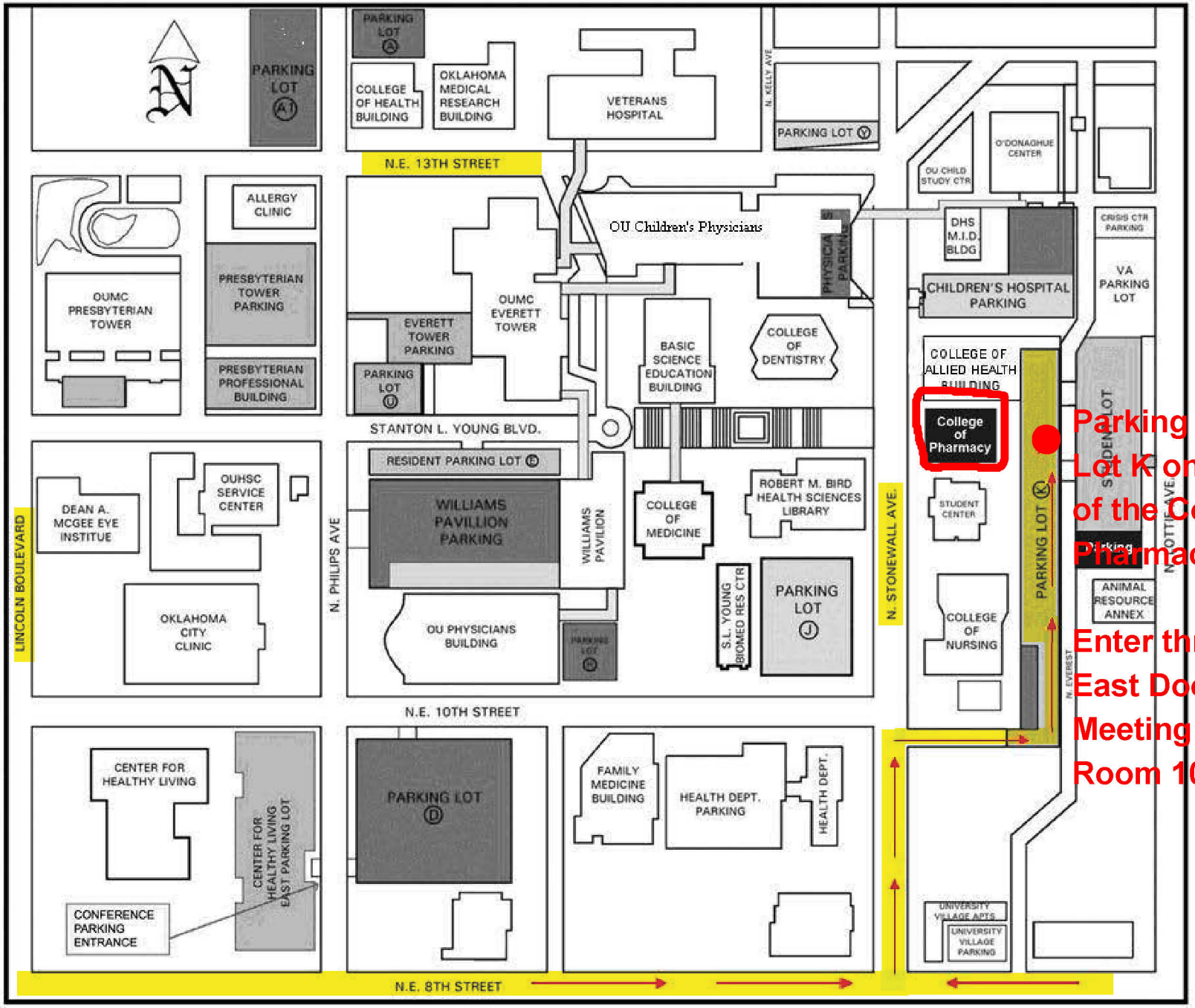
Drug Utilization Review Board

University of Oklahoma
College of Pharmacy
1110 N. Stonewall Avenue
Oklahoma City, Oklahoma 73117
Room 103

Wednesday
July 14, 2010
6:00 p.m.



Parking is available in Lot K on the East Side of the College of Pharmacy Building.

Enter through East Doors.

Meeting is on 1st Floor, Room 103.

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 – July 14, 2010**

DATE: July , 2010

NOTE: **THE DUR BOARD WILL MEET AT 6:00 P.M. THE MEETING WILL BE HELD AT THE UNIVERSITY OF OKLAHOMA COLLEGE OF PHARMACY BUILDING, ROOM 103.**

Enclosed are the following items related to the July 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 ProCentra™ - See Appendix C.

30 Day Notice to Prior Authorize Ampyra™ – See Appendix D.

30 Day Notice to Prior Authorize Qutenza® – See Appendix E.

30 Day Notice to Prior Authorize Special Formulation Antibiotics – See Appendix F.

Action Item – Annual Review of Byetta® and 30 Day Notice to Prior Authorize Victoza® and Bydureon® – See Appendix G.

30 Day Notice to Prior Authorize Anticonvulsant Drugs – See Appendix H.

FDA and DEA Updates – See Appendix I.

Future Business

Adjournment

Oklahoma Health Care Authority
Drug Utilization Review Board
(DUR Board)
Meeting – July 14, 2010 @ 6:00 p.m.

University of Oklahoma College of Pharmacy
1110 N. Stonewall Avenue
Oklahoma City, Oklahoma 73117
Room 103

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. June 9, 2010 DUR Minutes – Vote
B. June 10, 2010 DUR Recommendation Memorandum
C. Correspondence

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 February 2010
B. Retrospective Drug Utilization Review Response for December 2009
C. Medication Coverage Activity Audit for June 2010
D. Help Desk Activity Audit for June 2010

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

5. Action Item – Vote to Prior Authorize ProCentra™ - See Appendix C.

A. COP Recommendations

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

6. 30 Day Notice to Prior Authorize Ampyra™ – See Appendix D.

