JIM GIBBONS
Governor

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

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Director

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PHARMACY & THERAPEUTICS COMMITTEE

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

Committee Approved
Meeting Minutes
March 26, 2009

Committee Members Present:
Linda Flynn, R.Ph.
David Chan, R.Ph.
Justin Holt, Pharm.D.
Constance Kalinowski, MD
John Lee, MD
Chad Luebke, Pharm.D.
Rudy Manthei, DO
R.D. Prabhu, MD

Absent:
Judy Britt, Pharm.D.
Michael Karagiozis, DO

Others Present:
Mary Griffith-DHCFP, Darrell Faircloth-DAG, Jeff Monaghan-FHSC, Dave Wuest-FHSC, Shirley Hunting-FHSC, Dan Bay-Abbott Labs, Efran Altoro-Merck, Scott Burns-Merck, Robert Spivock-Gilead, Evette Brooks-Actelion, Dr. Lampert, Aaron Huwe-Gilead, Isam Herndon-GSK, Rick Kurehart-GSK, Felicia Fuller-Biogen, Jennifer Choi-CVT, Kara Thorsfeldt-Cephalon, Michael Steelman-Pfizer, Sandy Sierawski-Pfizer, Tom O'Connor-Novartis, Cindy Giambrone-Novartis, Sarah Day-VCG & Associates, Chris Johnson-UCB, Lori Horwarth-Bayer, Elizabeth Ariano-Rickitt Benckiser, Dean Donato-Alcon Laboratories.

I. Call to Order and Roll Call

Chairperson, Linda Flynn, called the meeting to order at 1:01 p.m.

II. Review and Approval of September 25, 2008 Meeting Minutes

MOTION: **David Chan motioned to approve the September 25, 2008, minutes as written.**
SECOND: **John Lee**
VOTES: **Unanimous**
MOTION CARRIED

Review and Approval of December 11, 2008 Meeting Minutes

MOTION: **John Lee motioned to approve the December 11, 2008, minutes as written,**
SECOND: **Justin Holt**
VOTES: **Unanimous**
MOTION CARRIED

Mary Griffith announced that Chris Shea has been appointed to the Nevada Medicaid Drug Use Review Board and has resigned his seat on the Pharmacy and Therapeutics Committee. Judy Britt, Pharm.D., has been appointed by the Governor's office to replace Dr. Shea. Dr. Britt received her doctor of pharmacy degree at the University of the Pacific and is board certified in psychiatric pharmacy. She has previously served on the P&T Committee and is currently employed by Home Town Health. Dr. Britt was not able to attend this meeting but will be at the June meeting.

Jeff Monaghan stated that in some cases, all drugs within a drug review will not be addressed today. A notation has been placed at the beginning of those drug reviews in the Committee's binders. He will also indicate which drugs when the drug review is presented.

Ms. Flynn noted that Dr. Manthei joined the meeting at 1:04 p.m.

III. New Drug Class Reviews

A. Pulmonary Arterial Hypertension Agents-Endothelin Receptor Antagonists (ERTAs)

1. Public Comment

Evette Brooks, Actelion Pharmaceuticals, spoke in support of Tracleer®. Tracleer® was evaluated in six randomized clinical trials and various patient populations. It's the only ERTA that's been shown to delay time to clinical worsening and improve acute hemodynamic parameters in three separate randomized placebo-controlled trials. It's been studied in functional class II patients and a supplemental new drug indication is pending for this indication. Tracleer® has a well characterized safety profile with over seven years of clinical experience. The class of ERTAs do have the potential for liver injury and do have black box warnings for liver function tests and pregnancy. In the Tracleer® pivotal trial program, 98% of patients remained on treatment without requiring discontinuation due to ALT elevations. Tracleer® is contraindicated with glyburide and cephalosporins but can be used with sildenafil or warfarin®. She introduced Dr. Lampert, pulmonologist.

