THE UNIVERSITY OF OKLAHOMA

MEMORANDUM

TO: Drug Utilization Review Board Members

FROM: Ron Graham, D.Ph.

SUBJECT: **Packet Contents for Board Meeting – December 14, 2004**

DATE: December 8, 2004

NOTE: **THE DUR BOARD WILL MEET AT 6:00 P.M.**

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

Call to Order

Public Comment Forum

Action Item – Approval of DUR Board Meeting Minutes and 2005 Meeting Dates – **See Appendix A.**

Update on DUR/MCAU Program - **See Appendix B.**

Action Item – Discussion and Vote on ADHD Prior Authorization Changes – **See Appendix C.**

Action Item – Discussion and Vote on Prior Authorization of Zegerid® - **See Appendix D.**

Action Item – Discussion and Vote on Prior Authorization of Xopenex® - **See Appendix E.**

Review and Discuss Economic Impact of Prior Authorization on Bladder Control Medications – **See Appendix F.**

Review and Discussion on Prior Authorization Requirements for Children Under 18 Years of Age with SSRI's – **See Appendix G.**

Review and Discuss Cymbalta® (New Product)- **See Appendix H.**

Review and Discuss Multiple Sclerosis Medications – **See Appendix I.**

FDA and DEA Updates – **See Appendix J.**

Future Business

Adjournment

Drug Utilization Review Board

(DUR Board)

Meeting – December 14, 2004 @ 6:00p.m.

Oklahoma Health Care Authority
4545 N. Lincoln Suite 124
Oklahoma City, Oklahoma 73105
Oklahoma Health Care Authority Board Room

AGENDA

Discussion and Action On the following Items:

Items to be presented by Dr. Whitsett, Chairman:

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

Items to be presented by Dr. Whitsett, Chairman:

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

Items to be presented by Dr. Whitsett, Chairman:

3. **Action Item - Approval of DUR Board Meeting Minutes – See Appendix A.**
   A. November 9, 2004 DUR Minutes – Vote
   B. Approval of Meeting Dates for 2005 - Vote

Items to be presented by Dr. Flannigan, Dr. Browning, Dr. Whitsett, Chairman:

4. **Update on DUR/MCAU Program - See Appendix B.**
   A. Retrospective DUR Report for September 2004
   B. Medication Coverage Activity Audit for November 2004
   C. Help Desk Activity Audit for November 2004

Items to be presented by Dr. McIlvain, Dr. Whitsett, Chairman:

5. **Action Item – Discussion and Vote on ADHD Prior Authorization Changes - See Appendix C.**
   A. Current Prior Authorization Process
   B. Suggested Changes to Process

Items to be presented by Dr. McIlvain, Dr. Whitsett, Chairman:

6. **Action Item – Discussion and Vote on Prior Authorization of Zegerid® – See Appendix D.**
   A. Drug Information
   B. COP Recommendations

Items to be presented by Dr. Flannigan, Dr. Whitsett, Chairman:

7. **Action Item – Discussion and Vote on Prior Authorization of Xopenex®– See Appendix E.**
   A. COP Recommendations
   B. Economic Impact

Items to be presented by Dr. Moore, Dr. Gorman, Dr. Whitsett, Chairman:

8. **Review and Discuss Economic Impact of Prior Authorization on Bladder Control Medications – See Appendix F.**
   A. Product Information
   B. Economic Impact
   C. COP Recommendations

Items to be presented by Dr. Le, Dr. Whitsett, Chairman:

9. **Review and Discussion on Prior Authorization Requirements in Children Under 18 Years of Age with SSRI's – See Appendix G.**
   A. Current Prior Authorization Criteria
   B. Citalopram Tier Status- Vote
   C. Current Safety Status (FDA and DUR Board)
   D. COP Recommendation Options- Vote

Items to be presented by Dr. Chonlahan, Dr. Whitsett, Chairman:

10. **Review and Discuss Cymbalta® (New Product) - See Appendix H.**
    A. Drug Monograph
    B. COP Recommendations

Items to be presented by Dr. Patel, Dr. Whitsett, Chairman:

11. **Review and Discuss Multiple Sclerosis Medications – See Appendix I.**
    A. Disease Overview
    B. Oklahoma Medicaid Utilization Review
    C. Treatment Guidelines
    D. COP Recommendations

12. **FDA and DEA Updates – See Appendix J.**

13. **Future Business**
    A. PBPA Annual Reviews
    B. Neurontin™ Follow-Up Review
    C. Zofran® Follow-Up Review
    D. SMAC Update
    E. Supplemental Rebate Update
    F. New Product Reviews

14. **Adjournment**

APPENDIX A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES of MEETING of NOVEMBER 9, 2004

BOARD MEMBERS:	PRESENT	ABSENT
Rick G. Crenshaw, D.O.	X	
Dorothy Gourley, D.Ph.	X	
Cathy Hollen, D.Ph.		X
Dan McNeill, Ph.D., PA-C	X	
Cliff Meece, D.Ph.	X	
Dick Robinson, D.Ph., Vice-Chair		X
James M. Swaim, D.Ph.	X	
Thomas Whitsett, M.D., Chair	X	
(VACANT)		
(VACANT)		

COLLEGE of PHARMACY STAFF:	PRESENT	ABSENT
Leslie Browning, D.Ph./Clinical Pharmacist		X
Metha Chonlahan, D.Ph.	X	
Karen Egesdal, D.Ph./Clinical Pharmacist/OHCA Liaison	X	
Kelly Flannigan, Pharm.D../Clinical Pharmacist	X	
Shellie Gorman, Pharm.D./Clinical Pharmacist	X	
Ronald Graham, D.Ph., Manager, Operations/DUR	X	
Chris Kim Le, Pharm.D.; Clinical Pharmacist		X
Ann McIlvain, Pharm.D.; Clinical Pharmacist	X	
Carol Moore, Pharm.D.; Clinical Pharmacist		X
Neeraj Patel, Pharm.D.; Clinical Pharmacist		X
Lester A. Reinke, Ph.D.		X
Mark Livesay, Office Manager/Pharmacotherapy Management	X	
Visiting Pharmacy Student: Elon Jacobs	X	

OKLAHOMA HEALTH CARE AUTHORITY STAFF:	PRESENT	ABSENT
Alex Easton, M.B.A.; Pharmacy Operations Manager	X	
Mike Fogarty, C.E.O	X	
Lynn Mitchell, M.D., M.P.H, Medical Director	X	
Nancy Nesser, D.Ph., J.D.; Pharmacy Director	X	
Howard Pallotta, J.D., Legal		X
Lynn Rambo-Jones, J.D., Legal		X
Rodney Ramsey; Pharmacy Claims Specialist		X

OTHERS PRESENT:

Alan Barreuther, Purdue Pharma	JoAnne Hargraves, Schering-Plough	Michelle Mentz, Santarus, Inc.
Mark DeClerk, Lilly	Holly Jacques, Merck	Richard Ponder, Johnson & Johnson
Toby Thompson, Pfizer	Brad Sheppard, Organon	Meg Propes, Lilly
Deron Grother, Solvay	Traci Miller, Sepracor	Chris Gerck, Sepracor
Michael Ivey, Sepracor	Rhonda Clark, Purdue	Bryan Charlton, Sepracor
Jill Miller, TAP		

PRESENT FOR PUBLIC COMMENT:
none

Special Presentation:
Mr. Mike Fogarty, C.E.O., for the Oklahoma Health Care Authority presented Dr. Rick Crenshaw, D.O., of Fairfax, Oklahoma with a plaque in appreciation for his years of service on the Oklahoma Health Care Authority's Drug Utilization Review Board. Dr. Crenshaw resigned his position on the Board to extend his career to Phlebology and Proctology procedures after finishing a Preceptorship.

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

1A: Roll Call

Dr. Whitsett called the meeting to order. Roll call by Dr. Graham established the presence of a quorum.

ACTION: NONE REQUIRED.

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

2A: Acknowledgement of Speakers and Agenda Item

There were no speakers for public comment.

ACTION: NONE REQUIRED.

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

3A: October 12, 2004 DUR Minutes

Dr. McNeill moved to approve minutes as submitted; motion seconded by Dr. Swaim.

ACTION: MOTION CARRIED

AGENDA ITEM NO. 4: **UPDATE ON DUR/MCAU PROGRAM**

4A: Retrospective DUR Report: August 2004

Contraindicated nursing home males over 65 years were selected for retrospective review for August 2004. Pharmacy and physician response was 0% and 0% respectively. Materials included in agenda packet; presented by Dr. Flannigan.

4B: Medication Coverage Activity Report: October 2004

The October 2004 activity audit noted total number of petitions submitted was 17,534 including super-PA's and special circumstance PA's. Approval/denial/duplicate percentages were indicated on the reports included in the agenda packet for this meeting; presented by Dr. Flannigan.

4C: Help Desk Activity Report: October 2004

Total calls for October 2004 numbered 17,300 (86.3% pharmacies, 8.99% clients, 1.97% physicians, 2.7% other); presented by Dr. Flannigan.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 5: **30-DAY NOTICE TO VOTE ON RECOMMENDED PRIOR AUTHORIZATION CHANGES FOR ADHD MEDICATIONS**

Materials included in agenda packet; presented by Dr. McIlvain. Dr. McNeill asked the question "Can the computer program identifying prior Tier 1 use be applied to all of the PA categories?" Dr. Nesser stated that most of the PA categories did utilize this program of the computer going back in a patient's history to find previous use of Tier 1's and then not requiring a PA request for the patient to move up to a Tier 2 drug. Dr. McNeill suggested that this information be included in the Newsletter to Providers so that everyone will know how this program works.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 6: **ANNUAL REVIEW OF PBPA CATEGORY - NSAIDS**

Materials included in agenda packet; presented by Dr. Gorman. Dr. Whitsett asked if it was possible to look back at history to see if there were any cardiac events in these clients that have been taking Vioxx and the other Cox-II's? Dr. Gorman said that she would investigate the data to see if there are any comparative information that would indicate possible adverse events within the Medicaid population.

ACTION: NONE REQUIRED.

AGENDA ITEM No. 7: **30-DAY NOTICE OF INTENT TO PRIOR AUTHORIZE ZEGERID® (NEW PRODUCT)**

Materials included in agenda packet; presented by Dr. McIlvain. Dr. McNeill asked if the manufacturer of this product would be able to participate in the supplemental rebate program and Dr. Nesser stated they would be offered participation.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 8: **REVIEW & DISCUSS ZYVOX® UTILIZATION**

Materials included in agenda packet; presented by Dr.Gorman. Dr. Whitsett asked about the duration stats on the drug utilization review. The duration information is included in the packet.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 9: **REVIEW & DISCUSS BLADDER CONTROL PRODUCT UTILIZATION**

Materials included in agenda packet; presented by Dr. Moore. Dr. McNeill asked if this category could be tiered? Dr. McNeill requested this category come to the DUR Board with a cost analysis.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 10: **30-DAY NOTICE OF INTENT TO PRIOR AUTHORIZE XOPENEX®**

Materials included in agenda packet; presented by Dr. Flannigan. Dr. McNeill asked about the 90 days of therapy recommended in the criteria.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 11: **FDA & DEA UPDATES**

Materials included in agenda packet; presented by Dr. Graham. Dr. Whitsett asked how the SSRI utilization was in children since the FDA warning came out on Paxil? He requested that we bring current utilization results back to the DUR Board.

ACTION: NONE REQUIRED.

AGENDA ITEM No. 12: **FUTURE BUSINESS**

11A: PBPA Annual Reviews
11B: Neurontin™ Follow-Up Review
11C: MS Copolymers Review
11D: SMAC Update
11E: Supplemental Rebate Update
11F: New Product Reviews

Materials included in agenda packet; submitted by Dr. Graham.

ACTION: NONE REQUIRED.

AGENDA ITEM No. 13: **ADJOURNMENT**

The meeting was declared adjourned.

Oklahoma Health Care Authority
Drug Utilization Review Board
Meeting Dates
For 2005

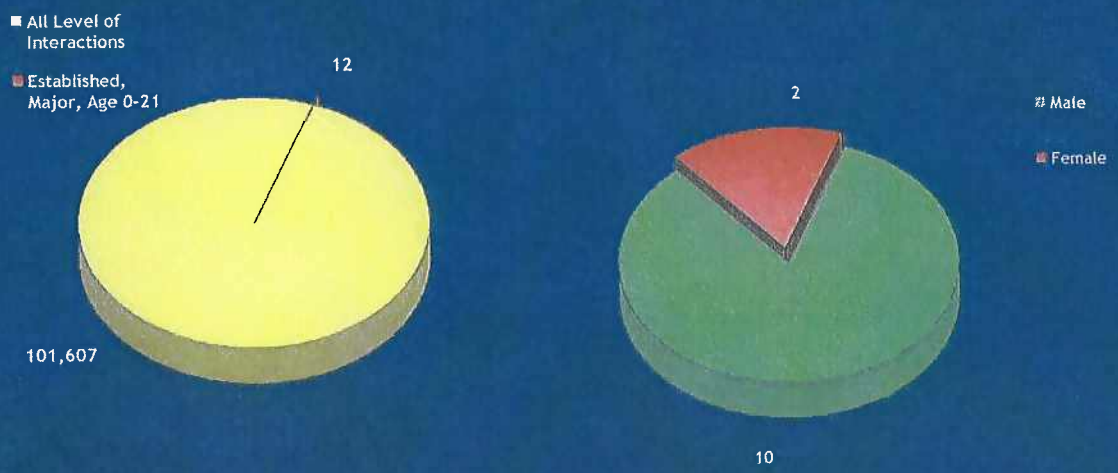
January 11
February 8
March 8
April 12
May 10
June 14
July 12
August 9
September 13
October 11
November 8
December 13

APPENDIX B

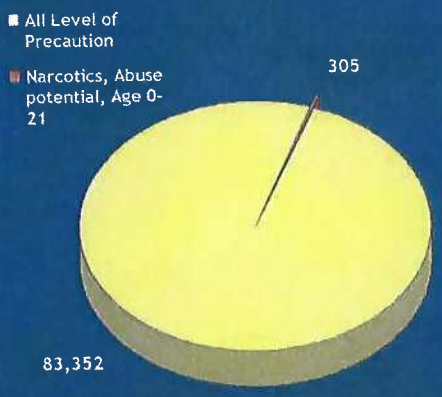
Response Follow-up for August 2004

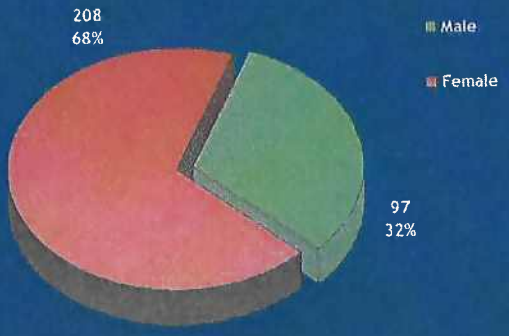
August Responses			
Pharmacy	=	8/30	37%
Physician	=	16/30	53%

Oklahoma Medicaid RetroDUR Activity Report September 2004 Drug Interaction Module - Established, Major, Age 0-21 years

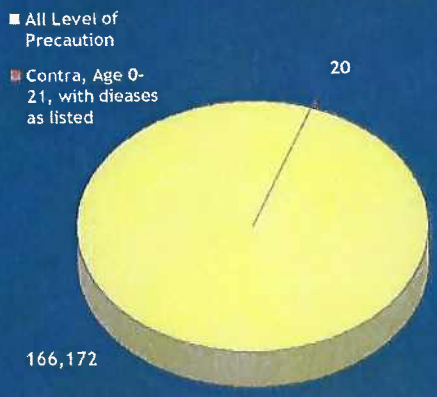


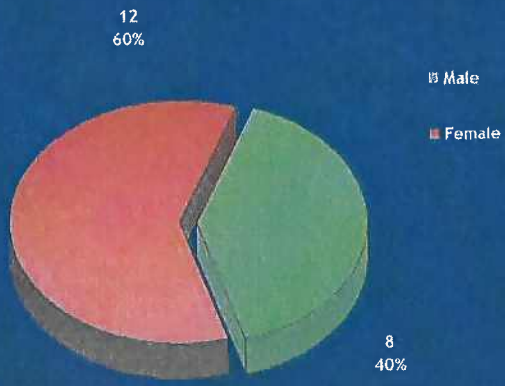
Oklahoma Medicaid RetroDUR Activity Report September 2004 Duplication Module - Narcotics, Abuse potential only, Age 0-21 years





Oklahoma Medicaid RetroDUR Activity Report September 2004 Drug-Disease Level - Contraindicated, Age 0-21 years, with Renal Disease, Asthma, Epilepsy, Migraine, or Muscular Dystrophy

