Drug Utilization Review Board

Oklahoma Health Care Authority

4545 N. Lincoln Suite 124

Oklahoma City, Oklahoma 73105

OHCA Board Room

December 13, 2006

@ 6:00 p.m.

THE UNIVERSITY OF OKLAHOMA

THE UNIVERSITY OF OKLAHOMA

MEMORANDUM

TO: Drug Utilization Review Board Members

FROM: Shellie Gorman, Pharm.D.

SUBJECT: **Packet Contents for Board Meeting – December 13, 2006**

DATE: December 06, 2006

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 – **See Appendix A.**

Action Item – Approval of DUR Board Meeting Dates – **See Appendix B.**

Update on DUR/MCAU Program – **See Appendix C.**

Action Item – Annual Review of Plavix® – **See Appendix D.**

Action Item – Annual Review of Bladder Products – **See Appendix E.**

Action Item – Annual Review of Benzodiazepines/Hypnotics – **See Appendix F.**

Action Item – Annual Review of Non-Sedating Antihistamines – **See Appendix G.**

Action Item – Annual Review of Fenofibrates – **See Appendix H.**

Utilization Review of Ocular Allergy Products – **See Appendix I.**

New for 2007 – **See Appendix J.**

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

Future Business

Adjournment

Drug Utilization Review Board

(DUR Board)

Meeting – December 13, 2006 @ 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. McNeill, Chairman:

1. Call To Order

A. Roll Call – Dr. Graham

Items to be presented by Dr. McNeill, Chairman:

2. Public Comment Forum

A. Acknowledgment of Speakers and Agenda Item

Items to be presented by Dr. McNeill, Chairman:

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

A. November 08, 2006 DUR Minutes – Vote
B. November 08, 2006 DUR Recommendations Memorandum
C. Provider Correspondence

Items to be presented by Dr. McNeill, Chairman:

4. Action Item – Approval of 2007 DUR Meeting Dates – See Appendix B.

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

5. Update on DUR/MCAU Program – See Appendix C.

A. Retrospective Drug Utilization Review for July 2006
B. Retrospective Drug Utilization Review Response for May 2006
C. Medication Coverage Activity Audit for November 2006
D. Help Desk Activity Audit for November 2006

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

6. Action Item – Annual Review of Plavix® – See Appendix D.

A. Current Prior Authorization Criteria
B. Utilization Review
C. COP Recommendations

Items to be presented by Dr. Moore, Dr. McNeill, Chairman

7. Action Item – Annual Review of Bladder Products – See Appendix E.

A. Current Prior Authorization Criteria
B. Utilization Review
C. COP Recommendations

Items to be presented by Dr. Browning, Dr. McNeill, Chairman:

8. Action Item – Annual Review of Benzodiazepines/Hypnotics – See Appendix F.

A. Current Prior Authorization Criteria
B. Utilization Review
C. Cost Comparisons
D. COP Recommendations

Items to be presented by Dr. Patel, Dr. McNeill, Chairman

9. Action Item – Annual Review of Non-Sedating Antihistamines – See Appendix G.

A. Current Prior Authorization Criteria
B. Utilization Review
C. Market Changes for FY07
D. COP Recommendations

Items to be presented by Dr. Le, Dr. McNeill, Chairman

10. Action Item - Annual Review of Fenofibrates – See Appendix H.

A. Current Prior Authorization Criteria
B. Utilization Review
C. COP Recommendations

Items to be presented by Dr. Gorman, Dr. McNeill, Chairman

11. Utilization Review of Ocular Allergy Products – See Appendix I.

A. Background
B. Utilization Review
C. COP Recommendations

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

12. New for 2007 – See Appendix J.

13. FDA and DEA Updates – See Appendix K.

14. Future Business

A. Annual Reviews
B. Topical Products Utilization Review
C. Hemophilia Utilization Review
D. Asthma Utilization Review
D. New Product Reviews and 30 Day Notices

15. Adjournment

APPENDIX A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES of MEETING of NOVEMBER 8, 2006

BOARD MEMBERS:	PRESENT	ABSENT
Brent Bell, D.O., D.Ph.	X	
Mark Feightner, D.Ph.	X	
Dorothy Gourley, D.Ph.	X	
Kyle Hrdlicka, D.O.		X
Dan McNeill, Ph.D., PA-C; Chairman	X	
Cliff Meece, D.Ph., Vice-Chairman	X	
John Muchmore, M.D.	X	
James Rhymer, D.Ph	X	

COLLEGE of PHARMACY STAFF:	PRESENT	ABSENT
Leslie Browning, D.Ph./PA Coordinator	X	
Metha Chonlahan, D.Ph./Clinical Pharmacist		X
Karen Egesdal, D.Ph./SMAC-ProDUR Coordinator/OHCA Liaison		X
Kelly Flannigan, Pharm.D../Operations Manager	X	
Shellie Gorman, Pharm.D./DUR Manager	X	
Ronald Graham, D.Ph./Pharmacy Director	X	
Chris Le, Pharm.D., Clinical Pharmacist/Coordinator	X	
Carol Moore, Pharm.D., Clinical Pharmacist		X
Neeraj Patel, Pharm.D., Clinical Pharmacist	X	
Lester A. Reinke, Ph.D.	X	
Pharmacy Resident: Kathryn Mathews, Pharm.D.		X
Visiting Pharmacy Students: April Tabler, Alicia Herringshaw	X	

OKLAHOMA HEALTH CARE AUTHORITY STAFF:	PRESENT	ABSENT
Alex Easton, M.B.A./ Pharmacy Operations Manager		X
Mike Fogarty, J.D., M.S.W./Chief Executive Officer		X
Nico Gomez, Director of Gov't and Public Affairs		X
Lynn Mitchell, M.D., M.P.H/Director of Medical Services	X	
Nancy Nesser, Pharm.D., J.D./Pharmacy Director	X	
Howard Pallotta, J.D./Director of Legal Services		X
Lynn Rambo-Jones, J.D./Deputy General Counsel III	X	
Rodney Ramsey/Drug Reference Coordinator	X	
Jill Ratterman, D.Ph./Pharmacy Specialist		X

OTHERS PRESENT:

Aaron Walker, Schering-Plough	Tim Donohue, VCG & Assoc.	Jerry Gomez, King Pharma
Mark DeClerk, Lilly	Jim Dunlap, Lilly	Roger Enix, Merck & Co.
Steve Fell, Schering-Plough	Steve Higgins, TAP Pharmaceuticals	Brody Onan, TAP Pharmaceuticals
Toby Thompson, Pfizer	Sandy Rube, FKG	Carl Rubenstein Heart Hospital
Robyn Schaiff, Pfizer	Jorge Saucedo, OU	

PRESENT FOR PUBLIC COMMENT:

Robyn Schaiff, Pfizer	Agenda Items 6, 7
Carl Rubenstein, Heart Hospital	Agenda Item 7
Jorge Saucedo, OU	Agenda Item 7

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

1A: Roll Call

Dr. McNeill 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**

Dr. McNeill acknowledged speakers for Public Comment for Agenda Items 6 and 7.

ACTION: NONE REQUIRED.

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

3A: October 11, 2006 DUR Minutes

Dr. Meece moved to approve minutes as submitted; seconded by Dr. Gourley.

ACTION: MOTION CARRIED.

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

4A: Retrospective Drug Utilization Review Report: June 2006
4B: Retrospective Drug Utilization Review Response: April 2006
4C: Medication Coverage Activity Report: October 2006
4D: Help Desk Activity Report: October 2006
4E: Pharmacotherapy Management Quarterly Report

Reports included in agenda packet; presented by Dr. Flannigan.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE FORTAMET®AND GLUMETZA™**

Materials included in agenda packet; presented by Dr. Gorman.

Dr. Muchmore moved to approve, changed from "clinical documentation of inability to take other forms of generic metformin ER" to "after slow titration of 500 mg ER at 2 week intervals up to 2000 mg daily"; seconded by Dr. Bell.

ACTION: MOTION CARRIED.

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE EXUBERA™**

For Public Comment, Dr. Robyn Schaiff: I just wanted everyone to know that we brought the device in case people wanted to look at it and that I'm here to work it.

Board Member: Could we have a demonstration?

Dr. Schaiff: This is how it looks when it's collapsed. You pull this an open it till it snaps open. Then there's little foil blister packs that you insert into this opening right here, and they have either 1 mg or 3 mg. You pump this which pressurizes the device and then you pull this, which activates the fan. It'll make a cloud in here of very small particles and then the patient just puts this in their mouth and breathes normally for five seconds. And if they need an additional dose, you just repeat. You pop the used blister pack out, put an additional one in, pump it again, push this and then breathe normally for another five seconds. A 1 mg blister pack is three units and a 3 mg is eight units, so it's important that patients know not to use three ones instead of .....

Board Member: The clear part has to be replaced every two weeks?

Toby Thompson: Yessir.

Board Member: And what about the base? What's the life of the base?

Dr. Schaiff: One year. No batteries. When you pump this, that's pressurizing and then when you push this, that's what makes it ..... so there's no battery in the device.

Toby Thompson: And I will let you know this is the part that she was talking about, needs to be replaced every two weeks. And it comes with the prescription.

Board Member: Oh, you don't have to replace the clear chamber?

Toby Thompson: No, you just replace this and you rinse this out and wash it. It comes with two of these .....

Ron Graham: What's the maintenance on those things?

Toby Thompson: You wash it once a week. And you'll have two chambers so you can just let it dry and use this one.

Board Member: That central part comes with the prescription?

Toby Thompson: This little part does, yes sir.

Board Member: What's the cost of replacement . . . is it in the packet?

Dr. Schaiff: One other thing. Initially it's been sold as a packet with a set amount of ones and threes, that's simply an initial step. The plan is then the patient would later be able to order exactly what they needed, either ones or threes or both. So that's a temporary step for them.

Materials included in agenda packet; presented by Dr. Gorman.

Dr. Muchmore moved to approve with revision of Type II Diabetics Criteria 1 to state " ..... after a minimum of six months of oral therapy on two oral agents"; seconded by Dr. Feightner. (Other COP recommendations were approved as submitted with this motion and vote).

ACTION: MOTION CARRIED.

AGENDA ITEM NO. 7: **ANNUAL REVIEW OF STATINS AND VOTE TO AUTHORIZE CRITERIA CHANGES**

For Public Comment, Dr. Carl Rubenstein: Thank you. I'm Carl Rubenstein, clinical lipidologist with the Oklahoma Cardiovascular Association of the Oklahoma Heart Hospital. I thank you for letting me join you today to make some comments regarding the selection of lipid-lowering medicines to have available on the formulary. Please know that I do understand and support the meaning of this Board to make selections that take into account the most cost effective way to achieve medication goals. I'm here as a physician who has been and is intensively involved in preventative cardiology and especially the management of lipids to prevent atherosclerotic ischemic progression and events. I also speak as a physician who takes care of a fair number of patients who are on Medicaid, as well as many who fall in the category of the working poor, and I wrestle daily with cost factors of medicines impacting that care. Our national guidelines for lipid control, the NCPE guidelines, the Adult Treatment Program guidelines, have gotten significantly lower over time based on strong studies showing that morbidity and mortality, plaque stabilization and regression are improved by achieving lower lipid levels. As I'm sure you know, for patients with atherosclerotic disease, the LDL goal now is to get to 70 or even lower. For patients with major risk factor status, the LDL goal now is 100 or even less, and with very good justification. While many patients can be brought to these goals with diet plus a statin alone, many cannot reach these goals with monotherapy. Ezetimibe added to a statin has far greater LDL lowering effect than simply titrating up the statin. In many instances, 18-20% additional reduction versus 6-7% by doubling the statin dose. So having ezetimibe available for this purpose, I think, really should have a high priority. There is an advantage to having several statin options at least because of differences in side effect tolerability from person to person. It is not reasonable to ignore the sometimes painful myalgias, for example. I've personally made extensive use over a span of years of bile acid binding resins with and without nyacin and the success rate and patient adherence with the statins clearly is better. Because of the concentration of my practice on difficult lipid control problems, I have a significant number of patients taking two, three and even some taking four lipid control agents to achieve our goals. That the various statins differ in potency certainly is well known, and although atorvastatin is more potent than simvastatin and rosuvastatin more potent than either, the combination of simvastatin and ezetimibe available as a single tablet of Vytorin appears to be at least as effective as comparable doses of atorvastatin. From a patient adherence standpoint, one tablet is better than two. Whether that makes sense in optimizing the Medicaid budget dollars depends, as you know better than I, on how willing the pharmaceutical contracting agents are to discount the price. I made that statement clear when I was asked by Merck/Schering-Plough to make comments today. I thank you for the opportunity to speak and would be happy to answer any questions you might like to pose to me.

For Public Comment, Dr. Robyn Schaiff: I'm Dr. Robyn Schaiff from Pfizer US Medical and I'm here to make the case that patients, or certain patient groups need to have access to atorvastatin without a trial period of another generic and preferably without a prior authorization. My recommendation is based on the fact that we are the only statin to show significant improvement in the early days after an acute MI or acute coronary syndrome, and delaying therapy with atorvastatin may result in numerous events occurring during that time period. There's also as you mentioned in your recommendation, concerns about drug interactions which I share. Although Lipitor and simva and lova are all 3A4 metabolized, because simva and lova have very low bioavailability of about 5% or less, when you use an interacting drug, 3A4 inhibitor, their increases in near end of the curve are in the magnitude of 6 to 10 to 12, as opposed with atorvastatin you get an increase in the near end of the curve more on the order of 1.4 to 2.5. So the concern I have is with interactions with over the counter medications including cimetidine, St. John's Wort and other things that certain populations at risk for drug interactions may be at risk without being on an interacting drug. So the concerns I have are better outcome data in acute coronary syndrome patients. While other agents can get the cholesterol lower, we are the agent that has been studied in the two outcome studies showing that lower is better, 80 mg, Vytorin was the control arm in the PROVE IT trial as well as the TNT as well as the IDEAL study. So we're the agent with the outcomes. And so I would propose that patients need access to that without undue responsibility on the physician. Agreed, you guys definitely have been waiting for these drugs to go generic and I agree that you need to be able to save money on those and I agree that there are many patients that can use the generic drugs. I just think that there are certain high risk patients that ought to have access without prior authorization. And I'll turn it over to Dr. Saucedo who I walked because I didn't see him ..... he moved.

