any public comment? None.

Carl Jeffery: Natroba had clinical criteria added by the DUR Board. Optum recommends these be considered clinically and therapeutically equivalent.

Adam Zold: I motion these be considered clinically and therapeutically equivalent.
Joseph Adashek: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Our recommendation is to move Natroba to non-preferred, simply because the DUR Board evaluated it and decided it was best to add a clinical PA.
Mark Decerbo: What is the PA criteria?
Carl Jeffery: There are some requirements to use RID or permethrin before moving to the Natroba.
Adam Zold: I motion to go with Optum's recommendation.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.

F. Electrolytic and Renal Agents: Phosphate Binding Agents

Shamim Nagy, Chair: Electrolyte and renal agents, phosphate binding agents.
Any public comment? No.

Carl Jeffery: No new medications in this class, just some shift in the market. We wanted to talk about Fosrenol. Calcium acetate is the most commonly used. The evidence for depleting phosphorus shows some debate about how effective this really is. The guidelines always recommend a calcium based binder as first line. Optum recommends these be considered clinically and therapeutically equivalent.
Michael Hautekeet: I make the motion that these are clinically and therapeutically equivalent.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Optum recommends moving Fosrenol to non-preferred because the guidelines suggest using a calcium containing binder first for most patients.
Michael Hautekeet: I make the motion to accept the recommendation.
Evelyn Chu: Second.
Voting: Ayes across the board. The motion carries.

G. Gastrointestinal Agents: Antiemetics: Miscellaneous

Shamim Nagy, Chair: Gastrointestinal Agents, antiemetic, miscellaneous.
Public comment? No.

Carl Jeffery: This class is here because the DUR Board asked the P&T Committee to review using the separate ingredients vs. the combined product Diclegis. As most are aware, these products are available over the counter, getting the dose the same is a challenge. Emend doesn't really fall in with Diclegis as far as indications, but it doesn't really fit in to any other classes currently on the PDL, so with that caveat, Optum recommends this class be considered clinically and therapeutically equivalent.

Joseph Adashek: I move that these are clinically and therapeutically equivalent for the miscellaneous class.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Our idea, and this is open to discussion, if you do get a physician to train a patient to track down the medications, then they are welcome to do that.
Joseph Adashek: We use Diclegis, it is a great medication.
Mark Decerbo: For historical perspective, are there any coverage limitations with OTCs?
Carl Jeffery: OTCs are a covered benefit, they need a prescription. So the prescriber would need to write out the separate ingredients. There is a limit to two agents per class for OTCs.
Mark Decerbo: So it is important to let the prescriber know that they need to write a prescription.
Joseph Adashek: I move we accept the recommendation.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

H. Hormones and Hormone Modifiers: Antidiabetic Agents: Dipeptidyl Peptidase-4 Inhibitors

Shamim Nagy, Chair: Next topic is Hormones and hormone modifiers, antidiabetic agents, dipeptidyl peptidase-4 inhibitors.
Public comment? No.

Carl Jeffery: This class has some authorized generics, alogliptin and combos. Same ingredients as Nesina. They are the same medications, not changes to the therapeutics. Optum recommends these be considered clinically and therapeutically equivalent.
Adam Zold: I move they are considered clinically and therapeutically equivalent.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Optum recommends removing the Juvisync, it is no longer available. And then to make the authorized generics as non-preferred.
Shamim Nagy, Chair: Any discussion? We need a motion.
Adam Zold: I move to accept Optum's recommendations.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.

I. Hormones and Hormone Modifiers: Antidiabetic Agents: Incretin Mimetics

Shamim Nagy, Chair: Next is antidiabetic agents, incretin mimetics.
Any public comment? No.
Carl Jeffery: This is another established class that we want to move things around a little. Tanzeum and Trulicity are the newer ones. The difference is how often they are given, weekly vs. daily. Within the class, all have been shown to decrease