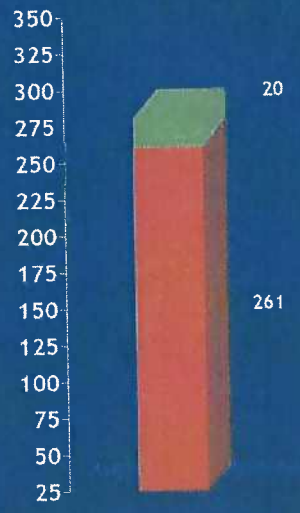




Oklahoma Medicaid RetroDUR Activity Report Follow-Up

September 2004 Pediatric Clients Age 0-21 years - All modules

Total Clients Reviewed = 281



Follow-Up
No Action Needed

Total Responses			
Pharmacy	=	9/15	60%
Physician	=	9/28	32%

PHARMACY management consultants

Activity Audit for

November 01, 2004 Through November 30, 2004

Date	Antiulcers app.	Antiulcers den.	Anxiolytic/ Hypnotics app.	Anxiolytic/ Hypnotics den.	Antihistamine app.	Antihistamine den.	Growth Hormone app.	Growth Hormone den.	Stimulant app.	Stimulant den.	Smoking Cess. app.	Smoking Cess. den.	Nsaids app.	Nsaids den.	ACE Inhibitors app.	ACE Inhibitors den.	HTN Combos app.	HTN Combos den.	Calcium Channel Blockers app.	Calcium Channel Blockers den.	Plavix app.	Plavix den.	ARB app.	ARB den.	Anti-depressants app.	Anti-depressants den.	Daily Total
1	11	12	189	24	34	29	0	0	53	19	0	0	3	21	0	1	0	0	0	10	24	5	0	1	17	29	482
2	17	13	214	37	29	26	0	0	86	40	0	0	14	33	2	5	0	0	6	14	35	14	1	0	29	30	645
3	13	12	200	32	33	28	2	0	63	34	0	0	18	31	1	7	0	0	7	14	18	12	0	0	25	20	570
4	3	22	201	36	40	26	1	0	57	27	0	0	11	22	3	6	0	0	5	16	24	17	0	0	28	23	568
5	10	24	216	38	48	35	11	0	105	24	1	0	7	29	1	10	0	1	1	14	21	21	0	0	20	35	672
6	1	2	37	12	7	7	0	0	11	2	0	0	5	2	1	1	0	0	0	4	3	3	0	0	3	5	106
7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
8	7	15	131	36	28	19	0	0	50	17	0	0	7	25	3	4	0	0	8	12	26	16	0	0	23	24	451
9	5	17	205	30	47	24	2	0	132	46	0	0	12	20	2	7	0	0	2	19	29	12	0	0	31	25	667
10	8	17	151	39	49	26	0	0	60	26	0	0	12	32	3	4	0	0	5	18	38	24	0	0	26	34	572
11	11	7	194	25	46	23	3	0	92	32	0	0	13	17	2	5	0	1	6	9	17	4	0	1	30	31	569
12	10	14	165	18	44	39	1	0	77	29	0	0	6	31	2	4	0	0	5	14	25	13	0	0	23	27	547
13	1	2	13	3	2	3	0	0	5	0	0	0	0	1	0	1	0	0	0	2	0	0	0	0	1	6	40
14	0	3	24	8	9	6	0	0	7	4	0	0	0	1	0	2	0	0	2	1	5	0	1	0	4	9	86
15	5	8	85	19	27	4	0	0	67	15	0	0	8	8	2	2	1	0	3	2	13	8	0	0	10	22	309
16	15	26	225	28	48	42	7	0	97	37	1	0	10	36	3	6	0	1	4	14	22	16	0	0	36	35	709
17	5	7	88	14	32	8	0	0	37	10	0	0	4	10	0	2	0	0	2	6	13	7	0	0	7	14	266
18	10	19	165	41	42	35	7	0	140	37	0	0	6	20	3	8	1	0	4	19	15	14	0	0	27	29	642
19	10	16	173	31	40	32	1	1	125	32	1	0	8	24	7	11	0	2	4	20	29	13	0	0	32	40	652
20	1	9	60	21	13	11	14	0	38	21	0	0	2	16	0	4	0	0	0	4	6	15	0	0	10	16	261
21	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
22	10	6	160	22	29	12	0	0	68	24	0	0	7	19	0	3	2	0	3	12	30	9	0	0	13	14	443
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29	10	22	169	30	38	25	0	0	84	21	0	0	8	14	1	5	0	0	3	6	28	11	0	0	20	19	514
30	11	15	170	50	58	42	2	0	103	31	0	0	8	25	5	10	0	0	4	11	28	13	0	0	19	29	634

Activity Audit for

November 01, 2004 Through November 30, 2004

Date	Antiulcers app.	Antiulcers den.	Anxiolytic/ Hypnotics app.	Anxiolytic/ Hypnotics den.	Antihistamine app.	Antihistamine den.	Growth Hormone app.	Growth Hormone den.	Stimulant app.	Stimulant den.	Smoking Cess. app.	Smoking Cess. den.	Nsaids app.	Nsaids den.	ACE Inhibitors app.	ACE Inhibitors den.	HTN Combos app.	HTN Combos den.	Calcium Channel Blockers app.	Calcium Channel Blockers den.	Plavix app.	Plavix den.	ARB app.	ARB den.	Anti-depressants app.	Anti-depressants den.	Daily Total
App.	194		3635		845		57		1825		3		198		47		4		85		519		2		509		
Den.		330		645		596		2		629		0		495		130		7		272		280		2		579	
Average Length of Approvals in Days		89		93		98		148		278		61		334		232		274		311		267		186		211	

Smoking Cessation	0 PA's for Zyban	3 Total PA's Approved
	3 PA's for Nicotine Patch	3 Unique RID's

Changes to existing PA's	1,338
Total (Previous Year)	7,201

* Denial Codes	
762 = Lack of clinical information	33.79%
763 = Medication not eligible	2.47%
764 = Existing PA	22.63%
772 = Not qualified for requested Tier	15.45%

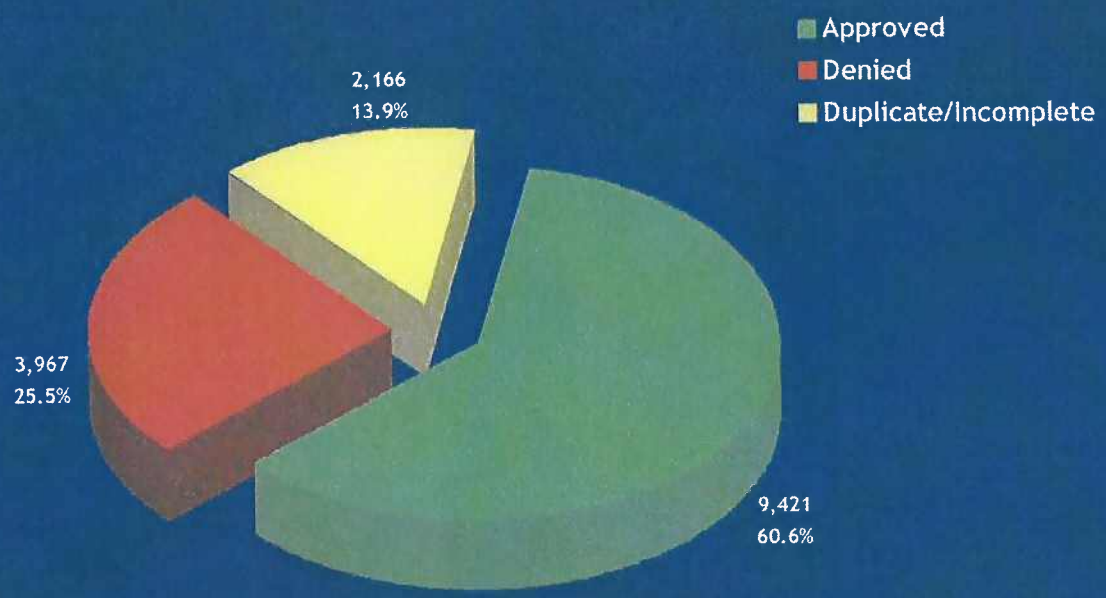
SUPER PA's	
Early Refill Attempts	84,090
Dosing Change	621
lost/stolen/broke	171
Other	104
wrong DS	84
Quantity vs. Days Supply	424

Monthly Totals

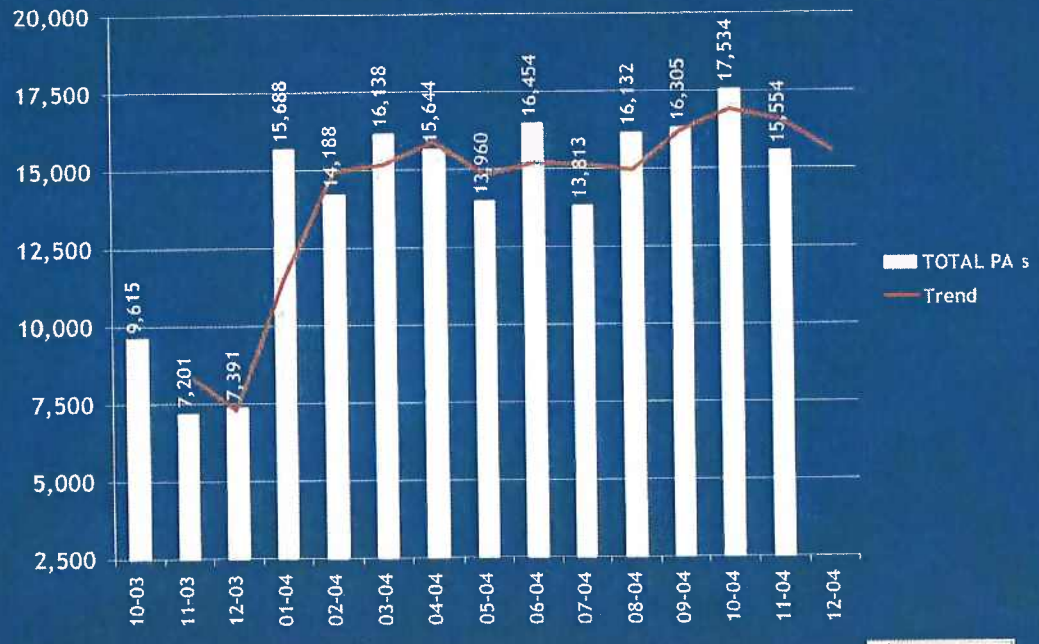
	Number	Percent of Total
Approved	7,923	50.94%
Additional PA's	16	0.10%
SUPER PA's	1,473	9.47%
Emergency PA's	9	0.06%
Duplicates	1,023	6.58%
Incompletes	1,143	7.35%
Denied*	3,967	25.50%
Total	**15,554**	**100.00%**
Daily Average of 622.16 for 25 Days		

Changes to existing PA's: Backdates, changing units, end dates, etc.
Additional PA's: Done by the help desk (doctor letter responses, PA ran for the wrong person)
Incompletes: Missing necessary information (NDC, SIG, Diagnosis, etc.)

PRIOR AUTHORIZATION ACTIVITY REPORT
November 2004

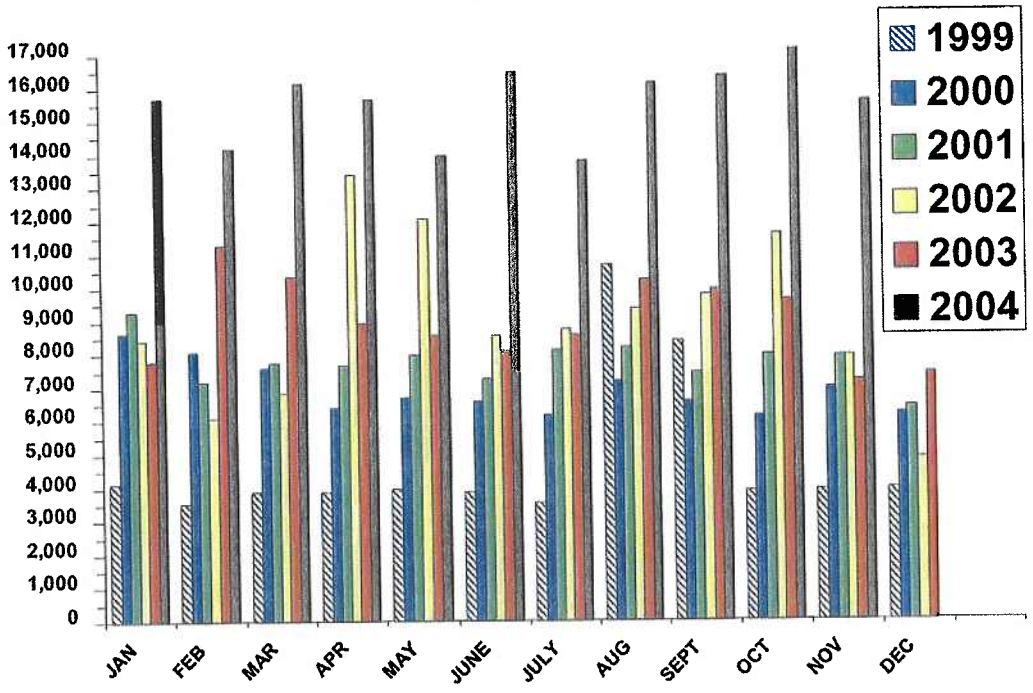


PRIOR AUTHORIZATION REPORT
November 2003 - November 2004



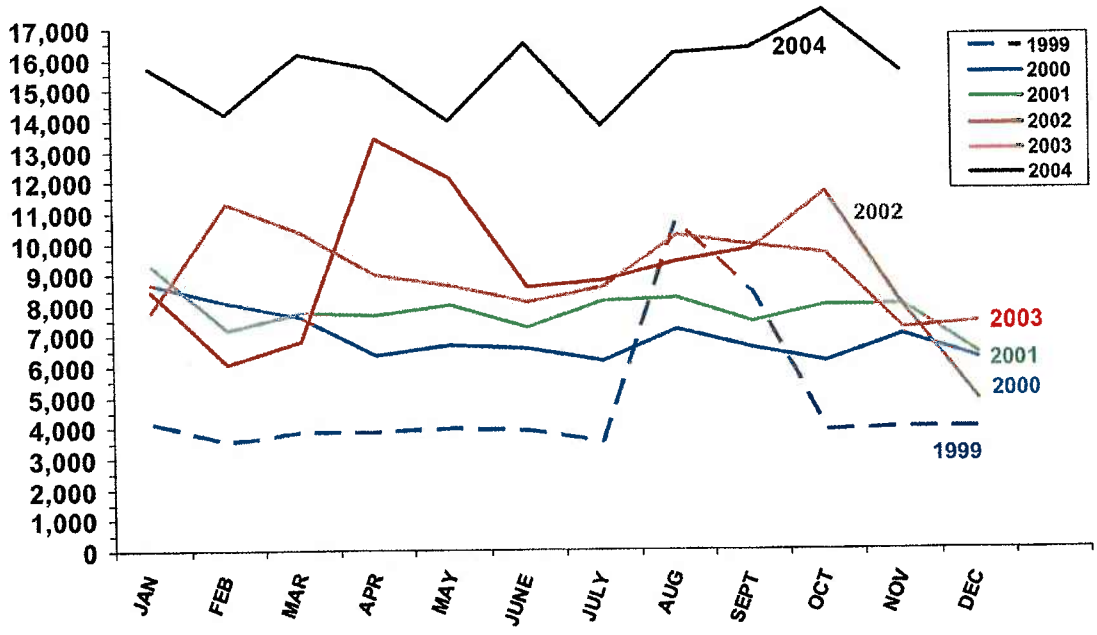
Monthly PA Activity

Calendar Years 2000-2004



Monthly PA Activity

Calendar Years 2000-2004



PRIOR AUTHORIZATION ACTIVITY AUDIT

Monthly Totals

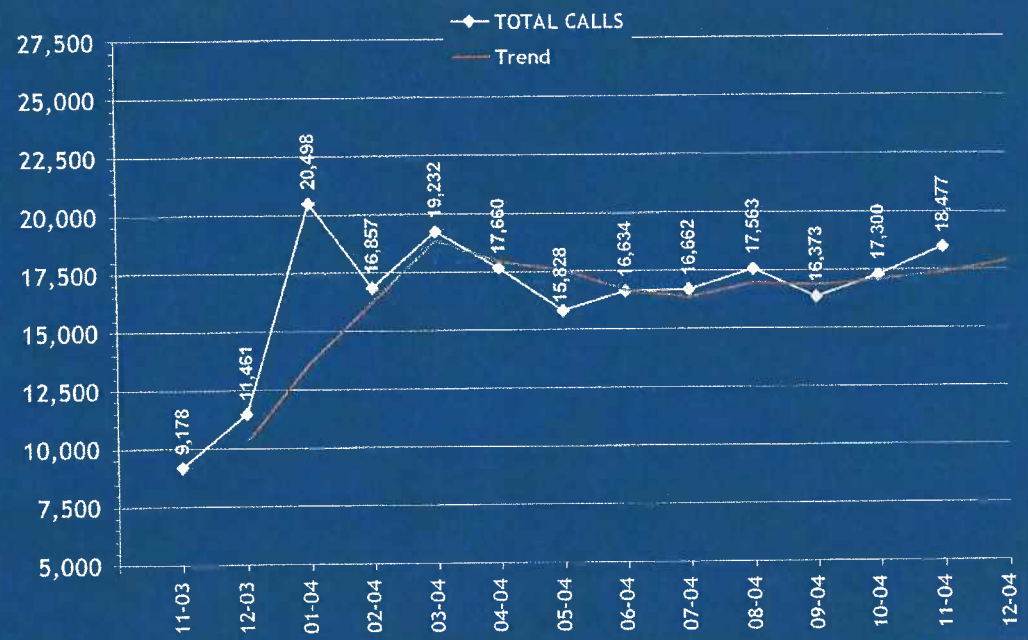
MONTH	1999 Total *(approved/ duplicates/ denied)*	2000 Total *(approved/ duplicates/ denied)*	2001 Total *(approved/ duplicates/ denied)*	2002 Total *(approved/ duplicates/ denied)*	2003 Total *(approved/ duplicates/ denied)*	2004 Total *(approved/ duplicates/ denied)*
January	4,124	8,669	9,296	8,427	7,797	15,688
February	3,542	8,077	7,194	6,095	11,272	14,188
March	3,856	7,588	7,748	6,833	10,358	16,138
April	3,867	6,390	7,676	13,381	8,953	15,644
May	3,959	6,711	7,980	12,082	8,589	13,960
June	3,884	6,565	7,249	8,550	8,084	16,454
July	3,523	6,181	8,133	8,775	8,565	13,813
August	10,676	7,183	8,195	9,353	10,213	16,132
September	8,387	6,585	7,438	9,793	9,918	16,305
October	3,863	6,140	7,956	11,584	9,615	17,534
November	3,919	6,961	7,949	7,921	7,201	15,554
December	3,953	6,206	6,385	4,867	7,391	
Calendar Year Total	**57,553**	**83,256**	**93,199**	**107,661**	**107,956**	**171,410**