Dr. Lampert disclosed that he is not being paid by any pharmaceutical company to speak today. There are two endothelin antagonists which are available in the U.S. for the treatment of pulmonary arterial hypertension (PAH). They both work; both have slightly different nuances, different side effects and similar indications. PAH is a rare disease and if left untreated, has devastating consequences. He requested that the Committee allow both agents to be available allowing the physician to decide which would be the appropriate medication to use.

David Chan asked since this is a rare disease, how often Dr. Lampert sees a patient with PAH. Dr. Lampert replied he has fifteen to twenty patients and his guess is that there are approximately one-hundred patients state-wide.

Jeff Monaghan stated that the Committee is asked to determine therapeutic equivalency, and asked in Dr. Lampert's experience, if one of these agents is not working, does it make sense to try the other one? Dr. Lampert replied that the side effect profiles can be different. These are oral agents. If the oral agents don't work, the next move is to intravenous agents which require hospitalization. He felt that the agents are equivalent to each other.

Aaron Huwe, Gilead, spoke in support of Letairis® (ambrisentan), the newest agent for the treatment of PAH. He stated that PAH afflicts approximately 80,000 Americans and the relative predominance is about 15 per million lives. Letairis® is an endothelin receptor antagonist indicated for the treatment of PAH patients exhibiting WHO functional Class II or III symptoms. It's approved specifically for improvement in exercise capacity and to offset the

time to clinical worsening. Functional Class II or III patients represent the majority of PAH patients (70%). The indication for Letairis® is based on two prospective randomized control trials, ARIES-1 and ARIES-2. One year data is now published and two year data was recently presented at the CHEST Conference. Overall, for the primary end point to six minute walk distance, patients receiving Letairis® had an early sustained and dose proportional placebo adjusted median increase from baseline ranging from 31 to 59 meters and had a statistically significant delay in the time to clinical worsening representing approximately a 71% risk reduction. Letairis® currently has two black box warnings for potential for liver injury and pregnancy. Monthly monitoring of LFTs is required as well as pregnancy testing. Because of the risk of liver injury and birth defects, Letairis® is only available through a restricted distribution access program called LEAP (Letairis® Education and Access Program). Letairis® is only available to prescribers and patients who have enrolled in this program. Common side effects include peripheral edema, fluid retention, nasal congestion, sinusitis and flushing. It has a relative lack of drug interactions. Letairis® should be initiated at a 5mg dose with or without food and increased to 10mg if the 5mg is tolerated or clinically warranted. He requested Letairis® be included as a preferred agent on the PDL.

Ms. Flynn asked if pharmacies have to be enrolled in the LEAP Program. Mr. Huwe replied that these agents are usually handled through specialty pharmacies. Prescribers and patients are enrolled for the exchange of information of the risk versus the benefits.

Dr. Prabhu asked how Letairis® compares to the other agents in the class. Mr. Huwe replied that there is not a head-to-head study based on the fact that it's a small patient population. The side effect and LFT profiles are different and Letairis® can be used at two FDA-approved and effective doses with no need for dose titration.

2. Drug Class Review Presentation – First Health Services

Jeff Monaghan stated that only Letairis® and Tracleer® are being addressed. The other oral treatment options for this disease state are calcium channel blockers and sildenafil (Revatio®) which will not be addressed at this time. There have been some studies which indicate that Letairis® does seem to raise liver function enzymes less and has been used in a RESCUE study effectively, however, there are black box warnings regarding liver function and pregnancy for both agents. Safety and efficacy in children have not been established for either agent. This is a challenging and progressive disease. Both of these agents have been shown to improve exercise capacity, hemodynamics, and quality of life and increase time to clinical worsening in short term studies. It is the recommendation of DHCFP and First Health that Letairis® and Tracleer® be considered therapeutic alternatives.

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

MOTION: **R.D. Prabhu motioned that Letairis® and Tracleer® be considered therapeutic alternatives.**
SECOND: **John Lee**
VOTES: **Unanimous**
MOTION CARRIED

4. 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 based on the clinical evidence and safety profile, it is the recommendation of DHCFP and First Health that Letairis® be added to the PDL and that patients currently on Tracleer® be grandfathered forever. The non-preferred agent (Tracleer®) would be available through the prior authorization (PA) process. There are currently 6-8 Medicaid recipients taking Tracleer®.

