Drug Utilization Review Board

Oklahoma Health Care Authority
4545 North Lincoln Boulevard, Suite 124
Oklahoma City, Oklahoma 73105
OHCA Board Room

Wednesday
August 12, 2009
6:00 p.m.

The University of Oklahoma

Health Sciences Center

COLLEGE OF PHARMACY

PHARMACY MANAGEMENT CONSULTANTS

MEMORANDUM

TO: Drug Utilization Review Board Members

FROM: Shellie Keast, Pharm.D., M.S.

SUBJECT: **Packet Contents for Board Meeting – August 12, 2009**

DATE: August 6, 2009

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

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

Call to Order

Public Comment Forum

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

Update on DUR / MCAU Program – See Appendix B.

Action Item – Vote to Prior Authorize Gelnique™ and Update Bladder Control Product Based Prior Authorization Category – See Appendix C.

Action Item – Vote to Apply Quantity Restrictions to Hydrocodone Products – See Appendix D.

60 Day Notice to Prior Authorize Otic Anti-Infective Products – See Appendix E.

60 Day Notice to Prior Authorize Fibromyalgia Products – See Appendix F.

SoonerCare Program Overview

FDA and DEA Updates – See Appendix G.

Future Business

Adjournment

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Drug Utilization Review Board

(DUR Board)

Meeting – August 12, 2009 @ 6:00 p.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. Muchmore, Chairman:

1. Call To Order

A. Roll Call – Dr. Graham

Items to be presented by Dr. Muchmore, Chairman:

2. Public Comment Forum

A. Acknowledgment of Speakers and Agenda Items

Items to be presented by Dr. Muchmore, Chairman:

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

A. July 8, 2009 DUR Minutes – Vote
B. July 9, 2009 DUR Recommendation Memorandum

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

4. Update on DUR / Medication Coverage Authorization Unit – See Appendix B.

A. Retrospective Drug Utilization Review for April 2009
B. Retrospective Drug Utilization Review Response for March 2009
C. Medication Coverage Activity Audit for July 2009
D. Help Desk Activity Audit for July 2009
E. Medication Therapy Management Services Activity Audit for FY 2009

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

5. Action Item – Vote to Prior Authorize Gelnique™ and Update Bladder Control Product Based Prior Authorization Category – See Appendix C.

A. COP Recommendations

Items to be presented by Dr. Keast, Dr. Muchmore, Chairman

6. Action Item – Vote to Apply Quantity Restrictions to Hydrocodone Products – See Appendix D.

A. COP Recommendations
B. SoonerCare Program Operations and Benefits Update – OHCA Staff
C. SoonerCare Quality Assurance / Quality Improvement Update – OHCA Staff

Items to be presented by Dr. Keast, Dr. Chonlahan, Dr. Muchmore, Chairman

7. 60 Day Notice to Prior Authorize Otic Anti-Infective Products – See Appendix E.

A. Utilization Review
B. COP Recommendations

Items to be presented by Dr. Keast, Dr. Patel, Dr. Muchmore, Chairman

8. 60 Day Notice to Prior Authorize Fibromyalgia Products – See Appendix F.

A. Utilization Review
B. COP Recommendations

Items to be presented by Dr. Nesser, Dr. Muchmore, Chairman

9. SoonerCare Program Overview

Items to be presented by Dr. Graham, Dr. Muchmore, Chairman

10. FDA and DEA Updates – See Appendix G.

11. Future Business

A. Synagis Annual Review
B. Anxiolytic Criteria Review
C. New Product Reviews
D. Annual Reviews

12. Adjournment

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES of MEETING of JULY 8, 2009

BOARD MEMBERS:	PRESENT	ABSENT
Brent Bell, D.O., D.Ph.: Vice-Chairman	X	
Mark Feightner, Pharm.D.		X
Anetta Harrell, Pharm.D.	X	
Evelyn Knisely, Pharm.D.	X	
Thomas Kuhls, M.D.	X	
John Muchmore, M.D., Ph.D.: Chairman	X	
Paul Louis Preslar, D.O., MBA	X	
James Rhymer, D.Ph.		X
Bruna Varalli-Claypool, PA-C, B.A.	X	
Eric Winegardener, D.Ph.	X	

COLLEGE of PHARMACY STAFF:	PRESENT	ABSENT
Metha Chonlahan, D.Ph.; Clinical Pharmacist	X	
Karen Egesdal, D.Ph.; SMAC-ProDUR Coordinator/OHCA Liaison	X	
Ronald Graham, D.Ph.; Pharmacy Director	X	
Shellie Keast, Pharm.D, M.S..; DUR Manager	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.; Associate Dean for Graduate Studies & Research	X	
Leslie Robinson, D.Ph.; PA Coordinator	X	
Visiting Pharmacy Student(s): Dustin Smith, Rachel Carlson	X	

OKLAHOMA HEALTH CARE AUTHORITY STAFF:	PRESENT	ABSENT
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 Medicaid/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
Kerri Wade, Senior Pharmacy Financial Analyst	X	

OTHERS PRESENT:

Jeff Himmelberg, GlaxoSmithKline	David Williams, Forest Managed Care	Stephen McFadden, Forest Labs
Bryan Dillonn, Bristol Myers Squibb	Kathryn Daniel, Forest Labs	Holly Turner, Merck
Lisa Sherman, Stratinova	Paul Love, Forest	John Seidenberger, Boehringer-Ingelheim
Jim Dunlap, Eli Lilly	Richard Ponder, J&J	Charlene Kaiser, Amgen
Paul Konovodoff, Acordia Therapeutics	Candy Ting, D.O.	Mark DeClerk, Lilly
Kirsten Mar, Lilly	Janie Huff, Takeda	Paul Sparks, Genzyme Pharmaceuticals
Kim Greenberg, Amylin	Sam Smothers, MedImmume	Rob Baxter, MedImmune
David Barton, Schering Plough		

PRESENT FOR PUBLIC COMMENT:

Agenda Item No. 5	Chaouki Khoury, M.D.; OU Neurology (Did not speak)
Agenda Item No. 8	Mike DeLucia, R.Ph.; Forest Research Institute
Agenda Item No. 8	Candy Ting, D.O.

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

1A: Roll Call

Dr. Muchmore called the meeting to order. Dr. Graham introduced new DUR Board members, Ms. Bruna Varalli-Claypool, Dr. Eric Winegardener and Dr. Anetta Harrell. Roll call by Dr. Graham established a quorum.

ACTION: NONE REQUIRED

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

Dr. Muchmore recognized the speakers for public comment:
For Agenda Item No. 5; Chaouki Khoury, M.D.; OU Neurology
For Agenda Item No. 8; Mike DeLucia, R.Ph.; Forest Research Institute and Candy Ting, D.O.

ACTION: NONE REQUIRED

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

3A: June 10, 2009 DUR Minutes

Dr. Kuhls moved to approve as submitted; seconded by Dr. Preslar.

ACTION: MOTION CARRIED

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

4A: Retrospective Drug Utilization Review: March 2009
4B: Medication Coverage Activity Audit: June 2009
4C: Help Desk Activity Audit: June 2009

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE ANTI-MIGRAINE PRODUCTS**

Dr. Khoury was not in attendance for public comment.
Materials included in agenda packet; presented by Dr. Keast.
Dr. Kuhls moved to approve as submitted and to grandfather those individuals currently approved for Tier 2 or Tier 3 products; and use supplemental rebate for Tier 2 products only; seconded by Dr. Winegardener.

ACTION: MOTION CARRIED

AGENDA ITEM NO. 6: **30-DAY NOTICE TO APPLY QUANTITY RESTRICTIONS TO HYDROCODONE PRODUCTS**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 7: **30-DAY NOTICE TO PRIOR AUTHORIZE GELNIQUE™ AND UPDATE OF BLADDER CONTROL PRODUCTS PRODUCT BASED PRIOR AUTHORIZATION CRITERIA**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 8: **UTILIZATION REVIEW OF FIBROMYALGIA PRODUCTS**

For Public Comment, Mike DeLucia: Good evening ladies and gentlemen. Thank you for the opportunity to speak here this evening. My name is Mike DeLucia and I'm the senior managed care clinical specialist with Forest Research Institute. Milnacipran was first developed in Europe for the treatment of depression and is approved in the United States exclusively for the management of fibromyalgia. Pharmacologically, milnacipran is a serotonin and norepinephrine reuptake inhibitor. Research shows that the SNRI's work to restore the pain signaling of the descending inhibitory pathway, which is abnormally reduced in fibromyalgia patients. There have been peer review publications as well as metanalysis recently that have shown that the SSRI's and the tricyclic antidepressants have limited clinical benefit in fibromyalgia. Newer, more specific SNRI's have shown increases in clinical efficacy and there is emerging animal evidence which suggests that the SNRI's with a preference for norepinephrine reuptake inhibition may actually play a more important role in chronic pain states. Milnacipran is reported to

inhibit norepinephrine reuptake within approximately threefold higher potency over that of serotonin reuptake inhibition; and also does not significantly inhibit other receptors or ion channels, such as dopamine cholinergic receptors or gabanergic receptors. Pharmacokinetically, its' oral bioavailability is 85% and its' half-life is 8 to 10 hours; 13% protein binding and not affected by food in its' absorption. It is primarily excreted through the urine. Now if you look at efficacy, there were two pivotal trials. One of six months in duration and the other in three months in duration, which looked at a combined total of over 2,000 patients and compared 100 and 200 mg of milnacipran to placebo in a double blind fashion. These trials were unique in that in order to study the improvements appropriately for fibromyalgia and to look and evaluate the pain and symptoms that they struggle with each and every day, it was a group of physicians known as OMERACT got together and decided and looked at developing composite responder analysis. These composite responder analysis actually looked at clinical meaningful improvements in pain of 30% or greater improvement. Personal impression of change measured to the PGIC of one or two very much improved or much improved. And improvements in physical function of six points or greater on the SF 36. Again the composite responder approach demanded simultaneous improvement within a single patient, and results showed that 100 and 200 mg doses were statistically and significantly superior to that of placebo, with a third of the patients that approximately 1,400 milnacipran patients meeting the rigorous composite responder criteria for up to six months. Milnacipran is safe, well tolerated and weight neutral. Weight is an issue for these patients, whether it be due to just the illness itself or whether it be to some of the drugs that they take in order to manage the illness. In studies, approximately 25% of milnacipran patients versus 12% on placebo prematurely discontinued due to adverse effects. The most common reason for discontinuation, nauseousness, palpitations and headache. It is also recommended that patients on milnacipran have their blood pressure and heart rate monitored, both prior to treatment and during treatment. Milnacipran also has an FDA class label warning or black box precaution for suicidality and serotonin syndrome and it's contraindicated in patients taking MAO inhibitors or with uncontrolled narrow angle glaucoma. Milnacipran is available in two doses and is recommended most commonly at 100 mg per day, administered 50 mg bid, or an escalated dose of 200 mg per day, 100 mg bid for those patients who have clinical issues or that warrant it. In summary, milnacipran demonstrates in simultaneous and significant improvement in the areas of pain, patient global impression of change and physical function. It has negligible and manageable side effect profile and appears to offer a number of additional unique treatment attributes in comparison to other FDA approved and non-FDA approved fibromyalgia medications. With that I will conclude and thank you for the opportunity to speak at this meeting. I'll gladly answer any questions you may have.