A1c and there is not a recommendation to prefer one over the other. Optum recommends these be considered clinically and therapeutically equivalent.
Michael Hautekeet: I move we accept Optum's recommendation that they are clinically and therapeutically equivalent.
Adam Zold: Second.
Voting: Ayes across the board.
Carl Jeffery: Optum recommends Tanzeum preferred.
Nikki Beck: I was curious why Tanzeum over Trulicity?
Carl Jeffery: Tanzeum has some good clinical information, as does Trulicity. It comes down to how we recommend the preferred drug list.
Nikki Beck: Trulicity is a much easier pen device and it much easier to administer and train than the Tanzeum.
Mark Decerbo: Along with this, would Tanzeum have the same PA criteria as the others?
Carl Jeffery: Right now, until we can get this to the DUR board, Tanzeum and Trulicity will not have clinical criteria. We will get this to the DUR Board, but I might suggest PA requirements be removed. But until then, PA criteria only apply to Bydureon, Byetta and Victoza.
Michael Hautekeet: On a personal note, I used to use Bydureon, the injection sites were very bad. Where with Trulicity it did not have the same effect. I would recommend to make Trulicity preferred with the Tanzeum.
Christopher Highley: Second.
Voting: Ayes across the board, the motion carries.
Gabe Lither: The motion was to make them all preferred.
Carl Jeffery: The PA criteria will have to be reviewed and we will get this back to the DUR Board.

J. Hormones and Hormone Modifiers: Antidiabetic Agents: Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors

Shamim Nagy, Chair: Antidiabetic agents, sodium-glucose co-transporter 2 inhibitors.
Public comment?

Bill O'Neil: Hi my name is Bill O'Neil, a pharmacist with Boeringer Ingleheim. I want to talk about Glyxambi, Jardiance, Synjardy. I would like to point out the cardiovascular outcome studies, it does change the class dynamics. The guidelines do suggest one agent at a time, but in practice, the combinations are really used for patients with high A1c's. There are studies showing combo agents reduce A1c quickly and there are better outcomes. Synjardy is the combination of Jardiance and metformin, we would ask consideration for access to these medications.
Mark Decerbo: With the cardiovascular data, you are referring to the New England Journal that was published about a year ago?
Bill O'Neil: That is correct.

Christopher Highley: Just clinically from my practice experience, I have noticed improved compliance with the combination, in addition to lowering A1c, and tolerability, delaying the need for insulin products.
Shamim Nagy, Chair: Thank you, any other public comments?
Carl Jeffery: The SGLT-2's and the combinations are shown on this slide. We have combos with metformin and DDP-4's. All indications are the same. This has been a pretty good class to work with, as we have seen with the cardiovascular studies. Studies show good results in combination. I will remind the Committee too that they only need to try one agent before moving to a non-preferred. Optum recommends these be considered clinically and therapeutically equivalent.
Adam Zold: I motion these be clinically and therapeutically equivalent.
Christopher Highley: Second.
Voting: Ayes across the board.
Carl Jeffery: Optum recommends moving the combination agents to non-preferred. This is because clinically by the guidelines, you are supposed to stabilize medication independently before moving to a combination product. This is easy with this class because they only need to try one agent before getting a non-preferred.
Nikki Beck: With the recent cardiovascular studies, Jardiance was shown to be one that decreased cardiovascular events over Invokana. Invokana had some other guidelines as far as increased fractures. I would consider adding Jardiance to preferred. In place of the Invokana if needed.
Mark Decerbo: I would agree, the newer clinical information showing the cardiovascular outcomes with Jardiance, I would support adding Jardiance. I move accepting as is with the addition of Jardiance as preferred. This is based on new clinical data.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.

K. Ophthalmic Agents: Antiglaucoma Agents: Ophthalmic Prostaglandins

Shamim Nagy, Chair: Next is ophthalmic agents, anti-glaucoma, ophthalmic prostaglandins.
Public comment?

Carl Jeffery: There is a new generic out for a couple of these agents and that is why we are reviewing these today. They all have the same indication. There is one agent formulated as preservative free, Zioptan. Bimatoprost shows the greatest IOP reduction, but the clinical significance is unknown. The guidelines do not recommend one agent over another. Based on this, Optum recommends these products be considered clinically and therapeutically equivalent.
Evelyn Chu: I motion that we accept these as clinically and therapeutically equivalent.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.

Carl Jeffery: We want to shake things up a little bit in this class. Optum is recommending moving Zioptan to non-preferred and Lumigan to preferred, the new generic travoprost will be non-preferred.
Michael Hautekeet: I make the motion to accept the recommendations.
Joseph Adashek: Second.
Voting: Ayes across the board, the motion carries.