A. Product Summary
B. Utilization Review
C. COP Recommendations

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

7. 30 Day Notice to Prior Authorize Qutenza® – See Appendix E.

A. Product Summary
B. Cost Comparison
C. COP Recommendations
D. Product Details

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

8. 30 Day Notice to Prior Authorize Special Formulation Antibiotics – See Appendix F.

A. Product Summaries and COP Recommendations
B. Product Details

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

9. Action Item – Annual Review of Byetta ® and 30 Day Notice to Prior Authorize Victoza® and Bydureon® – See Appendix G.

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

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

10. 30 Day Notice to Prior Authorize Anticonvulsant Drugs – See Appendix H.

A. Current Anticonvulsant Policies
B. Utilization Review
C. COP Recommendations

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

11. FDA and DEA Updates – See Appendix I.

12. Future Business

A. Annual Review of Synagis
B. Annual Review of Growth Hormones
C. 2010 Annual Reviews
D. New Product Reviews

13. Adjournment

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES of MEETING of JUNE 9, 2010

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, MHS, PA-C	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	
Jennifer Sipols, Pharm.D.; Clinical Pharmacist		X
Visiting Pharmacy Student(s): Carrie Carter, Ryan Pettway	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
Garth Splinter, M.D., M.B.A.; 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:

Toby Thompson, Pfizer	John Harris, Abbott	Connie Lindsay, AstraZeneca
Pat Trahan, Taro	Lance Burcham, MedImmune	Meg Propes, AstraZeneca
Jon Arnold, Pfizer	Jim Dunlap, Lilly USA	John Seidenberger, Boehringer-Ingelheim
Jeff Himmelberg, GSK	Randy Beckner, GSK	Sam Smothers, MedImmune
Aaron Mays, Alcon	Emerald Groom, Alcon	Mark DeClerk, Lilly
Holly Turner, Merck	Warren Tayes, Merck	Russ Wilson, OMJPI
Donna Erwin, BMS	Brian Maves, Pfizer	Vanessa Papion, UCB

PRESENT FOR PUBLIC COMMENT:

Agenda Item No. 9: Janelle Hardisty, Ph.D.; Astra Zeneca and Mike Jamieson, M.D.; Pfizer
Agenda Item No. 11: Donald Stone, M.D.; Dean McGee Eye Institute

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

1A: Roll Call

Dr. Muchmore 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. Muchmore recognized the speakers for public comment.

Agenda Item No. 9: Janelle Hardisty, Ph.D.; Astra Zeneca and Mike Jamieson, M.D.; Pfizer

Agenda Item No. 11: Donald Stone, M.D.; Dean McGee Eye Institute

ACTION: NONE REQUIRED

Dr. Nancy Nesser: Good evening. Last month we said goodbye to Dr. Mitchell and tonight we say hello to her replacement. Dr. Garth Splinter is here with us tonight just so he can hang out and have some fun, and I don't think he's officially on the job until July 1, but Dr. Splinter's with us tonight.

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

3A: MAY 12, 2010 DUR Minutes

Dr. Kuhls moved to approve as submitted; seconded by Ms. Varalli-Claypool.

ACTION: MOTION CARRIED

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

4A: Retrospective Drug Utilization Review: January 2010

4B: Retrospective Drug Utilization Review Response: November 2009

4C: Medication Coverage Activity Audit: May 2010

4D: Help Desk Activity Audit: May 2010

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **REVIEW OF ALBUTEROL HFA PRODUCTS**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE ILARIS®**

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

Dr. Bell moved to approve as submitted; seconded by Dr. Harrell.

ACTION: MOTION CARRIED

AGENDA ITEM NO. 7: **VOTE TO PRIOR AUTHORIZE REQUIP XL™ AND MIRAPEX ER™**

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

Dr. Muchmore recommended amending criteria to stipulate that there be a justifiable reason for not taking the immediate release in a multiple dose format.

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

ACTION: MOTION CARRIED

AGENDA ITEM NO. 8: **VOTE TO PRIOR AUTHORIZE LOVAZA®**

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

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

ACTION: MOTION CARRIED

AGENDA ITEM NO. 9: **VOTE TO PRIOR AUTHORIZE LIVALO® AND STATIN UTILIZATION REVIEWS**

For Public Comment, Dr. Janelle Hardisty: Good evening. I'm Janelle Hardisty. I'm a cardiovascular regional scientific manager with AstraZeneca Pharmaceuticals and I do appreciate the opportunity just to very briefly update you on the two new clinical indications that were approved for Crestor in the last year. First in October of 2009, based on the PLUTO trial data, the FDA approved Crestor for use in pediatric patients 10 to 17 years old with heterozygous familial hypercholesterolemia. The second indication I'd like to briefly review was approved on February 8 of 2010 and the FDA approved Crestor to reduce the risk of stroke, heart attack and arterial revascularization in patients without clinically evident coronary artery disease, but with an increased risk for CVD based on three primary criteria; one being age, men greater than or equal to 50 years old and women greater than or equal to 60 years old; an hsCRP level of greater than 2 mg per liter; and then finally, one additional cardiovascular risk factor, and that could be inclusive of hypertension, low LDL, smoking or premature family history of coronary disease. This indication was based on results of the JUPITER study, and the JUPITER study enrolled 17,802 patients who were randomized on a placebo or 20 mg of Crestor. This was given once daily and they were followed for a mean duration of two years. In comparison to placebo, Crestor significantly reduced the relative risk of heart attack by 54%, stroke by 48%, and arterial revascularization by 46%. There were a higher percentage of patients who discontinued due to adverse events in the Crestor treated arm as compared to placebo, and myalgia was the most common adverse reaction for this discontinuation. Furthermore, I would like to tell you that in JUPITER, there was a significantly higher percentage of patients who were diagnosed by their physicians with diabetes compared to placebo, and those rates were 2.8% for the Crestor treated arm as compared to the 2.3% in the placebo treated arm. The mean hemoglobin A1C was significantly increased by .1% in the Crestor arm as compared to placebo. I would like to tell you though that the increases in hemoglobin A1-C, fasting serum glucose levels have been reported with other HMG-CoA reductase inhibitors including Crestor. So in addition to the new indications that I've just reviewed, I do want to let you know that several previous studies have shown Crestor to be highly efficacious at lowering LDL, raising HDL and just slowing the progression of atherosclerosis. I appreciate your time and attention and I'd be happy to take questions.