Board Member Kuhls: Do you have any in your company that at all, that looks comparatively versus other products that are available for fibromyalgia in some well controlled studies, direct comparison versus, compared to just placebo?

Dr. DeLucia: There are no head-to-head studies with milnacipran, with any of the other products.

Chairman, Dr. Muchmore: Dr. Kuhls and I would like to see a lot more head-to-head studies that are done.

Dr. Knisely: Is there intention to go after any type of a depression in the patient?

Dr. DeLucia: No ma'am. The patent for milnacipran in the United States is a use only patent and we have no agreements to change that patent, so we will only look for fibromyalgia.

Board Member Kuhls: The major problem with the whole psychiatric medications in the world is that the FDA has required all their medicines to be compared to placebo and instead what should have been done very early is take a gold standard medicine and then compare to that, so that at least you have some idea starting to look at comparative trials and unfortunately, the FDA has never required that.

For Public Comment, Candy Ting: Good afternoon. Thanks for letting me come. I'm a practicing family physician in Tulsa. I'm with Omni Medical Group and I also spend my Thursday afternoon off except Sunday I mean in the summer and teaching at the OSU Medical Center for second year students getting them ready for their rotations. I treat a lot of primary care type patients where that's from a lot a people coming in with pain, a lot of people have had lots of previous experiences with seeing different doctors, so-called pain doctors, or real anesthesia pain doctors, or depression, all types doctors. We've had lots of fibromyalgia. I remember when I was in medical school, fibromyalgia was kind of one my professor was like oh, fibromyalgia, I think it was mentioned in one class in one of my text books. I think all of us kind of now, Mr. DeLucia has explained quite well exactly, but the definition for fibromyalgia is not what just everybody comes in, I have pain all over and then you say it's fibromyalgia. It is a heightened kind of pain, it is somebody that has had it for more than three months. They have to have more than eleven of the eighteen tender points. I do see a lot of those people and we've only had three fibromyalgia medications approved so far, and I've been using the Lyrica, the Cymbalta and, just as of seven weeks ago, we have Savella approved and I actually can get samples on hand and to try them. I've had, seen so much results. I've called some of the patients that I've been waiting for to try this medication, because they've tried every one that's available. They've been on Tramadol, they've taken all kinds. I just want to bring to you as a patient advocate, I have two patients I wanted to share with you. This patient is a 63-year old legally blind patient. Her son lives real close to her, just next door, in the next door apartment and checks on her so she still wants to live in her home setting. She has been quote fibromyalgic, she has PTSD from previous abusive marriages and then you know, she became blind from the injury and so she's been on Tramadol and she became addicted to it when she was taking so much that they had to actually put her at one of the hospitals and detox her. She was even, Lyrica, where her dose was increased to the maximum dose and she had so much swelling that when she went in the emergency room they labeled her CHF and then she was sent home with all kinds of Lasix and all other kinds of medications. She's legally blind, remember, so someone before she came to me, was, he gave her authorization to go see a pain doctor. Well now she's on a lot of hydrocodone because that seems to work and cyclobenzaprine and that seems to help her. She has fallen several times. She went to emergency room several times and she came in once when I was actually working that night, I get to kind of visit with her and kind of suggest to her fibromyalgia, you really don't treat with all this kind of medicine. She takes this med, cyclobenzaprine and lortab. And now she has fallen and one time actually when she came in was she was bruised all over. She really looks literally like a raccoon with her cane and her son holding her arm on the other side. She told me that the only thing that give her relief is this pain medicine

and the cyclobenzaprine for fibromyalgia. So she is one that as soon as the medicine came out, when the samples came out which was first week in May, I called her son then and gave her samples. She called me in week three. Of course we do the titration packages so really we don't get on the 50 mg bid until the second week. She called me and said "Oh my gosh, why didn't you give me this medicine earlier?" and then she said "You can ask Rick". Rick is her son. "I have not taken any Flexoril". Not Flexoril, cyclobenzaprine, and she said, like "I have been only taking one lortab and that's only for at night". And she has not been falling because she has not been sleepy. This is just one case though so I want to see if she, she is now on her seventh week. I called her yesterday just to make sure that she's still doing good before I bring her as a testimony. And now the young girl, she's 27 years old. She's a medical assistant. She went to medical assistant school and then she got her LPN and she had two abusive marriages. She has been called fibromyalgia, diagnosed by a rheumatologist and her medication is lortab and cyclobenzaprine and elavil for bedtime, amitriptyline. And she could not work. She said with this med she could not work. Her sister has been seeing me for a while, so she got her to come see me. And she first came to see me I thought I'll put her on the Cymbalta, Lyrica regimen and she said "I've already tried that. I'm not depressed. I don't want to take Cymbalta. I know it's antidepressant. I work in a doctor's office". Well anyway I insist that she take it, I gave her samples. I knew she didn't really like to take it and she didn't want to take the Lyrica because she says it make her swell and you definitely feel very sleepy. So amongst all this, she has been, before she came to me she's already been on the six months of FMLA. She got her maximum six months. I had to try to get her a second time six months, and then fibromyalgia Savella got approve, so I gave this to her. She was supposed to come in to get her extension for her third FMLA which she is at this time contemplating getting on disability because she told me her rheumatologist suggested that she get on disability and her supervisor at work told her she couldn't really work if they can't let her come back to work. She has been on it for about three weeks when her husband came in to see me as a patient and to make a long story short, asked when the husband's visit was over, said "Dr. Ting, I need . . ." and then I kind of like, gosh, she wants this FMLA paperwork. I said "You don't have an appointment". She said like "I want a release to go back to work". I said like "You want to go back to work?", and "When is your appointment?". She say "My appointment's not till four weeks later. I don't want to wait for getting another FMLA. I have to tell you since you put me on this medicine I have had less pain. I'm not telling you I don't have any pain. If I ever call for lortab I want you to give me some, but I'm not telling you I'm not in any pain, but I want to go back to work. I went to medical assistants for LPN school and I haven't really worked. I want to work." This are just two cases that have the longest experience I've been having other patients. I have very good experience and I just felt like we want studies. We want to compare other studies. The practicing physician that has seen a lot of patients. They have used all these drugs. Really has seen the results and with these two cases I think I'm saving this first lady chances of not having had to go back to emergency room. She has a more quality of life. She tells me now she's going to the club where all the senior people goes in her neighborhood. She's going to a club and she's talking with them. She's sharing those stories with each other and she's not sitting at home all drowsed out and just needing her son to come at night to help her get her shower and change her clothes and get ready to go to bed again for a miserable night. And this other lady that I thought was going to get another extension for FMLA, I didn't think three weeks would make that much difference. I forgot that I gave her that medicine because when I was focused on her husband, there was this new visit, no wonder she switched her husband from another doctor to see me because she felt like I'm the one that listened to her and gave her a medicine that worked. I told her I'm not the only one that gave it to her just because the other doctors didn't have this medicine available yet. It just brand new. She told me that it's a good medicine. She told me never to not give her again. All these people have been generally getting medicine provided by the pharmaceutical company because now right now it's real hard to find on the formulary, so knowing that opportunity for me to share with a lot of physicians and pharmacists and who are very well knowledge of how to help a patient, to get them out from taking all this 240 tabs of hydrocodone, I think this will be a great drug for it to be on easier access for us so we don't have to spend all this time and do prior auth if our patients do have fibromyalgia. This is truly the only one of the three that supposedly has the least side effects. Patients don't look it as antidepressant because they know it's not. (unintelligible) SSRI, SNRI kind of norepinephrine thing. And this one with the ratio Mr. DeLucia has also mentioned which ones of the serotonin component is really low. So thank you for this opportunity. I just kind of wanted to share with you too. I have lots of them if you wanted to hear more, but I just kind of confirmed these two before I came because these are the two that I actually have seen them back that really is telling me these results. The rest of them have been coming less. My nurse even told me like Dr. Ting since you use that Savella, I'm not getting these calls for these pain pills all the time and Flexeril all the time refill. And Melody, my nurse, told me that before I came out here, too. I asked her like, can you tell me if this is really good, so I haven't had one person to like it, that's for sure. So our samples are flying off the shelf. We really been using a lot of it. I don't think I can keep getting samples to help these people. I hope they can get it on their own, insurance. And thank you for your time. Any other questions?

Board Member Kuhls: I have a question. Obviously many of these patients, like you have said, bounced around. Most of your patients have received courses of Tramadol, received lortabs up the wazoo, amitriptyline, the whole bit, right? So when you see most of your patients and you have been using Savella as samples, most of those patients have had trials of some of the other medications, right?

Dr. Ting: Correct. I have not had a brand new fibromyalgia that I start them on it. This is (unintelligible). I don't have a brand new one. I got them all treated I guess.

Board Member Kuhls: So that's my real question to you. Is, do you believe that you have a patient who comes in first time, de novo, hasn't had any treatment for fibromyalgia, do you believe that some other agents should be tried and then, like those patients that fail, then use these other medications, or do you believe that, hey, any patient with fibromyalgia, I'm just going to give them Savella now right to begin with.

Dr. Ting: Well, I believe a good physician will do a good history and physical. If it is truly fibromyalgia and since we do have fibromyalgia FDA indications, why am I giving them tricyclics that make them sleepy, gain weight and when they gain weight, these Fibromyalgia patients, most of them are overweight. Because they are miserable, they can't go exercise. They mostly eat

carbs, so Elavil we all know that has a lot as far as increasing their appetite. They all gain weight. They all are sleepy. They don't have quality of life. Some of these people, not only they can't go to work, they can't enjoy their own family, their children, so I believe I'm not going to put them through all that unless they just really cannot afford the medication. I'll ask them, if I only use Elavil I use a very small dose. It's only to help them sleep at night. But that may not cure their whole fibromyalgia for the other sixteen hours of the day.

Board Member Kuhls: I think what we're going to hear, we'll see. But I think what we're going to hear in a couple of minutes is that there are studies though that show that Elavil works in studies of fibromyalgia and that we're going to hear that in meta-analyses that there are studies that show that it helps, and so to me, since there's not comparative trials, that's why I was asking a little while ago, what makes me nervous is the concept of any patient with fibromyalgia should be put on a certain drug. I think it's part of the protocol and like your two patients, it sounds like Savella was a great choice because they've going through other tiers, but it concerns me a little that right off the bat, everybody in the world should get Savella with fibromyalgia.

Chairman Muchmore: When you take the group that has failed other therapies and give them the Savella, you may have selected out a group that's more likely to respond. If you take de novo untreated fibromyalgia, some of them may respond better to amitriptyline or fluoxetine than to Savella. You know, there's a tremendous variety in these patients.

Board Member Kuhls: Yeah, that's true. That's true. And we don't know the genetics and …… I agree totally. And so that's the, I mean I think it's part, I'm glad those two patients got your medication. The only thing that I might differ on is you know, I think there needs to be some steps of therapy to do some more well tested, less expensive, not proven to be worse medications before you jump.

