Oklahoma Health Care Authority

Drug Utilization Review Board

Wednesday,
September 10, 2014
4 p.m.

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

The University of Oklahoma
Health Sciences Center
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

MEMORANDUM

TO: **Drug Utilization Review Board Members**

FROM: **Bethany Holderread, Pharm.D.**

SUBJECT: **Packet Contents for Board Meeting – September 10, 2014**

DATE: **September 2, 2014**

NOTE: **The DUR Board will meet at 4:00 p.m. The meeting will be held at 4345 N Lincoln Blvd.**

Enclosed are the following items related to the September meeting. Material is arranged in order of the Agenda.

Call to Order

Public Comment Forum

Action Item – Approval of DUR Board Meeting Minutes – See Appendix A

Update on Medication Coverage Authorization Unit/Drug Utilization Review of Prenatal Vitamins – See Appendix B

Action Item – Vote to Prior Authorize Zohydro™ ER (Hydrocodone Bitartrate) and Xartemis™ XR (Oxycodone/Acetaminophen) – See Appendix C

Action Item – Vote to Prior Authorize Zontivity™ (Vorapaxar) – See Appendix D

Action Item – Annual Review of Synagis® (Palivizumab) – See Appendix E

Annual Review of Atypical Antipsychotics and 30-Day Notice to Prior Authorize Versacloz™ (Clozapine Oral Suspension) – See Appendix F

Action Item – Annual Review of ADHD and Narcolepsy Medications – See Appendix G

30-Day Notice to Prior Authorize Grastek® (Timothy Grass Pollen Allergen Extract) and Ragwitek™ (Short Ragweed Pollen Allergen Extract) – See Appendix H

FDA and DEA Updates – See Appendix I

Future Business

Adjournment

Oklahoma Health Care Authority

Drug Utilization Review Board

(DUR Board)

Meeting – September 10, 2014 @ 4:00 p.m.

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma 73105

AGENDA

Discussion and Action on the Following Items:

Items to be presented by Dr. Muchmore, Chairman:

1. **Call To Order**
   A. Roll Call – Dr. Cothran

Items to be presented by Dr. Muchmore, Chairman:

2. **Public Comment Forum**
   A. Acknowledgment of Speakers and Agenda Items

Items to be presented by Dr. Muchmore, Chairman:

3. **Action Item – Approval of DUR Board Meeting Minutes – See Appendix A**
   A. July 9, 2014 DUR Minutes – Vote
   B. July 9, 2014 DUR Recommendations Memorandum

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

4. **Update on Medication Coverage Authorization Unit/Drug Utilization Review of Prenatal Vitamins – See Appendix B**
   A. Medication Coverage Activity for July 2014
   B. Pharmacy Help Desk Activity for July 2014
   C. Drug Utilization Review of Prenatal Vitamins

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

5. **Action Item – Vote to Prior Authorize Zohydro™ ER (Hydrocodone Bitartrate) and Xartemis™ XR (Oxycodone/Acetaminophen) – See Appendix C**
   A. COP Recommendations

Items to be presented by Dr. Anderson, Dr. Muchmore, Chairman:

6. **Action Item – Vote to Prior Authorize Zontivity™ (Vorapaxar) – See Appendix D**
   A. COP Recommendations

Items to be presented by Dr. Anderson, Dr. Muchmore, Chairman:

7. **Action Item – Annual Review of Synagis® (Palivizumab) – See Appendix E**
   A. Current Prior Authorization Criteria
   B. Utilization of Synagis®
   C. Prior Authorization of Synagis®
   D. Market News and Updates
   E. COP Recommendations

Items to be presented by Dr. Holderread, Dr. Muchmore, Chairman:

8. Annual Review of Atypical Antipsychotics and 30-Day Notice to Prior Authorize Versacloz™ (Clozapine Oral Suspension) – See Appendix F

A. Current Tier Structure
B. Utilization of Atypical Antipsychotics
C. Prior Authorization of Atypical Antipsychotics
D. Atypical Antipsychotic Utilization Trends
E. Market News and Updates
F. COP Recommendations
G. Utilization Details

Items to be presented by Dr. Adams, Dr. Muchmore, Chairman:

9. Action Item – Annual Review of ADHD and Narcolepsy Medications – See Appendix G

A. Current Prior Authorization Criteria
B. Utilization of ADHD & Narcolepsy Medications
C. Prior Authorization of ADHD & Narcolepsy Medications
D. Market News and Updates
E. COP Recommendations
F. Utilization Details

Items to be presented by Dr. Nawaz, Dr. Muchmore, Chairman:

10. 30-Day Notice to Prior Authorize Grastek® (Timothy Grass Pollen Allergen Extract) and Ragwitek™ (Short Ragweed Pollen Allergen Extract) – See Appendix H

A. Introduction
B. Product Summaries
C. COP Recommendations

Items to be presented by Dr. Cothran, Dr. Muchmore, Chairman:

11. FDA and DEA Updates – See Appendix I

Items to be presented by Dr. Cothran, Dr. Muchmore, Chairman:

12. Future Business

A. Annual Reviews
B. New Product Reviews

Items to be presented by Dr. Muchmore, Chairman:

13. Adjournment

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES OF MEETING OF JULY 9, 2014

BOARD MEMBERS:	PRESENT	ABSENT
Mark Feightner, Pharm.D.		x
Anetta Harrell, Pharm.D.	x	
John Muchmore, M.D., Ph.D.; Chairman	x	
James Osborne, Pharm. D	x	
Paul Louis Preslar, D.O., MBA	x	
James Rhymer, D.Ph.	x	
Bruna Varalli-Claypool, MHS, PA-C	x	
Eric Winegardener, D.Ph.	x	

COLLEGE OF PHARMACY STAFF:	PRESENT	ABSENT
Terry Cothran, D.Ph.; Pharmacy Director	x	
Michyla Adams, Pharm.D.; Clinical Pharmacist	x	
Karen Egesdal, D.Ph.; SMAC-ProDUR Coordinator/OHCA Liaison	x	
Bethany Holderread, Pharm. D.; Clinical Coordinator	x	
Shellie Keast, Ph.D.; Assistant Professor	x	
Carol Moore, Pharm.D.; Clinical Pharmacist	x	
Brandy Nawaz, Pharm.D.; Clinical Pharmacist	x	
Leslie Robinson, D.Ph.; PA Coordinator		x
Jennifer Sipols, Pharm.D.; Clinical Pharmacist		x
Ashley Teel, Pharm.D.; Clinical Pharmacist	x	
Melissa Anderson, Pharm.D.; Clinical Pharmacist	x	
Graduate Students: David George; Pharm. D.	x	
Tammy Lambert; Pharm .D.	x	
Timothy Pham, Pharm. D.	x	
Visiting Pharmacy Student(s): Whitney Putt	x	

	PRESENT	ABSENT
Marlene Asmussen, R.N.; Population Care Management Director	x	
Nico Gomez, Chief Executive Officer		x
Sylvia Lopez, M.D., FAAP; Chief Medical Officer		x
Ed Long, Chief Communications Officer	x	
Kelli Brodersen, Marketing Coordinator		x
Nancy Nesser, Pharm.D., J.D.; Pharmacy Director	x	
Rebecca Pasternik-Ikard, Deputy State Medicaid Director		x
Lynn Rambo-Jones, J.D.; Deputy General Counsel III	x	
Jill Ratterman, D.Ph.; Pharmacy Specialist	x	
Garth Splinter, M.D., M.B.A.; Medicaid Director	x	
Kerri Wade, Pharmacy Operations Manager	x	

OTHERS PRESENT:		
Phillip Lafferty , Celgene	Mark DeClerk, Lilly	Clint Degner, Novartis
Melvin Nwamadi, Abbott	Warren Tayes, Merck	Jim Fowler, Astra Zeneca
Sam Smothers , Medimmune	Russ Wilson, Johnson & Johnson	Jon Maguire, GSK
Mai Duong, Novartis	Brian Maves, Pfizer	Tom O'Donnell, GenenTech
Amie Gardiner, Pharma	Charlene Kaiser, Amgen	David Williams, Forest

PRESENT FOR PUBLIC COMMENT:	
Tom O'Donnell	GenenTech

AGENDA ITEM NO. 1: **CALL TO ORDER**

1A: ROLL CALL

Dr. Muchmore called the meeting to order. Roll call by Dr. Cothran established the presence of a quorum.

ACTION: NONE REQUIRED

AGENDA ITEM NO. 2: **PUBLIC COMMENT FORUM**

TOM O'DONNELL **AGENDA ITEM NO. 11**

ACTION: NONE REQUIRED

AGENDA ITEM NO. 3: **APPROVAL OF DUR BOARD MINUTES**

3A: JUNE 11, 2014 DUR MINUTES-VOTE

3B: JUNE 11, 2014 DUR RECOMMENDATIONS MEMORANDUM

Dr. Rhymer moved to approve; seconded by Dr. Harrell

ACTION: MOTION CARRIED

AGENDA ITEM NO. 4: **UPDATE ON MEDICATION COVERAGE AUTHORIZATION UNIT/OPIOID RETRO DUR**

4A: MEDICATION COVERAGE ACTIVITY FOR JUNE 2014

4B: PHARMACY HELP DESK ACTIVITY FOR JUNE 2014

4C: OPIOID PRESCRIPTIONS IN PREGNANT WOMEN

4D: CONCOMITANT BENZODIAZEPINE AND OPIOID UTILIZATION

Materials included in agenda packet; presented by Dr. Holderread

Dr. Muchmore recommends *"beginning edit on 3rd opioid while pregnancy diagnosis or give OB a free pass and prior authorize anyone else over 3 claims."* Dr. Preslar recommends "A*nything over 90 days, send out letter."* Dr. Preslar recommends *"We use the same criteria we are currently using for Lock-In members."*

ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE ESOMEPRAZOLE STRONTIUM AND ACIPHEX® SPRINKLE™ (RABEPRAZOLE)**

5A: COP RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Teel

Ms. Varalli- Claypool moved to approve; seconded by Dr. Preslar

ACTION: MOTION CARRIED

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE LIPTRUZET™ (EZETIMIBE/ATORVASTATIN) AND OMTRYG™ (OMEGA-3-ACID ETHYL ESTERS A)**

6A: COP RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Nawaz

Dr. Preslar moved to approve; seconded by Dr. Winegardener

ACTION: MOTION CARRIED

AGENDA ITEM NO. 7: **VOTE TO PRIOR AUTHORIZE ZECUITY® (SUMATRIPTAN IONTOPHORETIC TRANSDERMAL SYSTEM) AND UPDATE THE TRIPTAN ANTI-MIGRAINE MEDICATION PRIOR AUTHORIZATION CATEGORY**

7A: COP RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Adams

Dr. Winegardener moved to approve; seconded by Dr. Harrell.

ACTION: MOTION CARRIED

AGENDA ITEM NO. 8: **ANNUAL REVIEW OF RELISTOR® (METHYLNALTREXONE), LINZESS® (LINACLOTIDE), AND AMITIZA® (LUBIPROSTONE)**

8A: CURRENT AUTHORIZATION CRITERIA

8B: UTILIZATION OF RELISTOR®, LINZESS®, AND AMITIZA®

8C: PRIOR AUTHORIZATION

8D MARKET NEWS AND UPDATES

8E: COP RECOMMENDATIONS

8F: UTILIZATION DETAILS

Materials included in agenda packet; presented by Dr. Adams

Dr. Muchmore recommends *"One of the three trials tried and failed should be PEG 3350."* Dr. Harrell recommends *"trials for all three products be removed for cancer patients."*

Dr. Rhymer moved to approve; seconded by Dr. Harrell.

ACTION: MOTION CARRIED

AGENDA ITEM NO. 9: **ANNUAL REVIEW OF ANTICOAGULANTS AND PLATELET AGGREGATION INHIBITORS AND 30-DAY NOTICE TO PRIOR AUTHORIZE ZONTIVITY™ (VORAPAXAR)**

9A: CURRENT AUTHORIZATION CRITERIA

9B: UTILIZATION OF ANTICOAGULANTS AND PLATELET AGGREGATION INHIBITORS

9C: PRIOR AUTHORIZATION

9D: MARKET NEWS AND UPDATES

9E: SUMMARY

9F: COP RECOMMENDATIONS

9G: UTILIZATION DETAILS

9H: PRODUCT DETAILS

Materials included in agenda packet; presented by Dr. Anderson

ACTION: NONE REQUIRED

AGENDA ITEM NO. 10: **ANNUAL REVIEW OF OPIOID ANALGESICS AND 30-DAY NOTICE TO PRIOR AUTHORIZE ZOHYDRO™ ER (HYDROCODONE BITARTRATE) AND XARTEMIS™ XR (OXYCODONE/ACETAMINOPHEN)**

10A: CURRENT AUTHORIZATION CRITERIA

10B: UTILIZATION OF OPIOID ANALGESICS

10C: PRIOR AUTHORIZATION

10D: UTILIZATION TREND

10E: MARKET NEWS AND UPDATES

10F: SUMMARY

10G: COP RECOMMENDATIONS

10H: UTILIZATION DETAILS

Materials included in agenda packet; presented by Dr. Holderread

ACTION: NONE REQUIRED

AGENDA ITEM NO. 11: **ANNUAL REVIEW OF XOLAIR® (OMALIZUMAB)**

11A: INTRODUCTION

11B: CURRENT AUTHORIZATION CRITERIA

11C: UTILIZATION OF XOLAIR®

11D: PRIOR AUTHORIZATION

11E: SUMMARY

11F: COP RECOMMENDATIONS

Materials included in agenda packet; presented by Dr. Nawaz

Dr. Muchmore recommends *"to remove the 8-week trial of cyclosporine daily titrated to maximum recommended dose."* Dr. Muchmore *"recommends adding Advanced Care Practitioner with the allergist, immunologist or dermatologist as their supervising physician."* Dr. Muchmore recommends *"Roman III to add in combination with leukotriene antagonist."*

Dr. Winegardener moved to approve; seconded by Ms. Varalli-Claypool.

ACTION: MOTION CARRIED

AGENDA ITEM NO. 12: **FDA AND DEA UPDATES**

Materials included in agenda packet; presented by Dr. Cothran

ACTION: NONE REQUIRED

AGENDA ITEM NO. 13: **FUTURE BUSINESS**

13A: ANNUAL REVIEWS

13B: NEW PRODUCT REVIEWS

Materials included in agenda packet; submitted by Dr. Cothran

ACTION: NONE REQUIRED

AGENDA ITEM NO. 14: **ADJOURNMENT**

The meeting was adjourned at 5:33pm.

The University of Oklahoma
Health Sciences Center
COLLEGE OF PHARMACY
PHARMACY MANAGEMENT CONSULTANTS

Memorandum

Date: July 10, 2014

To: Nancy Nesser, Pharm.D., J.D.
Pharmacy Director
Oklahoma Health Care Authority

From: Bethany Holderread, Pharm.D.
Clinical Pharmacist
Pharmacy Management Consultants

Subject: DUR Board Recommendations From Meeting of July 09, 2014

Recommendation 1: Vote to Prior Authorize Esomeprazole Strontium and Aciphex® Sprinkle™ (Rabeprazole)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the addition of Aciphex® Sprinkle™ and Esomeprazole Strontium to Tier-3 of the Anti-Ulcer Product Based Prior Authorization category. The existing criteria for this category will apply.

Anti-Ulcer Medications		
Tier-1	**Tier-2**	**Tier-3**
omeprazole (Prilosec®)	dexlansoprazole (Dexilant®)	esomeprazole magnesium (Nexium® Capsules, Packets, and I.V.)
pantoprazole (Protonix® Tablets)	lansoprazole (Prevacid® and ODT)	esomeprazole strontium
	rabeprazole sodium (Aciphex® Tablets)	omeprazole (Prilosec® Suspension and Powder)
		pantoprazole (Protonix® Suspension & I.V.)
		rabeprazole sodium (Aciphex® Sprinkle™)

Anti-Ulcer Medications Tier-2 Approval Criteria:

1. A 14-day trial of all available Tier-1 medications titrated up to the recommended dose that has resulted in inadequate relief of symptoms or intolerable adverse effects; or
2. Contraindication to all available Tier-1 medications; or
3. An indication not covered by lower tiered medications.

Anti-Ulcer Medications Tier-3 Approval Criteria:

1. A 14-day trial of all available Tier-1 and Tier-2 medications that has resulted in inadequate relief of symptoms or intolerable adverse effects; or
2. Contraindication to all available Tier-1 and Tier-2 medications; or
3. An indication not covered by lower tiered medications.
4. Special formulations including ODTs, Sprinkle Capsules, Granules, Suspension, and Solution for I.V. require special reason for use.

Proton-Pump Inhibitors for Pediatric Members Approval Criteria:

1. A recent 14-day trial of an H_2 receptor antagonist that has resulted in inadequate relief of symptoms or intolerable adverse effects; or
2. Recurrent or severe disease such as:
    a. GI bleed
    b. Zollinger-Ellison Syndrome or similar disease

Recommendation 2: Vote to Prior Authorize Liptruzet™ (Ezetimibe/Atorvastatin) and Omtryg™ (Omega-3-Acid Ethyl Esters A)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the placement of Liptruzet™ (ezetimibe/atorvastatin) into the Special PA category of the Statin and Zetia® Product Based Prior Authorization category. The existing criteria for this category will apply.

Statin Medications and Zetia® (Ezetimibe) Tier-2 Approval Criteria:

1. A trial with atorvastatin, consisting of at least 8 weeks of continuous therapy, titrated to 40mg, which did not yield adequate LDL reduction. The minimum starting dose of the Tier-2 medication may only be at the moderate to high LDL lowering doses (20mg rosuvastatin or higher); or
2. Documented adverse effect or contraindication to all available lower tiered products; and
3. A clinical exception will apply for Crestor® (rosuvastatin) 40mg for high risk members hospitalized for recent acute myocardial infarction or acute coronary syndrome.

Special PA Approval Criteria:

1. A patient-specific, clinically significant reason why lower tiered medications with similar or higher LDL reduction cannot be used; and
2. Simcor® (simvastatin/niacin) and Advicor® (lovastatin/niacin) will also require a patient-specific, clinically significant reason why the member cannot use the individual products separately; and
3. Clinical exceptions for Zetia® (ezetimibe) include the following:
   i. Documented active liver disease; or
   ii. Documented unexplained, persistent elevations of serum transaminases; or
   iii. Documented statin related myopathy.

Statin Medications and Zetia® (Ezetimibe)		
Tier-1	**Tier-2**	**Special PA**
atorvastatin (Lipitor®)	rosuvastatin (Crestor®)*	ezetimibe (Zetia®)
lovastatin (Mevacor®)		ezetimibe/atorvastatin (Liptruzet™)
pravastatin (Pravachol®)		fluvastatin (Lescol®, Lescol® XL)
simvastatin (Zocor®)		lovastatin (Altoprev®)
		lovastatin/niacin (Advicor®)
		pitavastatin (Livalo®)
		simvastatin/ezetimibe (Vytorin®)
		simvastatin/niacin (Simcor®)

* Crestor® 5mg and Crestor® 10mg require special reason for use.

Additionally the College of Pharmacy recommends the prior authorization of Omtryg™ (omega-3-acid ethyl esters A) with the following criteria:

Omtryg™ (Omega-3-Acid Ethyl Esters A) Approval Criteria:

1. Laboratory documentation of severe hypertriglyceridemia (fasting triglycerides >500mg/dL), and controlled diabetes (fasting glucose <150mg/dL at the time of triglycerides measurement and HgA_1C <7.5%); and
2. Previous failure with both nicotinic acid and fibric acid medications.

% LDL Reduction	*Lovastatin (Mevacor®)*	*Pravastatin (Pravachol®)*	*Simvastatin (Zocor®)*	*Atorvastatin (Lipitor®)*	*Rosuvastatin (Crestor®)*	*Pitavastatin (Livalo®)*	*Fluvastatin (Lescol®)*
25-32 %	20mg	20mg	10mg			1 mg	40mg
31-39 %	40mg	40mg	20mg	10mg		2 mg	80mg*
37-45 %		80mg	40mg	20mg	5mg	4 mg	
48-52 %			80mg	40mg	10mg		
55-60 %				80mg	20mg		
60-63 %					40mg		

*Lescol® 40mg twice daily and Lescol® XL 80mg both fall into 31-39% LDL reduction category.

Recommendation 3: Vote to Prior Authorize Zecuity® (Sumatriptan Iontophoretic Transdermal System)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the addition of Zecuity® to Tier-3 of the Triptan Anti-Migraine Medications Product Based Prior Authorization category. The existing criteria for this category will apply. Additionally, use of Zecuity® will require a patient-specific, clinically significant reason why the member cannot use all available generic formulations of sumatriptan (tablets, nasal spray, and injection). A quantity limit of four Zecuity® TDS per month will apply, based on the prescribing information and recommended dosing. Furthermore, the College of Pharmacy recommends the following changes to the Triptan Anti-Migraine Medications Product Based Prior Authorization category:

1. Move products to lower tiers when appropriate and cost effective.
2. Change the quantity limit on zolmitriptan 2.5mg tablets and ODTs to 6 tablets per 30 days to be consistent with the other existing quantity limits.
3. Use of any non-oral formulation in a higher tier will require a patient-specific, clinically significant reason why member cannot use the oral tablet formulation.

Triptan Anti-Migraine Medications		
Tier-1	**Tier-2**	**Tier-3**
rizatriptan (Maxalt®, Maxalt MLT®) sumatriptan tablets (Imitrex®)	naratriptan (Amerge®) zolmitriptan tablets & ODTs (Zomig®, Zomig-ZMT®)	almotriptan (Axert®) eletriptan (Relpax®) frovatriptan (Frova®) sumatriptan injection (Imitrex®) sumatriptan nasal spray (Imitrex®) sumatriptan (Sumavel® DosePro®) sumatriptan (Zecuity® TDS) sumatriptan/Naproxen (Treximet®) zolmitriptan nasal spray (Zomig®)

ODT= Orally Disintegrating Tablet

Triptan Anti-Migraine Medication Tier-2 Approval Criteria:

1. A trial of all available Tier-1 products with inadequate response; or
2. Documented adverse effect to all available Tier-1 products; or
3. Previous success with a Tier-2 product within the last 60 days.

