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Governor

STATE OF NEVADA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF HEALTH CARE FINANCING AND POLICY
NEVADA MEDICAID

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Pharmacy & Therapeutics Committee

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

Minutes
March 27, 2008
1:00 p.m.

Committee Members Present:
Robert Horne, MD, Chairman
David Chan, R.Ph.
Linda Flynn, R.Ph.
Justin Holt, Pharm.D.
Michael Karagiozis, DO
John Lee, MD
Chad Luebke, Pharm.D.
Rudy Manthei, DO
R.D. Prabhu, MD
Chris Shea, Pharm.D.

Others Present:
Coleen Lawrence-DHCFP, Gabriel Lither, DAG, Jeff Monaghan-FHSC, Dave Wuest-FHSC, Shirley Hunting-FHSC, Sandy Sierawski-Pfizer, Mike Steelman-Pfizer, Felicia Fuller-Biogen Idec, Kay Leslie-Genentech, Russell Ruspin-Genentech, John Stockton-Genentech, Trisha Williams-Teva, Rick Szymiatis-Lilly, Roland Baldwin-Wyeth, Jane Stephen-Allergan, Alan Rich-UNSOM, Rob Meier-Pfizer, Lori Howarth, Deziree Jones-Amgen, Spencer Holt-Astra Zeneca, Dave Wilson-GSK, Bert Jones-GSK, Contessa Fincher-EMD Serono, Chris Almeida-Purdue, Doug Powell-Forest, Pauline Patrick-Forest, Pete Hurstz-Lilly, Trenell (illegible)-Lilly, Dan Bay-Abbott.

I. Call to Order and Roll Call

Dr. Robert Horne called the meeting to order at 1:00 p.m.

Dr. R.D. Prabhu joined the meeting at 1:05 p.m.

II. *Review and Approval of December 13, 2007, Meeting Minutes

Correction to minutes: page 9, last paragraph, line one, change "his" to "this."

MOTION: Linda Flynn motioned to accept the minutes as presented with the correction as noted above.
SECOND: David Chan
AYES: Unanimous
MOTION CARRIED

III. Division of Health Care Financing and Policy Report

Coleen Lawrence, Chief, Program Services, provided the following updates:

Tamper-resistant Prescription Pads
Effective April 1, 2008, Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery and Iraq Accountability Appropriations Act of 2007, requires that all written, non-electronic prescriptions for fee-for-service Medicaid outpatient drugs be written on tamper-resistant prescription pads. Notifications outlining the requirements for tamper-resistant prescription pads have been sent to prescribers and pharmacy providers and posted to the DHCFP and First Health websites. The requirement applies to written prescriptions and will not apply to e-prescriptions transmitted to the pharmacy, prescriptions faxed to the pharmacy or prescriptions communicated to the pharmacy via telephone by a prescriber. Ms. Lawrence stated that she will have an update on e-prescribing at the next meeting.

Dr. Horne asked if this requirement only applies to controlled substance claims. Ms. Lawrence replied that this applies to all drugs written for Medicaid recipients even if Medicaid is the secondary payer.

NDC Project
The NDC Project went live on January 1, 2008. Physicians are now required to submit the National Drug Code (NDC) for physician-administered drugs utilizing the National Council for Prescription Drug Programs (NCPDP) billing units. The Healthcare Common Procedure Coding System (HCPCS) codes and Current Procedural Terminology (CPT) codes (with the exception of immunizations) for physician-administered drugs~~will~~ can no longer be utilized for billing Medicaid the drug portion of these claims.

Utilizing the NDC on these claims will increase the rebates to the State as well as provide improved drug utilization data.

National Provider Identifier (NPI)
Effective May 23, 2008, NPI will be required for claims submitted to Medicaid. Medicaid will enforce the requirement of NPI submission on claims.

IV. Growth Hormone Review

A. Public Comment

Kay Leslie, Genentech, spoke in support of Nutropin® and Nutropin® AQ. The approved FDA indications for these products are pediatric growth hormone deficiency, chronic renal insufficiency, Turner Syndrome, idiopathic short stature, and adult growth hormone deficiency. Nutropin® AQ is a premixed liquid version of Nutropin® that is ready for immediate injection and is available in 10mg 2ml vials or 10mg 2ml cartridges for the pen device. Nutropin® powder is mixed with diluent which can be customized by the physician to adjust the concentration for injection. Genentech has a personalized reimbursement support system, Nutropin® Access Solutions, to assist with authorization, documentation submission, appeals, re-certification and other processes for families. Injection training can be provided for families and the patients. Stepping Stones is a Genentech compliance building program for patients on Nutropin® and Nutropin® AQ, which has a hotline with live professional help and on-line tracking for doctors' appointments, pharmacy re-orders and growth tracking for children. In January, 2008, FDA approval was received for a 20mg 2ml pen device allowing for twice the concentration and half the volume ~~for~~ per injection. FDA approval was also received in January, 2008, for the Nutropin® AQ disposable pen, which is available in 5mg, 10mg, and 20mg sizes. She requested Nutropin® and Nutropin® AQ be added to the PDL.