Dr. Ting: Well, I hope that my patients show you that just because the medicine is cheap at the pharmacy level may not mean that it is the least expensive overall. Because they are not going to work. They are going to emergency room and they fall and they get X-rays or they get CAT scans on their head because she fell. So and Elavil is really, the studies may show that it may work, but it's really not FDA indicated and a lot of patients, remember for several years though we tried to stay away from this class of medication because of the side effects, because of the sedation and because of all the many drug-drug interactions with the rest of the class. And I'm not saying that I want you to take Elavil out of this treatment regimen, just saying that Savella is a good one and this patient that came to me that has tried all those, you know, you need to use those and not every patient's going to respond to Elavil. And if Elavil, they may work, but they may not tell us what's the side effect. They may take care of the pain, but they are sitting at home all day long eating carbs. And they are not going to work, they are gaining weight, you'll be replacing their knees in a few years.

Board Member Kuhls: I understand that. Patients that fail medication or have side effects, you need to do something different. My last question is real quickly, I just have one quick other question, because I don't treat fibromyalgia, or I have, but it's hard in teenagers. But how long of a trial of a medication do you need before you say it's effective or not, because you were talking in terms of three weeks.

Dr. Ting: Well the second patient is three weeks and I haven't even asked her to come back for re-check. She wanted to go back to work. So the first patient has been on it for the full two months by now because she was the first one that got on, and it was approved like the first week in May, I believe. I got samples right away, so I've been trying them on.

Board Member Kuhls: Okay, but my question is, is in general, in the world of fibromyalgia, how long do you have to keep people, you know, Dr. Bell would tell you that with antidepressants, it takes a certain amount, a number of weeks and months before you may see an effect. My question is, in the fibromyalgia world, how long do you have to keep somebody on a dose before you start altering and making changes, because in some of the recommendations that are going to be made here, they're going to talk about a time period in trials, so I'm trying to get a concept …….

Chairman Muchmore: In other words, can you tell in two weeks if it's going to be an effective drug?

Board Member Kuhls: Yeah, how long do you wait before you dump it and say we've got to do something else, or we're not seeing an effect. Is it months? Is it weeks? Because I don't know. I'm asking because I don't know.

Dr. Ting: Well I think every patient's different. I think the company might have more studies. I'm a practicing physician. I don't do clinical studies as far those. I kind of use them on my patients to see how it helps them, because these people are desperate and I'm glad that there's something that can help. Before the days of Savella, not only I had to get them off this medication, I had to do OM osteopathic manipulation. I mean these patients, it takes thirty minutes to do it and of course, you know the Medicaid doesn't repay you for those, but you just treat it as while we are talking to them, we kind of do a treatment. It takes a lot of time to try and they feel good for a week and two and then they are back. They wanted to do more treatment. I'm very excited that this medicine's out because so far I've seen very good results. It makes sense to treat them for the norepinephrine and then they don't get the fatigue they get the pain receptors. It saves pain in ascending and descending receptors. I think for the rest of those questions you asked we'd probably have to take a little longer time for the company to come up with even more longer trials, they have to get FDA approval, otherwise we wouldn't be able to use it. I think you have the answer for these questions, right?

Dr. DeLucia: If I may readdress the committee just to kind of address this question and to provide some information on the amitriptyline issue. Regarding this issue of longevity in fibromyalgia patients, the first clinical trial of greater than three months was the six month trial that we conducted and it demonstrated that at least of third, and in fibromyalgia, that's a huge percentage of patients, a third of those patients responded for the full six months and had the pain, the physical function and the improvement that they reported the entire time. And they were all statistically significant for the full time period. To address your second question regarding amitriptyline, it's not really addressing your questions, but to provide a little bit of information. Clearly there is efficacy with the tricyclic antidepressants. The difference between the tricyclics and the SNRI's and in particular, milnacipran is the ratio of norepinephrine reuptake inhibition versus serotonin. Tricyclics, it's a one to one. And giving that the recent literature and in fact the animal model suggests that the more norepinephrine reuptake inhibition you

have, the more pain relief, the more effectiveness you get. That's one thing to consider as you look at the agents and the classes as a whole. So I provide that as information. Hopefully it helps and if you have any other questions along that line I'll gladly answer those.

Chairman Muchmore: Thank you. The people that treat fibromyalgia say they need a basket of therapies, because what works well on patient A doesn't work well on patient B and it's certainly true that some patients get terrible fatigue and weight gain with amitriptyline. It's also true that other people take it and feel wonderful, not sleepy and don't gain weight, you know. And so, people are made different.

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 9: **UTILIZATION REVIEW OF OTIC ANTIBIOTICS**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 10: **FDA & DEA UPDATES**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 11: **FUTURE BUSINESS**

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

11A: Proton Pump Inhibitors Annual Review
11B: Anxiolytic Criteria Review
11C: New Product Reviews
11D: Annual Reviews
ACTION: NONE REQUIRED

AGENDA ITEM NO. 12: **ADJOURNMENT**

The meeting was adjourned at 7:43 p.m.

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

Memorandum

Date: July 9, 2009

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

From: Shellie Keast, Pharm.D., M.S.
Drug Utilization Review Manager
Pharmacy Management Consultants

Subject: DUR Board Recommendations from Meeting of July 8, 2009

Recommendation 1: Vote to Prior Authorize Anti-Migraine Products

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the addition of the Anti-Migraine class to the Product Based Prior Authorization program once a reasonable SMAC has been placed on the generic sumatriptan.

Approval Criteria
To qualify for a Tier 2 product the member must meet one of the following criteria:
- Trial of all available Tier 1 products with inadequate response, or
- Documented adverse effect to all the Tier 1 products, or
- Previous success with a Tier 2 product within the last 60 days.

To qualify for a Tier 3 product the member must meet one of the following criteria:
- Trial of all available Tier 2 products with inadequate response, or
- Documented adverse effect to all available Tier 2 products, or
- Previous success with a Tier 3 medication within the last 60 days.

Approvals will be granted for one year.

Tier 1	Tier 2	Tier 3†
Sumatriptan (**Imitrex®**)*	(Supplemental rebated Tier 3)	Almotriptan **(Axert®)** Eletriptan **(Relpax®)** Frovatriptan **(Frova®)** Naratriptan **(Amerge®)** Rizatriptan **(Maxalt®; Maxalt MLT®)** Zolmitriptan **(Zomig®; Zomig-ZMT®)** Sumatriptan/Naproxen **(Treximet®)**

*Mandatory Generic Plan
†May be Rebated to Tier 2 Only

Appendix B

Retrospective Drug Utilization Review Report

Claims Reviewed for April 2009

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Total # of messages returned by system when no limits were applied	44,951	57,590	1,034,135	34,297
Limits which were applied	Established, Major, Males and Females, Age 52-65	Males and Females, Benzodiazepine Anticonvulsants, Age 51-150	Contraindicated, Asthma, Males and Females, Age 76-150	High dose and Duration , Benzodiazepines, Males and Females, Age 26-150
Total # of messages after limits were applied	138	80	2	4
Total # of members reviewed after limits were applied	138	73	2	4

LETTERS			
Prescribers		**Pharmacies**	
Sent	**Responded**	**Sent**	**Responded**
25		3	

Retrospective Drug Utilization Review Report

Claims Reviewed for March 2009

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females, Age 31-51	Benzodiazepine Anticonvulsants, Males and Females, Age 0-50	Contraindicated, Asthma, Males and Females, Age 51-75	High Dose and Duration, Benzodiazepines, Males and Females, Age 0-25

Response Summary (Prescriber)
Letters Sent: 79
Response Forms Returned: 50

The response forms returned yielded the following results:

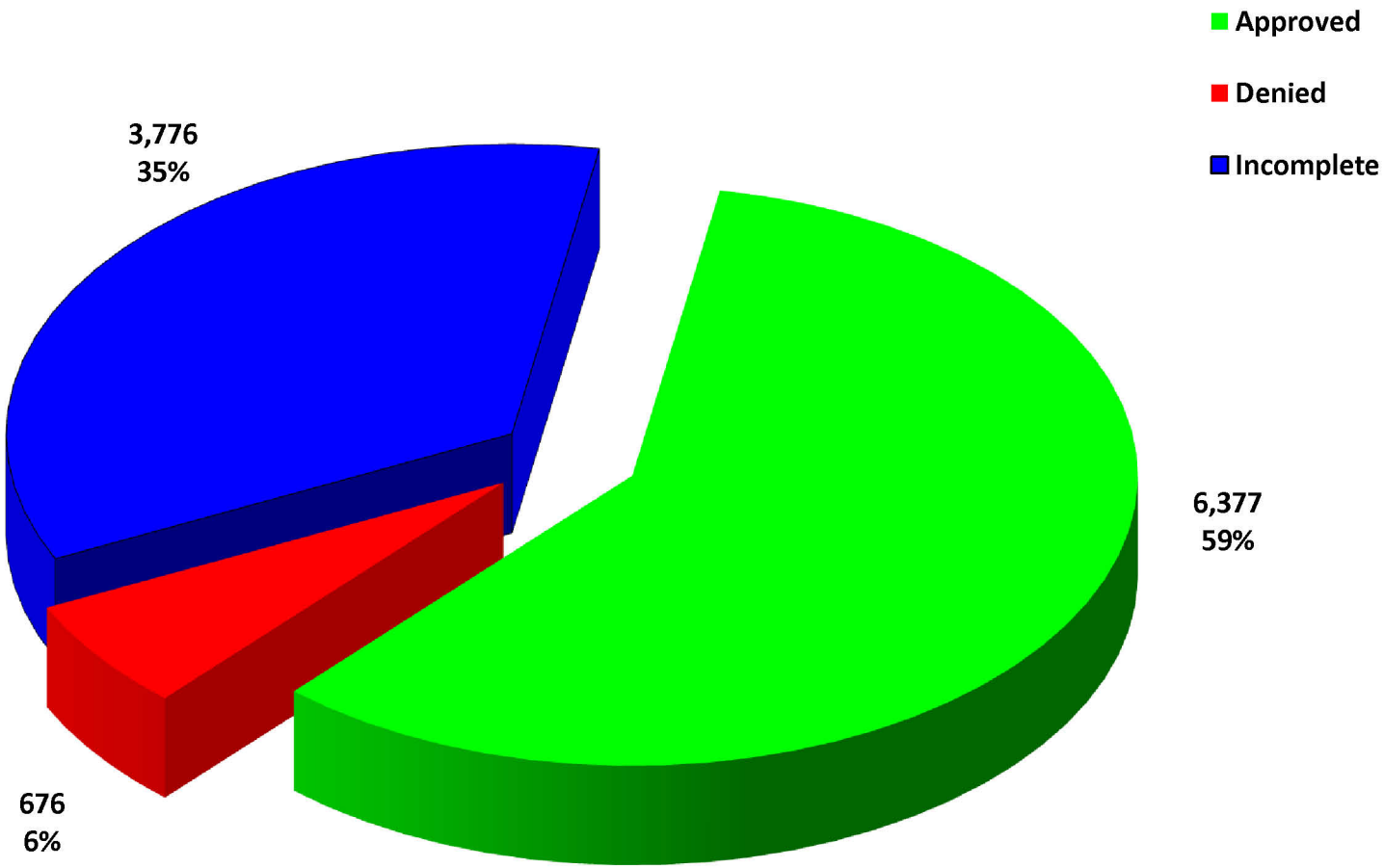
1 (2%)	*Record Error—Not my patient.*
8 (16%)	*No longer my patient.*
4 (8%)	*Medication has been changed prior to date of review letter.*
7 (14%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
23 (46%)	*I am aware of this situation and will plan to continue monitoring therapy.*
7 (14%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 4
Response Forms Returned: 2