Triptan Anti-Migraine Medication Tier-3 Approval Criteria:

1. A trial of all available Tier-2 products with inadequate response; or

2. Documented adverse effect to all available Tier-2 products; or
3. Previous success with a Tier-3 product within the last 60 days.
4. Use of any non-oral formulation will require a patient-specific, clinically significant reason why member cannot use the oral tablet formulation
5. Additionally, Zecuity® will require a patient-specific, clinically significant reason why member cannot use all available generic formulations of sumatriptan (tablets, nasal spray, and injection).

Recommendation 4: Annual Review of Relistor® (Methylnaltrexone), Linzess® (Linaclotide), and Amitiza® (Lubiprostone)

MOTION CARRIED by unanimous approval.

Relistor® (Methylnaltrexone) Approval Criteria:

1. An FDA approved indication for the treatment of Opioid-Induced Constipation (OIC) in patients with severe terminal disease who are receiving only palliative care (life expectancy less than six months); and
2. Current use of opioid medications; and
3. Documented treatment attempts with a minimum of three alternate products, excluding bulk forming laxatives; and
    a. One of the three trials must be polyethylene glycol 3350 (PEG-3350).
    b. Members with an oncology-related diagnosis are exempt from the trial requirements.
4. Mechanical gastrointestinal obstruction has been ruled out.
5. The 12mg single-use vials, syringes or kits will be the preferred products. Criteria for consideration of 8mg single-use syringes:
    a. Weight range of 38kg -62kg; and/or
    b. Caregiver unable to draw up dose from vial.
6. A quantity limit of 30 units per month will apply.

Linzess® (Linaclotide) Approval Criteria:

1. An FDA approved diagnosis of Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome characterized by constipation (IBS-C) in members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members >50 years of age; and
4. Documentation of hydration attempts and trials of at least three different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be OTC or prescription (does not include fiber or stool softeners).
    a. One of the three trials must be polyethylene glycol 3350 (PEG-3350).
    b. Members with an oncology-related diagnosis are exempt from the trial requirements.

5. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment.
6. A quantity limit of 30 units for a 30 day supply will apply.

Amitiza® (Lubiprostone) Approval Criteria – Chronic Idiopathic Constipation (CIC) or Irritable Bowel Syndrome:

1. An FDA approved diagnosis of Chronic Idiopathic Constipation (CIC) in members 18 years of age or older, or Irritable Bowel Syndrome characterized by constipation (IBS-C) in female members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members >50 years of age; and
4. Documentation of hydration attempts and trials of at least three different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be OTC or prescription (does not include fiber or stool softeners).
    a. One of the three trials must be polyethylene glycol 3350 (PEG-3350).
    b. Members with an oncology-related diagnosis are exempt from the trial requirements.
5. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment.
6. A quantity limit of 60 units for a 30 day supply will apply.

Amitiza® (Lubiprostone) Approval Criteria – Opioid-Induced Constipation (OIC):

1. An FDA approved diagnosis of Opioid-Induced Constipation (OIC) in members 18 years of age or older with chronic, non-cancer pain who are currently on chronic opioid therapy, except methadone; and
2. Documentation of the underlying cause of chronic pain, or reason why member is on chronic opioid therapy; and
3. Documented and updated colon screening for members >50 years of age; and
4. Documentation of hydration attempts and trials of at least three different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be OTC or prescription (does not include fiber or stool softeners).
    a. One of the three trials must be polyethylene glycol 3350 (PEG-3350).
    b. Members with an oncology-related diagnosis are exempt from the trial requirements.
5. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment.
6. A quantity limit of 60 units for a 30 day supply will apply.

Recommendation 5: Annual Review of Anticoagulants and Platelet Aggregation Inhibitors and 30-Day Notice to Prior Authorize Zontivity™ (Vorapaxar)

NO ACTION REQUIRED.

Recommendation 6: Annual Review of Opioid Analgesics and 30-Day Notice to Prior Authorize Zohydro™ ER (Hydrocodone Bitartrate) and Xartemis™ XR (Oxycodone/Acetaminophen)

NO ACTION REQUIRED.

Recommendation 7: Annual Review of Xolair® (Omalizumab)

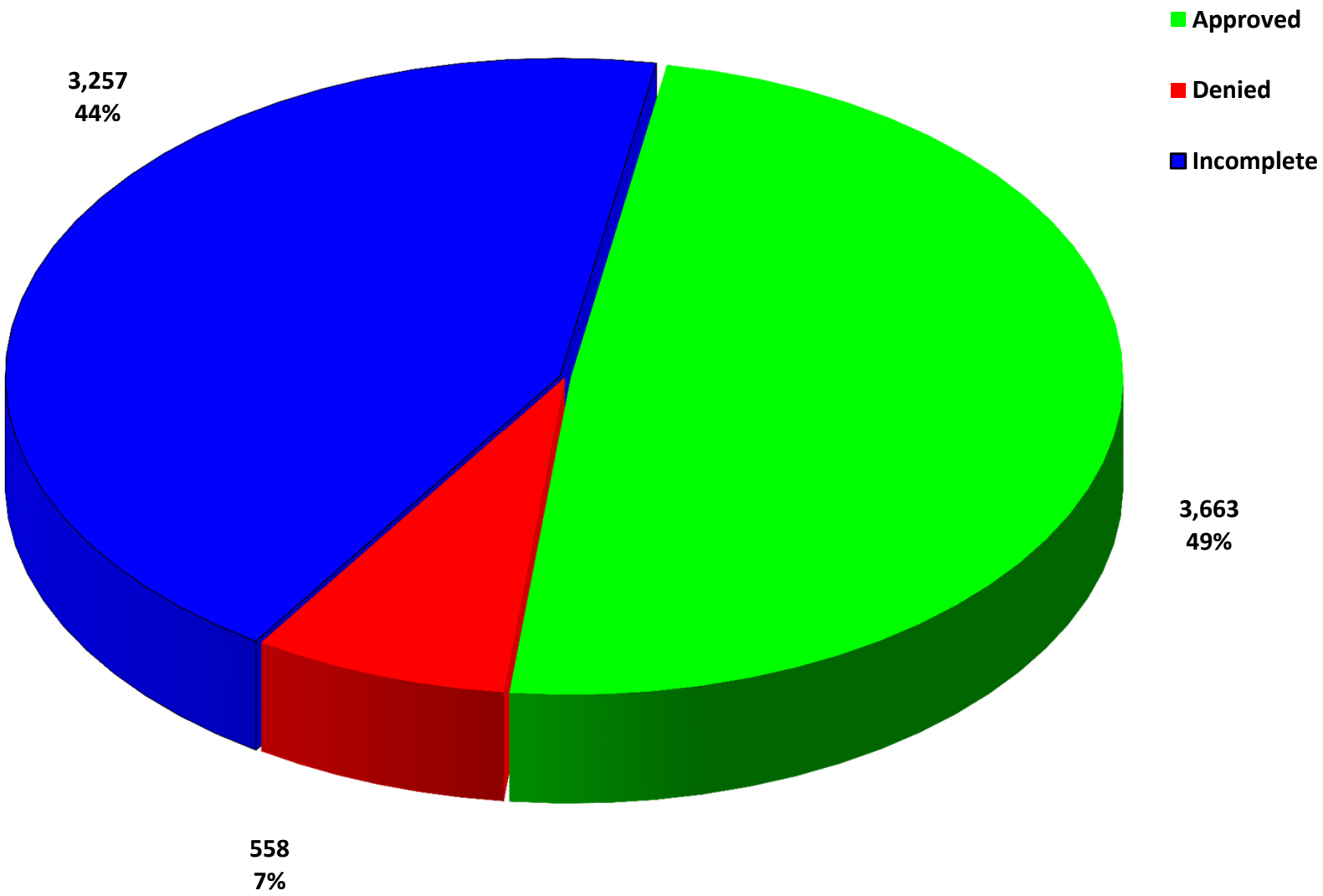
MOTION CARRIED by unanimous approval.

Xolair® (Omalizumab) Approval Criteria for Chronic Idiopathic Uritcaria:

1. Member must be 12 years of age or older; and
2. Other forms of urticaria must be ruled out; and
3. Other potential causes of urticaria must be ruled out; and
4. Member must have an Urticaria Activity Score (UAS) ≥16; and
5. Prescriber must be an allergist, immunologist, dermatologist, or be an advanced care practitioner with a supervising physician that is an allergist, immunologist, or dermatologist; and
6. Member must have tried and failed to obtain relief from other treatments including the following trials within the last 6 months (member must fail all classes unless contraindicated):
    a. At least two different H1 -antihistamine trials for a minimum duration of two weeks each:
        i. One trial must be a second generation antihistamine dosed four times the maximum FDA dose; and
        ii. One trial must be tried in combination with an H2-antihistamine; and
    b. A 4-week trial of a leukotriene receptor antagonist in combination with a 4-week trial of doxepin 10-50mg daily; and
7. Initial dosing will only be approved at 150mg every 4 weeks. If inadequate results at this dose, then the dose may be increased to 300mg every 4 weeks.

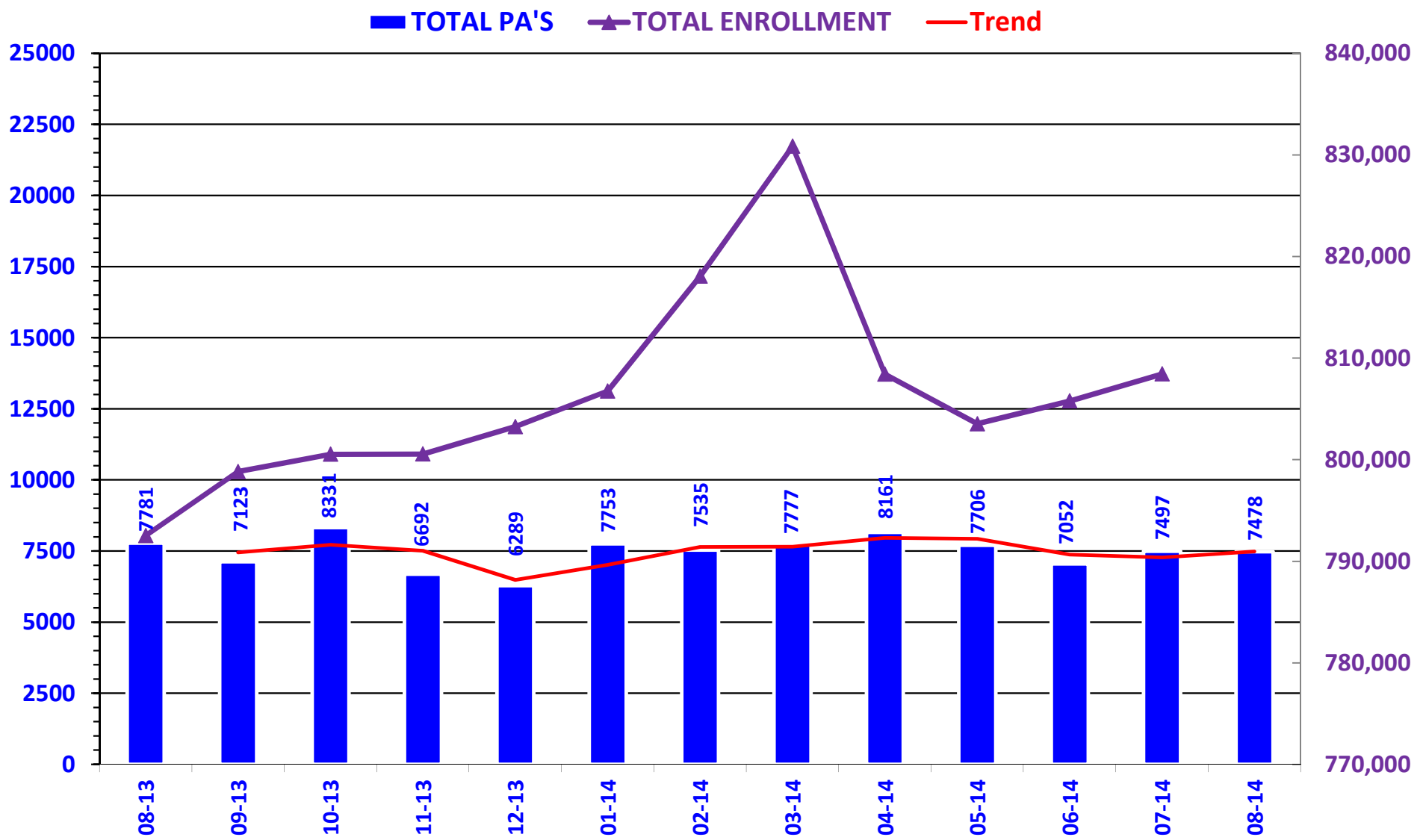
Appendix B

PRIOR AUTHORIZATION ACTIVITY REPORT: AUGUST



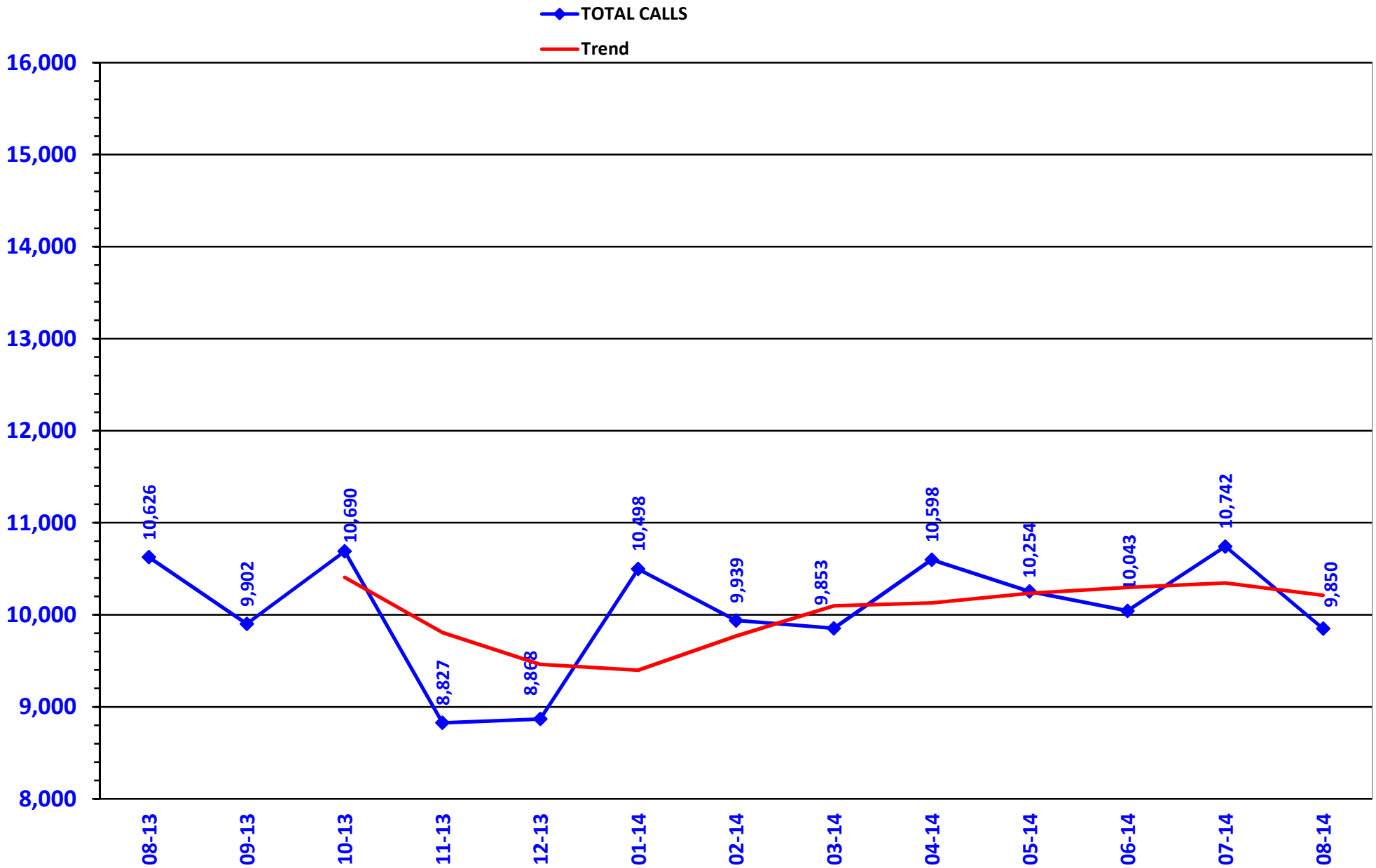
PA totals include approved/denied/incomplete/overrides

PRIOR AUTHORIZATION REPORT: AUGUST 2013 - AUGUST 2014



PA totals include approved/denied/incomplete/overrides

CALL VOLUME MONTHLY REPORT:
AUGUST 2013 – AUGUST 2014



Prior Authorization Activity
8/1/2014 Through 8/31/2014

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort/Dulera	332	158	6	168	354
Analgesic - NonNarcotic	19	0	1	18	0
Analgesic, Narcotic	368	193	15	160	199
Angiotensin Receptor Antagonist	41	5	2	34	358
Antiasthma	180	76	15	89	330
Antibiotic	21	9	3	9	181
Anticoagulant	90	51	4	35	281
Anticonvulsant	80	42	3	35	302
Antidepressant	221	67	17	137	336
Antidiabetic	137	65	5	67	355
Antifungal	17	2	6	9	106
Antigout	10	5	0	5	254
Antihistamine	249	223	7	19	356
Antimigraine	68	9	10	49	170
Antiplatelet	22	10	1	11	340
Antiulcers	184	46	37	101	125
Anxiolytic	97	73	8	16	258
Atypical Antipsychotics	370	206	8	156	328
Benign Prostatic Hypertrophy	15	0	6	9	0
Biologics	49	25	4	20	358
Bladder Control	40	7	7	26	258
Botox	34	22	5	7	343
Cardiovascular	43	25	2	16	316
Cephalosporins	17	7	0	10	6
Chronic Obstructive Pulmonary Disease	22	6	0	16	359
Dermatological	110	16	41	53	89
Endocrine & Metabolic Drugs	60	36	12	12	142
Erythropoietin Stimulating Agents	33	20	0	13	115
Fibromyalgia	124	34	15	75	351
Fish Oils	28	7	4	17	311
Gastrointestinal Agents	64	8	24	32	113
Genitourinary Agents	10	2	0	8	49
Glaucoma	12	2	0	10	182
Growth Hormones	59	47	1	11	166
Hematopoietic Agents	11	7	0	4	206
Hepatitis C	78	45	5	28	8
HFA Rescue Inhalers	59	22	1	36	310
Insomnia	40	10	2	28	196
Linzess, Amitiza, and Relistor	69	6	7	56	221
Multiple Sclerosis	26	13	2	11	220
Muscle Relaxant	79	24	31	24	55
Nasal Allergy	90	10	24	56	171
Neurological Agents	91	69	3	19	270
Nsaids	149	15	16	118	336
Ocular Allergy	44	8	7	29	145
Ophthalmic Anti-infectives	23	7	0	16	31
Ophthalmic Corticosteroid	17	11	0	6	31
Osteoporosis	19	7	4	8	358
Other*	141	16	23	102	292
Otic Antibiotic	50	8	1	41	9
Pediculicide	105	33	12	60	23
Prenatal Vitamins	10	0	0	10	0
Statins	78	22	2	54	347
Stimulant	1,139	485	32	622	341
Suboxone/Subutex	168	131	10	27	74

* Includes any therapeutic category with less than 10 prior authorizations for the month.

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Testosterone	55	13	3	39	358
Thyroid	11	6	1	4	99
Topical Antibiotic	13	1	0	12	7
Topical Antifungal	35	2	4	29	11
Topical Corticosteroids	80	0	10	70	0
Vitamin	56	12	33	11	329
Pharmacotherapy	115	104	0	11	237
Emergency PAs	0	0	0	0	
Total	**6,077**	**2,591**	**502**	**2,984**	

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Overrides					
Brand	60	41	3	16	275
Cumulative Early Refill	7	7	0	0	154
Dosage Change	367	335	1	31	5
High Dose	5	4	0	1	156
Ingredient Duplication	62	50	2	10	6
Lost/Broken Rx	84	76	4	4	4
NDC vs Age	7	7	0	0	281
Nursing Home Issue	69	68	0	1	7
Other*	36	27	4	5	5
Prescriber Temp Unlock	1	0	1	0	0
Quantity vs. Days Supply	655	430	30	195	261
STBS/STBSM	6	6	0	0	43
Stolen	8	7	0	1	8
Temporary Unlock	13	7	5	1	17
Third Brand Request	29	14	7	8	7
Overrides Total	**1,401**	**1,072**	**56**	**273**	
Total Regular PAs + Overrides	**7,478**	**3,663**	**558**	**3,257**	

Denial Reasons	
Unable to verify required trials.	2,750
Does not meet established criteria.	542
Lack required information to process request.	515

Other PA Activity	
Duplicate Requests	442
Letters	3,419
No Process	13
Changes to existing PAs	471
Helpdesk Initiated Prior Authorizations	912
PAs Missing Information	65

* Includes any therapeutic category with less than 10 prior authorizations for the month.

Drug Utilization Review of Prenatal Vitamins

Update: Drug Utilization Review of Prenatal Vitamins

Oklahoma Health Care Authority
September 2014

Educational Initiative

The annual review of prenatal vitamins conducted in November of 2013 revealed a decrease in usage of prenatal vitamins among SoonerCare members despite an increase in pregnancies in the SoonerCare population. Based on these results the Drug Utilization Review (DUR) board recommended an educational initiative to prescribers of prenatal vitamins to encourage utilization of these medications in the pregnant SoonerCare population.

In January 2014 a letter was sent to more than 3,000 SoonerCare prescribers emphasizing the importance of prenatal vitamins. The mailing included a list of prenatal vitamins covered without prior authorization as well as a sample prescription detailing how a physician could write for the desired ingredients in a prenatal vitamin and the pharmacist could substitute to a covered product.

A similar fax blast was sent in January to all contracted SoonerCare pharmacies which included a list of the prenatal vitamins that do not require prior authorization along with the National Drug Codes (NDCs) so the pharmacy could easily order a product from the list. The pharmacies and prescribers also received directions for accessing the SoonerCare website and locating the updated prenatal vitamin list of non-prior authorized products.

In addition, the prior authorization process was updated. A fax is now automatically sent to prescribers and pharmacies who submit prior authorizations for non-preferred prenatal vitamins. The automated fax now includes a list of the products covered without a prior authorization. The pharmacy will receive an updated copy of the list of NDC's each time they submit a prior authorization for a product not on the preferred list.