L. Ophthalmic Agents: Ophthalmic Anti-infective/Anti-inflammatory Combinations: Ophthalmic Quinolones
Shamim Nagy, Chair: The next topic is ophthalmic quinolones.
Public comment?

Carl Jeffery: For the ophthalmic quinolones, there are all short treatments for acute infections. The studies show equal effectiveness. There is one study showing levofloxacin showed a slight better response, but really nothing else. Optum recommends these be considered clinically and therapeutically equivalent.
Joseph Adashek: I motion we accept the recommendations.
Adam Zold: Second.
Voting: Ayes across the board.
Carl Jeffery: We are going to recommend adding ofloxacin to non-preferred and we just realized we are missing levofloxacin and we recommend adding that as preferred.
Nikki Beck: I motion that we accept the recommendations.
Evelyn Chu: Second.
Voting: Ayes across the board, the motion carries.

M. Respiratory Agents: Respiratory Anti-inflammatory Agents: Respiratory Corticosteroids

Shamim Nagy, Chair: The next topic is respiratory anti-inflammatory agents, corticosteroids.
Any public comment? None.

Carl Jeffery: Another class that we want to change around. This class has both metered dose inhalers and nebulizer solution. They are all indicated for the maintenance treatment of asthma. Many placebo controlled trials show these are effective. Guidelines recommend steroid inhalers should be used pretty early in the treatment progress. The guidelines do not call out any specific product even though they may differ in potency. Optum recommends this class be considered clinically and therapeutically equivalent.
Mark Decerbo: I move these be considered clinically and therapeutically equivalent as listed.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: At one of the last meetings we moved Pulmicort to non-preferred, we want to move that back as preferred and swap the Aerospan to non-preferred,

and make Arnuity preferred. Members will still have access to budesonide through the brand name.
Evelyn Chu: I motion that we accept the recommended preferred drug list.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

N. Respiratory Agents: Respiratory Beta-Agonists: Long-Acting Respiratory Beta-Agonist

Shamim Nagy, Chair: Long-acting respiratory beta-agonists.
Any comments?

Carl Jeffery: This is another class that has been available for a long time. The guidelines to not recommend a single agent over another. They are shown to be effective for asthma related therapies. Optum recommends these be considered clinically and therapeutically equivalent.
Michael Hautekeet: I make a motion to accept Optum's recommendation of clinically and therapeutically equivalent.
Mark Decerbo: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: We want to swap two agents in this class, similar agents, but move Striverdi to preferred and Arcapta to non-preferred.
Michael Hautekeet: I make the motion to accept the recommendation.
Evelyn Chu: Second.
Voting: Ayes across the board, the motion carries.

O. Respiratory Agents: Respiratory Beta-Agonists: Short-Acting Respiratory Beta-Agonist

Shamim Nagy, Chair: The next class is short-acting respiratory beta-agonists. Public comment?

Carl Jeffery: Another long-established class. The most common in this class is the albuterol metered dose inhalers. I don't think there is any real significance between the inhalers. Based on this information Optum recommends these be considered clinically and therapeutically equivalent.
Evelyn Chu: I motion they be considered clinically and therapeutically equivalent.
Mark Decerbo: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: A couple changes we would like to recommend. First, Maxair inhaler is no longer available, so we are going to remove that from the list. We are going to switch the levalbuterol with the brand Xopenex, this only applies to the nebulizer solution. The other is moving Proair HFA to non-preferred, that will leave Proventil HFA as the sole preferred metered dose inhaler for albuterol.
Christopher Highley: What is behind the recommendation, a couple slides back there was some difference.

Carl Jeffery: The reason with the slide was to show they are about the same, in fact Proventil has slightly faster on-set than Proair. I think it is an equivalent medication, we are just trying to push the market share to Proventil.
Adam Zold: I motion to go with Optum's recommendation.
Mark Decerbo: Second.
Voting: Ayes across the board, the motion carries.

P. Toxicology Agents: Substance Abuse Agents: Mixed Opiate Agonists/Antagonists

Shamim Nagy, Chair: Substance abuse agents, mixed opiate agonists, antagonists. Any public comment?