Rick Szymiatis, Lilly, spoke in support of Humatrope®. Humatrope® is the first approved recombinant DNA somatropin marketed for 22 years making it the longest

somatropin product in the US. Lilly is the only company to have performed placebo-controlled non-treatment controlled trials to adult height to formally evaluate the long-term efficacy of somatropin treatment in patients with Turner Syndrome and idiopathic short stature. Humatrope® has FDA approval for a broad spectrum of indications including pediatric growth hormone deficiency, adult growth hormone deficiency, Turner Syndrome, idiopathic short stature and the only one approved for SHOX deficiency. Humatrope® is safe for newborn use because the diluent does not contain benzyl alcohol**,** the toxicity which precludes the use of other somatropin brands in newborn infants. Humatrope® is available in a 24mg cartridge which decreases the frequency of cartridge changes. Lilly maintains ongoing research in the understanding of growth hormone disorders and the optimization of treatment outcomes in both pediatric and adult patients and maintains two long-term observational studies in pediatrics and adults monitoring efficacy and safety. To ensure appropriate use, Lilly markets Humatrope® only to endocrinologists. He respectfully requested the Committee consider providing full access to all growth hormones for the benefits of the citizens of Nevada.

Dr. Karagiozis joined the meeting at 1:13 p.m.

Alan Rice, MD, assistance professor, University of Nevada School of Medicine, board certified pediatric endocrinologist, practicing at Sunrise Hospital, spoke in support of the pen device for growth hormone. He stated that there are situations that parents cannot draw growth hormone from a vial due to rheumatoid arthritis or visual problems and it's helpful for them to have a pen device. Pre-filled syringes are also available which have set doses that can be carried and not refrigerated. There are a number of companies that make pen devices but there's also companies that only have the vial and syringe option. He stated that parents should have the option of using a pen. He felt another concern is that Congress is currently working on a bill to change the schedule status of growth hormone to a Schedule III medication or keeping the basis of use the same as the past but toughening the penalties for abuse similar to penalties that would apply to the inappropriate manufacture or distribution of any Schedule III controlled substance. There is concern about the potential abuse of growth hormone. There is no single growth hormone that has all the FDA-approved indications. He felt that a wide range of growth hormone options covering all the currently approved indications should be available on the PDL as well as at least one pen device be available.

Dr. Monaghan asked Dr. Rice, for the record, if he is representing himself or is receiving any financial support from a drug company. Dr. Rice replied that he is not receiving any financial support from drug companies and he does not work for any drug companies.

Dr. Horne asked that other than the fact that different companies have not done the studies to get label extensions, is there any difference in the growth hormone itself. Dr. Rice replied that it's not known. Sandoz and Gate/Teva have not tested their growth hormone for use in other indications. Only one company has assessed growth hormone in the use of small for gestational age. Between the companies, he has not seen much of a difference clinically. Unless an actual head-to-head trial is done, there's no way to know.

Dr. Karagiozis asked if anyone has done a study that has found there is a clear clinical difference between classes of growth hormone, specifically, was there demonstrable inferiority or superiority within a class of indications for any specific growth hormone. His understanding is that they are essentially pharmacologically similar. Dr. Rice felt that such studies would have been done with growth hormone deficiency. He stated that he is not aware of any differences.

Sandy Sierawski, Pfizer, spoke in support of Genotropin®. Genotropin® has over 20 years of clinical experience in over 62 countries and is one of the top three agents used per number of prescriptions in Nevada Medicaid; i.e., 15% are for Genotropin® compared to the other agents, and is cost competitive in that realm of agents. It has a wide range of indications including the pediatric and adult growth hormone deficiency

coverage, and also Turner Syndrome, but unique to this product are the indications for small for gestational age and Prader-Willi Syndrome. Pfizer has a Bridge Program which is a case management and patient advocacy program offering ways for patients to start therapy by providing personalized support. Genotropin® offers a wide range of delivery devices; prefilled devices, injection pens and standard syringe systems that utilize an innovative two chamber cartridge. There's also a MINIQUICK system, which is a single dose device and does not require refrigeration, helps with compliance, and is prefilled and available in ten strengths in a seven day supply. Needles cannot be reused.