For Public Comment, Dr. Jorge Saucedo: Good evening. Thank you for having me here tonight. I'm Jorge Saucedo. I'm the Vice Chief of Cardiology at the University. I'm an interventional cardiologist so I do take care of many of Medicaid population. Indeed the type of patients that I do take care of the most are those patients that were seen with acute coronary syndrome. So most of my practice, at least as it pertains to the Medicaid patients is for secondary prevention of coronary events. Now I want to second some of Dr. Rubenstein's comments indeed. I do believe that very few things would have learned in medicine over the past years and very few medications indeed can prolong life. In the area of cardiovascular medicine we know that statins indeed have a central role in preventing major cardiovascular events including death for patients with high cholesterol, primary prevention. Patients with a few risk factors also, primary prevention, and clearly, for secondary prevention, patients who have already had the cardiovascular event. Now in this area indeed we know that the lower the LDL cholesterol, the better. Now we're talking about LDL as a surrogate endpoint and true, the majority of us believe that it is a decent surrogate endpoint to believe, that is the lower the LDL, the bettter. There have been recent stories shown that indeed if we reach LDL of about 60, we may indeed regress atherosclerosis in patients as much as 10%. I think the most important part of this game is not so much regress atherosclerosis but make plaques stable so they less rupture plaques, less fissure plaques and less acute coronary events. No although I believe in great part that LDL is a good surrogate for event, still, in cardiology, we need to focus on clinical trials that have shown us clearly that any given drug reduces events, not only a surrogate endpoint but events. And I'm talking about major events . . death, MI, stroke. I don't believe that there is any other drug in cardiovascular medicine and I don't think there is any

other drug in medicine that has been studied as much as atorvastatin alone. The reason I decided to come here to talk to you about atorvastatin is because I feel in my practice that giving this drug as an interventional cardiologist that I am indeed and put in stents and treating atherosclerosis by angioplasty and stents every day, I believe that I do most part not as much good as treating the risk factors and indeed treating cholesterol. And I also believe that atorvastatin is I feel, on the level of safety, how comfortable I feel. I'm used to prescribing this drug as probably as much as aspirin indeed, so those two drugs are probably the drugs that I feel the most comfortable on terms as safety profile and how much good I am giving my patients. Now again, the clinical trial that we have on atorvastatin (UNINTELLIGIBLE) indeed. And we have major large randomized clinical trials that have clearly shown that atorvastatin is better therapy in terms of reducing events, maximum dose, as compared to a simvastatin, for instance 40 mg and the IDEAL trial or that larger doses of atorvastatin which are very well tolerated at 80 mg are much better than lower doses of atorvastatin 10 mg for instance, for secondary prevention as the TNT trials have shown us. So in summary, the data that we have for patients with acute coronary syndromes with 80 mg with atorvastatin that is reducing events in someone that presents with chest pain and acute coronary syndromes has not been reproduced with any other statin to my knowledge, number one. Number two, that atorvastatin at the highest dose is probably the drug with the safest profile that we have currently as a statin, and those I feel very comfortable prescribing this drug for the reduction of LDL but most important, for the reduction of clinical events clearly shown in very large (UNINTELLIGIBLE) clinical trials. Thank you very much for your attention. Are there any questions?
Materials included in agenda packet; presented by Dr. Gorman.
Dr. Gourley moved to approve as amended; seconded by Dr. Bell.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 8: **ANNUAL REVIEW OF NSAIDs AND VOTE ON MOBIC®**
Materials included in agenda packet; presented by Dr. Patel.
Dr. Meece moved to approve as submitted; seconded by Dr. Feightner.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 9: **ANNUAL REVIEW OF ANTIDEPRESSANTS AND VOTE ON RECOMMENDATIONS**
Materials included in agenda packet; presented by Dr. Le.
Dr. Meece moved to approve as submitted; seconded by Dr. Bell.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 10: **UTILIZATION REVIEW OF SUBOXONE®**
Materials included in agenda packet; presented by Drs. Flannigan and Gorman.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 11: **NEW PRODUCT REVIEWS**
Materials included in agenda packet; presented by Dr. Gorman.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 12: **FDA & DEA UPDATES**
Materials included in agenda packet; presented by Dr. Graham.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 13: **FUTURE BUSINESS**
13A: Annual Reviews
13B: Hemophilia Utilization Review
13C: Topical Products Utilization Review
13D: New Product Revices and 30-Day Notices
Materials included in agenda packet; submitted by Dr. Graham.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 14: **ADJOURNMENT**
The meeting was declared adjourned.

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

1A: Roll Call

Dr. McNeill 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**

Dr. McNeill acknowledged speakers for Public Comment for Agenda Items 6 and 7.

ACTION: NONE REQUIRED.

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

3A: October 11, 2006 DUR Minutes

Dr. Meece moved to approve minutes as submitted; seconded by Dr. Gourley.

ACTION: MOTION CARRIED.

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

4A: Retrospective Drug Utilization Review Report: June 2006
4B: Retrospective Drug Utilization Review Response: April 2006
4C: Medication Coverage Activity Report: October 2006
4D: Help Desk Activity Report: October 2006
4E: Pharmacotherapy Management Quarterly Report

Reports included in agenda packet; presented by Dr. Flannigan.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE FORTAMET®AND GLUMETZA™**

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Dr. Muchmore moved to approve, changed from "clinical documentation of inability to take other forms of generic metformin ER" to "after slow titration of 500 mg ER at 2 week intervals up to 2000 mg daily"; seconded by Dr. Bell.

ACTION: MOTION CARRIED.

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE EXUBERA™**

For Public Comment, Dr. Robyn Schaiff: I just wanted everyone to know that we brought the device in case people wanted to look at it and that I'm here to work it.

Board Member: Could we have a demonstration?

Dr. Schaiff: This is how it looks when it's collapsed. You pull this an open it till it snaps open. Then there's little foil blister packs that you insert into this opening right here, and they have either 1 mg or 3 mg. You pump this which pressurizes the device and then you pull this, which activates the fan. It'll make a cloud in here of very small particles and then the patient just puts this in their mouth and breathes normally for five seconds. And if they need an additional dose, you just repeat. You pop the used blister pack out, put an additional one in, pump it again, push this and then breathe normally for another five seconds. A 1 mg blister pack is three units and a 3 mg is eight units, so it's important that patients know not to use three ones instead of .....

Board Member: The clear part has to be replaced every two weeks?

Toby Thompson: Yessir.

Board Member: And what about the base? What's the life of the base?

Dr. Schaiff: One year. No batteries. When you pump this, that's pressurizing and then when you push this, that's what makes it ..... so there's no battery in the device.

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Dr. Muchmore moved to approve with revision of Type II Diabetics Criteria 1 to state " ..... after a minimum of six months of oral therapy on two oral agents"; seconded by Dr. Feightner. (Other COP recommendations were approved as submitted with this motion and vote).

ACTION: MOTION CARRIED.

AGENDA ITEM NO. 7: **ANNUAL REVIEW OF STATINS AND VOTE TO AUTHORIZE CRITERIA CHANGES**

For Public Comment, Dr. Carl Rubenstein: Thank you. I'm Carl Rubenstein, clinical lipidologist with the Oklahoma Cardiovascular Association of the Oklahoma Heart Hospital. I thank you for letting me join you today to make some comments regarding the selection of lipid-lowering medicines to have available on the formulary. Please know that I do understand and support the meaning of this Board to make selections that take into account the most cost effective way to achieve medication goals. I'm here as a physician who has been and is intensively involved in preventative cardiology and especially the management of lipids to prevent atherosclerotic ischemic progression and events. I also speak as a physician who takes care of a fair number of patients who are on Medicaid, as well as many who fall in the category of the working poor, and I wrestle daily with cost factors of medicines impacting that care. Our national guidelines for lipid control, the NCPE guidelines, the Adult Treatment Program guidelines, have gotten significantly lower over time based on strong studies showing that morbidity and mortality, plaque stabilization and regression are improved by achieving lower lipid levels. As I'm sure you know, for patients with atherosclerotic disease, the LDL goal now is to get to 70 or even lower. For patients with major risk factor status, the LDL goal now is 100 or even less, and with very good justification. While many patients can be brought to these goals with diet plus a statin alone, many cannot reach these goals with monotherapy. Ezetimibe added to a statin has far greater LDL lowering effect than simply titrating up the statin. In many instances, 18-20% additional reduction versus 6-7% by doubling the statin dose. So having ezetimibe available for this purpose, I think, really should have a high priority. There is an advantage to having several statin options at least because of differences in side effect tolerability from person to person. It is not reasonable to ignore the sometimes painful myalgias, for example. I've personally made extensive use over a span of years of bile acid binding resins with and without nyacin and the success rate and patient adherence with the statins clearly is better. Because of the concentration of my practice on difficult lipid control problems, I have a significant number of patients taking two, three and even some taking four lipid control agents to achieve our goals. That the various statins differ in potency certainly is well known, and although atorvastatin is more potent than simvastatin and rosuvastatin more potent than either, the combination of simvastatin and ezetimibe available as a single tablet of Vytorin appears to be at least as effective as comparable doses of atorvastatin. From a patient adherence standpoint, one tablet is better than two. Whether that makes sense in optimizing the Medicaid budget dollars depends, as you know better than I, on how willing the pharmaceutical contracting agents are to discount the price. I made that statement clear when I was asked by Merck/Schering-Plough to make comments today. I thank you for the opportunity to speak and would be happy to answer any questions you might like to pose to me.

For Public Comment, Dr. Robyn Schaiff: I'm Dr. Robyn Schaiff from Pfizer US Medical and I'm here to make the case that patients, or certain patient groups need to have access to atorvastatin without a trial period of another generic and preferably without a prior authorization. My recommendation is based on the fact that we are the only statin to show significant improvement in the early days after an acute MI or acute coronary syndrome, and delaying therapy with atorvastatin may result in numerous events occurring during that time period. There's also as you mentioned in your recommendation, concerns about drug interactions which I share. Although Lipitor and simva and lova are all 3A4 metabolized, because simva and lova have very low bioavailability of about 5% or less, when you use an interacting drug, 3A4 inhibitor, their increases in near end of the curve are in the magnitude of 6 to 10 to 12, as opposed with atorvastatin you get an increase in the near end of the curve more on the order of 1.4 to 2.5. So the concern I have is with interactions with over the counter medications including cimetidine, St. John's Wort and other things that certain populations at risk for drug interactions may be at risk without being on an interacting drug. So the concerns I have are better outcome data in acute coronary syndrome patients. While other agents can get the cholesterol lower, we are the agent that has been studied in the two outcome studies showing that lower is better, 80 mg, Vytorin was the control arm in the PROVE IT trial as well as the TNT as well as the IDEAL study. So we're the agent with the outcomes. And so I would propose that patients need access to that without undue responsibility on the physician. Agreed, you guys definitely have been waiting for these drugs to go generic and I agree that you need to be able to save money on those and I agree that there are many patients that can use the generic drugs. I just think that there are certain high risk patients that ought to have access without prior authorization. And I'll turn it over to Dr. Saucedo who I walked because I didn't see him ..... he moved.

For Public Comment, Dr. Jorge Saucedo: Good evening. Thank you for having me here tonight. I'm Jorge Saucedo. I'm the Vice Chief of Cardiology at the University. I'm an interventional cardiologist so I do take care of many of Medicaid population. Indeed the type of patients that I do take care of the most are those patients that were seen with acute coronary syndrome. So most of my practice, at least as it pertains to the Medicaid patients is for secondary prevention of coronary events. Now I want to second some of Dr. Rubenstein's comments indeed. I do believe that very few things would have learned in medicine over the past years and very few medications indeed can prolong life. In the area of cardiovascular medicine we know that statins indeed have a central role in preventing major cardiovascular events including death for patients with high cholesterol, primary prevention. Patients with a few risk factors also, primary prevention, and clearly, for secondary prevention, patients who have already had the cardiovascular event. Now in this area indeed we know that the lower the LDL cholesterol, the better. Now we're talking about LDL as a surrogate endpoint and true, the majority of us believe that it is a decent surrogate endpoint to believe, that is the lower the LDL, the bettter. There have been recent stories shown that indeed if we reach LDL of about 60, we may indeed regress atherosclerosis in patients as much as 10%. I think the most important part of this game is not so much regress atherosclerosis but make plaques stable so they less rupture plaques, less fissure plaques and less acute coronary events. No although I believe in great part that LDL is a good surrogate for event, still, in cardiology, we need to focus on clinical trials that have shown us clearly that any given drug reduces events, not only a surrogate endpoint but events. And I'm talking about major events . . death, MI, stroke. I don't believe that there is any other drug in cardiovascular medicine and I don't think there is any

other drug in medicine that has been studied as much as atorvastatin alone. The reason I decided to come here to talk to you about atorvastatin is because I feel in my practice that giving this drug as an interventional cardiologist that I am indeed and put in stents and treating atherosclerosis by angioplasty and stents every day, I believe that I do most part not as much good as treating the risk factors and indeed treating cholesterol. And I also believe that atorvastatin is I feel, on the level of safety, how comfortable I feel. I'm used to prescribing this drug as probably as much as aspirin indeed, so those two drugs are probably the drugs that I feel the most comfortable on terms as safety profile and how much good I am giving my patients. Now again, the clinical trial that we have on atorvastatin (UNINTELLIGIBLE) indeed. And we have major large randomized clinical trials that have clearly shown that atorvastatin is better therapy in terms of reducing events, maximum dose, as compared to a simvastatin, for instance 40 mg and the IDEAL trial or that larger doses of atorvastatin which are very well tolerated at 80 mg are much better than lower doses of atorvastatin 10 mg for instance, for secondary prevention as the TNT trials have shown us. So in summary, the data that we have for patients with acute coronary syndromes with 80 mg with atorvastatin that is reducing events in someone that presents with chest pain and acute coronary syndromes has not been reproduced with any other statin to my knowledge, number one. Number two, that atorvastatin at the highest dose is probably the drug with the safest profile that we have currently as a statin, and those I feel very comfortable prescribing this drug for the reduction of LDL but most important, for the reduction of clinical events clearly shown in very large (UNINTELLIGIBLE) clinical trials. Thank you very much for your attention. Are there any questions?
Materials included in agenda packet; presented by Dr. Gorman.
Dr. Gourley moved to approve as amended; seconded by Dr. Bell.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 8: **ANNUAL REVIEW OF NSAIDs AND VOTE ON MOBIC®**
Materials included in agenda packet; presented by Dr. Patel.
Dr. Meece moved to approve as submitted; seconded by Dr. Feightner.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 9: **ANNUAL REVIEW OF ANTIDEPRESSANTS AND VOTE ON RECOMMENDATIONS**
Materials included in agenda packet; presented by Dr. Le.
Dr. Meece moved to approve as submitted; seconded by Dr. Bell.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 10: **UTILIZATION REVIEW OF SUBOXONE®**
Materials included in agenda packet; presented by Drs. Flannigan and Gorman.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 11: **NEW PRODUCT REVIEWS**
Materials included in agenda packet; presented by Dr. Gorman.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 12: **FDA & DEA UPDATES**
Materials included in agenda packet; presented by Dr. Graham.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 13: **FUTURE BUSINESS**
13A: Annual Reviews
13B: Hemophilia Utilization Review
13C: Topical Products Utilization Review
13D: New Product Revices and 30-Day Notices
Materials included in agenda packet; submitted by Dr. Graham.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 14: **ADJOURNMENT**
The meeting was declared adjourned.

The University of Oklahoma College of Pharmacy

Pharmacy Management Consultants
ORI W-4403; PO Box 26901
Oklahoma City, OK 73190
(405)-271-9039

Memorandum

Date: November 13, 2006

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

From: Shellie Gorman, Pharm.D.
Drug Utilization Review Manager
Pharmacy Management Consultants

Subject: DUR Board Recommendations from Meeting of November 08, 2006.

Recommendation 1: Vote to Prior Authorize Glumetza® and Fortamet™

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends prior authorization of Fortamet® and Glumetza™ with approval to be based on clinical documentation of inability to take other forms of generic metformin ER (after slow titration of 500 mg ER at 2 week intervals up to 2000 mg daily).

Recommendation 2: Vote to Prior Authorize Exubera®

MOTION CARRIED by majority approval.

PRODUR EDITS

1. A quantity limit based on the manufacturer's packaging per 30 days.
2. Members must be 18 years of age or older.

PRIOR AUTHORIZATION

Type II Diabetics:

1. Inability to maintain HbA1c levels at or below 7% after a minimum of six months on two oral agents, *and*
2. Diagnosis of injection-phobia, provided no additional injectable medications (including other forms of insulin) are being utilized.
3. *Or* member currently using injectable insulin and experiencing severe persistent problems with injection sites, such as lipohypertrophy.

Type I Diabetics:

1. Currently using injectable insulin and experiencing severe persistent problems with injection sites, such as lipohypertrophy. (Exubera® is not approved as monotherapy in type 1 diabetics.)

For both types:

Patients must not be smokers or have discontinued smoking in the past 6 months, or have unstable or poorly controlled lung disease (asthma, COPD, etc). Pulmonary function must be assessed prior to initiating therapy.