Carl Jeffery: Since there are no recommended changes, I don't think there is any action necessary by the Committee. We thought there was going to be some market changes. I think we just need a quick vote. Optum recommends this class is clinically and therapeutically equivalent.
Michael Hautekeet: I make the motion they are clinically and therapeutically equivalent
Mark Decerbo: Second.
Voting: Ayes across the board.
Carl Jeffery: Optum recommends the class remain the same.
Evelyn Chu: I motion we accept the recommendation.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.

6. Annual Review - Established Drug Classes Being Reviewed Due to the Release of New Drugs

A. Analgesics: Opiate Agonists - Abuse Deterrent

Shamim Nagy, Chair: Next is established drug classes being reviewed due to the release of new drugs. First is analgesics, opiate agonists, abuse deterrent.
Any public comment?

Carl Jeffery: There is a new drug in this class, Xtampza ER, it is an oxycodone product. Indicated for the same things as the others in the class, management of pain. Administered every 12 hours with food. The capsule can be opened up and sprinkled on apple sauce or given via an NG tube. The microspheres form some kind of gum if tampered. The abuse studies show people still prefer it crushed and ingested over placebo. With this class, Optum recommends these be considered clinically and therapeutically equivalent.
Christopher Highley: I move these be considered clinically and therapeutically equivalent.
Michael Hautekeet: Second.
Voting: Ayes across the board, the motion carries.

Carl Jeffery: Optum recommends moving Hysingla ER to preferred. This is based on the current political environment with opioid abuse, we wanted to provide another abuse deterrent option, a once a day hydrocodone product. And we will keep Embeda as preferred and make the new Xtampza ER as non-preferred.
Mark Decerbo: I move we accept the recommendations.
Evelyn Chu: Second.
Voting: Ayes across the board, the motion carries.

B. Biologic Response Modifiers: Multiple Sclerosis Agents: Injectable

Shamim Nagy, Chair: Next is biologic response modifiers, multiple sclerosis agents, injectable.
Any public comment?

Laura Hill: Hi, my name is Laura Hill, I am with Medical Affairs at Abbvie, and I would like to provide comments on Zinbryta. Prescribing, mechanism of action, indications, administration, black box warning and efficacy information is presented. It is available only through REMS program.
Nikki Beck: A question for you, did you say it requires failure of two agents before moving to this product?
Laura Hill: In general, because of the safety and REMS program, it is not recommended as a first-line treatment, so it would be recommended following two or more agents.
Nikki Beck: So according to the label, you have to fail two.
Laura Hill: Generally, yes, depending on how you write the PA criteria.
Carl Jeffery: We have a new drug in this category. Laura gave us some good information. I will just reiterate the risk of liver damage and why it is not generally considered first line. Optum makes the recommendation these be considered clinically and therapeutically equivalent.
Adam Zold: I motion they are clinically and therapeutically equivalent.
Mark Decerbo: Second>
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Optum recommends the Zinbryta be non-preferred since that is how it falls in with the label anyway. The P&T Committee made the decision a few years ago to require failure of just one drug.
Mark Decerbo: Are there any special stipulation with ID medications?
Carl Jeffery: The PA in our preferred drug list does not apply to drugs given in the physician's office. If this is billed through the physician's office, it will not hit the PDL. These medications that need to be given by a health care provider, these rules won't apply.
Evelyn Chu: I make the motion we accept the recommendations as presented.
Voting: Ayes across the board, the motion carries.

C. Cardiovascular Agents: Antilipemics: Fibric Acid Derivatives

Shamim Nagy, Chair: Cardiovascular agents, anti-lipemics, fibric acid derivatives.
Any public comment? No.

Carl Jeffery: There is a new generic, fenofibrate for the Lipofen. No clinical changes. Optum recommends these be considered clinically and therapeutically equivalent.
Michael Hautekeet: I make the motion that we accept these as clinically and therapeutically equivalent.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Our only recommendation is to move the brand Lipofen to non-preferred, the generic is already included as preferred.
Michael Hautekeet: I make the motion to accept the list.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

D. Genitourinary Agents: Benign Prostatic Hyperplasia (BPH) Agents:5-Alpha Reductase Inhibitors

Shamim Nagy, Chair: Genitourinary agents, benign prostatic hypertrophy.
Public comment?