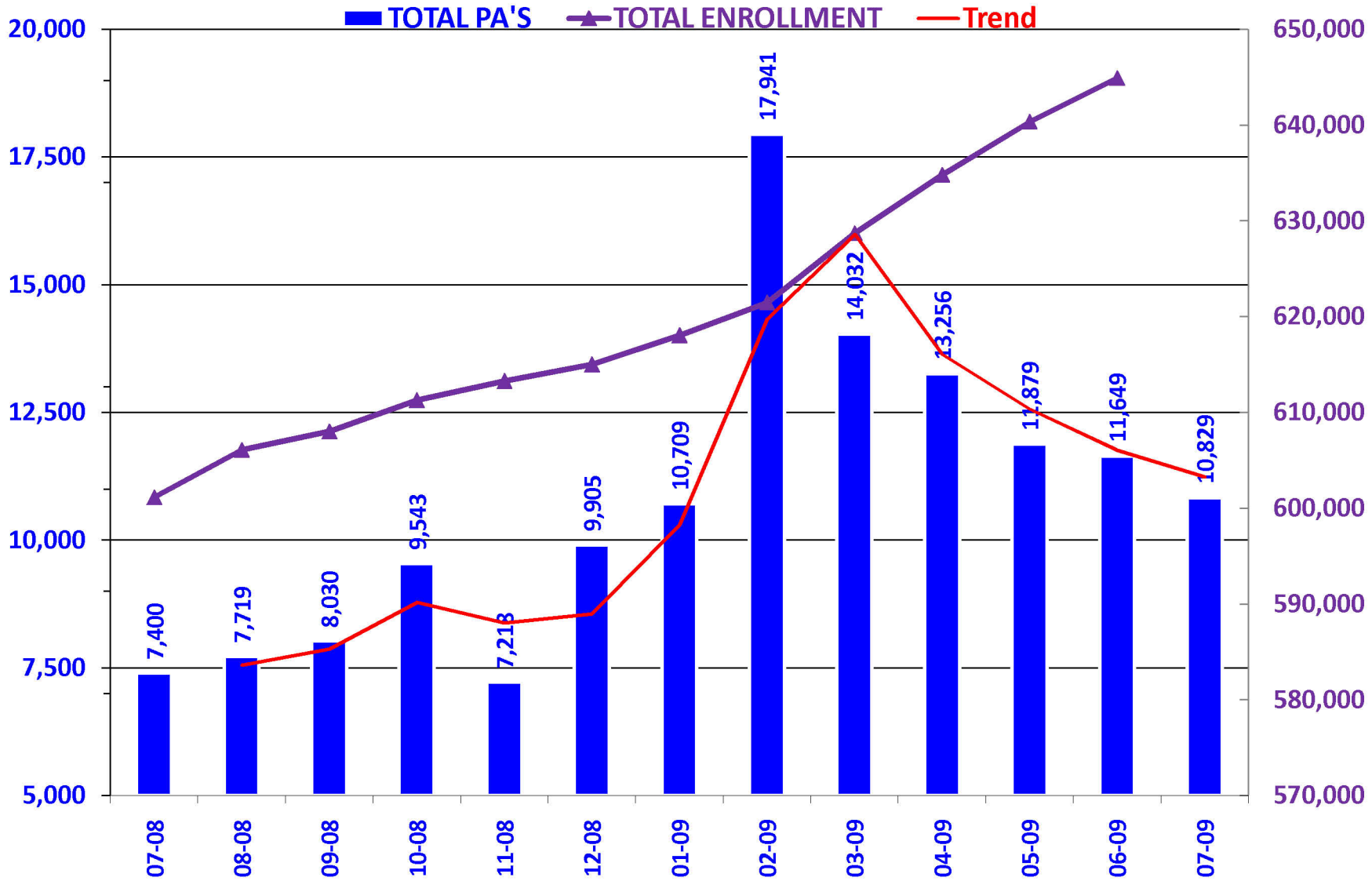
The response forms returned yielded the following results:

0 (0%)	*Record Error—Not my patient.*
0 (0%)	*No longer my patient.*
1 (50%)	*Medication has been changed prior to date of review letter.*
1 (50%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
0 (0%)	*I am aware of this situation and will plan to continue monitoring therapy.*
0 (0%)	*Other*

PRIOR AUTHORIZATION ACTIVITY REPORT: July 2009



PRIOR AUTHORIZATION REPORT: July 2008 – July 2009



PA Activity Audit for

7/1/2009 Through 7/31/2009

	Average Length of	Approved	Denied	Incomplete	Total
Amitiza	113	11	1	27	39
Antidepressant	340	195	61	355	611
Antihistamine	298	148	38	190	376
Antihypertensives	336	73	19	89	181
Benzodiazepines	93	3,954	99	729	4,782
Bladder Control	260	8	0	20	28
Brovana (Arformoterol)	278	2	1	3	6
Byetta	336	7	0	4	11
Elidel/Protopic	86	27	6	53	86
ESA	62	179	12	69	260
Fibric Acid Derivatives	228	2	0	8	10
Fortamet/Glumetza	359	3	0	3	6
Forteo	359	1	1	2	4
Glaucoma	288	6	1	15	22
Growth Hormones	165	23	3	2	28
HFA Rescue Inhalers	186	59	5	66	130
Insomnia	144	44	21	85	150
Misc Analgesics	131	6	27	21	54
Muscle Relaxant	63	52	73	84	209
Nasal Allergy	210	6	53	117	176
NSAIDS	299	40	10	56	106
Ocular Allergy	184	1	3	21	25
Ocular Antibiotics	11	12	1	26	39
Opioid Analgesic	144	113	26	131	270
Other	162	169	39	292	500
Pediculicides	9	9	9	29	47
Plavix	357	110	3	69	182
Proton Pump Inhibitors	121	125	61	315	501
Qualaquin (Quinine)	0	0	1	0	1
Singulair	272	334	31	372	737
Smoking Cessation	62	19	4	64	87
Statins	350	26	15	38	79
Stimulant	226	550	30	268	848
Symlin	365	1	1	1	3
Synagis	80	4	0	1	5
Topical Antibiotics	21	9	10	57	76
Topical Antifungals	36	4	9	29	42
Ultram ER and ODT	178	1	0	16	17
Xolair	0	0	0	1	1
Xopenex Nebs	244	24	0	37	61
Zetia (Ezetimibe)	360	19	2	11	32
Emergency PAs		1	0	0	1
Total		**6,377**	**676**	**3,776**	**10,829**

Overrides					
Brand	146	51	1	11	63
Dosage Change	16	441	11	27	479
High Dose	183	2	0	0	2
IHS - Brand	103	45	0	1	46
Ingredient Duplication	13	3	0	1	4
Lost/Broken Rx	13	67	1	2	70
Nursing Home Issue	11	109	0	4	113
Other	11	17	1	3	21
Quantity vs. Days Supply	213	249	45	138	432
Stolen	2	2	0	0	2
Wrong D.S. on Previous Rx	0	0	0	1	1
Overrides Total		**986**	**59**	**188**	**1,233**
Regular PA + Overrides Total		**7,363**	**735**	**3,964**	**12,062**

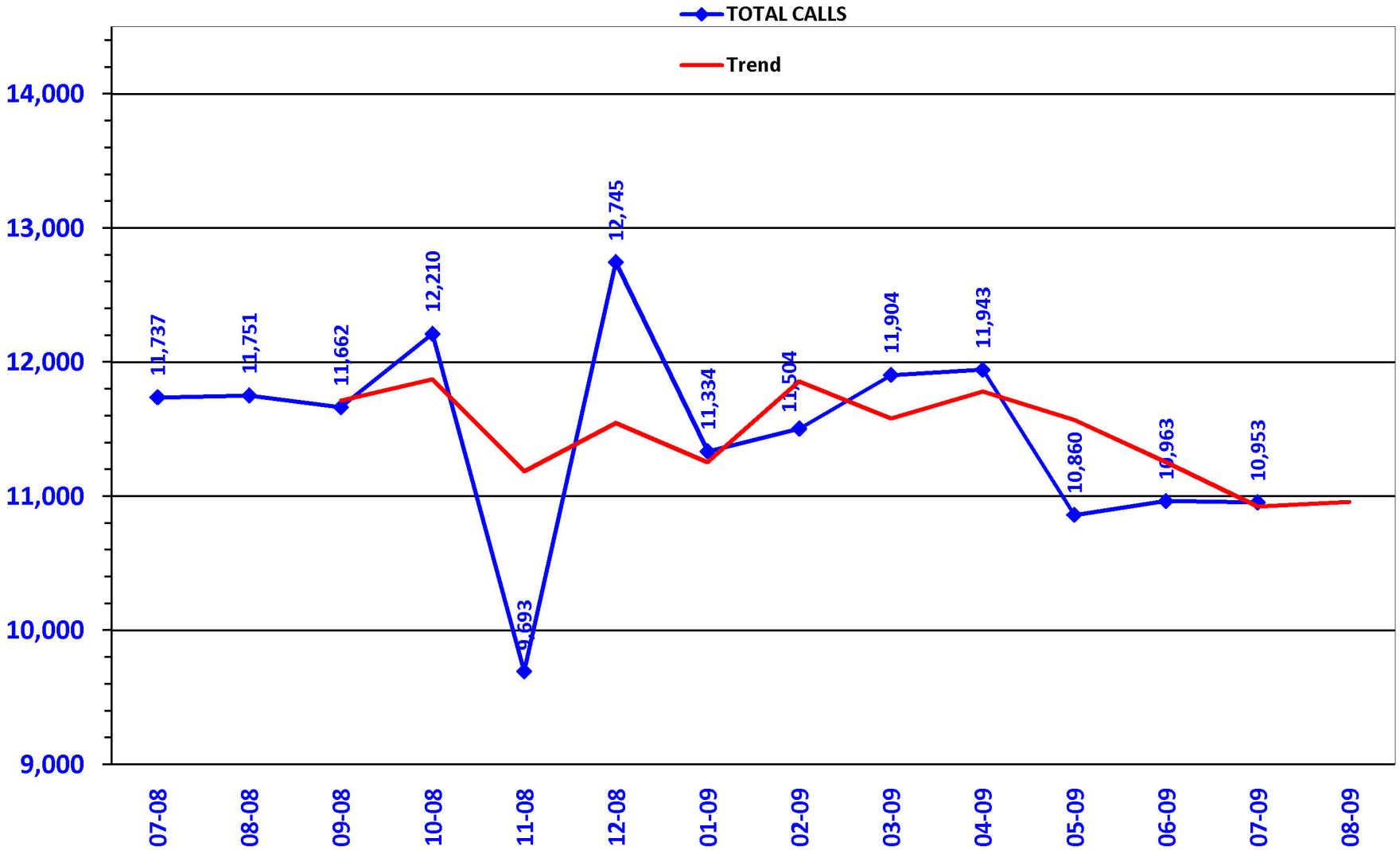
Denial Reasons

Lack required information to process request.	2,293
Unable to verify required trials.	1,570
Does not meet established criteria.	324
Not an FDA approved indication/diagnosis.	151
Member has active PA for requested medication.	120
Requested dose exceeds maximum recommended FDA dose.	108
Considered duplicate therapy. Member has a prior authorization for similar medication.	62
Medication not covered as pharmacy benefit.	25
Drug Not Deemed Medically Necessary	8