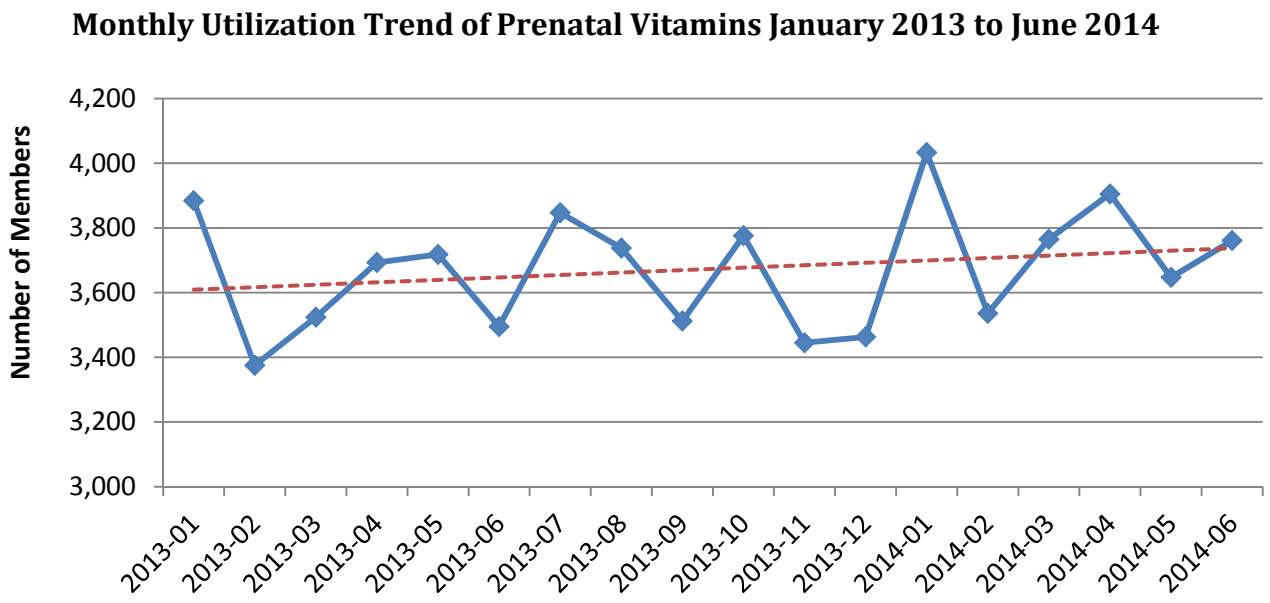
Finally, an educational article regarding the importance of taking prenatal vitamins was put in the SoonerCare member newsletter. Additionally, an article similar to the prescriber mailing was put in the SoonerCare provider newsletter.

Utilization of Prenatal Vitamins

Comparison of First Six Months of 2013 vs 2014

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2013	12,988	22,053	$543,938.90	$24.67	$0.53	1,035,780	1,022,810
2014	13,358	23,030	$640,835.98	$27.83	$0.62	1,074,278	1,040,124
% Change	**2.85%**	**4.43%**	**17.81%**	**12.81%**	**16.98%**	**3.72%**	**1.69%**
Change	**370**	**977**	**$96,897.08**	**$3.16**	**$0.09**	**38,498**	**17,314**

*Total number of unduplicated members.



Discussion

A boost in number of members utilizing prenatal vitamins was seen after the prescriber letter was mailed in January. Additionally the red trend line on the above chart shows a steady incline in the number of members utilizing prenatal vitamins. The comparison of the first six months of 2013 and 2014 also shows a total increase in claims and members utilizing prenatal vitamins since the educational interventions have begun. The utilization of these products will continue to be evaluated and additional educational opportunities will be considered.

Appendix C

Vote to Prior Authorize Zohydro™ ER (Hydrocodone Bitartrate) and Xartemis™ XR (Oxycodone/Acetaminophen)

Oklahoma Health Care Authority
September 2014

Recommendations

The College of Pharmacy recommends the addition of Zohydro™ ER (hydrocodone bitartrate) and Xartemis™ XR (oxycodone/acetaminophen) to the Special PA category of the Opioid Analgesics Product Based Prior Authorization category with the following criteria:

Zohydro™ ER (Hydrocodone Bitartrate) Extended-Release Capsules Approval Criteria:

1. A chronic pain condition requiring daily, around-the-clock, long-term opioid treatment; and
2. A patient-specific, clinically significant reason why the member cannot use all other available long-acting Tier-2 and Tier-3 medications.
3. Tier structure rules still apply.

Xartemis™ XR (Oxycodone/APAP) Extended-Release Tablets Approval Criteria:

1. A pain condition requiring around-the-clock opioid treatment; and
2. A patient-specific, clinically significant reason for the following:
    a. Why the member cannot use any other opioid medication for treatment of acute pain; and
    b. Why the member requires a long-acting medication for an acute pain condition; and
    c. Why the member cannot use Oxycontin® (oxycodone ER) and OTC acetaminophen individual products in place of this combination product.
3. A quantity limit of 4 tablets per day will apply with a maximum approval duration of 10 days; and
4. The member must not exceed 3,250mg of acetaminophen per day from all sources.
5. Tier structure rules still apply.

Opioid Analgesics			
Tier-1	**Tier-2**	**Tier-3**	**Special PA**
codeine hydrocodone/APAP (Lortab®, Norco®) hydrocodone/IBU (Vicoprofen®, Ibudone®, Reprexain™) hydromorphone (Dilaudid®) methadone(Dolophine®) morphine IR (MSIR®) oxycodone/APAP (Percocet®) oxycodone/ASA (Percodan®) oxycodone IR (Oxy IR®) tramadol/APAP (Ultracet®) tramadol (Ultram®)	**Long-Acting:** fentanyl patches (Duragesic®) morphine ER tablets (MS Contin®) **Short-Acting:** tapentadol IR (Nucynta®) oxymorphone IR (Opana®)	**Long-Acting:** morphine sulfate ER (Avinza®) morphine sulfate ER (Kadian®) morphine/naltrexone (Embeda®) oxycodone ER (OxyContin®) oxymorphone (Opana® ER)* tramadol ER (Ultram ER®, Ryzolt®) hydromorphone ER (Exalgo®) buprenorphine patch (Butrans®) tapentadol ER (Nucynta® ER) **Short-Acting:** hydrocodone/APAP (Xodol®, Zamicet®, Hycet®, Zolvit®, Liquicet®) hydrocodone/APAP/caffeine (Trezix™) oxycodone/APAP (Primlev™, Xolox®) tramadol ODT (Rybix®) oxycodone (Oxecta®)	hydrocodone bitartrate ER (Zohydro™ ER) oxycodone/APAP ER (Xartemis™ XR) **Oncology Only:** fentanyl (Actiq®) fentanyl (Fentora®) fentanyl (Onsolis® buccal film) fentanyl (Abstral®,Lazanda®) fentanyl (Subsys™) SL spray

*Brand name Opana® ER preferred. Generic oxymorphone extended release tablets require special authorization. The generic formulation is not abuse-deterrent.

Appendix D

Vote to Prior Authorize Zontivity™ (Vorapaxar) and Update the Anticoagulant Prior Authorization Criteria

Oklahoma Health Care Authority
September 2014

Recommendations

The College of Pharmacy recommends the prior authorization of Zontivity™ (vorapaxar) with the following criteria:

Zontivity™ (Vorapaxar) Approval Criteria:

1. An FDA approved diagnosis of one of the following: history of myocardial infarction (MI) or peripheral arterial disease (PAD); and
2. Zontivity™ must be used in combination with aspirin and/or clopidogrel (not monotherapy); and
3. Zontivity™ will not be approved for members with the following situations: history of transient ischemic attack (TIA), stroke, or intracranial hemorrhage (ICH), or active pathological bleeding; and
4. A quantity limit of 30 tablets per 30 days will apply.

The College of Pharmacy also recommends updating the prior authorization criteria for the following medications to reflect new FDA approved indications:

Pradaxa® (Dabigatran) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Non-valvular atrial fibrillation; or
    b. Treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) after treatment with parenteral anticoagulant for 5 to 10 days; or
    c. To reduce the risk of recurrent DVT or PE in patients who have been previously treated.

Eliquis® (Apixaban) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Non-valvular atrial fibrillation; or
    b. Treatment of deep vein thrombosis (DVT) or pulmonary embolism (PE) and for the reduction in the risk of recurrent DVT and PE following initial therapy; or
    c. PE or DVT prophylaxis in patients who have had hip or knee replacement surgery.

Appendix E

Fiscal Year 2014 Annual Review of Synagis® (Palivizumab)

Oklahoma Health Care Authority
September 2014

Current Prior Authorization Criteria

A prior authorization is required for all members who receive Synagis® in an outpatient setting. Synagis® is approved for members who meet the established criteria based on a modified version of the American Academy of Pediatrics (AAP) guidelines.

Synagis® (Palivizumab) Approval Criteria:

A. Member Selection: *Members must be included in one of the following age groups at the beginning of the RSV season:
   1. Infants and children less than 24 months old with Chronic Lung Disease (CLD) (formerly bronchopulmonary dysplasia) who have required medical treatment (O2, bronchodilator, corticosteroid, or diuretic therapy) for CLD in the 6 months prior to RSV season
   2. Infants up to 24 months old with moderate to severe pulmonary hypertension, cyanotic heart disease, or those on medications to control congestive heart failure
   3. Infants less than 12 months of age, born at 28 weeks gestation or earlier
   4. Infants less than 6 months of age, born at 29 to 31 weeks gestation
   5. Infants less than 12 months of age, with congenital abnormalities of the airway
   6. Infants less than 12 months of age, with severe neuromuscular disease
   7. Infants up to 3 months old at the start of RSV season, born at 32 to 34 weeks gestation, who have one of the following risk factors (up to three doses only):
      a. Child care attendance
      b. Siblings younger than 5 years of age

   *Treatment is authorized for the entire RSV season (as indicated) except for members meeting criteria #7, in which case, a maximum of 3 doses will be authorized. Prescribers may request special consideration for additional doses (up to the end of the RSV season as indicated) on an individual patient basis for members meeting criteria #7.

B. Length of treatment: Synagis® is approved for use only during RSV season. Approval dates will be November 1 through March 31.

C. Units authorized: The maximum duration of therapy is five doses, with a dose to be administered no more often than every 30 days. Infants born at 32-34 weeks gestation will receive a maximum of three doses. Members given doses more frequently than every 30 days will not be authorized for additional doses. Doses administered prior to the member's discharge from a hospital will be counted as one of the approved total.

D. Dose-pooling: To avoid unnecessary risk to the patient, multiple patients are not to be treated from a single vial. Failure to follow this recommendation will result in referral of the provider to the Quality Assurance Committee of the Oklahoma Health Care Authority.

Utilization of Synagis®

Comparison of Fiscal Years: Synagis®

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Total Units	Total Days
2013	628	2,416	$5,198,147.97	$2,151.55	2,167	72,440
2014	632	2,346	$5,133,995.99	$2,188.40	2,016	70,252
% Change	**0.60%**	**-2.90%**	**-1.20%**	**1.70%**	**-7.00%**	**-3.00%**
Change	**4**	**-70**	**-$64,151.98**	**$36.85**	**-151**	**-2,188**

*Total number of unduplicated members.

Pharmacy Claim Details for Season 2013-2014

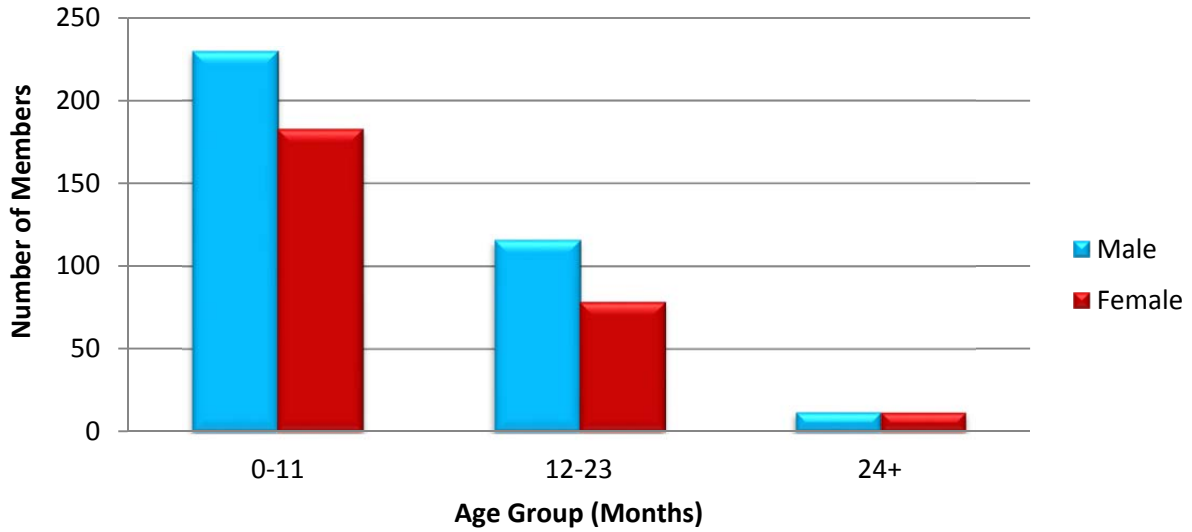
Product Utilized	Total Claims	Total Members	Total Cost	Claims/ Member	Cost/ Claim	% Cost
SYNAGIS INJ 100MG/ML	1,549	541	$4,062,858.97	2.86	$2,622.89	79.14%
SYNAGIS INJ 50MG/0.5ML	797	430	$1,071,137.02	1.85	$1,343.96	20.86%
Total	**2,346**	**632***	**$5,133,995.99**	**3.71**	**$2,188.40**	**100%**

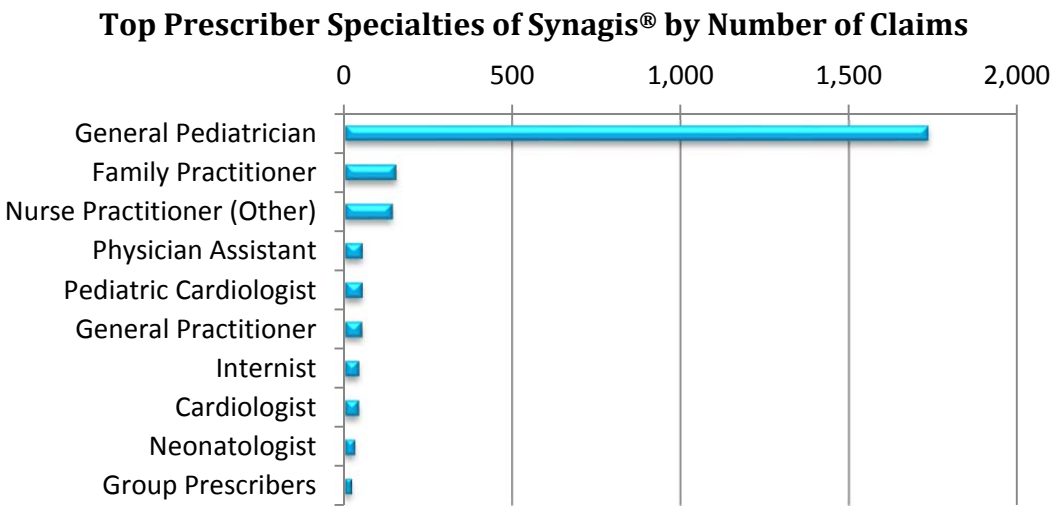
*Total number of unduplicated members.

Cost per Vial

Vial Size	Cost per Vial
Synagis® 100mg/ml vial	$2,542.74
Synagis® 50mg/ml vial	$1,348.08

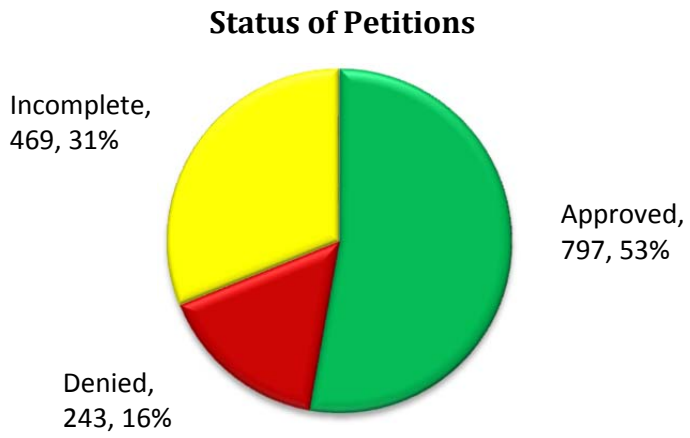
Demographics of Members Utilizing Synagis®

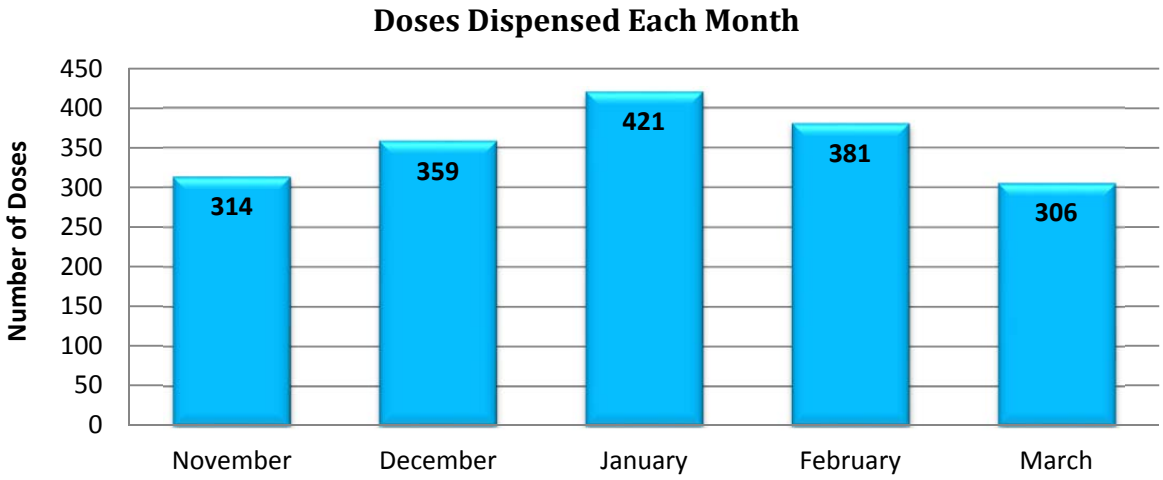


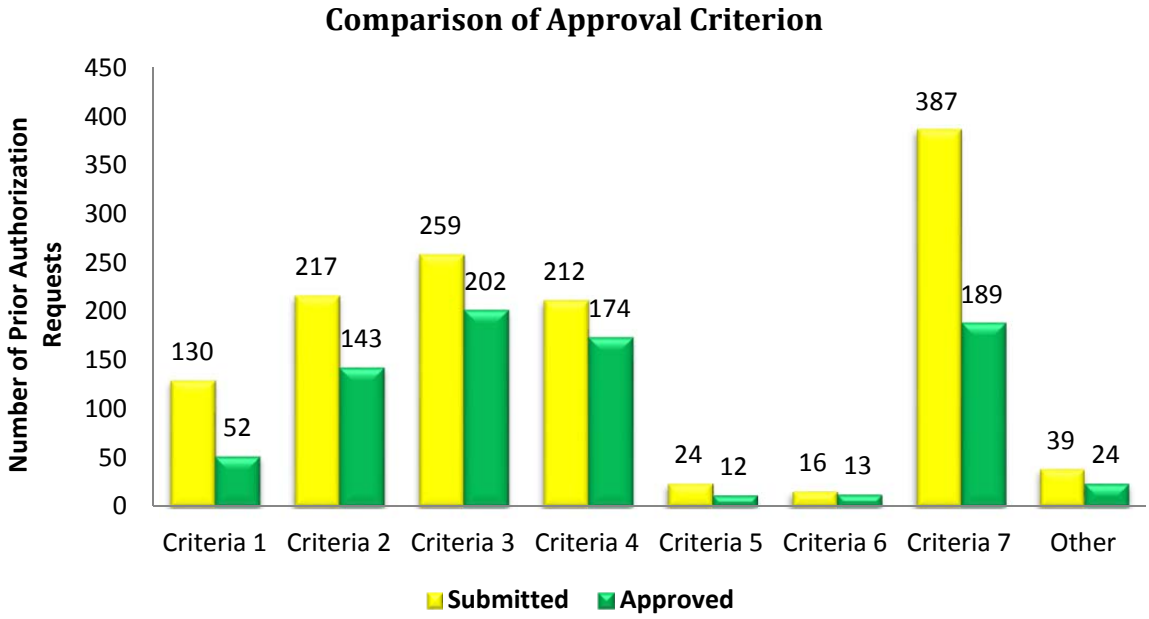


Prior Authorization of Synagis®

There was a total of 1,509 petitions submitted for Synagis® during fiscal year 2014. The following chart shows the status of the submitted petitions.







Please see the current criteria listed on the first page of this report.

Referrals to Care Management Services

OHCA Care Management Services are available to assist with infants felt to be at increased risk of noncompliance. Nurse Managers contact the parents to discuss and educate them about the importance of getting Synagis® each month, along with other safety issues. The following message is sent back to the prescriber and the pharmacy with each approved petition:

- *For patients at risk of non-compliance, OHCA Care Management Services are available to assist. Please contact them at 877-252-6002.*

For the 2013-2014 RSV season, 11 children were referred to the Care Management Services.

Market News and Updates[1]

Guideline Updates:

- **July 2014:** The American Academy of Pediatrics released *Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection*. The following table highlights differences in the updated guidance for Synagis® prophylaxis compared to previous guidance.