Approval for 6 months with a follow up HbA1c. If HbA1c has not decreased by a minimum of 1% or if not at or below 7%, further renewal will not be granted without supporting information for continued use of the product.

All members who are approved for Exubera® will be enrolled in the Diabetes Disease Management Program, if not already participating.

Recommendation 3: Annual Review of Statins

MOTION CARRIED by unanimous approval.

HMG-CoA Reductase Inhibitors (Statins)*	
*Tier One**	*Tier Two*
lovastatin fluvastatin (Lescol® and Lescol XL®) **simvastatin (Zocor®)←** **pravastatin (Pravachol®)←**	rosuvastatin (Crestor®) **→atorvastatin (Lipitor®)** pravastatin/aspirin (Pravagard®) ezetimibe/simvastatin (Vytorin®) lovastatin (Mevacor® Altoprev®) lovastatin/Niacin (Advicor®)

*Use of the brand name products are subject to the brand name override process.

To qualify for a tier-2 medication, there must be:

1. Previous failure to achieve desired LDL reduction with a Tier-1 statin - defined by at least **8** weeks of continuous therapy at standard to high dose.
2. Previous stabilization with Tier-2 medication.
3. Documented increased risk for drug interactions. Specifically: concurrent immunosuppressant therapy, HIV antiretroviral therapy, and therapy with other potent inhibitors of CYP450 system.
4. Documented adverse effect or contraindication to the Tier-1 products.
5. Clinical exception for atorvastatin 80 mg for members hospitalized for recent acute myocardial infarction or acute coronary syndrome.

Recommendation 4: Annual Review of NSAIDs

MOTION CARRIED by majority approval.

The College of Pharmacy recommends moving Meloxicam to tier 1 once a SMAC has been placed on it.

Recommendation 5: Annual Review of Antidepressants

MOTION CARRIED by unanimous approval.

- Vote to move the generic sertraline and venlafaxine to tier-1.
- Vote to continue to move drugs from Tier-2 to Tier-1 as they become available as generic and have a SMAC applied.
- Vote to remove the prior authorization on fluoxetine 10 and 20 mg tablets.
- Vote to prior authorize Emsam® with the following criteria:
  1. Recent and continuous 4 week trial with at least one agent from each of the other antidepressant classes (the dual acting antidepressants, the SSRIs, and a tricyclic antidepressant) and
  2. A diagnosis indicating that the client has a condition that prevents him/her from swallowing tablet medications.

Oklahoma Association of Regional Councils
Counties ~ Cities & Towns ~ Conservation Districts
429 N.E. 50th Street ~ 1st Floor
Oklahoma City, OK 73105
Phone 405-521-8444 ~ Fax 405-557-0899
Email tweedn@coxinet.net

November 1, 2006

Oklahoma Health Care Authority
%Nancy Nesser
4545 Lincoln
Oklahoma City, Oklahoma 73105

Dear Nancy,

I am writing this letter in support of the Health Care Authority approving, without prior authorization, the drug EXUBERA, (insulin human [DNA origin) Inhalation Powder. As I understand the medication, this is a breakthrough for people with Diabetes.

I know many people who are currently being treated for Diabetes, especially children and seniors that are taking insulin shots each day. This is a very painful treatment and one that I hope the Health Care Authority would look to eliminate as soon as possible for as many as possible.

I understand that some people with Type 2 diabetes can use EXUBERA alone for treatment purposes and because of this I would encourage the Board to approve the use of EXUBERA in the State of Oklahoma.

If you have any questions, please don't hesitate calling me.

Sincerely,

Trish Weedn
Executive Director

APPENDIX B

Vote on 2007 DUR Meeting Dates

Oklahoma Health Care Authority
December 2006

Meetings are held the second Wednesday of each month.

January 10, 2007
February 14, 2007
March 14, 2007
April 11, 2007
May 09, 2007
June 13, 2007
July 11, 2007
August 08, 2007
September 12, 2007
October 10, 2007
November 14, 2007
December 12, 2007

APPENDIX C

Retrospective Drug Utilization Review Report

Claims Reviewed for July 2006

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Total # of messages returned by system when no limits were applied	39,050	47,825	679,562	25,971
Limits which were applied	Established, Major, Males 0-40 years	Antianxiety Agents, Males and Females, age 0-21 years	Contraindicated, Female Age 0-21 years, Drug Dependence/Abuse	High dose, Starlix, Prandin, Biguanides. Males and Females, Age 0-150
Total # of messages after limits were applied	33	107	65	45
Total # of members reviewed after limits were applied	38	94	52	45

LETTERS			
Prescribers		**Pharmacies**	
Sent	**Responded**	**Sent**	**Responded**
96		43	

Retrospective Drug Utilization Review Report

Claims Reviewed for May 2006

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females Age 66-150	Narcotics, Females, Age 45-48	Contraindicated, Age 32-34, Pregnancy	High dose, Carbamates, Tingabine, Hydantoins, Oxazolidinedions, Succinimides, Valproic Acid, Miscellaneous Anticonvulsants, Males and Females, Age 41-65

Response Summary (Prescriber)
Letters Sent: 142
Response Forms Returned: 99

The response forms returned yielded the following results:

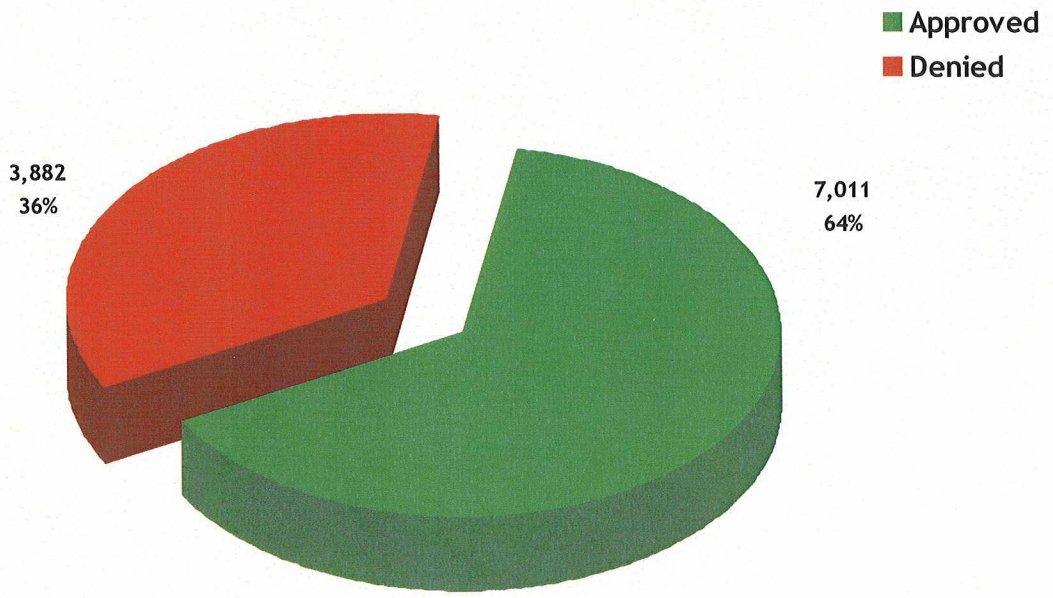
9 (9%)	*Record Error—Not my patient.*
18 (18%)	*No longer my patient.*
12 (12%)	*Medication has been changed prior to date of review letter.*
20 (20%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
28 (28%)	*I am aware of this situation and will plan to continue monitoring therapy.*
12 (12%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 124
Response Forms Returned: 84

The response forms returned yielded the following results:

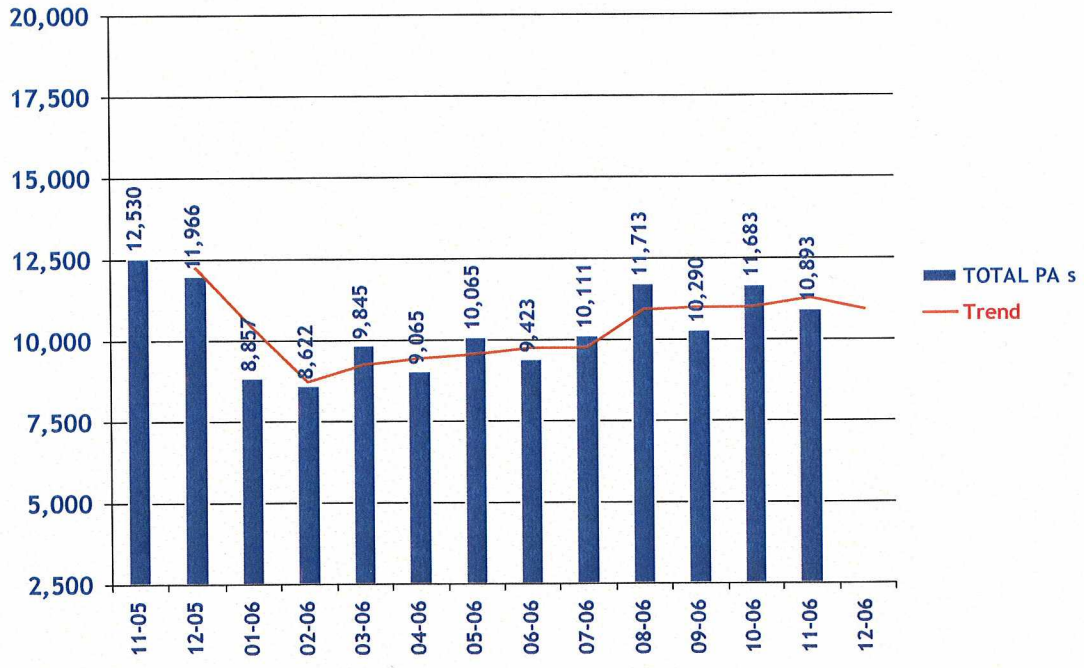
1 (1%)	*Record Error—Not my patient.*
8 (10%)	*No longer my patient.*
8 (10%)	*Medication has been changed prior to date of review letter.*
27 (32%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
29 (35%)	*I am aware of this situation and will plan to continue monitoring therapy.*
11 (13%)	*Other*

PRIOR AUTHORIZATION ACTIVITY REPORT
November 2006



PHARMACY Management Consultants

PRIOR AUTHORIZATION REPORT
November 2005 - November 2006



PHARMACY Management Consultants

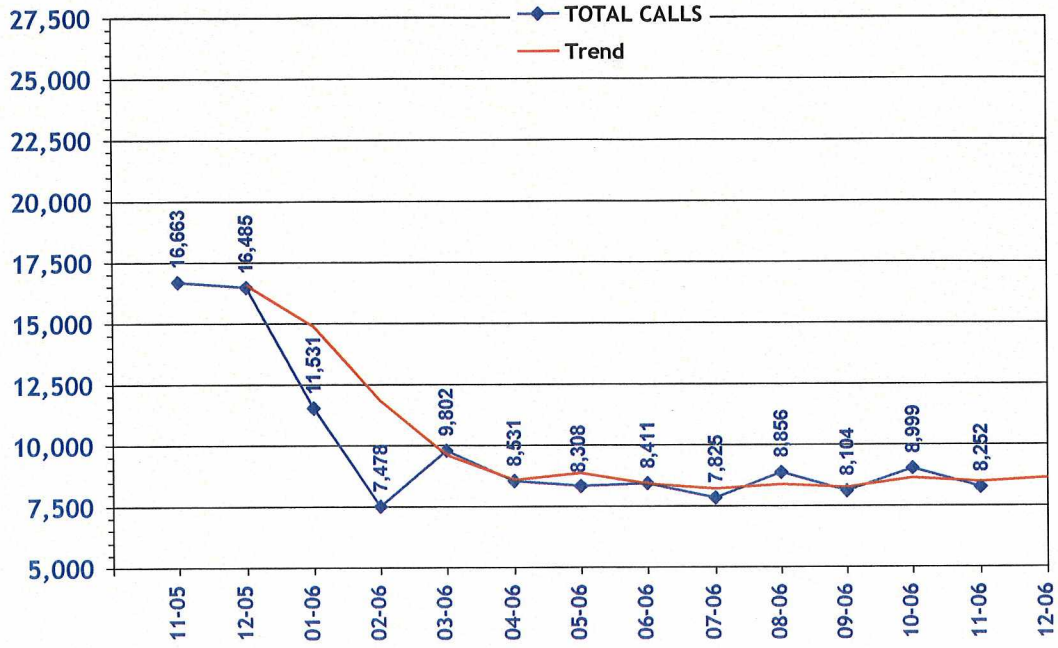
Activity Audit for
November 01, 2006 Through November 30, 2006

	Average Length of Approvals in Days	Approved	Denied	Total
ACE Inhibitors	259	10	13	23
Angiotensin Receptor Antagonist	339	14	42	56
Antidepressant	274	236	520	756
Antihistamine	99	1016	682	1698
Antiulcers	4	9	9	18
Anxiolytic	94	3169	476	3645
Calcium Channel Blockers	298	16	69	85
Growth Hormones	175	29	4	33
HTN Combos	292	10	18	28
Hypnotics	91	451	170	621
Nsaids	298	21	65	86
Plavix	358	177	31	208
Stimulant	202	731	372	1103
Others	121	1116	1411	2527
Emergency PAs		6	0	6
Total		**7011**	**3882**	**10893**
Overrides				
Brand	308	26	23	49
Dosage Change	3	1	1	2
Dosage Change	11	307	32	339
High Dose	30	1	2	3
Lost/Broken Rx	14	73	13	86
Nursing Home Issue	12	57	21	78
Other	18	18	9	27
Quantity vs. Days Supply	4	1	5	6
Quantity vs. Days Supply	203	193	227	420
Stolen	7	18	4	22
Wrong D.S. on Previous Rx	0	0	6	6
Overrides Total		**693**	**337**	**1030**

Denial Reasons

Lack required information to process request.	3097
Unable to verify required trials.	1228
Does not meet established criteria.	207
Not an FDA approved indication/diagnosis.	180
Member has active PA for requested medication.	170
Considered duplicate therapy. Member has a prior authorization for similar medication.	118
Requested dose exceeds maximum recommended FDA dose.	84
Medication not covered as pharmacy benefit.	28
Duplicate Requests	656
* Changes to existing	856

CALL VOLUME MONTHLY REPORT
November 2005 - November 2006



PHARMACY Management Consultants

APPENDIX D

Prior Authorization Annual Review – FY'06

Plavix® (clopidogrel)

Oklahoma Health Care Authority
December 2006

Category Criteria for FY'06

Plavix® (clopidogrel) requires prior authorization for all members.

Plavix® (clopidogrel) therapy will be authorized for members meeting approved diagnostic criteria who:

a) have failed aspirin therapy (due to either side effects or event recurrence), or
b) have a documented aspirin allergy, or
c) use Plavix® (clopidogrel) concomitantly with aspirin.

The approved diagnoses are as follows:

- Recent stroke
- Recent myocardial infarction
- Established peripheral artery disease
- Acute coronary syndrome (unstable angina/non-Q-wave MI)
- Percutaneous coronary intervention with stent placement (aspirin trial not required)
- Transient ischemic attacks

Members are approved for 12 months of therapy per authorization.

New Indication for Plavix

For patients with ST-segment elevation acute myocardial infarction, Plavix® has been shown to reduce the rate of death from any cause and the rate of a combined endpoint of death, re-infarction or stroke. This benefit is not known to pertain to patients who receive primary angioplasty.

For this indication, Plavix® is dosed concomitantly with aspirin.

Utilization

For the 2006 fiscal year, 6,520 members received Plavix® through the *SoonerCare* program.