Dr. Karagiozis asked if Pfizer has looked into the level of diversion that's happening with the MINIQUICK and pediatric doses. Ms. Sierawski stated that she did not know. Dr. Karagiozis said that pediatric doses are not a significant source of diversion.

Contessa Fincher, EMD Serrano, spoke in support of Saizen®. Saizen® is available for use in a wide range of easy-to-use drug delivery devices and ranging in patients from newborns to adults. It's distributed in 8.8mg and 5mg vials as well as 8.8mg click easy cartridges. EMD Serrano offers the only needle-free delivery device, Cool Click, as well as an auto-injector pen with a hidden needle. Easy Pod is the new delivery device approved by the FDA in October, 2007. EMD Serrano provides this device free of charge as well as the needles and batteries. For patients, Easy Pod requires three simple steps for daily injection use: attaching the needle, inject the Saizen®, detach the needle. For healthcare providers, Easy Pod offers an adherence log allowing the clinician to monitor patient adherence. Easy Pod features also include a dose adjustment setting specifically designed to reduce growth hormone waste by adjusting the content in the cartridge so all the drug is used and there is nothing left in the cartridge. EMD Serrano offers a patient support program, Connections for Growth, which is available to assist patients with education and training for Saizen® and its devices.

Dr. Horne asked what the difference between Saizen® and Serostim® is. Ms. Fincher replied that Serostim® is used in ~~aids~~ AIDS wasting and Saizen® is used for growth hormone deficiency. Dr. Monaghan asked if she agreed that they are chemically identical products and marketed for two different indications and she agreed. Dr. Karagiozis stated that he is the largest growth hormone prescriber of Serostim® in the State because of his HIV practice and referred to page 2 of the drug review which states, "The amino acid sequence of somatropin is identical to that of hGH of pituitary origin." He asked if she disagreed with that statement and she replied that she did not. Dr. Karagiozis said that the answer is dosage because with HIV patients, the dosage is typically 4mg to 6mg per day and none of the other dosage forms available including Saizen® approach that. He again stated that research shows that the pediatric forms and doses do not appear to be the diversion risk for growth hormone; large multi-use vials are the diversion risk for growth hormone.

B. **Drug Class Review Presentation – First Health Services**

Jeff Monaghan stated that this is a drug class which has not been reviewed by the P&T Committee in the past. With the advent of DNA derived human growth hormone, somatropin, the number of uses for this product and the number of suppliers has greatly increased both legitimate and illegitimate. The Drug Use Review (DUR) Board recently revised and updated the prior authorization (PA) criteria for growth hormone. There are controls in place to ensure that this drug is used appropriately. Currently, there are seven suppliers of somatropin. These products, by definition, are very similar in their clinical effects and essentially the same chemical entity. The differences are in some of their FDA approved indications. It reflects that the manufacturer of the specific product has pursued and received approval for a particular indication but it does not distinguish their product and there is no head-to-head data on one product against another. The American Association of Endocrinologist Guidelines speaks in general terms about somatropin and they do not specify any particular product for any disease state. The differences in the products might be the concentration of the drug, various dosage forms and the product packaging. He applauded the industry for coming up with good ways to administer this drug particularly in the pediatric population. Some of the products are available in

solution versus having to be reconstituted and some data indicates that this results in a reduced level of pain at the site of injection. It is the recommendation of DHCFP and First Health that all forms of somatropin presented today be considered therapeutic alternatives.

C. **Committee Discussion and Action to Approve Clinical/Therapeutic Equivalency of Agents in Class and Identify Exclusions/Exceptions for Certain Patient Groups**

MOTION: Michael Karagiozis motioned that all forms of somatropin be considered therapeutic alternatives.
Dr. Karagiozis stated that he personally feels that all these agents are the same but felt use of the individual marketed drugs should be restricted to their FDA indications.
Dr. Horne stated that this motion is to determine therapeutic alternative and limitations can be included in the next motion to determine agents that will be added to the PDL.
SECOND: Rudy Manthei
Ms. Lawrence offered clarification that per Nevada Medicaid policy for drug coverage, use is limited to FDA approved indications.
Dr. Manthei stated that off-label use has always been the prerogative of the physician for therapy as long as it's identified to the patient.
Dr. Monaghan stated there would be no way to enforce this restriction currently, and added CMS does recognize off-label use if supported by peer-reviewed literature. Dr. Horne added that the Committee's role is to establish a Preferred Drug List.
AYES: Unanimous
MOTION CARRIED

D. **Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by First Health Services and the Division of Health Care Financing and Policy**
Dr. Monaghan stated that he would like to remove Serostim® from discussion as it is not within the market basket of the products that will be placed on the PDL. Serostim® will not be recommended for inclusion in this category but that does not mean that it will not be available. This category is for growth hormone indications only.