CALL VOLUME -NOVEMBER 2004

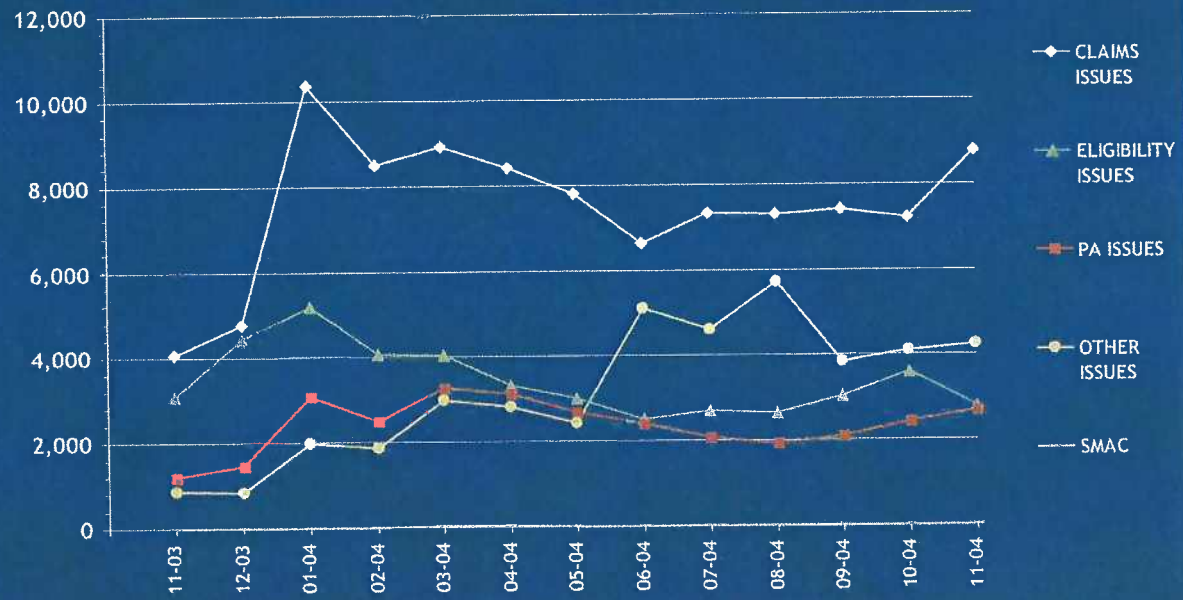
NOVEMBER 2004	CALLER					ISSUE					TYPE OF CALL					RESOLUTION							
																	Resolved						
	Call Volume	Physician	Pharmacies	Clients	Other	Eligibility	Claims	PA Issue	SMAC	Other	Regular	Callback	Proactive	ProDUR	Other	Helpdesk Resolved	Transferred Pharmacist	Transferred Supervisor	OHCA	Reversals/ Adjustments	EDS	Customer Service	Provider Contracts
1	976	13	874	79	10	261	362	105	0	248	958	0	0	13	5	964	6	0	1	2	1	2	0
2	801	19	702	56	24	107	390	108	0	196	767	11	1	16	6	783	1	1	1	0	0	5	10
3	795	19	682	74	20	95	370	138	0	192	771	5	0	9	10	773	6	0	0	1	0	5	10
4	841	19	732	65	25	74	453	117	0	197	818	6	0	6	11	822	5	0	0	0	0	10	4
5	748	21	619	87	21	177	264	136	0	171	725	3	1	10	9	726	4	2	1	0	0	6	9
6	154	0	147	4	3	39	56	21	0	38	145	1	0	6	2	153	0	1	0	0	0	0	0
7	71	0	69	1	1	25	24	4	0	18	67	1	0	3	0	70	0	0	0	0	0	1	0
8	826	27	710	71	18	125	378	144	0	179	797	5	3	13	8	796	5	2		1	1	11	10
9	807	24	621	62	100	97	266	140	0	304	677	16	87	19	8	780	7	1	2	0	0	8	9
10	854	20	757	59	18	94	415	105	0	240	840	11	0	2	1	837	1	0	0	1	0	8	7
11	686	7	651	21	7	76	406	69	0	135	673	2	0	9	2	670	1	0	1	0	0	10	4
12	828	14	698	89	27	103	373	138	0	214	786	7	1	21	13	801	2	1	1	2	0	14	7
13	231	0	224	6	1	31	140	9	0	51	229	0	1	1	0	230	0	0	0	0	0	1	0
14	81	0	78	2	1	11	38	7	0	25	81	0	0	0	0	80	0	0	0	0	0	1	0
15	881	20	771	84	6	66	509	99	0	207	827	13	10	28	3	854	3	1	1	1	0	13	8
16	811	15	681	98	17	134	319	131	0	225	786	5	1	14	5	777	4	2	2	1	0	16	9
17	887	18	802	56	11	169	466	106	0	146	858	7	0	17	5	860	4	1	0	2	0	13	7
18	882	9	773	75	25	184	337	162	0	198	839	14	0	22	7	843	6	3	0	3	0	16	11
19	897	21	753	105	18	240	321	180	0	156	862	9	1	20	5	869	6	2	0	0	1	15	4
20	190	0	179	10	1	23	105	24	0	41	183	1	0	4	2	188	1	1	0	0	0	0	0
21	76	0	72	4	0	13	42	8	0	13	76	0	0	0	0	74	0	0	0	0	0	2	0
22	1027	23	903	75	26	97	600	128	0	204	1000	4	0	21	2	982	4	5	0	1	3	24	8
23	991	29	859	83	20	92	538	144	0	215	968	11	1	7	4	956	8	3	0	0	2	13	9
24	920	20	818	66	16	94	527	123	0	176	900	5	0	12	2	903	0	2	1	0	1	10	2
25	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
26	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
27	222	1	214	6	1	37	133	15	0	37	221	0	0	0	1	220	1	1	0	0	0	0	0
28	47	0	46	1	0	9	32	0	0	6	46	0	0	1	0	47	0	0	0	0	0	0	0
29	1013	22	855	115	21	111	539	166	0	197	967	10	0	23	4	988	7	3	0	0	0	9	6
30	934	28	789	101	16	205	367	156	0	206	912	10	1	10	1	897	10	0	3	0	0	13	11
Total	18,477	389	16,079	1,555	454	2,789	8,770	2,683	0	4,235	17,779	157	108	307	116	17,943	92	32	14	15	9	226	145
Percentage	100.00%	2.11%	87.02%	8.42%	2.46%	15.09%	47.46%	14.52%	0.00%	22.92%	96.22%	0.85%	0.58%	1.66%	0.63%	97.11%	0.50%	0.17%	0.08%	0.08%	0.05%	1.22%	0.78%

22nd: Started to receive calls on Brand Name Edit

CALL VOLUME MONTHLY REPORT
November 2003 - November 2004

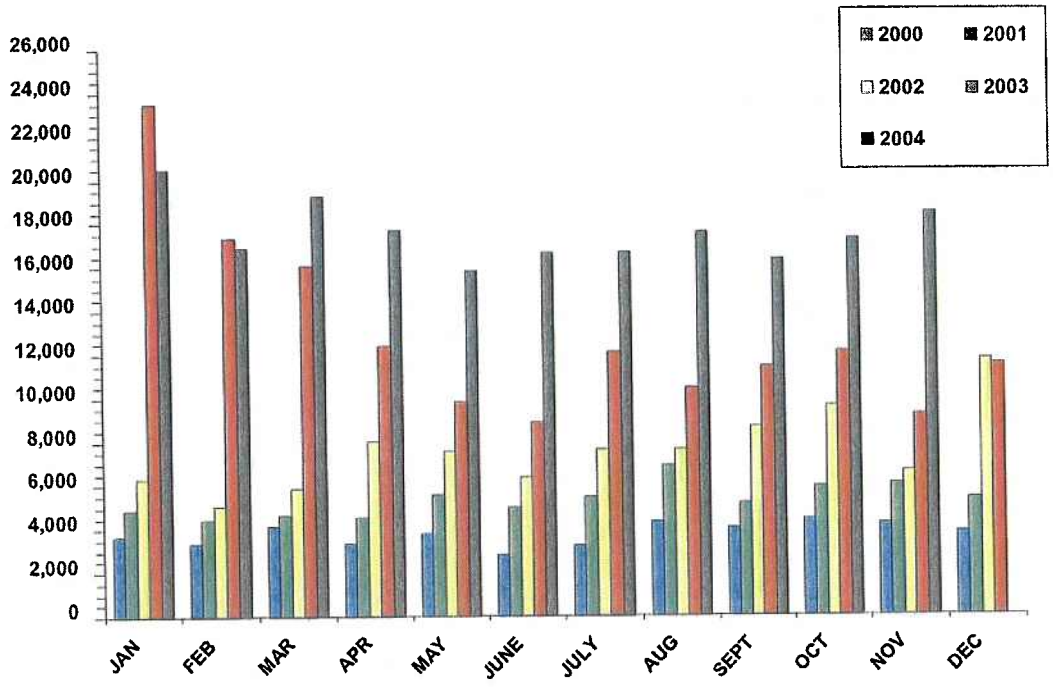


CALL VOLUME ISSUES
November 2003 - November 2004



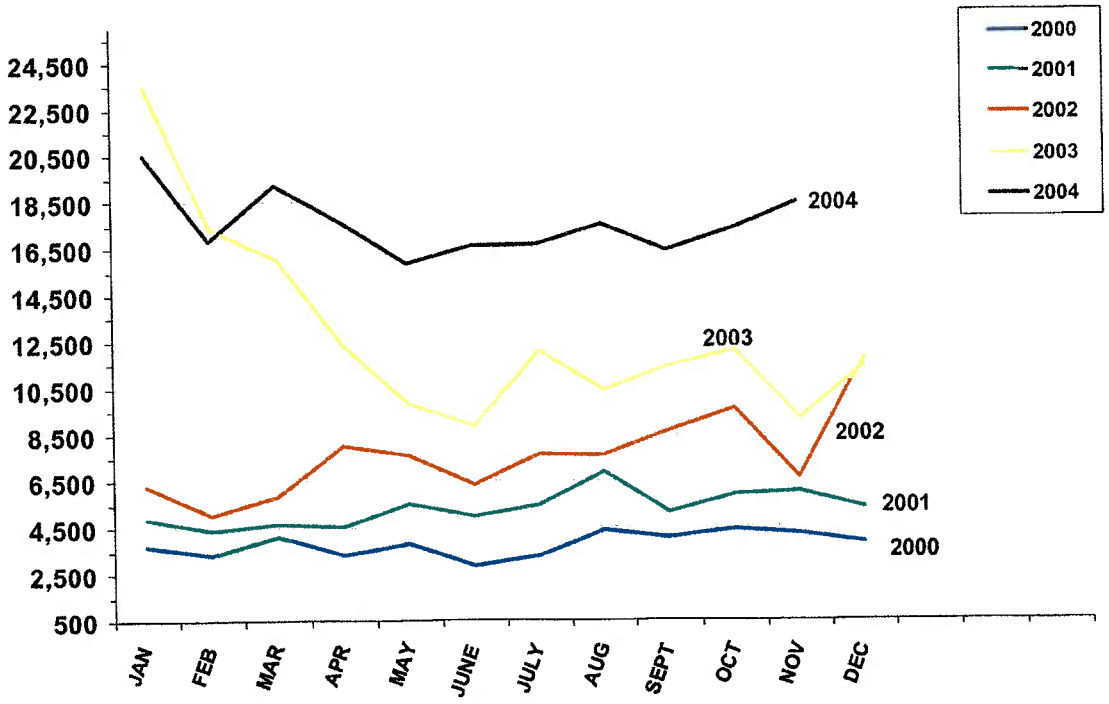
Monthly Call Volume

Calendar Years 2000-2004



Monthly Call Volume

Calendar Years 2000-2004



CALL VOLUME

Monthly Totals

MONTH	1999 Total	2000 Total	2001 Total	2002 Total	2003 Total	2004 Total
January	* 0	3,697	4,905	6,295	23,499	20,498
February	* 0	3,335	4,393	5,049	17,354	16,857
March	* 0	4,157	4,668	5,858	16,081	19,232
April	* 0	3,337	4,556	8,047	12,378	17,660
May	* 0	3,804	5,540	7,586	9,836	15,828
June	* 0	2,820	4,982	6,368	8,917	16,634
July	* 0	3,242	5,465	7,651	12,126	16,662
August	3,883	4,333	6,881	7,629	10,454	17,563
September	2,360	4,015	5,145	8,664	11,449	16,373
October	1,963	4,398	5,912	9,608	12,102	17,300
November	1,721	4,216	6,011	6,627	9,178	18,477
December	2,475	3,804	5,314	11,710	11,461	
Calendar Year Total	**12,402**	**45,158**	**63,772**	**91,092**	**154,835**	**193,084**

* Help Desk Call Center implemented in August 1999.

APPENDIX C

ADHD/Narcolepsy Drugs – Change to Step Therapy
Oklahoma Medicaid
December 2004

Product Based Prior Authorization

With respect to the ADHD/narcolepsy medications, there are two tiers of medications in the therapeutic category. A failed trial with a tier-1 ADHD medication or a clinical exception to a tier-1 trial is required before a tier-2 ADHD medication can be approved.

Medication	Age Groups	PA Requirements
Ritalin, Ritalin SR, Dexedrine, Dexedrine Spansule, Adderall	Children up to 21 years old	No PA required
	Adults	PA required – Diagnosis of ADHD or narcolepsy.
Ritalin LA, Concerta, Metadate CD, Focalin, Adderall XR, Strattera	Children and Adults	PA Required – Requires failed trial with Ritalin, Dexedrine or Adderall. Diagnosis of ADHD or narcolepsy.
Desoxyn and Cylert	Children and Adults	PA Required – Requires failed trial with Ritalin and Dexedrine. Diagnosis of ADHD or narcolepsy.

Current process:

Tier 1 drugs are set in the computer system to pay without PA for clients up to 21 years of age; PA is required for adult clients. Tier 2 drugs are set to require a PA for all ages. Providers must submit a new PA petition every time the drug dosing strength changes.

Suggested change in the process:

- Tier 1 stimulants would be in the step therapy edit as Tier 1 and on the drug file as PA for over 21 years old.
- Tier 2 stimulants would be in the step therapy edit as Tier 2 and on the drug file as PA for over 21 years old.

- Strattera would continue to have a PA on the drug file for all ages. This would provide a means to monitor concurrent use of stimulants and Strattera.
- Quantity limits of one unit per day would be placed on the Tier 2 drugs. Any quantity greater than this would require a PA.

How this would affect clients:

- Adults: The process would stay the same as it currently is for adult clients - all drugs in this category would require a PA, including all dosing strength changes.

- Children up to 21 years old: Everything would stay the same except the following: when the pharmacy tries to run a claim for a tier-2 drug in this category, the computer would look into the client's Medicaid claims history. If the computer finds any drug in this category in the claims history, the computer would allow the tier-2 ADHD/narcolepsy drug claim to pay without requiring a PA, as long as the claim does not exceed the quantity limit. If the claim does exceed the quantity limit, PA would be required.

Advantage:

Once a tier-2 drug in this category has been approved for a patient, providers would be able to change the dosage and strength of the drug without having to submit a new PA petition. This would reduce the number of PA petitions that providers have to submit and that the COP's PA unit has to process.

Disadvantage:

The computer system would allow clients to get more than one tier-2 drug at a time. It would allow clients to get several strengths of the same drug or several different drugs in this category, and clients could use this duplication to exceed the 1.5 times the FDA approved maximum dose limit currently in place. OHCA will make every effort to program the system so that it won't allow such duplication.

APPENDIX D

Omeprazole Powder for Oral Suspension (Zegerid™)

Oklahoma Medicaid
December 2004

Manufacturer's Main Selling Point (from Zegerid.com):
"Until now, all oral PPIs were delayed release. PPIs are acid labile and rapidly degrade in the presence of gastric acid. To protect the drug from degradation in the stomach, delayed-release PPIs are formulated as enteric-coated granules or as enteric-coated tablets. Enteric coating delays release, which delays absorption and bioavailability. Initial acid suppression effect occurs in 2 to 6 hours.
Zegerid is the first immediate-release oral PPI. A novel formulation protects Zegerid from acid degradation and allows immediate release of omeprazole. Immediate release results in peak plasma levels of Zegerid in ~30 minutes. Immediate-release Zegerid provides 24-hour acid control."

Indications:
- *Duodenal Ulcer*: short-term treatment of active duodenal ulcer.
- *Gastroesophageal Reflux Disease (GERD)*: heartburn and other symptoms
- associated with GERD.
- *Erosive Esophagitis*: short-term treatment (4-8 weeks) of erosive esophagitis which has been diagnosed by endoscopy.
- *Maintenance of Healing of Erosive Esophagitis*: maintain healing of erosive esophagitis.

Dosing:
One 20 mg single-dose packet once-daily, on an empty stomach one hour prior to a meal. Directions for use: Empty packet contents into a small cup containing 2 tablespoons of water. Do not use other liquids or foods. Stir well and drink immediately. Refill cup with water and drink.

Precautions & Adverse Effects:
The most frequently reported adverse events with Zegerid are headache, diarrhea and abdominal pain. Symptomatic response to therapy does not preclude the presence of gastric malignancy. Atrophic gastritis has been noted occasionally in gastric corpus biopsies from patients treated long term with omeprazole.
Zegerid contains 460mg sodium per dose in the form of sodium bicarbonate (1680mg/20mEq), which should be taken into consideration for patients on a sodium-restricted diet. Sodium bicarbonate is contraindicated in patients with metabolic alkalosis and hypocalcemia. Sodium
bicarbonate should be used with caution in patients with Bartter's syndrome, hypokalemia, and respiratory alkalosis. Long-term administration of bicarbonate with calcium or milk can cause milk-alkali syndrome.

Cost:
Average Wholesale Price (AWP): $4.86 per packet.
AWP of Prilosec OTC 20 mg tablet: $0.68 per tablet.

Cost comparison:

	Estimated Acquisition Cost (EAC)	State Maximum Allowable Cost (SMAC)	Daily Dose	Monthly Dose* (30 day supply)
Zegerid® 20 mg Suspension	$4.28 per packet	$0.00	20 mg	$128.40
Omeprazole 20 mg	$3.65 per capsule	$1.86	20 mg	$ 55.80
Prevacid® Suspension	$4.37 per packet	$0.00	30 mg	$131.10
Prevacid® Solutab	$3.03 per tablet	$0.00	30 mg	$ 90.90

*SMAC pricing used where appropriate. No rebate information was incorporated.

Related products under development by the manufacturer:
Zegerid™ Powder for Oral Suspension 40mg (expected to be through FDA review by the end of 2004)
Zegerid™ Chewable Tablets
Zegerid™ Capsules

Current tiers

Anti-Ulcer Medications	
Tier 1	**Tier 2**
Prilosec OTC & generic rx omeprazole	ranitidine (Zantac) - all forms except tablets
esomeprazole magnesium (Nexium)	brand rx omeprazole (Prilosec)
lansoprazole (Prevacid) capsules	rabeprazole sodium (Aciphex)
pantoprazole sodium (Protonix)	lansoprazole (Prevacid) – tablets & granules

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Recommendation

Place all Zegerid products on tier-2 status. Criteria for approval would be the same as the criteria for approval of Aciphex: a documented 14 day trial of a tier 1 anti-ulcer medication within the last 60 days.

APPENDIX E

Action Item
Proposed Prior Authorization Criteria
Estimated Economic Impact
Xopenex® (levalbuterol)
Oklahoma Medicaid
December 2004

Proposed Prior Authorization Criteria

Xopenex® (levalbuterol) use in excess of 90 days of therapy in a floating 360 day period will require prior authorization. The current quantity limit of 288units/30 days supply would still apply.

1. In the prior authorization request, the prescriber should explain why the client is unable to use long acting bronchodilators and/or inhaled corticosteroid (ICS) therapy for long-term control per NAEPP guidelines.
2. Clinical exceptions will be made for clients with COPD.