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

Dr. Lee stated that Dr. Lampert requested both agents be preferred and asked Dr. Lampert if it's because the side effects are slightly different between the two and how often was there a use for both when one doesn't work or is not tolerated. Dr. Lampert responded that Tracleer® has been available for seven years and Letairis® about two years. He said that there is not a lot of difference between the two agents other than subtle differences in tolerability. There are no head-to-head studies stating which is superior. The decision should be left to the prescriber. He felt that patients could be placed on calcium channel blockers or sildenafil prior to being placed on one of these agents.

Dr. Monaghan reminded the Committee that non-preferred drugs are available through the PA process if exception criteria are met; e.g., therapeutic failure of preferred agents, history of side effects, allergy to preferred medication, etc.

Dr. Lee asked if a patient does not respond well to one of these agents, is it common to prescribe the other. Dr. Lambert replied that another medication would be added (sildenafil, iloprost or intravenous medications).

Dr. Prabhu said that the mechanism of action is somewhat different in these agents. Tracleer® is an oral medication for which there is a lot of experience. At this point in time, there is not enough data to state that one agent is better than the other. Once the decision is made to treat a patient with an ERTA, he felt the physician should have a choice and recommended both agents be preferred.

MOTION: **R.D. Prabhu motioned that ambrisentan (Letairis®) and bosentan (Tracleer®) be added to the PDL.**
SECOND: **Rudy Manthei**
VOTES: **Unanimous**
MOTION CARRIED

B. Direct Renin Inhibitors

Ms. Flynn stated that only aliskiren (Tekturna®) and aliskiren/HCTZ (Tekturna HCT®) will be addressed.

1. Public Comment

Cindy Giambrone, Novartis, spoke in support of Tekturna®. Tekturna® is a direct renin inhibitor and represents a new class of anti-hypertensive. It works at the initial rate limiting step of a renin-angiotensin system, decreases plasma renin activity and inhibiting the conversion of angiotensinogen to angiotensin. It's indicated for the treatment of hypertension and can be used as monotherapy or in combination with other anti-hypertensive agents although the use with maximal doses of an ACE inhibitor has not been adequately studied. There are efficacy studies looking at monotherapy both placebo controlled trials and head-to-head studies with ramipril. Up to 90% of the blood pressure lowering effect is observed within the first two weeks of therapy. Efficacy studies also looked

at combinations with other anti-hypertensive agents such as hydroclorothiazide and valsartan resulting in greater blood pressure reduction versus monotherapy. The initial dose is 150mg once daily. If blood pressure is not adequately controlled, the daily dose can be increased to 300mg. In clinical trials, the drug was well tolerated. Tekturna HCT® is a combination of aliskiren and hydroclorothiazide indicated for the treatment of hypertension. It can be used as add on therapy in patients whose blood pressure is not controlled on Tekturna® alone. The combination product is not indicated for initial therapy. She referred the Committee to the handouts regarding Tekturna® for further information.

2. Drug Class Review Presentation – First Health Services

Jeff Monaghan stated that this is a new drug class in the angiotensin modulator category. There are only two agents in the class, Tekturna® and Tekturna HCT® so a motion for therapeutic equivalency can be bypassed.

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

It is the recommendation of DHCFP and First Health that Tekturna® and Tekturna HCT® be added to the PDL.

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

MOTION: R.D. Prabhu motioned that Tekturna® and Tekturna HCT® be added to the PDL.
SECOND: John Lee
VOTES: Unanimous
MOTION CARRIED

C. Ophthalmic Non-Steroidal Anti-Inflammatory Agents

1. Public Comment

No Comment

2. Drug Class Review Presentation – First Health Services

Letters of public testimony for this class have been distributed to the Committee.

Dave Wuest stated that this is a new drug class to the PDL. These agents decrease inflammation in the eye and also exhibit analgesic activity. Most of the usage is secondary to ophthalmic surgeries. Precautions, side effects, and indications are similar throughout the class. Acular® has the youngest safety profile (approved down to age three). Depending on the product and indication, the dosage ranges from one drop twice daily to one drop four times daily. It is the recommendation of DHCFP and First Health that the agents in this class be considered therapeutic alternatives.