Product	# of Claims	Total Units	Total Days	Total Cost	Per Diem
Plavix® 75 mg	24,097	947,766	947,460	$3,924,392.86	$ 4.14

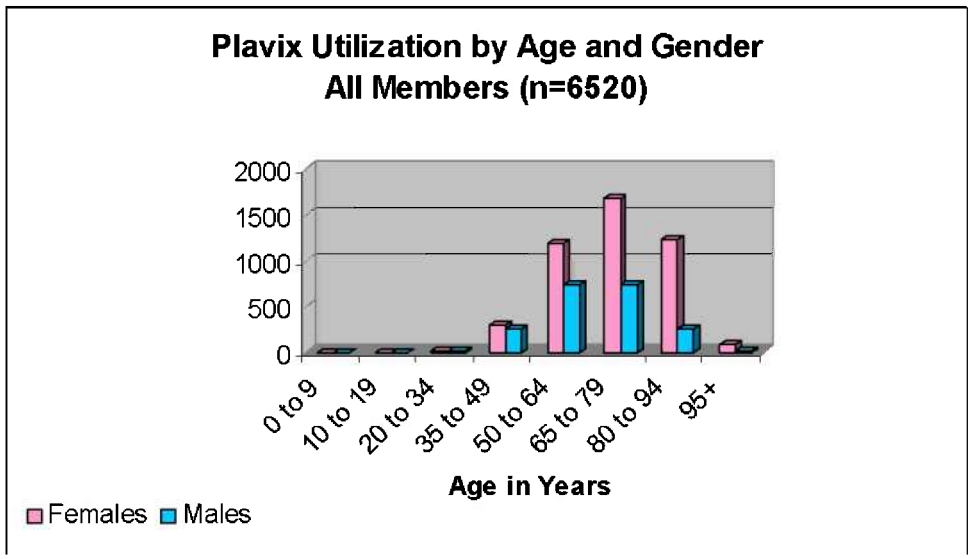
	# of Members	# of Claims	Total Units	Total Days	Total Cost	Per Diem
Duals	5,082	17,327	670,472	670,583	$ 2,757,885.30	4.11
Non-Duals	1,438	6,770	277,294	276,877	$ 1,166,507.56	4.21

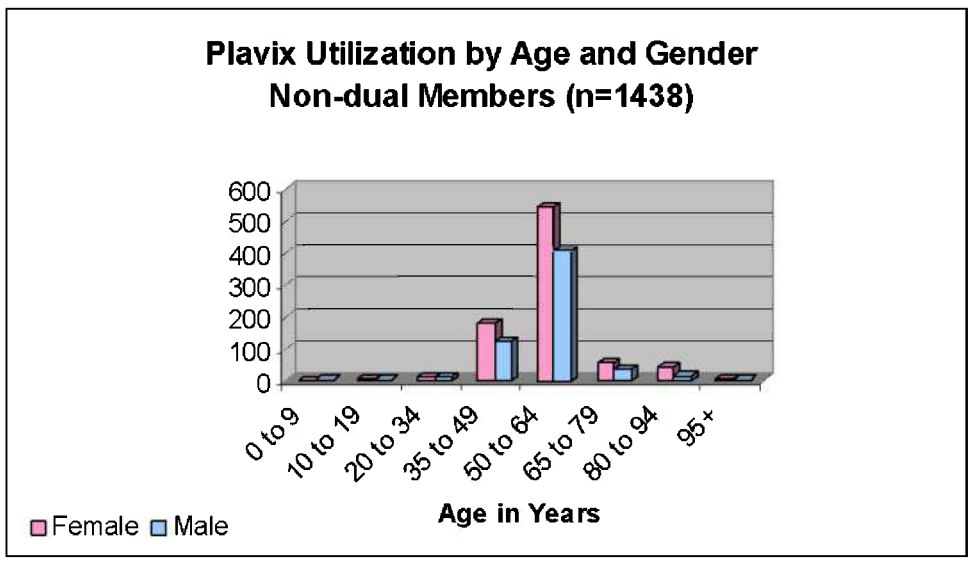
	Fiscal Year 2005	*Fiscal Year 2006*	*Percent Change*
Total Cost	**$5,385,643.91**	**$3,924,392.86**	**- 36.1%**
Total Claims	**33,293**	**24,097**	**- 27.6%**
Total Members	**6,657**	**6,520**	**- 2.1%**
Per Diem	**$ 4.09**	**$ 4.14**	**+ 1.2%**

	Non-Duals FY'05	*Non-Duals FY'06*	*Percent Change*
Total Cost	**$ 976,070.57**	**$ 1,166,507.56**	**+ 19.5%**
Total Claims	**5,937**	**6,770**	**+ 14.0%**
Total Members	**1,312**	**1,438**	**+ 9.6%**
Per Diem	**$ 4.12**	**$ 4.21**	**+ 2.2%**

Total petitions submitted in for this category during specified time period:

Approved	*4,714*
Denied	478
Incomplete	1,826
Number of denied/incomplete petitions later approved	1,950

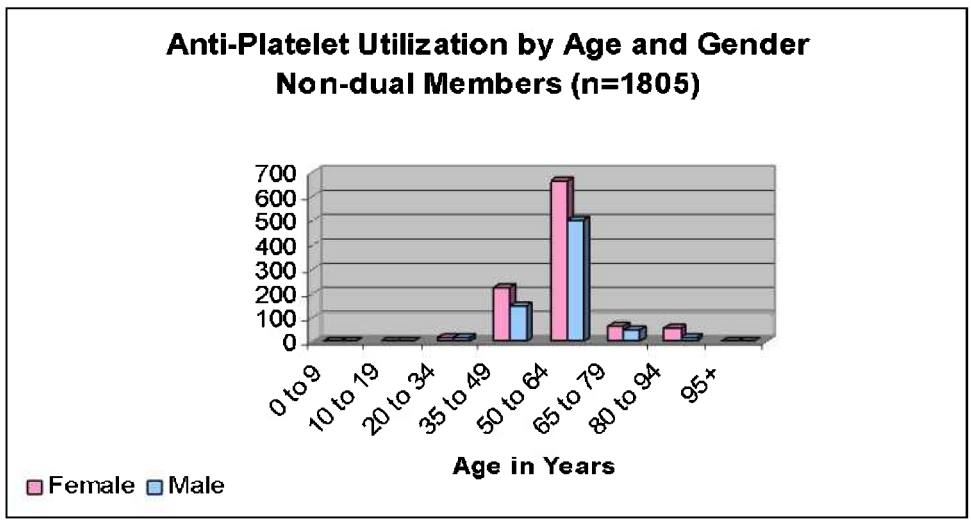




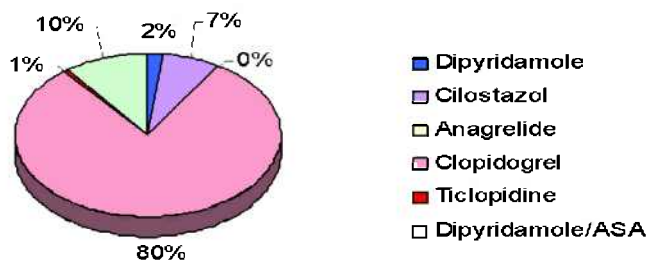
Non-Dual Anti-Platelet Use

Non-Dual anti-platelet utilization in number of claims, total units, total days, total dollars, and per diem.

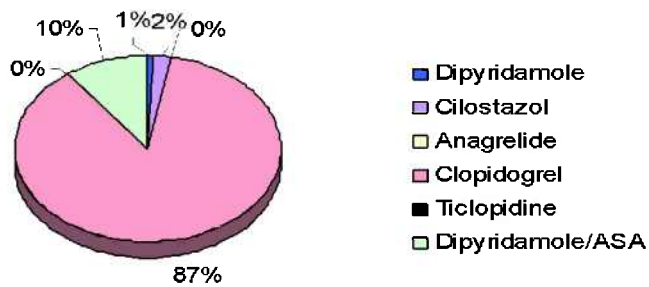
Product	# of Claims	Total Units	Total Days	Total Cost	Per Diem
Dypridamole	203	17,251	6,835	$ 8,006.19	$1.17
Cilostazol	586	43,340	23,762	$ 28,429.45	$1.20
Anagrelide	11	750	300	$ 362.87	$1.21
Clopidogrel	6,770	277,294	276,877	$ 1,166,507.56	$4.21
Ticlopidine	63	4,640	2,133	$ 1,239.30	$0.58
Dipyridamole/ASA	1,142	66,010	35,194	$ 138,639.81	$3.94



Market Share - Total Days



Market Share - Total Dollars



Recommendations

At this time, the College of Pharmacy does not recommend any changes to the prior authorization of Plavix®.

APPENDIX E

Prior Authorization Annual Review - Fiscal Year 2006

Bladder Control Drugs

Oklahoma Health Care Authority
December 2006

Product Based Prior Authorization

In order to get a Tier 2 drug, member 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
- Stabilization on the Tier 2 drug, or
- A unique indication which the Tier 1 drugs lack.

Members who are currently stabilized on a Tier 2 medication will be allowed to continue their current treatment without prior authorization.

FY 06 Tier Structure

Incontinence Medications	
Tier 1	**Tier 2**
Darifenacin **(Enablex)****, Flavoxate **(Urispas),** Hyoscyamine* **(Levbid, Levsin, Cystospaz)** Oxybutynin transdermal **(Oxytrol)****, Oxybutynin **(Ditropan),** Solifenacin **(VESIcare)****, Tolterodine Extended-Release **(Detrol LA)****, Tolterodine **(Detrol),** Trospium **(Sanctura)****	Oxybutynin Extended-Release **(Ditropan XL)**

*Hyoscyamine may be used as adjuvant therapy only. By itself, it will not count as a Tier 1 trial.
**Tier 1 due to supplemental rebate agreement.

Fiscal Year '06 Changes

- Medications for dual eligible members were covered by Medicare Part D effective January 1, 2006.

Fiscal Year '07 Changes

- Effective August 1, 2006, the tier structure changed when manufacturers of Detrol LA, Sanctura, Enablex, and Oxytrol did not renew supplemental rebate agreements. These drugs were moved from Tier 1 to Tier 2. See below.
- Ditropan XL (oxybutynin) became available in generic form in November 2006.

Current PBPA Structure (since 8/1/06)

Incontinence Medications	
Tier 1	**Tier 2**
Flavoxate (**Urispas**)	Darifenacin (**Enablex**)
Hyoscyamine* (**Levbid, Levsin, Cystospaz**)	Oxybutynin Extended-Release (**Ditropan XL**)
Oxybutynin (**Ditropan**)	Oxybutynin (**Oxytrol**)
Solifenacin (**VESIcare**)**	Tolterodine Extended-Release (**Detrol LA**)
Tolterodine (**Detrol**)	Trospium (**Sanctura**)

*Hyoscyamine may be used as adjuvant therapy only. By itself, it will not count as a Tier 1 trial.
**Tier 1 due to supplemental rebate agreement.

Utilization

Total Cost FY '06		**$2,665,975.70**†
	Total Cost FY '05	*$4,099,108.25*
Total Claims FY '06		**27,490**
	Total Claims FY '05	*40,946*
Total Clients FY '06		**7,337**
	Total Clients FY '05	*7,920*
Per Diem FY '06		**$2.80**
	Per Diem FY '05	*$2.89*

†Total does not include supplemental rebates.

For the period of July 2005 through June 2006, a total of 7,337 members received bladder control drugs through the Medicaid fee-for-service program.

All Claims

Product	# of Claims	Total Units	Total Days	Units/day	Total Cost	Total Members	Per Diem
Tier 1	22,601	1,193,334	772,434	1.54	$2,005,241.49	6,371	$2.60
Tier 2	4,889	209,563	178,496	1.17	$660,734.21	1,205	$3.70
Total	**27,490**	**1,402,897**	**950,930**	**1.48**	**$2,665,975.70**	**7,337***	**$2.80**

*Total unduplicated members for FY06.

Non-Duals

Product	# of Claims	Total Units	Total Days	Units/day	Total Cost	Total Members	Per Diem
Tier 1	8,622	542,296	293,946	1.84	$710,997.88	2,398	$2.42
Tier 2	1,765	78,950	64,712	1.22	$253,051.14	353	$3.91
Total	**10,387**	**621,246**	**358,658**	**1.73**	**$964,049.02**	**2,645***	**$2.69**

*Total unduplicated members for FY06.

Duals

Product	# of Claims	Total Units	Total Days	Units/day	Total Cost	Total Members	Per Diem
Tier 1	13,979	651,037	478,488	1.36	$1,294,243.61	3,973	$2.70
Tier 2	3,124	130,613	113,784	1.15	$407,683.07	852	$3.58
Total	**17,103**	**781,650**	**592,272**	**1.32**	**$1,701,926.68**	**4692***	**$2.87**

*Total unduplicated members for FY06.

Utilization by Individual Product

Product	# of Claims	Total Units	Total Days	Unduplicated Members	Per Diem	Total Cost
Enablex 7.5 mg	557	20,402	18,967	226	$3.17	$60,034.15
Enablex 15 mg	374	13,376	12,951	138	$3.09	$39,961.47
Flavoxate 100 mg	425	29,773	8,940	181	$4.12	$36,827.87
Urispas 100 mg	46	3,340	1,126	26	$4.76	$5,356.17
Oxytrol 2.9mg/24h	719	6,384	21,415	205	$3.19	$68,383.21
Ditropan 5 mg	13	780	390	1	$2.10	$820.56
Oxybutynin 5 mg	4,712	339,940	145,928	1,434	$0.24	$35,251.42
Oxybutynin 5 mg/5ml	693	162,458	16,790	291	$0.50	$8,401.33
Ditropan XL 5 mg	1,515	62,644	53,159	390	$3.68	$195,886.49
Ditropan XL 10 mg	2,572	110,437	94,855	677	$3.63	$344,027.95
Ditropan XL 15 mg	802	36,482	30,482	205	$3.96	$120,819.77
Cystospaz 0.15 mg	7	648	202	3	$1.60	$322.42
Hyoscyamine 0.15 mg	22	2,084	579	6	$1.34	$777.49
Hyospaz 0.15 mg	1	120	30	1	$0.85	$25.59
VESIcare 5 mg	535	20,846	19,496	205	$3.41	$66,391.83
VESIcare 10 mg	70	2,434	2,441	35	$3.06	$7,461.37
Detrol 1 mg	208	10,681	6,634	63	$2.86	$19,003.15
Detrol 2 mg	1,189	70,164	40,180	327	$3.13	$125,815.31
Detrol LA 2 mg	1,473	55,801	49,549	433	$3.33	$164,771.81
Detrol LA 4 mg	11,199	433,220	415,273	3,219	$3.21	$1,334,834.24
Sanctura 20 mg	360	20,883	11,603	121	$2.65	$30,802.10
Total	**27,490**	**1,402,897**	**950,930**	**7,337***	**$3.19**	**$2,665,975.70**

*Total unduplicated members for the time period.

Prior authorization activity

A total of 322 petitions were submitted for this category during FY2006. These included 246 regular petitions, 23 Super PA's, and 63 Therapy Management petitions.

Prior Authorizations	Petitions
Approved	128
Denied	150
Incomplete	54
Denied/Incomplete → Approved	38
Total	322

Demographics

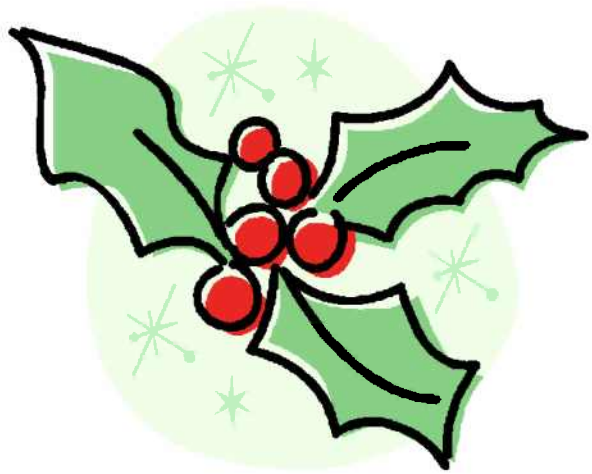
Claims were reviewed to determine the age/gender of the members.