Estimated Economic Impact

Utilization for July 2003 through June 2004

	Clients	*Cost*	*Claims*	*Days/ Client**	*Cost/ Client/ Day*	*Cost/ Claim*	*Cost/ Day*	*Cost/ Client*	*Claims/ Client*
</= 3 Claims	4,144	$ 706,979.08	5,841	22.45	7.60	$121.04	$ 7.66	$ 170.60	1.41
> 3 Claims	565	$ 531,058.07	4,510	125.14	7.51	$117.75	$ 9.40	$ 939.93	7.98
COPD </= 3 Claims	196	$ 46,343.36	289	31.66	7.47	$160.36	$ 8.35	$ 236.45	1.47
COPD> 3 Claims	98	$ 123,869.42	900	169.25	7.47	$137.63	$ 9.29	$ 1,263.97	9.18
Total	**5,003**	**$1,408,249.93**	**11,540**	**37.29**	**7.55**	**$122.03**	**$ 8.40**	**$ 281.48**	**2.31**

*Days/Client = (Units÷ 9.6ml/daily) ÷ Clients
**Cost/Client/Day = Cost/Client ÷ Days/Client

Projected Program Savings/Cost Calculations

	Clients[1]	*Current Reimbursement*	*PA Cost*[2]	*Clients Approved*[3]	*90 Day No PA*[4]	*Post 90 Day*[5]	*Projected Savings*[6]
No PA	4,144	$ 706,979.08	$ 0.00	4,144	$ 706,979.08	$ 0.00	$ 0.00
Need PA	565	$ 531,058.07	$(7,163.31)	188	$ 381,934.81	$49,620.13	$92,339.82
COPD No PA	196	$ 46,343.36	$ 0.00	196	$ 46,343.36	$ 0.00	$ 0.00
COPD PA	98	$ 123,869.42	$(1,271.06)	98	$ 65,868.69	$58,001.04	$(1,271.37)
Totals	**5,003**	**$1,408,249.93**	**$(8,434.37)**	**4,626**	**$ 1,201,125.94**	**$107,621.17**	**$91,068.45**

[1]Clients divided by those with less than or equal to 3 claims for the year for COPD and no COPD.
[2]The average cost for processing petitions is calculated at $6.75 per petition with the maximum cost at $12.97 per petition. The maximum cost was used in the estimation of administrative costs.
[3]Approved clients based on those requiring less than 90 days of therapy and an approximate approval rate of 1/3 for clients with a duration of therapy greater than 90 days.
[4]Cost for clients with less than 90 days of therapy.
[5]Cost for clients with greater than 90 days of therapy.
[6]Projected Savings = Current Reimbursement – Pre and Post 90 Day Cost + PA Cost.

APPENDIX F

Bladder Control Drugs
Product Information
December 14, 2004

Introduction [1, 2]

Overactive bladder (OAB)

Overactive bladder is a medical condition that affects the detrusor muscle, which is the muscle that contracts to empty the bladder. Normally, a signal is sent to the brain when the bladder is full, and the detrusor muscle then receives the signal to contract and empty the bladder. For patients with overactive bladder, the muscle contracts while the bladder is filling with urine (instead of waiting for the bladder to be full), thus creating the urge to urinate more frequently and before the bladder is completely full.

Symptoms of OAB

- **urinary frequency**--urination 8 or more times a day or 2 or more times at night
- **urinary urgency**--the sudden, strong need to urinate immediately
- **urge incontinence**--leakage or gushing of urine that follows a sudden, strong urge

Urinary incontinence

Types of Urinary Incontinence

- Stress - Leakage of small amounts of urine during physical movement (coughing, sneezing, exercising)
- Urge - Leakage of large amounts of urine at unexpected times, including during sleep
- Functional - Untimely urination because of physical disability, external obstacles, or problems in thinking or communicating that prevent a person from reaching a toilet
- Overflow - Unexpected leakage of small amounts of urine because of a full bladder.
- Mixed - Usually the occurrence of stress and urge incontinence together
- Transient - Leakage that occurs temporarily because of a condition that will pass (infection, medication)

Prevalence (2001)

- In community dwelling adults, urinary incontinence affects an estimated 35 percent of women 65 years or older and 10 percent of women younger than 65 years;
- An estimated 22 percent of men 65 years or older and 1.5 percent of men younger than 65 years
- 30 to 50 percent of institutionalized adults 65 years or older have urinary incontinence.

Costs (1995):

$16.3 billion annually in direct expenditures for routine care, evaluations, and treatments in persons aged 15 years and older

Available FDA Approved Treatment[3]

Drug	How Supplied	Indications
Flavoxate (Urispas®)	100 mg Tablet	Symptomatic relief of dysuria, nocturia, suprapubic pain, urgency, and incontinence due to detrusor instability and hyper-reflexia in elderly with cystitis, urethritis, urethrocystitis, urethrotrigonitis, and prostatitis
Hyoscyamine (Anaspaz®, Cystospaz®, Cystospaz-M®)	0.15 mg Tablet (Cystospaz®), 0.375 mg Capsule, timed release (Cystospaz-M®)	Adjunctive therapy for neurogenic bladder/bowel*

Drug	How Supplied	Indications
Oxybutynin (Ditropan, Ditropan XL, Oxytrol)	5 mg Tablet (Ditropan®), 5 mg/5 mL syrup (Ditropan®) 5 mg, 10 mg, 15 mg Tablet, extended release (Ditropan® XL): Transdermal system (Oxytrol™): 3.9 mg/ [39 cm^2; total oxybutynin 36 mg]	Antispasmodic for neurogenic bladder (urgency, frequency, urge incontinence) and uninhibited bladder
Tolterodine (Detrol, Detrol LA)	1 mg, 2 mg Tablet (Detrol®) 2 mg, 4 mg Caps, extended release (Detrol® LA)	Treatment of patients with an overactive bladder with symptoms of urinary frequency, urgency, or urge incontinence
Trospium (Sanctura™) (App'd 5/04)	20 mg Tablet - EAC $1.31	Treatment of overactive bladder with symptoms of urgency, incontinence, and urinary frequency
Solifenacin succinate (Vesicare®) App'd 11/04	5 mg, 10 mg tablet	Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency, and urinary frequency

*Also used as adjunctive therapy for peptic ulcers, irritable bowel; treatment of infant colic, GI tract disorders caused by spasm; to reduce rigidity, tremors, sialorrhea, and hyperhidrosis associated with parkinsonism; as a drying agent in acute rhinitis

Warnings/Side Effects[3]

Drug	Contraindication	Caution	Side Effect
Flavoxate	Hypersensitivity to flavoxate; pyloric or duodenal obstruction; GI hemorrhage; GI obstruction; ileus; achalasia; obstructive uropathies of lower urinary tract (BPH)	May cause drowsiness, vertigo, and ocular disturbances; administer cautiously in patients with suspected glaucoma	Tachycardia, palpitations, drowsiness, confusion (especially in the elderly), nervousness, fatigue, vertigo, headache, hyperpyrexia, rash, urticaria, constipation, nausea, vomiting, xerostomia, dry throat, dysuria, leucopenia, increased intraocular pressure, blurred vision
Hyoscyamine	Hypersensitivity to belladonna alkaloids or any component of the formulation; glaucoma; obstructive uropathy; myasthenia gravis; obstructive GI tract disease, paralytic ileus, intestinal atony of elderly or debilitated patients, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis;	Use with caution in children with spastic paralysis. Use with caution in patients with autonomic neuropathy, coronary heart disease, CHF, cardiac arrhythmias, prostatic hyperplasia, hyperthyroidism, hypertension, chronic lung disease, renal disease, and hiatal hernia associated with reflux esophagitis. Use with caution in the elderly, may precipitate undiagnosed glaucoma and/or severely impair memory function (especially in those patients with previous memory problems). May increase the risk of heat prostration.	Palpitations, tachycardia, ataxia, dizziness, drowsiness, headache, insomnia, mental confusion/excitement, nervousness, speech disorder, urticaria, lactation suppression, bloating, constipation, dry mouth, loss of taste, nausea, vomiting, impotence, urinary hesitancy, urinary retention, weakness, blurred vision, cycloplegia, increased ocular tension, mydriasis, allergic reactions, decreased sweating

Drug	Contraindication	Caution	Side Effect
	unstable cardiovascular status in acute hemorrhage, myocardial ischemia		
Oxybutynin	Hypersensitivity to oxybutynin or any component of the formulation; untreated glaucoma; partial or complete GI obstruction; GU obstruction; urinary retention; megacolon; toxic megacolon	Use with caution in patients with urinary tract obstruction, angle-closure glaucoma (treated), hyperthyroidism, reflux esophagitis (including concurrent therapy with oral bisphosphonates or drugs which may increase the risk of esophagitis), heart disease, hepatic or renal disease, prostatic hyperplasia, autonomic neuropathy, ulcerative colitis (may cause ileus and toxic megacolon), hypertension, hiatal hernia, myasthenia gravis, ulcerative colitis, or intestinal atony. The extended release formulation consists of drug within a nondeformable matrix; following drug release/absorption, the matrix/shell is expelled in the stool. The use of nondeformable products in patients with known stricture/narrowing of the GI tract has been associated with symptoms of obstruction. Caution should be used in elderly due to anticholinergic activity (eg, confusion, constipation, blurred vision, and tachycardia). May increase the risk of heat prostration.	**Oral:** Dizziness, somnolence, xerostomia, constipation, Urination impaired, headache, confusion, insomnia, nervousness, dry skin, skin rash, nausea, dyspepsia, abdominal pain diarrhea, flatulence, gastrointestinal reflux, taste perversion, Post-void residuals increased, urinary tract infection, weakness, blurred vision, dry eyes, rhinitis, dry nasal and sinus membranes. **Transdermal:** Application site reaction, pruritus, xerostomia, diarrhea, constipation, dysuria, erythema, vesicles, rash, vision changes
Tolterodine	Hypersensitivity to tolterodine or any component of the formulation; urinary retention; gastric retention; uncontrolled narrow-angle glaucoma; myasthenia gravis	Use with caution in patients with bladder flow obstruction, may increase the risk of urinary retention. Use with caution in patients with gastrointestinal obstructive disorders (ie, pyloric stenosis), may increase the risk of gastric retention. Use with caution in patients with controlled (treated) narrow-angle glaucoma; metabolized in the liver and excreted in the urine and feces, dosage adjustment is required for patients with renal or hepatic impairment. Patients on CYP3A4 inhibitors require lower dose. Safety and efficacy in pediatric patients have not been established.	Dry mouth (35%; extended release 23%), Chest pain, headache (7%; extended release 6%), somnolence (3%; extended release 3%), fatigue (4%; extended release 2%), dizziness (5%; extended release 2%), anxiety (extended release 1%) dry skin, abdominal pain (5%; extended release 4%), constipation (7%; extended release 6%), dyspepsia (4%; extended release 3%), diarrhea, weight gain, dysuria (2%; extended release 1%), arthralgia, abnormal vision (2%; extended release 1%), dry eyes (3%; extended release 3%), bronchitis, sinusitis (extended release 2%)

Drug	Contraindication	Caution	Side Effect
Trospium	Hypersensitivity to trospium or any component of the formulation; urinary retention; gastric retention; uncontrolled narrow-angle glaucoma; myasthenia gravis	Use with caution in patients with bladder flow obstruction, may increase the risk of urinary retention. Use with caution in patients with GI obstructive disorders (eg, pyloric stenosis); may increase the risk of gastric retention. Use with extreme caution in patients with controlled (treated) narrow-angle glaucoma. Use with caution in renal dysfunction; dosage adjustment is required. Monitor closely when used concurrently with other medications that are eliminated by active tubular secretion (eg, digoxin, procainamide, pancuronium, morphine vancomycin, metformin, tenofovir); may increase levels of trospium and/or the co-administered drug. Use caution in Alzheimer's patients. Use caution in patients with moderate-to-severe hepatic dysfunction. Use caution in the elderly (≥75 years); increased anticholinergic side effects are seen. Safety and efficacy in pediatric patients have not been established.	Xerostomia, tachycardia, headache, fatigue, dry skin, constipation, abdominal pain, dyspepsia, flatulence, abdominal distention, vomiting, dysgeusia, urinary retention, dry eyes, blurred vision, angioneurotic edema
Solifenacin[4]	Contraindicated in patients with urinary retention, gastric retention, uncontrolled narrow-angle glaucoma, and in patients who have demonstrated hypersensitivity to the drug substance or other components of the product.	Use with caution in patients with clinically significant bladder outflow obstruction because of the risk of urinary retention. Use with caution in patients with decreased gastrointestinal motility. Use with caution in patients being treated for narrow-angle glaucoma. Use with caution in patients with reduced renal function. Doses of VESIcare greater than 5 mg are not recommended in patients with severe renal impairment (CLcr < 30 mL/min). Use with caution in patients with reduced hepatic function. Doses of VESIcare greater than 5 mg are not recommended in patients with moderate hepatic impairment (Child-Pugh B). VESIcare is not recommended for patients with severe hepatic impairment (Child-Pugh C).	Dry Mouth, constipation, nausea, dyspepsia, upper abdominal pain, vomiting, urinary tract infection, influenza, pharyngitis, dizziness, blurred vision, dry eyes, urinary retention, edema lower limb, fatigue, depression, cough, hypertension

Geriatric Effects[3]

Flavoxate: Caution should be used in the elderly due to anticholinergic activity (eg, confusion, constipation, blurred vision, and tachycardia).

Hyoscyamine: Avoid long-term use. The potential for toxic reactions is higher than the potential benefit, elderly are particularly prone to CNS side effects of anticholinergics (eg, confusion, delirium, hallucinations). Side effects often occur before clinical response is obtained. Generally not recommended because of the side effects.

Oxybutynin: Caution should be used in the elderly due to anticholinergic activity (eg, confusion, constipation, blurred vision, and tachycardia). Start with lower doses. Oxybutynin may cause memory problems in the elderly. A study of 12 health volunteers with an average age of 69 showed cognitive decline while taking the drug (*J Am Geriatr Soc*, 1998, L46:8-13).

Tolterodine: Safety and efficacy in patients >64 years was found to be similar to that in younger patients; no dosage adjustment is needed based on age

Trospium: In studies, the incidence of anticholinergic side effects was higher in patients ≥75 years of age as compared to younger adults.

Potential Economic Impact

Based on a future projected use of the recommended tier-1 products a net cost savings and administrative cost has been calculated.

Projected percent shift in market share to tier-1 products:	7 %
Estimated Annual Savings (minus rebate and dispensing fees):	$ 183,848.80
Potential Annual Administrative Cost*:	48,248.40
Total Net Plan Savings:	**$ 135,600.40**

Projected percent shift in market share to tier-1 products:	13 %
Estimated Annual Savings (minus rebate and dispensing fees):	$ 330,762.81
Potential Annual Administrative Cost*:	43,981.27
Total Net Plan Savings:	**$ 286,781.54**

* The average cost for processing petitions is calculated at $6.75 per petition with the maximum cost at $12.97 per petition. The maximum cost was used in the estimation of administrative costs.

Recommendations

The College of Pharmacy recommends prior authorizing this class of drugs utilizing the PBPA program. Authorization will be given for 1 year.

- Tier-1 – Detrol, Oxybutynin, hyoscyamine*
- Tier-2 - Detrol LA, Ditropan XL, Flavoxate, Oxytrol, Sanctura, VESIcare

*hyoscyamine can be used as adjuvant therapy only; by itself, it will not count toward a tier-2

Prior authorization criteria:

In order to get a tier-2 drug, client must meet one of the following criteria:

- tier-1 drug failure (i.e. inadequate clinical response or adverse effect), or
- contraindication to the tier-1 drugs , or
- already stabilized on the tier-2 drug, or
- using the tier-2 drug for a unique indication which the tier-1 drugs lack

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APPENDIX G

Update on Selective Serotonin Re-uptake Inhibitors

Oklahoma Medicaid

December 2004

Current Prior Authorization Criteria of SSRI

The following prior authorization criteria were approved by the Oklahoma Healthcare Authority in July of 2004. The prior authorization of selective serotonin reuptake inhibitors (SSRIs) became effective on October 11, 2004.

Selective Serotonin Reuptake Inhibitors (SSRIs)

*Tier One**	*Tier Two*
Fluoxetine (Prozac®)	Citalopram (Celexa®)
Paroxetine (Paxil®)	Escitalopram (Lexapro®)
Fluvoxamine (Luvox®)	Fluoxetine (Sarafem®)
Sertraline (Zoloft®)	
Paroxetine (Paxil CR®)	
Paroxetine mesylate (Pexeva®)	

*The tier one products per action of the DUR Board's vote were generic Fluoxetine, Paroxetine, and Fluvoxamine. All other products are in the tier one category due to the manufacturers' participation in the Supplemental Rebate Agreement.

The following criteria are recommended for approval of a tier-2 product:

1. Failure with a tier one medication defined as no beneficial or minimally beneficial response after at least four weeks of continuous use.
2. Documented adverse effect, drug interaction, or contraindication to the tier one medications.
3. Clients who have been on a tier two medication within the last 100 days would be allowed to continue current therapy without interruption.

Citalopram (Celexa®)

- The application for production of the generic form of Citalopram gained FDA approval in July of 2004. Citalopram was first released in October of 2004, and was readily available to pharmacies across Oklahoma by November.
- Due to the presence of several different manufacturers, a State Maximum Allowable Cost (SMAC) price has been applied to Citalopram.
- Utilization of generics is a well known cost-saving mechanism in all health-care systems. The annualized estimated cost savings based on 4 weeks of claims data for citalopram is about 1.5 million dollars. This is the projected savings from switching from brand name Celexa® to Citalopram calculated by the difference in estimated acquisition costs.
- Citalopram can be reclassified as tier one upon the agreement of the DUR Board.

Current Safety Status of Selective Serotonin Re-uptake Inhibitors

In June of 2003, the FDA issued a warning on the use of paroxetine in pediatric patients as there was concern about the safety of this medication when used in this population. The United Kingdom earlier that month had just reached the conclusion, after a review of paroxetine controlled trials in pediatric patients, that there is an increase in the rate of self harm and potentially suicidal behavior in this age group when paroxetine was used for depressive illnesses.

The FDA went on to further evaluate the occurance of suicidality in clinical trials for antidepressant drugs used in pediatric depressive disorders. In September 2004 the FDA met with the committee on Psychopharmacologic Drugs and the Pediatric Advisory Committees in which several recommendations were made based upon conclusions the committees reached.

In summary, the members of the advisory committees[8]:

- **Endorsed** FDA's approach to classifying and analyzing the suicidal events and behaviors observed in controlled clinical trials and expressed their view that the new analyses increased their confidence in the results;
- **Concluded** that the finding of an increased risk of suicidality in pediatric patients applied to all the drugs studied (Prozac, Zoloft, Remeron, Paxil, Effexor, Celexa Wellbutrin, Luvox and Serzone) in controlled clinical trials;
- **Recommended** that any warning related to an increased risk of suicidality in pediatric patients should be applied to all antidepressant drugs, including those that have not been studied in controlled clinical trials in pediatric patients, since the available data are not adequate to exclude any single medication from an increased risk;
- **Reached** a split decision (15-yes, 8-no) regarding recommending a "black-box" warning related to an increased risk for suicidality in pediatric patients for all antidepressant drugs;
- **Endorsed** a patient information sheet ("Medication Guide") for this class of drugs to be provided to the patient or their caregiver with every prescription;
- **Recommended** that the products not be contraindicated in this country because the Committees thought access to these therapies was important for those who could benefit; and
- **Recommended** that the results of controlled pediatric trials of depression be included in the labeling for antidepressant drugs.