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

MOTION: Rudy Manthei motioned that the agents in this class be considered therapeutic alternatives.
SECOND: John Lee
VOTES: Unanimous
MOTION CARRIED

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

Dave Wuest stated that is it the recommendation of DHCFP and First Health that diclofenac, flurbiprofen, Acular®, Acular LS®, Acular PF® and Nevanac® be added to the PDL.

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

Dr. Manthei stated that Acular® is the most common drug used in cataract surgery and the prevention and treatment of systemic and diabetic macular edema. Long term Nevanac® works well. Comparing Xibrom® and Nevanac®, there is no issue using one versus the other; neither has a superior effect.

MOTION: John Lee motioned to accept First Health's recommendation to add diclofenac, flurbiprofen, Acular®, Acular LS®, Acular PF® and Nevanac® to the PDL.
SECOND: Rudy Manthei
VOTES: Unanimous
MOTION CARRIED

D. Combination Benzoyl Peroxide and Clindamycin Products

1. Public Comment

No comment.

2. Drug Class Review Presentation – First Health Services

Dave Wuest stated that although there are many acne agents within the drug review, only the combination benzoyl peroxide and clindamycin products will be reviewed, BenzaClin® and Duac® (Duac® CS includes a cleanser). The three products are exactly the same agents containing 5% benzoyl peroxide and 1% clindamycin as a topical gel. It is the recommendation of DHCFP and First Health that these agents be considered therapeutic alternatives.

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

MOTION: R.D. Prabhu motioned that BenzaClin®, Duac® and Duac® CS be considered therapeutic alternatives.
SECOND: Chad Luebke
VOTES: Unanimous
MOTION CARRIED

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

Dave Wuest stated that it is the recommendation of DHCFP and First Health to add Duac® and Duac® CS to the PDL.

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

MOTION: Justin Holt motioned to accept First Health's recommendation to add Duac® and Duac® CS to the PDL.
SECOND: Rudy Manthei
VOTES: Unanimous
MOTION CARRIED

E. Topical Antibiotics

1. Public Comment

Rick Kurehart, GlaxoSmithKline, spoke in support of Altabax®, which is available as a 1% ointment. Altabax® represents the first drug available in the class of prescription topical antibacterial agents referred to as pleuromutilins. It was approved in April, 2007, for impetigo due to susceptible strains of staphylococcus aureus and streptococcus pyogenes in patients nine months of age and older. Altabax® has a unique mode of action in that it selectively inhibits bacterial protein synthesis in three different ways which is distinct from the binding sites of other antibiotics. Altabax® exhibits potent antibacterial activity in vitro against key pathogens associated with impetigo and has been shown to be thirty-two times more potent than mupirocin (Bactroban®) against staph aureus and sixty-eight times more potent than mupirocin against strep pyogenes. It maintains consistently low minimum inhibitory concentration (MIC) and minimum inhibitory concentrations for passages that are both susceptible as well as resistant to other antibacterials. When compared to other antibiotics including mupirocin, Altabax® has demonstrated no specific cross-resistance to other antibacterial classes. In clinical trials, it has shown superior clinical and microbiological efficacy in the treatment of impetigo compared to placebo in patients nine months of age and older and is well tolerated. Altabax® offers a convenient five day, twice a day dosing regimen which can be fulfilled with a five gram tube. He respectfully requested the Committee consider Altabax® for the PDL.

Dave Wuest asked if Altabax® has an indication for methicillin-resistant staphylococcus aureus (MRSA). Mr. Kurehart replied no and the reason is the number of isolates in the clinical trials was not adequate, but they are in the process of conducting MRSA studies in impetigo as well as secondarily infected traumatic lesions in order to obtain the data and submit back to the FDA.

Dr. Monaghan said since the recommended dose is to apply twice a day for five days, is the five gram tube the most commonly dispensed size. Mr. Kurehart replied yes and that it is also available in larger sizes but the five gram covers the five day treatment.