Carl Jeffery: This is an easy one too, a generic for the Jalyn is available, duterasteride and tamsulosin. Optum recommends these be considered clinically and therapeutically equivalent.
Michael Hautekeet: I make the motion to accept the recommendation.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Optum recommends the new generic dutesteride and tamsulosin be added as non-preferred.
Michael Hautekeet: I make a motion to accept the recommendation.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

E. Hormones and Hormone Modifiers: Antidiabetic Agents: Insulins (Vials, Pens and Inhaled)

Shamim Nagy, Chair: Hormones and hormone modifiers, antidiabetic agents, insulins.
Any public comment? No.

Carl Jeffery: A new long-acting Tresiba, a once a day medication. There have been some studies against Lantus, It causes a slower release without regard to meals for type 1 and 2. Good results with reducing A1c. The one caveat with this one is less hypoglycemic episodes as the Lantus. The charts show how the

kinetics of the different products are. All the others remain the same, they have been available for a long time. Optum recommends these be considered clinically and therapeutically equivalent.
Adam Zold: I make the motion that these be considered clinically and therapeutically equivalent.
Mark Decerbo: Second.
Voting: Ayes across the board.
Carl Jeffery: Optum recommends that because we already have a few long-acting insulins as preferred and failure of one is needed to move to a non-preferred agent, we recommend Tresiba be added as non-preferred. If for some reason they were having an issue with hypoglycemia, then they could get Tresiba.
Nikki Beck: Can I make a comment about Tresiba? Working with diabetic agents with Tresiba and we are seeing less hypoglycemia especially at night. It is working well with type 1 and type 2 diabetics which is really nice. Plus with the increase in duration, with Lantus it only lasts 8 to 12 hours in some patients, this really does last a full 24 hours. I think we have a greater chance of getting our patients to goal with Tresiba. So I would recommend moving Tresiba to preferred.
Adam Zold: I agree with Dr. Beck, I second.
Voting: Nay – 2, Aye – 5 – the motion carries.

F. Neurological Agents: Anticonvulsants

Shamim Nagy, Chair: Neurological agents, anticonvulsants. Public comment?

Danielle Moreno: Hi my name is Danielle Moreno, I am the Executive Director of the Epilepsy Foundation of Nevada. I am an advocate for the people in Nevada living with epilepsy. Limiting access is putting lives in danger, and increasing chances of death. Patient's having their medication switched may cause breakthrough seizures. Patients shouldn't be required to appeal decisions. We believe everyone should have open access to all the medications for the treatment of epilepsy.
Nikki Beck: Was there one drug you were thinking of, or just in general.
Danielle Moreno: Just in general.
Rick Arnado: My name is Rick Arnado, I am a Pharm.D. here on behalf of UCB speaking on Briviact. Indications, mechanism of action, available trials, results, adverse reactions, contraindications, and dosing recommendations information is presented. Briviact is schedule 5. Please consider adding access to this medication.
Carl Jeffery: I think we heard about the Briviact and the dosage forms available. The other medication Spritam, levetriacetam is indicated for the adjunctive therapy. It is available in an oral tablet that disintegrates in the mouth. This class has some protections in that only one preferred needs to be tried before a non-preferred. And any product on the market on June 30, 2010 needs to be listed as preferred. Optum recommends this class be considered clinically and therapeutically equivalent.

Mark Decerbo: I move these medications be considered clinically and therapeutically equivalent.
Michael Hautekeet: Second.
Voting: Ayes across the board.
Carl Jeffery: We recommend the two new agents Briviact and Spritam be added as non-preferred because they are both indicated for adjunctive treatment, they are not indicated alone. They are new agents and have never been preferred, so there is nobody that would have these removed. And because only one agent is necessary, having them non-preferred just assures that they are already on another agent. That is what justifies our reasoning here.
Nikki Beck: I have a question, on the comment made earlier about brand vs. generic, if a provider write brand necessary, will that be covered.
Carl Jeffery: The way the statute is, this class is excluded from the requirement,
Mary Griffith: There are no drug classes that are excluded from the generic requirement. But it would depend on which would be less costly, but we do override the generic if the brand is needed for medical necessity. It is as dispense as written PA.
Evelyn Chu: I make a motion that we accept the list as presented.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

I. Respiratory Agents: Respiratory Antimuscarinics

Shamim Nagy, Chair: Respiratory agents, respiratory antimuscarinics.
Public comment? No.