FDA is working to adopt new labeling for the all the antidepressants. The new labeling will include a black box warning on the risk of suicidality in children and adolescents. A black box warning is the most serious warning placed on the labeling of prescription medications. Certain ads, such as reminder ads, are not allowed for products with a black box warning. Other labeling changes are currently being discussed such as the inclusion of additional information on pediatric studies of the medication.

Also according to the recommendations, the FDA is in the process of drafting a Patient Medication Guide (MedGuide.) This will be an FDA approved, easy to understand, patient information leaflet to be distributed to patients by the pharmacist with every new prescription or refill. In addition, the FDA is also working with manufacturers to implement "unit of use" packaging of antidepressants.

Current Safety Measures of Oklahoma Medicaid

In response to the FDA's warning on use of paroxetine in pediatric patients the Drug Utilization Review Board voted to implement a special prior authorization for paroxetine in October of 2003 for clients under 18 years of age. Clients who have been on paroxetine are allowed to continue without interruption. Criteria for approval would be based on two factors:

1. Both the following:
   - Documented failure of other therapy choices, and
   - Evaluation and initiation of the medication by a pediatric psychiatrist.
2. An acknowledgement from the prescriber that he/she is aware of the FDA warning and that the benefits of using the medication cleary outweigh the risks.

In light of recent conclusions reached by the examining and recommending bodies to the FDA, including the actions the FDA has taken, the DUR board may consider changing the current safety measures taken for the Oklahoma Medicaid population.

Option One:

Apply a prior authorization to all antidepressants for clients under the age of 18 as it was concluded that the available data are not adequate to exclude any single medication from possessing an increased risk to the client.

The criteria will be altered to exclude the documented failure of other therapy choices as none can be deemed safer than the other in this aspect.

The prior authorization will mainly serve to ensure the prescription is prescribed by a pediatric psychiatrist, and that the prescriber is aware of the FDA warnings and risks.

Option Two:

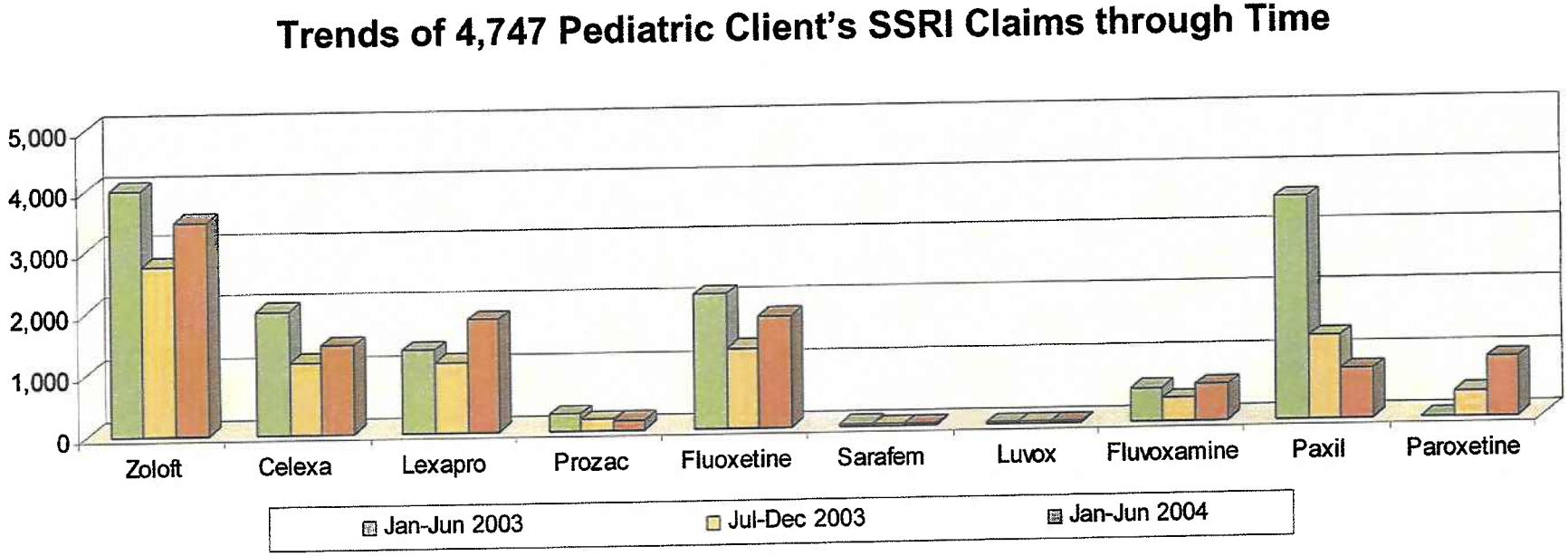
Remove the existing prior authorization of paroxetine as it is no longer singled out by the FDA to exhibit risks to the pediatric population.

If so, the DUR Board may discuss other measures deemed necessary to further awareness and ensure appropriate prescribing of antidepressants.

Pediatric SSRI Utilization

The following claims data has been compiled to give an overall picture of SSRI prescription claims activity during an 18 month period. From January through June of 2003 a total of 4,747clients in the Medicaid fee for service population had at least one paid claim for an SSRI. These same clients were followed from July of 2003 through July of 2004 to see how many were still getting an SSRI, and how the claims may have shifted between the products.

	Clients with Active Claims	Clients with SSRI Claims	All Clients with SSRI Claims
Jan-Jun 2003	4,747	4,747	4.747
Jul-Dec 2003	3,579	2,537	4,870
Jan-Jun 2004	3,332	2,046	7,059



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APPENDIX H

Cymbalta® (duloxetine HCl)

Oklahoma Medicaid
December 2004

Manufacturer	Eli Lilly and Company
Pharmacologic Category	Selective Serotonin and Norepinephrine Reuptake Inhibitor (SSNRI); Dual-acting Antidepressant
Status	Prescription only

Summary

The active ingredient in Cymbalta® is duloxetine hydrochloride. Each Cymbalta® capsule contains enteric-coated pellets containing either an equivalent of 20, 30, or 60mg of duloxetine hydrochloride. The enteric-coated pellets are used to protect the duloxetine from degradation by the acidic environment in the stomach while providing a delayed-release effect in absorption. The U.S. Food and Drug Administration have recently approved marketing for Cymbalta® on August 04, 2004. It is therapeutically indicated for the treatment of Major Depressive Disorder (MDD) and the first approved treatment for Diabetic Peripheral Neuropathy Pain (DPNP). Oral administration is well absorbed reaching maximum plasma concentrations (C_{max}) 6 hours post dose. The elimination half-life is about 12 hours with steady-state plasma concentrations occurring about 3 days of dosing. Elimination of Cymbalta® occurs primarily through hepatic metabolism pathways involving 1A2 and 2D6 cytochrome P450 enzymes. Cymbalta® capsules must be administered orally without regard to meals. Capsules should be swallowed whole and should not be chewed, crushed, or sprinkled on meals due to the compromising of enteric coating. Side effects which occurred in 2% or more of the population in the pre-marketing clinical trials included: nausea; dry mouth, constipation, decreased appetite; fatigue; somnolence; and increased sweating. Gradual reduction of therapy rather than abrupt cessation is recommended whenever possible due to possible severe adverse events. Cymbalta® is contraindicated in patients with known hypersensitivity to any components of the formulation. Concomitant use with patients with narrow-angle glaucoma or patients taking monoamine oxidase inhibitors (MAOIs) is contraindicated. Recently, the U.S. Food and Drug Administration has asked manufacturers of certain antidepressant medications to include a warning that recommends close observations of adult and pediatric patients for worsening depression or emergence of suicide risk. Recommended adult dose is 40 mg/day or 60mg/day (20mg BID or 30mg BID respectively) for the indication of Major Depressive Disorder. Cymbalta® should be administered at a 60mg/day once daily dose for Diabetic Peripheral Neuropathic Pain indication. Cymbalta® is currently available in 20, 30, and 60 mg strength capsules. Cymbalta® is currently a part of the federal rebate program and is a covered product under Oklahoma Medicaid.

Recommendations

The college of pharmacy recommends consideration of a prior authorization category similar to the SSRIs. In the meantime, the college of pharmacy intends to further evaluate and monitor the use of these newer antidepressants pending new clinical literature and newly approved indications.

Pharmacological data
The active ingredient in Cymbalta® is duloxetine hydrochloride. Duloxetine is a potent inhibitor of serotonin and norephinephrine reuptake and a weak inhibitor of dopamine reuptake. The exact mechanisms which are linked to the antidepressant and pain relief activity are still unknown but it is thought to be due to the serotonergic and noradrenergic potentiation within the central nervous system. The enteric-coated pellets within in each capsule were designed to resist degradation within the acidic environment of the stomach. This formulation also allows for a delayed-release action during absorption.

Therapeutic indications
- Major Depressive Disorder (MDD)
- Diabetic Peripheral Neuropathy Pain (DPNP)
- Investigational Indications: Stress Urinary Incontinence and Treatment of Fibromyalgia pain

Bioavailability/pharmacokinetics
Absorption
- There is a 2-hour lag before absorption begins. Mean time to peak plasma levels occurs at 6 hours post dose.
- Steady-state plasma levels achieved after 3 days of dosing.
- Cymbalta® may be taken with or without food.
- Capsules should be swallowed whole and not crushed or chewed.

Distribution
- Duloxetine hydrochloride is approximately 90% protein bound.

Metabolism
- Elimination is primarily through the hepatic pathway involving 2D6 AND 1A2 liver enzymes.

Elimination
- Plasma half-life is 12 hours.
- 70% is excreted in the urine, mostly as metabolites.
- Remainder of dose is eliminated in the feces.

Dosage forms
Oral
- Capsules: 20mg, 30mg, and 60mg (contains enteric-coated pellets).

Dosage range
- Major Depressive Disorder (MDD)
  - Recommended adult dose is 40mg/day (given as 20mg BID) up to 60mg/day (given as one 30mg capsule twice-daily or one 60mg capsule once-daily).
- Diabetic Peripheral Neuropathy Pain (DPNP)
  - Recommended adult dose is 60mg/day (given as one 60mg capsule daily).

Known adverse effects/toxicities
Side effects which occurred in 2% or more of the population in the pre-marketing clinical trial included: nausea, dry mouth, constipation, decreased appetite, fatigue, somnolence, and increased sweating. Reliable estimates of sexual dysfunction are difficult to obtain due to reluctance of patients or physicians to

discuss such matters. No literature exists showing significant impact on systolic or diastolic blood pressure.

Special precautions
Worsening depression or suicide risk may occur especially at the initiation or during the treatment with antidepressants. This risk persists until remission is achieved during therapy. Patients should be closely monitored for increased occurrence of suicide ideation or behavior which may indicate a need for dosage reduction or therapy discontinuation. A gradual discontinuation of therapy is recommended rather than a sudden withdrawal from therapy due to adverse events which may occur during abrupt cessation of treatment.

It is not recommended to take monoamine oxidase inhibitors (MAOIs) in conjunction with Cymbalta® due to several reports of severe reactions which may occur while taking both a SNRI and a MAOI. A patient should not start a SNRI within 14-days of discontinuation of a MAOI and patients must allow 5 days to lapse after discontinuation of a SNRI before initiating MAOI therapy.

Cymbalta® has shown in pre-marketing clinical trials to increase levels of serum transaminase. It is recommended that patients with alcohol abuse and hepatic impairment should avoid treatment with Cymbalta®.

Patients with mood disorders should be aware of the risks of the activation of mania with the treatment of SNRIs.

Urinary hesitation may occur and patients should report any events of urinary difficulty or resistance.

Caution should also be taken when patients have history of seizure disorders or narrow-angle glaucoma.

Contraindications
Cymbalta® is contraindicated in patients with known hypersensitivity to any components of the formulation.

Drug interactions
- Duloxetine hydrochloride is primarily metabolized by 1A2 and 2D6 hepatic isoenzymes. Medications that inhibit 1A2 and 2D6 may result in increase concentrations of duloxetine. Some quinolone antibiotics may have these effects and should be avoided.
- Duloxetine is also a moderate inhibitor of 2D6. This role does not affect its own metabolism but medications metabolized by this isoenzyme should be used cautiously.
- Drugs that increase in gastric acidity or delay gastric emptying may lead to increase in absorption resulting in increased levels of duloxetine.

Patient information
- Cymbalta® may be taken with or without food.
- Cymbalta® is currently supplied in 20, 30, and 60mg capsules and should be swallowed whole and not chewed or crushed.

Cost comparison of Dual-Acting Antidepressants for treatment of Major Depressive Disorder(MDD)

	Estimated Acquisition Cost (EAC)	State Maximum Allowable Cost (SMAC)	Daily Dose (Initial)	Monthly Dose* (30 day supply)
Selective Serotonin and Norepinephrine Reuptake Inhibitors (SSNRI)				
Cymbalta® 20mg	$2.79 per capsule	$0.00	40mg	$167.40
Cymbalta® 30mg	$3.14 per capsule	$0.00	60mg	$188.40
Cymbalta® 60mg	$3.14 per capsule	$0.00	60mg	$94.20
Effexor XR® 37.5mg	$2.68 per capsule	$0.00	37.5mg	$80.40
Effexor XR® 75mg	$3.00 per capsule	$0.00	75mg	$90.00
Effexor XR® 150mg	$3.27 per capsule	$0.00	150mg	$98.01
Effexor® 25mg	$1.61 per tablet	$0.00	75mg	$144.90
Effexor® 37.5mg	$1.66 per tablet	$0.00	75mg	$99.60
Effexor® 50mg	$1.71 per tablet	$0.00	75mg	$76.95
Effexor® 75mg	$1.81 per tablet	$0.00	75mg	$54.30
Effexor® 100mg	$1.92 per tablet	$0.00	100mg	$57.60
Selective Alpha-2 Antagonist****				
Remeron® 15mg	$2.77 per tablet	$0.25	15mg	$7.50
Remeron® 30mg	$2.86 per tablet	$0.38	30mg	$11.40
Remeron® 45mg	$2.91 per tablet	$0.52	45mg	$15.60
Remeron® 15mg Soltab	$2.54 per tablet	$0.00	15mg	$76.20
Remeron® 30mg Soltab	$2.62 per tablet	$0.00	30mg	$78.60
Remeron® 45mg Soltab	$2.79 per tablet	$0.00	45mg	$83.70
Mirtazapine 15mg Soltab	$2.29 per tablet	$0.00	15mg	$68.70
MIrtazapine 30mg Soltab	$2.35 per tablet	$0.00	30mg	$70.50
Mirtazapine 45mg Soltab	$2.50 per tablet	$0.00	45mg	$75.00

Selective Dopamine Reuptake Inhibitor* **				
Wellbutrin® 75mg	$1.15 per tablet	$0.21	300mg	$25.20
Wellbutrin® 100mg	$1.53 per tablet	$0.31	300mg	$27.90
Wellbutrin® 100mg SR	$1.86 per tablet	$1.31	300mg	$117.90
Wellbutrin® 150mg SR	$1.99 per tablet	$1.51	300mg	$90.60
Wellbutrin® 200mg SR	$3.69 per tablet	$0.00	400mg	$221.40
Wellbutrin® 150mg XL	$2.82 per tablet	$0.00	150mg	$84.60
Wellbutrin® 300mg XL	$3.73 per tablet	$0.00	300mg	$111.90
Selective Serotonin Reuptake Inhibitors/Antagonist (SARI)**				
Serzone® 50mg	$1.54 per tablet	$0.29	200mg	$34.80
Serzone® 100mg	$1.58 per tablet	$0.32	200mg	$19.20
Serzone® 150mg	$1.61 per tablet	$0.32	300mg	$19.20
Serzone® 200mg	$1.64 per tablet	$0.33	200mg	$9.90
Serzone® 250mg	$1.67 per tablet	$0.34	500mg	$20.40

*SMAC pricing used where appropriate and indicates generic availability. No rebate information was incorporated.
**Bristol-Myers Squibb announced discontinuation of sales of Serzone® 06/14/2004, generic still available.
***Some norepinephrine reuptake inhibition.
****Increase release of norepinephrine and serotonin.

Presented by the University of Oklahoma College of Pharmacy, Pharmacy Management Consultants to the Drug Utilization Review Board on 12/14/2004.

