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Governor

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

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NEVADA MEDICAID
PHARMACY & THERAPEUTIC COMMITTEE

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

Nevada State Health Division
4150 Technology Way, Room 300
Carson City, NV 89706

Meeting Minutes
June 23, 2011

Committee Members Present
Las Vegas: Joseph Adashek, MD; Weldon Havins, MD; Constance Kalinowski, MD; Shamim Nagy, MD
Reno: Judy Britt, Pharm.D.; David Chan, R.Ph.; Michael Hautekeet, R.Ph.
Absent: Rudy Manthei, MD; Chad Luebke, Pharm.D.; Justin Holt, Pharm.D

Others Present
DHCFP:
Las Vegas: Gabriel Lither, Deputy Attorney General
Carson City: Coleen Lawrence, Chief, Program Services; Mary Griffith, RN, Social Services Program Specialist; Amy Crowe, Deputy Attorney General

Magellan Medicaid Administration, Inc.
Las Vegas: Paula Townsend, Pharm.D., Clinical Account Manager; Shirley Hunting
Carson City: Judy LaFleur

Others:
Las Vegas: Tony Molchan-Abbott; Ben Skoug-Abbott; Ymi Yamato-Merck; Steve Nelson-Merck; Brian Strenb-GSK; Steve Fox-GSK; Raza Karim-GSK; Ginny Gay-Teva; Scott Goldy-Teva; Diana Glanton-Astellas; Tania Simon-Astellas; Leigh Platte-Astellas; Craig Nakamura, MD; Andi Stratton-Vertex; Tava Golden-BMS: Carrie Stiles-BMS; Tom Damienbank-Otsuka; Laura Litzenberger-Jansen; Charissa Anne-J&J; Peter Berggsen-Janssen; Lori Horwarth-Bayer; Robert Martin-Bayer; Michelle Yee Mui-Shionogi; Robert Olson-Shionogi; Joe Sunderman-Merck; Tim Hartman-Pfizer; Susan Tappen-Sunovion; Dan Hillbay-Sunovion; Rajiv Dats-Sunovion; Mary Garcia-Sunovion; Brett Merritt-Novo Nordisk; Mike Ketcher-Novo Nordisk; Phil Ariola-Shire; Bruce Uyeda-Cal Medi-Cal; John Brokars-Lilly; Steve Farmer-Amgen; Betty Iverson-J&J; Nathanial Singer-J&J; Kirstin Aldrich-J&J; Carol Gaines-EMD Serono; Brett Brewer-EMD Serono; Felicia Fuller-Biogen; Sharon Cahoon-Metzger; Chris Almeda-Purdue; Mike O'Donnell-Sunovion; Courtney Smith-Sunovion; Carol Ricciotti-Sunovion; Gil Astrue-Takeda; Michael Vaughn-Astra Zeneca; Taka Brascia-CF Center; Melissa Walsh-Novartis; Tom O'Connor-Novartis; Brooks Hubbard-Boehringer; Doug Powell-Forest; Steve Granzyk-Elan; Dean Donato-Alcon; Yvonne Overton-MS Society; Kara Thorsfeldt-Cephalon; Roger Wurtsman-Strativa; M. Gabriela Gregory-NV Neuroscience; Dave Vaught-Eisai; Jim Schaedel-Eisai; V. Shane Lacanienta-Pfizer; Dr. Charles Costas; Lynne Windle-NV PEP; T.J. Rosenberg-NV PEP; Bret Fergoson-Pfizer; Tyler Allred-Pfizer; Lynn Horne, MD; Pat Wiseman-Medimmune; David Block-Shire; Johanna Fricke, MD; Carol Gaines-EMD Serono; Sterling Tanner, MD.

Reno:
Lynn Whitmire-Astra Zeneca; Rob Earnest-SXC; Mariellen Rich-SXC; Mark Kohn-Med Metrics; Sarah Hartman-Med Metrics; Sabrina Aery-Bristol-Myers Squibb; Elizabeth Bellocchio-Bristol-Myers Squibb; Brian Meissner-Brystol-Myers Squibb; Karen Santilla-Astra Zeneca; Ed Arnold-HP; Judy Martin-NV PEP; Joe Tyler-NAMI; Donna Shibovich-NAMI; Kathy Rusco-NAMI; Steve Freedman-NAMI.

I. Call to Order and Roll Call

Chairperson, Judy Britt, called the meeting to order at 1:00 p.m.

Ms. Lawrence stated that Judy Britt will be chairing today's meeting due to Dr. Manthei's absence. On behalf of the State, she thanked the P&T members for volunteering their valuable time and expertise by serving on the committee. The Governor's office has sent letters of term renewals to members whose terms will be expiring soon and she encouraged the members to renew.

Ms. Lawrence stated that in January, 2011, the Medical Management Information System (MMIS) contract was awarded to Hewlett Packard Enterprise Systems (HP). HP has subcontracted the pharmacy benefit management system to SXC Health Solutions which will include the management of the drug rebate program. October 1, 2011, is the tentative transition date from Magellan Medicaid Administration to HP and SXC.

Ms. Lawrence stated that an annual review of the Preferred Drug List (PDL) is required by statute. The review consists of two categories, drug classes that will be considered for change and drug classes without proposed changes. The criteria used to determine drug classes with proposed changes are: new drugs within the class approved since the last annual review; clinician's input and/or new clinical evidence since the last annual review; classes the Committee and/or DHCFP has requested to be reviewed. She noted that proposed drug classes without changes that may have new information or drugs released following the forty-five day advance posting of the agenda will be presented at the next meeting. Public comment is limited to five minutes and only new clinical information will be permitted for comment per individual, organization or agency.

II. Review and Approval of the December 16, 2010 Meeting Minutes

MOTION: David Chan motioned to approve the minutes as presented.
SECOND: Shamim Nagy
VOTES: Unanimous
MOTION CARRIED

III. New Drug Class Reviews

Copies of written testimony submitted by the public were distributed to the Committee.

A. Gastrointestinal Agents: Pancreatic Enzymes

Public Comment

Craig Nakamura, MD, Director, Cystic Fibrosis Center of Southern, Nevada, stated that over 30,000 Americans have Cystic Fibrosis (CF). 85% of CF patients need pancreatic enzymes. The amount of enzymes in each capsule has varied so the FDA has required that each manufacturer resubmit for approval of their products. Currently, there are three FDA approved enzymes on the market. If a specific product is selected, patients will be required to fail that therapy before accessing the alternatives. All of the pancreatic enzymes are enteric-coated and each company has a different enteric coating. There are also different sizes (microspheres versus micro-tablets). Some patients respond to some enzyme products better than others. There are no head-to-head studies comparing the enzymes. He requested equal access to all of the pancreatic enzymes.

Tara Brascia, Program Coordinator, Cystic Fibrosis Center of Southern Nevada, spoke in support of equal access to all pancreatic enzymes. As in hypertension, not one type of medicine works for all patients. She requested that the products from all the different companies be approved as well as all of the available strengths so dosages can be manipulated.