Carl Jeffery: Another new agent in this class, Seebri, glycopyroloate, it is another long-acting anticholinergic for the treatment of COPD. It falls in with the GOLD guidelines. No head-to-head studies, no recommendation for one agent over another. Optum recommends these be considered clinically and therapeutically equivalent.
Christopher Highley: I make the motion these be considered clinically and therapeutically equivalent.
Evelyn Chu: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Given the understanding that the Seebri doesn't offer any benefit over the Spiriva, Optum recommends Seebri be added as non-preferred.
Christopher Highley: I make the motion that we accept the recommendation
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

G. Respiratory Agents: Respiratory Long-Acting Antimuscarinic/Long-Acting Beta-Agonist Combinations

Shamim Nagy, Chair: The next is respiratory agents, long-acting antimuscarinic, long-acting beta-agonist combinations.

Public comment? No.
Carl Jeffery: Another new agent, Utibron, combo of glycopyrolate with a long-acting beta agonist. Approved for COPD. Guidelines recommend adding it as a first line. No agent has been shown to be better than another. Optum recommends these be considered clinically and therapeutically equivalent.
Michael Hautekeet: I make the motion to accept these as clinically and therapeutically equivalent.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: Optum recommends Utibron be added as non-preferred, this leaves Anoro and Stiolto as preferred.
Michael Hautekeet: I make the motion we accept the list as presented.
Adam Zold: Second.
Voting: Ayes across the board, the motion carries.

7. ANNUAL REVIEW – DRUG CLASSES WITHOUT PROPOSED CHANGES

Shamim Nagy, Chair: Annual review of drug classes without proposed changes.
David Crosby: Good afternoon, I am David Crosby, I am an MSL with Bristol Meyers Squibb here to talk briefly on Orencia for rheumatoid arthritis. Indication, dosage, side effects, new dosage delivery device, and recommendations for the treatment of patients with rheumatoid arthritis is presented. I ask you consider adding Orencia to the preferred drug list.
Michelle William: I am Michelle William with UCB, I am here to talk about Cimzia. Dr. Stone did talk about this in his clinical practice. Indication, mechanism of action, dosage forms, and administration information is presented. Cimzia is pregnancy category B. Refer to the website for the most current contraindications. I request you consider adding Cimzia to the preferred drug list.
Shamim Nagy, Chair: Any other comments.
Carl Jeffery: I don't know if there is any discussion from the Committee on these classes. We could bring something back for the December 8th meeting.
Adam Zold: I would like to bring up the oral anticoagulants. Could we discuss today. I run a bedside delivery service and I would like to see more access to Savaysa.
Gabe Lither: Do you want to make a motion today or wait until December?
Adam Zold: I would like to make a motion to add Savaysa as preferred in the oral anticoagulant class.
Christopher Highley: Is that once daily or twice daily?
Adam Zold: Once daily.
Shamim Nagy, Chair: Do we have a second.
Christopher Highley: I would second that.
Gabe Lither: Carl, could you go over this class real quick?
Carl Jeffery: I we refer the Committee to the preferred drug list in your binder, Savaysa is the only non-preferred in the class, we have Coumadin, Eliquis, Jantoven, Pradaxa, Warfarin and Xarelto as preferred. The DUR Board just did make some changes to remove PA requirements if the appropriate diagnosis is on the claim. It is all dependent

on what it is indicated for. Other than that the only reason we didn't include it was at the time it was so new.
Mark Decerbo: Was there any other PA's on Savaysa. The one thing that concerns me is the comparative less efficacy with better renal function. Is this something we could kick back to the DUR Board for discussion?
Carl Jeffery: The DUR Board wanted to make better access to these medications, and the easiest way was to add the diagnosis. The renal function point is good, but our system is not able to look at renal function measures at the time of the claim. We can take this back to the DUR Board for further review to add additional criteria.
Shamim Nagy, Chair: We have a motion and second, voting.
Voting: Ayes across the board, the motion carries.
Carl Jeffery: The classes might be easier to see in your agenda. Optum recommends no changes to the classes listed except for the oral anticoagulants now.
Mark Decerbo: Can we revisit the two products the speakers talked about today?
Michael Hautekeet: Second.
Voting: Ayes across the board.
Carl Jeffery: I think that is it. The next thing on the agenda is the new drugs to market, but I don't have anything right now.