Dr. Kuhls: Just a real quick question. Do you know the other statins of what age they go down to for FDA approval, because I don't know that offhand.

Dr. Hardisty: As far as this FDA indication is for primary prevention and it was based off the JUPITER trial, and the JUPITER study design, the inclusion criteria were men greater than or equal to 50 years old and women greater ……..

Dr. Muchmore: But what he's wanting to know is are there any other approved for kids that are heterozygous?

Dr. Hardisty: Oh, I'm sorry. I misunderstood. I was thinking about the primary prevention. There are other statins that do have pediatric indications, but I will be honest with you, I am not certain which ones are inclusive of that specific patient population and this is specific for children with heterozygous familial hypercholesterolemia.

For Public Comment, Dr. Mike Jamieson: Thank you very much. I'm Dr. Michael Jamieson and I'm a fulltime employee of Pfizer I'm the senior medical director for the cardiovascular group and a licensed physician practicing, excuse me licensed to practice and a clinical pharmacologist by training. The answer for Lipitor to the previous question is for pediatric indications 10 to 17 years. Since the last review, we don't really have any new information. There are some sub analyses but (unintelligible). I wanted to talk about a couple of things here. Realizing that the principle consideration for the Board is maximizing cost effectiveness of therapy. I just want to talk about a couple of points, the first on is safety issues and some of the recent concerns with muscle safety (unintelligible), so can you hear me okay? Although I'm licensed to practice in Texas. I'm not a Texan (unintelligible) from Texas. So safety with regard to muscle safety, I'm sure you are aware there was a recent change to the simvastatin labeling around muscle safety, so to paraphrase that a little bit from their own clinical trial database of around 41,000 patients, the instance of myopathy and by myopathy I mean increase in CPK to ten times or more the upper limit of normal. So the incidence across the dose range at 20 mg, .02%; at 40 mg, .08%; and at 80 mg, .053%. And that makes by my calculation around 217 patients at the 80 mg dose range out of 41,000 patients. In contrast and this is not (unintelligible) this was published in the American Journal of Cardiology 2007, so it represents data we collected from our own database, the Pfizer database, until late 2006. So that was in 49 trials, well over 14,000 patients or 10,000 patient-years experience across the dose range. And this particular study was a comparison only of trials that study 10 mg Lipitor versus 80 mg, so not across the dosage range, but the extremes of the dose range and in that analysis there was one case of myopathy at 10 mg and one case of myopathy at 80 mg. And so bottom line from those are that myopathy is actually (unintelligible) most of the, even in the simvastatin database, we're talking less than 1% incidence of myopathy. As far as randomized controlled clinical trials, I realize this is a caveat that you have to (unintelligible) that we're talking about, randomized clinical trials (unintelligible) database and also the simvastatin database (unintelligible) real world (unintelligible) there doesn't seem to be as far as we can tell there doesn't seem to be a dose dependent increase in muscle toxicity with atorvastatin. The numbers are very small to judge but there's no signal for that. And then it seems that at least for simvastatin even though the 80 mg dose is an outlier, it seems to be a special case that was an issue for simvastatin (unintelligible)

Dr. Muchmore: What did you say about simvastatin 80 mg?

Dr. Jamieson: It's an outlier. Outlier, yeah. So the incidence, to go back to their database, the incidence of myopathy was 25 times higher at 80 mg than it was at 20 mg. The other thing I wanted to mention and you're familiar with, but it's just a reminder, in terms of drug-drug interactions, there are certain circumstances where simvastatin is not appropriate. The labeling for simvastatin is to avoid the drug in certain patients. I just want to compare simva versus atorva in patients taking HIV protease inhibitors the label says to avoid these patients, whereas for atorvastatin the label says to take care using doses of more than 20 mg, 10 to 20 mg is probably okay. I mean you have to be careful with these patients in general but I'm talking the