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APPENDIX I

Multiple Sclerosis

Oklahoma Medicaid
December 2004

Introduction

Multiple Sclerosis (MS) affects approximately 350,000 patients in the United States and 1 million worldwide, with an estimated 10,000 new cases diagnosed in the United States annually. Most people experience their first symptoms and are diagnosed between the ages of 15 and 50. MS affects women more than men (approx. 3:1).[1]

Signs and Symptoms[2]

Most common symptoms include: fatigue, weakness, spasticity, balance problems, bladder and bowel problems, numbness, vision loss, tremors and depression.
Not all symptoms affect all MS patients. Symptoms may be persistent or cease from time to time. Depending on location of lesion, MS patients may experience the following signs and symptoms:

Lesion location	Signs/symptoms
Cerebrum and Cerebellum	Balance/speech problems, coordination, tremors
Motor Nerve Tracts	Muscle weakness, spasticity, paralysis, vision/bladder/bowel problems
Sensory Nerve Tract	Altered sensation, numbness, prickling, burning sensation

Types of MS[3]

Name	Characteristics
Relapsing- Remitting Multiple Sclerosis (RRMS)	Symptom flare-ups followed by recovery; stable between attacks
Secondary-Progressive Multiple Sclerosis (SPMS)	Second phase of RRMS; progressive worsening of symptoms w/ or w/o superimposed relapses; treatment may delay or prevent this phase
Primary-Progressive Multiple Sclerosis (PPMS)	Gradual but steady accumulation of neurological problems from onset
Benign	Few attacks and little or no disability after 20 years
Progressive-Relapsing Multiple Sclerosis (PRMS)	Progressive course from the onset, sometimes combined with occasional acute symptom flare-ups
Malignant or Fulminant Multiple Sclerosis	Rapidly progressive disease course

Diagnosis

No single test is available to identify or rule out MS. Several tests and procedures are needed. These include:

1. Complete medical history
    - Overall view of individual's health, including symptoms and when they began
2. Nervous system functioning
    - Testing of reflexes, balance, coordination, vision and checking for areas of numbness
3. Diagnostic tests:
    - MRI- gives detailed view of brain
    - Evoked potential tests- measures how quickly and accurately a person's nervous system responds to certain stimuli
    - Spinal tap- checks spinal fluid for signs of the disease

Treatment- Disease Modifying Agents (DMA)

Drug	Type	Dose	EAC/month
Betaseron	INF beta-1b	250mcg SC qod	$1,219.50
Avonex	INF beta-1a	30mcg IM q wk	Inj- $1,191.32 Kit- $1,069.24
Rebif	INF beta-1a	22mcg SC 3x/wk 44mcg SC 3x/wk	$1,474.68 $1,474.68
Copaxone	Glatiramer acetate	20mg SC qd	$1,119.93

EAC= Average Estimated Acquisition Cost per month; SC= Subcutaneous; IM= Intra-Muscular; INF- Interferon; qod= every other day

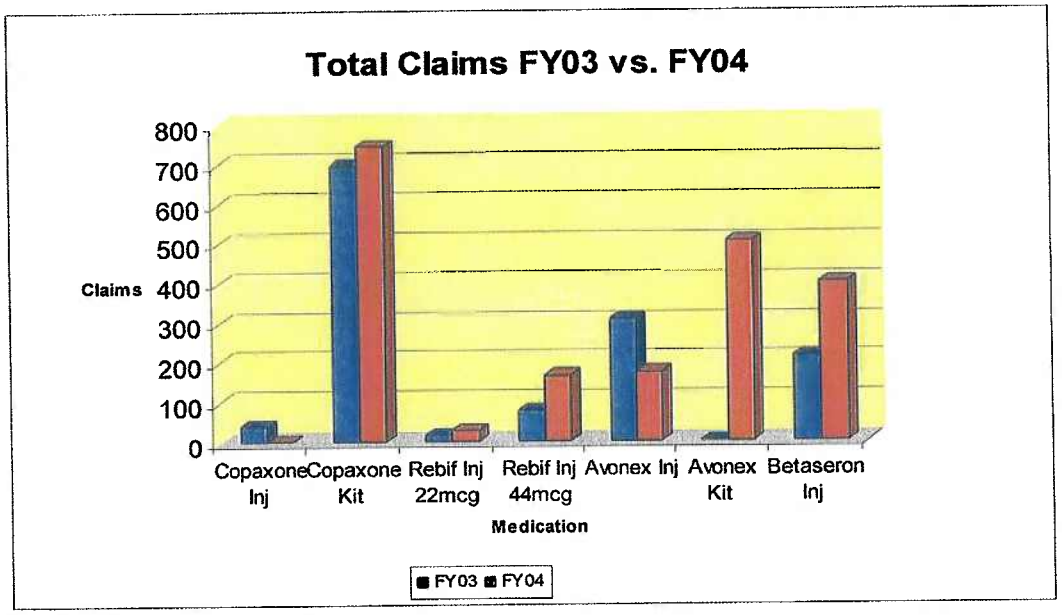
Adverse Effects/Contraindications [4]

Drug	Common AE's	Serious AE's	Contraindications
Betaseron	Injection site rxn, flu-like sx's (fever, chills, myalgia), HA, asthenia	Depression, mental disorders, anaphylaxis, ↑LFT's, palpitations, leukopenia	Hypersensitivity to natural/recombinant INF beta or human albumin products
Avonex	Injection site rxn, flu-like sx's (fever, chills, myalgia), HA	Anaphylaxis, ↑LFT's, anemia, leukopenia, thrombocytopenia, psychiatric disorders, seizures	Hypersensitivity to natural/recombinant INF beta or human albumin products
Rebif	Injection site rxn, flu-like sx's (fever, chills, myalgia), HA	Anaphylaxis, ↑LFT's, anemia, leukopenia, thrombocytopenia, psychiatric disorders, seizures	Hypersensitivity to natural/recombinant INF beta or human albumin products
Copaxone	Anxiety, hypertonia, tremor, arthralgia, asthenia, facial edema, palpitations, transient chest pain, vasodilation, Injection site rxn	HTN, dyspnea, lymphadenopathy, eosinophilia	Hypersensitivity to glatiramer or mannitol

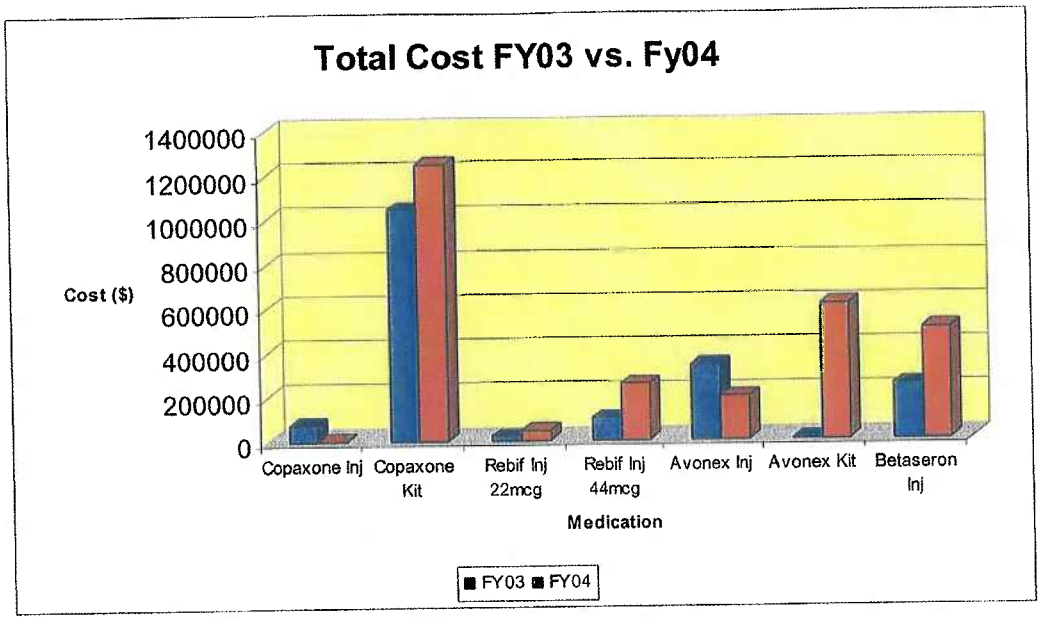
Sx's= symptoms; HA= headaches; rxn= reaction; LFT= Liver function tests;

Trends in Utilization

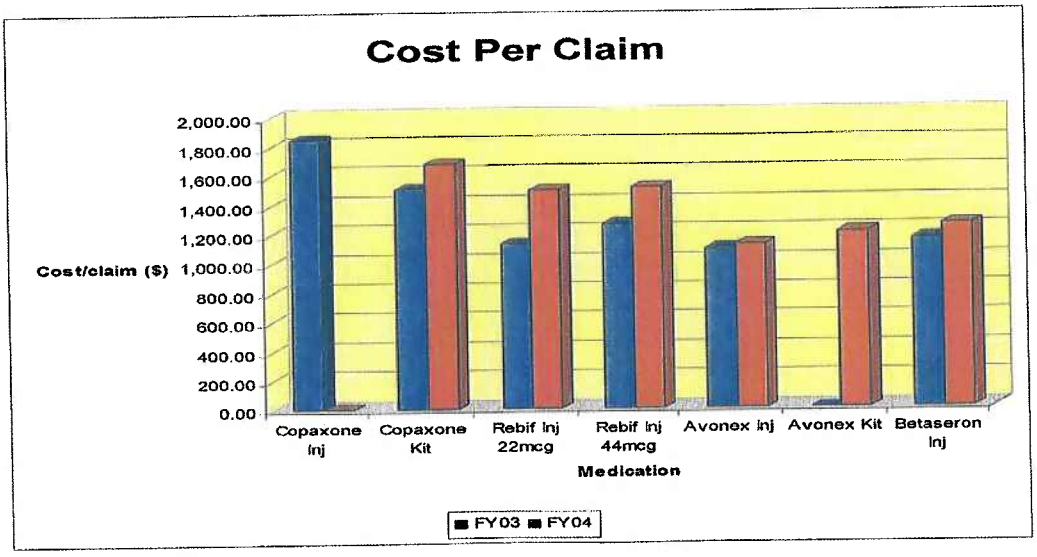
	Fiscal Year 2003	*Fiscal Year 2004*	*Percent Change*
Total Claims	**1349**	**2016**	**33%**
Copaxone Inj 20mg	39	0	-100%
Copaxone Kit 20mg/ml	696	744	6.5%
Rebif Inj 22mg/0.5ml	16	28	43%
Rebif Inj 44mcg/0.5ml	77	166	54%
Avonex Inj 30mcg	308	173	-78%
Avonex Kit	0	506	100%
Betaseron Inj 0.3mg	213	399	47%



	Fiscal Year 2003	*Fiscal Year 2004*	*Percent Change*
Total Cost	**1,813,809.85**	**2,835,827.67**	**36%**
Copaxone Inj 20mg	72,011.97	0	-100%
Copaxone Kit 20mg/ml	1,045,707.42	1,245,470.65	16%
Rebif Inj 22mg/0.5ml	18,092.35	41,911.21	57%
Rebif Inj 44mcg/0.5ml	97,040.17	251,172.82	61%
Avonex Inj 30mcg	336,011.07	193,450.55	-74%
Avonex Kit	0	606,950.96	100%
Betaseron Inj 0.3mg	244,946.87	496,871.48	50%



	Fiscal Year 2003	*Fiscal Year 2004*	*Percent Change*
Cost Per Claim	**7,980.88**	**8246.95**	**3%**
Copaxone Inj 20mg	1,846.46	0	-100%
Copaxone Kit 20mg/ml	1,502.45	1,674.02	10%
Rebif Inj 22mg/0.5ml	1,130.77	1,496.83	24%
Rebif Inj 44mcg/0.5ml	1,260.26	1,513.09	17%
Avonex Inj 30mcg	1,090.95	1,118.21	2%
Avonex Kit	0	1,199.51	100%
Betaseron Inj 0.3mg	1,149.99	1,245.29	8%

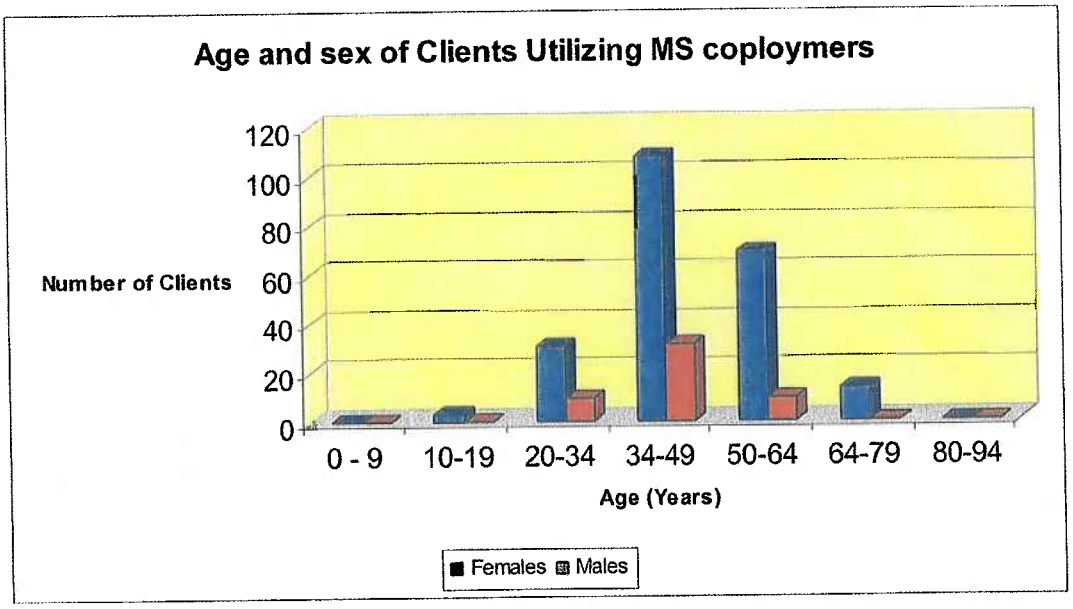


FY03

Drug	Clients	Claims	Cost ($)	Cost/Claim ($)	Claim/Client	Days/Claim	Units/Day
Copaxone Inj 20mg	17	39	72,011.97	1,846.46	3	40	0.56
Copaxone Kit 20mg/ml	98	696	1,045,707.42	1,502.45	7	30	0.32
Rebif Inj 22mg/0.5ml	11	16	18,092.35	1,130.77	2	29	0.22
Rebif Inj 44mcg/0.5ml	13	77	97,040.17	1,260.26	6	30	0.24
Avonex Inj 30mcg	62	308	336,011.07	1,090.95	5	30	0.19
Avonex Kit	-	-	-	-	-	-	-
Betaseron Inj 0.3mg	39	213	244,946.87	1,149.99	6	29	0.56

FY04

Drug	Clients	Claims	Cost ($)	Cost/Claim ($)	Claim/Client	Days/Claim	Units/Day
Copaxone Inj 20mg	-	-	-	-	-	-	-
Copaxone Kit 20mg/ml	113	744	1,245,470.65	1,674.02	7	31	0.30
Rebif Inj 22mg/0.5ml	16	28	41,911.21	1,496.83	2	32	0.29
Rebif Inj 44mcg/0.5ml	25	166	251,172.82	1,513.09	7	29	0.28
Avonex Inj 30mcg	59	173	193,450.55	1,118.21	3	28	0.17
Avonex Kit	77	506	606,950.96	1,199.51	7	29	0.15
Betaseron Inj 0.3mg	53	399	496,871.48	1,245.29	8	29	0.54



Current Treatment Guidelines[5]:
Regarding the use of current disease modifying agents, the Executive Committee of the Medical Advisory Board of the National Multiple Sclerosis Society recommends:

Immunomodulators:	Betaseron® (beta INF 1b)
	Avonex® (beta INF 1a- IM)
	Rebif® (beta INF 1a- SC)
	Copaxone® (glatiramer acetate)
Immunosuppressant:	Novantrone® (Mitoxantrone)

- Initiation with an immunomodulator is advised as soon as possible following a definitive diagnosis on MS with a relapsing course, may be considered in patients with a first attack who are at high risk
- Patient's access to medication should not be limited by frequency of relapses, age or level of disability
- Treatment is not to be stopped while insurers evaluate for continuing coverage
- Therapy is to be continued indefinitely, except for the following circumstances:
  - there is a clear lack of benefit
  - there are intolerable side effects
  - new data reveals other reasons for cessation
  - better therapy becomes available
- All agents should be included in formularies and covered by third party payers so that physicians and patients can determine the most appropriate agent on an individual basis
- Movement from one immunomodulatory drug to another should be permitted
- None of the four therapies has been approved for use by women who are trying to become pregnant, are pregnant, or are nursing mothers.

In light of the FDA's recent approval of Tysabri® (Natalizumab) for relapsing forms of MS, the society's medical advisory board is currently reviewing these recommendations.

Recommendations:
Based in the information presented and with the current review of the treatment recommendations by the medical advisory board of the National Multiple Sclerosis Society, the college of pharmacy recommends continued monitoring until the new guidelines are published.

Reference:
[1,3,5] Multiple Sclerosis Association of America. Available on the internet at: http://www.msaa.com/reading.html
[2] Multiple Sclerosis Foundation: Available on the internet at: http://msfocus.org/info/info_symptoms.html
[4] Micromedex Healthcare Series. Available on the internet at: http://micromedex.ouhsc.edu/

APPENDIX J

FDA Talk Paper

T04-50
November 17, 2004

Media Inquiries: 301-827-6242
Consumer Inquiries: 888-INFO-F

Black Box Warning Added Concerning Long-Term Use of Depo-Provera Contraceptive Injection

The Food and Drug Administration (FDA) announced today that a "black box" warning, highlighting prolonged use may result in the loss of bone density, will be added to the labeling of Depo-Provera Contraceptive Injection, an established injectable drug approved for use in women to prevent pregnancy.

Although Depo-Provera Contraceptive Injection has been used for decades for birth control throughout the world and remains a safe and effective contraceptive, FDA and Pfizer, the drug's manufacturer, are taking this action to ensure that physicians and patients have access to this important information.

The black box warning for Depo-Provera highlights that prolonged use of the drug may result in significant loss of bone density, and that the loss is greater the longer the drug is administered. This bone density loss may not be completely reversible after discontinuation of the drug. Thus the warning states that a woman should only use Depo-Provera Contraceptive Injection as a long-term birth control method (for example, longer than two years) if other birth control methods are inadequate for her.

Black box warnings are designed to highlight special problems, particularly those that are serious, and to give health care professionals a clear understanding of a potential medical complication associated with a drug. Black box warnings provide physicians with important insights as to how to prescribe a drug that may be associated with serious side effects in a way that maximizes its benefits and minimizes its risks.

The addition of the black box warning came as a result of the drug manufacturer's and FDA's analysis of data that clarified the drug's long-term effects on bone density.

In addition to the black box warning on the labeling, the drug's manufacturer will issue a "Dear Health Care Practitioner" letter regarding the effect of long-term treatment on bone mineral density to prescribers likely to prescribe the drug, and will incorporate the new information in the patient information sheet distributed with the drug.

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FDA Talk Paper

T04-53
November 23, 2004

Media Inquiries: 301-827-6242
Consumer Inquiries: 888-INFO-F

FDA Announces Enhancement to Isotretinoin Risk Management Program

The Food and Drug Administration (FDA) today announced the strengthening of the risk minimization action plan (RiskMAP) for Accutane (isotretinoin) and its generic equivalents. Isotretinoin is a drug indicated for the treatment of a specific type of severe acne (severe recalcitrant nodular acne) that is not responsive to other therapies. The goal of the strengthened RiskMAP is to reduce the risk of birth defects associated with fetal exposure to isotretinoin.

The strengthened RiskMAP reflects agency and sponsor's consideration of the recommendations from the February 2004 joint Advisory Committee of the Drug Safety and Risk Management and the Dermatologic and Ophthalmic Drug Advisory Committees which examined the current isotretinoin risk management program known as the System to Manage Accutane Related Teratogenicity (S.M.A.R.T.) program. SMART was implemented in 2002 in response to agency recommendations at that time to further decrease fetal exposures to isotretinoin.

The February 2004 joint Advisory Committee discussion focused on whether changes were necessary to SMART and its generic equivalents, based on FDA assessments of the program's performance and its ongoing surveillance of pregnancy exposures to isotretinoin.

The committees agreed that changes were called for, especially in light of the fact that the SMART program, operated by Roche Pharmaceuticals, was only one of several similar programs that had been created with the introduction of generic isotretinoin to the market. The multiple programs created confusion and the concern that patients would not receive appropriate counseling and testing to prevent the possibility of birth defects.

Today's changes reflect a joint response by the agency and the sponsors of isotretinoin drug products to the Advisory Committee's recommendations that the sponsors strengthen the isotretinoin RiskMAP. Under the new program, sponsors will obtain registration of not only prescribers, but also pharmacies that dispense and patients who use isotretinoin. The program also includes documentation of a negative pregnancy test before giving isotretinoin to women who are capable of becoming pregnant. Importantly, the registration system will be built to incorporate physician and patient identification codes that will also protect the privacy of patients. The innovator and generic sponsors of isotretinoin have jointly contracted with Covance, Inc., to design, build, implement, and operate a single strengthened isotretinoin riskMAP incorporating these elements.