Duplicate Requests: 918

Changes to existing PAs: 929

CALL VOLUME MONTHLY REPORT: July 2008 – July 2009



Medication Therapy Management Services

Activity Audit

SFY 2009

	MEMBER PROFILES REVIEWED		PRIOR AUTHORIZATIONS				COMMUNICATIONS
Month	# New Members	# Established Members	Total	Approved	Denied	Incomplete	Letters
July 2008	19	18	335	177	49	109	79
August 2008	20	15	359	173	32	154	59
Sept 2008	27	10	233	148	48	37	246
1st Quarter	**66**	**43**	**927**	**498**	**129**	**300**	**384**
Oct 2008	20	20	321	193	38	90	40
Nov 2008	24	18	258	129	63	66	25
Dec 2008	16	22	257	160	11	86	23
2nd Quarter	**60**	**60**	**836**	**482**	**112**	**242**	**88**
Jan 2009	18	26	220	110	1	109	197
Feb 2009	20	24	294	153	2	139	108
March 2009	21	21	256	125	10	121	122
3rd Quarter	**59**	**71**	**770**	**388**	**13**	**369**	**427**
April 2009	23	24	305	179	5	121	91
May 2009	22	26	217	135	2	80	55
June 2009	24	22	342	194	2	146	98
4th Quarter	**69**	**72**	**864**	**508**	**9**	**347**	**244**
Totals	254	246	3,397	1,876	263	1,258	1,143
1st Quarter	66	43	927	498	129	300	384
2nd Quarter	60	60	836	482	112	242	88
3rd Quarter	59	71	770	388	13	369	427
4th Quarter	69	72	864	508	9	347	244
Totals	**254**	**246**	**3,397**	**1,876**	**263**	**1,258**	**1,143**

Appendix C

Vote to Prior Authorize Gelnique™ (oxybutynin) and Update of Bladder Control Product Based Prior Authorization Criteria

Oklahoma Health Care Authority
August 2009

Recommendations

The College of Pharmacy recommends immediate placement of Gelnique™ into Tier 2 of the Bladder Control PBPA Category. The College of Pharmacy also recommends a 3 tiered system for this category to be effective January of 2010. The College recommends product placement in Tier 1 and Tier 3 as shown below, in which Tier 3 products may rebate down to Tier 2. The following criteria will apply.

Tier 2 Authorization Criteria:

1. Trial of one Tier 1 medication that yielded inadequate clinical response or adverse effects, or
2. A unique indication which the Tier 1 drugs lack.

Tier 3 Authorization Criteria:

1. Trial of all Tier 2 medications that yielded inadequate clinical response or adverse effects, or
2. A unique indication which the Tier 2 drugs lack.

The College also recommends grandfathering of medications in this category.

Bladder Control Medications		
Tier 1	*Tier 2*	*Tier 3*
Flavoxate **(Urispas®)** Oxybutynin **(Ditropan®)** Tolterodine **(Detrol®)**	**Supplemental Rebated Tier 3**	Trospium **(Sanctura™, Sanctura XR™)** Oxybutynin ER Tabs **(Ditropan XL®)** Oxybutynin Patch **(Oxytrol®)** Oxybutynin Gel **(Gelnique™)** Tolterodine ER Tabs **(Detrol LA®)** Darifenacin **(Enablex®)** Solifenacin **(VESIcare®)** Fesoterodine **(Toviaz™)**

*Hyoscyamine can be used as adjuvant therapy only. By itself, it will not count as a Tier 1 trial.

Appendix D

VOTE TO APPLY QUANTITY RESTRICTIONS TO HYDROCODONE COMBINATION PRODUCTS

OKLAHOMA HEALTHCARE AUTHORITY

AUGUST 2009

RECOMMENDATIONS

1. Retain Ingredient Duplication Module.
2. Establish a new quantity limit for a maximum of 6 tablets per day or 3,250 mg of APAP per day, whichever is less.
3. Establish an annual claim limit of 12 per 365 days.

Approval Criteria for Greater than 12 Claims:

1. Members may be approved for greater than 12 claims per year if the member has a pain contract with a single prescriber. A copy of the pain contract should be submitted with the prior authorization request. Requests outside of the plan outlined in the contract will not be approved.
2. Members with a current oncology related diagnosis may be approved for greater than 12 claims per year if the medication is being used as a break-through therapy and adjustments to dosing are required.
3. Medication will not be approved as the only therapy for chronic pain use. Members with chronic pain who require around-the-clock pain control should be on a long-acting pain medication. An additional claim may be approved to allow time for changes in therapy to be made.

Appendix E

60 Day Notice to Prior Authorize Otic Anti-Infective Products

Oklahoma HealthCare Authority, August 2009

This category was introduced for possible inclusion in the Product Based Prior Authorization program in July 2009. See the July DUR packet for a more complete discussion of the category. This notice and statement of potential economic impact are presented to meet the statutory requirements of 63 O.S. Sec. 5030.5.

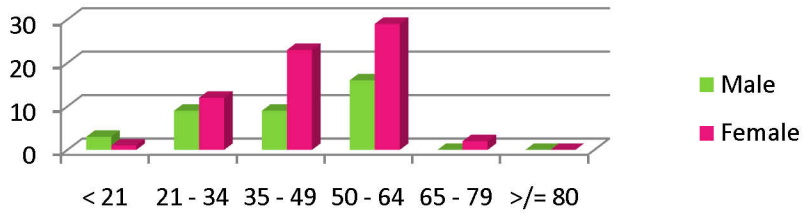
Summary of Paid Claims – Jan 2009 through Jun 2009

RANK COST	GENERIC NAME	CLAIMS	UNITS	DAYS	MEMBERS	UNITS/ DAY	CLAIMS/ MEMBER
1	Ciprofloxacin-Dexamethasone	7,788	58,867	77,144	6,521	0.76	1.19
2	Ofloxacin	4,626	34,183	44,885	4,132	0.76	1.12
4	Neomycin-Polymyxin-HC	4,293	43,195	45,030	4,106	0.96	1.05
3	Ciprofloxacin-Hydrocortisone	739	8,411	8,764	707	0.96	1.05
5	Antipyrine-Benzocaine-Zinc Acetate	296	5,854	3,077	286	1.9	1.03
6	Hydrocortisone w/ Acetic Acid	88	915	1,027	80	0.89	1.1
7	Chloroxylenol-Pramoxine-Zinc Acetate	84	1,290	767	81	1.68	1.04
9	Acetic Acid	84	1,400	1,018	81	1.38	1.04
8	Neomycin-Colistin-HC-Thonzonium	60	610	522	60	1.17	1
11	Acetic Acid 2% in Aluminum Acetate	28	1,635	406	23	4.03	1.22
12	Pramoxine-Chloroxylenol	14	140	167	13	0.84	1.08
10	Neomycin-Colistin-HC	9	50	92	6	0.54	1.5
		18,109	**156,550**	**182,899**	**14,882***	**0.86**	**1.22**

*Unduplicated Members

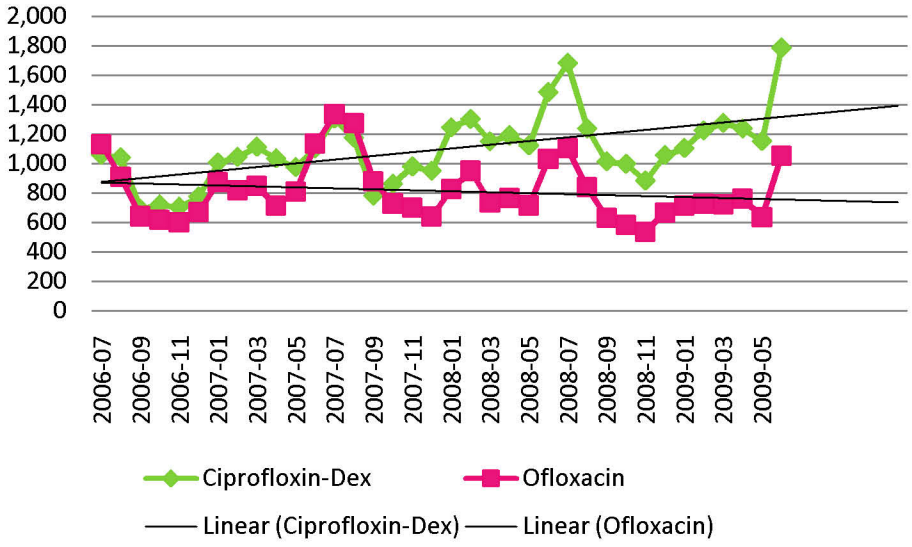
Select Member Demographics

Of the 14,409 members utilizing these medications during this time period, 104 members were in a select population. A total of 44 were categorized as Advantage Waiver and 60 were in nursing homes.

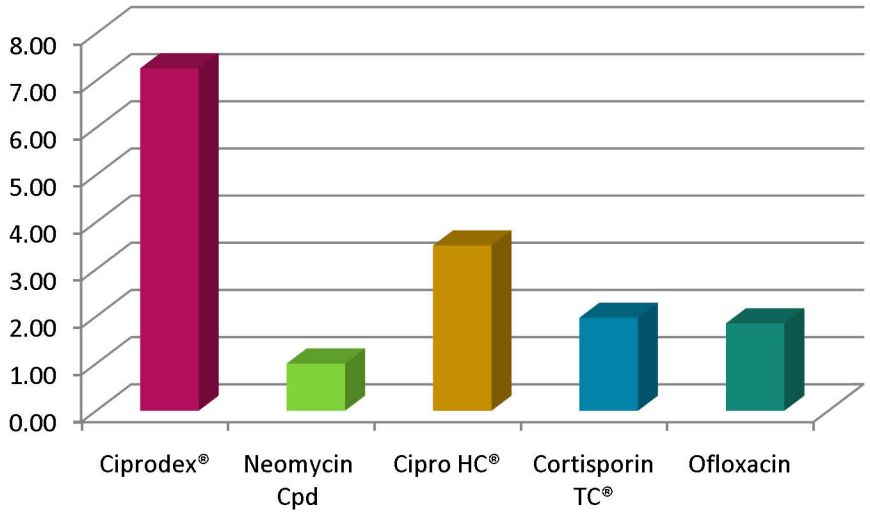


Market Analysis

The two major products in this group are the ciprofloxacin/dexamethasone combination product and the ofloxacin. The ofloxacin generic products came on the market in March 2008. There has been an increasing trend downward in the utilization of ofloxacin since the generic product has become available. It does not appear that the patent for ciprofloxacin/dexamethasone will expire until 2020.