It is the recommendation of DHCFP and First Health to add Norditropin®, Nutropin®, Nutropin® AQ, Saizen® and Genotropin®. These four products will give the practitioner the breadth of product as well as delivery devices they would like to have available.

E. **Committee Discussion and Approval of Drugs for Inclusion in the PDL**

MOTION: Linda Flynn motioned to accept First Health's recommendation to add Norditropin®, Nutropin®, Nutropin® AQ, Saizen® and Genotropin®
SECOND: Michael Karagiozis
AYES: Unanimous
MOTION CARRIED

V. Erythropoiesis Stimulating Proteins Review

A. Public Comment

No comment.

B. Drug Class Review Presentation – First Health Services
Dave Wuest presented an overview of this drug class. He stated that there are three drugs within this category, Procrit®, Epogen® and Aranesp®. He said that he will refer to Procrit® and Epogen® as epoetin ~~alpha~~ alfa since they are the exact same chemical and both manufactured by Amgen. Procrit® is distributed by Ortho Biotech and Epogen® is distributed by Amgen. Aranesp® is chemically similar to the two with two amino acid chains added on to the end which decreases the clearance of the drug therefore making it

a little longer acting by lengthening the dosing intervals and extending the half-life. The FDA placed a black box warning on these agents in 2007 to limit the indications. They are all indicated to achieve and maintain hemoglobin levels in the range from 10-12 g/dL. FDA indications are treatment of anemia secondary to myeloid suppressive anti-cancer therapy; treatment of anemia related to zidovudine therapy in HIV infected patients; treatment of anemia secondary to end stage renal disease. In January, 2008, the DUR Board accepted these indications as clinically good indications for use. Epoetin ~~alpha~~alfa is also indicated but Aranesp® is not indicated to achieve and maintain hemoglobin levels within the range of 10-13 g/dL in the reduction of allogeneic blood transfusions in surgery patients due to the long-acting nature of the drug. Most studies have shown clear dose equivalence between epoetin ~~alpha~~alfa and Aranesp® throughout the whole dosing range, however, the drugs are not considered equivalent. It is the recommendation of DHCFP and First Health that Procrit® and Epogen® be considered therapeutic alternatives and Aranesp® be considered a unique ESA.

C. **Committee Discussion and Action to Approve Clinical/Therapeutic Equivalency of Agents in Class and Identify Exclusions/Exceptions for Certain Patient Groups**
Dr. Horne asked if Aranesp® would be on the PDL because there is no alternative and would this be considered as two drug classes. Dr. Monaghan stated that this drug class has not been addressed by the Committee before and the three agents will be in the same class. Mr. Wuest added that Aranesp® is different enough in dosing that it cannot be considered equivalent but remains in the same drug class.

MOTION: **R.D. Prabu motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Linda Fynn**
AYES: **Unanimous**
MOTION CARRIED

D. **Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by First Health Services and the Division of Health Care Financing and Policy**
Dave Wuest said that it is the recommendation of DHCFP and First Health to add Procrit® and Aranesp® to the PDL.

E. **Committee Discussion and Approval of Drugs for Inclusion in the PDL**

MOTION: **Michael Karagiozis motioned to accept First Health's recommendation to add Procrit® and Aranesp® to the PDL.**
SECOND: **John Lee**
AYES: **Unanimous**
MOTION CARRIED