	All		Non Dual		Dual	
Age	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
0 to 9	215	220	215	220	0	0
10 to 19	213	127	210	127	3	0
20 to 34	320	130	257	78	63	52
35 to 49	857	207	569	64	288	143
50 to 64	1260	271	648	90	612	181
65 to 79	1489	304	62	17	1427	287
80 to 94	1421	202	66	15	1356	187
95 & over	92	9	6	1	85	8
Totals	**5,867**	**1,470**	**2,033**	**612**	**3,834**	**858**

Recommendations

The College of Pharmacy recommends moving extended-release oxybutynin to Tier 1 when a SMAC is applied.

APPENDIX F



Prior Authorization Annual Review - Fiscal Year 2006

Anxiolytics/Hypnotics

Oklahoma Health Care Authority
December 2006

Definition of Prior Authorization Category for FY '06

With respect to the anxiolytic/hypnotic medications:

- Members may receive two medications in this category if one is used during the day for one diagnosis and the other is used at night as a hypnotic agent; or if they are using two different strengths to reach a target dose not available in a single unit.
- Clarification of dosing schedule and diagnosis are important to assure that the member is not receiving duplicate therapy (e.g. an anxiolytic and hypnotic both dosed at bedtime).
- Additional information regarding recent attempts at dose reductions should be requested on recurrent petitions for high dose anxiolytics and hypnotic medications.
- There are currently quantity limits on temazepam, Lunesta®, Rozerem®, Sonata®, Ambien® and Ambien CR®.

Utilization

From July 1, 2005 to June 30, 2006 a total of 41,641 members received benzodiazepines/hypnotics through the Medicaid fee-for-service program for fiscal year 2006.

Product	# of Claims	Total Units	Total Days	Units/Day	Total Cost	Total Clients	Per Diem
Alprazolam 0.25mg	13,313	746,670	315,320	2.37	$78,940.97	4,194	$0.25
Alprazolam 0.5mg	23,741	1,637,512	623,734	2.63	$167,144.41	6,477	$0.27
Xanax 0.5mg	12	1,305	345	3.78	$1,611.19	3	$4.67
Alprazolam 1mg	25,299	2,033,464	703,437	2.89	$209,238.22	5,690	$0.30
Xanax 1mg	16	1,080	510	2.12	$1,860.77	6	$3.65
Alprazolam 2mg	9,539	790,978	267,332	2.96	$141,180.50	2,052	$0.53
Xanax 2mg	9	800	276	2.90	$2,293.21	3	$8.31
Alprazolam 1mg/ml	1	30	10	3.00	$59.42	1	$5.94
Niravam 0.5mg	1	16	8	2.00	$25.82	1	$3.23
Niravam 1mg	1	12	12	1.00	$24.83	1	$2.07
Alprazolam ER 0.5mg	15	600	415	1.45	$1,167.67	13	$2.81

Product	# of Claims	Total Units	Total Days	Units/Day	Total Cost	Total Clients	Per Diem
Alprazolam ER 1mg	11	280	265	1.06	$684.45	8	$2.58
Xanax XR 1mg	30	857	782	1.10	$2,197.84	9	$2.81
Alprazolam ER 2mg	31	1,200	885	1.36	$3,419.03	11	$3.86
Xanax XR 2mg	31	1,170	930	1.26	$3,955.03	8	$4.25
Alprazolam ER 3mg	6	360	180	2.00	$1,669.19	3	$9.27
Xanax XR 3mg	2	60	60	1.00	$269.88	1	$4.50
CDP 5mg	291	17,339	7,528	2.30	$2,556.81	103	$0.34
CDP 10mg	1,010	70,887	25,854	2.74	$8,171.26	292	$0.32
CDP 25mg	833	53,265	20,260	2.63	$6,846.58	304	$0.34
Cloraze DIP 3.75mg	1,517	106,567	43,166	2.47	$15,727.12	298	$0.36
Cloraze Dip 7.5mg	1,578	110,977	45,750	2.43	$23,526.96	361	$0.51
Tranxene 7.5mg	24	2,050	738	2.78	$6,044.22	4	$8.19
Cloraze Dip 15mg	371	28,775	11,401	2.52	$8,478.22	69	$0.74
Tranxene T 15mg	7	600	210	2.86	$2,370.65	3	$11.29
Tranxene-SD 11.25mg	8	240	240	1.00	$1,456.40	1	$6.07
Tranxene-SD 22.5mg	15	1,140	388	2.94	$8,662.96	4	$22.33
Diazepam 2mg	2,323	116,231	47,278	2.46	$12,054.32	997	$0.25
Diazepam 5mg	12,531	698,861	290,985	2.40	$66,908.34	4,489	$0.23
Diazepam 10mg	12,668	917,470	336,114	2.73	$79,397.23	3,334	$0.24
Diazepam 5mg/ml con	47	2,278	824	2.76	$2,010.00	21	$2.44
Diazepam 1mg/ml sol	297	45,245	4,896	9.24	$5,973.72	117	$1.22
Diazepam 5mg/ml inj	114	1,679	896	1.87	$1,394.10	79	$1.55
Ativan 0.5mg	9	600	270	2.22	$599.86	4	$2.22
Lorazepam 0.5mg	14,690	787,931	337,563	2.33	$90,757.53	4,340	$0.27
Ativan 1mg	11	930	330	2.82	$609.30	3	$1.85
Lorazepam 1mg	15,317	918,965	367,184	2.50	$110,827.26	4,623	$0.30
Lorazepam 2mg	4,104	253,732	108,130	2.35	$38,826.14	1,121	$0.36
Lorazepam 2m/ml Con	95	2,971	1,239	2.40	$4,238.23	61	$3.42
Ativan 2mg/ml inj	121	387	298	1.30	$2,709.61	85	$9.09
Lorazepam 2mg/ml inj	1,028	6,805	3,379	2.01	$19,503.24	511	$5.77
Oxazepam 10mg	344	23,046	9,577	2.41	$7,640.94	81	$0.80
Oxazepam 15mg	384	30,099	11,080	2.72	$14,616.69	91	$1.32
Oxazepam 30mg	96	6,981	2,868	2.43	$6,834.05	18	$2.38
Estazolam 1mg	97	3,087	2,533	1.22	$1,248.14	36	$0.50
Estazolam 2mg	225	6,693	6,768	1.00	$3,583.21	66	$0.53
Flurazepam 15mg	150	4,915	3,940	1.25	$913.89	54	$0.23
Flurazepam 30mg	448	14,055	13,922	1.01	$2,541.46	140	$0.18
Doral 15mg	8	600	600	1.00	$2,217.79	2	$3.70
Restoril 7.5mg	1,679	49,674	47,459	1.05	$145,868.03	501	$3.07
Temazepam 7.5	18	675	575	1.17	$465.91	8	$0.81
Temazepam 15mg	9,691	323,031	280,425	1.15	$60,527.04	3,198	$0.22
Restoril 22.5mg	11	390	390	1.00	$1,163.68	6	$2.98
Temazepam 30mg	11,683	384,474	371,008	1.04	$79,624.41	3,037	$0.21
Triazolam 0.125mg	93	2,909	2,084	1.40	$972.10	44	$0.47
Halcion 0.25mg	10	600	300	2.00	$905.82	1	$3.02
Triazolam 0.25mg	1,417	42,612	32,451	1.31	$15,662.99	610	$0.48
Lunesta 1mg	449	12,027	12,049	1.00	$40,878.58	213	$3.40
Lunesta 2mg	2,324	62,985	63,515	1.00	$214,776.72	1,173	$3.38

Product	# of Claims	Total Units	Total Days	Units/Day	Total Cost	Total Clients	Per Diem
Lunesta 3mg	3,210	91,840	92,054	1.00	$312,225.20	1,295	$3.40
Sonata 5mg	175	4,752	4,777	1.00	$12,553.90	83	$2.63
Sonata 10mg	794	24,800	21,182	1.17	$76,368.11	273	$3.61
Ambien 5mg	6,671	183,107	177,837	1.03	$554,742.56	2,818	$3.12
Ambien 10mg	19,750	540,391	546,863	1.00	$1,735,463.25	6,512	$3.17
Ambien CR 6.25mg	132	3,556	3,556	1.00	$11,414.92	88	$3.21
Ambien CR 12.5mg	892	25,252	25,282	1.00	$80,021.63	483	$3.16
Rozerem	768	21,872	22,029	1.00	$56,239.59	453	$2.55
Total	**202,556**	**11,226,739**	**5,324,546**		**$4,574,893.10**	***43,357**	**$0.86**

*Total unduplicated clients for FY06

Total Cost FY '06	**$4,574,893.10**
Total Cost FY '05	*$4,137,356.00*
Total Claims FY '06	**202,556**
Total Claims FY '05	*190,454*
Total Clients FY '06	**43,357**
Total Clients FY '05	*41,641*
Per Diem FY '06	**$0.86**
Per Diem FY '05	*$0.83*

Total petitions submitted in for this category during specified time period:

Approved	33,311
Denied	3,914*
Incomplete	2,701*
Supers	724

*Of the 6,615 petitions that were denied or incomplete, 5,410 were subsequently approved.

	# of Members	# of Claims	Total Units	Total Days	Total Cost	Per Diem
Duals	22,018	109,741	6,050,889	2,939,502	$2,245,102.19	$0.76
Non-Duals	21,339	92,815	5,175,850	2,385,044	$2,329,790.91	$0.98

Claims were reviewed to determine the age/gender of the clients.

All Members FY '06

Age	Female	Male	Totals
0 to 9	365	423	788
10 to 19	1,663	1,041	2,704
20 to 34	5,739	1,311	7,050
35 to 49	7,300	3,235	10,535
50 to 64	6,709	3,091	9,800
65 to 79	5,519	1,832	7,351
80 to 94	4,041	770	4,811
95 and Over	287	31	318
Totals	**31,623**	**11,734**	**43,357**

Non Dual Members FY '06

Age	Female	Male	Totals
0 to 9	365	422	787
10 to 19	1,661	1,035	2,696
20 to 34	5,129	830	5,959
35 to 49	5,025	1,493	6,518
50 to 64	3,294	1,494	4,788
65 to 79	213	102	315
80 to 94	196	58	254
95 and Over	19	3	22
Totals	**15,902**	**5,437**	**21,339**

All Members FY '05

Totals	**30,108**	**11,533**	**41,641**

Non Dual Members FY '05

Totals	**14,107**	**5,149**	**19,256**

Hypnotic Cost Comparison

	Estimated Acquisition Cost (EAC)	State Maximum Allowable Cost (SMAC)	Daily Dose	Monthly Cost (30 day supply) w/o Dispensing Fee	Percent Cost Increase/ Decrease per Unit from Last Year
Lunesta® 3 mg	$3.55/unit	N/A	3 mg	$106.50	8.2%↑
Ambien® 10 mg	$3.81/unit	N/A	10 mg	$114.30	18.4%↑
Ambien CR®	$3.40/unit	N/A	12.5	$102.00	16.8%↑
Rozerem®	$2.72/unit	N/A	8 mg	$81.60	17.3%↑
Sonata® 10 mg	$3.27/unit	N/A	10 mg	$98.10	4.0%↑
temazepam 30 mg	$0.71/unit	$0.12	30 mg	$ 3.60	5.3%↓

Comparison of Current Non-Benzodiazepine Products

	FY 06		FY 05		
Product	**# Claims**	**Total Cost**	**# Claims**	**Total Cost**	**% Cost ↓/↑**
Lunesta® 1mg	449	$40,878.58	59	$5,902.17	85.6↑
Lunesta® 2mg	2,324	$214,776.72	235	$20,599.32	90.4↑
Lunesta® 3mg	3,210	$312,225.20	222	$20,974.68	93.3↑
Sonata® 5mg	175	$12,553.90	273	$17,438.26	28.0↓
Sonata® 10mg	764	$76,368.11	1,075	$97,356.13	21.6↓
Ambien® 5mg	6,671	$554,742.56	9,262	$644,675.21	14.0↓
Ambien® 10mg	19,750	$1,735,463.25	21,319	$1,768,787.23	1.9↓
Ambien CR® 6.25mg	132	$11,414.92	N/A	N/A	N/A
Ambien CR® 12.5mg	892	$80,021.63	N/A	N/A	N/A

Recommendations

The College of Pharmacy recommends the following changes to the current anxiolytic/hypnotic prior authorization category:

1. Split category into
   a) benzodiazepine/non-benzodiazepine hypnotics and
   b) non-hypnotic benzodiazepine anxiolytics.

2. New Hypnotic Product Based Prior Authorization category:

Tier 1*	Tier 2
estazolam ▒ temazepam ▒ flurazepam ▒ zolpidem ▒	Lunesta® Sonata® Rozerem® triazolam Restoril® 7.5 and 22.5 mg Ambien CR®

*Brand products would still require a brand name override.
▒ Covered for Dual-Eligible members.
▒ Tier 1 once generic becomes available.

Tier 2 Hypnotic Approval Criteria:
1. Minimum of 30 day trial with at least 2 tier 1 products (including zolpidem*) and clinical documentation of attempts to correct any primary cause for insomnia.
2. FDA approved diagnosis.
3. No concurrent anxiolytic benzodiazepine therapy greater than TID dosing and no concurrent ADHD medications.
4. Approvals granted for 6 months.

Also, age limits placed based on FDA approved limits and quantity limits of 30 units for a 30 day supply.

*Once generic becomes available.

3. Explore Possible Recommendations for New Anxiolytic Prior Authorization Category:

   a) Exclude coverage of benzodiazepines.
      i) States may exclude or restrict coverage of benzodiazepines from Medicaid coverage as part of the Medicaid Drug Rebate Program, created by OBRA 1990 in section 1927(d)(2)(4,5).
      ii) Medicare Part D plans do not cover benzodiazepines for Medicare eligible members; Oklahoma SoonerCare Dual Eligible members may still receive coverage of these medications as long as benzodiazepines are a part of the pharmacy benefit.

   b) Continue current benzodiazepine criteria with the following changes:
      i) Extend approval length to twelve months, and
      ii) Add age and quantity limit restrictions.

   c) Remove prior authorization requirement and implement age and quantity limit restrictions.

   d) Develop new prior authorization criteria.
      i) Clonazepam to remain as non-prior authorized product along with diazepam rectal gel. Short-term authorizations for pre-dental or surgical use may be approved.
      ii) Add age restrictions based on FDA approvals.
      iii) Quantity limits of 4 units per day for all solid oral formulations.
      iv) The following diagnoses can be given a prior authorization for a twelve month supply: seizures, muscle spasticity (multiple sclerosis, paralysis, cerebral palsy, and muscular dystrophy); anxiety/agitation 2° to Alzheimer's Disease, Huntington's Chorea, and Organic Brain Syndrome.
      v) First 90 days do <u>not</u> require prior authorization. Subsequent 90 day therapy can be approved with a prior authorization. No additional approval will be given. Only one 90 day prior authorization every 365 days (total of 180 out of every 365 days), for those members currently on benzodiazepine therapy, physicians can request *an additional 90 days* of therapy if a dosage titration schedule is also provided.
      vi) No concurrent use with ADHD medications.