The following graphs show the ratios of the net unit costs (reimbursement – federal rebate). The lowest net unit cost is a 1:1 ratio and is reflected as a 1.00 on the graph. The other bars indicate the ratio of each product's net unit cost to the product with the lowest net unit cost. The ratios do not reflect actual dollar amounts but provide a visual comparison of the net unit cost of each product to the lowest net unit cost.



Recommendations:

The College of Pharmacy recommends establishing a PBPA category for Otic Anti-Infectives to ensure appropriate use in accordance with current treatment guidelines. The following Tier 1 drug list has been reviewed and determined to be acceptable for use as initial therapy for the majority of members. The College of Pharmacy recommends this list to the Drug Utilization Review Board based on cost and clinical effectiveness for approval before referral to the Oklahoma Healthcare Authority. No supplemental rebate will be offered for this category.

Prior Authorization Criteria:

1. Member must have adequate 14-day trial of at least two Tier 1 medications, or
2. Approval may be granted if there is a unique FDA approved indication not covered by Tier 1 products or infection by organism not known to be covered by all Tier 1 agents.
3. A ciprofloxacin combination product may be approved when a steroid containing product is required for severe otitis externa and the tympanic membrane is not intact.

A Tier 1 fact sheet will be included with the prior authorization response to assist physicians in choosing an appropriate Tier 1 product.

Otic Antibiotics

Tier-1*	Tier-2	Special PA†
Ofloxacin (Floxin Otic)	Ofloxacin (Floxin Otic) Droperette	Acetic Acid, Antipyrine, Benzocaine, Glycerin (Auralgan)
Acetic acid (Generics Only)	Ciprofloxacin, Dex or HC (Ciprodex or Cipro HC)	Acetic Acid, HC (Acetasol HC, Vosol HC)
Neomycin Combination Products (Generics Only)	Neomycin Combination Products (Branded)	
Chloroxylenol/Pramoxine	Chloroxylenol Combination Products (Branded)	

*Mandatory generic plan
†Special Prior Authorization criteria previously approved by DUR Board.

Potential Secondary Costs

Overall efficacy is considered to be equal across this class, but drug selection requires individual patient history which includes, but is not limited to: other illnesses, disease risk factors, and current symptoms.

Potential Administrative Costs

Based on a potential shift of proposed Tier 2 products to a Tier 1 product of 50%, it is estimated that approximately 5,000 petitions would be required. The proposed tier changes would affect approximately 50% of the total population for this PBPA category.

Previously, it has been theorized that total cost per petition to the *healthcare system* (includes cost to physicians, pharmacists, and program) is between $7.63 and $14.82. Total cost for prior authorization to the *healthcare system* is estimated to be between $38,150 and $74,100 annually. Anticipated actual administrative cost to the program is projected to be less than $30,000.

Potential Program Savings

Potential net ingredient savings to the program based on recommended tiers and a potential shift of 50% of market share from Tier 2 to Tier 1 is estimated to be 32 % of the 2009 total reimbursement to pharmacies for this category of drugs.

Appendix F

60 Day Notice to Prior Authorize Fibromyalgia Medications

Oklahoma HealthCare Authority, August 2009

This category was introduced for possible inclusion in the Product Based Prior Authorization program in July 2009. See the July DUR packet for a more complete discussion of the category. This notice and statement of potential economic impact are presented to meet the statutory requirements of 63 O.S. Sec. 5030.5.

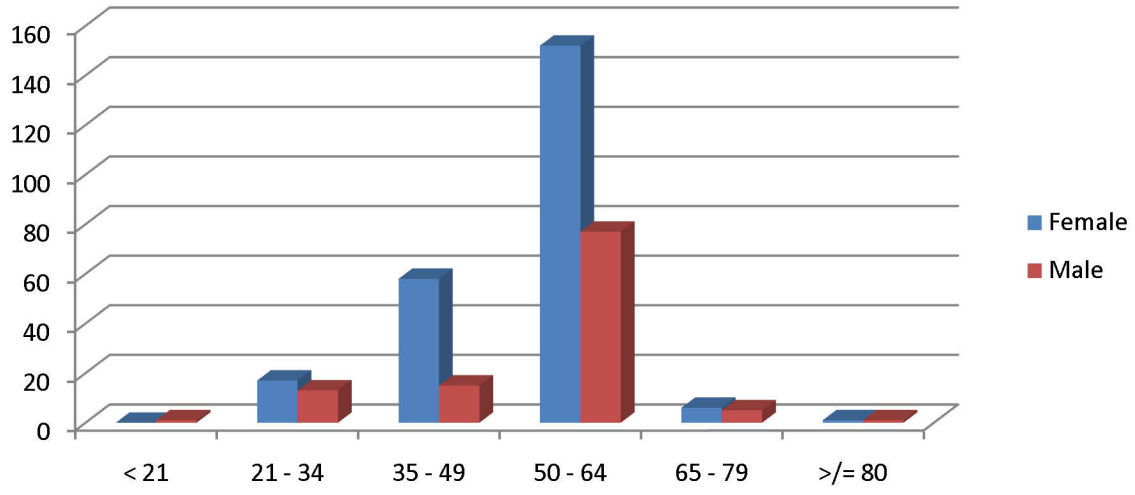
Summary of Paid Claims – Jan 2009 through Jun 2009

RANK COST	GENERIC NAME	CLAIMS	UNITS	DAYS	MEMBERS	UNITS/ DAY	CLAIMS/ MEMBER
1	Pregabalin (Lyrica®)	7,738	555,645	233,418	2,612	2.38	2.96
2	Duloxetine (Cymbalta®)	5,779	221,172	197,402	1,609	1.12	3.59
3	Milnacipran (Savella™)	21	1275	635	19	2.01	1.10
		5,153	47,488	68,108	4,003*	0.70	2.21

*Unduplicated Members

Select Population Demographics

Of the 4,003 members utilizing these medications during this time period, 346 members were in a select population. A total of 146 were categorized as Advantage Waiver and 200 were in nursing homes or other care facilities.



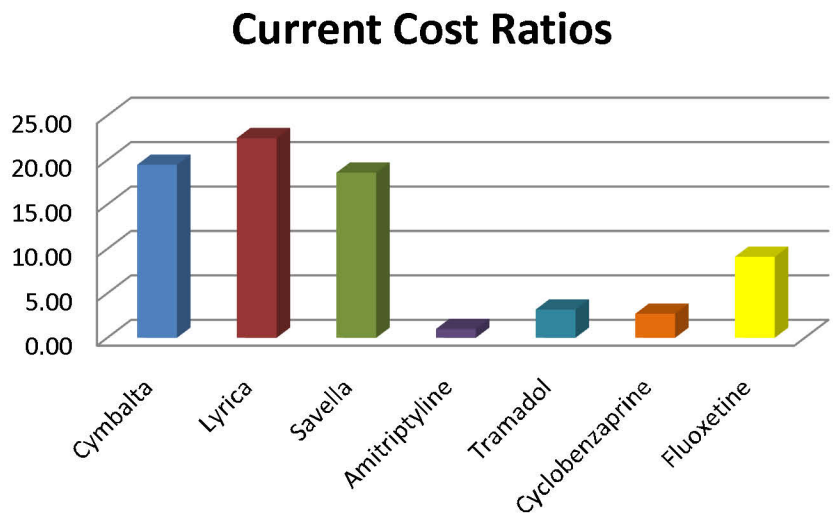
Market Analysis

Currently there are three agents with the FDA approved indication for treatment of Fibromyalgia:

- Lyrica® (Pregabalin)- Approved June 2007
- Cymbalta® (Duloxetine HCl)- Approved June 2008
- Savella™ (Milnacipran)- Approved January, 2009

According to an article published in the Pharmaceutical Business Review in September 2007, the fibromyalgia market is expected to grow to $2 billion by 2016 due to an increase in new therapies. At the time of the article there were more than 20 drugs in development for Fibromyalgia. The article further speculated that following additional FDA approvals, there would be an increase in diagnosis and treatment rates.[1] A search of the website ClinicalTrials.gov using the keyword "Fibromyalgia" produced 218 studies. Studies listed included both pharmacological and non-pharmacological treatments. Some of the listed studies were for existing drugs currently being marketed under an unrelated diagnosis. The market for Fibromyalgia appears to be poised for continued growth.

The following graphs show the ratios of the net unit costs (reimbursement – federal rebate) for the currently available products. The lowest net unit cost is a 1:1 ratio and is reflected as a 1.00 on the graph. The other bars indicate the ratio of each product's net unit cost to the product with the lowest net unit cost. The ratios do not reflect actual dollar amounts but provide a visual comparison of the net unit cost of each product to the lowest net unit cost.



Recommendations:

The College of Pharmacy recommends placing Fibromyalgia products into the Product Based Prior Authorization Program. The following Tier 1 drug list has been reviewed and determined to be acceptable for use as initial therapy for the majority of members. The College of Pharmacy recommends this list to the Drug Utilization Review Board based on cost and clinical effectiveness for approval before referral to the Oklahoma Healthcare Authority.

Tier 1	Tier 2	Tier 3*
Amitriptyline Cyclobenzaprine Fluoxetine Tramadol	Supplemental Rebated Tier 3	Lyrica® (Pregabalin) Cymbalta® (Duloxetine HCl) Savella™ (Milnacipran)

*May be rebated to Tier 2 status only.

Approval Criteria:

1. Recent trials (within the last six months) of two Tier 1 medications and all available Tier 2 medications at least 3 weeks in duration that did not provide adequate response, or resulted in intolerable adverse effects, or
2. Contraindication(s) to all available lower tiered medications,
3. Current stabilization on a Tier 2 or 3 medication (samples will not be accepted if member has not had appropriate lower tiered trials).
4. Clinical Exceptions include:
    a. Diagnosis of seizures, diabetic neuropathy, or neuropathy for Lyrica®(Pregabalin)
    b. Diagnosis of diabetic neuropathy for Cymbalta® (Duloxetine HCl)

A Fibromyalgia information sheet will also be included with the prior authorization response to the pharmacies and physicians.

Potential Secondary Costs

Overall efficacy is considered to be equal across this class, but drug selection requires individual patient history which includes, but is not limited to: other illnesses, disease risk factors, and current symptoms.

Potential Administrative Costs

Due to the inability to accurately identify members with a diagnosis of Fibromyalgia, the percentage of current users of proposed Tier 2 products with Fibromyalgia is projected to be 15%. Based on a potential shift of 50% from a proposed Tier 2 product to a Tier 1 product, it is estimated that approximately 300 petitions would be required based on the current utilization. This number may increase as the market for these products also increases. The proposed tier changes would affect approximately 50% of the total population for this PBPA category.