VI. Beta-blockers Review

A. Public Comment
Dave Nilson, GlaxoSmithKline, spoke in support of Coreg® CR. Coreg® CR is differentiated from other once daily beta-blockers in that its mechanism of action includes triple blockade of beta-1, beta-2, and alpha-1 adrenergic receptors. Coreg® CR was approved by the FDA for the same indications of carvedilol mainly mild to severe heart failure to reduce cardiovascular mortality in patients who are post-myocardial infarction with left ventricular dysfunction and hypertension. Recently, the American Association of Clinical Endocrinologists recommended Coreg® as a preferred beta-blocker in Type II diabetics due to its neutral effect on Hba1c parameters compared to beta-1 selective agents. The basis for the recommendation was data reported in the Gemini Study and this data has recently been incorporated into the prescribing information. Studies have shown that decreasing the number of doses taken per day increases patient adherence to medications. During the earlier heart failure studies with Coreg®, the adult response study, MOCHA, demonstrated dose-related benefits with regard to ejection fraction improvements, mortality and hospitalization and patients

achieving optimum target doses of Coreg®. An analysis of adherence data with Coreg® in patients with heart failure and/or post-MI with MVD, demonstrated that for every 10% increase in adherence, the risks for cardiovascular and hospitalization were decreased by 9%. The adverse event profile for twice daily Coreg® and Coreg® CR are similar. In some hypertension trials, Coreg® CR was associated with a lower incidence of adverse events especially headache which may lead to better tolerability to the once daily formulation. In June 2007, the Nevada PDL review, Coreg® CR was made available for patients on an ACE inhibitor or an angiotension receptor blocker and a diuretic. Its usage has been appropriate with these step-edits. He asked that Coreg® CR remain on the PDL as determined last year.

Pauline Patrick, Forest Laboratories, spoke in support of nebivolol (Bystolic®). Nebivolol is an FDA approved beta-blocker for the treatment of hypertension alone or in combination with other antihypertensive agents. Nebivolol has been available internationally for over 10 years and dispensed to over 10 million patients. It's a novel beta-blocker that provides significant blood pressure reductions with a favorable tolerability profile. Nebivolol has the highest selectivity for beta-1 receptors of all beta-blockers that are currently marketed in the United States. Unlike other vasodilating beta-blockers, nebivolol's ~~vasodilatation~~vasodilation is not caused by action on the alpha-1 adrenergic receptors, but it is produced by ~~vasodilatation~~ vasodilation through enhancement of nitric oxide through the vascular endothelium. Over 70 clinical trials involving nebivolol have been completed including comparative trials with other beta-blockers, ace inhibitors, ARBs and calcium channel blockers. As part of the FDA new application process, three monotherapy trials were conducted with minor to moderate hypertension. *The Journal of Clinical Hypertension* published two of these trials in September and November, 2007. Pooled analysis of these trials showed nebivolol demonstrated significant dose-dependent decreases in both sitting diastolic and systolic blood pressure. Nebivolol has demonstrated efficacy in a broad range of patient populations including African-Amercians, obese and diabetic patients.

Dr. Lee asked how this compares to other beta-1 selective beta-blockers such as metoprolol, atenolol and carvedilol. Ms. Patrick replied that there was a study done comparing the ratio of beta-1 to beta-2 blockade which showed there was a 40 fold beta-1 to beta-2 selectivity with nebivolol versus the beta-2. Carvedilol in that study was .73 because it's non-selective. Bisoprolol and metoprolol were also more cardio selective, but it was about half of what was seen with nebivolol.

Dr. Horne referred to the drug review which states that "Nebivolol (Bystolic) is effective in lowering blood pressure, appears to be well tolerated, and has the unique mechanism on the nitric oxide pathway, however, it does not confer additional clinical benefit over existing beta-blockers…and long term outcome data…are lacking." He asked what the additional clinical benefit is over the existing beta-blockers. Ms. Patrick replied that her company has no outcomes data in hypertension but there is outcomes data in heart failure in Europe, however, they do not have an indication in the United States. She said nebivolol can be of benefit specifically in the African-American population and the obese population. Studies have shown that nebivolol was as effective in those populations as in the general population in lowering blood pressure. Dr. Horne asked if there was an active control in that study and Ms. Patrick replied that it was a monotherapy study with placebo as required by the FDA.

Dr. Monaghan asked in terms of the beta-1 selectivity is there still a warning on use in asthmatic patients. Ms. Patrick replied as with all beta-blockers, there is class labeling to recommend caution.

Dr. Prabu stated that it's a more selective beta-blocker so you can safely use it in patients with bronchospasms, asthma and COPD. Dr. Lee added beta-blockers are given to patients with COPD until they experience problems. Because it's a beta-1 selective, it gives a little more comfort level.

Dr. Shea asked if there is any data that shows that beta-1 selectivity improved safety over metoprolol or atenolol. Ms. Patrick replied that she is not aware of any studies that document better tolerability in asthmatics or COPD.