2. Drug Class Review Presentation – First Health Services

Letters of public testimony for this class have been distributed to the Committee.

Dave Wuest stated that impetigo agents are a new class of drug for the PDL. All of the agents in this class are indicated in the treatment of impetigo. The current practice guidelines from the Infectious Disease Society of America is that mupirocin ointment is the topical antibiotic of choice for the treatment of impetigo. Side effects and adverse effects are similar throughout the class. It is the recommendation of DHCFP and First Health that the agents in this class be considered therapeutic alternatives.

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

MOTION: John Lee motioned that the agents in this class be considered therapeutic alternatives.
SECOND: R.D. Prabhu
VOTES: Unanimous
MOTION CARRIED

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

Dave Wuest stated that it is the recommendation of DHCFP and First Health that mupirocin 2% topical ointment and Altabax® be added to the PDL.

David Chan asked if five days is the maximum treatment for Altabax®. Mr. Kurehart replied five days with a maximum area of 2% body surface or one-hundred square centimeters. Mr. Wuest added that Altabax® is available in a 5gm, 10gm or 15gm tube. He suggested that consideration could be given to applying a quantity limit to ensure the appropriate amount is given to the patient.

Dr. Manthei asked if there is any clinical indication for giving more than 5gm and Mr. Kurehart replied no.

Darrell Faircloth stated that the P&T Committee is not empowered to impose quantity limitations. It is in the province of the DUR Board.

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

MOTION: Rudy Manthei motioned to accept First Health's recommendation to add mupirocin ointment and Altabax® to the PDL.
SECOND: David Chan
VOTES: Unanimous
MOTION CARRIED

F. Skeletal Muscle Relaxants

1. Public Comment

No comment.

2. Drug Class Review Presentation – First Health Services

Jeff Monaghan stated that this is a new drug class to the PDL. The drugs in this class are FDA-approved to treat two different types of conditions: muscular pain or spasms from peripheral musculoskeletal conditions or spasticity from upper motor neuron motor syndromes. Baclofen, tizanidine and dantrolene are normally reserved for spasticity. Due to a lack of quality comparative studies, choice of agent comes down to side effect and adverse event profile. There is no good data which indicates that one agent is more effective than another. Adverse effects common to all of these agents are drowsiness, dizziness, and GI effects. CNS depression is additive with other CNS depressants such as opioids and alcohol. Pharmacists routinely counsel patients receiving these agents about the additive effects. There are some nuances with some of these drugs such as dependence abuse with carisoprodol. Cyclobenzaprine ER products should not be used in the elderly because of the cumulative effect they can experience with hepatic impairment and the cumulative effect with the dosing over time. Hepatotoxicity with dantrolene is well known. It is the recommendation of

DHCFP and First Health that the agents in this class be considered therapeutic alternatives.

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

Dr. Manthei asked regarding Botox® which can be used for cerebral palsy in children for spasticity. Dr. Monaghan stated that Botox® is not classified pharmacologically as a skeletal muscle relaxant. He suggested a utilization review of Botox® since there are currently no controls. Dr. Manthei and Ms. Flynn agreed.

MOTION: Rudy Manthei motioned that the agents in this class are considered therapeutic alternatives.
SECOND: John Lee
VOTES: Unanimous
MOTION CARRIED

4. 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 baclofen, carisoprodol, carisoprodol compound, chlorzoxazone, cyclobenzaprine dantrolene, methocarbamol, methocarbamol/aspirin, orphenadrine citrate, orphenadrine compound, and tizanidine to the PDL and exclude Fexmid®, Amrix® and Skelaxin® and Zanaflex® capsules from the PDL.