Previously, it has been theorized that total cost per petition to the *healthcare system* (includes cost to physicians, pharmacists, and program) is between $7.63 and $14.82. Total cost for prior

authorization to the *healthcare system* is estimated to be between $2,289 and $4,446 annually. Anticipated actual administrative cost to the program is projected to be less than $3,000.

Potential Program Savings

Potential net ingredient savings to the program based on recommended tiers and a potential shift of 50% of market share from Tier 2 to Tier 1 is estimated to be 28 % of the 2009 total reimbursement to pharmacies for this category of drugs.

Reference

1. "New treatments will drive Fibromyalgia market forward - Pharmaceutical Business Review." 14 September 2007. Pharmaceutical Business Review. 14 July 2009 <http://www.pharmaceutical-business-review.com/comment/new_treatments_will_drive_fibromyalgia_market_forward>.

Appendix G

Hydrocodone

Hydrocodone in an analgesic and antitussive agent structurally similar to codeine. When the CSA was enacted in 1971, hydrocodone substance was placed in schedule II. Products containing hydrocodone in specified amounts and in combination with other active ingredients were placed in schedules III and V. At that time, hydrocodone was primarily utilized as a cough suppressant with limited prescriptions. Today, hydrocodone products are increasingly utilized for pain management and are the most frequently dispensed opioid pharmaceuticals in the United States.

The **National Forensic Laboratory Information System (NFLIS)** is a DEA database that collects scientifically verified data on analyzed drug seizures from state and local forensic laboratories. It also includes data from the **System to Retrieve Information from Drug Evidence (STRIDE)**, which provides information on analyzed seizures from DEA laboratories. Hydrocodone continues to be the most frequently encountered narcotic analgesic in forensic laboratories. The following table shows hydrocodone data from 2000 through 2006.

NFLIS/STRIDE
ANALYZED HYDROCODONE SEIZURES

Source	2000	2001	2002	2003	2004	2005	2006	Total
NFLIS	4,084	6,517	10,176	13,145	17,688	22,415	25,136	99,161
STRIDE	259	314	335	511	449	598	654	3,120
Total	4,343	6,831	10,511	13,656	18,137	23,013	25,790	102,281

IMS National Prescription Audit *Plus*™, a provider database managed by IMS Health, estimates total U.S. dispensed prescriptions through all channels of distribution from 2000 to 2006 (extracted 09/10/2007). Data for 2006 indicates that hydrocodone prescriptions have steadily increased. From 2000 thru 2006 there was nearly a 48 percent increase in the number of prescriptions dispensed for hydrocodone products in the United States (from about 88 million to 130 million).

IMS Total Prescriptions

DRUG	YR2000	YR2001	YR2002	YR2003	YR2004	YR2005	YR2006
HYDROCODONE	88,000,000	96,000,000	102,000,000	110,000,000	114,000,000	124,000,000	130,000,000

DEA establishes **Aggregate Production Quota (APQ)** for the maximum amount of schedule I and II substances which may be manufactured in the United States for legitimate national scientific, medical and export needs, and for the maintenance of stocks. The APQ for hydrocodone has increased over 100 percent since 2000 (from 21,417 kg in 2000 to 46,000 kg in 2007).

Aggregate Production Quota (Kgs)

DRUG	YR2000	YR2001	YR2002	YR2003	YR2004	YR2005	YR2006	YR2007	Total
Hydrocodone (sale)	21,417	23,825	25,702	30,622	34,000	37,604	42,000	46,000	261,170

According to the 2005 **International Narcotics Control Board (INCB) Report**, the United States manufactures nearly 100% of the total hydrocodone manufactured worldwide. It also constitutes 99% of the world consumption of hydrocodone.

The **National Survey on Drug Use and Health** (formerly the National Household Survey on Drug Abuse) is a Substance Abuse and Mental Health Services Administration (SAMSHA) database that measures drug use by people living in households. Data is listed for 2000 through 2006. Information is collected for Vicodin, Lortab, Lorcet, and other hydrocodone products for lifetime use (i.e., it was used at least once in their life).

National Survey on Drug Use and Health
Hydrocodone Products

YEAR	2000	2001	2002	2003	2004	2005	2006	Total
USERS	6,708,000	9,453,000	13,952,000	16,808,000	17,734,000	18,875,000	20,755,000	104,285,000

Monitoring the Future (MTF), a National Institute on Drug Abuse (NIDA) funded study conducted by the University of Michigan, measures prevalence of drug use among eighth, tenth, and twelfth graders. In 2002, a question was added regarding the annual prevalence of the nonmedical use of Vicodin. The table below provides this data.

Annual Prevalence of Nonmedical Use of Vicodin
Monitoring the Future (2002-2006)
(Data Expressed in Percent of Students)

	2002	2003	2004	2005	2006
8th Grade	2.5	2.8	2.5	2.6	3.0
10th Grade	6.9	7.2	6.2	5.9	7.0
12th Grade	9.6	10.5	9.3	9.5	9.7

The **American Association of Poison Control Centers (AAPCC)** data suggest that hydrocodone products are involved in a number of toxic exposures that have resulted in 334 deaths from 2002 through 2005. In 2005, hydrocodone was associated with more exposures that resulted in death than any other narcotic analgesic. In addition, of the 22,165 exposures reported to the American Association of Poison Control Centers (AAPCC) in 2005, 5,200 were for individuals less than 20 years of age. Data for hydrocodone exposures reported to AAPCC from 2002 thru 2005 are provided in the tables below.

Poison Control Center Data for Hydrocodone

	2002	2003	2004	2005	Total
Hydrocodone Exposures	17,386	19,538	22,594	22,165	81,683

Serious Outcomes Associated With Hydrocodone Exposures

	2002	2003	2004	2005	Total
Deaths	66	82	86	100	334
Major Effect*	531	606	751	808	2,696
Moderate Effect**	2,033	2,301	2,868	2,832	10,034
Total	2,630	2,989	3,705	3,740	13,064

*Major effect: the patient exhibited signs or symptoms as a result of the exposure that were life-threatening or resulted in significant residual disability or disfigurement.
**Moderate effect: the patient developed signs or symptoms as a result of the exposure that were more pronounced, more prolonged or more systemic in nature than minor effects.

The **Drug Abuse Warning Network (DAWN)** is another SAMSHA database which collects data on drug-related emergency department (ED) visits from a nationally representative sample of hospitals from selected metropolitan areas within the United States. In 2002, the last year national data is available, hydrocodone with acetaminophen was the tenth most reported drug among the top 150 controlled substances.

DAWN ED

National Estimates Of Abuse Incidents

DRUG	1998	1999	2000	2001	2002	Total
HYDROCODONE	13,611	15,252	20,098	21,567	25,187	95,715

The DAWN database also collects data on drug-related deaths reported Medical Examiner (ME) Offices in 32 metropolitan areas. In 2002, the last year national data is available; hydrocodone was the eighth most reported drug among the top 20 controlled substances.

DAWN ME

NATIONAL REPORTS OF DRUG-RELATED DEATHS

DRUG	YR1998	YR1999	YR2000	YR2001	YR2002	TOTAL
HYDROCODONE	294	447	548	592	618	2,499

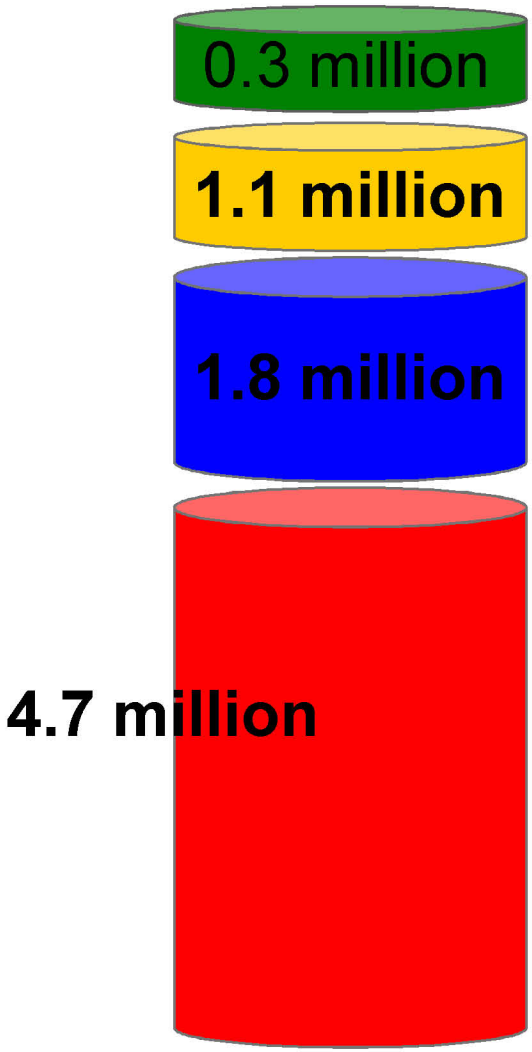
Trend in Prescription Drug Abuse

- In 2004, 19.1 million Americans were current illicit drug users (7.9% of the U.S. population)[1]
- Nonmedical use of prescription pain relievers was the illicit drug category with the largest number of new abusers (2.4 million)[1]
- Nonmedical use of prescription drugs ranks second only to marijuana as the most prevalent category of drug abuse[1]
- 25% of emergency department visits associated with non-medical use of pharmaceuticals[2]

1 SOURCE: 2004 National Survey on Drug Use and Health (NSDUH) published Sept 2005 by the Dept of HHS / Substance Abuse and Mental Health Services Administration (SAMHSA)

2 SOURCE: 2004 DAWN (Drug Abuse Warning Network) Report published May 2006

In 2005, 6.4 million Americans Age 12+ used a prescription drug for non-medical purposes in past month



Sedatives

Stimulants

Anti-Anxiety Medication

Narcotic Pain Relievers

SOURCE: 2005 National Survey on Drug Use and Health (NSDUH), published Sept 2005 by Dept of HHS / Substance Abuse and Mental Health Services Administration (SAMHSA)

2005 Partnership and Attitude Study (PATS)*

- Alarming number of teens have a false sense of security about the safety of abusing prescription medications
- 19% of teens report abusing prescription medications to get high
- 40% believe that prescription medicines are “much safer” to use than illegal drugs
- 31% believe there’s “nothing wrong” with using prescription medicines without a prescription “once in a while”
- 29% believe prescription pain relievers are not addictive

*18th annual study of teen drug use and attitudes
Released in April 2006 by The Partnership for a Drug-Free America

Methods of Diversion

- Rogue Internet “Pharmacies”
- Inappropriate prescribing
- Illegal sales
- Employee theft
- Prescription rings
- Doctor shopping
- Fraudulent prescriptions
- Pharmacy theft
- Foreign diversion and smuggling into the U.S.
- “Pharming”

Hydrocodone

- **Vicodin®, Lortab®, Lorcet®**
- **DEA Diversion Drug Trend Report identifies hydrocodone as the most commonly diverted and abused controlled pharmaceutical in the U.S.**
- **2004 – United States used 99% of the global hydrocodone supply***
- **Approximately 125 million hydrocodone prescriptions were dispensed in U.S. in 2005****

* 2005 INCB report
**IMS data

Hydrocodone Situation

- Hydrocodone products are the most frequently prescribed drug in the U.S.