Ben Skoug, Abbott, spoke in support of Creon®. He offered four key points pertaining to Creon®: 1) there is a strong correlation between higher BMI and improved lung function with survival in CF patients; 2) Creon® is the first FDA approved pancreatic enzyme to be marketed in the U.S. and is not interchangeable with any other product; 3) demonstrated safety and efficacy of Creon® in treating exocrine pancreatic insufficiency (EPI) due to CF and chronic pancreatitis; 4) a new dosage strength of Creon® (3,000 lipase units designed to make dosing easier for infants) was FDA approved last week. Creon® consists of lipase, proteases and amylases to aid in the digestion of carbohydrates and proteins, and is available in strengths of 3,000, 6,000, 12,000 and 24,000 lipase units. It has an enteric coating to resist destruction by gastric acids. Creon® is indicated for the treatment of EPI due to CF or other conditions and it is the only pancreatic enzyme indicated for the treatment of pancreatic insufficiency due to pancreatectomy or chronic pancreatitis. Four pivotal studies evaluated the efficacy and safety of Creon® in adults and children with EPI due to CF and in adults with EPI due to chronic pancreatitis. The primary efficacy endpoint was the mean difference in coefficient of fat absorption (CFA) between Creon® and placebo. A statistically higher CFA was seen with Creon® compared to placebo in all four studies. GI complaints, cough, dizziness and headaches were the most commonly reported adverse effects. He requested Creon® be considered for PDL inclusion.

Dr. Nagy asked how long the product has been on the market. Mr. Skoug replied since 2009. Prior to that, these drugs were on the market before the Food, Drug and Cosmetic Act. Recently, the FDA required that all of the enzyme manufacturers resubmit a new drug application and to have a zero overfill to make dosing easier.

Laura Litzenberger, Janssen, spoke in support of Pancreaze™. She stated that Pancreaze™ is the same product as Pancrease MT® which has been available since the early 1990s. The FDA asked the manufacturers to submit new drug applications (NDA) for these products to regulate overfill in the products. Upon FDA approval of Pancrease®, the name was changed to Pancreaze™. The dosage form is the same but the label dosage is different to represent the zero overfill. The labeling of these products is not interchangeable; there are different ratios of the three enzymes lipase, proteases and amylases. If patients are switched back and forth, there is a period of time for the patient to get used to the product and they go through gastrointestinal stress during the time it takes to recalibrate. She requested that all of the enzyme products be available on the PDL.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that although the pancreatic enzymes have been used for several decades, they have been marketed in the U.S. as unapproved products over-the-counter. Several years ago, the FDA noted that unapproved pancreatic enzymes contained variable amounts of the active enzymes lipase, proteases and amylases, resulting in either decreased efficacy or adverse effects. The deadline for all marketed products to obtain FDA approval was April 28, 2010. There are currently four approved products on the market (Creon®, Pancreaze™, Zenpep®, and the generic pancrelipase 5,000 lipase units (generic for Zenpep 5000 strength). Creon® is currently 50% of the market share and has a new infant specific dose (3,000 lipase units) which was approved on June 14, 2011, and is the lowest dose available of the products. Creon® also has the highest available dose. The products differ in enzyme content and bioavailability. All are porcine derived, can be opened for those patients unable to swallow and all have labeled doses for infants through adults. There are no comparative studies; adverse event profiles and efficacy are similar with all products. It is the recommendation of DHCFP and Magellan Medicaid Administration that the products in this class be considered therapeutic alternatives.

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

MOTION:	**Michael Hautekeet motioned that the agents in this class be considered therapeutic alternatives.**
SECOND:	**Weldon Havins**
VOTES:	**Unanimous**

MOTION CARRIED

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration to add the new class to the PDL and add Creon® and the generic pancrelipase as the preferred agents.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

MOTION: **David Chan motioned to establish the new PDL class (Gastrointestinal Agents: Pancreatic Enzymes) and include Creon® and pancrelipase as the preferred agents in the class.**
SECOND: **Shamim Nagy**
VOTES: **Unanimous**
MOTION CARRIED

IV. Established Drug Class Reviews

A. Central nervous System: ADHD/Stimulants

Public Comment

Johanna Fricke, MD, said that she has represented children in Nevada since 1976. She asked why Concerta® is limited to 36mg since 70% of teens with ADHD need 54mg to 72mg and over 30% of school age kids (8-10 years old) need 36mg to 54mg. She also stated that she has patients that have experienced adverse reactions when using generic Concerta® and asked if the branded product is available if documentation is provided.

Ms. Lawrence informed Dr. Fricke that the clinical criteria are outside of the scope of the P&T Committee and falls within the duties of the Drug Use Review Board (DUR). She provided her contact information to Dr. Fricke to discuss the DUR Board process.

Dr. Fricke stated that Intuniv™ is not on the PDL and asked if it's being considered. There are currently non-stimulants on the PDL (Provigil® and Strattera®) and short-acting Tenex® is not approved for ADHD. Intuniv® is approved both as an adjunct and a single agent in the treatment of ADHD. Guanfacine (Intuniv™) is a neuro-adrenergic agent that does not cause as much drowsiness as clonidine, Catapres® or Kapvay™ because it works on the presynaptic neuron. She has experienced clinical success with guanfacine in children who cannot tolerate stimulants. Strattera® works in some children with Autism, but in others, the dose has to be increased causing the child to get activated, disinhibited and, at times, very aggressive as the dose is increased. She requested Intuniv® be considered as an additional option on the PDL.

Michelle Mui, Shionogi, spoke in support of Kapvay™, a non-stimulant, centrally acting agonist indicated for the treatment of ADHD as a monotherapy or as an add-on to stimulants in children and adolescents 6 to 17 years of age. Kapvay™ is an extended release formulation of clonidine with a different pharmacokinetic profile compared to the immediate release clonidine. It is designed specifically to delay the absorption of active drug using a gel matrix technology which minimizes the peak to trough ratio differences. The delayed absorption of active drugs offers a smoother delivery of medication, 50% reduction in the peak plasma levels compared to the immediate release clonidine and a five hour delayed absorption compared to one hour with the immediate release. Kapvay™ is the first ADHD medication approved for use with stimulants and is the only clonidine product approved for ADHD. Studies demonstrated a statistically significant improvement in the ADHD Rating Scale and a 40% reduction from baseline of ADHD symptoms. In a long-term safety study, Kapvay™ demonstrated continued efficacy, safety and was well tolerated in up to twelve months of chronic use. Major adverse events were somnolence, fatigue, headache and upper abdominal pain. She requested that Kapvay™ be added to the PDL without prior authorization.