A. Analgesics: Analgesic/Miscellaneous: Neuropathic Pain/Fibromyalgia Agents
B. Analgesics: Analgesic/Miscellaneous: Tramadol and Related Drugs
C. Analgesics: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) - Oral
D. Antihistamines:H1 blockers: Non-Sedating H1 Blockers
E. Antiinfective Agents: Aminoglycosides: Inhaled Aminoglycosides
F. Antiinfective Agents: Antivirals: Alpha Interferons
G. Antiinfective Agents: Antivirals: Anti-hepatitis Agents: Ribavirins
H. Antiinfective Agents: Antivirals: Anti-Herpetic Agents
I. Antiinfective Agents: Antivirals: Influenza Agents
J. Antiinfective Agents: Cephalosporins: Second-Generation Cephalosporins
K. Antiinfective Agents: Cephalosporins: Third-Generation Cephalosporins
L. Antiinfective Agents: Macrolides
M. Antiinfective Agents: Quinolones: Quinolones - 2nd Generation
N. Antiinfective Agents: Quinolones: Quinolones - 3rd Generation
O. Autonomic Agents: Sympathomimetics: Self-Injectable Epinephrine
P. Biologic Response Modifiers: Immunomodulators: Disease-Modifying Antirheumatic Agents
Q. Biologic Response Modifiers: Multiple Sclerosis Agents: Specific Symptomatic Treatment
R. Cardiovascular Agents: Antihypertensive Agents: Angiotensin II Receptor Antagonists
S. Cardiovascular Agents: Antihypertensive Agents: Angiotensin-Converting Enzyme Inhibitors (ACE Inhibitors)
T. Cardiovascular Agents: Antihypertensive Agents: Beta-Blockers
U. Cardiovascular Agents: Antihypertensive Agents: Calcium-Channel Blockers
V. Cardiovascular Agents: Antihypertensive Agents: Direct Renin Inhibitors
W. Cardiovascular Agents: Antihypertensive Agents: Vasodilators:Inhaled