words on the label. And there also are labeled restrictions of use of simvastatin above 20 mg in patients taking amiodarone and verapamil there is no label restrictions on Lipitor for these patients. And then the next thing, I'll be fairly brief on this, I will be brief. In terms of getting to goal the information you have in front of you, looking at the LDL cholesterol change across the dose ranges of simvastatin, between 20 and 40 mg of simvastatin the average reduction was 38 to 41 percent. For patients at high risk especially. So CHD patients, CHD equivalent patients including diabetic patients with the new goals (unintelligible) standard of care goals of less than 70 mg/dL these patients will not get to goal if their starting LDL cholesterol is higher than 119 mg/dL so you're basically not going to get patients to goal with 20 to 40 mg in that particular kind of, category of patient. Atorva by comparison 20 mg is 43%; 40 mg is 45%. And there really aren't (unintelligible) and in general head-to-head studies of any statin or designed to be true head-to-head studies. The one trial that compared simvastatin against atorvastatin which was the IDEAL study which was in north Europe and that was done in 8,888 patients, I'm sure you are familiar with the 4S trial, essentially, mindful the standard of care moved from the past eleven years, the active group in the first trial, sim 20 to 40 was the control group in the IDEAL trial and 80 mg was the active, so it was a comparison of atorva 80 versus simva 20 to 40, so it was not a direct comparison but a comparison of the standard of care based on the simvastatin against a much more intensive treatment. These are patients with CHD history or MI and there were significant changes and some of the endpoints again, to be transparent, the primary endpoint of the study which was major coronary events was nonsignificant, it was 11% reduction with a p-value of .07, but it was secondary endpoints, major CV events, which includes stroke or significant (unintelligible) there was a 13% reduction. There was a 17% reduction in non-fatal MI, 23% reduction in revascularization. The reason I bring that up is that 20 to 40 mg of simvastatin clearly in this high risk patient population of CHD is not equivalent to intensive treatment. So in conclusion my understanding is that as things stand, that Lipitor is Tier 2, so in conclusion our suggestion would be that Lipitor remain a Tier 2 and that lower doses, 10 and 20 mg would remain available for patients in whom simvastatin is inappropriate because of label drug-drug interactions. Now then patients who are well controlled on 20, 40, 80 mg of Lipitor, these patients due to points of safety and efficacy should remain on these doses. Thanks very much for your time, if you like to ask any questions.

Dr. Feightner: Why not a trial on a patient on 40 mg of simvastatin that has a 41% LDL reduction, why not try that on patients that are on 20 mg of atorvastatin when you only have a 43% LDL reduction? That (unintelligible) really .....

Dr. Jamieson: I think that would be fine. I mean it kind would be up to the discretion of the physician, 2% difference is not (unintelligible)

Dr. Feightner: I'm with you on the 80 mg atorvastatin if they're not, you know, if they've tried the 40 and 80 mg of simvastatin, doing the 80 mg of Lipitor. Right now we only have 480 members on Lipitor 80, you know. A vast majority are on 10, 20 and 40 mg of Lipitor, so a very small, or smaller population of people on it.

Dr. Jamieson: I think the concern is not to have patients going 80 mg of atorvastatin, that's the judgment.

Dr. Feightner: I agree, yeah.

Dr. Jamieson: And there are arguments that physicians you know I've practiced, I've chaired the P&T committees and so one of the concerns is that when you start on one product and switch to another it's kind of an admission of failure in the mind of the patient may confuse things. In an ideal world, physicians would like to see, do you need a 50% reduction, I'm going to start you on Lipitor but I'm not going to start you on 80 mg because I want to see if you tolerate this. I'll start you on 20 and then work up, for example.

Dr. Graham: Doctor, do you treat Medicaid patients?

Dr. Jamieson: When I was in practice I did. I mean I keep stumbling over that. I've worked with Pfizer for nine years and I worked for six months. I treated indigent patients at University health system in San Antonio.

Dr. Graham: But you agree compliance is really a problem?

Dr. Jamieson: Yeah, even in Medicaid patients. Mine was a large Hispanic population so you know we had communication issues with them with my accent, but I mean, no we're talking with compliance rates of what, 40 to 50% most (unintelligible).

Dr. Muchmore: If you have a supply of a branded statin, it's sellable to your uncle who doesn't have insurance. There's lots of problems. Okay, just a couple of comments. These drugs, of course, all lower cholesterol, but there are pharmacological differences. Simvastatin is highly lipophilic, atorvastatin is hydrophilic, and so there's difference in their muscle effects. The lipophilic like simvastatin is more likely to cause myopathy than atorvastatin. However, when you get into the lower dose ranges where you're talking about 10 mg of atorvastatin, you have choices of simvastatin and pravastatin at reasonable non, usually non-myopathic doses that will achieve this equivalent reductions in cholesterol. And I think atorvastatin's a wonderful drug and at 40 and 80 mg for the people who need it, it's a lifesaver. But for a lot of people who just have a high cholesterol and need that along with lifestyle recommendations, pravastatin and simvastatin are excellent choices and worth what, spend a million dollars for 20 mg atorvastatin, that's a lot of the taxpayers' money.

Dr. Feightner: The incidence is rare in both drugs, the myopathies.

Dr. Muchmore: The incidence of people complaining, you know, their joints act up and they get a little ache in their knees and their shoulders and they quit taking the medicine. It happens all the time.

Dr. Feightner: It does, it does. And it's not a true myopathy in a majority of the cases. Because the actual true myopathy, the rhabdo, is very, very small in majority of cases.

Dr. Muchmore: We had a lot of problem with it back in the '80's when we were initially trying to prevent heart transplant patients from getting post-transplant atherosclerosis and all we had was lovastatin. You know, we had to be very careful because they'd come in with a CPK of 20, 30,000 and muscle pain that was real. But that's not even a problem in transplant patients anymore because most of them are getting other drugs. But it can be a real phenomenon, but it's usually somebody that's got renal failure or transplant drugs or HIV drugs or something like that. But these pharmacological differences have to be taken into account when we're doing PA's because they are real effects. Okay, any other comments? But I agree. Complaints of myopathy are common and mostly related to joints and actual myopathy is rare.