John Brokars, Lilly, spoke in support of Strattera®, a non-stimulant, selective norepinephrine reuptake inhibitor indicated for the treatment of ADHD. Strattera® carries a black box warning for suicidal ideation in children. It has been studied in six clinical trials and is not contraindicated in patients with comorbid anxiety, comorbid tics or comorbid substance abuse disorders. He requested Strattera® be maintained on the PDL.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010. The drugs being discussed today are for the treatment of ADHD. The stimulants, Provigil® and Nuvigil® will not be part of the discussion. The stimulants on the PDL represent all available stimulants for ADHD (dexmethylphenidate, methylphenidate, dextroamphetamine, amphetamine mixed salts and lisdexamfetamine. Drugs indicated for ADHD are Schedule II stimulants with the exception of atomoxetine (Strattera®), guanfacine (Intuniv™) and clonidine (Kapvay™). All are approved for use in school age children; most are approved for adults. The new approved product in the class is clonidine ER (Kapvay™). Intuniv™ and Kapvay™ are extended-release alpha2-agonists for the treatment of ADHD in children 6-17 years old. Both are anti-hypertensives and were used off-label for years to treat ADHD either alone or with stimulants particularly in children with tics. The extended release formulations are not substitutable with the immediate release formulations; peak levels occur at three and five hours later and are 50-60% lower than with the immediate release drugs. Intuniv™ is dosed once daily and Kapvay™ twice daily. Intuniv™ has been shown to be more effective than placebo in producing improvements in ADHD symptoms but somnolence has been an issue and it appears to be less effective than stimulants. Kapvay™ has been shown to be superior to placebo and effective as add-on therapy to stimulants alone. It appears to be less effective than stimulants based on studies using immediate release drugs and is more sedating than Intuniv™. Neither product can be chewed or crushed. Abrupt discontinuation of either drug can result in increases in blood pressure and both should be tapered. According to the *Medical Letter* consultants, clonidine can cause irritability, emotional flattening and possibly depression. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

MOTION: **Connie Kalinowski motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Weldon Havins**
VOTES: **Unanimous**
MOTION CARRIED

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that Intuniv™ be added to the PDL, Kapvay™ be non-preferred with no other changes made to the class.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

Dr. Adashek asked if there is failure of the preferred agents, will Kapvay™ be available. Dr. Townsend referred to the PDL Exception Criteria stating that if there is failure of two preferred agents, a non-preferred agent will be authorized.

MOTION: **Shamim Nagy motioned to add Intuniv™ to the PDL; Kapvay™ will be non-preferred with no other changes to the PDL in this class.**
SECOND: **Connie Kalinowski**
VOTES: **Unanimous**
MOTION CARRIED

B. Gastrointestinal Agents: PPIs

Public Comment

No comment.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010. At that time, the Committee recommended no changes to the class. There is no new efficacy data to present. In October, 2010, the FDA sent out a reminder to avoid concomitant use of clopidrogel (Plavix®) and omeprazole as it can result in significant reductions in clopidrogel's active metabolite levels and antiplatelet activity. Strong or moderate CYP 2C19 inhibitors should be avoided. Esomeprazole (Nexium®) has a similar effect. There is recent data demonstrating that pantoprazole has less of an effect compared to omeprazole (this data is included on the Plavix® label). It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

MOTION: **Weldon Havins motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Shamim Nagy**
VOTES: **Unanimous**
MOTION CARRIED

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that Nexium®, OTC omeprazole, OTC Prilosec® and generic pantoprazole be the preferred agents.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

MOTION: **Joseph Adashek motioned that Nexium®, OTC omeprazole, OTC Prilosec® and pantoprazole be the preferred agents.**
SECOND: **Weldon Havins**
VOTES: **Unanimous**
MOTION CARRIED

C. Multiple Sclerosis Agents: Disease Modifying

Public Comment

Gabriela Gregory, MD, neurologist specializing in Multiple Sclerosis (MS) patients stated over the past year, the main change in MS care has been the approval of Gilenya™, a new oral medication for MS. It has a different mechanism of action from the previous established medications. There are some precautions; it does produce lymphopenia and there is a high risk of certain infections including herpes encephalitis and inflammation of the eyes. For patients who have not been able to tolerate the other agents, it has been shown to be an excellent alternative. The standard agents remain as the first-line agents and the position of the International MS Society is that all of the agents should be available to patients with MS due to the different side effect profiles, administrations and support structures with the various agents. She requested that the current preferred agents be maintained on the PDL and to consider the addition of Gilenya™ to the PDL.

Carol Gaines, neurologist representing EMD Serono, spoke in support of Rebif®. She stated that most neurologists would like to have choice in the care and treatment of MS. The patients are quite variable and for many reasons when an optimal therapeutic strategy is determined, choice is the most important thing in this therapeutic class. The basis for the approval of Rebif® was two pivotal trials, PRISMS (placebo controlled trial) and the EVIDENCE Trial. EVIDENCE is a head-to-head Class I trial with Avonex® that showed clinical superiority in relapsing MS. All of the agents are different and the patients vary in their onset, symptoms and progression. She requested that the Committee continue to provide Rebif® unrestricted to Medicaid patients.

Melissa Walsh, Novartis, spoke in support of Gilenya™. Gilenya™ is the first oral disease modifying therapy indicated for patients with relapsing forms of MS to reduce the frequency of clinical exacerbations and to delay the accumulation of physical disability. It is dosed as 0.5mg once daily with or without food and is a first-line choice for patients with MS. Gilenya™ targets the inflammatory components of MS through sphingosine 1-phosphate receptor modulation. Approval was based on the largest clinical program ever conducted including two clinical studies (FREEDOMS and TRANSFORM) both published in *The New England Journal of Medicine*. The studies confirmed the efficacy and safety of Gilenya™. The first dose of Gilenya™ may cause a decrease in heart rate and it is recommended that patients be observed for six hours following the first dose. It may also increase the risk of serious infections; decreases the peripheral lymphocyte count to 70% of baseline which returns to normal within two months of discontinuation of Gilenya™. Macular edema was seen in 0.4% of patients on Gilenya™ 0.5mg generally occurring within three to four months after starting the drug; ophthalmic exams are recommended at baseline and at month three to four. Gilenya™ may cause liver enzyme elevations and may cause fetal harm. Gilenya™ has been approved in the U.S. with REMS which includes a safety and medication guide for patients. She requested that the Committee consider adding Gilenya™ to the PDL.

Sharon Cahoon-Metzger, Biogen, supporting the drug Avonex®, stated that new information has not been released since the last annual PDL review, but she would like to speak to gray matter atrophy and disability data. Dr. Britt reminded her of the annual review guidelines that only new clinical evidence released since the last review of the drug will be accepted for comment today.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010, and is being reviewed due to the release of the new drug, Gilenya™. Gilenya™, the first oral MS drug, is a sphingosine 1-phosphase receptor modulator indicated for patients with relapsing forms of MS to decrease the frequency of clinical exacerbations and delay the accumulation of physical disability. There were two pivotal trials; one versus placebo and one versus interferon beta1a. Two doses were studied; the higher 1.25mg dose was not approved by the FDA as it was not found to be more effective and had a higher frequency of adverse events. Eligibility required patients had at least one relapse in previous year or two in the last two years. Recent use of interferon was allowed and 47% of interferon group and 50% of those on Gilenya™ had received interferon prior to the study and had relapsed despite treatment. It is notable that the interferon chosen as a comparator is the one considered by some meta analysis to be the least effective although it may be better tolerated than others. Some of the data I am presenting is from the *Oregon Health Sciences University Drug Effectiveness Project* analysis of these trials, as well as from the *FDA review* and the *Medical Letter*. As presented, Gilenya™, both doses resulted in a lower annualized relapse rate vs. interferon beta 1a (0.16, 0.20 and 0.33, $p<0.001$). Of note, these relapse rates are all lower than what has been previously reported in previous trials of disease modifying drugs. For Gilenya™, more patients had no confirmed relapse at 1 year; The NNT for the proportion relapse-free compared to interferon was 8.3 for the 0.5 mg group. The benefit of Gilenya™ over interferon was greater in the subgroup that had prior exposure to a disease modifying drug than in the treatment-naïve group. Progression of disability was not different between the groups at twelve months. The rate of confirmed disability was low in both groups 5.9% Gilenya™ versus 7.9% interferon. There is little information on the durability of the beneficial effects of Gilenya™. Patients with significant comorbidity were excluded. The higher dose resulted in higher numbers and more