As stated in 2002, the goal of the agency was to eliminate fetal exposure to isotretinoin by ensuring that no woman start isotretinoin therapy if pregnant and no woman on isotretinoin therapy become pregnant. The agency and the sponsors believe this new program will go a long way to achieving this goal.

While the program development itself is complex, FDA has emphasized the need to make it as unintrusive as possible for healthcare providers and patients. At the same time that FDA has asked industry to be mindful of the need for simplicity and minimal burden on the health care community and patients. Keeping this in mind, the sponsors' new program will include, but will not be limited to, the following:

- Registration of all prescribers, patients and dispensing pharmacies will be registered in a single centralized "clearinghouse".
- Before a registered pharmacy first dispenses the medication for a particular patient, the following will occur:
    - Completion of patient education by the prescriber
    - An appropriately timed and documented negative pregnancy test prior to dispensing the medication
    - Completion of the informed consent, education and risk management components by the patient.
    - Electronic or other verification of the above actions.
- For all subsequent prescriptions, the following will occur monthly:
    - Ongoing patient education by the prescriber
    - Repeated negative pregnancy test within a specified window prior to dispensing
    - Completion of the education and risk management components by the patient.
    - Electronic or other verification of the above actions.

The isotretinoin sponsors will play a large role in determining compliance and effectiveness of the strengthened RiskMAP. In addition to shipping drug only to authorized distributors, the sponsors have agreed to perform the following tasks:

- Establish and maintain the clearinghouse.
- Monitor for sales of the drug outside of approved distribution channels, including via the Internet.
- Develop procedures to monitor and evaluate each component of the RiskMAP to include clearinghouse compliance with specified responsibilities, prescriber and pharmacy registration and prescribing and dispensing by non-registered prescribers and pharmacies, respectively.
- Evaluate the effectiveness of the program in reducing and limiting pregnancy exposures.

In order to implement the new program, the innovator and generic sponsors of isotretinoin have worked diligently to reach an agreement with Celgene Corporation, which holds patents on a successful program for preventing pregnancy exposures to thalidomide. Because this agreement with Celgene has now been achieved, the program can move forward in full compliance with recommendations of the agency and members of the Drug Safety and Risk Management and the Dermatologic and Ophthalmic Drug Advisory Committees.

The FDA will continue to monitor all adverse events reported with isotretinoin use, to include neuropsychiatric adverse events, in order to protect the public health by ensuring that the risks associated with isotretinoin use are minimized for those patients who need treatment with this drug.

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Additional Information

Media Contacts | FDA News Page

U.S. Food and Drug Administration
Department of Health and Human Services
CENTER FOR DRUG EVALUATION AND RESEARCH

FDA Proposed Medication Guide: About Using Antidepressants in Children or Teenagers

The FDA has written a proposed Medication Guide about Using Antidepressants in Children or Teenagers and sent this Medication Guide to all the sponsors on October 21, 2004. It appears here to inform other groups and individuals with an interest in this Medication Guide. The FDA hopes to finalize the language of this Medication Guide by December 2004 so that the Medication Guide can be produced and made available to patients by the end of January 2005.

What is the most important information I should know about antidepressants?

Parents or guardians need to know about four important things to help them decide whether their child or teenager should take an antidepressant:

- The risks of self-injury or suicide
- How to try to prevent self-injury or suicide
- What to watch for in children or teens taking antidepressants
- The benefits and risks of antidepressants

1. Risk of Injury to Self or Suicide

Children or teenagers with depression sometimes think about suicide. They may even try to kill themselves. Antidepressants may increase suicidal thoughts or actions in some children and teens. Thinking about killing yourself or trying to kill yourself is called *suicidality* or *being suicidal.*

A large study combined the results of 24 different smaller studies of children and teenagers who took either sugar pills or antidepressants for 1 to 4 months. **Although no one committed suicide in these studies**, some young patients became suicidal. On sugar pills, 2 out of every 100 became suicidal. On the antidepressants, 4 out of every 100 young patients became suicidal.

2. How to try to prevent self-injury or suicide

To try to prevent self-injury and suicide in children and teens using antidepressants, everyone (patients, parents, teachers, and other important people in the lives of young people) should pay close attention to sudden changes in their moods or behaviors. These are listed below under "What to Watch For." Whenever an antidepressant is started or its dose is changed, close attention is needed.

In general, after starting an antidepressant, patients should see their doctor

- Once a week for four weeks
- Every 2 weeks for the next month
- At the end of their 12th week taking the drug
- More often if problems or questions arise (see other side)

3. What to Watch Out For in Children or Teens Taking Antidepressants

If any of the following behaviors appear for the first time, seem worse, or worry the child, parent, or guardian, a medical professional should be contacted **right away.**

- New or more thoughts of suicide
- Trying to commit suicide
- New or worse depression
- New or worse anxiety
- Feeling very agitated or restless
- Panic attacks
- Difficulty sleeping (insomnia)
- New or worse irritability
- Acting aggressive, being angry, or violent
- Acting on dangerous impulses
- Being extremely hyperactive in actions and talking (hypomania or mania)
- Other unusual changes in behavior

4. The Benefits and Risks of Antidepressants

Antidepressants are used to treat people with depression. Depression can lead to suicide. In some people, treatment with an antidepressant causes suicidal thinking or actions or makes them worse. The doctor, the patient, and the patient's parents or guardians should discuss all treatment choices, including the use of antidepressants.

Of all antidepressants, only fluoxetine (brand name: Prozac) has been FDA approved to treat pediatric depression.

For obsessive compulsive disorder, FDA considers only fluoxetine (brand name: Prozac), sertraline (brand name: Zoloft), fluvoxamine (no marketed brand name product), and clomipramine (brand name: Anafranil) to be of proven benefit in children and teens.

The past experiences of the patient with other treatments or antidepressants may lead the doctor to suggest other antidepressants than the ones listed above.

For some young people, the risks of suicidal behaviors caused by antidepressants may be especially high. These include young people with

- Bipolar illness (sometimes called manic-depressive illness)
- A family history of bipolar illness
- A personal or family history of attempting suicide

If any of these are present, make sure the doctor knows about them before the doctor prescribes any antidepressant.

Is this all I need to know about antidepressants?

No. This is a general warning for all antidepressants about suicidality. Other side effects can occur with antidepressants. Be sure to ask the doctor to explain all the side effects of the particular drug you are taking. Ask your pharmacist where to find additional information.

Back to Top Back to Antidepressants

Date created: November 03, 2004

U.S. Food and Drug Administration
Department of Health and Human Services
CENTER FOR DRUG EVALUATION AND RESEARCH

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U.S. Food and Drug Administration

FDA News

FOR IMMEDIATE RELEASE
P04-107
November 23, 2004

Media Inquiries: 301-827-6242
Consumer Inquiries: 888-INFO-F

First Monoclonal Antibody Treatment For Multiple Sclerosis Approved

FDA today licensed a new biologic approach to treat patients with relapsing forms of multiple sclerosis (MS) to reduce the frequency of symptom flare-ups or exacerbations of the disease. MS is a chronic, often disabling disease of the brain and spinal cord.

Natalizumab, the new product, is a monoclonal antibody bioengineered from part of a mouse antibody to closely resemble a human antibody. It is being marketed under the tradename Tysabri. The product is given intravenously once a month in a physician's office.

According to the Multiple Sclerosis Association of America, approximately 350,000 individuals have been diagnosed with MS in the U.S., with an estimated 10,000 new cases diagnosed each year. The most common form of MS at the time of initial diagnosis is a relapsing-remitting form, in which acute symptoms or worsening of neurologic function (referred to as "relapses," "attacks," or "exacerbations") occur intermittently. The symptoms can diminish or disappear for months or years between relapses.

Although the cause of MS is unknown, it is widely considered to be an autoimmune disease in which the person's immune system attacks the brain and/or spinal cord. Tysabri appears to work by binding to these immune system cells, thus preventing them from traveling to the brain where they can cause damage.

Antibodies are proteins produced by a person's immune system to fight foreign substances, such as infections. Monoclonal antibodies, such as natalizumab, can be produced in large quantities in cell culture in a laboratory setting. They can be designed to bind to proteins on the body's normal cells. By recognizing and attaching to these proteins, monoclonal antibodies can interfere with (or alter) normal or abnormal cellular responses. In this way, monoclonal antibodies may be useful in the treatment of certain diseases such as MS.

"This innovative treatment for multiple sclerosis represents a new approach to treating MS -- exciting news for patients with this serious disease," said Dr. Lester M. Crawford, Acting FDA Commissioner. "While we eagerly await long-term results from ongoing clinical trials, we have reason to believe that Tysabri will significantly reduce relapses in MS."

The approval of Tysabri is based on positive results seen in patients after one year of treatment. This product received accelerated approval because it appears to provide substantial benefit for patients with a serious disease. As part of that approval, the manufacturer has committed to continuing its trials of this product for another year.

Tysabri was evaluated for safety and efficacy in two ongoing randomized, double-blind, placebo-controlled trials in patients with relapsing forms of MS. In the first clinical trial of the product's safety and efficacy, the drug reduced the frequency of relapses by 66 percent

relative to placebo.

In a second trial, patients who had been treated with Avonex (interferon beta-1a), an approved treatment for MS, but who had experienced one or more relapses while on Avonex, were randomized to receive Tysabri or placebo. Avonex was continued throughout the study for both groups. In this trial, natalizumab reduced the frequency of relapses by 54 percent relative to placebo.

The most frequently reported serious adverse reactions were infections, including pneumonia, temporary hypersensitivity reactions (such as rash, fever, low blood pressure, and chest pain), depression, and gallstones. These serious adverse reactions were uncommon. Common adverse reactions were generally

mild and included non-serious infections (such as urinary tract, lower respiratory tract, GI system, and vaginal infections), headache, depression, joint pains, and menstrual disorders.

Tysabri is marketed by Biogen Idec, Inc., of Cambridge, Massachusetts, and Elan Pharmaceuticals, Inc., of Dublin, Ireland.

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Oklahoma City KFOR.com NewsChannel 4

Chat rooms help kids find drug, police say

Silent epidemic: teens find instant 'high' in oxycontin

QUIN TRAN reports

Updated: November 23, 2004 8:21 AM

You've heard plenty about pot and meth, but now Oklahoma teenagers are getting hooked on a drug that's 100 percent legal.

"A lot of people don't really know about it," said John Kaiser, who admits he abused oxycontin.

Not every teenager may know about it. Plenty are keeping the addiction a secret.

"They just say it makes you feel higher than weed does, they say it makes you feel great," Kaiser said.

And, it's getting users hooked.

"Relaxes them, makes them feel good and the after-effects screw them up," said Kaiser, who knows all about that.

"We crushed it up and snorted it," he said. "And it was an instant high "

What gave Kaiser an instant high is known on the streets as "oxy" or "hillbilly heroin."

But, it's not a street drug or homemade cocktail. It's found in medicine cabinets.

"It's funny," Kaiser said. "Now that I think about how it controlled my life. Because I was, when I'd meet somebody that I'd never met before, within the first five minutes, my first thing I'd say is, 'You happen to know anybody with oxys?' "

Oxys is short for oxycontin.

For two-and-a-half years Kaiser abused the pain relief medication. He said it's the new up-and-coming drug among high school and college students.

And, at $30 a pill it soon became a daily addiction.

"I always made sure I had one for the next morning, or half of one for the next morning," he said. "There were times I'd say, 'I'll be able to do this' and find one tomorrow and not be able to find it. And it was hell.

"I was in an evil depression," he said. "Bad, and it was a depression because I couldn't find pills."

Kaiser couldn't find the pills because they require a prescription. And if the drug dealers were sold out, Kaiser said he was out of luck.

But law enforcement officials say kids are finding them through others on-line.

The Stillwater police department recently came across a chat room where the talk was all about oxys.

"I would call prescription drug abuse the silent epidemic in this country," said Mark Woodward, spokesman for the Oklahoma Bureau of Narcotics. OBN officials warn parents it may be hard to tell that their kids are addicted, unless they've taken too much of the drug. And by then, officials say, it may be too late.

"I've talked to heroin addicts who said, 'I got off of heroine easier than I'm getting off of oxycontin.' And, that tells me how powerful this drug is," Woodward said.

The drug is so powerful it can kill.

John Kaiser is now trying to get clean, after three of his friends died abusing the drug.

"It was having to answer to a pill every day," he said. "It wasn't the way I wanted to live. I would not wish doing oxy on my worst enemy. If you've never done it, do not start. It's that bad."

Officials in Stillwater recently set up a task force specifically to deal with the problem in that city. But, lawmen admit, oxycontin abuse is a growing concern in just about every community.

Drugs and Chemicals of Concern

Summary of Medical Examiner Reports on Oxycodone-Related Deaths

Preface: The following is a summary of an ongoing study of medical examiner data regarding OxyContin® that is being conducted by the Drug Enforcement Administration (DEA).

The DEA wrote letters to 775 medical examiners (MEs) from the National Association of Medical Examiners (NAME) requesting their reports (autopsy, toxicology, and ME investigative reports) on all deaths induced by, associated with, or related to oxycodone and/or, specifically, the oxycodone product, OxyContin® for 2000 and 2001. Based on the criteria described below, the reports received were categorized into four groups: 1) OxyContin® verified deaths; 2) OxyContin® likely deaths; 3) undetermined deaths; and 4) incomplete reports.

Some jurisdictions have "coroners" which are "elected officials" of the local governments, while others refer to their medical examiners as "coroners". The elected officials are not necessarily medical doctors. In these cases, the coroners are merely the state's competent authority to certify that a death has occurred for legal purposes (such as social security, life insurance and testate cases, etc.). These legal authorities do not make the determinations of "cause of death" and do not perform the autopsies. In Kentucky, for example, under the jurisdiction of county coroner's the "cause of death" is determined by a medical doctor. If the death is suspected to be "drug related" the toxicology samples are sent to the States Forensic Laboratories for analysis. The county coroner only certifies for the state that the "John Doe" has died.

The toxicology reports alone do not discriminate between the presence of any one specific product of the 59 Schedule II oxycodone-containing products available in the United States. However, there are currently only a limited number of single entity oxycodone products that do not also contain the pain relievers acetaminophen (the active ingredient in Tylenol®) or salicylates (aspirin). Of the 7,185,000 prescriptions of these single-entity oxycodone products sold in 2000, approximately 5.8 million were for OxyContin® - 81.4% of the single entity product market. In addition, the oxycodone product Intensol® (20 mg) and an oxycodone generic product (30 mg) are the only other dosage forms containing oxycodone in excess of the standard dosage strengths. There were approximately 24,000

and 1,000 total prescriptions of these two products, respectively, dispensed in 2000. With these facts in mind, any oxycodone positive toxicology without the presence of acetaminophen or salicylates was categorized as an "**OxyContin® likely**" death.

Medical Examiners most typically classify deaths by drug substance only. Therefore, until recently, OxyContin® toxicity was not listed as a cause of death, but rather oxycodone-toxicity. Since its request, DEA is now receiving more ME reports that list "OxyContin® overdose" as the specific cause of death.

Oxycodone-positive autopsy reports that described tablet contents in the gastrointestinal tract that, upon analysis, could be identified as OxyContin® were re-categorized by DEA as "**OxyContin® verified**" deaths. OxyContin® tablets have a unique, trade-specific logo – "OC" on one side, and a number "10", "20", "40", "80" or "160" on the other side. They are also color-coded and have different sizes that can accurately discriminate between these specific products and others containing oxycodone. In addition, the ME investigative reports were scrutinized for the presence of an OxyContin® prescription or tablet at the crime scene, on the person, or reported to be consumed by the decedent, a family member or any other credible witness present at the death. If found, these oxycodone-positive deaths were also re-categorized by DEA as "**OxyContin® verified**".

As of February 14, 2002, DEA has received 1,304 complete ME reports from 32 states. One hundred thirty four (134) complete reports with oxycodone positive toxicologies were excluded because the deaths were attributed to processes not under review, such as

1. self-inflicted gun shot wound to the head while intoxicated with oxycodone
2. cancer
3. Complications from Acquired Immune Deficiency Syndrome
4. Blunt trauma, etc.

Two hundred twenty one (221) additional ME summaries, without toxicology reports, were received but were not included in this study because they were incomplete and of limited usefulness.

Of the 949 complete ME reports received by DEA and using the above criteria, 146 deaths were categorized as "OxyContin® verified" deaths; 318 deaths were re-categorized as "OxyContin® likely". The remainder were categorized as undetermined deaths (i.e., DEA was not able to determine whether or not OxyContin® was involved in the deaths).

These data suggest that 49% (464 out of 949) of all oxycodone positive toxicology reports were likely related to the specific oxycodone product, OxyContin® . In addition, 15% of all oxycodone positive toxicology reports received were verified to be OxyContin® (146 out of 949).

Of the 949 complete medical examiner reports received, the majority were associated with polydrug toxicologies. More than 40% contained a benzodiazepine (Valium-like drugs); approximately 40% contained an opiate in addition to oxycodone; about 30% contained an antidepressant; about 14% contained over-the-counter antihistamines or cold medications;

about 15% contained cocaine or its metabolites. These drugs reflect the typical drug combination patterns described in the published scientific literature associated with opiate addiction/dependence and show up as common "drug mentions" in the Drug Abuse Warning Network (DAWN) emergency department mentions of heroin/morphine episodes. Limiting the comparison to just the 464 OxyContin® likely and OxyContin® verified toxicologies showed a similar pattern of polydrug use.

A critical point to note is that of the 464 deaths linked, or most likely linked, to OxyContin® there were only 88 that had quantifiable levels of blood alcohol at the time of death. Contrary to some reports, the documented evidence clearly shows that only 19% of the OxyContin® deaths can be verified to be the result of a alcohol-drug interaction. Important also is the fact that only nine (9) deaths were associated with the presence of a "recent injection site", and only one death associated with snorting the drug; the vast majority of deaths have been associated with oral consumption of the drug.