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

MOTION: Rudy Manthei motioned to accept First Health's recommendation to add baclofen, carisoprodol, carisoprodol compound, chlorzoxazone, cyclobenzaprine, dantrolene, methocarbamol, methocarbamol/aspirin, orphenadrine citrate, orphenadrine compound, and tizanidine to the PDL and exclude Fexmid®, Amrix®, Skelaxin® and Zanaflex® capsules from the PDL.
SECOND: R.D. Prabhu
VOTES: Unanimous
MOTION CARRIED

IV. Established Drug Classes for Review

A. Calcium Channel Blockers and Combinations

1. Public Comment

Cindy Giambrone, Novartis, spoke in support of Exforge®, which is a combination of the dihydropyridine calcium channel blocker, amlodipine, and the angiotensin II receptor blocker, valsartan. By complementary mechanisms of action, amiodipine and valsartan work to lower peripheral resistance and lower blood pressure. Exforge® is indicated for the treatment of hypertension in patients whose blood pressure is not adequately controlled on monotherapy and used as initial therapy in patients who are likely to require multiple drugs in order to achieve their blood pressure target. She referred to studies cited in her handout which was distributed to the Committee. Adverse experiences have generally been mild. The majority of antihypertensive effect is attained within the first two weeks of therapy.

2. Drug Class Review Presentation – First Health Services

Jeff Monaghan stated that this is a review of an existing category on the PDL. On the PDL, the calcium channel blockers (CCB) and calcium channel blocker combinations are listed together; however, he will be addressing each separately.

Calcium Channel Blockers

There are several CCBs on the PDL in both the dihydropyridine and the nondihydropyridine class. He referred to the full list on page one of the CCB review. Since this class was last reviewed, Sular® (nisoldipine ER), has been reformulated in different strengths to avoid generic competition. It is the recommendation of DHCFP and First Health that the agents in this class be considered therapeutic alternatives.

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

MOTION: **John Lee motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **David Chan**
VOTES: **Unanimous**
MOTION CARRIED

4. 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 that the branded Sular® be removed from the PDL and the nisoldipine extended release generic product be added to the PDL.

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

MOTION: **John Lee motioned to accept First Health's recommendation to remove Sular® from the PDL and add nisoldipine extended release generic.**
SECOND: **Justin Holt**
VOTES: **Unanimous**
MOTION CARRIED

Angiotensin Modulators/Calcium Channel Blockers and Combinations

6. Drug Class Review Presentation – First Health Services

Jeff Monaghan stated that currently there is an ACE/CCB combination on the PDL, Lotrel®. The review today is of two drugs in a new combination which have not been Committee reviewed in the past [CCB in combination with an angiotensin receptor blocker (ARB)]. There are two products in this category; the products are not new but the combination is new. The two CCB/ARB combinations available for consideration today are amlodipine/olmesartan (Azor®) and amlodipine/valsartan (Exforge®). It is the recommendation of DHCFP and First Health that the agents in this category be considered therapeutic alternatives.

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

MOTION: Justin Holt motioned that the agents in this class be considered therapeutic alternatives.
SECOND: John Lee
VOTES: Unanimous
MOTION CARRIED

8. 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 that Exforge® be added to the PDL.

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

MOTION: Rudy Manthei motioned to accept First Health's recommendation to add Exforge® to the PDL.
SECOND: John Lee
VOTES: Unanimous
MOTION CARRIED

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

Jeff Monaghan referred to the report in the meeting packet and noted that brand name drugs converted to generic on the PDL were Zaditor® Ophthalmic Drops to ketotiprofen and Miacalcin® to calcitonin-salmon nasal spray. New drugs or dosage forms released but not added to the PDL will be reviewed at the annual review meeting in June.

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

The next meeting is scheduled for June 25, 2009, in Las Vegas and will be the annual review of the PDL as required by statute. Drug classes with recommended changes will be reviewed and classes with no recommended changes will be included on the agenda. At the annual review, Committee members can request review of a class listed with no recommended changes to be addressed at a future meeting. Committee members can also contact Mary Griffith or Jeff Monaghan prior to the annual review and request a drug class be included for review at the annual meeting.

VII. Public Comment

No comment.

VIII. Adjournment

MOTION: Justin Holt motioned to adjourn the meeting.
SECOND: John Lee
VOTES: Unanimous
MOTION CARRIED

Meeting adjourned at 2:15 p.m.