Risk Group/Topic	Previous Guidance	Updated Guidance
Preterm Infants (no CLD) & Prophylaxis	• Previously, prophylaxis was recommended for infants with preterm birth before 32 weeks gestation. • Infants with certain risk factors born at 32 weeks, 0 days to 34 weeks, 6 days were eligible.	• In the first year of life, Synagis® prophylaxis is recommended for infants born before 29 weeks, 0 days' gestation. • Synagis® prophylaxis is **not** recommended for otherwise healthy infants born at or after 29 weeks, 0 days' gestation.
Preterm Infants (with CLD) & Prophylaxis	• Previously no definition of chronic lung disease was provided.	• In the **first year of life**, Synagis® prophylaxis is recommended for preterm infants with chronic lung disease of prematurity defined as <32 weeks, 0 days' gestation and a requirement for >21% oxygen for at least 28 days after birth.
Infants with CHD & Prophylaxis	• Previously prophylaxis was recommended in the second year of life for this cohort. • In addition, consultation with a cardiologist currently is recommended for patients with cyanotic heart disease for decisions about prophylaxis	• Clinicians may administer Synagis® prophylaxis in the **first year of life** to certain infants with hemodynamically significant heart disease.
Number of Monthly Doses	• Previously, fewer than 5 monthly doses were recommended for some infants.	• Clinicians may administer up to a maximum of 5 monthly doses of Synagis® during the RSV season to infants who qualify for prophylaxis in the first year of life. • Qualifying infants born during the RSV season will require fewer doses. For example, infants born in January would receive their last dose in March.
Prophylaxis in Second Year of Life	• Previously, two seasons of prophylaxis were recommended.	• Synagis® prophylaxis is **not recommended in the second year of life** except for children who require at least 28 days of supplemental oxygen after birth and who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy).
RSV Breakthrough Hospitalization & Prophylaxis	• Previously, prophylaxis was recommended to continue in a child who experiences a breakthrough RSV hospitalization.	• Monthly prophylaxis should be **discontinued** in any child who experiences a breakthrough RSV hospitalization.

Risk Group/Topic	Previous Guidance	Updated Guidance
Neuromuscular Disease & Prophylaxis	• Previous recommendation was for two years of prophylaxis.	• Children with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways may be considered for prophylaxis in the **first year of life.**
Immunocompromised Children & Prophylaxis	• Previous recommendation was for two years of prophylaxis.	• Children less than 24 months of age who will be profoundly immunocompromised during the RSV season may be considered for prophylaxis.
Down Syndrome, Cystic Fibrosis (CF) & Prophylaxis	• Previously, the CF recommendation was for two years of prophylaxis. • Children with Down syndrome were not addressed previously.	• Insufficient data are available to routinely recommend Synagis® prophylaxis for children with cystic fibrosis or Down syndrome.
Alaska Natives & Prophylaxis	• Present recommendations allow for greater flexibility for Alaskan Native and Native American populations.	• The burden of RSV disease in certain remote areas may result in a broader use of Synagis® for RSV prevention in Alaskan Native populations and possibly in selected other Native American populations.

Additional Points:

- Synagis® pharmacokinetics:
  - 5 monthly doses provides more than 6 months of protective serum concentration for most infants
- Synagis® prophylaxis and subsequent wheezing:
  - Limited impact on subsequent wheezing episodes
- Synagis® prophylaxis is not recommended for prevention of nosocomial disease
- Synagis® is not recommended for treatment of RSV disease
  - Not licensed for and not recommended for this purpose

Recommendations

Based on the recommendations from the American Academy of Pediatrics, the College of Pharmacy recommends updating the prior authorization criteria of Synagis® (palivizumab) to the following criteria:

A. Member Selection:
   1. Infants less than 12 months old at the start of RSV season:
      a. Born before 29 weeks, 0 days gestation; or
      b. Born before 32 weeks, 0 days gestation and develop chronic lung disease (CLD) of prematurity (require > 21% oxygen supplementation for at least 28 days after birth); or
      c. Have hemodynamically significant congenital heart disease (acyanotic heart disease and receiving medication to control Congestive Heart Failure (CHF) and will require surgical procedures, or moderate to severe pulmonary hypertension); or
      d. May be considered for:
         i. Infants with neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway because of ineffective cough
         ii. Infants who undergo cardiac transplantation during RSV season
         iii. Infants who are profoundly immunocompromised during RSV season
         iv. Infants with cystic fibrosis with clinical evidence of CLD and/or nutritionally compromised
   2. Infants 12 to 24 months old at the start of RSV season:
      a. Born before 32 weeks, 0 days gestation and have CLD of prematurity (required at least 28 days of oxygen after birth) and continue to require medical support (chronic corticosteroid therapy, bronchodilator therapy, or supplemental oxygen) during the 6 months before the start of the RSV season

B. Length of treatment. Synagis® is approved for use only during RSV season. Approval dates will be November 1 through March 31.

C. Units authorized. The maximum duration of therapy is five (5) doses, with a dose to be administered no more often than every 30 days. Members given doses more frequently than every 30 days will not be authorized for additional doses. Doses administered prior to the member's discharge from a hospital will be counted as one of the approved total.

D. Dose-pooling. To avoid unnecessary risk to the patient, multiple patients are not to be treated from a single vial. Failure to follow this recommendation will result in referral of the provider to the Quality Assurance Committee of the Oklahoma Health Care Authority.

[1] Committee on Infectious Diseases and Bronchiolitis Guidelines Committee. "Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection." *Pediatrics: Official Journal of the American Academy of Pediatrics* (2014): 415-20. Available online at: http://pediatrics.aappublications.org/content/early/2014/07/23/peds.2014-1665. Last accessed: August 26, 2014.

Appendix F

Fiscal Year 2014 Annual Review of Atypical Antipsychotics and 30-Day Notice to Prior Authorize Versacloz™ (Clozapine Oral Suspension)

Oklahoma Health Care Authority
September 2014

Current Tier Structure

Atypical Antipsychotics*		
Tier-1	**Tier-2**	**Tier-3+**
clozapine (Clozaril®)¥	aripiprazole (Abilify®)	clozapine (Fazaclo®)
olanzapine (Zyprexa®)	Aripiprazole (Abilify Maintena®)	olanzapine/fluoxetine (Symbyax®)
quetiapine (Seroquel®)	asenapine (Saphris®)	paliperidone (Invega®)
risperidone (Risperdal®)	iloperidone (Fanapt™)	paliperidone (Invega Sustenna®)
risperidone (Risperdal Consta®)	lurasidone (Latuda®)	
ziprasidone (Geodon®)	quetiapine ER (Seroquel XR®)	

Tier structure based on supplemental rebate participation.
*Mandatory Generic Plan Applies
+ May be rebated to Tier-2 status only
¥ Does not count toward a Tier-1 trial
ER = extended-release

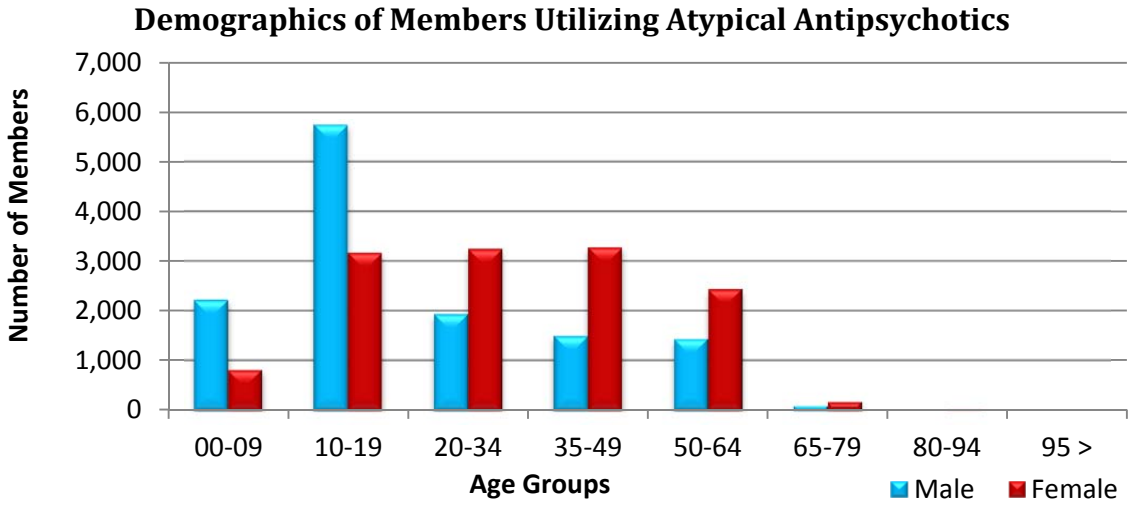
Current tier trial requirements can be found in the recommendations section at the end of this report.

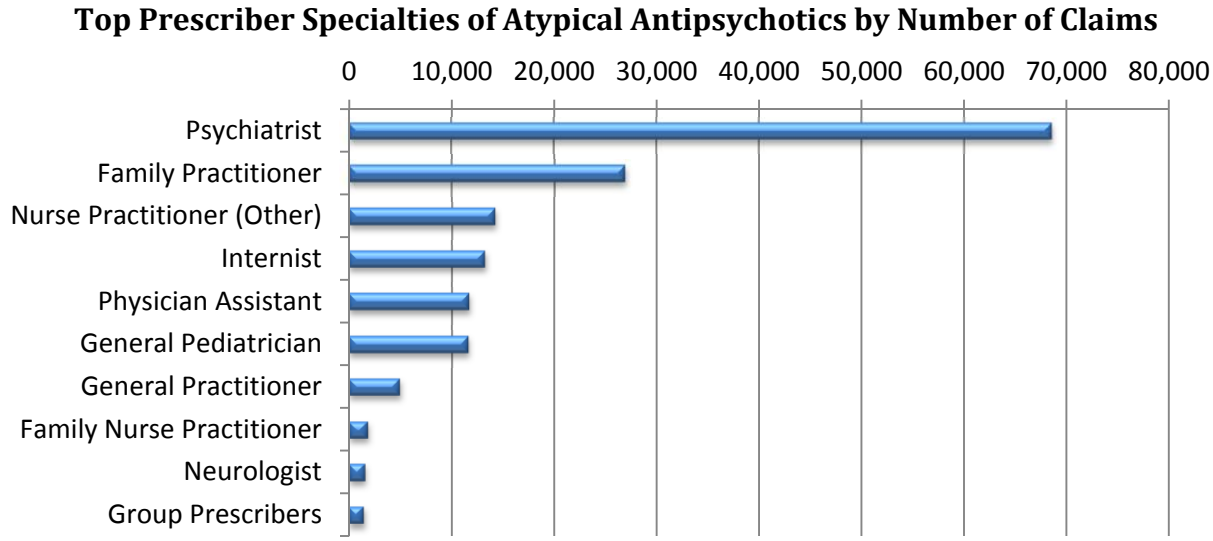
Utilization of Atypical Antipsychotics

Comparison of Fiscal Years

Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2013	26,301	183,285	$45,820,026.70	$249.99	$8.25	7,592,670	5,554,161
2014	26,202	183,556	$50,603,455.05	$275.68	$9.12	7,549,112	5,549,915
% Change	**-0.40%**	**0.10%**	**10.40%**	**10.30%**	**10.50%**	**-0.60%**	**-0.10%**
Change	**-99**	**271**	**$4,783,428.35**	**$25.69**	**$0.87**	**-43,558**	**-4,246**

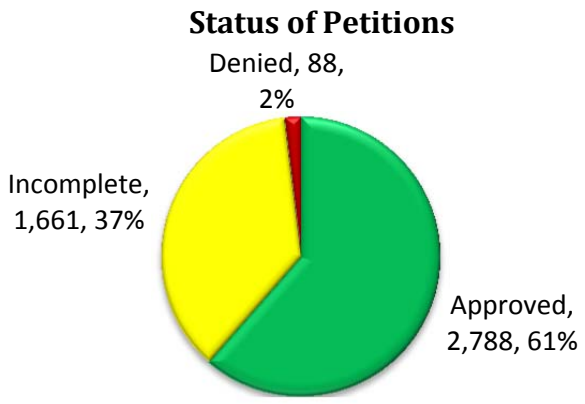
*Total number of unduplicated members.



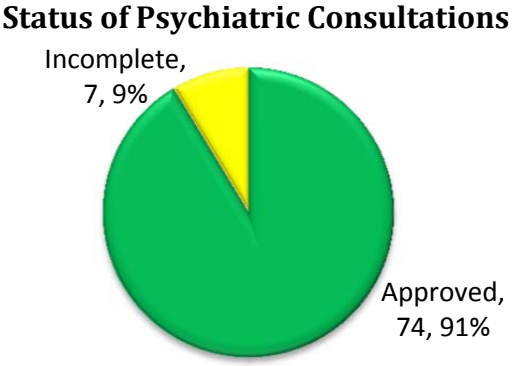


Prior Authorization of Atypical Antipsychotics

There was a total of 4,537 petitions submitted for the Atypical Antipsychotics Product Based Prior Authorization category during fiscal year 2014. Computer edits are in place to detect Tier-1 medications in the member's recent claims history and generate automated prior authorizations where possible. The following chart shows the status of the submitted petitions.

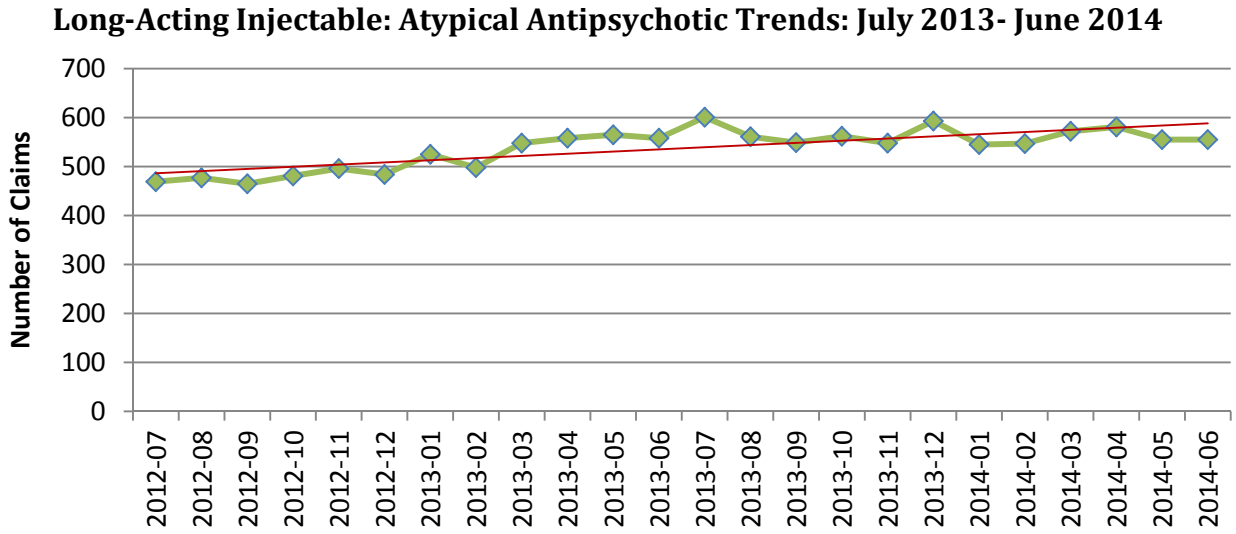


There was a total of 81 petitions submitted for a total of 74 unique members for atypical antipsychotics during fiscal year 2014 that were referred for a psychiatric consultation. Most requests were for children between the ages of 0 and 4 years of age. The following chart shows the status of the submitted petitions.



Atypical Antipsychotic Utilization Trends

The chart below indicates the number of monthly claims for long-acting injectable atypical antipsychotic medications for fiscal year 2014. The claims were not impacted by the incorporation of the injectable products into the oral atypical antipsychotic tier structure on January 1, 2014. Additionally, claims for oral atypical antipsychotics remained consistent.



Market News and Updates[1,2,3,4,5,6]

Anticipated Patent Expirations:

- Invega® (paliperidone tablets)- 10/2014
- Abilify® (aripiprazole tablets)- 04/2015
- Fanapt® (iloperidone tablets)- 11/2016
- Seroquel XR® (quetiapine ER tablets)- 05/2017
- Latuda® (lurasidone tablets)- 07/2018
- Saphris® (asenapine sublingual tablets)- 04/2026

FDA Update:

- **04/2014:** Novartis, the makers of Fanapt®, updated the prescribing information to include additional details regarding drug interactions and use in specific populations.
    - **Drug Interactions:** Fanapt® co-administration with dextromethorphan or midazolam resulted in an increase in total exposure of dextromethorphan and midazolam.
    - **Specific Populations:** No dose adjustment of Fanapt® is needed in patients with mild hepatic impairment. Exercise caution when administering it to patients with moderate hepatic impairment. Fanapt® is not recommended for patients with severe hepatic impairment.

New Medications/Indications:

- **02/2013:** The FDA approved Versacloz™ (clozapine oral suspension) to reduce suicidal behavior in patients with schizophrenia or schizoaffective disorder, and use in treatment-resistant schizophrenia. Clozapine is currently available as an oral tablet (Clozaril®) and an orally disintegrating oral tablet (Fazaclo®). Due to the serious risk of agranulocytosis, these two formulations are currently available only through a limited distribution system that ensures monitoring of white blood cell counts (WBC) and absolute neutrophil counts (ANC) before, during, and after use of this medication. Versacloz™ is only available through a REMS program that ensures close monitoring required for use of this medication. Other black box warnings include increased risk of seizures, myocarditis, orthostatic hypotension with or without syncope that may result in collapse, respiratory or cardiac arrest.
- **05/2014:** Janssen Pharmaceuticals submitted a supplemental New Drug Application (NDA) to the FDA for use of Invega® Sustenna® (paliperidone palmitate) for the treatment of shizoaffective disorder.
- **Janssen Pharmaceuticals** is currently conducting a phase III controlled trial for the use of Invega® Sustenna®/Xeplion® (paliperidone palmitate long-acting injectable) for the treatment of schizophrenia dosed as a long-acting injectable every three months.

Versacloz™ (Clozapine Oral Suspension)[3]

FDA Approved: February 2013

Indications: Versacloz™ (clozapine oral suspension) is indicated for the treatment of severely ill patients with schizophrenia who fail to respond adequately to standard antipsychotic treatment. Because of the significant risk of agranulocytosis and seizure associated with its use, Versacloz™ should be used only in patients who have failed to respond adequately to standard antipsychotic treatment.

Dosing:

- Versacloz™ is available as 50mg/mL amber bottles containing 100mLs each.
- The starting dose of Versacloz™ is 12.5mg once daily or twice daily and the target dose of Versacloz™ is 300mg to 450mg per day (administered in divided doses). The maximum dose is 900mg per day.
- Versacloz™ is administered to the mouth by the oral syringes provided. After shaking the bottle for 10 seconds prior to each use, the syringe adaptor is pressed on top of the

bottle. The prescribed amount of the suspension is drawn from the bottle and dispensed directly to the mouth.
- Versacloz™ can be taken with or without food.

Efficacy: The efficacy of Versacloz™ is based on efficacy studies of the oral tablet formulation. Clozapine tablets are equally bioavailable relative to Versacloz™ oral suspension.

Utilization/Cost:
- Versacloz™ has been utilized by one member for a total of two claims in the SoonerCare population during fiscal year 2014.
- Generic clozapine oral tablets were utilized by 435 members for a total of 7,466 claims during fiscal year 2014.

Medication	EAC Per mL or Tablet	EAC Per Day	EAC for 30 Days of Therapy
Versacloz™ Oral Suspension 50mg/mL	$7.75	$62.00	$1,860.00
Clozapine Oral Tablets 200mg	$2.56 +	$5.12	$153.60

EAC= estimated acquisition cost
+ State maximum allowable cost (SMAC) pricing
Dosing based on recommended target dose of Versacloz™ 400mg per day.

Recommendations

The College of Pharmacy recommends the addition of Versacloz™ (clozapine oral suspension) to Tier-3 of the Atypical Antipsychotics Product Based Prior Authorization category with the following criteria:

Atypical Antipsychotics*		
Tier-1	**Tier-2**	**Tier-3+**
clozapine (Clozaril®)¥	Supplemental Rebated Products	aripiprazole (Abilify®)
olanzapine (Zyprexa®)		aripiprazole (Abilify Maintena®)
quetiapine (Seroquel®)		asenapine (Saphris®)
risperidone (Risperdal®)		clozapine (Fazaclo®)
risperidone (Risperdal Consta®)		clozapine oral suspension (Versacloz™)
ziprasidone (Geodon®)		iloperidone (Fanapt™)
		lurasidone (Latuda®)
		olanzapine/fluoxetine (Symbyax®)
		paliperidone (Invega®)
		paliperidone (Invega Sustenna®)
		quetiapine ER (Seroquel XR®)

*Mandatory Generic Plan Applies
+ May be rebated to Tier-2 status only
¥ Does not count toward a Tier-1 trial
ER = extended-release

Atypical Antipsychotic Tier-2 Approval Criteria:

1. A trial of two Tier-1 products (not including clozapine), at least 14 days in duration, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.

2. Clozapine is available without prior authorization, but does not count towards a Tier-1 trial.

Atypical Antipsychotic Tier-3 Approval Criteria:

1. A trial of two Tier-1 products (not including clozapine), at least 14 days in duration, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects; and
2. A trial of two Tier-2 medications, at least 14 days in duration each, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.
3. A manual prior authorization may be submitted for consideration of a Tier-3 product when the member has had at least four trials of Tier-1 and Tier-2 products (two trials must be from Tier-1) that did not yield an adequate response or resulted in intolerable adverse effects.
4. Use of Versacloz™ (clozapine oral solution) and Fazaclo® (clozapine orally disintegrating tablet) would require a patient-specific, clinically significant reason why the member cannot use the oral tablet formulation.

Atypical Antipsychotic for Adjunctive Treatment for Depression Approval Criteria:

1. Use of Abilify® (aripiprazole), Seroquel XR® (quetiapine extended release), or Symbyax® (olanzapine/fluoxetine) for a diagnosis of depression requires current use of an antidepressant, and previous trials with at least two other antidepressants from both categories (an SSRI and a dual acting antidepressant) that did not yield adequate response.
2. Tier structure rules still apply.

Current Users or Inpatient Discharge Approval Criteria:

1. Members currently stabilized on a higher tiered medication defined by paid claim(s) for the higher tiered medication in the past 90 days will be approved.
2. Members being released from a hospital and stabilized on a higher tiered medication will be approved.

Clinical Exceptions:

1. Approvals will be granted for members with clinical conditions for which lower tiered drugs are contraindicated.
2. Approvals will be granted for members whose current regimen includes drugs known to adversely interact with all lowered tiered drugs.
3. Lurasidone (Latuda®) may be approved for pregnant women with appropriate diagnosis.

Second Opinion Process for Children 0 - 4 Years of Age:

1. Children less than 5 years of age will require a “second opinion” prior authorization to be reviewed by an OHCA-contracted child psychiatrist.