severe ADRs including herpes zoster infections, symptomatic bradycardia after the first dose and more discontinuations (10%). Discontinuation due to adverse drug events with Gilenya™ 0.5 and interferon were not different. The most common adverse drug events with Gilenya™ were headache, cough, diarrhea, back pain and transaminase elevation. Those in the interferon group had more pyrexia, myalgia and flu-like symptoms, those in the Gilenya™ group had a higher rate of elevated liver enzymes. The dose-dependent decrease in peripheral lymphocyte count may increase the risk of serious viral infection; 2 fatal infections with the higher dose were reported (disseminated varicella-zoster and one herpes encephalitis). Herpes virus infections were diagnosed in 5.5% of the 1.25 mg group, in 2.1% of the 0.5 mg group and in 2.8% of the interferon group. As presented, the first dose can cause transient bradycardia and AV conduction delays including 1st or 2nd degree AV block and patients should be monitored for 6-8 hours. Macular edema was identified in the first 3-4 months and occurred in 0.5% of the 0.5 mg group and in 1% of the 1.25 mg group. In 4/6 patients it resolved with discontinuation. Dose dependent reductions in pulmonary function have been reported; 2-3% reduction in FEV1. This parameter was monitored due to findings of pulmonary fibrosis and small muscle hypertrophy in animal studies and dyspnea and pulmonary edema in the renal transplant studies. There were 10 cases of localized skin cancers in the study; 1 was in the interferon group, although these are small numbers. The overall safety and efficacy of Gilenya™ is still emerging. A one year study is short for a MS study. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

MOTION: **Weldon Havins motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Joseph Adashek**
VOTES: **Unanimous**
MOTION CARRIED

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that Avonex®, Betaseron® and Copaxone® be the preferred agents in this class.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

Dr. Adashek asked why Rebif® is being removed from the PDL. Dr. Townsend responded that it's in the best interest of the State and added that the non-preferred agents are available through the PA process.

MOTION: **Joseph Adashek motioned not to remove Rebif® from the PDL and Avonex®, Betaseron®, Copaxone® and Rebif® be the preferred agents on the PDL.**
SECOND: **Shamim Nagy**
Dr. Adashek stated that Rebif® is currently on the PDL and physicians are using it. To remove it from the PDL would be onerous for patients who are now on it.
AYES: **Hautekeet, Britt, Chan, Adashek, Havins, Nagy**
NAYES: **Kalinowski**
MOTION CARRIED

D. Respiratory: Short-Acting Beta Adrenergics-Inhalers/Nebs

Public Comment

No comment.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010; no changes were made to the PDL at that time. Albuterol (nebs/solution) and Proventil HFA® are currently the preferred agents. There are numerous albuterol HFA inhalers available in the marketplace and no new clinical information within this class to present. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

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

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that Proventil HFA®, Ventolin HFA® and albuterol nebs/solution be the preferred agents in this class.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

Dr. Adashek stated that Xopenex® has less cardiac side effects in pregnant women with asthma and there is less shakiness and tremors in children using Xopenex®.

MOTION: **Joseph Adashek motioned to add Xopenex® to the PDL and accept Magellan's recommendation that Proventil HFA®, Ventolin HFA® and albuterol nebs/solution also be preferred agents in this class.**
Dr. Britt asked Dr. Adashek for clarification that the motion includes Xopenex HFA® and Xopenex® nebulizers be added to the PDL.
Dr. Adashek stated that is correct.
SECOND: **Shamim Nagy**
AYES: **Hautekeet, Chan, Adashek, Kalinowski, Havins, Nagy**
NAYES: **Britt**
MOTION CARRIED

E. Skeletal Muscle Relaxants

Public Comment

No comment.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010; no changes were made to the PDL at that time. All of the drugs in this class are generically available and can be broken down into those used in the treatment of spasticity (baclofen, tizanidine, dantrolene) and those for musculoskeletal disorders (cyclobenzaprine, carisoprodol, chlorzoxazone, metaxalone, methocarbamol, orphenadrine). The Drug Use Review Board (DUR) has requested a specific review of the status of carisoprodol, which is indicated for musculoskeletal conditions, due to its association with post-marketing reports of dependence, withdrawal and abuse. Carisoprodol is metabolized to meprobamate. Data being presented today is primarily based on the evidence based medicine review by the *Oregon Health Science Drug Effectiveness Review Project*. Data regarding comparative efficacy of skeletal

muscle relaxants in patients with musculoskeletal conditions are limited. Long-term data are lacking and outcome measures are often not validated. There is insufficient evidence from head-to-head trials to suggest that any skeletal muscle relaxant is more effective than another. The effectiveness of the various drugs compared to placebo varies in both quality and quantity. The most robust data is for cyclobenzaprine being superior to placebo in a variety of measures. For carisoprodol, orphenadrine and tizanidine there is a consistent trend favoring them over placebo. There is limited data demonstrating efficacy for chlorzoxazone, methocarbamol, baclofen or dantrolene in this population. Date on metaxalone is mixed. There is insufficient evidence to judge whether any one is safer than another; again the data are quite limited both in quality and in quantity. Withdrawals due to AEs (an indicator of intolerable AEs) are similar in head-to-head trials. Severe adverse events appear rare so relative frequency cannot be assessed. Chlorzoxazone and tizanidine have both been associated rarely with serious hepatotoxicity. There is insufficient data to assess comparative abuse and addiction risk of these drugs although almost all case reports of abuse and addiction have been in patients taking carisoprodol. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

MOTION: **Shamim Nagy motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Weldon Havins**
VOTES: **Unanimous**
MOTION CARRIED

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of the Nevada Medicaid Drug Use Review Board that carisoprodol and carisoprodol compound be non-preferred. Baclofen, chlorzoxazone, cyclobenzaprine, dantrolene, methocarbamol, methocarbamol/aspirin, orphenadrine citrate, orphenadrine compound and tizanidine will continue to be the preferred agents on the PDL.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

MOTION: **Joseph Adashek motioned to accept the DUR Board's recommendation that carisoprodol and carisoprodol compound be non-preferred.**
SECOND: **Connie Kalinowski**
VOTES: **Unanimous**
MOTION CARRIED