An additional caveat must be made regarding standard OxyContin® treatment regimens as they apply to poly-drug use. OxyContin®, by its design and indications-for-use can be viewed as an "entourage" prescription. That is, OxyContin® is indicated for the treatment of moderate to severe pain of long duration such as cancer, severe forms of arthritis, or for "chronic pain syndromes". According to the manufacturers product information, most of these patients receiving around the clock opiate therapy will need to have immediate release medications available for "rescue" from breakthrough pain or to prevent pain that occurs predictably during certain patient activities (typically referred to as "incident pain). Incident pain may occur as a result of the performance of normal activities of daily living, physical therapy, or simply ambulation to the physician's office for treatment. Rescue medications are suggested to be immediate-release opiate formulations either alone or in combination with acetaminophen, aspirin, or other non-steroidal anti-inflammatory drugs (NSAID's). These would include drugs like Vicodin®, Lortab®, Percodan®, Ketoprofen®, etc. The manufacturer's product information clearly states, "Food has no significant effect on the extent of absorption from OxyContin®". There is no adverse reaction notification for the co-administration of OxyContin® and nicotine from cigarette smoking or with caffeine – a psychoactive drug found in many food products, including coffee. By these treatment designs a "normal" patient receiving a standard OxyContin® prescription regimen approved by the Food and Drug Administration may be a poly-drug user. One treatment strategy recommended for "chronic pain" patients is the co-administration of opioids with anti-depressants – again, a treatment strategy, by its design, results in polydrug usage. With these facts in mind it was not surprising to find that many of the OxyContin® deaths were associated with polydrug toxicologies. This does not minimize the significance of the role of OxyContin® in these deaths.

This ongoing effort will continue to collect and analyze reports received from the MEs. DEA can verify 146 deaths in which OxyContin® was the direct "cause of" or a contributing factor to the deaths; an additional 318 deaths lacking acetaminophen and/or salicylates in the toxicology findings most likely involved OxyContin® , as well.

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Substance Abuse Treatment Admissions by Primary Substance of Abuse, According to Sex, Age Group, Race, and Ethnicity

YEAR=2003

STATE: OKLAHOMA		Total	PRIMARY SUBSTANCE														
			Alcohol only	Alcohol with secondary drug	Cocaine (smoked)	Cocaine (other route)	Marijuana	Heroin	Other opiates	PCP	Hallucinogens	Amphetamines	Other stimulants	Tranquilizers	Sedatives	Inhalants	Other/ Unknown
Total	No.	16,604	3,543	3,254	1,311	399	2,876	154	501	31	23	3,442	10	119	93	39	809
	%	100	21.3	19.6	7.9	2.4	17.3	0.9	3	0.2	0.1	20.7	0.1	0.7	0.6	0.2	4.9
SEX		60.9	72	67.5	58.2	59.1	64	57.8	46.7	64.5	78.3	50	40	51.3	33.3	82.1	38.7
Male	%																
Female	%	39.1	28	32.5	41.8	40.9	36	42.2	53.3	35.5	21.7	50	60	48.7	66.7	17.9	61.3
Total	%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
AGE AT ADMISSION		2.5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	51.5
0-11 years	%																
12-17 years	%	6.6	1.8	5.3	0.5	2.8	24.3	0.6	0.8	0	30.4	1	0	3.4	5.4	12.8	8.9
18-20 years	%	7.3	4.9	6.2	1.9	6.5	14.5	3.2	4.6	19.4	13	8.1	0	10.9	6.5	7.7	4.4
21-25 years	%	15.6	10.3	15.5	8.2	11.5	20.7	26.6	11.2	16.1	13	22.4	10	19.3	12.9	25.6	5.3
26-30 years	%	13.4	9.3	12.3	12.2	16	14	14.3	15.6	38.7	21.7	19.6	30	14.3	15.1	17.9	5.8
31-35 years	%	14.5	12.2	15.6	18	17.3	10.3	11.7	18.2	3.2	4.3	19.6	10	12.6	20.4	7.7	6.4
36-40 years	%	14.7	17.2	17.1	24.3	21.1	7.1	11.7	16.4	12.9	4.3	13.7	10	12.6	14	7.7	6.2
41-45 years	%	13.4	18.5	15.6	21.1	14	5.7	14.3	18.8	0	13	10.8	20	15.1	12.9	15.4	5.1
46-50 years	%	7.1	13.2	8.3	9.1	6.3	2.3	8.4	9.4	6.5	0	3.7	10	8.4	6.5	2.6	3.6
51-55 years	%	3.2	7.4	3.4	3.7	3	1	5.8	4.6	3.2	0	0.8	0	1.7	4.3	2.6	0.9
56-60 years	%	1	2.9	0.5	0.8	0.8	0	1.3	0.4	0	0	0.3	0	1.7	2.2	0	1.1
61-65 years	%	0.4	1.6	0.2	0.2	0.8	0.1	1.9	0	0	0	0	10	0	0	0	0.4
66 years and over	%	0.2	0.8	0	0.1	0	0	0	0.2	0	0	0	0	0	0	0	0.4
Unknown	%	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
RACE		69	70.8	68.2	38.2	68.9	63.3	80.5	85.6	16.1	60.9	84.1	60	83.2	87.1	48.7	58.1
White	%																
Black or African- American	%	14.5	7.7	15.3	54.7	17	20.5	7.1	3.6	83.9	30.4	1.2	10	2.5	3.2	0	18.7
American Indian or Alaska	%	12	16.3	12.9	3.8	8	9.8	5.2	6.6	0	0	12	0	10.1	9.7	41	15.8
Asian or Native Hawaiian o	%	0.4	0.5	0.2	0.5	0	0.6	0	0	0	0	0.2	10	0.8	0	0	0.7
Other	%	2.9	3.8	2.4	2.2	4.8	4.5	6.5	1	0	8.7	1.1	10	2.5	0	5.1	3.5
Unknown	%	1.2	1	1	0.6	1.3	1.3	0.6	1.2	0	0	1.3	10	0.8	0	5.1	3.2
Total	%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
ETHNICITY		2	2.5	1.6	1.7	3.3	3.1	5.2	1.2	0	0	0.7	0	0.8	0	5.1	3.7
Hispanic or Latino	%																
Not Hispanic or Latino	%	96.7	95.9	97.4	97.5	95	94.8	93.5	98.8	100	91.3	98.6	90	97.5	100	94.9	94.1
Unknown	%	1.3	1.5	1	0.8	1.8	2.1	1.3	0	0	8.7	0.7	10	1.7	0	0	2.2
Total	%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Click here to view descriptions of drug categories

– Quantity is zero

SOURCE: Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS).

Based on administrative data reported by States to TEDS through 10.05.2004.

Drug and Alcohol Services Information System

The DASIS Report

July 23, 2004

Treatment Admissions Involving Narcotic Painkillers: 2002 Update

In Brief

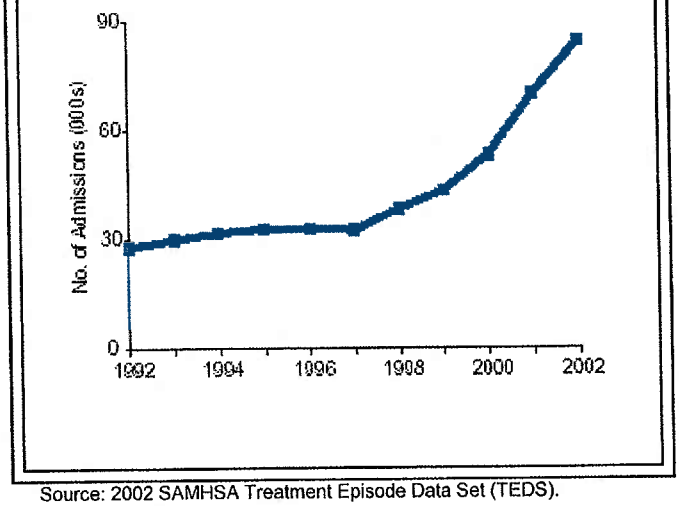
- Between 1992 and 2002, treatment admission rates for abuse of narcotic painkillers more than doubled
- The proportion of new users of narcotic painkillers (those entering treatment within 3 years of beginning use) increased from 26 percent in 1997 to 39 percent in 2002
- Between 1997 and 2002, the number of treatment admissions involving narcotic painkillers increased for all ages, especially among people aged 20 to 30

Admissions to treatment involving the abuse of narcotic painkillers[1] made up a small proportion—about 4 percent—of the 1.9 million admissions reported to the Treatment Episode Data Set (TEDS) in 2002. However, these treatment admissions have increased in publicly funded substance abuse treatment facilities across the nation during the last few years.

In 2002, there were about 84,000 admissions to treatment where the primary, secondary, or tertiary substance of abuse was a narcotic painkiller. In about half of these admissions, narcotic painkillers represented the primary substance of abuse.[2] In the other half of these 84,000 admissions, abuse of narcotic painkillers was secondary to abuse of another substance, generally alcohol or heroin.

The number of treatment admissions in which narcotic painkillers were involved was relatively stable between 1992 and 1997, but increased between 1997 and 2002 (Figure 1). In 1992, the treatment admission rate for narcotic painkiller abuse in the United States was 14 admissions per 100,000 persons aged 12 or older.[3] By 2002, it had increased to 35 admissions per 100,000, more than doubling the rate since 1992.

Figure 1. Narcotic Painkiller Treatment Admissions: 1992-2002

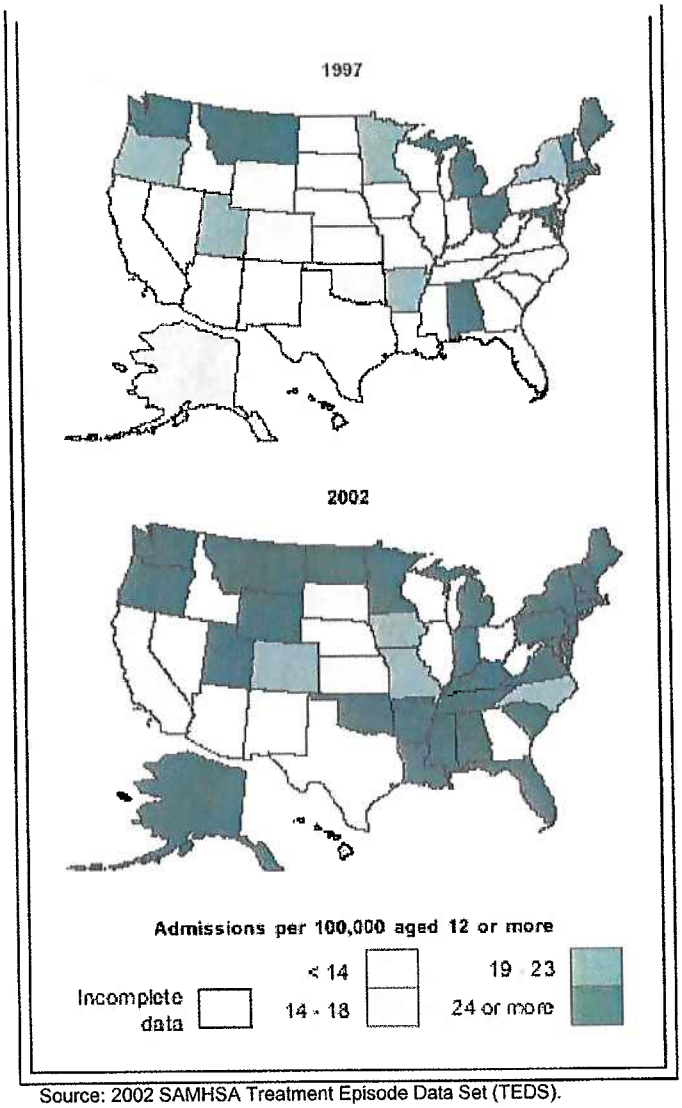


Source: 2002 SAMHSA Treatment Episode Data Set (TEDS).

Admission Rates by State

In 1992, 5 States had an admission rate for narcotic painkillers of 24 per 100,000 aged 12 or older. By 1997, 11 States had admission rates that high, and by 2002, 31 States had narcotic painkiller admission rates of 24 per 100,000 or more (Figure 2). Five of the 6 New England States reported the highest rates in the nation, ranging from 89 per 100,000 in Connecticut to 207 per 100,000 in Maine.

Figure 2. Narcotic Painkiller Admission Rates, by State: 1997 and 2002

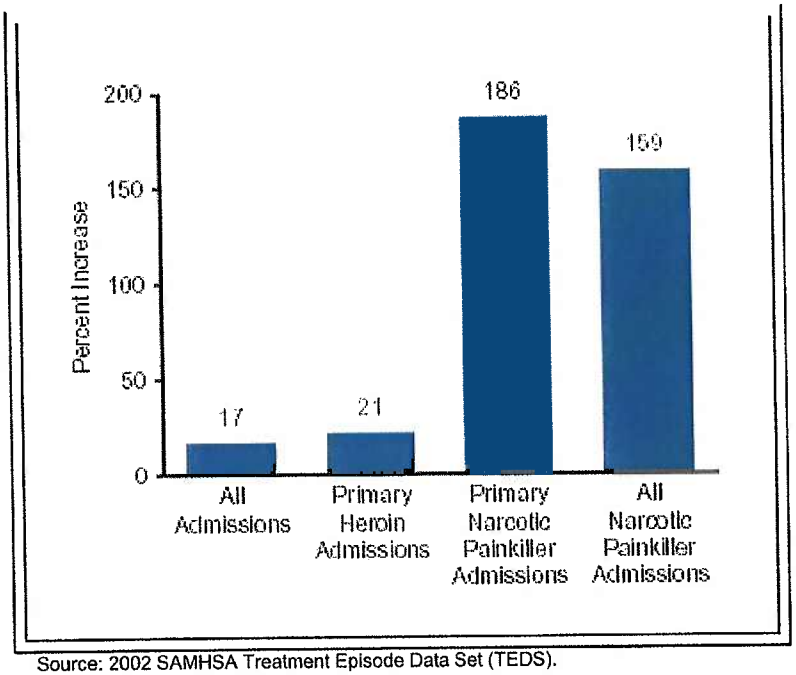


Source: 2002 SAMHSA Treatment Episode Data Set (TEDS).

Number of Admissions

The increase in admissions involving narcotic painkillers was much larger than the overall increase in treatment admissions (Figure 3). In TEDS, the number of treatment admissions increased by 17 percent between 1997 and 2002. During that same period, admissions for primary heroin abuse increased 21 percent. Admissions for primary abuse of narcotic painkillers increased 186 percent, and the number of admissions involving any primary, secondary, or tertiary abuse of narcotic painkillers increased by 159 percent.

Figure 3. Percent Increase in Number of Treatment Admissions: 1997-2002



Source: 2002 SAMHSA Treatment Episode Data Set (TEDS).

Characteristics

The characteristics of admissions for abuse of narcotic painkillers changed little between 1997 and 2002. Over half (56 percent in 1997 and 57 percent in 2002) were male, and the majority were White (83 percent in 1997 and 87 percent in 2002). Referral to treatment through the criminal justice system was relatively rare (17 percent in both 1997 and 2002), with about half of narcotic painkiller admissions seeking treatment on their own (47 percent in 1997 and 49 percent in 2002) and one quarter being referred by substance abuse treatment or other health care providers (26 percent in 1997 and 25 percent in 2002). In 2002, a larger proportion entered detoxification than in 1997 (27 percent vs. 22 percent).

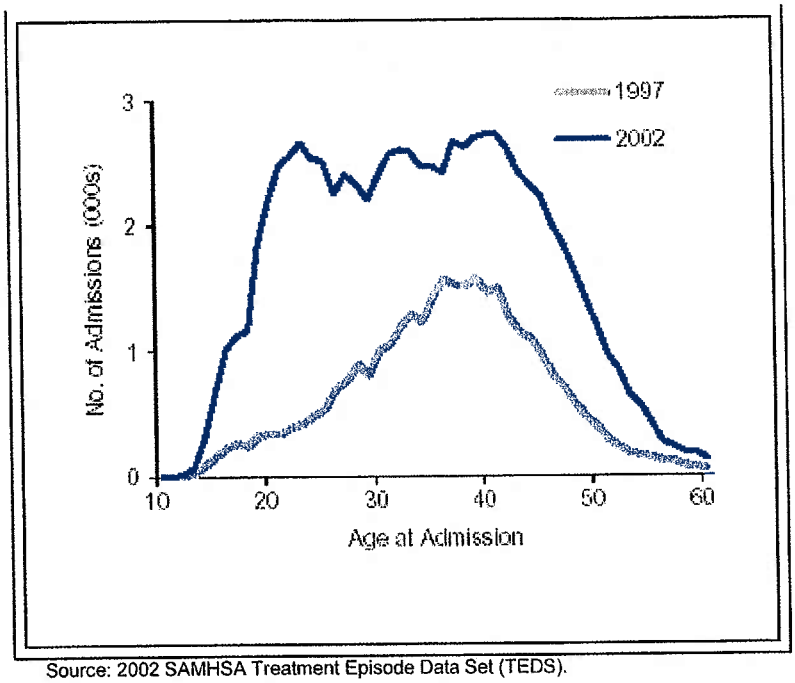
New Users

The major change between 1997 and 2002 was the substantial increase in the proportion of new users of narcotic painkillers (those entering treatment within 3 years of beginning use). The proportion of new users increased from 26 percent in 1997 to 39 percent in 2002.

Age

Over the 5-year span 1997 to 2002, the number of treatment admissions involving narcotic painkillers increased for all ages (Figure 4). However, the largest increase was in the number of admissions among people aged 20 to 30.

Figure 4. Narcotic Painkiller Admissions, by Age: 1997 and 2002



Source: 2002 SAMHSA Treatment Episode Data Set (TEDS).

Duration of Use

The median duration of use before first seeking treatment decreased, from 9 years in 1992, to 7 years in 1997, to 4 years in 2002.

End Notes

[1] Narcotic painkiller admissions include all admissions reporting primary, secondary, or tertiary abuse of narcotic painkillers such as codeine, hydrocodone, hydromorphone, meperidine, morphine, oxycodone, pentazocine, propoxyphene, and any other drug with morphine-like effects. Admissions involving abuse of heroin and/or methadone, unless reported in addition to abuse of narcotic painkillers, are excluded from this report.

[2] The primary substance of abuse is the main substance reported at the time of admission.

[3] States continually review the quality of their data processing. When systematic errors are identified, States may revise or replace historical TEDS data files. While this process represents an improvement in the data system, the historical statistics in this report will differ slightly from those in earlier reports.

The Drug and Alcohol Services Information System (DASIS) is an integrated data system maintained by the Office of Applied Studies, Substance Abuse and Mental Health Services Administration (SAMHSA). One component of DASIS is the Treatment Episode Data Set (TEDS). TEDS is a compilation of data on the demographic characteristics and substance abuse problems of those admitted for substance abuse treatment. The information comes primarily from facilities that receive some public funding. Information on treatment admissions is routinely collected by State administrative systems and then submitted to SAMHSA in a standard format. Approximately 1.9 million records are included in TEDS each year. TEDS records represent admissions rather than individuals, as a person may be admitted to treatment more than once.

The DASIS Report is prepared by the Office of Applied Studies, SAMHSA; Synectics for Management Decisions, Inc., Arlington, Virginia; and RTI, Research Triangle Park, North Carolina.

Information and data for this issue are based on data reported to TEDS through March 1, 2004.

Access the latest TEDS reports at:
http://www.oas.samhsa.gov/dasis.htm

Access the latest TEDS public use files at:
http://www.oas.samhsa.gov/SAMHDA.htm