X. Cardiovascular Agents: Antihypertensive Agents: Vasodilators: Oral
Y. Cardiovascular Agents: Antilipemics: Bile Acid Sequestrants
Z. Cardiovascular Agents: Antilipemics: Cholesterol Absorption Inhibitors
AA. Cardiovascular Agents: Antilipemics: HMG-CoA Reductase Inhibitors (Statins):
BB. Cardiovascular Agents: Antilipemics: Niacin Agents
CC. Cardiovascular Agents: Antilipemics:Omega-3 Fatty Acids
DD. Dermatological Agents: Antipsoriatic Agents: Topical Vitamin D Analogs
EE. Dermatological Agents: Topical Analgesics
FF. Dermatological Agents: Topical Antiinfectives: Acne Agents: Topical, Benzoyl Peroxide, Antibiotics and Combination Products
GG. Dermatological Agents: Topical Antiinfectives: Impetigo Agents: Topical
HH. Dermatological Agents: Topical Antiinfectives: Topical Antifungals (onychomycosis)
II. Dermatological Agents: Topical Antiinfectives: Topical Antivirals
JJ. Dermatological Agents: Topical Antiinflammatory Agents: Immunomodulators: Topical
KK. Dermatological Agents: Topical Antineoplastics: Topical Retinoids
LL. Gastrointestinal Agents: Antiemetics: Serotonin-receptor antagonists/Combo
MM. Gastrointestinal Agents: Antiulcer Agents:H2 blockers
NN. Gastrointestinal Agents: Antiulcer Agents: Proton Pump Inhibitors (PPIs)
OO. Gastrointestinal Agents: Gastrointestinal Anti-inflammatory Agents
PP. Gastrointestinal Agents: Gastrointestinal Enzymes
QQ. Genitourinary Agents: Benign Prostatic Hyperplasia (BPH) Agents: Alpha-Blockers
RR. Genitourinary Agents: Bladder Antispasmodics
SS. Hematological Agents: Anticoagulants: Injectable
TT. Hematological Agents: Anticoagulants: Oral
UU. Hematological Agents: Erythropoiesis-Stimulating Agents
VV. Hematological Agents: Platelet Inhibitors
WW. Hormones and Hormone Modifiers: Androgens
XX. Hormones and Hormone Modifiers:Antidiabetic Agents: Alpha-Glucosidase Inhibitors/Amylin analogs/Misc.
YY. Hormones and Hormone Modifiers: Antidiabetic Agents: Biguanides
ZZ. Hormones and Hormone Modifiers: Antidiabetic Agents: Meglitinides
AAA. Hormones and Hormone Modifiers: Antidiabetic Agents: Sulfonylureas
BBB. Hormones and Hormone Modifiers: Antidiabetic Agents: Thiazolidinediones
CCC. Hormones and Hormone Modifiers: Pituitary Hormones: Growth hormone modifiers
DDD. Hormones and Hormone Modifiers: Progestins for Cachexia
EEE. Musculoskeletal Agents: Antigout Agents
FFF. Musculoskeletal Agents: Bone Resorption Inhibitors: Bisphosphonates
GGG. Musculoskeletal Agents: Bone Resorption Inhibitors: Nasal Calcitonins
HHH. Musculoskeletal Agents: Restless Leg Syndrome Agents
III. Musculoskeletal Agents: Skeletal Muscle Relaxants
JJJ. Neurological Agents: Alzheimer's Agents
KKK. Neurological Agents: Anticonvulsants: Barbiturates

LLL. Neurological Agents: Anticonvulsants: Benzodiazepines
MMM. Neurological Agents: Anticonvulsants: Hydantoins
NNN. Neurological Agents: Anti-Migraine Agents: Serotonin-Receptor Agonists
OOO. Neurological Agents: Antiparkinsonian Agents: Non-ergot Dopamine Agonists
PPP. Ophthalmic Agents: Antiglaucoma Agents: Carbonic Anhydrase Inhibitors/Beta-Blockers
QQQ. Ophthalmic Agents: Ophthalmic Antiinfectives: Ophthalmic Macrolides
RRR. Ophthalmic Agents: Ophthalmic Antihistamines
SSS. Ophthalmic Agents: Ophthalmic Anti-inflammatory Agents: Ophthalmic Corticosteroids
TTT. Ophthalmic Agents: Ophthalmic Anti-inflammatory Agents: Ophthalmic Nonsteroidal Anti-inflammatory Drugs (NSAIDs)
UUU. Otic Agents: Otic Antiinfectives: Otic Quinolones
VVV. Psychotropic Agents: Antidepressants: Other
WWW. Psychotropic Agents: Antidepressants: Selective Serotonin Reuptake Inhibitors (SSRIs)
XXX. Psychotropic Agents: Anxiolytics, Sedatives, and Hypnotics
YYY. Psychotropic Agents: Psychostimulants: Narcolepsy Agents
ZZZ. Respiratory Agents: Nasal Antihistamines
AAAA. Respiratory Agents: Respiratory Antiinflammatory Agents: Leukotriene Receptor Antagonists
BBBB. Respiratory Agents: Respiratory Antiinflammatory Agents: Nasal Corticosteroids
CCCC. Respiratory Agents: Respiratory Antiinflammatory Agents: Phosphodiesterase Type 4 Inhibitors
DDDD. Respiratory Agents: Respiratory Corticosteriod/Long-Acting Beta-Agonist Combinations
EEEE. Toxicology Agents: Antidotes: Opiate Antagonists

8. Report by OptumRx on New Drugs to Market, New Generic Drugs to Market, and New Line Extensions

9. Closing Discussion

Shamim Nagy, Chair: Closing discussion, any comments?

Audience member: When will this be effective?
Carl Jeffery: January 1, 2017.
Shamim Nagy, Chair: No other comments. The next meeting is December 8th. The meeting is adjourned.

Meeting adjourned at 4:06 PM