V. ANNUAL REVIEW – DRUG CLASSES BEING REVIEWED DUE TO RELEASE OF NEW DRUGS

A. Analgesics: Long-Acting Narcotics

Public Comment

No comment.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010; no changes were made to the PDL at that time. This class is being reviewed due to the release of the new product, Butrans® (buprenorphine transdermal patch), a once weekly matrix patch. This drug is a partial agonist at mu opiate receptor with high binding affinity and slow dissociation. It's also an antagonist at the kappa receptor. Butrans® is approved for the treatment of persistent moderate to severe pain in adults who need continuous analgesia for an extended period and is

available in 5, 10 and 20 mcg per hour strengths. Transdermal buprenorphine is more potent than morphine sulfate on a milligram per milligram basis but the relative potency has not been well studied. The recommendation for opiate-naïve patients or those on less than 30mg of morphine sulfate equivalents per day is to start with the 5mcg per hour patch. Because this drug may precipitate opiate withdrawal, it is recommended that patients on greater than 80mg morphine sulfate equivalents per day should taper the current opiate down to less than 80mg long-acting morphine equivalent and use short-acting opiates to cover. Patients on 30-80 mg per day of morphine equivalent should start Butrans® 10mcg per hour patch. The drug should be titrated at intervals not less than 72 hours. Due to the risk of QTc prolongation, the maximum dose is 20mcg per hour. The product has "do not exceed labeling" which limits its utility for pain. Patients requiring doses of opiates greater than 80mg per day of morphine sulfate equivalents may not be appropriate since they would require greater than 20mcg Butrans® per hour. Butrans® was studied in four unpublished twelve week trials in moderate to severe back pain or osteoarthritis. In one, naïve patients with back pain who tolerated the patch and achieved adequate relief during the 4-week open label titration phase were randomized to continued treatment or placebo. A total of 53% of the 1024 enrolled were randomized (25% dropped out due to ADRs and 14% due to lack of efficacy). In those who were randomized, 9% discontinued for lack of efficacy and 16% due to ADRs. For placebo, 13% discontinued due to lack of efficacy and 7% due to ADRs. Patients at endpoint on Butrans® had lower pain scores. In another similar study in 1,160 opiate experienced patients, 57% tolerated and achieved adequate analgesia with the 20mcg per hour patch during the open-label run-in and were randomized to continue or switch to the 5mcg patch. Of those randomized to 20 mcg/hr, 11% discontinued for lack of efficacy and 13% for ADRs. In the 5 mcg/hr group, 24% discontinued for lack of efficacy and 6% for ADRs. In two other studies, no detailed information is available in the package insert; both were failed studies. The most common adverse drug events were nausea, vomiting, dizziness, headache, somnolence and constipation. Erythremia and pruritus occurred frequently at the application site. Buprenorphine is associated with QTc prolongation so all conditions which put one at risk make this contraindicated. There is a warning to avoid the application of heat which may increase absorption of buprenorphine; heat related warnings include patients with fever. In overdose, naloxone may not be effective in reversing respiratory depression; this product has a half-life of 26 hours. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

MOTION: **Weldon Havins motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Joseph Adashek**
VOTES: **Unanimous**
MOTION CARRIED

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that no changes be made to the PDL in this class. Kadian®, sustained release morphine tablets (generic MS Contin®) and Duragesic® transdermal patch will continue to be the preferred agents.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

MOTION: **David Chan motioned that no changes be made to the PDL in this class.**
SECOND: **Michael Hautekeet**
VOTES: **Unanimous**
MOTION CARRIED

B. Androgenic Agents: Topical

Public Comment

John Brokars, Lilly, spoke in support of Axiron®, a testosterone topical solution indicated for primary and secondary hypogonadism. The differentiating component of this agent is the applicator and the location of application. The solution is available as a metered-dose pump with an applicator cup. 60mg, two pump actuations, is put into the cup and applied to the underarm. It's dosed once per day at the same time each morning and should be applied to a clean underarm. Axiron® was tested in 155 hypogonodal men over 120 days; 85% reached normal testosterone levels. Two months following the trial, a safety study was conducted. 7% of the patients had some skin irritation. He requested that Axiron® be added to the PDL.

Dr. Adashek asked if there has been a prospective study to bring that to the other two approved drugs. Mr. Brokars said no that testosterone has been approved since 1953 in the U.S. and the method of application is what differentiates Axiron® from the other products.

Ben Skoug, Abbott, spoke in support of Androgel®. Androgel® 1% is currently on the PDL. A new formulation, Androgel® 1.62%, was FDA-approved in April, 2011. Androgel® 1.62% was approved for replacement therapy in adult males for conditions associated with primary and secondary hypogonadism. The recommended starting dose is 1.62% as two pump actuations applied topically once daily in the morning to clean, dry intact skin of the shoulders and upper arms. This application differs from Androgel® 1% which can be applied to the upper arms as well as the abdomen. Androgel® should be allowed to dry prior to dressing and hands should be washed with soap and water. A pivotal study evaluated efficacy for Androgel® 1.62% in 274 hypogonodal men. 82% had a mean testosterone level within the normal range on day twelve meeting the primary endpoint. Efficacy was maintained in 78% of the men who received Androgel® for one full year. The most side effects reported in greater than 2% of patients were increased prostates specific antigen, emotional liability, hypertension, increased red blood cell count and contact dermatitis. Application site reactions were reported in 1% of patients; no discontinuations occurred due to application side reactions. Androgel® 1.62% carries similar box warnings as other prescription topical testosterone gel products. He requested the Committee to continue to have Androgel® 1% on the PDL and to add Androgel® 1.62%.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010, and is being reviewed today due to the release of two new products, Axiron® and Fortesta®. The current products on the PDL are Androderm® (transdermal patch) and Androgel® (topical gel). Axiron® has been described by the manufacturer in public comment. Fortesta® is a topical testosterone gel in a metered-dose pump delivering 10mg per pump. It should be applied once daily to the front and inner thigh. The dose is 10mg to 70mg titrated to testosterone levels. Both products were studied in open-label trials of 150 hypogonadal men. The dose was titrated based on serum testosterone. Outcome was serum level within the normal range (Fortesta® 78% were in normal range at day 90; Axiron® 85% were in normal range at day 60). There is no data comparing these products to other available testosterone supplementation. Studies did not mention symptoms at either baseline or endpoint. Both products contain warnings for skin-to-skin contact with other people. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

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

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that no changes be made to the PDL in this class and to continue to prefer Androderm® and Androgel®.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

Dr. Britt asked if there is utilization management for this class. Dr. Townsend responded that there are based on published guidelines and that the DUR Board has applied clinical criteria to this class of drugs.

Dr. Britt asked if the recommendation includes both strengths of Androgel® and Dr. Townsend stated that the product line will be preferred.

MOTION: Weldon Havins motioned that no changes be made to the PDL in this class.
SECOND: Connie Kalinowski
VOTES: Unanimous
MOTION CARRIED

C. Antipsychotics: Oral, Atypical

Public Comment

Donna Marie Shibovich, consumer representative, NAMI of Nevada, stated that she is in contact with the mentally ill on a daily basis and sees people going through hoops to receive the better, state-of-the art medicines that all mentally ill so deserve. These people are forced to fail first which she feels is inhumane. Doctors should be able to prescribe what medicines they wish since they have much experience in knowing which ones work and which ones don't. When Clozaril® came on the market, she was given the chance to trial "this very effective medicine" and has not been hospitalized for over twenty years and wished others had the same opportunity. Cost is a problem in this arena, but what new medicines offer are priceless - sanity, employment, a good combination of medicines that make psychotherapy possible and fruitful; a chance to function outside of the hospital or jail. Money will be saved by properly medicating the mentally ill by not having to go to the psych ward or jail. Mental illnesses are prevalent in all of our lives in some form or another so don't turn the mentally ill down by denying them access to medicines that would work wonders. Our mentally ill are worth it. She thanked the Committee for their time and consideration.