Dr. Feightner: Yes, very rare. That's true myopathy. And a lot of physicians will switch, you know, without, can't test, because somebody calls in and says my muscle hurts, you know, and they're OK, well I'm going to switch you over to something else.
Dr. Muchmore: And that happens a lot without thinking about it. Okay, any other comments, questions?
Dr. Feightner: What, what about, both simvastatin and generic Pravachol, are they both, pravastatin, are they both lipophilic? Simvastatin is, but is it lipophilic as well? What's the incidence of rhabdo in pravastatin?
Dr. Muchmore: Lovastatin is lipophilic. And so is rosuvastatin. Rosuvastatin, simvastatin and lovastatin are the hydrophilic ones, or lipophilics. But those are real differences. Okay, Dr. Le.
Materials included in agenda packet; presented by Dr. Le.
Dr. Kuhls moved to accept the STATIN-CE recommendations (see recommendations memo); seconded by Dr. Winegardener.
ACTION: MOTION CARRIED
Ms. Varalli-Claypool moved to put pitavastatin in Tier 2; seconded by Dr. Harrell.
ACTION: MOTION CARRIED

AGENDA ITEM NO. 10: **VOTE TO PRIOR AUTHORIZE OLEPTRO™**
Reports included in agenda packet; presented by Dr. Le.
Dr. Winegardener moved to approve as submitted; seconded by Ms. Varalli-Claypool.
ACTION: MOTION CARRIED

AGENDA ITEM NO. 11: **ANNUAL REVIEW OF OPHTHALMIC ANTI-INFECTIVES AND VOTE TO PRIOR AUTHORIZE BESIVANCE™**
For Public Comment, Dr. Donald Stone: Good evening. Thanks for the refresher on the statins. I do appreciate the opportunity to come and speak to everyone tonight. I have no financial interest in any of the drugs being discussed this evening and my thoughts, these represent mine and may or may not represent those of the University or the Dean A. McGee Eye Institute where I work. I brought a letter that puts down most of my thoughts tonight so if you would like to pass that around? I may just have nine or ten copies so I apologize if I'm short. I didn't know how many were on the Board, so I apologize. I just want to offer some perspective from an ophthalmologist and my speciality is in infectious inflammatory disease of the eye and so I have a little bit of unique perspective on some of these medications. Over the past few years I've been involved via e-mail with some of the other people that were helping developing this tier system for ophthalmic anti-infectives and I think the system we came up with was fairly rational in that for primary care doctors, emergency physicians, for those that are on the front lines, that the Tier 1 system including most of the aminoglycosides, polys, trimethoprim, those are the things that are all Tier 1 and used very effectively, very cost effective because they're cheap medications, been around for a long time, for treating the usual things like bacterial conjunctivitis or honestly, viral conjunctivitis, what a lot of those are going to be used for. My concern as we've stressed the last time this came up is that, as ophthalmologists and those of us that treat severe corneal infections and more severe infections has a much different scenario and so the parameters are all completely different. One concern we have is that the first indication that we often might can use these later generation fluoroquinolones is in microbial keratitis so if somebody gets a fingernail scratch or were a contact lens wearer and develops infection. Often these are gram positives and the onset of damage is very rapid, so I'd liken this to the septic patient it prevents. You don't want to do a trial of tetracycline before you considered vancomycin and you don't have time to do that stepwise approach and so we want to use things that we think have the mostly likelihood of eradicating infection. Another scenario where there is also significant risk for significant vision loss is post-surgical endophthalmitis and these are patients having intraocular surgery, cataract surgery, anything else (unintelligible). Endophthalmitis is not common but when it happens, the outcome is usually very, very poor. Most of the patients are blind no matter how aggressively you treat it. Once they develop endophthalmitis, you've lost the game and so you're very cautious to prevent that. And over the years, experience has shown us that there is actually a big difference in the way certain medications behave. (unintelligible) are also (unintelligible) staph epidermidis, staph aureus and then a lot of the strep species so as you can imagine aminoglycosides aren't particularly attractive. A lot of the older medications don't have a good susceptibility profile for those microbes. The moxifloxacin, gatifloxacin and then possibly the newer one, besifloxacin which I don't know as much about as (unintelligible) do seem to have better gram positive coverage and they also have better intraocular penetration which is where you want to treat. The mechanism of post-operative endophthalmitis is probably egress of bugs into the eye at the time of surgery or shortly thereafter if the wound is incompetent, and so you treat with these frequent antibiotic drops that must soak into the eye, into the interior chamber, and hopefully kill whatever bugs happen to be left there. And so as for example, ciprofloxacin was first brought to the market, everyone was so excited because we have this fluoroquinolone with a little better gram positive coverage and so a lot of people switched to it and endophthalmitis rates went up and then it was discovered that it doesn't penetrate into the eye very well, so lesson learned there. And it does appear of course, this is all extrapolating you know rapid data and other midpoints not end-point data of treating endophthalmitis rates. But for example the moxifloxacin, gatifloxacin penetrate into the eye much better than for example, ciprofloxacin and aminoglycosides and so you can achieve much higher concentrations which are hopefully bactericidal in the anterior chamber. So I think that's why you had supported the original rationale of the separate system for this Tier system for primary care doctors, nurse practitioners, ER physicians, those people that are treating ocular surface infections; bacterial conjunctivitis; I think it makes complete sense to start with, choose your preference from the list there, they probably all are self-limited anyway and so you're going to be fine. But I think in the scenarios we treat for severe infections like microbial keratitis, post-operative endophthalmitis prophylaxis, then that

makes most of pretty nervous if we're using agents that are probably less effective and less potent. And so we would like to keep that caveat that optometrists and ophthalmologists still have that bypass for those agents, knowing that yes, they do cost a little more, but in our mind, it's probably worth it. And we really don't have the true endpoint. I mean it may cost more, but what's the quality of adjusted life year data? We don't know that. We can't tell you that it costs more. Maybe it's cheaper to prevent one or two kids from going blind and having to take care of them for the rest of their life as a blind adult for the next 70 years, so the cost figure we actually can't really make a good judgment on without data points. I'm certainly happy to answer any questions, help out any way that you feel appropriate.