APPENDIX G

Prior Authorization Annual Review - Fiscal Year 2006

Non-Sedating Antihistamines (NSA)

Oklahoma Health Care Authority
December 2006

Current Definition of NSA Prior Authorization Category

PA Criteria:

- Tier 2 non-sedating antihistamine only products are covered after a previous trial failure with an over-the-counter antihistamine. A 14 day trial of over-the-counter loratadine is required prior to coverage of a tier 2 product for all age groups.
  - Trials should have been in the last month and be of adequate dose and duration,
  - Over-the-counter loratadine is a covered benefit for clients under the age of 21 years without prior authorization, and
  - For clients 21 years of age or greater, loratadine is available with prior authorization AFTER documented over-the-counter failure of a non-loratadine product.
- For clients six months to two years of age, cetirizine syrup is available without prior authorization.
- Diagnosis must be for a chronic allergic condition.
- Clinical exceptions include asthma and COPD. For diphenhydramine exceptions are made for EPS and insomnia.
- Prior authorization will not be approved for a time period greater than 90 days for clients without a diagnosis which requires continuous coverage.

Tier 1	Tier 2
• Over-the-counter loratadine • Cetirizine syrup for clients 6 months to 2 years of age • Singulair (monotherapy only)**	• Cetirizine • Desloratadine • Fexofenadine*

*Fexofenadine will be moved to tier-1 once an appropriate SMAC has been applied.
**Tier 1 due to supplemental rebate.

Utilization

For the period of July 2005 through June 2006, a total of 48,541 members received non-sedating antihistamines products through the Medicaid fee-for-service program.

Product*		# of Claims	Total Units	Total Days	Units/Day	Total Cost	Per Diem
Rx	*Solid*	18,126	647,089	575,895	1.12	$ 1,230,700.91	2.14
	Liquid	18,383	2,180,958	523,332	4.18	$ 626,293.78	1.20
OTC	*Solid*	49,018	1,573,459	1,574,916	1.00	$ 786,561.02	0.50
	Liquid	30,285	4,128,137	796,832	5.18	$ 320,354.16	0.40
All Products		**115,812**	**8,529,643**	**3,470,975**	**2.46**	**$ 2,963,909.87**	**0.85**

*Does not include Singulair®.

Total Cost FY '06 **$ 2,963,909.87**
Total Cost FY '05 *$ 2,733,010.01*
Total Claims FY '06 **115,812**
Total Claims FY '05 *108,464*
Per Diem FY '06 **$ 0.85**
Per Diem FY '05 *$ 0.84*

Market share for select products.

Brand Name	Total Days/ Brand FY '06	% Share/ Brand FY '06	Total Days/ Brand FY '05	% Share/ Brand FY '05
Allegra	208,310	6%	134,220	4.13%
Clarinex	40,251	1.16%	16,933	0.52%
Zyrtec	880,965	25.38%	726,443	22.36%
Claritin (OTC)	2,341,449	67.46%	2,371,937	72.99%

Total petitions submitted in for this category during FY06: 21,275 for a total of 11,030 members

Approved *12,511*
Denied 6,268
Incomplete 2,496
*4,694 denied or incomplete petitions were subsequently approved

	# of Claims	Total Units	Total Days	Total Cost	Per Diem
Duals	1,189	52,114	43,322	$ 96,824.93	2.24
*OTC loratadine**	1,335	44,025	41,606	$ 18,151.59	0.20
Non-Duals	113,288	8,433,504	3,386,047	$ 2,848,933.35	0.84

*Coverage of OTC loratadine only will continue for Dual members.

Age/Gender FY06

Age	Female	Male	Totals
0 to 10	15,177	17,370	32,547
11 to 20	7,571	6,998	14,569
21 to 34	306	86	392
35 to 49	179	73	252
50 to 64	194	57	251
65 to 79	197	67	264
80 to 94	212	30	242
≥95	21	3	24
Totals	**23,857**	**24,684**	**48,541**

Market Changes for FY07

1. **Allegra® (Fexofenadine) 30mg/5ml Suspension-** Approved October 16, 2006 for the treatment of:
   - ***Seasonal Allergic Rhinitis*** *- Children 2 to 11 Years:* Recommended dose 30 mg twice daily. For pediatric patients with decreased renal function a starting dose of 30 mg once daily is recommended.
   - ***Chronic Idiopathic Urticaria-*** *Children 6 Months to 11 Years:* Recommended 30 mg twice daily for patients *2 to 11 years of age* and 15 mg twice daily for patients *6 months to less than 2 years of age*. For pediatric patients with decreased renal function, the recommended starting doses of 30 mg once daily for patients *2 to 11 years of age* and 15 mg once daily for patients *6 months to less than 2 years of age*.

2. **Xyzal® (Levocetirizine dihydrochloride)-** New Drug Application (NDA) submitted by UCB (co-promoted by Sonafi-aventis) seeking FDA approval for the following indications: Seasonal Allergic Rhinitis, Perennial Allergic Rhinitis, and Chronic Idiopathic Urticaria.

3. **Clarinex® (Desloratadine)-** Patent expiration on 03/31/2007

4. **Zyrtec® (Cetirizine)-** Patent expiration on 06/25/2007

Recommendations

The College of Pharmacy recommends the addition of Allegra® Suspension to the tier 2 category once it becomes available.

APPENDIX H

Annual Review of Fibric Acid Derivatives

Oklahoma Healthcare Authority
December 2006

Introduction

The fibric acid derivatives were added to the Product Based Prior Authorization program during fiscal year 2006. The following table shows the currently available fibric acid derivatives:

Fibric Acid Derivatives	
Tier One	*Tier Two*
Fenofibrate 54mg Tabs	Antara® 43mg Caps
Fenofibrate 67mg Caps	Antara® 130mg Caps
Fenofibrate 134mg Caps	
Fenofibrate 160mg Tabs	
Fenofibrate 200mg Caps	
Lofibra® 54mg Caps	
Lofibra® 67mg Caps	
Lofibra® 134mg Caps	
Lofibra® 200mg Caps	
*Tricor® 48mg Tabs	
*Tricor® 145mg Tabs	
*Triglide® 50mg Tabs	
*Triglide® 160mg Tabs	
Gefibrozil 600mg Tabs	
Clofibrate 500mg Caps	

*Tier one due to supplemental rebate participation

The approval criteria for a tier-2 medication are as follows:

1. Laboratory documented failure with a tier one medication after 6 months trial with a tier one medication.
2. Documented adverse effect, drug interaction, or contraindication to tier-1 products.
3. Prior stabilization on the tier-2 medication documented within the last 100 days.

Utilization

For the period of July 2005 through June 2006, a total of 2,719 members received fibric acid derivatives. The following charts outline the utilization:

Utilization Trends of Fibric Acid Derivatives

	Fiscal Year 2005	Fiscal Year 2006	Percent Change	
Total Clients	**2,133**	**2,719**	**Increased**	**27.5 %**
Total Claims	**9,120**	**9,480**	**Increased**	**3.95 %**
Total Cost	**$543,999.50**	**$636,207.16**	**Increased**	**16.9 %**
Total Days	**364,146**	**369,979**	**Increased**	**1.60 %**
Per Diem	**$1.49**	**$1.72**	**Increased**	**15.4 %**

Utilization of Fibric Acid Derivatives for FY 2006

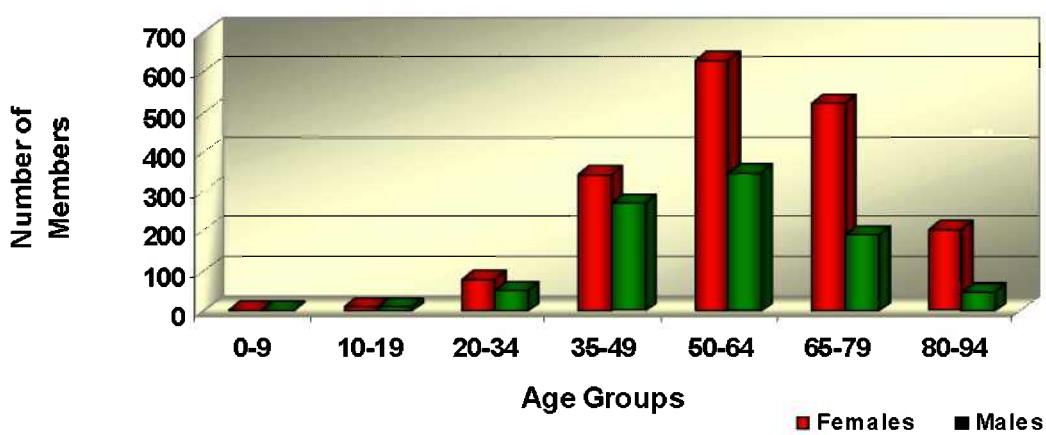
DRUG		CLAIMS	UNITS	DAYS	MEMBERS	COST
TRICOR	TAB 48MG	806	36,405	32,512	246	$40,791.65
TRICOR	TAB 54MG	11	507	405	10	$548.91
TRICOR	TAB 145MG	3,075	146,295	144,926	1030	$471,248.47
TRICOR	TAB 160MG	21	1,411	1,390	18	$4,182.78
TRIGLIDE	TAB 160MG	44	2,030	2,030	15	$5,136.27
ANTARA	CAP 43MG	8	480	390	4	$511.80
ANTARA	CAP 130MG	115	4,668	4,668	43	$14,969.70
LOFIBRA	CAP 67MG	3	210	150	2	$170.42
LOFIBRA	CAP 134MG	12	360	360	2	$570.80
LOFIBRA	CAP 200MG	16	732	732	6	$1,737.06
FENOFIBRATE	CAP 134MG	3	90	90	2	$129.78
FENOFIBRATE	CAP 200MG	10	360	360	4	$789.75
GEMFIBROZIL	TAB 600MG	5,356	344,627	181,966	1461	$95,419.77
TOTALS		**9,480**	**538,175**	**369,979**	**2,719***	**$636,207.16**

* Number of unduplicated clients

Utilization of Non-Duals vs. Dual Eligible Members

	CLAIMS	UNITS	DAYS	MEMBERS	COST
Non-Duals	**4,112**	**237,058**	**160,106**	**1,027**	**$263,371.65**
Duals	**5,368**	**301,117**	**209,873**	**1,692**	**$372,835.51**
Totals	**9,480**	**538,175**	**369,979**	**2,719**	**$636,207.16**

Demographics of Members Utilizing Fibric Acid Derivatives



Recommendations

The College of Pharmacy recommends continued monitoring of this PBPA category.

APPENDIX I

Utilization Review of Ocular Allergy Products

Oklahoma Health Care Authority
December 2006

Background

Ocular allergies affect approximately 15 to 20 % of the population in most developed countries. There are several categories of ocular allergies:

- seasonal and perennial allergic conjunctivitis (SAC/PAC),
- atopic keratoconjunctivitis (AKC),
- vernal keratoconjunctivitis (VKC),
- drug-induced allergic conjunctivitis (DIAC), and
- giant papillary conjunctivitis (GPC) – often included, but not a true allergy.

AKC and VKC are severe, chronic forms and represent less than 5% of all ocular allergies. Both typically occur more in males than females. Treatment is focused on alleviating symptoms, maintaining vision, and minimizing medication side effects.

The most common forms of ocular allergy are SAC and PAC. These represent over 95% of all ocular allergies. Avoidance is the first treatment option followed by cool compresses and sterile irrigation. There are multiple pharmacological treatments available for SAC and PAC they include:

- antihistamines,
- decongestants,
- topical mast cell stabilizers,
- combination topical antihistamines and mast cell stabilizers,
- nonsteroidal anti-inflammatory agents, and
- corticosteroids.

Utilization Review

	Fiscal Year 2005	Fiscal Year 2006	Percent Change	
Total Clients	**5,457**	**5,374**	**Decreased**	**1.5 %**
Total Claims	**9,492**	**8,700**	**Decreased**	**8.3 %**
Total Cost	**$ 690,252.55**	**$ 656,123.64**	**Decreased**	**4.9 %**
Total Days	**185,805**	**177,382**	**Decreased**	**4.5 %**
Per Diem	**$ 3.71**	**$ 3.70**	**Decreased**	**0.3 %**

Groups	Non-Duals	Duals	Total Cost
Mast Cell Stabilizers	**$ 7,597.36**	**$ 5,391.52**	**$ 12,988.88**
Antihistamines	**$ 517.72**	**$ 296.35**	**$ 814.07**
Antihistamines/Mast Cell	**$ 496,035.50**	**$ 146,285.19**	**$ 642,320.69**
Totals FY 2006	**$ 504,150.58**	**$ 151,973.06**	**$ 656,123.64**
Totals FY 2005	**$ 450,699.69**	**$ 239,552.86**	**$ 690,252.55**

DRUGNAME	CLAIMS	UNITS	DAYS	MEMBERS	COST	PER DIEM
Optivar 0.05%	453	2,748	8,789	305	$ 35,938.70	$ 4.09
Elestat 0.05%	779	4,130	15,760	526	$ 60,165.17	$ 3.82
Zaditor 0.025%	516	2,627	9,291	334	$ 33,566.30	$ 3.61
Patonol 0.1%	6,665	34,063	138,340	4,144	$ 512,650.52	$ 3.71
Emadine 0.05%	3	15	37	2	$ 188.67	$ 5.10
Livostin 0.05%	10	75	245	8	$ 625.40	$ 2.55
Cromolyn Sodium 4%	110	1,111	1,956	78	$ 1,297.70	$ 0.66
Alocril 2%	104	525	1,809	44	$ 7,529.96	$ 4.16
Alomide 0.1%	15	150	295	11	$ 1,140.53	$ 3.87
Alamast 0.1%	45	450	860	23	$ 3,020.69	$ 3.51
TOTALS	**8,700**	**45,894**	**177,382**		**$ 656,123.64**	**$ 3.70**

Market Changes and Patent Expirations

Zaditor™ has been FDA approved for marketing as an over-the-counter product.

Patanol® has one patent expiration date of October 2006, however no generics are currently available.

Recommendations

The College of Pharmacy recommends further review of this category to determine suitability of establishing a Product Bases Prior Authorization Category once pricing is available for OTC Zaditor™.