B. **Drug Class Review Presentation – First Health Services**

Dr. Monaghan stated this class is being reviewed due to the entry into the market of nebivolol and new data on carvedilol. Coreg® CR was reviewed in June, 2007, and at that time, Coreg® CR was added to the PDL. Since then, a generic carvedilol has become available. In the past, the Committee was concerned that carvedilol or Coreg® would be used first-line as an antihypertensive when its strength is in the heart failure arena, therefore, an ICD-9 restriction was placed on this drug; i.e., ICD-9 for heart failure would be required to obtain the drug without prior authorization. There's also a step-edit in place that when a claim is submitted, the system looks back to see if the recipient is on a diuretic with either an ACEI or an ARB, the claim will process without prior authorization.

Currently, there are three beta-blockers that are recommended for heart failure: metoprolol succinate ER (Troprol XL), carvedilol (Coreg® and Coreg® CR), and bisoprolol (Zebeta). Bisoprolol has an indication for heart failure in Europe not the United States; however, there is good outcomes data. Because of that, the American College of Cardiology and the American Heart Association recommend not one but any of the three for treating heart failure. In terms of treating garden variety hypertension, although beta-blockers are not first-line, there are a number of beta-blockers available generically and the current PDL includes an extensive list of those. There was considerable testimony at the June, 2007, meeting regarding the benefits of carvedilol for the hypertensive diabetic patient. This was based on the favorable results that came out of the GEMINI Trial and because of that, the American Association of Clinical Endocrinologists have designated carvedilol as a preferred beta-blocker for Type II diabetics.

The new agent, nebivolol (~~Bistoli~~Bystolic~~e~~®), is a beta-1 selective adrenergic antagonist which purports to have more beta-1 selectivity most of which is theoretical at this point. There is no good head-to-head data clinically in terms of outcomes. It is only indicated for hypertension and has not been approved for heart failure at this time. It's an option for the treatment of uncomplicated to moderate hypertension, but there are other available beta-blockers that are more well-established with more robust outcomes data to support their use particularly in heart failure.

It is the recommendation of DHCFP and First Health that the agents in this category be considered therapeutic alternatives.

C. **Committee Discussion and Action to Approve Clinical/Therapeutic Equivalency of Agents in Class Identify Exclusions/Exceptions for Certain Patient Groups**

MOTION: **R.D. Prabu motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Justin Holt**
AYES: **Unanimous**
MOTION CARRIED

D. **Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by First Health Services and the Division of Health Care Financing and Policy**

Dr. Monaghan stated that it is the recommendation of DHCFP and First Health that nebivolol (Bystolic®) not be added to the PDL at this time, and now that carvedilol is available generically, Coreg® CR be removed from the PDL. Coreg® CR has had very little utilization and with the entry into the market of several generic products, it would be to the State's advantage to promote the generic version. Because of the data coming in on carvedilol, it is recommended to remove the current ICD-9 and step-edit requirements.

Dr. Horne asked if the removal of the step-edit and ICD-9 requirement needs to be referred to the DUR Board. Dr. Monaghan stated that the P&T Committee can make that determination. Ms. Lawrence added that the requirement of the ICD-9 was used as a mechanism to allow Coreg® CR to be included on the PDL. It was utilized as a step-edit and not step-therapy which is under the control of the DUR Board.

E. Committee Discussion and Approval of Drugs for Inclusion in the PDL

MOTION: Chris Shea motioned to remove Coreg® CR from the PDL and remove the ICD-9 and step edit requirements for carvedilol.
SECOND: John Lee
AYES: Unanimous
MOTION CARRIED

MOTION: Chad Luebke motioned to not add nebivolol Bystolic® to the PDL.
SECOND: Justin Holt
AYES: Shea, Lubke, Holt, Flynn, Chan
NAYES: Manthei, Prabu, Lee
Before offering his vote, Dr. Karagiozis asked Dr. Lee why he is in favor of adding nebivolol to the PDL. Dr. Lee stated that he prescribes beta-blockers for heart failure and hypertension and many of his patients have COPD or asthma. A beta-blocker with documented higher beta-1 selectivity is attractive and Dr. Prabu agreed.
Dr. Horne asked if it would be appropriate to include nebivolol to the PDL with an ICD-9 requirement for COPD or asthma.
Dr. Prabu said that there are patients with hypertension who also have other conditions that will benefit from Bystolic® because it's the most beta-1 selective adrenergic antagonist. He recommended that Bystolic® be added to the PDL for selective use in hypertensive patients who cannot tolerate other beta-blockers that are less selective.
~~**Motion tabled.**~~