Dr. Muchmore: What you just said is why we traditionally have said, you know, post-surgery that there's no problem, or from an ophthalmologist or optometrist because you've got a lot to lose in an eye; whereas people got over conjunctivitis garden variety back before they had antibiotics.

Dr. Feightner: What's the penetration of Quixin and Ocuflox? Just curious. How do those compare to moxifloxacin and …….

Dr. Stone: It is probably …. you know there's been a few studies that sort of, poster presentations that I've seen, but it's probably somewhere between the ciprofloxacin and moxifloxacin, gatifloxacin group. Then the downside that we see is then that you don't have much gram positive coverage, or at least not as good as the newer generation fluoroquinolones.

Dr. Kuhls: I don't necessarily disagree with you. But I sorta get tickled when I hear the ophthalmologists talk about infectious diseases and so you talk in terms of concentrations of antibiotics and so on. What data do you have, efficacy wise, that moxifloxacin is better in a comparative trial, okay, endophthalmitis?

Dr. Stone: Well there are not many endophthalmitis studies because it's rare enough that no drug company's going to spend the money to perform an adequately powered study.

Dr. Kuhls: Exactly. And they're going to do a lot of intraocular early treatments or intravenous treatments. For endophthalmitis, don't you do a lot of intravenous treatments?

Dr. Stone: Not, actually no. If an endophthalmitis develops you immediately inject antibiotics into the vitreous ……

Dr. Kuhls: Exactly. So it's not just a matter of the drops.

Dr. Stone: Yeah, and they still go blind once they've developed endophthalmitis.

Dr. Kuhls: That's my whole point. So when you talk in terms of efficacy in endophthalmitis as we've used drops are so important, I think that's sort of ……..

Dr. Stone: Well there was a recent study done in the Consortium of European Ophthalmologists with, I think it was fourteen or sixteen thousand patients and the study arms were topical, I think it was levofloxacin was one they used, versus intracameral cefuroxime in the surgery which was not available in the United States versus both. And they both decreased incidence of postoperative endophthalmitis. Intracameral cefuroxime was actually a little better, but again, there's nothing in the United States available like that.

Dr. Kuhls: Yeah, I think what I'm saying is that your conclusions based on concentration is probably not fair and if anything, if you're at OU it would be awesome, these are the kinds of things that need to be studied and, in other words, prevention of endophthalmitis, I'd like to see that data in a real true American-controlled trial.

Dr. Stone: Sure, and if you'll write me a check I'll sign up 20,000 patients ……

Dr. Kuhls: But the reason that that check will never come to you, because it's easier for companies to come to you and say hey, our drug gives you this intraocular antibiotic, it covers everything, use that eyedrop. And so that's partly what has happened in ophthalmology is that everybody's been marketed that it's better without a lot of data.

Dr. Stone: Well it's like most systemic antibiotics which are approved for sinusitis. If I get bacterial meningitis, I don't want you to, you know, not treat me because (unintelligible) ……

Dr. Kuhls: That's right, so I don't necessarily think that this shouldn't be part of your armamentarium and I'm not here to stop that, but I think a lot of your arguments from infectious diseases standpoint are relatively weak when you look at the data, other than, oh, this covers everything and oh, this gets into the eye rate; when in reality, the studies aren't really there. You've been marketed as a group.

Dr. Stone: Exactly. We have to extrapolate from what we do know.

Dr. Muchmore: The problem is that the end result if it's bad is very bad.

Dr. Kuhls: The end is bad, but the data that the more expensive antibiotic is better is incredibly weak, nonexistent, nonexistent.

Dr. Muchmore: The biggest problem is that we get this mindset that if this kid comes to me with garden variety conjunctivitis, if I use moxi or gati or whatever, they're less likely to have any problems, you know. And if I use sodium sulfacetamide it'll sting their eyes, you know when in truth, sulfacetamide works just fine for garden variety conjunctivitis.

Dr. Kuhls: But what I'm trying to say and be respectful, okay, is that it is unfortunate and hopefully if you're interested in infectious diseases, the infectious diseases world looks down on the ophthalmologists because there aren't the controlled trials and the studies to make all the statements that you've made, okay? And so I hope that you recommend this but in reality, probably there needs to be, you know, more narrow spectrum drugs for the infection that you culture and true prophylaxis studies and a whole development of a field instead of your community, your group just being marketed, which is happening. Because I get marketed in my office the same way as you do, and I know what that marketing is like.

Dr. Muchmore: Dr. Kuhls is an infectious disease specialist, so this is of very great interest to him. Thank you very much for coming and talking to us. Now our intention is to leave this the same as it is for moxifloxacin, is that correct?

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

Dr. Muchmore recommended change to criteria for Tier 3 medication: Sentences 1 and 2, add "Tier 1 or" in front of Tier 2.

Dr. Kuhls: So, Dr. Stone, what's the …….. do you feel that optometrists that aren't doing post-surgery, aren't treating endophthalmitis, I hope, do they need to be treated …….. are optometrists equal to ophthalmologists?

Dr. Stone: That's a very loaded question.