APPENDIX J

Late Stage Product Pipeline Summaries

Oklahoma Healthcare Authority
December 2006

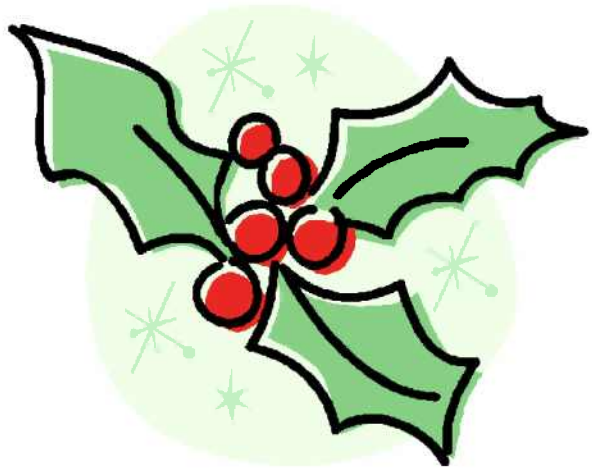
Compound/ Generic	Trade Name	Mechanism	Indication	Phase	Manufacturer
arformoterol	Brovana	Long acting B2 agonist for nebulization	COPD	Approved	Sepracor
alvimopan	Entereg	Peripherally acting mu opioid receptor antagonist	Post operative ileus; opioid induced GI symptoms	Approvable	GSK
armodafinil	Nuvigil	Same as modafinil	To improve wakefulness	Approvable	Cephalon
cilomilast	Ariflo	Phosphodiesterase (PDE) IV inhibitor	COPD	Approvable	GSK
etoricoxib	Arcoxia	Cox-2 inhibitor	Arthritis and pain	Approvable	Merck
nebivolol		Beta blocker	Treatment of hypertension	Approvable	MylanBertek/ Forest
paliperidone ER	Invega	Mixed serotonin-dopamine antagonist	Treatment of schizophrenia	Approvable	Johnson & Johnson
rimonabant	Accomplia	Selective cannabinoid type 1 blocker	Obesity	Approvable	Sanofi-Aventis
aliskiren	Rasilez	Oral renin inhibitor	Treatment of hypertension	Submitted	Novartis
amlodipine/ valsartan	Exforge	CCB/ARB	Treatment of hypertension	Submitted	Novartis
bazedoxifene		Selective estrogen receptor modulator	Postmenopausal osteoporosis	Submitted	Wyeth
budesonide/ formoterol	Symbicort	ICS and long acting beta agonist	Asthma	Submitted	AstraZeneca
carvedilol CR	Coreg CR	Beta blocker	Treatment of hypertension; congestive heart failure	Submitted	GSK
certolizumab pegol	Cimzia	PEGylated Fab' fragment of humanized anti-TNF alpha antibody	Crohn's Disease	Submitted	UCB

desvenlafaxine succinate		Serotonin-norepinephrine reuptake inhibitors	Treatment of major depressive disorder	Submitted	Wyeth
dronedarone		Class III anti-arrhythmic	Atrial Fibrillation	Submitted	Sanofi-Aventis
faropenem	Orapem	Oral ester prodrug of beta-lactam antibiotic	Acute bacterial sinusitis, community acquired pneumonia, acute exacerbation of chronic bronchitis, uncomplicated skin and skin structure infections	Submitted	Replidyne/ Forest
fosaprepitant		Inhibits substance P/neurokinin 1 (NK1) receptor	Chemotherapy induced nausea and vomiting	Submitted	Merck
fluticasone furoate	Allermist	Nasal corticosteroid	Seasonal allergic rhinitis; perennial allergic rhinitis	Submitted	GSK
garenoxacin		Des-fluoroquinolone antibiotic	Treatment of a variety of gram-positive and gram-negative bacterial infections, including CAP, bronchitis exacerbations, and acute sinusitis	Submitted	Schering-Plough
levocetrizine	Xyzal	Antihistamine	Allergy	Submitted	UCB
lumiracoxib	Prexige	Cox-2 inhibitor	Treatment of osteoarthritis and pain	Submitted	Novartis
quetiapine sustained release	Seroquel SR	D2 and 5-HT2 antagonist	Treatment of schizophrenia	Submitted	AstraZeneca
retapamulin	Altabax	Pleuromutilin antibiotic	Topical treatment of skin infections	Submitted	GSK
ropinerole modutab/XL	ReQuip Modutab/XL	D2 and D3 dopamine receptor agonist	Parkinson's Disease	Submitted	GSK
sitagliptin/ metformin	Janumet	DDP-4 inhibitor/metformin	Diabetes	Submitted	Merck
sumatriptan/ naproxen	Trexima	5HT1/NSAID	Treatment of migraine	Submitted	GSK
AGI-1067		Phenolic antioxidant	Treatment of atherosclerosis in patients with CAD	3	AstraZeneca
AZD-6140		Reversible oral adenosine diphosphate receptor antagonist	Prevention of vascular events in ACS patients	3	AstraZeneca
azithromycin/ chloroquine		Macrolide antibiotic/inhibits DNA and RNA polymerase	Treatment of malaria	3	Pfizer
belatacept		Inhibits T-cell antibody response	Renal transplant anti-rejection	3	Bristol-Myers Squibb
bifeprunox		Partial D2 agonist and 5-HT1A	Treatment of schizophrenia	3	Wyeth

		agonist			
ceftobiprole		Cephalosporin antibiotic	Treatment of bacterial infections including complicated skin and skin structure infections, nosocomial pneumonia, and hospitalized community acquired pneumonia (CAP)	3	Johnson & Johnson
ciclesonide	Alvesco	Inhaled corticosteroid	Asthma	3	Sanofi-Aventis
doripenem		Carbepenum Antibiotic	Treatment of complicated urinary tract infections, complicated intra-abdominal infections, and nosocomial pneumonia	3	Johnson & Johnson
eltrombopag		Thrombopoietin receptor agonist	Thrombocytopenia	3	GSK
eplivanserin		5HT2A antagonist	Treatment of insomnia	3	Sanofi-Aventis
epratuzumab		Humanized monoclonal antibody CD22 IgG1 antibody	Systemic Lupus Erythematosus (SLE)	3	UCB
gaboxadol		Selective extrasynaptic GABA-A receptor agonist	Treatment of primary and transient insomnia	3	Merck/Lundbeck
golimumab		Anti TNF-ά agent	Inflammatory diseases	3	Schering-Plough
ICA-17043		Gardos channel blocker	Sickle cell disease	3	Johnson & Johnson
idraparinux		Indirect factor Xa inhibitor	Once weekly long term treatment of DVT/PE	3	Sanofi-Aventis
inhaled insulin			Diabetes	3	Lilly
ipilimumab		Immunopotentiator	Treatment of metastatic melanoma	3	Bristol-Myers Squibb
ixabepilone		Epothilone analogs	Treatment of taxane resistant metastatic breast cancer	3	Bristol-Myers Squibb
lamotrigine XR	Lamictal XR	Sodium channel inhibitor	Epilepsy	3	GSK
lestaurtinib		Selectively inhibits receptor tyrosine kinases	Acute myeloid leukemia	3	Cephalon
licarbazine		Sodium channel blocker	Treatment of acute manic episodes of bipolar I disorders	3	Novartis
lonafarnib	Sarasar	Inhibits farnesyl transferase	Myelodysplastic syndrome	3	Schering-Plough
loratadine/ montelukast		Anti-histamine/leukotriene receptor antagonist	Seasonal allergic rhinitis	3	Merck/Schering-Plough

maraviroc		CCR-5 receptor antagonist	HIV	3	Pfizer
methylnaltrexone		Peripheral opioid receptor antagonist	Opioid-induced constipation in advanced medical illness	3	Wyeth
MK-0518		Integrase inhibitor	HIV	3	Merck
MK-0524A			Atherosclerosis	3	Merck
MK-0524B			Atherosclerosis	3	Merck
NXY-059		Free radical trapping agent	Treatment of acute ischemic stroke	3	AstraZeneca
prasugrel		Oral adenosine diphosphate receptor blocker	Treatment of patients with ACS who undergo PCI	3	Lilly
rivaroxaban		Oral factor Xa inhibitor	Prevention of venous thromboembolism in hip and knee replacement surgery	3	Bayer/Johnson & Johnson
ropinerole ER		D2 and D3 dopamine receptor agonist	Restless leg syndrome	3	GSK
rosiglitazone/ metformin XR	Avandamet XR	PPAR gamma agonist/metformin	Treatment of type 2 diabetes	3	GSK
saredutant		Neurokinin-2 receptor antagonist	Treatment of depression	3	Sanofi-Aventis
saxagliptin		DPP-4 inhibitor	Treatment of Diabetes	3	Bristol-Myers Squibb
SR 58611		Beta3-adrenoreceptor agonist	Treatment of depression	3	Sanofi-Aventis
temsirolimus		Targets mTOR	Mantle cell lymphoma, renal cell carcinoma	3	Wyeth
teriflunomide		Immunomodulator	Multiple sclerosis	3	Sanofi-Aventis
vatalanib		Angiogenesis inhibitor blocks all VGEF	Colorectal cancer	3	Novartis
vildagliptin	Galvus	DPP-4 inhibitor	Diabetes	3	Novartis
vinflunine		Novel florinated vinca alkaloid	Treatment of bladder, small-cell lung, and breast	3	Bristol-Myers Squibb
xaliproden		Unclear; may mimic activity or stimulate synthesis of endogenous neurotrophins	Chemotherapy induced neuropathies; Alzheimer's	3	Sanofi-Aventis

APPENDIX K



FDA Statement

FOR IMMEDIATE RELEASE
Statement
December 3, 2006

Media Inquiries:
Kristen Neese, 301-827-6242
Consumer Inquiries:
888-INFO-FDA

Pfizer Stops All Torcetrapib Clinical Trials in Interest of Patient Safety

On December 2, 2006, FDA was notified that Pfizer will suspend a large, Phase 3 trial evaluating the investigational cardiovascular therapy torceptrapib/atorvastatin (T/A) due to an increased rate of mortality (death) in patients receiving the combination compared to those receiving atorvastatin alone. With the T/A development program, as it does with all such development programs, FDA assured that Pfizer had the appropriate protections in place for patients participating in the drug's development, including informed consent, a Data Safety Monitoring Board (DSMB) for its outcome study, and that the development program was done in a careful, stepwise manner.

For this trial, the DSMB was conducting a monthly analysis of mortality data and a quarterly analysis of a number of outcomes including stroke, heart attack, and revascularizations (e.g. coronary stents or bypass surgery) to ensure the ongoing safety of patients in this trial. This independent board notified Pfizer of the mortality finding early the morning of December 2, 2006 and FDA was notified at 4:00 PM EST that evening that Pfizer planned to halt this trial and the development program overall.

FDA fully supports Pfizer's decision to suspend this trial. The system of biomedical research monitoring was effective in this case, assuring that once a certain signal was seen, the trial was halted. FDA will continue to work with Pfizer and other sponsors developing molecules in this class of drugs to ensure that appropriate protections are in place to identify any safety signals as early in the development process as possible.

Clinical trials are an integral part of the process for developing new medical innovations and the healthcare system is dependent upon this research, and the patients willing to participate, to advance therapies. Clinical trials often tell us unexpected things, both positive and negative, about new medical products, which is why carefully designed and conducted trials are an essential part of the pre-market process for demonstrating that new drugs are safe and effective before they can be approved for marketing.

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FDA News

FOR IMMEDIATE RELEASE
P06-190
November 22, 2006

Media Inquiries:
Megan Moynahan, 301-827-6242
Consumer Inquiries:
888-INFO-FDA

FDA Approves First Generic Ondansetron Injection

The U. S. Food and Drug Administration (FDA) today approved first generic versions of Zofran (Ondansetron) Injection and Zofran (Ondansetron) Injection Premixed.

Ondansetron is indicated for the prevention of nausea and vomiting associated with initial and repeat courses of emetogenic cancer chemotherapy (cancer therapy that causes vomiting) and prevention of postoperative nausea and vomiting. According to the online magazine Drug Topics, Zofran was the 20th most expensive brand-name drug used in hospitals in the United States, in 2005, with total costs of $839.26 million.

"These approvals will result in significant savings for the American public," said Gary J. Buehler, Director, FDA Office of Generic Drugs. "Generic drugs undergo a thorough scientific and regulatory review, and are safe and effective alternatives to brand name drugs."

Ondansetron Injection packaged in single (4 mg/2 mL) and multi-dose (40 mg/20 mL) vials are manufactured by Teva Pharmaceuticals USA in North Wales, PA. Ondansetron Injection Premixed, 32 mg/50 mL in 5 percent dextrose is manufactured by SICOR Pharmaceuticals, Inc. in Irvine, CA. GlaxoSmithKline, the manufacturer of the innovator drug, has agreed to waive the remainder of a six-month exclusivity period to permit approval of the applications submitted by Teva and SICOR Pharmaceuticals.

The economic benefits of FDA's generic drug approval program are significant because generic drug products are used to fill more than 50 percent of all prescriptions and can cost a fraction of the price of the brand name drugs. Competition from generic drugs that are safe and effective alternatives to brand name drugs may quickly lead to reductions in costs. The savings would likely increase as more competitors enter the market. (See www.fda.gov/cder/ogd/generic_competition.htm).

The Office of Generic Drugs (OGD) continues to review and take action on generic drug applications as quickly as possible. For more information on other first generic versions of innovator products, see www.fda.gov/cder/ogd/approvals/1stgen0506.htm.

For additional information related to FDA's Office of Generic Drugs, go to: www.fda.gov/cder/consumerinfo/generic_equivalence.htm.

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Roche

Pharmaceuticals

November 13, 2006

IMPORTANT PRESCRIBING INFORMATION

Dear Healthcare Professional:

Roche Laboratories Inc. would like to advise you of a recent update to the TAMIFLU® (oseltamivir phosphate) package insert. The revision to the product label is a result of information about adverse events reported during postmarketing clinical use of TAMIFLU.

The revised PRECAUTIONS section of the TAMIFLU Capsules and Oral Suspension package insert now includes the following information and guidance under a new Neuropsychiatric Events subheading:

> ***Neuropsychiatric Events***
>
> There have been postmarketing reports (mostly from Japan) of self-injury and delirium with the use of TAMIFLU in patients with influenza. The reports were primarily among pediatric patients. The relative contribution of the drug to these events is not known. Patients with influenza should be closely monitored for signs of abnormal behavior throughout the treatment period.

In addition, the following statement has been added to the TAMIFLU Patient Information, in the ***What are the possible side effects of TAMIFLU?*** section:

> People with the flu, particularly children, may be at an increased risk of self-injury and confusion shortly after taking TAMIFLU and should be closely monitored for signs of unusual behavior. A healthcare professional should be contacted immediately if the patient taking TAMIFLU shows any signs of unusual behavior.

TAMIFLU is indicated for the treatment of uncomplicated acute illness due to influenza infection in patients 1 year and older who have been symptomatic for no more than 2 days. TAMIFLU is indicated for the prophylaxis of influenza in patients 1 year and older. TAMIFLU is not a substitute for early vaccination on an annual basis as recommended by the Centers for Disease Control's Immunization Practices Advisory Committee. Please see page 2 of this letter for other important TAMIFLU safety information.

We encourage you to become familiar with these label revisions. If you have any questions or require additional information concerning TAMIFLU, please contact the Roche Pharmaceuticals Service Center at 1-800-526-6367. An updated package insert is enclosed for your information. In addition, healthcare professionals can access the revised TAMIFLU complete product information at http://www.rocheusa.com/products/tamiflu/pi.pdf.

Roche Laboratories will continue to monitor the safety of TAMIFLU through established reporting mechanisms and notify regulatory authorities of any serious adverse events for evaluation. We will continue to provide you with the most current product information for TAMIFLU moving forward. You can assist us in monitoring the safety of TAMIFLU by reporting adverse reactions to us at 1-800-526-6367, by FAX at 1-800-532-3931, or to FDA at www.fda.gov/medwatch, or by mail to MedWatch, HF-2, Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20851.

Roche Laboratories Inc. 340 Kingsland Street
Nutley, New Jersey 07110-1199

Safety Information

There is no evidence for efficacy against any illness caused by agents other than influenza types A and B.

Treatment efficacy in subjects with chronic cardiac and/or respiratory disease has not been established. No difference in the incidence of complications was observed between the treatment and placebo groups in this population.

No information is available regarding treatment of influenza in patients at imminent risk of requiring hospitalization.

Efficacy of Tamiflu has not been established in immunocompromised patients.

Safety and efficacy of repeated treatment of prophylaxis courses have not been studied.

There have been postmarketing reports (mostly from Japan) of self-injury and delirium with the use of TAMIFLU in patients with influenza. The reports were primarily among pediatric patients. The relative contribution of the drug to these events is not known. Patients with influenza should be closely monitored for signs of abnormal behavior throughout the treatment period.

In postmarketing experience, rare cases of anaphylaxis and serious skin reactions, including toxic epidermal necrolysis, Stevens-Johnson syndrome and erythema multiforme, have been reported with TAMIFLU.

In treatment studies in adult patients, the most frequently reported adverse events (incidence ≥ 1%) were nausea and vomiting. Other events reported numerically more frequently in patients taking TAMIFLU compared with placebo were bronchitis, insomnia and vertigo. In treatment studies in patients 1 to 12 years old, the most frequently reported adverse event (incidence ≥ 1%) was vomiting (15%). Other events reported more frequently in patients taking TAMIFLU compared with placebo included abdominal pain (5% vs 4%), epistaxis (3% vs 3%), ear disorder (2% vs 1%) and conjunctivitis (1% vs ≤ 1%).