MOTION: Michael Karagiozis motioned to add nebivolol Bystolic® to the PDL with the requirement of an ICD-9 code for obstructive or reactive airway disease.
SECOND: John Lee
Dr. Shea asked the physicians if they had success with nebivolol in respiratory patients.
Dr. Lee stated that the previous beta-one selective drugs like metoprolol or atentolol are better tolerated than non-selective beta-1 blockers like labetolol or Coreg®. The fact that this drug is more beta-1 selective should result in better tolerability. The clinical data is not there, but as a clinician, when patients need additional blood pressure treatment and they also have COPD, the last thing is to increase a medication and have them end up on a respirator. To have a novel beta-blocker that has demonstrated beta-1 selectivity is very attractive.
Dr. Horne said that at this point, it's theoretical since there have been no head-to-head clinical trials showing better outcomes than with the already approved beta-1 selectors.
AYES: Manthei, Prabu, Flynn, Lee, Karagiozis, Horne
(Dr. Horne stated that his vote will be to include nebivolol to the PDL at this time with the understanding that this will be reconsidered at the June, 2008, meeting when more data with a placebo control and an active control may be available.
NAYES: Shea, Holt, Lubke, Chan
MOTION CARRIED
Ms. Lawrence asked, for clarification, that this drug will be re-reviewed at the annual meeting in June, 2008, based upon clinical information.
Dr. Horne stated that is correct with clinical information from Europe since U.S. data is not expected to be available**.**

VII. Antidepressants (other than SSRIs) Review

A. Public Comment

No comment.

B. Drug Class Review Presentation – First Health Services

Jeff Monaghan stated that this class, novel antidepressants or non-SSRIs, was reviewed at the annual review in June, 2007. Dr. Horne requested that this class be reviewed because there has been generic activity with one of the drugs, buproprion once daily version (extended release). The twice daily dose, buproprion SR, is currently on the PDL. The drugs in this category exert their effects by inhibiting reuptake or blocking of the receptor sites of not just serotonin but potentially several neurotransmitters (dopamine, norepinephrine or serotonin). There's also a drug in this category which is unique, Emsam® (selegiline). It's a transdermal form of monoamine oxidase inhibitor that was released in the last year. Up to this point, the Committee did not place it on the PDL thinking it would be a second-line drug. All of the second generation antidepressants are effective at reducing symptoms of depression. There have been no significant differences in efficacy in clinical trials. It's been estimated that as many as half of the patients suffering from major depressive disorder will not respond adequately to drug therapy. As with many psychotropic drugs, patients failing to respond to one antidepressant may respond to another agent with a different mechanism of action. The overall incidence of adverse events and the rates of discontinuation are, in general, equivalent but there are some differences in the side effect profiles within this class. Venlafaxine has a higher rate of nausea and vomiting versus fluoxetine. Buproprion seems to have the lowest rate of sexual side effects and has been shown to cause weight loss versus weight gain. Mirtazapine, which is currently on the PDL, has been associated with weight gain. Nafazadone, which is not on the PDL, is similar to trazodone in that it has a high incidence of sedation which could be a benefit for insomnia-related depression. Nafazadone was removed from the market in Europe and it is no longer manufactured in the United States. There are some generic versions available but it's not considered a preferred agent. There is a significant rate of skin reactions to Emsam®. One thing all the agents have in common is the black box warning regarding suicidality not only in children and adolescents, but recently it's been extended in adults up to age 24.

It is the recommendation of DHCFP and First Health that the agents in this class be considered therapeutic alternatives.

C. Committee Discussion and Action to Approve Clinical/Therapeutic Equivalency of Agents in Class and Identify Exclusions/Exceptions for Certain Patient Groups

MOTION: **Michael Karagiozis motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Linda Flynn**
AYES: **Unanimous**
MOTION CARRIED

D. Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by First Health Services and the Division of Health Care Financing and Policy

Jeff Monaghan stated that it is the recommendation of DHCFP and First Health to add the once daily version of buproprion 150mg and 300mg to the PDL.

Dr. Horne asked if the brand or generic version would be added and would the SR version be removed. Dr. Monaghan stated that currently it would be to the State's advantage to add the brand name product and the recommendation is that the SR form will remain on the PDL. Dr. Horne asked if the immediate release can be removed.

Dr. Karagiozis felt removing the immediate release depended on utilization. Dr. Monaghan did not have the utilization data available but felt it is not heavily utilized and

asked Dr. Horne if there is a reason to have it on the PDL. Dr. Horne felt there was no reason to have it and that it should be removed from the PDL.