Utilization Details of Atypical Antipsychotic Medications: Fiscal Year 2014

Oral and Short-Acting Injectable Atypical Antipsychotics

Product Utilized	Total Claims	Total Members	Total Cost	Cost/ Day	Cost/ Claim
Clozapine Products					
CLOZAPINE TAB 25MG	673	79	$18,318.93	$1.62	$27.22
CLOZAPINE TAB 50MG	897	84	$35,657.38	$2.56	$39.75
CLOZAPINE TAB 100MG	5,042	385	$417,202.80	$4.46	$82.75
CLOZAPINE TAB 200MG	802	69	$67,652.30	$5.30	$84.35
CLOZARIL TAB 100MG	52	4	$57,977.29	$52.56	$1,114.95
Subtotal	**7,466**	**435**	**$596,808.70**	**$4.50**	**$79.94**
Olanzapine Products					
OLANZAPINE TAB 2.5MG	599	216	$6,033.83	$0.32	$10.07
OLANZAPINE TAB 5MG	1,989	704	$21,393.64	$0.34	$10.76
OLANZAPINE 5MG TAB	57	12	$596.50	$0.35	$10.46
OLANZAPINE TAB 7.5MG	296	77	$3,240.20	$0.36	$10.95
OLANZAPINE TAB 10MG	3,469	1,043	$42,163.00	$0.39	$12.15
OLANZAPINE TAB 10MG	48	22	$508.37	$0.36	$10.59
OLANZAPINE TAB 15MG	1,545	390	$27,458.40	$0.55	$17.77
OLANZAPINE TAB 15MG	8	3	$150.92	$0.68	$18.87
OLANZAPINE TAB 20MG	3,896	785	$83,712.01	$0.65	$21.49
OLANZAPINE TAB 20MG	631	108	$12,723.82	$0.66	$20.16
OLANZAPINE TAB 5MG ODT	221	92	$17,926.07	$2.62	$81.11
OLANZAPINE TAB 10MG ODT	364	132	$48,962.18	$3.90	$134.51
OLANZAPINE TAB 15MG ODT	303	109	$64,538.23	$4.77	$213.00
OLANZAPINE TAB 20MG ODT	486	178	$166,495.83	$6.82	$342.58
ZYPREXA TAB 2.5MG	10	2	$2,916.90	$9.89	$291.69
ZYPREXA TAB 5MG	1	1	$388.19	$12.94	$388.19
ZYPREXA TAB 10MG	15	3	$4,768.39	$10.60	$317.89
ZYPREXA TAB 15MG	13	4	$8,811.23	$23.56	$677.79
ZYPREXA TAB 20MG	44	5	$46,099.91	$35.46	$1,047.73
OLANZAPINE INJ 10MG	10	4	$990.70	$55.04	$99.07
Subtotal	**14,005**	**2,822**	**$559,878.32**	**$1.22**	**$39.98**
Quetiapine Products					
QUETIAPINE TAB 25MG	3,172	1,052	$41,120.89	$0.42	$12.96
QUETIAPINE TAB 50MG	5,102	1,630	$74,536.80	$0.48	$14.61
QUETIAPINE TAB 100MG	7,914	2,329	$116,371.45	$0.48	$14.70
QUETIAPINE TAB 200MG	6,204	1,700	$123,807.04	$0.64	$19.96
QUETIAPINE TAB 200MG	195	63	$4,266.40	$0.76	$21.88
QUETIAPINE TAB 300MG	5,901	1,410	$167,029.50	$0.91	$28.31
QUETIAPINE TAB 400MG	5,078	1,024	$148,088.80	$0.93	$29.16
SEROQUEL TAB 25MG	18	8	$238.65	$0.48	$13.26
SEROQUEL TAB 100MG	23	12	$279.59	$0.42	$12.16
SEROQUEL TAB 200MG	2	2	$59.70	$1.00	$29.85
SEROQUEL TAB 300MG	17	2	$20,345.28	$39.89	$1,196.78
SEROQUEL TAB 400MG	25	4	$24,604.59	$32.81	$984.18
Subtotal	**33,651**	**6,665**	**$720,748.69**	**$0.69**	**$21.42**
Risperidone Products					
RISPERIDONE TAB 0.25MG	6,972	1,813	$65,612.87	$0.31	$9.41

Product Utilized	Total Claims	Total Members	Total Cost	Cost/ Day	Cost/ Claim
RISPERIDONE TAB 0.5MG	16,866	4,530	$165,811.18	$0.32	$9.83
RISPERIDONE TAB 1MG	21,498	5,376	$203,587.04	$0.31	$9.47
RISPERIDONE TAB 2MG	11,604	2,922	$147,755.75	$0.41	$12.73
RISPERIDONE TAB 3MG	5,674	1,158	$72,594.83	$0.41	$12.79
RISPERIDONE TAB 4MG	3,134	618	$45,529.74	$0.46	$14.53
RISPERIDONE TAB 0.25 ODT	66	20	$10,859.18	$5.89	$164.53
RISPERIDONE TAB 0.5MG ODT	346	93	$23,873.43	$2.31	$69.00
RISPERIDONE TAB 1MG ODT	224	64	$19,111.52	$2.85	$85.32
RISPERIDONE TAB 2MG ODT	149	39	$19,504.98	$3.95	$130.91
RISPERIDONE TAB 3MG ODT	30	9	$8,878.68	$10.02	$295.96
RISPERIDONE TAB 4MG ODT	35	6	$16,372.61	$16.69	$467.79
RISPERDAL TAB 0.25MG	24	4	$4,783.25	$6.64	$199.30
RISPERDAL TAB 0.5MG	5	2	$2,618.10	$17.45	$523.62
RISPERDAL TAB 1MG	24	3	$14,766.84	$20.51	$615.29
RISPERDAL TAB 2MG	10	1	$11,118.02	$37.06	$1,111.80
RISPERDAL TAB 3MG	43	5	$37,902.82	$29.38	$881.46
RISPERDAL TAB 4MG	9	1	$12,926.70	$47.88	$1,436.30
RISPERIDONE SOL 1MG/ML	1,085	196	$43,213.79	$1.22	$39.83
RISPERDAL SOL 1MG/ML	20	2	$13,804.66	$24.26	$690.23
RISPERDAL M TAB 3MG	2	1	$2,844.32	$33.86	$1,422.16
Subtotal	**67,820**	**12,893**	**$943,470.31**	**$0.45**	**$13.91**
Ziprasidone Products					
ZIPRASIDONE CAP 20MG	893	340	$97,797.18	$3.58	$109.52
ZIPRASIDONE CAP 40MG	1,328	452	$134,936.04	$3.28	$101.61
ZIPRASIDONE CAP 60MG	1,375	338	$177,875.92	$4.19	$129.36
ZIPRASIDONE CAP 80MG	2,724	486	$395,094.22	$4.64	$145.04
GEODON CAP 20MG	12	3	$4,444.45	$12.88	$370.37
GEODON CAP 40MG	39	12	$9,643.48	$8.80	$247.27
GEODON CAP 60MG	35	9	$10,534.38	$10.03	$300.98
GEODON CAP 80MG	78	18	$25,064.83	$10.85	$321.34
GEODON INJ 20MG	18	9	$2,251.61	$28.87	$125.09
Subtotal	**6,502**	**1,295**	**$857,642.11**	**$4.27**	**$131.90**
Tier-1 Subtotal	**129,444**	**21,501**	**$3,678,548.13**	**$0.94**	**$28.42**
Aripiprazole Products					
ABILIFY TAB 2MG	2,356	662	$1,761,471.20	$24.66	$747.65
ABILIFY TAB 5MG	7,454	1,982	$5,419,252.84	$24.32	$727.03
ABILIFY TAB 10MG	7,799	1,981	$5,970,672.16	$24.61	$765.57
ABILIFY TAB 15MG	5,023	1,201	$3,665,214.04	$23.34	$729.69
ABILIFY TAB 20MG	3,629	812	$3,943,971.71	$34.94	$1,086.79
ABILIFY TAB 30MG	2,671	474	$3,041,177.10	$35.29	$1,138.59
ABILIFY DISC TAB 10MG	24	6	$19,543.19	$25.06	$814.30
ABILIFY DISC TAB 15MG	4	2	$5,033.24	$30.14	$1,258.31
ABILIFY SOL 1MG/ML	129	30	$88,397.51	$22.48	$685.25
ABILIFY INJ 9.75MG	1	1	$26.08	$13.04	$26.08
Subtotal	**29,090**	**5,068**	**$23,914,759.07**	**$26.64**	**$822.10**
Asenapine Products					
SAPHRIS SUB 5MG	554	188	$302,609.85	$17.99	$546.23
SAPHRIS SUB 10MG	1,055	291	$611,511.82	$19.28	$579.63

Product Utilized	Total Claims	Total Members	Total Cost	Cost/ Day	Cost/ Claim
Subtotal	**1,609**	**425**	**$914,121.67**	**$18.83**	**$568.13**
Iloperidone Products					
FANAPT TAB 1MG	14	8	$9,547.96	$24.05	$682.00
FANAPT TAB 2MG	156	52	$102,517.20	$22.15	$657.16
FANAPT TAB 4MG	319	90	$220,086.93	$23.34	$689.93
FANAPT TAB 6MG	749	191	$464,842.16	$21.06	$620.62
FANAPT TAB 8MG	530	121	$338,958.90	$22.68	$639.55
FANAPT TAB 10MG	179	33	$123,289.11	$24.95	$688.77
FANAPT TAB 12MG	344	61	$237,493.62	$24.58	$690.39
FANAPT PAK	6	6	$637.72	$17.71	$106.29
Subtotal	**2,297**	**408**	**$1,497,373.60**	**$22.65**	**$651.88**
Lurasidone Products					
LATUDA TAB 20MG	349	159	$230,386.47	$22.32	$660.13
LATUDA TAB 40MG	1,746	603	$1,210,982.03	$22.86	$693.58
LATUDA TAB 60MG	128	65	$95,037.27	$23.78	$742.48
LATUDA TAB 80MG	1,623	450	$1,239,504.37	$25.40	$763.71
LATUDA TAB 120MG	605	157	$637,860.68	$33.48	$1,054.32
Subtotal	**4,451**	**1,080**	**$3,413,770.82**	**$25.26**	**$766.97**
Quetiapine Extended-Release Products					
SEROQUEL XR TAB 400MG	1,702	288	$1,609,156.33	$30.43	$945.45
SEROQUEL XR TAB 300MG	1,542	339	$1,227,464.40	$25.23	$796.02
SEROQUEL XR TAB 200MG	764	179	$351,160.14	$14.47	$459.63
SEROQUEL XR TAB 150MG	580	166	$236,992.92	$12.79	$408.61
SEROQUEL XR TAB 50MG	387	109	$108,432.83	$9.19	$280.19
Subtotal	**4,975**	**841**	**$3,533,206.62**	**$22.63**	**$710.19**
Tier-2 Subtotal	**42,422**	**7,161**	**$33,273,231.78**	**$25.52**	**$784.34**
Clozapine Special Formulation Products					
CLOZAPINE TAB 25MG ODT	134	16	$22,152.54	$9.80	$165.32
CLOZAPINE TAB 100/ODT	426	51	$207,039.53	$24.15	$486.01
FAZACLO TAB 25MG ODT	254	27	$65,043.57	$12.11	$256.08
FAZACLO TAB 100/ODT	708	74	$606,923.62	$36.09	$857.24
FAZACLO TAB 150MG	336	37	$203,277.07	$25.40	$604.99
FAZACLO TAB 200MG	203	28	$225,767.61	$39.53	$1,112.16
VERSACLOZ SUS 50MG/ML	2	1	$1,551.54	$48.49	$775.77
Subtotal	**2,063**	**140**	**$1,331,755.48**	**$28.48**	**$645.54**
Olanzapine/Fluoxetine Combination Products					
OLANZA/FLUOX CAP 3-25MG	6	1	$1,483.02	$8.24	$247.17
OLANZA/FLUOX CAP 6-25MG	50	7	$20,952.47	$12.14	$419.05
OLANZA/FLUOX CAP 6-50MG	11	3	$6,979.52	$12.24	$634.50
OLANZA/FLUOX CAP 12-25MG	14	4	$15,965.34	$19.01	$1,140.38
OLANZA/FLUOX CAP 12-50MG	30	5	$30,544.84	$23.42	$1,018.16
SYMBYAX CAP 6-25MG	16	2	$6,805.60	$14.18	$425.35
SYMBYAX CAP 12-25MG	2	1	$1,281.54	$21.36	$640.77
SYMBYAX CAP 12-50MG	23	3	$17,939.01	$26.00	$779.96
Subtotal	**152**	**19**	**$101,951.34**	**$17.43**	**$670.73**
Paliperidone Products					
INVEGA TAB 1.5MG	35	11	$24,306.58	$23.42	$694.47
INVEGA TAB 3MG	502	120	$371,102.67	$24.00	$739.25

Product Utilized	Total Claims	Total Members	Total Cost	Cost/ Day	Cost/ Claim
INVEGA TAB 6MG	1,360	247	$1,232,320.21	$29.11	$906.12
INVEGA TAB 9MG	810	137	$938,676.34	$34.94	$1,158.86
Subtotal	**2,707**	**408**	**$2,566,405.80**	**$29.95**	**$948.06**
Tier-3 Subtotal	**4,922**	**566**	**$4,000,112.62**	**$28.92**	**$812.70**
Total	**176,788**	**25,907**	**$40,951,892.53**	**$7.64**	**$231.64**

*Total number of unduplicated members

Long-Acting Injectable Atypical Antipsychotics

Product Utilized	Total Claims	Total Members	Total Cost	Cost/ Day	Cost/ Claim
Risperidone Long-Acting Injectable Products					
RISPERDAL INJ 50MG	775	97	$807,028.41	$40.68	$1,041.33
RISPERDAL INJ 25MG	334	62	$149,402.69	$20.68	$447.31
RISPERDAL INJ 37.5MG	261	40	$201,353.69	$30.64	$771.47
RISPERDAL INJ 12.5MG	24	4	$6,858.33	$10.45	$285.76
Subtotal	**1,394**	**171**	**$1,164,643.12**	**$33.96**	**$835.47**
Tier-1 Subtotal	**1,394**	**171**	**$1,164,643.12**	**$33.96**	**$835.47**
Aripiprazole Long-Acting Injectable Products					
ABILIFY MAIN INJ 400MG	544	110	$842,803.34	$53.96	$1,549.27
ABILIFY MAIN INJ 300MG	51	16	$59,559.06	$40.41	$1,167.82
Subtotal	**595**	**117**	**$902,362.40**	**$52.79**	**$1,516.58**
Tier-2 Subtotal	**595**	**117**	**$902,362.40**	**$52.79**	**$1,516.58**
Paliperidone Long-Acting Injectable Products					
INVEGA SUST INJ 39/0.25ML	3	2	$967.55	$11.52	$322.52
INVEGA SUST INJ 78/0.5ML	48	14	$30,429.77	$21.92	$633.95
INVEGA SUST INJ 117/0.75ML	462	91	$434,109.95	$32.84	$939.63
INVEGA SUST INJ 156MG/ML	1,544	331	$1,949,744.14	$44.10	$1,262.79
INVEGA SUST INJ 234/1.5ML	2,722	470	$5,169,305.59	$65.84	$1,899.08
Subtotal	**4,779**	**691**	**$7,584,557.00**	**$55.19**	**$1,587.06**
Tier-3 Subtotal	**4,779**	**691**	**$7,584,557.00**	**$55.19**	**$1,587.06**
Total	**6,768**	**930**	**$9,651,562.52**	**$51.12**	**$1,426.06**

*Total number of unduplicated members.

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[1] FDA: Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm. Last revised 08/22/14. Last accessed 08/2014.

[2] FDA: Safety: Fanapt (iloperidone) Tablets. Available online at: http://www.fda.gov/safety/medwatch/safetyinformation/ucm289978.htm. Last revised 05/16/14. Last accessed 08/2014.

[3] Versacloz™ Product Information. Jazz Pharmaceuticals. Available at: http://versacloz.com/docs/VERSACLOZ-Full-Prescribing-Information.pdf. Last revised 08/2013. Last accessed 08/2014.

[4] Versacloz REMS Program. FDA. Available at: http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM338961.pdf Last revised 04/2013. Last accessed 08/2014.

[5] Janssen Pharmaceutical Companies of Johnson & Johnson: Supplemental New Drug Applications for Once-Monthly Long-Acting Therapy Invega Sustenna (paliperidone palmitate) Submitted to the U.S. FDA for the Treatment of Schizoaffective Disorder. Available online at: http://www.janssenpharmaceuticalsinc.com/assets/IS%20SCA%20sNDA%20Press%20Release%20-%20Final.pdf. Last revised 05/2014. Last accessed 08/2014.

[6] Janssen Pharmaceutical Companies of Johnson & Johnson: Selected Pharmaceuticals in Late Stage U.S. and E.U. Development or Registration. Available online at: http://files.shareholder.com/downloads/JNJ/3421649192x0x674691/1423ebb6-9534-413e-9af6-c0b1c429da15/JNJ_Pipeline.pdf . Last revised 07/15/2014. Last accessed 08/2014.

Appendix G

Fiscal Year 2014 Annual Review of ADHD & Narcolepsy Medications

Oklahoma Health Care Authority
September 2014

Current Prior Authorization Criteria

ADHD & Narcolepsy Medications			
Tier-1*	**Tier-2***	**Tier-3***	**Special PA**
Amphetamine			Daytrana™ (methylphenidate ER) Desoxyn® (methamphetamine) Dexedrine® (dextroamphetamine) Dexedrine Spansules® (dextroamphetamine ER) Methylin® (methylphenidate soln & chew tabs) Nuvigil® (armodafinil) ProCentra™ (dextroamphetamine) Provigil® (modafinil) Quillivant XR® (methylphenidate ER) Xyrem® (sodium oxybate)
Short-Acting			
Adderall® (amphetamine/ dextroamphetamine)			
Long-Acting			
Vyvanse® (lisdexamfetamine)	Adderall XR® brand name only (amphetamine/ dextroamphetamine ER)	amphetamine/ dextroamphetamine ER (generic Adderall XR®)	
Methylphenidate			
Short-Acting			
Focalin® (dexmethylphenidate) Methylin® (methylphenidate) Ritalin® (methylphenidate)			
Long-Acting			
Metadate CD® brand name only (methylphenidate ER) Metadate ER® (methylphenidate ER) Methylin ER® (methylphenidate ER) Ritalin SR® (methylphenidate ER)	Focalin XR® (dexmethylphenidate ER) Ritalin LA® brand name only (methylphenidate ER)	Concerta® (methylphenidate ER) methylphenidate ER (generic Metadate CD®) methylphenidate ER (generic Ritalin LA®)	
Non-Stimulants			
Strattera® (atomoxetine)	Intuniv® (guanfacine ER)	Kapvay® (clonidine ER)	

*Tier structure based on State Maximum Allowable Cost (SMAC) and/or supplemental rebate participation.

ADHD & Narcolepsy Medications Tier-2 Approval Criteria:

1. An FDA approved diagnosis; and
2. A trial with at least one long-acting Tier-1 stimulant:
    a. Trials should have been within the last 180 days; and
    b. Trials should have been dosed up to maximum recommended dose or documented adverse effects at higher doses should be included; and
    c. If trials are not in member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the physician.
3. Use of Intuniv® requires:
    a. An FDA approved diagnosis; and
    b. A recent trial with a long-acting Tier-1 stimulant, and a trial of Strattera® within the past 6 months, unless contraindicated, that did not yield adequate results; and
    c. A patient-specific, clinically significant reason why member cannot use guanfacine immediate release tablets.

ADHD & Narcolepsy Medications Tier-3 Approval Criteria:

1. An FDA approved diagnosis; and
2. A trial with at least one long-acting Tier-1 stimulant; and
3. A trial with at least one long-acting Tier-2 stimulant that did not yield adequate response:
    a. Trials should have been within the last 365 days; and
    b. Trials should have been dosed up to maximum recommended dose or documented adverse effects at higher doses should be included; and
    c. If trials are not in member's claim history, the pharmacy profile should be submitted or detailed information regarding dates and doses should be included along with the signature from the physician.
4. A clinical exception may apply for special formulation products when there is a patient-specific, clinically significant reason why member cannot use the available long-acting capsule formulation.
5. Use of Kapvay® requires:
    a. An FDA approved diagnosis; and
    b. Recent trials with a long-acting Tier-1 stimulant and a long-acting Tier-2 stimulant, and a trial of Intuniv® and Strattera® within the past 6 months, unless contraindicated, that did not yield adequate results; and
    c. A patient-specific, clinically significant reason why member cannot use clonidine immediate release tablets.

ADHD & Narcolepsy Medications Special Prior Authorization Approval Criteria:

1. Desoxyn®, Dexedrine®, Dexedrine Spansules®, and ProCentra® Solution Criteria:
    a. A covered diagnosis; and
    b. A patient-specific, clinically significant reason why member cannot use all other available stimulant medications.
2. Daytrana®, Quillivant XR®, and Methylin® Chewable Tablets and Solution Criteria:
    a. An FDA approved diagnosis; and
    b. A patient-specific, clinically significant reason why member cannot use all other available formulations of long-acting stimulant medications that can be used for members who cannot swallow capsules or tablets.
3. Provigil®, Nuvigil®, and Xyrem® Criteria:
    a. An FDA approved diagnosis; and
    b. Use of Provigil® or Nuvigil® requires a patient-specific, clinically significant reason why member cannot use stimulant medications to improve wakefulness during the daytime.
    c. Use of Xyrem® requires recent trials with Tier-1 and Tier-2 stimulants from different chemical categories, and trials with both Provigil® and Nuvigil® within the past 6 months, unless contraindicated, that did not yield adequate results.
    d. The diagnosis of obstructive sleep apnea requires concurrent treatment for the obstructive sleep apnea.
    e. The diagnosis of shift work sleep disorder requires the member's work schedule to be included with the prior authorization request.

ADHD & Narcolepsy Medications Additional Criteria:

1. Doses exceeding 1.5 times the FDA maximum are not covered.
2. Prior Authorization is required for all tiers for members greater than 20 years of age and for members 0-4 years of age. All prior authorization requests for members under the age of 5 years must be reviewed by an OHCA contracted psychiatrist.