- Comparable 2005 data shows that hydrocodone was prescribed three times more frequently than any other controlled substance*

- Hydrocodone is the most frequently encountered pharmaceutical in submissions of evidence to federal, state and local labs**

- DAWN 2005 data– from 2004-2005 emergency department visits involving nonmedical use of opiate/opioid pain medications increased 24% overall

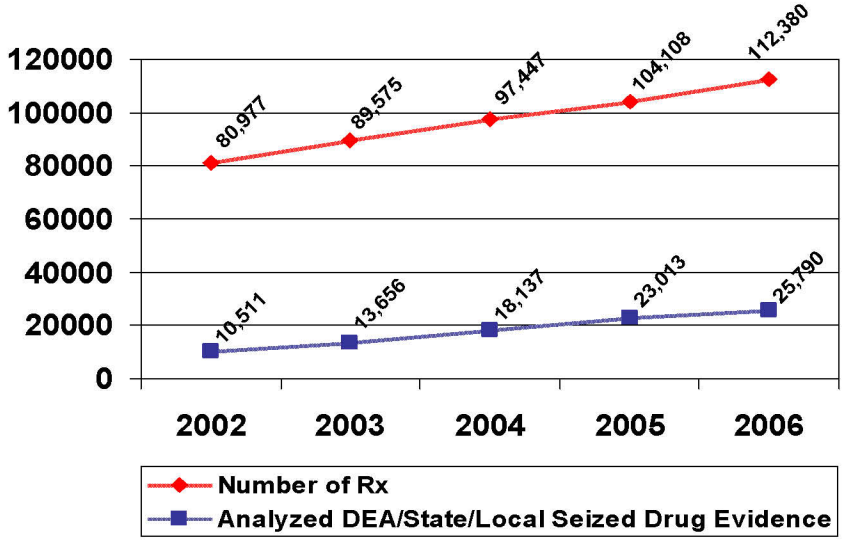
- The Aggregate Production Quota for hydrocodone has increased 100% since 2000 (21,417 kg to 42,000 kg)

* RxList data

* * STRIDE / NFLIS data

Prescription Drug Trends

Number of Hydrocodone Prescriptions*

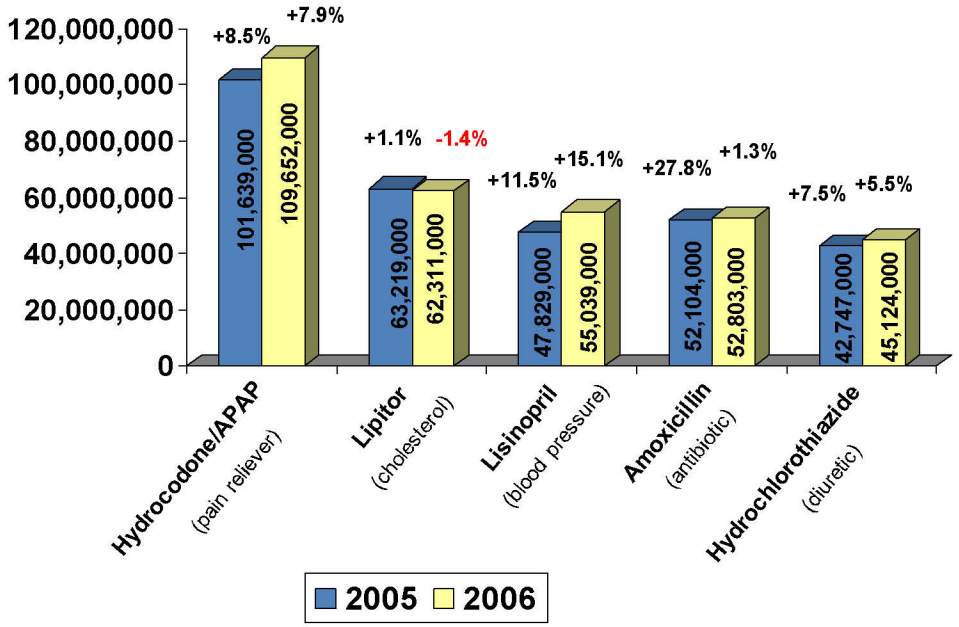


- Hydrocodone in combination with acetaminophen is the #1 prescribed drug in the U.S.
- The U.S. has only 4 percent of the world's population, but consumed 99% of the world's supply of hydrocodone in 2004.
- One in 10 high school seniors have admitted to abusing hydrocodone in 2006 (MTF).

SOURCE: IMS prescription data.

Top Five Prescription Drugs Sold in the U.S.*

(By Number of Prescriptions Sold)



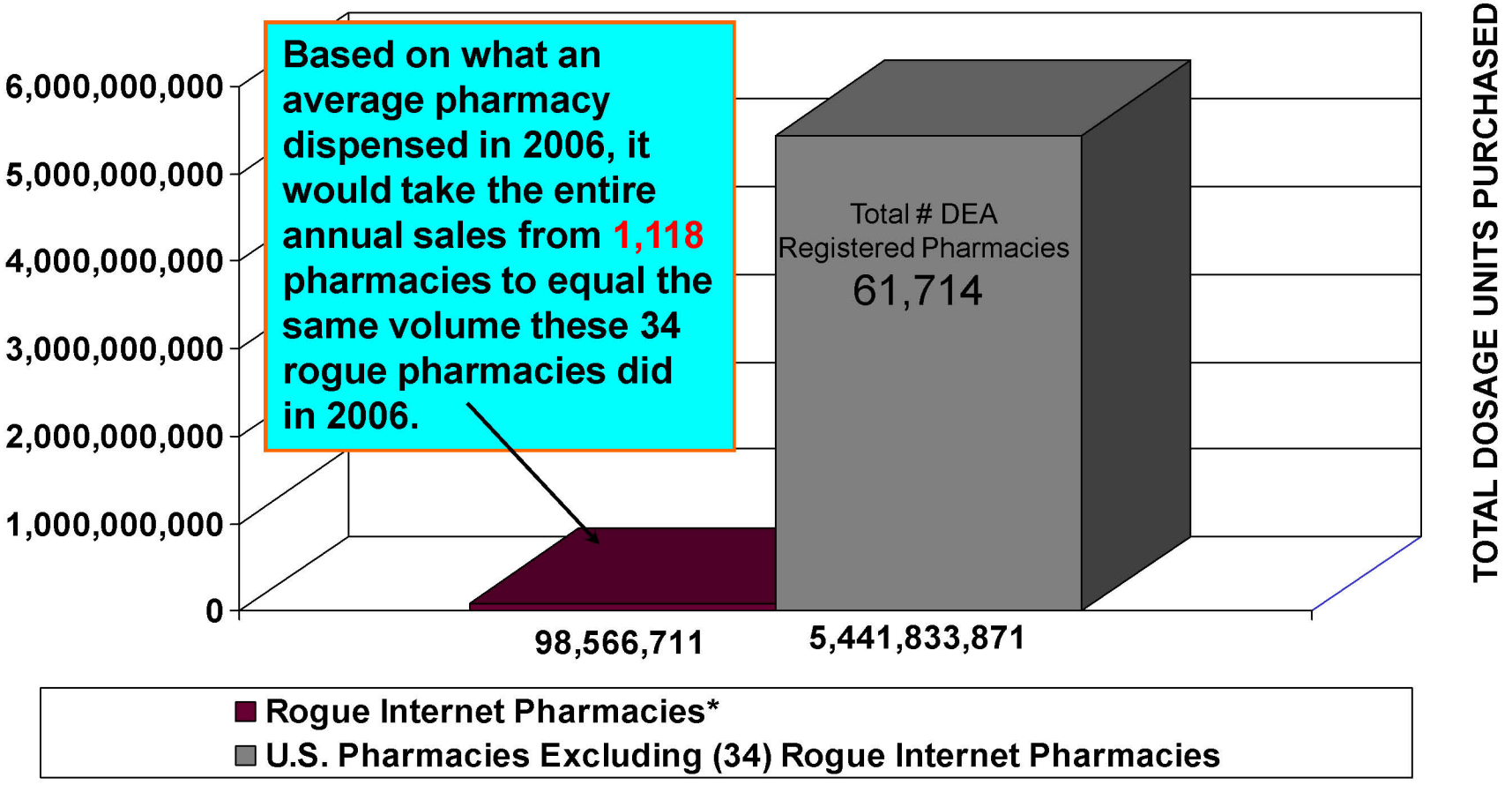
Note: Percentage change from the number of prescriptions sold in the previous years.

Source: Drug Topics, Rx List

Revised May 24, 2007

* Prescription data is from two separate prescription monitoring sources.

Comparison of CY2006 Purchases of Hydrocodone by Pharmacies



* Based on 34 Known and Suspected Internet Pharmacies

Date Prepared: 03/07/2007
Source: ARCOS

FDA NEWS RELEASE

For Immediate Release: July 31, 2009

Media Inquiries: Karen Riley, 301-796-4674, karen.riley@fda.hhs.gov
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FDA Approves New Drug Treatment for Type 2 Diabetes

The U.S. Food and Drug Administration today approved Onglyza (saxagliptin), a once-daily tablet to treat Type 2 diabetes in adults. The medication is intended to be used with diet and exercise to control high blood sugar levels.

The hormone insulin keeps blood sugar (glucose) levels within a narrow range in people who don't have diabetes. People with Type 2 diabetes are either resistant to insulin or do not produce enough insulin to maintain normal blood sugar levels.

Onglyza is in a class of drugs known as dipeptidyl peptidase-4 (DPP-4) inhibitors which stimulate the pancreas to make more insulin after eating a meal.

"Keeping blood sugar levels in adequate control is essential to the good health of the 24 million people in the United States with Type 2 diabetes," said Mary Parks, M.D., director of the Division of Metabolism and Endocrinology Products in the FDA's Center for Drug Evaluation and Research. "High blood sugar levels can cause blurry vision and excessive urination and eventually result in such serious conditions as kidney and eye disease."

The most common side effects observed with Onglyza are upper respiratory tract infection, urinary tract infection, and headache. Other side effects include allergic-like reactions such as rash and hives.

Approval of Onglyza was primarily based on the results of eight clinical trials. The application seeking FDA approval was submitted before December 2008 when the agency recommended that manufacturers of new diabetes drugs carefully design and evaluate their clinical trials for cardiovascular safety. Although Onglyza was not associated with an increased risk for cardiovascular events in patients who were mainly at low risk for these events, the FDA is requiring a postmarket study that will specifically evaluate cardiovascular safety in a higher risk population.

Onglyza is manufactured by Bristol-Myers Squibb Co. of Princeton, N.J., and marketed by Bristol-Myers and AstraZeneca Pharmaceuticals LP, of Wilmington, Del.