Dr. Kuhls: I actually, yeah, in the State of Oklahoma, I said that purposely like that. So you believe that every optometrist out there should be able to get a quinolone just because they're marketed first?
Dr. Stone: They can perform surgery in the State of Oklahoma, so, yes.
Dr. Muchmore: You've got to remember there are a lot of communities in Oklahoma where they are only served by an optometrist.
Dr. Kuhls: Well we could argue this all day. I think it's already been argued, then I'm not sure the winner, I agree, the winner should be the winner, but I just want to make sure that Dr. Stone agreed to that.
Dr. Stone: I think if they're treating severe microbial keratitis and performing incisional surgery, then those (unintelligible) that's what's happened.
Dr. Kuhls: So that's going to continue to happen?
Dr. Muchmore: And what unfortunately continues to happen is treating garden variety conjunctivitis with moxifloxacin at $80 bucks a pop when you can get sulfacetamide for $1.98.
Dr. Kuhls: In your tiers, what's going to happen in terms of, in your proposed tiers, what's going to happen with supplemental rebates?
Dr. Le: The Board voted to not accept any supplemental rebates in this category. It is as it is. There will be no products moving.
Dr. Kuhls moved to approve as submitted; seconded by Dr. Winegardener.
ACTION: MOTION CARRIED

AGENDA ITEM NO. 12: **ANNUAL REVIEW OF STIMULANTS AND 30-DAY NOTICE TO PRIOR AUTHORIZE PROCENTRA™**

Reports included in agenda packet; presented by Dr. Moore.
Dr. Winegardener moved to approve as submitted; seconded by Ms. Varalli-Claypool.
ACTION: MOTION CARRIED

AGENDA ITEM NO. 13: **FDA & DEA UPDATES**

Materials included in agenda packet; presented by Dr. Graham.
ACTION: NONE REQUIRED

AGENDA ITEM NO. 14: **FUTURE BUSINESS**

Materials included in agenda packet; submitted by Dr. Graham.
A: Review Ribavirin Prior Authorization
B: Annual Review of Growth Hormones
C: Utilization Review of Epilepsy Medications
D: New Product Reviews
ACTION: NONE REQUIRED

AGENDA ITEM NO. 15: **ADJOURNMENT**

The meeting was adjourned at 7:18 p.m.

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

Memorandum

Date: June 10, 2010

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 June 9, 2010

Recommendation 1: Vote to Prior Authorize Ilaris® (canakinumab)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends pharmacy prior authorization of ILARIS® (canakinumab) with the following criteria.

1. FDA approved indication of Cryopyrin-Associated Periodic Syndromes (CAPS) verified by genetic testing. This includes Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 4 and older.
2. The member should not be using a tumor necrosis factor blocking agent (e.g. adalimumab, etanercept, and infliximab) or anakinra
3. Should not be initiated in patients with active or chronic infection including hepatitis B, hepatitis C, human immunodeficiency virus, or tuberculosis.
4. Dosing should not be more often than once every 8 weeks.
5. **Approved dosing schedule based on weight:**
   a. Body weight >40 kg: 150mg
   b. Body weight 15 kg – 40 kg: 2mg/kg. If inadequate response, may be increased to 3mg/kg
6. Approval period is for one year.

Recommendation 2: Vote to Prior Authorize Requip XL™ (ropinirole) and Mirapex® ER™ (pramipexole)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends prior authorization for Requip XL™ (ropinirole) tablets and Mirapex ER™ (pramipexole) tablets to ensure appropriate utilization for the FDA approved indication for the treatment of signs and symptoms of Parkinson's Disease and a justifiable reason why the immediate release products cannot be utilized.

Recommendation 3: Vote to Prior Authorize Lovaza® (Omega-3-Acid Ethyl Esters)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends prior authorization of Lovaza® with the following criteria:

1. Laboratory documentation of severe hypertriglyceridemia (fasting triglycerides ≥500 mg/dL).
2. Previous failure with both nicotinic acid and fibric acid medications.

Recommendation 4: Vote to Update Statin Product Based Prior Authorization Criteria and Implement STepped Approach To INcreased Cost Effectiveness (STATIN-CE)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the DUR Board discuss and consider the STepped Approach To INcreased Cost Effectiveness (STATIN-CE) initiative in the SoonerCare population. As part of this initiative all 10 and 20 mg atorvastatin and 5 and 10 mg rosuvastatin will be required to switch to a Tier 1 medication and will be subject to the following criteria.

For current statin user to qualify for a Tier 2 medication, there must be:

1. A trial, defined by at least 8 weeks of continuous therapy titrated to the maximum recommended dose, of Tier 1 simvastatin or pravastatin that did not yield adequate LDL reduction, but the minimum initiation dosing of the Tier 2 medication may only be at the moderate to high LDL lowering doses (i.e.: doses equivalent to or higher than 20 mg rosuvastatin or 40 mg atorvastatin).
2. Documented adverse effect or contraindication to ~~all~~ two available lower tiered products.
3. Clinical exception for high risk members hospitalized for recent acute myocardial infarction or acute coronary syndrome for atorvastatin 40 mg or higher and rosuvastatin 20 mg or higher.
4. All other step therapy criteria will apply.

The DUR Board recommended the following changes to the current Statin PBPA criteria:

For members new to statin therapy to qualify for a Tier 2 medication, there must be:

1. A trial, defined by at least 8 weeks of continuous therapy titrated to the maximum recommended dose, of Tier 1 simvastatin or pravastatin that did not yield adequate LDL reduction, but the minimum initiation dosing of the Tier 2 medication may only be at the moderate to high LDL lowering doses (i.e.: doses equivalent to or 20 mg rosuvastatin or 40 mg atorvastatin).
2. Documented adverse effect or contraindication to ~~all~~ two available lower tiered products.
3. Clinical exception for high risk members hospitalized for recent acute myocardial infarction or acute coronary syndrome for atorvastatin 40 mg or higher and rosuvastatin 20 mg or higher.

To qualify for a Tier 3 medication, there must be:

1. A trial, defined by at least 8 weeks of continuous therapy titrated to the maximum recommended dose, of a Tier 2 medication that did not yield adequate LDL reduction.
2. Documented adverse effect or contraindication to ~~all~~ two Tier 2 products.
3. Clinical exceptions for Ezetimibe:
    a. Documented active liver disease.
    b. Documented unexplained, persistent elevations of serum transaminases.
    c. Documented statin related myopathy.