E. **Committee Discussion and Approval of Drugs for Inclusion in the PDL**

MOTION: Michael Karagiozis motioned to accept First Health's recommendation to add the once daily version of buproprion 150mg and 300mg to the PDL with the modification to remove immediate release from the PDL. Patients currently maintained on the immediate release can continue with a prior authorization.

SECOND: Chad Luebke

Linda Flynn stated that she would like to see utilization review that if a patient is currently on the immediate release, where do they end up; are they grandfathered in?
Dr. Monaghan stated that the system can be set up to allow patients currently maintained on the immediate release to be grandfathered in.
Coleen Lawrence stated that there are two avenues to consider, a look-back period whereas if the recipient has been on the drug, therapy can continue without going through the prior authorization process. If a clinical intervention is desired, the prior authorization process can be required.
Dr. Lee stated that if there is an exceptional case, the physician can obtain a prior authorization.
Ms. Flynn said that if the recipient is currently maintained on the drug, the physician would have to submit a prior authorization delaying getting the drug for a day or two.
Chad Luebke agreed stating his concern is continuation of care if there a prior authorization requirement, and supported a system look-back.
Dr. Horne asked if First Health could send a letter to those physicians utilizing immediate release suggesting the patients be converted to a newer formulation.
Ms. Lawrence stated that is the authority of the Drug Use Review Board and that functionality is there. For what the Committee wants to accomplish to the PDL is a separate issue.
Dr. Monaghan stated that the original motion to add this drug can be acted upon and at the June meeting, utilization can be reviewed and removal can be considered at that time. The Committee agreed.

Chad Luebke offered a friendly amendment to add all strengths of once a day extended release buproprion to the Preferred Drug List and review utilization of the immediate release version at the annual review meeting in June for consideration to maintain or remove it from the PDL.

SECOND: John Lee
AYES: Unanimous
MOTION CARRIED

VIII. Report from FHSC on Creation of Drug Class for Agents Used to Treat Macular Degeneration

Jeff Monaghan stated that First Health does not have a market basket of products to bring before the Committee in this therapeutic category at this time. Utilization on the pharmacy-based claims is very low.

Dr. Horne asked Dr. Manthei if he felt that there is anything that needed to be done from his perspective for presentation at the next meeting and Dr. Manthei replied no.

IX. Report by FHSC on Brand Name Preferred Drugs Converted to Generic Status and Line Extensions

Jeff Monaghan stated that there are two brand-name drugs which will be converted to a generic name on the next revision to the PDL, ceftin suspension and Duoneb Nebule.

X. Report from FHSC on Annual PDL Review Process Scheduled for the June 26, 2008 Meeting

Jeff Monaghan stated that by statute, an annual review of the Preferred Drug List must be conducted. In the past, complete class reviews have been limited to:

- drug classes with new drugs,
- new indications
- requests from Committee members to have a particular drug class reviewed or re-reviewed.
- drug classes impacted by the National Medicaid Pooling Initiative which can influence the recommendation for PDL inclusion and which can assist the State in conserving or saving funds.

Drug classes with proposed changes to the PDL will be presented and a list of drug classes without proposed changes will be presented. Drug classes without proposed changes can be considered for full review at a future meeting if there is compelling public comment or the Committee desires to review the class in more depth. Drug class review documents will only be provided for classes with proposed changes.

Ms. Lawrence stated that at the annual review, drug manufacturers are asked to present only new information that has come forward since the last clinical review.

Dr. Monaghan asked the Committee if there are specific drug classes they would like to have reviewed at the annual review, to contact him within the next two weeks.

Dr. Karagiozis requested that all three of the lipid classes be reviewed. Dr. Monaghan asked for clarification if Dr. Karagiozis is requesting specifically the statins or statin combinations. Dr. Karagiozis replied the statin combinations and the triglyceride lowering combinations.

XI. Review of Next Meeting Date and Location: June 26, 2008 – Las Vegas Chamber of Commerce

The next meeting is scheduled for June 26, 2008, at the Las Vegas Chamber of Chamber of Commerce. The meeting will be scheduled from 1:00 p.m. to 5:00 p.m.

XII. Public Comment

No comment.

XIII. Adjournment

MOTION: Linda Flynn motioned to adjourn the meeting.
SECOND: Chad Luebke
AYES: Unanimous
MOTION CARRIED
Meeting adjourned at 3:03 p.m.