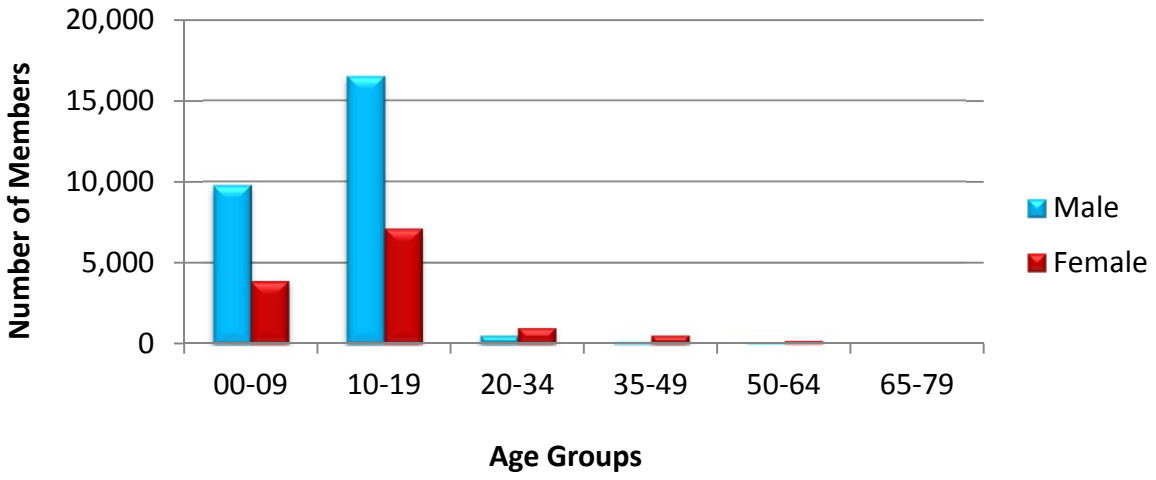
Utilization of ADHD & Narcolepsy Medications

Comparison of Fiscal Years

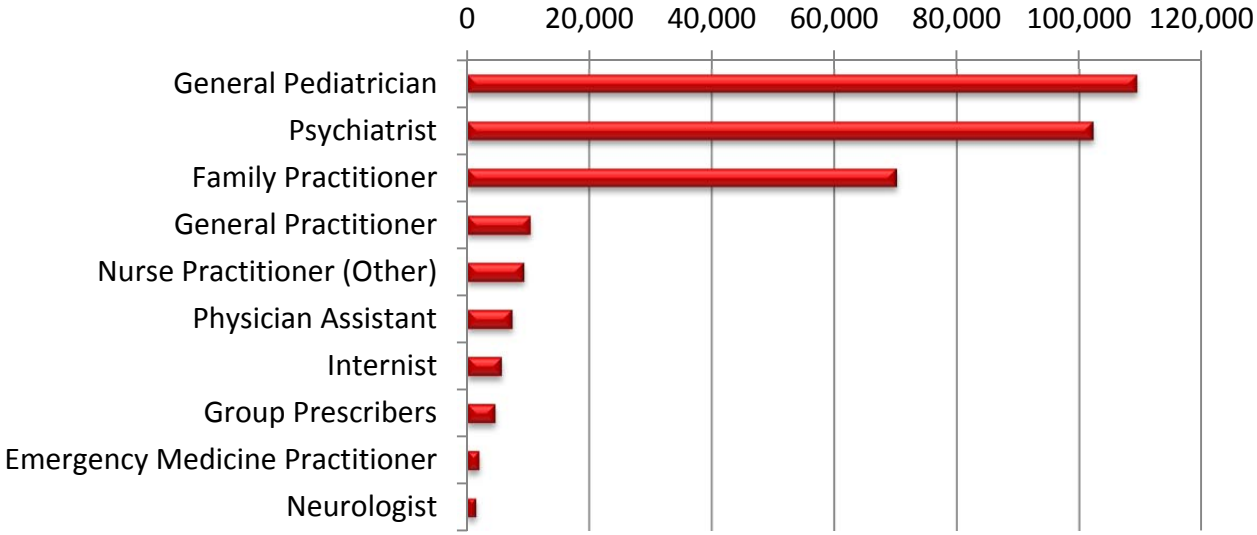
Fiscal Year	*Total Members	Total Claims	Total Cost	Cost/ Claim	Cost/ Day	Total Units	Total Days
2013	38,569	308,033	$50,566,713.02	$164.16	$5.53	10,707,822	9,145,488
2014	39,929	328,105	$59,201,853.04	$180.44	$6.08	11,365,386	9,743,647
% Change	**3.50%**	**6.50%**	**17.10%**	**9.90%**	**9.90%**	**6.10%**	**6.50%**
Change	**1,360**	**20,072**	**$8,635,140.02**	**$16.28**	**$0.55**	**657,564**	**598,159**

*Total number of unduplicated members.

Demographics of Members Utilizing ADHD & Narcolepsy Medications

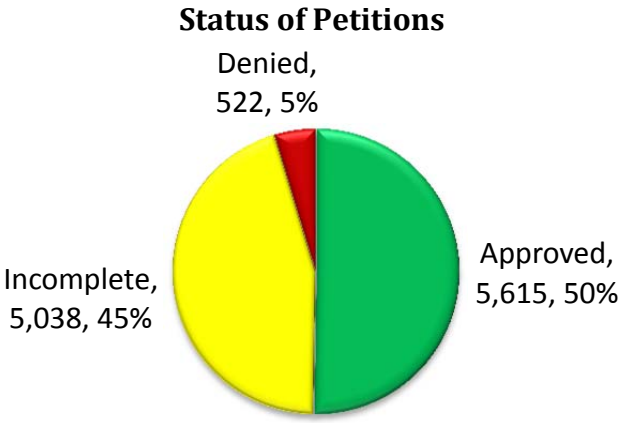


Top Prescriber Specialties of ADHD & Narcolepsy Medications by Number of Claims

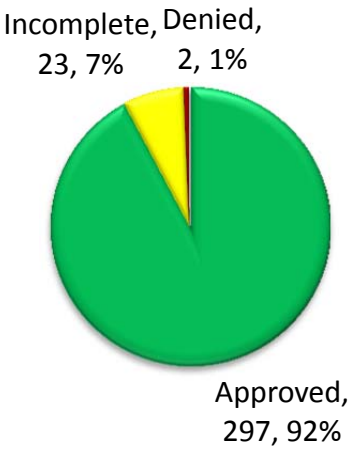


Prior Authorization of ADHD & Narcolepsy Medications

There was a total of 11,175 petitions submitted for the ADHD & narcolepsy medication category during fiscal year 2014. Computer edits are in place to detect Tier-1 medications in the member's recent claims history and generate automated prior authorizations where possible. The following chart shows the status of the submitted petitions.



There was a total of 322 petitions submitted for a total of 227 unique members for the ADHD & narcolepsy medication category during fiscal year 2014 that were referred for a psychiatric consultation. Most requests were for children between the ages of 0 and 4 years of age. The following chart shows the status of the submitted petitions.



Market News and Updates[1]

Anticipated Patent Expirations:

- Strattera® (atomoxetine capsules)- 5/2017
- Focalin XR® (dexmethylphenidate ER capsules)- 11/2019
- Intuniv® (guanfacine ER tablets)- 7/2022
- Vyvanse® (lisdexamfetamine capsules)- 6/2023
- Nuvigil® (armodafinil tablets)- 6/2024
- Xyrem® (sodium oxybate solution)- 6/2024
- Daytrana™ (methylphenidate ER patches)- 10/2025
- Quillivant XR® (methylphenidate ER suspension)- 2/2031

Recommendations

The College of Pharmacy recommends moving Quillivant XR® and Daytrana™ to Tier-3 of the ADHD & Narcolepsy Medications Product Based Prior Authorization category to promote supplemental rebate participation. If no supplemental rebate participation, these products will remain in the Special PA category. The existing criteria for this category will apply. Additionally, the College of Pharmacy recommends moving products to lower tiers when appropriate and cost effective, based on State Maximum Allowable Cost (SMAC).

ADHD & Narcolepsy Medications			
Tier-1*	**Tier-2***	**Tier-3***	**Special PA**
Amphetamine			Desoxyn® (methamphetamine) Dexedrine® (dextroamphetamine) Dexedrine Spansules® (dextroamphetamine ER) Methylin® (methylphenidate soln & chew tabs) Nuvigil® (armodafinil) ProCentra™ (dextroamphetamine) Provigil® (modafinil) Xyrem® (sodium oxybate)
Short-Acting			
Adderall® (amphetamine/ dextroamphetamine)			
Long-Acting			
Vyvanse® (lisdexamfetamine)	Adderall XR® brand name only (amphetamine/ dextroamphetamine ER)	amphetamine/ dextroamphetamine ER (generic Adderall XR®)	
Methylphenidate			
Short-Acting			
Focalin® (dexmethylphenidate) Methylin® (methylphenidate) Ritalin® (methylphenidate)			
Long-Acting			
Metadate CD® brand name only (methylphenidate ER) Metadate ER® (methylphenidate ER) Methylin ER® (methylphenidate ER) Ritalin SR® (methylphenidate ER)	Focalin XR® (dexmethylphenidate ER) Ritalin LA® brand name only (methylphenidate ER)	Concerta® (methylphenidate ER) **Daytrana™ (methylphenidate ER)** methylphenidate ER (generic Metadate CD®) methylphenidate ER (generic Ritalin LA®) **Quillivant XR® (methylphenidate ER)**	
Non-Stimulants			
Strattera® (atomoxetine)	Intuniv® (guanfacine ER)	Kapvay® (clonidine ER)	

*Tier structure based on State Maximum Allowable Cost (SMAC) and/or supplemental rebate participation.
Red color indicates that product placement is based on supplemental rebate participation. If no supplemental rebate participation, the products will be moved to the Special PA category.

Utilization Details of ADHD & Narcolepsy Medications: Fiscal Year 2014

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	UNITS/ DAY	COST/ CLAIM	PERCENT COST
LISDEXAMFETAMINE PRODUCTS						
VYVANSE CAP 30MG	14,038	4,475	$2,778,116.35	1.0	$197.90	4.69%
VYVANSE CAP 40MG	10,427	2,790	$2,079,533.20	1.0	$199.44	3.51%
VYVANSE CAP 20MG	10,002	3,919	$1,978,572.95	1.0	$197.82	3.34%
VYVANSE CAP 50MG	8,720	1,968	$1,725,356.26	1.0	$197.86	2.91%
VYVANSE CAP 70MG	6,827	1,087	$1,361,456.60	1.0	$199.42	2.30%
VYVANSE CAP 60MG	5,492	1,102	$1,085,785.52	1.0	$197.70	1.83%
SUBTOTAL	**55,506**	**15,341**	**$11,008,820.88**	**1.0**	**$198.34**	**18.60%**
AMPHETAMINE/DEXTROAMPHETAMINE PRODUCTS						
AMPHETAMINE TAB 10MG	10,990	2,807	$550,391.88	1.5	$50.08	0.93%
AMPHETAMINE TAB 5MG	7,203	2,076	$343,351.33	1.4	$47.67	0.58%
AMPHETAMINE TAB 20MG	6,439	1,364	$387,068.11	1.8	$60.11	0.65%
AMPHETAMINE TAB 30MG	3,449	617	$191,713.16	1.7	$55.59	0.32%
AMPHETAMINE TAB 15MG	2,296	606	$124,209.96	1.5	$54.10	0.21%
AMPHETAMINE TAB 7.5MG	427	129	$22,055.26	1.5	$51.65	0.04%
AMPHETAMINE TAB 12.5MG	200	44	$14,290.27	1.9	$71.45	0.02%
ADDERALL TAB 10MG	82	58	$16,315.04	1.4	$198.96	0.03%
ADDERALL TAB 20MG	43	32	$10,983.00	1.8	$255.42	0.02%
ADDERALL TAB 5MG	40	21	$7,881.85	1.4	$197.05	0.01%
ADDERALL TAB 15MG	32	17	$7,676.40	1.7	$239.89	0.01%
ADDERALL TAB 30MG	18	11	$4,552.09	1.8	$252.89	0.01%
SUBTOTAL	**31,219**	**7,782**	**$1,680,488.35**	**1.5**	**$53.83**	**2.84%**
METHYLPHENIDATE PRODUCTS						
METHYLPHENIDATE TAB 10MG	8,214	2,101	$332,539.79	1.6	$40.48	0.56%
METHYLPHENIDATE TAB 5MG	6,315	1,994	$190,945.19	1.6	$30.24	0.32%
METHYLPHENIDATE TAB 20MG	3,204	717	$221,205.73	1.9	$69.04	0.37%
METHYLPHENIDATE TAB 20MG ER	1,052	457	$68,961.68	1.2	$65.55	0.12%
METADATE CD CAP 20MG	889	525	$178,495.67	1.0	$200.78	0.30%
METADATE CD CAP 10MG	731	456	$143,156.02	1.0	$195.84	0.24%
METHYLPHENIDATE TAB 20MG SR	555	198	$39,710.49	1.3	$71.55	0.07%
METHYLPHENIDATE TAB 10MG ER	512	247	$22,771.53	1.1	$44.48	0.04%
METADATE CD CAP 30MG	511	269	$102,014.96	1.0	$199.64	0.17%
METADATE CD CAP 40MG	349	150	$95,904.12	1.0	$274.80	0.16%
METHYLIN TAB 10MG	185	60	$4,400.04	1.6	$23.78	0.01%
METADATE CD CAP 60MG	160	61	$51,998.73	1.0	$324.99	0.09%
METADATE CD CAP 50MG	132	54	$42,624.94	1.0	$322.92	0.07%
METHYLIN TAB 20MG ER	128	39	$4,976.84	1.2	$38.88	0.01%
METADATE TAB 20MG ER	107	58	$6,524.77	1.1	$60.98	0.01%
RITALIN TAB 20MG SR	58	21	$4,971.86	1.5	$85.72	0.01%
RITALIN TAB 10MG	34	19	$1,602.37	1.8	$47.13	0.00%
METHYLIN TAB 20MG	14	7	$545.34	1.9	$38.95	0.00%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	UNITS/ DAY	COST/ CLAIM	PERCENT COST
RITALIN TAB 20MG	10	3	$1,484.77	3.5	$148.48	0.00%
METHYLIN TAB 5MG	9	8	$133.11	1.2	$14.79	0.00%
METHYLIN TAB 10MG ER	2	2	$50.45	1.2	$25.23	0.00%
SUBTOTAL	**23,171**	**7,446**	**$1,515,018.40**	**1.5**	**$65.38**	**2.56%**
ATOMOXETINE PRODUCTS						
STRATTERA CAP 40MG	7,350	2,126	$1,847,868.32	1.1	$251.41	3.12%
STRATTERA CAP 25MG	5,887	1,933	$1,442,554.56	1.1	$245.04	2.44%
STRATTERA CAP 60MG	4,636	1,093	$1,121,212.60	1.0	$241.85	1.89%
STRATTERA CAP 80MG	3,243	770	$859,774.70	1.0	$265.12	1.45%
STRATTERA CAP 18MG	2,859	1,085	$687,472.65	1.1	$240.46	1.16%
STRATTERA CAP 10MG	1,874	793	$452,780.73	1.2	$241.61	0.76%
STRATTERA CAP 100MG	907	171	$240,368.28	1.0	$265.01	0.41%
SUBTOTAL	**26,756**	**7,971**	**$6,652,031.84**	**1.1**	**$248.62**	**11.24%**
DEXMETHYLPHENIDATE PRODUCTS						
DEXMETHYLPHENIDATE TAB 10MG	5,520	1,390	$243,877.86	1.3	$44.18	0.41%
DEXMETHYLPHENIDATE TAB 5MG	4,433	1,368	$130,059.69	1.3	$29.34	0.22%
DEXMETHYLPHENIDATE TAB 2.5MG	1,015	376	$28,383.54	1.5	$27.96	0.05%
FOCALIN TAB 5MG	254	151	$11,014.02	1.4	$43.36	0.02%
FOCALIN TAB 10MG	239	145	$15,497.67	1.6	$64.84	0.03%
FOCALIN TAB 2.5MG	96	58	$3,612.09	1.7	$37.63	0.01%
SUBTOTAL	**11,557**	**3,488**	**$432,444.87**	**1.3**	**$37.42**	**0.73%**
TIER-1 SUBTOTAL	**148,209**	**42,028**	**$21,288,804.34**	**1.2**	**$143.64**	**35.96%**
GUANFACINE PRODUCTS						
INTUNIV TAB 2MG	16,604	3,551	$4,021,968.93	1.0	$242.23	6.79%
INTUNIV TAB 3MG	11,404	2,251	$2,800,405.34	1.0	$245.56	4.73%
INTUNIV TAB 1MG	7,879	2,435	$1,865,637.05	1.0	$236.79	3.15%
INTUNIV TAB 4MG	6,519	1,127	$1,599,730.52	1.0	$245.40	2.70%
SUBTOTAL	**42,406**	**9,364**	**$10,287,741.84**	**1.0**	**$242.60**	**17.38%**
DEXMETHYLPHENIDATE PRODUCTS						
FOCALIN XR CAP 10MG	9,252	2,355	$1,971,041.59	1.0	$213.04	3.33%
FOCALIN XR CAP 20MG	7,287	1,534	$1,608,243.31	1.0	$220.70	2.72%
FOCALIN XR CAP 15MG	4,989	1,456	$1,072,611.15	1.0	$215.00	1.81%
FOCALIN XR CAP 5MG	3,714	1,229	$766,186.90	1.0	$206.30	1.29%
DEXMETHYLPHENIDATE CAP 15MG ER	2,119	848	$370,822.19	1.0	$175.00	0.63%
FOCALIN XR CAP 30MG	2,095	525	$432,334.27	1.0	$206.36	0.73%
FOCALIN XR CAP 25MG	2,032	432	$477,755.33	1.0	$235.12	0.81%
DEXMETHYLPHENIDATE CAP 30MG ER	1,390	452	$238,347.51	1.0	$171.47	0.40%
FOCALIN XR CAP 40MG	643	145	$145,723.51	1.0	$226.63	0.25%
DEXMETHYLPHENIDATE CAP 40MG ER	297	92	$57,512.85	1.0	$193.65	0.10%
FOCALIN XR CAP 35MG	295	64	$70,228.52	1.0	$238.06	0.12%
SUBTOTAL	**34,113**	**9,132**	**$7,210,807.13**	**1.0**	**$211.38**	**12.18%**
AMPHETAMINE/DEXTROAMPHETAMINE PRODUCTS						
ADDERALL XR CAP 20MG	8,832	1,981	$2,046,584.24	1.0	$231.72	3.46%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	UNITS/ DAY	COST/ CLAIM	PERCENT COST
ADDERALL XR CAP 30MG	7,718	1,293	$1,723,955.49	1.0	$223.37	2.91%
ADDERALL XR CAP 10MG	6,547	1,696	$1,468,915.74	1.0	$224.36	2.48%
ADDERALL XR CAP 15MG	6,027	1,403	$1,345,148.67	1.0	$223.19	2.27%
ADDERALL XR CAP 25MG	3,056	643	$686,168.79	1.0	$224.53	1.16%
ADDERALL XR CAP 5MG	1,744	645	$389,094.24	1.0	$223.10	0.66%
SUBTOTAL	**33,924**	**7,661**	**$7,659,867.17**	**1.0**	**$225.79**	**12.94%**
METHYLPHENIDATE PRODUCTS						
RITALIN LA CAP 10MG	137	42	$22,224.64	1.0	$162.22	0.04%
RITALIN LA CAP 40MG	96	26	$19,502.31	1.0	$203.15	0.03%
RITALIN LA CAP 30MG	92	27	$20,769.10	1.1	$225.75	0.04%
RITALIN LA CAP 20MG	87	36	$16,735.85	1.0	$192.37	0.03%
SUBTOTAL	**412**	**131**	**$79,231.90**	**1.0**	**$192.31**	**0.13%**
TIER-2 SUBTOTAL	**110,855**	**26,288**	**$25,237,648.04**	**1.0**	**$227.66**	**42.63%**
METHYLPHENIDATE PRODUCTS						
METHYLPHENIDATE TAB 36MG ER	22,813	4,355	$4,445,371.60	1.2	$194.86	7.51%
METHYLPHENIDATE TAB 54MG ER	17,015	2,875	$2,831,844.98	1.0	$166.43	4.78%
METHYLPHENIDATE TAB 27MG ER	12,286	2,836	$1,876,296.33	1.0	$152.72	3.17%
METHYLPHENIDATE TAB 18MG ER	8,867	2,540	$1,336,151.02	1.0	$150.69	2.26%
METHYLPHENIDATE CAP 30MG LA	243	57	$33,444.93	1.1	$137.63	0.06%
METHYLPHENIDATE CAP 20MG LA	223	66	$27,883.61	1.0	$125.04	0.05%
METHYLPHENIDATE CAP 40MG LA	175	43	$24,823.69	1.0	$141.85	0.04%
METHYLPHENIDATE CAP 40MG CD	141	39	$27,472.52	1.0	$194.84	0.05%
METHYLPHENIDATE CAP 30MG CD	129	40	$18,716.32	1.0	$145.09	0.03%
METHYLPHENIDATE CAP 20MG CD	113	40	$19,473.98	1.3	$172.34	0.03%
METHYLPHENIDATE CAP 60MG CD	56	18	$13,891.79	1.0	$248.07	0.02%
CONCERTA TAB 36MG	54	9	$14,550.50	1.2	$269.45	0.02%
METHYLPHENIDATE CAP 50MG CD	47	14	$11,237.82	1.0	$239.10	0.02%
METHYLPHENIDATE CAP 10MG CD	27	18	$3,902.03	1.0	$144.52	0.01%
CONCERTA TAB 18MG	27	12	$4,954.32	1.0	$183.49	0.01%
CONCERTA TAB 54MG	21	4	$5,210.81	1.0	$248.13	0.01%
CONCERTA TAB 27MG	1	1	$158.03	1.0	$158.03	0.00%
SUBTOTAL	**62,238**	**12,967**	**$10,695,384.28**	**1.1**	**$171.85**	**18.07%**
CLONIDINE PRODUCTS						
CLONIDINE TAB 0.1MG ER	1,632	326	$395,546.82	2.4	$242.37	0.67%
KAPVAY TAB 0.1 MG	1,301	366	$393,715.55	2.4	$302.63	0.67%
KAPVAY DOSE PACK 0.1MG & 0.2MG	2	2	$649.76	2.0	$324.88	0.00%
SUBTOTAL	**2,935**	**694**	**$789,912.13**	**2.4**	**$269.14**	**1.33%**
AMPHETAMINE/DEXTROAMPHETAMINE PRODUCTS						
AMPHETAMINE CAP 20MG ER	237	58	$46,246.36	1.5	$195.13	0.08%
AMPHETAMINE CAP 30MG ER	172	36	$23,941.36	1.0	$139.19	0.04%
AMPHETAMINE CAP 10MG ER	107	25	$14,330.34	1.0	$133.93	0.02%
AMPHETAMINE CAP 15MG ER	60	19	$8,021.62	1.0	$133.69	0.01%
AMPHETAMINE CAP 25MG ER	53	11	$7,271.14	1.0	$137.19	0.01%