Joseph Tyler, Executive Director, NAMI of Nevada and peer counselor, Dini-Townsend Hospital, stated that he is speaking on behalf of those who have schizophrenia or bipolar disorder with psychotic features who have a right to receive state-of-the art atypical medications without having to fail first on a less expensive atypical medication. There is a lot of pressure to being a doctor of psychiatry and practicing good medicine without the stresses of not being able to prescribe the medications patients need and deserve. He and Ms. Shibovich testified at the Legislature speaking to therapeutic equivalents pointing out that every drug works differently for every individual. The P&T Committee did prefer one atypical medication which is noted to not cause weight gain, but there are other medications known to be better tolerated and in controlling psychotic features which were not included. People with psychosis do not like to take medications and may go off their medications, particularly those with odd side effects. There are many suicides and accidental deaths due in part to patients going off their medications. He requested that doctors be given the tools they need. Getting the best possible medication to the right patient could be a matter of them taking the medication or not which could result in a happy life or becoming suicidal from not tolerating their medications. During the Legislature, there were many add-backs in mental health due to the economy improving and many important programs were put back in place. He stated that he hopes the Committee will find leniency and do the same for the controversial class of atypical antipsychotics. He thanked the Committee for their time.

Steven Freedman, NAMI, stated that he was diagnosed with schizophrenia and was put on different types of psychotropic medications at twenty years old. He was able to finish college and function on the medications though it was a struggle. When he was able to get on the better medications, he improved at every stage with each medication change. He is currently on Seroquel® and now has a quality of life he never expected. He asked that the Committee's decision not be based completely on economics but have compassion for people that have one of these diseases.

Elizabeth Bellocchio, Bristol Myers, spoke in support of Abilify® (aripiprazole). Aripiprazole is approved for a broad range of indications in the adult, pediatric and adolescent populations. The new indication is the maintenance treatment of Bipolar I Disorder as adjunctive therapy to either lithium or valproate in adult and pediatric patients (age 10-17) and is also approved as monotherapy in the same populations. Aripiprazole is approved for once daily dosing and its DACON ranges from a 1.01 to 1.14 across the available tablet strengths. In a study evaluating healthcare utilization and cost in Medicaid, patients with Bipolar Disorder initiating aripiprazole, inpatient psychiatric costs were lower than those who initiated olanzapine, quetiapine or risperidone. The hazards of psychiatric hospitalization were significantly lower with patients initiating therapy with aripiprazole as compared to olanzapine, quetiapine and risperidone. There are two box warnings with aripiprazole: increased mortality in elderly patients with dementia-related psychosis treated with antipsychotic drugs and it is not approved for patients with dementia-related psychosis**;** antidepressants increase the risk for suicidal thinking and behavior in children, adolescents and young adults in short term studies of major depressive disorder and other psychiatric disorders. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality or unusual changes in behavior. Aripiprazole is not approved for use in pediatric patients with depression. She requested that aripiprazole be added to the PDL and that open access to antipsychotics is available.

Dr. Britt asked Ms. Bellocchio to explain DACON data. Ms. Bellocchio stated that aripiprazole is to be dosed once per day. On average, aripiprazole is being given to patients once a day as recommended based on studies and the FDA.

Manny Garcia, Sunovion, spoke in support of Latuda®, a new atypical antipsychotic. Efficacy was established and presented to the FDA successfully in four six week double-blind placebo controlled trials. The safety and efficacy was of such significance, the FDA approved this drug as a first pass approval in ten months which has not been done with another atypical antipsychotic to date. Atypical antipsychotic drugs have a different profile. Latuda® has no binding in cholinergic and muscarinic receptors often associated with blunting and weight gain as may be involved with the other atypical antipsychotics. The value of this drug is the safety and tolerability profile. In a six week trial, the weight gain difference versus placebo was 1.1 pounds on average. Following patients six, nine and twelve months, there was a one pound weight loss over the course of time. Cholesterol and triglycerides decreased over the six week trial and persisted below baseline at six, nine and twelve months. This drug carries no QTc warning and is Pregnancy Category B as does Clozaril®; the other agents are Pregnancy Category C. The most common adverse reactions were akathisia, nausea, Parkinsonism and agitation. This is a unique drug with a long half-life and is given once a day without titration.

Lynn Horne, MD, requested that all of the antipsychotics be on the PDL. Even though they all have D_2 antagonism, they are not pharmacologically identical. Some patients who respond to one will not respond to another. He requested that Latuda® and Saphris® be included on the PDL. If open access is not approved, he asked that failure of one non-preferred agent, not two, be continued.

Tim Hartman, Pfizer, spoke in support of Geodon®. Geodon® goes generic in March, 2012. It's currently the fourth most commonly prescribed antipsychotic since placed on the PDL. An article presented in April, 2007, at the Academy of Managed Care Pharmacy, looking at adherence and persistence within the Medicaid claims database indicated that 2,446 met

criteria; 45% were deemed to be dosed effectively. Abilify® was the most prescribed at 77% with Geodon® second at 58%. Of these patients, 58% were adherent; Geodon® was number one at 62%. Median time to non-persistence was 96 days; Geodon® was number one at 117 days. Patients taking olanzapine were more likely to discontinue compared to Geodon®. Mental health prescription costs and overall prescription costs were less with the risperidone treatment group. There were no differences between groups with mental health costs or all costs. He requested that Geodon® be maintained on the PDL.

Dr. Charles Costas, pharmacy state-wide director for MHDS, stated that Abilify® on the decision matrix is now line two and he would like consideration for it to be the first-line choice. It has broader indications for schizophrenia, bipolar disorder, major depressive disorder, and autistic disorder with irritability symptoms. Because of the lengthiness of the prior authorization process, patients discharged from the emergency room with prescriptions for Abilify® may have episodic readmissions. To decrease the readmission rate, he requested that Abilify® be more readily available. He also requested Latuda® be included on the PDL for use in pregnant women.

Johanna Fricke, MD, stated that she only has two options for children with autism and aggression, Risperdal® and Abilify®. All of the neuroleptics cause weight gain. In her clinical experience, Risperdal® has been used off-label since 1994. When a child with autistic spectrum disorder becomes obese, it's not the same as trying to help a child that is not autistic. She currently uses metformin for children with metabolic syndrome and pre-diabetic conditions but would like to have other options available for these patients. She stated that Abilify® is the only agent approved for children with autism and aggression and requested it be available on the PDL.

Dr. Kalinowski stated that most of the recommendations are that Geodon® and Abilify® are relatively equivalent in terms of their metabolic effects and asked Dr. Fricke if she has a sense about what the success has been in using Geodon® in the pediatric population.

Dr. Fricke stated that she did not as Geodon® is not FDA-approved for the purpose that she uses.