In prophylaxis studies in adult patients, adverse events were similar to those seen in the treatment studies. Events reported more frequently in patients taking TAMIFLU compared with placebo (incidence ≥ 1%) were nausea (7% vs 3%), vomiting (2% vs 1%), diarrhea (3% vs 2%), abdominal pain (2% vs 1%), dizziness (1% vs 1%), headache (18% vs 18%) and insomnia (1% vs 1%). In household prophylaxis trial that included patients 1 to 12 years old, adverse events were consistent with those observed in pediatric treatment studies, with GI events being the most frequently observed.

The concurrent use of TAMIFLU with live attenuated influenza vaccine (LAIV) intranasal has not been evaluated. However, because of the potential for interference between these products, LAIV should not be administered within 2 weeks before or 48 hours after administration of TAMIFLU, unless medically indicated. The concern about possible interference arises from the potential for antiviral drugs to inhibit replication of live vaccine virus. Trivalent inactivated influenza vaccine can be administered at any time relative to use of TAMIFLU.

Vaccination is considered the first line of defense against influenza.

Sincerely,

Dominick Iacuzio, Ph.D.

Medical Director, Roche Laboratories Inc.

Enclosures:

- Complete Product Information for TAMIFLU® (oseltamivir phosphate) Capsules and for Oral Suspension.
- TAMIFLU® (oseltamivir phosphate) Patient Information

FDA News

FOR IMMEDIATE RELEASE
P06-183
November 9, 2006

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

FDA Informs Public of Nationwide Recall of 500mg Strength Store-Brand Acetaminophen Caplets

The U.S. Food and Drug Administration (FDA) is alerting the public to a voluntary recall being conducted by Perrigo Company (Perrigo) of Allegan, Michigan for 383 lots of acetaminophen 500mg caplets manufactured and distributed under various store-brands as a result of small metal fragments found in a small number of these caplets. Approximately 11 million bottles containing varying quantities of acetaminophen 500mg caplets are affected by this recall. For a list of batches affected, please see www.fda.gov/oc/po/firmrecalls/perrigo/perrigobatchlist.html. Consumers can determine if they are in possession of a recalled product by locating the batch number printed on the container label. A list of stores that carry store-brands potentially affected by this recall is located on FDA's website at www.fda.gov/oc/po/firmrecalls/perrigo/perrigocustlist.html.

To date, there have been no illness or injuries received related to this problem and no consumer complaints have been reported to the FDA or to Perrigo. Based on information currently available, the FDA believes the probability of serious adverse health consequences is remote; however if a consumer were to swallow an affected caplet, it could result in minor stomach discomfort and/or possible cuts to the mouth or throat. Consumers should consult their physician if they suspect they've been harmed by use of this product.

Consumers who believe they are in possession of the affected products should discontinue use immediately and call Perrigo's Consumer Affairs Department, 877-546-0454 for further instructions. Any adverse reactions experienced with the use of this product should be reported to Perrigo at the above number and the FDA's MedWatch Program by phone at 800-FDA-1088, by fax at 800-FDA-0178 or on the MedWatch website at www.fda.gov/medwatch.

FDA is currently investigating the cause of the metal particles found in the acetaminophen 500 mg. caplets. Perrigo originally informed FDA of this problem after discovering through their own regulatory quality control procedures that their tableting equipment was wearing down prematurely. The company is also investigating the cause of the problem. The ongoing investigations have revealed the presence of the metal fragments in caplets of acetaminophen, 500 mg. Perrigo reported to the FDA that 70 million caplets were passed through a metal detector; resulting in the discovery of approximately 200 caplets containing metal fragments ranging in size from "microdots" to portions of wire 8 mm in length.

At this time FDA does not anticipate that this action will cause a shortage of acetaminophen. Currently, only one strength (500 mg caplets) is affected. Consumers may wish to take additional amounts of the lower strengths of acetaminophen tablets or caplets, which are not affected by this recall, to reach the 500 mg dose or access acetaminophen produced by alternate manufacturers. In all instances, FDA advises consumers to follow labeled instructions for maximum daily dosage.

Perrigo is notifying its distributors and retailers of this issue and will inform them of steps it will take to facilitate product replacement.

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Information for Healthcare Professionals

Methadone Hydrochloride

FDA ALERT [11/2006]: Death, Narcotic Overdose, and Serious Cardiac Arrhythmias

FDA has reviewed reports of death and life-threatening adverse events such as respiratory depression and cardiac arrhythmias in patients receiving methadone. These adverse events are the possible result of unintentional methadone overdoses, drug interactions, and methadone's cardiac toxicities (QT prolongation and Torsades de Pointes). Physicians prescribing methadone should be familiar with methadone's toxicities and unique pharmacologic properties. Methadone's elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours). Methadone doses for pain should be carefully selected and slowly titrated to analgesic effect even in patients who are opioid-tolerant. Physicians should closely monitor patients when converting them from other opioids and changing the methadone dose, and thoroughly instruct patients how to take methadone. Healthcare professionals should tell patients to take no more methadone than has been prescribed without first talking to their physician.

This information reflects FDA's current analysis of data available to FDA concerning this drug. FDA intends to update this sheet when additional information or analyses become available.

To report serious adverse events associated with the use of these drugs, please contact the FDA MedWatch program using the contact information at the bottom of this sheet.

Considerations

Methadone is an effective analgesic and may provide pain relief when other analgesics are ineffective. However, methadone can cause significant toxicities. We are highlighting important safety information from the new label about using methadone for pain. See the methadone label (Dolophine) for more details.

Methadone's elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours). Methadone's peak respiratory depressant effects typically occur later, and persist longer than its peak analgesic effects. During treatment initiation, methadone's full analgesic effect is usually not attained until 3-5 days of dosing. Initiation and titration to analgesic effect and dose adjustments should be done cautiously and in consideration of these properties. In chronic use, methadone may be retained in the liver and then slowly released, prolonging the duration of action despite low plasma concentrations.

Cross-tolerance between methadone and other opioids is incomplete. This incomplete cross-tolerance makes the conversion of patients on other opioids to methadone complex and does not eliminate the possibility of methadone overdose, even in patients tolerant to other opioids. Deaths have been reported during conversion from chronic, high-dose treatment with other opioid agonists to methadone. It is critical to understand the pharmacokinetics of

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methadone when converting patients from other opioids to methadone. Particular vigilance is necessary during treatment initiation, during conversion from one opioid to another, and during dose adjustments.

Methadone can cause serious cardiac conduction effects, including QT interval prolongation and Torsades de Pointes.

There are pharmacokinetic and pharmacodynamic drug interactions between methadone and many other drugs. Drugs administered concomitantly with methadone should be evaluated for interaction potential.

Methadone is secreted into human milk.

What should physicians do?

- Read and follow the prescribing information for methadone.
- Carefully weigh methadone's risks with its potential benefits before prescribing methadone.
- Avoid prescribing methadone 40 mg dispersible tablets for pain. This product is only FDA-approved for detoxification and maintenance treatment of narcotic addition.
- Closely monitor patients who receive methadone, especially during treatment initiation and dose adjustments.

What should healthcare professionals tell patients when prescribing methadone for pain?

- Pain relief from methadone does not last as long as methadone stays in your body. Therefore, do not to take more methadone than prescribed because methadone could build up in your body and cause death.
- Methadone can cause life-threatening changes in breathing (it may slow or stop).
- Methadone can cause life-threatening changes to the heart beat that may not be felt.
- Seek medical attention right away if you experience symptoms suggestive of an arrhythmia such as palpitations, dizziness, lightheadedness, or fainting or if you experience symptoms suggestive of a methadone overdose such as slow or shallow breathing; extreme tiredness or sleepiness; blurred vision; inability to think, talk or walk normally; and feeling faint, dizzy or confused.
- Directions you should follow if your pain is not controlled after taking the prescribed amount of methadone.
- Pain relief from methadone should last longer after you have taken it for awhile.

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- Tell your doctor if you start or stop other medicines because other medicines can interact with methadone and possibly cause death or life threatening side effects, or result in less pain relief from methadone.
- Tell your doctor if you are breastfeeding because methadone is secreted into human milk. Babies can experience the same serious side effects from methadone as the mother.

Data and Background Information

There have been reports of serious adverse events such as death, respiratory depression, and serious cardiac arrhythmias in patients receiving methadone. Fatalities have been reported in patients who were switched from chronic, high-dose treatment with other opioids to methadone and in patients initiating treatment with methadone. These adverse events may have resulted from unintentional methadone overdoses, drug interactions, and/or methadone's cardiac toxicities (QT prolongation and Torsades de Pointes). Some of the unintentional overdoses were due to prescribers not being aware of methadone's pharmacokinetics and potential adverse effects.

FDA recently updated the methadone label following an extensive review of the medical literature and other available information. The new label provides new information on methadone's pharmacology, drug interactions, and instructions on converting patients from other opioids to methadone and dosing methadone based on a synthesis of recommendations from several palliative care organizations and treatment centers.

References

- Goodman F., Jones W., Glassman P. Methadone Dosing Recommendations for Treatment of Chronic Pain, Pharmacy Benefits Management Strategic Healthcare Group, United States Department of Veterans Affairs, December 2001. http://www.pbm.va.gov/archive/methadonedosing.pdf (accessed 10/16/06)
- Pain Management at the End of Life. A Physician's Self-Study Packet. For physicians with prescribing privileges. A Collaborative Project of the Main Hospice Council, Maine Pain Initiative, University of Southern Maine, Muskie School of Public Service, 2006. http://www.mainehospicecouncil.org/Pain%20Management%20web%20version.pdf (accessed 10/20/06)
- Pereira J, Lawlor P, Vigano A, Dorgan M, Bruera E. Equianalgesic dose ratios for opioids. a critical review and proposals for long-term dosing. *J Pain Symptom Manage.* 2001 Aug;22(2): 672-87.

Information for Healthcare Professionals
Erythropoiesis Stimulating Agents (ESA)
[*Aranesp (darbepoetin), Epogen (epoetin alfa), and Procrit (epoetin alfa)*]

FDA ALERT [11/16/2006]: FDA is issuing this alert to advise you of a newly published clinical study showing that patients treated with an erythropoiesis-stimulating agent (ESA) and dosed to a target hemoglobin concentration of 13.5 g/dL are at a significantly increased risk for serious and life threatening cardiovascular complications, as compared to use of the ESA to target a hemoglobin concentration of 11.3 g/dL. The "Correction of Hemoglobin and Outcomes in Renal Insufficiency" (CHOIR) study, published November 16, 2006 in the New England Journal of Medicine, reports the adverse cardiovascular complications as a composite of the occurrence of one of the following events: death, myocardial infarction, hospitalization for congestive heart failure, or stroke.

The CHOIR study findings underscore the importance of following the currently approved prescribing information for Procrit, Epogen, and Aranesp, including the dosing recommendation that the target hemoglobin not exceed 12 g/dL.

This information reflects FDA's current analysis of data available to FDA concerning these drugs. FDA intends to update this sheet when additional information or analyses become available.

To report any serious adverse events associated with the use of these drugs, please contact the FDA MedWatch program using the contact information at the bottom of this sheet.

Considerations

Physicians and other healthcare professionals should consider the following when using erythropoiesis stimulating agents:

- **For all patients:**
  - Adhere to dosing to maintain the recommended target hemoglobin range of 10 to12 g/dL.
  - Measure hemoglobin twice a week for 2 to 6 weeks after any dosage adjustment to ensure that hemoglobin has stabilized in response to the dose change.
  - Decrease the dose of the ESA if the hemoglobin increase exceeds 1g/dL in any 2 week period.
- **For chronic renal failure (CRF) patients**: Measure hemoglobin twice a week after initiating treatment until hemoglobin has stabilized

- **For cancer patients and zidovudine-treated HIV patients:** Measure hemoglobin once a week after initiating treatment until hemoglobin has stabilized
- **For patients with a history of cardiovascular disease or hypertension**: Closely monitor and control blood pressure

Information for the Patient

Physicians and other healthcare professionals should discuss the following with their patients:

- The goal of treatment with erythropoiesis stimulating agents (ESA) is to increase the number of red blood cells which can help them in treating their anemia.
- Treatment with an ESA can be harmful if not closely monitored.
- The importance of keeping their appointments for their blood tests
- The need to monitor their blood pressure every day (if appropriate) and call you if there are any changes outside of the range established for the patient.
- To call you if they experience any of the following symptoms:
    - Pain and/or swelling in the legs
    - Worsening in shortness of breath
    - Increases in blood pressures
    - Dizziness or loss of consciousness
    - Extreme tiredness
    - Blood clots in hemodialysis vascular access ports

Data Summary

Safety concerns related to the use of erythropoiesis-stimulating agents in the treatment of the anemia of chronic renal failure (CRF) is the topic of two clinical studies and an editorial published in *The New England Journal of Medicine* on November, 16, 2006. The 1,432 subject CHOIR study demonstrated increases in serious and potentially life threatening cardiovascular events when epoetin alfa (Procrit) is administered to reach higher target hemoglobin levels than lower target hemoglobin levels. The 603 subject CREATE study showed a trend toward more cardiovascular events in a pattern similar to the CHOIR study, thus supporting the findings of the CHOIR study. The CREATE study examined the use of epoetin beta, a product not approved in the USA.

- The CHOIR study was a randomized, open label design in which anemic chronic kidney disease (CKD) subjects were randomized to be dosed to either a higher average target hemoglobin (13.5 g/dL) or a lower average target hemoglobin (11.3 g/dL). All subjects received Procrit. The primary endpoint was a time to event analysis for a composite cardiovascular endpoint (all cause mortality, congestive heart failure (CHF) hospitalization, non-fatal MI, or non-fatal stroke).
- Procrit was administered as 10,000 Units SC weekly and titration allowed to a maximum dose of 20,000 Units weekly.
- Overall, 715 subjects were randomized to the high target hemoglobin (13.5 g/dL) and 717 randomized to the low target hemoglobin (11.3 g/dL). At the end of the study, the average hemoglobin was 12.6 g/dL for the high group and 11.3 g/dL for the low group.
- The composite cardiovascular endpoint was statistically worse in the higher target hemoglobin group with a hazard ratio of 1.3 [95% CI 1.03, 1.74] ($p = 0.03$ by log rank test).
- The rates for the individual components of the composite primary endpoint were (high target vs. low):

Death:	7.3% vs 5.0% (p = 0.07)
CHF hosp:	9.0% vs 6.6% (p = 0.07)
Non-fatal MI:	2.5% vs 2.8%
Non-fatal stroke:	1.7% vs 1.7%

- The analyses for this study found no correlation between rate of rise of hemoglobin and adverse cardiovascular events. However, the relationship between seizures and the rate of rise of hemoglobin as reported in the labeling for all three products remains a concern.

The CHOIR and CREATE study findings underscore the importance of the existing warnings regarding cardiovascular risks that include thrombotic events and increased mortality observed in hemodialysis patients with cardiac disease targeted to higher hemoglobin levels (> 14 g/dL), and recommendations not to exceed hemoglobin levels of 12 g/dL in approved labeling for Procrit, Epogen, and Aranesp. Please refer to the full prescribing information for additional information. Internet links to the full prescribing information for all approved ESA products may be found at the FDA page for this alert.

Report serious adverse events to
FDA's MedWatch reporting system by completing a form on line at
http://www.fda.gov/medwatch/report.htm, by faxing (1-800-FDA-0178),
by mail using the postage-paid address form provided online
(5600 Fishers Lane, Rockville, MD 20852-9787),
or by telephone (1-800-FDA-1088).

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Happy Holidays