PRODUCT UTILIZED	TOTAL CLAIMS	TOTAL MEMBERS	TOTAL COST	UNITS/ DAY	COST/ CLAIM	PERCENT COST
AMPHETAMINE CAP 5MG ER	29	14	$3,908.01	1.0	$134.76	0.01%
SUBTOTAL	**658**	**163**	**$103,718.83**	**1.2**	**$157.63**	**0.18%**
TIER-3 SUBTOTAL	**65,831**	**13,824**	**$11,589,015.24**	**1.2**	**$176.04**	**19.58%**
METHYLPHENIDATE PRODUCTS						
DAYTRANA DIS 30MG/9HR	745	112	$162,974.52	1.0	$218.76	0.28%
METHYLPHENIDATE SOL 5MG/5ML	412	114	$101,871.21	10.7	$247.26	0.17%
DAYTRANA DIS 20MG/9HR	312	81	$77,835.21	1.1	$249.47	0.13%
METHYLPHENIDATE SOL 10MG/5ML	290	80	$104,414.43	11.0	$360.05	0.18%
DAYTRANA DIS 15MG/9HR	273	72	$63,155.63	1.0	$231.34	0.11%
DAYTRANA DIS 10MG/9HR	239	73	$53,335.72	1.0	$223.16	0.09%
QUILLIVANT XR SUS 25MG/5ML	105	44	$23,870.96	5.6	$227.34	0.04%
METHYLIN SOL 5MG/5ML	27	14	$7,696.80	11.8	$285.07	0.01%
METHYLIN SOL 10MG/5ML	18	9	$6,505.09	10.5	$361.39	0.01%
SUBTOTAL	**2,421**	**599**	**$601,659.57**	**4.3**	**$248.52**	**1.02%**
MODAFINIL PRODUCTS						
MODAFINIL TAB 200MG	321	48	$214,500.95	1.2	$668.23	0.36%
MODAFINIL TAB 100MG	37	13	$16,575.67	1.3	$447.99	0.03%
SUBTOTAL	**358**	**61**	**$231,076.62**	**1.2**	**$645.47**	**0.39%**
DEXTROAMPHETAMINE PRODUCTS						
DEXTROAMPHETAMINE CAP 15MG ER	98	16	$24,996.76	2.2	$255.07	0.04%
DEXTROAMPHETAMINE TAB 10MG	72	13	$8,236.01	2.3	$114.39	0.01%
DEXTROAMPHETAMINE CAP 10MG ER	31	8	$8,612.88	2.4	$277.83	0.01%
DEXTROAMPHETAMINE CAP 5MG ER	25	5	$2,158.44	1.0	$86.34	0.00%
DEXTROAMPHETAMINE TAB 5MG	4	3	$263.59	1.8	$65.90	0.00%
PROCENTRA SOL 5MG/5ML	1	1	$191.55	5.0	$191.55	0.00%
SUBTOTAL	**231**	**46**	**$44,459.23**	**2.1**	**$192.46**	**0.08%**
ARMODAFINIL PRODUCTS						
NUVIGIL TAB 150MG	91	19	$46,532.34	1.1	$511.34	0.08%
NUVIGIL TAB 250MG	90	20	$42,485.75	1.0	$472.06	0.07%
NUVIGIL TAB 200MG	1	1	$531.69	1.0	$531.69	0.00%
SUBTOTAL	**182**	**40**	**$89,549.78**	**1.0**	**$492.03**	**0.15%**
SODIUM OXYBATE PRODUCTS						
XYREM SOL 500MG/ML	15	4	$117,886.72	16.7	$7,859.11	0.20%
SUBTOTAL	**15**	**4**	**$117,886.72**	**16.7**	**$7,859.11**	**0.20%**
METHAMPHETAMINE PRODUCTS						
DESOXYN TAB 5MG	3	1	$1,753.50	4.0	$584.50	0.00%
SUBTOTAL	**3**	**1**	**$1,753.50**	**4.0**	**$584.50**	**0.00%**
SPECIAL PA SUBTOTAL	**3,210**	**751**	**$1,086,385.42**	**3.6**	**$338.44**	**1.84%**
TOTAL	**328,105**	**39,929***	**$59,201,853.04**	**1.2**	**$180.44**	**100.00%**

*Total number of unduplicated members is only reflected in final total number of members.

[1] FDA: Orange Book: Approved Drug Products with Therapeutic Equivalence Evaluations. Available online at: http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm. Last revised 8/6/14. Last accessed 8/7/14.

Appendix H

30-Day Notice to Prior Authorize Grastek® (Timothy Grass Pollen Allergen Extract) and Ragwitek™ (Short Ragweed Pollen Allergen Extract)

Oklahoma Health Care Authority
September 2014

Introduction[1,2,3]

Allergic rhinitis is a symptomatic ailment of the nose induced after allergen exposure by an immunoglobulin E (IgE)-mediated inflammation of the membranes lining the nose. The three primary symptoms in nasal reactions occurring in allergic conditions are sneezing, nasal obstruction, and mucous discharge.

Current guidelines for the treatment of allergic rhinitis recommend environmental control measures for allergens and oral H_1-antihistamines and/or intranasal corticosteroids as first-line treatment. Intranasal corticosteroids are the most effective medication class in controlling allergic rhinitis symptoms. Second generation H_1-antihistamines are recommended over first generation due to their improved side effect profile. Leukotriene inhibitors may be considered next line if symptoms persist.

Allergen immunotherapy has evidence supporting effectiveness for the treatment of allergic rhinitis. Allergen-specific immunotherapy may be considered for patients with allergic rhinitis or rhinoconjunctivitis after natural exposure and who have demonstrable evidence of specific IgE antibodies to clinically relevant allergens. The severity of symptoms, duration of symptoms, and side effects or lack of response to other interventions should all be considered when assessing the need for specific-allergen immunotherapy. Asthma, sinusitis, and other coexisting medical conditions should also be assessed when evaluating a patient as a potential candidate for allergen immunotherapy. However, use of allergen immunotherapy in a patient with severe, unstable, or uncontrolled asthma is contraindicated. The risks of allergen immunotherapy include local reactions (pruritus and irritation), edema, and life-threatening and fatal allergic reactions.

Grastek® (Timothy Grass Pollen Allergen Extract) Summary[4]

- **Indications:** Grastek® (Timothy grass pollen allergen extract) is an allergen extract indicated as immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens. Grastek® is approved in ages 5 through 65 years of age.

- **Dosing:**
  - Grastek® is available as a sublingual tablet in the following strength: 2,800 Bioequivalent Allergy Units (BAUs).
  - The recommended regimen is one sublingual tablet once daily.
  - The patient should place the tablet immediately under the tongue and allow it to remain there until completely dissolved. The patient should not swallow for at least one minute.
  - Treatment should be initiated at least 12 weeks before the expected onset of each grass pollen season and continued throughout the season.
  - For sustained effectiveness for one grass pollen season after cessation of treatment, Grastek® may be taken daily for three consecutive years.
  - The first dose of Grastek® should be administered under the supervision of a physician with experience in the diagnosis and treatment of allergic diseases. The patient should be observed in the office for at least 30 minutes following the initial dose.

- **Mechanism of Action:** The precise mechanism of action of allergen immunotherapy is not known.

- **Contraindications:**
  - Severe, unstable or uncontrolled asthma
  - History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy
  - A history of eosinophilic esophagitis
  - Hypersensitivity to any of the inactive ingredients contained in this product

- **Efficacy:**
  - The efficacy of Grastek® for the treatment of allergic rhinitis with or without conjunctivitis was investigated in two placebo-controlled trials in subjects five years of age and older who were Timothy grass pollen allergic. Grastek® was compared to placebo during the first pollen season for approximately 24 weeks of treatment.
  - Efficacy was established by self-reporting of rhinoconjunctivitis daily symptom scores (DSS) and daily medication scores (DMS). The sums of the DSS and DMS were combined into the total combined score (TCS) which was averaged over the entire grass pollen season.
  - Subjects treated with Grastek® had a decrease in the TCS, DSS, and DMS throughout the grass pollen season compared to placebo-treated subjects. The difference in TCS relative to placebo was -23%.
  - The sustained effect of Grastek® was measured in a five year double blind study in subjects 18 years and older. Subjects received Grastek® or placebo daily for three years and subjects were observed for two years post treatment. Subjects treated with Grastek® had a decrease in TCS throughout the grass pollen season during the three years of active treatment versus placebo. The difference in TCS relative to placebo in treatment year three was -34%. This effect was sustained during the

grass pollen season in the first year after active treatment, but was not sustained in the second year.

- **Safety:** The use of Grastek® has a black box warning for severe allergic reactions.
  - Grastek® can cause life-threatening allergic reactions such as anaphylaxis and severe laryngopharyngeal restriction.
  - Do not administer Grastek® to patients with severe, unstable, or uncontrolled asthma.
  - Observe patients in the office for at least 30 minutes following the initial dose.
  - Prescribe auto-injectable epinephrine, instruct and train patients on its appropriate use, and instruct patients to seek immediate medical care upon its use.
  - Grastek® may not be suitable for patients with certain underlying medical conditions that may reduce their ability to survive a serious allergic reaction.
  - Grastek® may not be suitable for patients who may be unresponsive to epinephrine or inhaled bronchodilators, such as those taking beta-blockers.

Ragwitek™ (Short Ragweed Pollen Allergen Extract) Summary[5]

- **Indications:** Ragwitek™ (short ragweed pollen allergen extract) is an allergen extract indicated as immunotherapy for the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or *in vitro* testing for pollen-specific IgE antibodies for short ragweed pollen. Ragwitek™ is approved for use in adults 18 through 65 years of age.

- **Dosing:**
  - Ragwitek™ is available as a sublingual tablet in the following strength: 12 Amb a 1-Unit (Amb a 1-U).
  - The recommended regimen is one sublingual tablet once daily.
  - Treatment should be initiated 12 weeks before the expected onset of ragweed pollen season and continue treatment throughout the season.
  - The sublingual tablet should be placed immediately under the tongue and allowed to remain there until completely dissolved. The patient should not swallow for at least one minute.
  - The first dose of Ragwitek™ should be administered under direct supervision of a physician with experience in the diagnosis and treatment of allergic diseases. The patient should be observed in the office for at least 30 minutes following the initial dose.

- **Mechanism of Action:**
  - The precise mechanism of action of allergen immunotherapy is not known.

- **Contraindications:**
  - Severe, unstable or uncontrolled asthma
  - History of any severe systemic allergic reaction or any severe local reaction to sublingual allergen immunotherapy
  - A history of eosinophilic esophagitis
  - Hypersensitivity to any of the inactive ingredients contained in this product

- **Efficacy:**
  - The efficacy of Ragwitek™ in the treatment of ragweed pollen-induced allergic rhinitis with or without conjunctivitis, was investigated in two double-blind, placebo-controlled clinical trials in adults 18 through 50 years of age. Subjects received Ragwitek™ or placebo for approximately 12 weeks prior to the start of the ragweed pollen season and throughout the ragweed pollen season.
  - Efficacy was established by self-reporting of rhinoconjunctivitis daily symptom scores (DSS) and daily medication scores (DMS). The sums of the DSS and DMS were combined into the total combined score (TCS) which was averaged over the peak ragweed pollen season.
  - Subjects treated with Ragwitek™ had a decrease in the TCS, DSS, and DMS throughout the ragweed pollen season compared to placebo-treated subjects. The difference in TCS for the entire season relative to placebo was -26% for Trial One and -27% for Trial Two.

- **Safety:** The use of Ragwitek™ has a black box warning for severe allergic reactions.
  - Ragwitek™ can cause life-threatening allergic reactions such as anaphylaxis and severe laryngopharyngeal restriction.
  - Do not administer Ragwitek™ to patients with severe, unstable or uncontrolled asthma.
  - Observe patients in the office for at least 30 minutes following the initial dose.
  - Prescribe auto-injectable epinephrine, instruct and train patients on its appropriate use, and instruct patients to seek immediate medical care upon its use.
  - Ragwitek™ may not be suitable for patients with certain underlying medical conditions that may reduce their ability to survive a serious allergic reaction.
  - Ragwitek™ may not be suitable for patients who may be unresponsive to epinephrine or inhaled bronchodilators, such as those taking beta-blockers.

- **Cost:**

Medication	Dose	Cost per Unit	Cost for 24 Weeks of Therapy
Grastek® Sublingual Tablets	One tablet daily	$8.71+	$1,567.80
Ragwitek™ Sublingual Tablets	One tablet daily	$8.71+	$1,567.80
Fluticasone 50mcg Nasal	2 sprays daily	$0.75*	$72.00
Cetirizine 10mg Tablets	10mg daily	$0.12*	$21.60
Loratadine 10mg Tablets	10mg daily	$0.12*	$21.60
Montelukast 10mg Tablets	10mg daily	$0.33*	$59.40

*SMAC = state maximum allowable cost.
+Estimated acquisition cost (EAC)

Recommendations

The College of Pharmacy recommends the prior authorization of Grastek® and Ragwitek™ with the following criteria:

Grastek® (Timothy Grass Pollen Allergen Extract) Approval Criteria:

1. Member must be 5 years of age or older; and
2. Member must have a positive skin test or in vitro testing for pollen specific IgE antibodies for Timothy grass or cross-reactive grass pollen (cool season grasses); and
3. Member must not have severe uncontrolled asthma; and
4. Member must have failed conservative attempts to control allergic rhinitis; and
5. Member must have failed pharmacological agents used to control allergies including the following (dates and duration of trails must be indicated on the prior authorization request):
    a. **Antihistamines:** Trials of two different products for 14 days each during a previous season; and
    b. **Montelukast:** One 14-day trial during a previous season; and
    c. **Nasal steroids:** Trials of two different products for 21 days each during a previous season; and
6. Treatment must begin greater than or equal to 12 weeks prior to the start of the grass pollen season and continue throughout the season; and
7. The first dose must be given in the physician's office and the member must be observed for at least 30 minutes post dose; and
8. A quantity limit of one tablet daily will apply; and
9. Initial approvals will be for the duration of six months of therapy to include 12 weeks prior to the season and continue throughout the season; and
10. Member must not be allergic to other allergens for which they are receiving treatment via subcutaneous immunotherapy also known as "allergy shots"; and
11. Member or family member must be trained in the use of an auto-injectable epinephrine device and have such a device available for use at home.

Ragwitek™ (Short Ragweed Pollen Allergen Extract) Approval Criteria:

1. Member must be 18 years of age or older; and
2. Member must have a positive skin test or in vitro testing for pollen specific IgE antibodies to short ragweed pollen; and
3. Member must not have severe uncontrolled asthma; and
4. Member must have failed conservative attempts to control allergic rhinitis symptoms; and
5. Member must have failed pharmacological agents used to control allergies including the following (dates and duration of trails must be indicated on the prior authorization request):
    a. **Antihistamines:** Trials of two different products for 14 days each during a previous season; and
    b. **Montelukast:** One 14-day trial during a previous season; and
    c. **Nasal steroids**: Trials of two different products for 21 days each during a previous season; and

6. Treatment must begin greater than or equal to 12 weeks prior to the start of ragweed pollen season and continue throughout the season; and
7. The first dose must be given in the physician's office and the member must be observed for at least 30 minutes post dose; and
8. A quantity limit of one tablet daily will apply; and
9. Initial approvals will be for the duration of six months of therapy to include 12 weeks prior to the season and continue throughout the season; and
10. Member must not be allergic to other allergens for which they are receiving treatment via subcutaneous immunotherapy also known as "allergy shots"; and
11. Member or family member must be trained in the use of an auto-injectable epinephrine device and have such a device available for use at home.

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[1] Bousquet, J., N. Khaltaev, A. A. Cruz, et al. "Allergic Rhinitis and Its Impact on Asthma (ARIA) 2008*." *Allergy* 63 (2008): 8-160. Web. 8 Aug. 2014. <http://onlinelibrary.wiley.com/doi/10.1111/j.1398-9995.2007.01620.x/abstract;jsessionid=1D2C99C935991959F72BDE96F141BDF3.f02t03>.

[2] Wallace, D., M. Dykewicz, D. Bernstein, J. Blessingmoore, L. Cox, D. Khan, D. Lang, R. Nicklas, J. Oppenheimer, and J. Portnoy. "The Diagnosis and Management of Rhinitis: An Updated Practice Parameter." *Journal of Allergy and Clinical Immunology* 122.2 (2008): S1-S84. Web. 18 Aug. 2014. <www.aaaai.org/Aaaai/media/MediaLibrary/PDF%20Documents/Practice%20and%20Parameters/rhinitis2008-diagnosis-management.pdf>.

[3] Snellman L, Adams W, Anderson G, Godfrey A, Gravley A, Johnson K, Marshall P, Myers C, Nesse R, Short S. Institute for Clinical Systems Improvement. Diagnosis and Treatment of Respiratory Illness in Children and Adults. http://bit.ly/RespIll. Updated January 2013. Web 18 Aug. 2014

[4] Grastek® Product Information. Merck & Co, Inc. Available online at: http://www.merck.com/product/usa/pi_circulars/g/grastek/grastek_pi.pdf. Last revised 06/2014. Last accessed 08/08/2014.

[5] Ragwitek™ Product Information. Merck & Co, Inc. Available online at: http://www.merck.com/product/usa/pi_circulars/r/ragwitek/ragwitek_pi.pdf. Last revised 06/2014. Last accessed 08/08/2014.

Appendix I

FDA & DEA Updates (additional information can be found at http://www.fda.gov/Drugs/default.htm)

FDA NEWS RELEASE

For Immediate Release: August 13th, 2014

FDA approves new type of sleep drug, Belsomra

The U.S. Food and Drug Administration today approved Belsomra (suvorexant) tablets for use as needed to treat difficulty in falling and staying asleep (insomnia).

Belsomra is an orexin receptor antagonist and is the first approved drug of this type. Orexins are chemicals that are involved in regulating the sleep-wake cycle and play a role in keeping people awake. Belsomra alters the signaling (action) of orexin in the brain.

Insomnia is a common condition in which a person has trouble falling or staying asleep. It can range from mild to severe, depending on how often it occurs and for how long. Insomnia can cause daytime sleepiness and lack of energy. It also can make a person feel anxious, depressed, or irritable. People with insomnia may have trouble with attentiveness, learning, and memory.

Belsomra should be taken no more than once per night, within 30 minutes of going to bed, with at least seven hours remaining before the planned time of waking. The total dose should not exceed 20 mg once daily.

The most commonly reported adverse reaction reported by clinical trial participants taking Belsomra was drowsiness. Medications that treat insomnia can cause next-day drowsiness and impair driving and other activities that require alertness. People can be impaired even when they feel fully awake.

The FDA asked the drug manufacturer, Merck, Sharpe & Dohme Corp., to study next-day driving performance in people who had taken Belsomra. The testing showed impaired driving performance in both male and female participants when the 20 mg strength was taken. Patients using the 20 mg strength should be cautioned against next-day driving or activities requiring full mental alertness. Patients taking lower doses should also be made aware of the potential for next-day driving impairment, because there is individual variation in sensitivity to the drug.

The effectiveness of Belsomra was studied in three clinical trials involving more than 500 participants. In the studies, patients taking the drug fell asleep faster and spent less time awake during the remainder of the night compared to people taking an inactive pill (placebo). Belsomra was not compared to other drugs approved to treat insomnia, so it is not known if there are differences in safety or effectiveness between Belsomra and other insomnia medications.

Like other sleep medicines, there is a risk from Belsomra of sleep-driving and other complex behaviors while not being fully awake, such as preparing and eating food, making phone calls, or having sex. Chances of such activity increase if a person has consumed alcohol or taken other medicines that make them sleepy. Patients or their families should call the prescribing health care professional if this type of activity occurs.

Belsomra will be dispensed with an FDA-approved patient Medication Guide that provides instructions for its use and important safety information. Belsomra is a controlled substance (Schedule-IV) because it can be abused or lead to dependence.

Belsomra is made by Merck, Sharpe & Dohme Corp. of Whitehouse Station, N.J.

FDA NEWS RELEASE

For Immediate Release: August 14th, 2014

FDA approves Avastin to treat patients with aggressive and late-stage cervical cancer

The U.S. Food and Drug Administration approved a new use for Avastin (bevacizumab) to treat patients with persistent, recurrent or late-stage (metastatic) cervical cancer.

Cervical cancer grows in the tissues of the lower part of the uterus known as the cervix. It commonly occurs when human papillomaviruses (HPV), a virus that spreads through sexual contact, cause cells to become cancerous. Although there are two licensed vaccines available to prevent many types of HPV that can cause cervical cancer, the National Cancer Institute estimates that 12,360 American women will be diagnosed with cervical cancer and 4,020 will die from the disease in 2014.

Avastin works by interfering with the blood vessels that fuel the development of cancerous cells. The new indication for cervical cancer is approved for use in combination with chemotherapy drugs paclitaxel and cisplatin or in combination with paclitaxel and topotecan.
The FDA reviewed Avastin for treatment of patients with cervical cancer under its priority review program because the drug demonstrated the potential to be a significant improvement in safety or effectiveness over available therapy in the treatment of a serious condition. Priority review provides an expedited review of a drug's application.
The safety and effectiveness of Avastin for treatment of patients with cervical cancer was evaluated in a clinical study involving 452 participants with persistent, recurrent, or late-stage disease. Participants were randomly assigned to receive paclitaxel and cisplatin with or without Avastin or paclitaxel and topotecan with or without Avastin. Results showed an increase in overall survival to 16.8 months in participants who received chemotherapy in combination with Avastin as compared to 12.9 months for those receiving chemotherapy alone.
The most common side effects associated with use of Avastin in patients with cervical cancer include fatigue, decreased appetite, high blood pressure (hypertension), increased glucose in the blood (hyperglycemia), decreased magnesium in the blood (hypomagnesemia), urinary tract infection, headache and decreased weight. Perforations of the gastrointestinal tract and abnormal openings between the gastrointestinal tract and vagina (enterovaginal fistula) also were observed in Avastin-treated patients.
Avastin is marketed by South San Francisco, California-based Genentech, a member of the Roche Group.