Yumi Yamamoto, Merck, spoke in support of Saphris®. There are two new indications for Saphris® which are the maintenance treatment of schizophrenia in adults as well as adjunctive therapy with either lithium or valproate for the acute treatment of manic episodes and mixed episodes associated with Bipolar I. Of the three newer agents available in the class, Saphris® is the only agent that carries more than one indication. It's the only agent currently available that can be administered sublingually. Peak plasma levels occur within thirty to ninety minutes and the mean terminal half-life is twenty-four hours. She requested that Saphris® be added to the PDL.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that his class was last reviewed in May, 2010. Nevada Medicaid does not manage the injectable atypical antipsychotics or the older first generation antipsychotics; all are covered with equal status. Although they are in the therapeutic class review provided, only the oral atypical antipsychotics will be discussed. There is little new significant clinical information. New class labeling for use in the elderly with dementia-related psychosis was added as a black box warning to all of the atypical antipsychotics. The new drug to market, Latuda®, is the tenth atypical antipsychotic approved and is indicated for schizophrenia in adults. It's labeled with class warnings including metabolic changes, weight gain and cardiovascular risk. It's been studied in four six week placebo controlled trials. In the first trial, Latuda® 40mg and 120mg were compared to placebo in 149 patients in the U.S. The dropout was extremely high at 66% overall ranging from 59% to 70%. Both the 40mg and 120mg at endpoint were superior to placebo on the BPRSd total score and the CGI-S. The second trial compared Latuda® 80mg to placebo in 180 patients. The dropout rate was 42% and 48%. It was superior to placebo on the BPRSd total score and the CGI-S. Latuda® 40mg, 80mg and 120mg were compared to placebo in 489 patients in a combined U.S. and international trial. Only the 80mg dose was superior to placebo on the primary endpoint of

the PANSS total score and the CGI-S. In the FDA analysis of this data, Latuda® was not superior to placebo in the US site cohort, only in the international site cohort. In the fourth study, Latuda® 40mg and 80mg and the active-control olanzapine 15mg were compared to placebo in 473 patients in a multi-national trial. At endpoint, both doses of Latuda® and the active-control were superior to placebo on the PANSS total score and the CGI-S. The 120mg dose was not shown to be superior to the 40mg and was not approved. Effectiveness for greater than six weeks has not been established. Adverse events that occurred greater than 5% and twice as often with Latuda® as placebo included akathisia, nausea, Parkinsonism, agitation and somnolence. Akathisia, sedation, somnolence and elevated prolactin appeared to be dose related. Weight gain in short-term trials was similar to placebo. For ADRs, this drug appears probably closest to ziprasidone except with more EPS symptoms and less QTc prolongation. Latuda® has significant drugs interactions with CYP34A both inhibitors and inducers. Published data are sparse and comparative data are lacking. In short-term trials, it appears to be well tolerated with minimal metabolic effects but longer term studies are needed. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this class be considered therapeutic alternatives.

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

MOTION: **Connie Kalinowski motioned that the agents in this class be considered therapeutic alternatives.**
SECOND: **Joseph Adashek**
VOTES: **Unanimous**
MOTION CARRIED

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that no changes be made to the PDL in this class. Clozapine, Fanapt®, Geodon®, risperidone and Seroquel will continue to be preferred. She noted that the PDL exception criteria differ with this class requiring failure of only one preferred agent. Because these patients frequently go on and off of these medications, a non-preferred drug used in the past will be approved.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

Dr. Havins recommended that Latuda® be included on the PDL because of its safety for use in pregnancy.

Dr. Townsend stated Latuda® can be approved through the PA process for pregnancy.

Dr. Adashek stated that he treats high risk pregnancy patients and would not discontinue any of these medications if they were currently on one. Regardless of the pregnancy category, if the drug is effective, he will continue the patient on it. There is not much difference between Category B and C in terms of a dangerous profile for the fetus. He asked Dr. Townsend to comment on the letter of public testimony submitted by Dr. Lesley Dickson, Executive Director of the Nevada Psychiatric Association requesting Abilify® be included on the PDL as it works best for children in managing psychotic and other behavioral symptoms, and is FDA indicated for irritability in autistic disorders which most other antipsychotics are not.

Dr. Townsend replied that if there is a unique indication, Abilify® will be available through the PA process. Abilify® is currently not on the PDL, but has a large market share due to patients meeting the PDL exception criteria or use for unique indications.

Ms. Lawrence stated that the Legislature requires quarterly reports for this class of drugs based on the Clinical Call Center's call data for approved, denied, change in therapy, informational requests, etc. Since the P&T Committee took action on this class of drugs last year, there have been no denials based upon the current PDL exception criteria.

Dr. Kalinowski stated that when discussing this class, the adult population is usually individuals with persistent disabilities who are not native with respect to pharmacologic exposure so they have history of what does or does not work. The concern is the pediatric population, particularly with individuals with autistic spectrum diagnoses who are often pharmacologically naive and have not had previous trials. The experience with these medications in the pediatric population is relatively limited.

Dr. Townsend clarified that there is a 24 hour turnaround time for PA requests. Patients discharged from an acute mental health facility on a non-preferred drug will be approved for that drug. She added that age edits can be applied to drugs.

MOTION: Constance Kalinowski motioned to maintain the current agents on the PDL within this class and add Abilify® for juveniles under the age of 18 with autism spectrum diagnosis.
SECOND: Weldon Havins
VOTES: Unanimous
MOTION CARRIED

Ms. Lawrence stated that an off-label indication cannot be coded in the system and autism spectrum diagnosis is not covered in the package insert for Abilify®. She asked for public comment to clarify what is the actual autism diagnosis.

Dr. Johanna Fricke stated that the FDA has approved Abilify® in children ages 6 through 17 years of age for the indication of aggression in children with autism which includes any explosive outbursts in which they do harm to themselves or others.

Dr. Havins said that the package insert states the indication as irritability associated with autism disorder.

Elizabeth Bellocchio, Bristol-Myers Squibb, representing Abilify®, stated that the package insert specifically states that Abilify® is indicated for the treatment of irritability associated with autistic disorder. Irritability, as it states on the label, does include the symptoms mentioned by Dr. Fricke. The FDA approval is for ages 6 to 17 years of age.

Ms. Lawrence stated that Abilify® will be coded in the system specifically for the indication and age as covered in the package insert.

D. Bone Ossification Agents: Bisphosphonates

Public Comment

No comment.

Drug Class Review Presentation – Magellan Medicaid Administration

Dr. Townsend stated that this class was last reviewed on June 24, 2010, with no changes made to the PDL at that time. It is now being reviewed due to the release of a new product, Atelvia®. Atelvia® is delayed release risedronate 35mg indicated as a once weekly treatment for postmenopausal osteoporosis. It may be taken immediately after breakfast versus 30-60 minutes before and should not be taken when fasting due to a higher incidence of abdominal pain versus the immediate release. Atelvia® is designed to reduce interference with calcium, magnesium and other divalent cations. This product is enteric-coated preventing dissolution in the stomach and also contains EDTA to bind stray cations that would bind risidronate. It should be taken with at least four ounces of plain water and the patient must remain upright for at least 30-60 minutes. PPIs or H2s may interfere with the release mechanism which is ph dependent and should not be taken. Patients should separate any of the divalent cations and antacids as it's possible to overwhelm the EDTA's ability to bind. It is the recommendation of DHCFP and Magellan Medicaid Administration that the agents in this category be considered therapeutic alternatives.

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

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

Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that no changes be made to the PDL in this class. Alendronate and Fosamax Plus D® will continue to be the preferred agents.

Committee Discussion and Approval of Drugs for Inclusion on the PDL

MOTION: **Joseph Adashek motioned that no changes be made to the PDL in this class. Alendronate and Fosamax Plus D® will continue to be the preferred agents.**
SECOND: **Shamim Nagy**
VOTES: **Unanimous**
MOTION CARRIED

Dr. Britt stated that due to the time limitation, the next item of business for discussion will be agenda item VI. Annual Review - Drugs without Proposed Changes. Agenda items V. E through K will be deferred until the next meeting.

E. **Cardiovascular: Angiotensin II Receptor Blockers and Diuretic Combinations**
Deferred until the next meeting.

F. **Cardiovascular: Direct Renin Inhibitors and Combinations**
Deferred until the next meeting.

G. **Diabetic Agents: Other Agents**
Deferred until the next meeting.

H. **Ophthalmic Antihistamines**
Deferred until the next meeting.

I. **Ophthalmic Non-Steroidal Anti-Inflammatory Agents**
Deferred until the next meeting.

J. **Ophthalmic Quinolones**
Deferred until the next meeting.

K. **Respiratory: Inhaled Corticosteroid/Beta-Adrenergic Combinations**
Deferred until the next meeting.

VI. ANNUAL REVIEW – Drug Classes without Proposed Changes

A. Public Comment

Sterling Tanner, MD, pediatric endocrinologist, said that he received a letter from Amerigroup stating that coverage for blood sugar machines will be discontinued. Ms. Lawrence stated that Amerigroup is an MCO program and is addressed within a different

committee. She provided Dr. Tanner with her contact information to assist him with this issue.

B. Presentation of Recommendations for Preferred Drug List (PDL) Inclusion by Magellan Medicaid Administration and the Division of Health Care Financing and Policy without Changes

1. Acne Agents: Topical, Retinoid Agents and Combinations
2. Acne Agents: Topical, Benzoyl Peroxide and Clindamycin Combinations
3. Alzheimer's Agents
4. Analgesics/Anesthetics: Topical
5. Analgesics: Tramadol and Related Drugs
6. Anaphylaxis: Self-Injectable Epinephrine
7. Antibiotics: Cephalosporins 2nd Generation
8. Antibiotics: Cephalosporins 3rd Generation
9. Antibiotics: Macrolides
10. Antibiotics: Quinolones 2nd Generation
11. Antibiotics: Quinolones 3rd Generation
12. Anticoagulants: Injectable
13. Antidepressants: Other
14. Antidepressants: SSRIs
15. Antiemetics: Oral, 5-HT3s
16. Antifungals: Onychomycosis Agents
17. Antihistamines: 2nd Generation
18. Antihyperuricemics: Xanthine Oxidase Inhibitors for Gout
19. Anti-Migraine Agents: Triptans
20. Antiparkinson's Agents: Non-ergot Dopamine Agonists
21. Antiviral Agents: Influenza
22. Benign Prostatic Hyperplasia (BPH) Agents: Alpha-blockers
23. Benign Prostatic Hyperplasia (BPH) Agents: 5-alpha-reductase Inhibitors
24. Cardiovascular: ACE Inhibitors & Diuretic Combinations
25. Cardiovascular: Antihyperlipidemics, Bile Acid Sequestrants
26. Cardiovascular: Antihyperlipidemics, Cholesterol Absorption Inhibitors
27. Cardiovascular: Antihyperlipidemics, Statins & Statin Combinations
28. Cardiovascular: Antihyperlipidemics, Niacin Agents
29. Cardiovascular: Antihyperlipidemics, Triglyceride Lowering Agents
30. Cardiovascular: Beta Blockers
31. Cardiovascular: Calcium Channel Blockers and Combinations
32. Central Nervous System: Anticonvulsants, Barbiturates
33. Central Nervous System: Anticonvulsants, Benzodiazepines
34. Central Nervous System: Anticonvulsants, Hydantoins
35. Central Nervous System: Anticonvulsants, Miscellaneous
36. Central Nervous System: Sedative Hypnotics
37. Diabetic Agents: Biguanides
38. Diabetic Agents: Insulin Products
39. Diabetic Agents: Sulfonylureas
40. Diabetic Agents: Thiazolidinediones
41. Electrolyte Depleters
42. Erythropoiesis Stimulating Proteins
43. Fibromyalgia Agents
44. Gastrointestinal Agents: H2Ras
45. Gastrointestinal Agents: Ulcerative Colitis
46. Growth Hormone Agents
47. Hepatitis C Agents
48. Herpetic Antiviral Agents
49. Herpetic Antiviral Agents : Topical
50. Immunomodulators: Injectable
51. Immunomodulators: Topical
52. Impetigo Agents: Topical
53. Leukotriene Modifiers

54. Multiple Sclerosis Agents: Specific Symptomatic Treatment
55. Nasal Calcitonins
56. Ophthalmic Antibiotics: Macrolides
57. Ophthalmic Glaucoma Agents
58. Otic Fluoroquinolones
59. Platelet Aggregation Inhibitors
60. Progestins for Cachexia
61. Psoriasis Agents: Topical
62. Pulmonary Arterial Hypertension Agents: Inhaled Agents
63. Pulmonary Arterial Hypertension Agents: Oral Agents
64. Respiratory: Inhaled Anticholinergic Agents
65. Respiratory: Inhaled Corticosteroids/Nebs
66. Respiratory: Intranasal Rhinitis Agents
67. Respiratory: Long-Acting Beta Adrenergics
68. Urinary Tract Antispasmodics

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that the agents within the classes listed as 1 through 68 be considered therapeutic alternatives.

Committee Discussion and Approval of Drug Classes without changes for the PDL

MOTION: David Chan motioned that the agents in the classes listed as 1 through 68 be considered therapeutic alternatives.
SECOND: Michael Hautekeet
VOTES: Unanimous
MOTION CARRIED

Dr. Townsend stated that it is the recommendation of DHCFP and Magellan Medicaid Administration that no changes be made to the PDL in the classes listed as 1 through 68.

MOTION: Joseph Adashek motioned that no changes be made to the PDL in the classes listed as 1 through 68.
SECOND: Shamim Nagy
VOTES: Unanimous
MOTION CARRIED

VII. Report by FHSC on New Drugs to Market, New Generic Drugs to Market, and New Line Extensions

Dr. Townsend presented the report for Committee information.

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

The next meeting is scheduled for September 22, 2011, 1:00 p.m., at the Las Vegas Chamber of Commerce and the Nevada State Health Division in Carson City.

IX. Public Comment

No comment.

X. Adjournment

MOTION: David Chan motioned to adjourn the meeting.
SECOND: Michael Hautekeet
VOTES: Unanimous
MOTION CARRIED
The meeting was adjourned at 4:08 p.m.