FDA NEWS RELEASE

For Immediate Release: August 19th, 2014

FDA approves new drug to treat a form of Gaucher disease

The U.S. Food and Drug Administration today approved Cerdelga (eliglustat) for the long-term treatment of adult patients with the Type 1 form of Gaucher disease, a rare genetic disorder.
Gaucher disease occurs in people who do not produce enough of an enzyme called glucocerebrosidase. The enzyme deficiency causes fatty materials to collect in the spleen, liver and bone marrow. The major signs of Gaucher disease include liver and spleen enlargement, low red blood cell counts (anemia), low blood platelet counts and bone problems.
Cerdelga is a hard gelatin capsule containing eliglustat that is taken orally. In patients with Gaucher disease Type 1, the drug slows down the production of the fatty materials by inhibiting the metabolic process that forms them. Type 1 Gaucher disease is estimated to affect about 6,000 people in the United States.
The safety and effectiveness of Cerdelga were evaluated in two clinical trials with 199 participants with Type 1 Gaucher disease.
In one randomized, double-blind, placebo-controlled, multicenter clinical trial the safety and effectiveness of Cerdelga were evaluated in 40 participants with Type 1 Gaucher's disease who had not previously received enzyme replacement therapy. Subjects received the drug at a starting dose of 42 mg two times a day, with most receiving a dose of 84 mg two times a day after four weeks. Study participants continued the drug for nine months.
Compared to placebo, treatment with Cerdelga resulted in a greater reduction in spleen volume from baseline to the end of the study (by the 39th week), the trial's primary endpoint. Cerdelga also resulted in greater improvement in liver volume, blood platelet count, and red blood cell (hemoglobin) level, compared to placebo.
The other trial sought to determine the safety and effectiveness of Cerdelga compared to enzyme replacement therapy in 159 participants with Type 1 Gaucher disease previously treated and stabilized on enzyme replacement therapy. Subjects in the trial received either the enzyme replacement therapy drug imiglucerase or Cerdelga. The trial demonstrated that treatment with Cerdelga resulted in similar stabilization of hemoglobin level, platelet count and spleen and liver volume as imiglucerase.
The most commonly observed side effects in the Cerdelga clinical trials were fatigue, headache, nausea, diarrhea, back pain, pain in extremities, and upper abdominal pain.
Cerdelga is manufactured by Cambridge, Massachusetts-based Genzyme.

FDA NEWS RELEASE

For Immediate Release: July 28th, 2014

FDA expands approved use of Imbruvica for chronic lymphocytic leukemia

The U.S. Food and Drug Administration today expanded the approved use of Imbruvica (ibrutinib) to treat patients with chronic lymphocytic leukemia (CLL) who carry a deletion in chromosome 17 (17p deletion), which is associated with poor responses to standard treatment for CLL. Imbruvica received a breakthrough therapy designation for this use.

The FDA is also approving new labeling to reflect that Imbruvica's clinical benefit in treating CLL has been verified. In February 2014, Imbruvica received accelerated approval to treat CLL based on its effect on overall response rate. New clinical trial results examining progression-free survival and overall survival have confirmed the drug's clinical benefit.

A type of non-Hodgkin lymphoma, CLL is a rare blood and bone marrow disease that usually gets worse slowly over time, causing a gradual increase in white blood cells called B lymphocytes, or B cells. The National Cancer Institute estimates that 15,720 Americans will be diagnosed and 4,600 will die from CLL in 2014. Imbruvica works by blocking the enzyme that allows cancer cells to grow and divide.

Imbruvica is the fourth drug approved to treat CLL that received a breakthrough therapy designation, reflecting the promise of the breakthrough therapy designation program and demonstrating the FDA's commitment to working cooperatively with companies to expedite the development, review and approval of these important new drugs.

The other three drugs approved to treat CLL that received breakthrough designations are Gazyva (obinutuzumab) in November 2013, Arzerra (ofatumumab) in April 2014 and Zydelig (idelalisib) in July 2014. Imbruvica's application for accelerated approval to treat CLL did not receive breakthrough therapy designation.

Today's approval actions for Imbruvica are based on a clinical study of 391 previously treated participants, 127 of whom had CLL with 17p deletion. Participants were randomly assigned to receive Imbruvica or Arzerra until disease progression or side effects became intolerable.

The trial was stopped early for efficacy after a pre-planned interim analysis showed Imbruvica-treated participants experienced a 78 percent reduction in risk of disease progression or death (progression-free survival). Results also showed a 57 percent reduction in risk of death (overall survival) in participants treated with Imbruvica. Of the 127 participants who had CLL with 17p deletion, those treated with Imbruvica experienced a 75 percent reduction in risk of disease progression or death.

The most common side effects associated with Imbruvica observed in the clinical study include low levels of platelets in the blood (thrombocytopenia), a decrease in infection-fighting white blood cells called neutrophils (neutropenia), diarrhea, low red blood cells (anemia), fatigue, pain in the muscles and bones (musculoskeletal pain), upper respiratory tract infection, rash, nausea and fever (pyrexia).

Imbruvica's new use is being approved more than two months ahead of the product's prescription drug user fee goal date of Oct. 7, 2014, the date the FDA was scheduled to complete review of the drug application. The FDA reviewed Imbruvica's application for this new use under the agency's priority review program, which provides for an expedited review of drugs that are intended to treat a serious disease or condition and, if approved, would offer significant improvement compared to marketed products.

Imbruvica also received accelerated approval in November 2013 for the treatment of patients with mantle cell lymphoma who have received at least one prior therapy. Clinical studies to verify and describe Imbruvica's clinical benefit in mantle cell lymphoma are ongoing.

Imbruvica is co-marketed by Pharmacyclics, based in Sunnyvale, Calif., and Janssen Biotech, based in Horsham, Penn.

FDA NEWS RELEASE

For Immediate Release: July 31st, 2014

FDA approves Striverdi Respimat to treat chronic obstructive pulmonary disease

Today, the U.S. Food and Drug Administration approved Striverdi Respimat (olodaterol) inhalation spray to treat patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema that are experiencing airflow obstruction. Striverdi Respimat can be used once daily over a long period of time.

COPD is a serious lung disease that makes breathing difficult and worsens over time. Symptoms can include wheezing, cough, chest tightness, and shortness of breath. Cigarette smoking is the leading cause of COPD. According to the National Heart, Lung, and Blood Institute, COPD is the third leading cause of death in the United States.

Striverdi Respimat is a long-acting beta-adrenergic agonist (LABA) that helps the muscles around the airways in the lungs stay relaxed to prevent symptoms. The safety and effectiveness of Striverdi Respimat was evaluated in 3,104 people diagnosed with COPD. People who received Striverdi Respimat showed improved lung function compared to placebo.

The drug carries a boxed warning that LABAs increase the risk of asthma-related death. The safety and effectiveness of Striverdi Respimat in people with asthma has not been established and it is not approved to treat asthma. Striverdi Respimat should not be used as a rescue therapy to treat sudden breathing problems (acute bronchospasm).

Striverdi Respimat should not be used in patients with acutely deteriorating COPD and may cause serious side effects, including narrowing and obstruction of the respiratory airway (paradoxical bronchospasm) and cardiovascular effects.

The FDA approved Striverdi Respimat with a patient medication guide that includes instructions for use and information about the potential risks of taking the drug.

The most common side effects reported by people using Striverdi Respimat in the clinical study were nasopharyngitis (runny nose), upper respiratory tract infection, bronchitis, cough, urinary tract infection, dizziness, rash, diarrhea, back pain and arthralgia (joint pain).

Striverdi Respimat is distributed by Boehringer Ingelheim Pharmaceuticals, Inc., Ridgefield, Connecticut.

FDA NEWS RELEASE

For Immediate Release: August 6th, 2014

FDA approves Orbactiv to treat skin infections

The U.S. Food and Drug Administration today approved Orbactiv (oritavancin), a new antibacterial drug to treat adults with skin infections.

Orbactiv is approved to treat patients with acute bacterial skin and skin structure infections (ABSSSI) caused by certain susceptible bacteria, including Staphylococcus aureus (including methicillin-susceptible and methicillin-resistant strains), various Streptococcus species and Enterococcus faecalis. Orbactiv is administered intravenously.

Orbactiv is the third new antibacterial drug approved by the FDA this year to treat ABSSSI. The agency approved Dalvance (dalbavancin) in May 2014 and Sivextro (tedizolid) in June 2014.

Orbactiv is also the third new drug designated as a Qualified Infectious Disease Product (QIDP) to receive FDA approval. Under the Generating Antibiotic Incentives Now (GAIN) title of the FDA Safety and Innovation Act, Orbactiv was granted QIDP designation because it is an antibacterial or antifungal human drug intended to treat a serious or life-threatening infection.

As part of its QIDP designation, Orbactiv was given priority review, which provides an expedited review of the drug's application. Orbactiv's QIDP designation also qualifies it for an additional five years of marketing exclusivity to be added to certain exclusivity periods already provided by the Food, Drug, and Cosmetic Act.

Orbactiv's safety and efficacy were evaluated in two clinical trials with a total of 1,987 adults with ABSSSI. Participants were randomly assigned to receive Orbactiv or vancomycin. Results showed Orbactiv was as effective as vancomycin for the treatment of ABSSSI.

The most common side effects identified in the clinical trials were headache, nausea, vomiting, the formation of skin and soft tissue abscesses on arms and legs and diarrhea. Orbactiv's label also includes a warning regarding interference with coagulation tests and interaction with warfarin, a drug used to prevent blood clots.

Orbactiv is marketed by The Medicines Company, based in Parsippany, N.J.

FDA NEWS RELEASE

For Immediate Release: August 1st, 2014

FDA expands approval of drug to treat Pompe disease to patients of all ages; removes risk mitigation strategy requirements

The U.S. Food and Drug Administration today announced the approval of Lumizyme (alglucosidase alfa) for treatment of patients with infantile-onset Pompe disease, including patients who are less than 8 years of age. In addition, the Risk Evaluation and Mitigation Strategy (REMS) known as the Lumizyme ACE (Alglucosidase Alfa Control and Education) Program is being eliminated.

Pompe disease is a rare genetic disorder and occurs in an estimated 1 in every 40,000 to 300,000 births. Its primary symptom is heart and skeletal muscle weakness, progressing to respiratory weakness and death from respiratory failure.

The disease causes gene mutations to prevent the body from making enough of the functional form of an enzyme called acid alpha-glucosidase (GAA). This enzyme is necessary for proper muscle functioning. GAA is used by the heart and muscle cells to convert a form of sugar called glycogen into energy. Without the enzyme action, glycogen builds up in the cells and, ultimately, weakens the heart and muscles. Lumizyme is believed to work by replacing the deficient GAA, thereby reducing the accumulated glycogen in heart and skeletal muscle cells.

Lumizyme, a lysosomal glycogen-specific enzyme, was approved by the FDA in 2010 with a REMS to restrict its use to treatment of patients with late (non-infantile) onset Pompe disease who are 8 years of age and older. The REMS was required to mitigate the potential risk of rapid disease progression in the infantile-onset Pompe disease patients and patients with late onset disease less than 8 years of age, and to communicate the risks of anaphylaxis, severe allergic reactions and severe skin and systemic immune mediated reactions to prescribers and patients.

At the time of Lumizyme's approval, there were insufficient data to support the safety and efficacy of Lumizyme in the infantile-onset Pompe population, so Lumizyme was approved for use only in late onset Pompe disease patients who are at least 8 years of age. Pompe patients with infantile-onset disease and patients younger than 8 years of age continued treatment with Myozyme, which was already approved. Myozyme and Lumizyme, both manufactured by Genzyme Corporation, are produced from the same cell line at different production scales.

This approval provides access to Lumizyme for all Pompe disease patients, regardless of their age.

The FDA reviewed newly available information and determined that Lumizyme and Myozyme are chemically and biochemically comparable. Consequently, the safety and effectiveness of Lumizyme and Myozyme are expected to be comparable. In addition, a single-center clinical study of 18 infantile-onset Pompe disease patients, aged 0.2 to 5.8 months at the time of first infusion, provides further support that infantile-onset patients treated with Lumizyme will have a similar improvement in ventilator-free survival as those treated with Myozyme.

Because data were submitted supporting approval of Lumizyme for all Pompe patients, a REMS restricting its use to a specific age group is no longer necessary. While the risk of anaphylaxis, severe allergic reactions, and severe cutaneous and immune mediated reactions for Lumizyme still exist, these risks are comparable to Myozyme and are communicated in labeling through the Warnings and Precautions, and a Boxed Warning.

Health care professionals and patients should also be aware:

- The Warnings and Precautions section of the Lumizyme product label and the Clinical Studies section of the Lumizyme label have been updated to include the safety information of the drug in infantile-onset Pompe disease patients. This includes information from the currently approved Myozyme label and information from a new, uncontrolled study in which patients with infantile onset disease were treated with Lumizyme.
- Lumizyme is approved with a Boxed Warning because of the risk of anaphylaxis, severe allergic reactions, immune-mediated reactions and cardiorespiratory failure.
- Health care professionals should continue to refer to the drug prescribing information for the latest recommendations on prescribing Lumizyme and report adverse events to the FDA's MedWatch program (http://www.fda.gov/Safety/MedWatch/default.htm).
- Distribution of Lumizyme will no longer be restricted. Health care professionals, healthcare facilities, and patients will no longer be required to enroll in the Lumizyme REMS program (Lumizyme ACE Program) to be able to prescribe, dispense, or receive Lumizyme.

The most commonly reported side effects for Lumizyme were infusion-related reactions and included severe allergic reactions, hives, diarrhea, vomiting, shortness of breath, itchy skin, skin rash, neck pain, partial hearing loss, flushing, pain in extremities, and chest discomfort.
Myozyme and Lumizyme are marketed by Cambridge, Massachusetts-based Genzyme.

Safety Announcements

Cubist Pharmaceuticals Issues Voluntary Nationwide Recall of Nine Lots of CUBICIN (daptomycin for injection) 500 mg in 10 mL single use vials Following Complaints of Foreign Particulate Matter in Reconstituted Vials

[August 8, 2014] Cubist Pharmaceuticals, Inc. announced today it is voluntarily recalling nine lots of CUBICIN® (daptomycin for injection) to the user level following complaints of foreign particulate matter in reconstituted vials.
The administration of particulate matter, if present in an intravenous drug, poses a potential safety risk to patients such as a thromboembolism or a life-threatening pulmonary embolism. Other events such as phlebitis, mechanical block of the capillaries or arterioles, activation of platelets or subsequent generation of microthrombi are also possible. Patients with a preexisting condition of trauma or other medical condition that adversely affects the microvascular blood supply are at an increased risk. Administration of a particulate can also lead to formation of granulomas, which represent a protective local inflammatory response to the foreign material. To date, no reports of adverse events have been associated with product complaints of particulate matter from these lots.
CUBICIN is an intravenously administered prescription product indicated for the treatment of skin infections and certain blood stream infections.
Cubist is notifying customers by letter and phone. Anyone with an existing inventory of the product should determine whether they have product from the recalled lots, quarantine, and discontinue distribution of these recalled lots of the product and call Cubist at (855) 534-8309 between the hours of 9 a.m. to 7 p.m. EDT, Monday through Friday, to arrange for return and replacement of the affected lots.
As noted in the package insert for CUBICIN, parenteral drug products should be carefully inspected visually for particulate matter prior to administration. Healthcare providers should not use any CUBICIN vials containing particulate matter.
Cubist is arranging for return of recalled product. For healthcare professionals and pharmacists with medical questions regarding this recall may contact Cubist Medical Information at (877) 282-4786 between the hours of 8 a.m. to 5:30 p.m. EDT, Monday through Friday.
Adverse events or quality problems experienced with the use of this product may be reported to the FDA's MedWatch Adverse Events Program either online, by regular mail or by fax.

- Complete and submit the report Online: http://www.fda.gov/MedWatch/report.htm
- Regular mail or Fax: Download form http://www.fda.gov/MedWatch/getforms.htm or call 1-800-332-1088 to request a reporting form, then complete and return to the address on the pre-addressed form, or submit by fax to 1-800-FDA-0178.

This recall is being conducted with the knowledge of the U.S. Food and Drug Administration.

Current Drug Shortages Index (as of September 2, 2014):

The information provided in this section is provided voluntarily by manufacturers.

Acetohydroxamic Acid (Lithostat) Tablets	***Currently in Shortage***
Amikacin Injection	***Currently in Shortage***
Ammonium Chloride Injection	***Currently in Shortage***
Atropine Sulfate Injection	***Currently in Shortage***
Barium Sulfate for Suspension	***Currently in Shortage***
Bumetanide Injection	***Currently in Shortage***
Bupivacaine Hydrochloride (Marcaine, Sensorcaine) Injection	***Currently in Shortage***
Caffeine Anhydrous (125mg/mL); Sodium Benzoate (125mg/mL) Injection[12]	***Currently in Shortage***

Calcium Gluconate Injection	***Currently in Shortage***
Cefazolin Injection	***Currently in Shortage***
Cefotetan Disodium Injection	***Currently in Shortage***
Chloramphenicol Sodium Succinate Injection	***Currently in Shortage***
Chromic Chloride Injection	***Currently in Shortage***
Cidofovir Injection	***Currently in Shortage***
Clindamycin Phosphate (Cleocin) Injection	***Currently in Shortage***
Clonidine HCL Injection (Duraclon)	***Currently in Shortage***
Copper Injection	***Currently in Shortage***
Cyanocobalamin (Vitamin B12) Injection	***Currently in Shortage***
Daunorubicin Hydrochloride Solution for Injection	***Currently in Shortage***
Dexamethasone Sodium Phosphate Injection	***Currently in Shortage***
Dexmethylphenidate Hydrochloride (Focalin) Tablet	***Currently in Shortage***
Dextrose 5% Injection Bags	***Currently in Shortage***
Dihydroergotamine Mesylate Injection	***Currently in Shortage***
Disopyramide Phosphate (Norpace) CR	***Currently in Shortage***
Doxorubicin (Adriamycin) Lyophilized Powder	***Currently in Shortage***
Ephedrine Sulfate Injection	***Currently in Shortage***
Epinephrine 1mg/mL (Preservative Free)[13]	***Currently in Shortage***
Epinephrine Injection	***Currently in Shortage***
Erythrocin Lactobionate Lyophilized Powder for Injection	***Currently in Shortage***
Ethiodol (Ethiodized Oil) Ampules	***Currently in Shortage***
Famotidine Injection	***Currently in Shortage***
Fentanyl Citrate (Sublimaze) Injection	***Currently in Shortage***
Fluorescein Sodium Injection	***Currently in Shortage***
Haloperidol Lactate Injection	***Currently in Shortage***
Heparin Sodium Injection	***Currently in Shortage***
Indigo Carmine Injection	***Currently in Shortage***
Irrigation Solutions	***Currently in Shortage***
Leucovorin Calcium Lyophilized Powder for Injection	***Currently in Shortage***
Leuprolide Acetate Injection	***Currently in Shortage***
Lidocaine Hydrochloride (Xylocaine) Injection	***Currently in Shortage***
Liotrix (Thyrolar) Tablets	***Currently in Shortage***
Magnesium Sulfate Injection	***Currently in Shortage***
Mecasermin [rDNA origin] (Increlex) Injection	***Currently in Shortage***
Memantine Hydrochloride (Namenda) XR Capsules	***Currently in Shortage***
Methazolamide (Neptazane) Tablets	***Currently in Shortage***
Methyldopate Hydrochloride Injection	***Currently in Shortage***
Methylin Chewable Tablets	***Currently in Shortage***
Methylphenidate Hydrochloride Tablets	***Currently in Shortage***
Morphine Sulfate (Astramorph PF, Duramorph, Infumorph) Injection (Preservative Free)	***Currently in Shortage***
Multi-Vitamin Infusion (Adult and Pediatric)	***Currently in Shortage***

Nalbuphine Hydrochloride (Nubain) Injection	***Currently in Shortage***
Nitroglycerin (Nitronal) Injection	***Currently in Shortage***
Nitroglycerin in 5% Dextrose Injection	***Currently in Shortage***
Ondansetron (Zofran) Injection	***Currently in Shortage***
Pancuronium Bromide Injection	***Currently in Shortage***
Papaverine Hydrochloride Injection	***Currently in Shortage***
Peritoneal Dialysis Solutions	***Currently in Shortage***
Phenylephrine Hydrochloride Ophthalmic Solution	***Currently in Shortage***
Phosphate (Glycophos) Injection	***Currently in Shortage***
Piperacillin and Tazobactam (Zosyn) Injection	***Currently in Shortage***
Potassium Chloride Injection	***Currently in Shortage***
Prochlorperazine Injection	***Currently in Shortage***
Ranitidine Hydrochloride (Zantac) Injection	***Currently in Shortage***
Reserpine Tablets	***Currently in Shortage***
Secretin Synthetic Human (ChiRhoStim) Injection	***Currently in Shortage***
Selenium Injection	***Currently in Shortage***
Sincalide (Kinevac) Lyophilized Powder for Injection	***Currently in Shortage***
Sodium Chloride 0.9% Injection Bags	***Currently in Shortage***
Sodium Chloride 23.4% Injection	***Currently in Shortage***
Sodium Phosphate Injection	***Currently in Shortage***
Succinylcholine (Anectine, Quelicin) Injection	***Currently in Shortage***
Sufentanil Citrate (Sufenta) Injection	***Currently in Shortage***
Sulfamethoxazole and Trimethoprim (Bactrim) Oral Suspension	***Currently in Shortage***
Technetium tc99m Exametazime Injection (Ceretec Kit)	***Currently in Shortage***
Tesamorelin (Egrifta) Injection Kit	***Currently in Shortage***
Thiotepa (Thioplex) for Injection	***Currently in Shortage***
Tiopronin (Thiola)	***Currently in Shortage***
Tobramycin Solution for Injection	***Currently in Shortage***
Trace Elements	***Currently in Shortage***
Trimipramine Maleate (SURMONTIL) Capsules	***Currently in Shortage***
Verapamil Hydrochloride Injection, USP	***Currently in Shortage***
Vitamin A Palmitate (Aquasol A) Injection	***Currently in Shortage***
Zinc Injection	***Currently in Shortage***