Recommendation 5: Vote to Prior Authorize Livalo® (pitavastatin)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the addition of Livalo® to Tier 2 of the Statin PBPA Category. The revised criteria for this category (see recommendation 4) will apply.

Recommendation 6: Vote to Prior Authorize Oleptro™ (trazodone hydrochloride) Extended Release Tablets

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends placement of Oleptro™ in Tier 3 of the Antidepressants PBPA Category. The existing criteria for this category will apply.

Recommendation 7: Annual Review of Ophthalmic Anti-Infectives and Vote to Prior Authorize Besivance™ (besifloxacin)

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends placement of Besivance™ and movement of Quixin® (levofloxacin) into Tier 3 of the Ophthalmic Antibiotic Products Product Based Prior Authorization Category. The existing criteria for this category will apply.

Recommendation 8: Annual Review of ADHD Product Based Prior Authorization Program

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends the following changes to the criteria for Intuniv® (guanfacine): Intuniv® will remain in Tier 2, but will be subject to a hard PA; no concomitant use with other ADHD medications, except on a case-by-case basis, will be allowed; and no stabilization on immediate release guanfacine or Intuniv® samples without a previous Tier 1 stimulant trial.

From: Jennifer Perkins [mailto:jperkinsarnp@yahoo.com]
Sent: Sunday, June 06, 2010 3:36 PM
To: Graham, Ronald D. (HSC)
Subject: statin availability to Medicaid participants

Dear Mr. Graham,

It is very important that name brand drugs belonging to the HMG Co-A reductase inhibitors class remain available as at least a second tier option to individuals covered by Medicare and Medicaid who have, at any time in the past, demonstrated failure on simvastatin.

According to the simvastatin package insert, patients who need >40% reduction in LDL cannot achieve goal even on 80mg of simvastatin. When individuals are placed on high doses of statin medications, the incidence of side-effects increases which often causes decreased patient compliance while taking the medication and when a drug from the same class is suggested in the future.

I understand changes are being made in coverage to save money, however, witholding indicated medications when one has already tried and failed simvastatin will not result in long-term savings. Patients with existing cardiovascular disease at risk for disease progression will potentially require increase hospitalizations, procedures, etc. Once therapy has failed using simvastatin, it is not reasonable to think that "trying again" is going to produce a different result.

When I am making decisions regarding the care of my patients, I always consider what I would want for myself or my family members.
Think about what you would want for yourself or a family member in this situation. Please call or email me with any questions or comments.

Respectfully,
Jennifer Perkins, MS, ARNP
Neighborhood Family Medical Care, LLC
821 S Pine
Stillwater, OK 74074
(405)533-1332

From: Arrington, Malinda [mailto:malinda.arrington@okstate.edu]
Sent: Friday, June 04, 2010 12:59 PM
To: Graham, Ronald D. (HSC)
Subject: medicaid formulary

Dear Dr. Graham,

I understand that the formulary committee for medicaid will be meeting next week, and will be discussing statin therapy.

I am a family nurse practitioner whose practice is approximately 40% medicaid. Many of these patients have chronic diseases such and diabetes and coronary artery disease. The current guidelines recommend that these patients receive aggressive lipid lowering therapy. It is not possible to get many of these patients to goal with generic statins; therefore, I am changing drugs and dosages more frequently in attempt to get them to goal. This in turn requires more frequent monitoring of lab values which is not cost effective. It also puts these patients at greater risk for compications by not getting them to goal.

There is not one statin that fits all patients, so as a provider I would welcome more flexibility in being able to treat my patients appropriately by the current guidelines.

Please consider adding Crestor and Lipitor to tier 1 status.

Sincerely,
Malinda Arrington, ARNP

From: mohamad amer mahayni [mailto:mamahayni@yahoo.com]
Sent: Tuesday, June 08, 2010 5:27 PM
To: Graham, Ronald D. (HSC)
Subject: crestor

Dear Mr.Graham

I am writing to you regarding rosuvastatin. Most of my patients as a cardiologist have established CAD/PVD & would like to achieve LDL target of<70. In addition, significant portion have low HDL. As you know high dose Atorvastatin decreases HDL & is less effective in reducing LDL, however I'm unable to use rosuvastatin for my Medicaid patients since it's not on formulary. I would appreciate your help in this matter

M. A. Mahayni, MD; FACC; FSCAI.

Appendix B

RETROSPECTIVE DRUG UTILIZATION REVIEW REPORT
February 2010

MODULE	DRUG INTERACTION	DUPLICATION OF THERAPY	DRUG-DISEASE PRECAUTIONS	DOSING & DURATION
Total # of messages	48,404	60,569	959,342	31,736
Limits applied	Established, Major, Males and Females, Age 51-57	Males and Females, Bupropion Products, Age 0-150	Contraindicated, Diabetes Mellitus, Males and Females Age 53-58	High Dose & Duration, Emergency Contraceptives, Males and Females, Age 0-150
Total # of messages after limits were applied	65	60	214	4
Total # of members reviewed	65	60	179	4

LETTERS

Category	Prescribers	Pharmacies	Total Letters
Drug Interaction	6	0	6
Duplication of Therapy	6	2	8
Drug-Disease Precautions	53	15	68
Dosing & Duration	0	0	0
Total Letters Sent	65	17	82

Retrospective Drug Utilization Review Report

Claims Reviewed for December 2009

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females, Age 0-21	Narcotics, Males and Females, Age 36-37	Contraindicated, Diabetes Mellitus, Males and Females, Age 36-45	High Dose & Low Dose, Ortho Evra, Males and Females, Age 0-150

Response Summary (Prescriber)
Letters Sent: 93
Response Forms Returned: 58

The response forms returned yielded the following results:

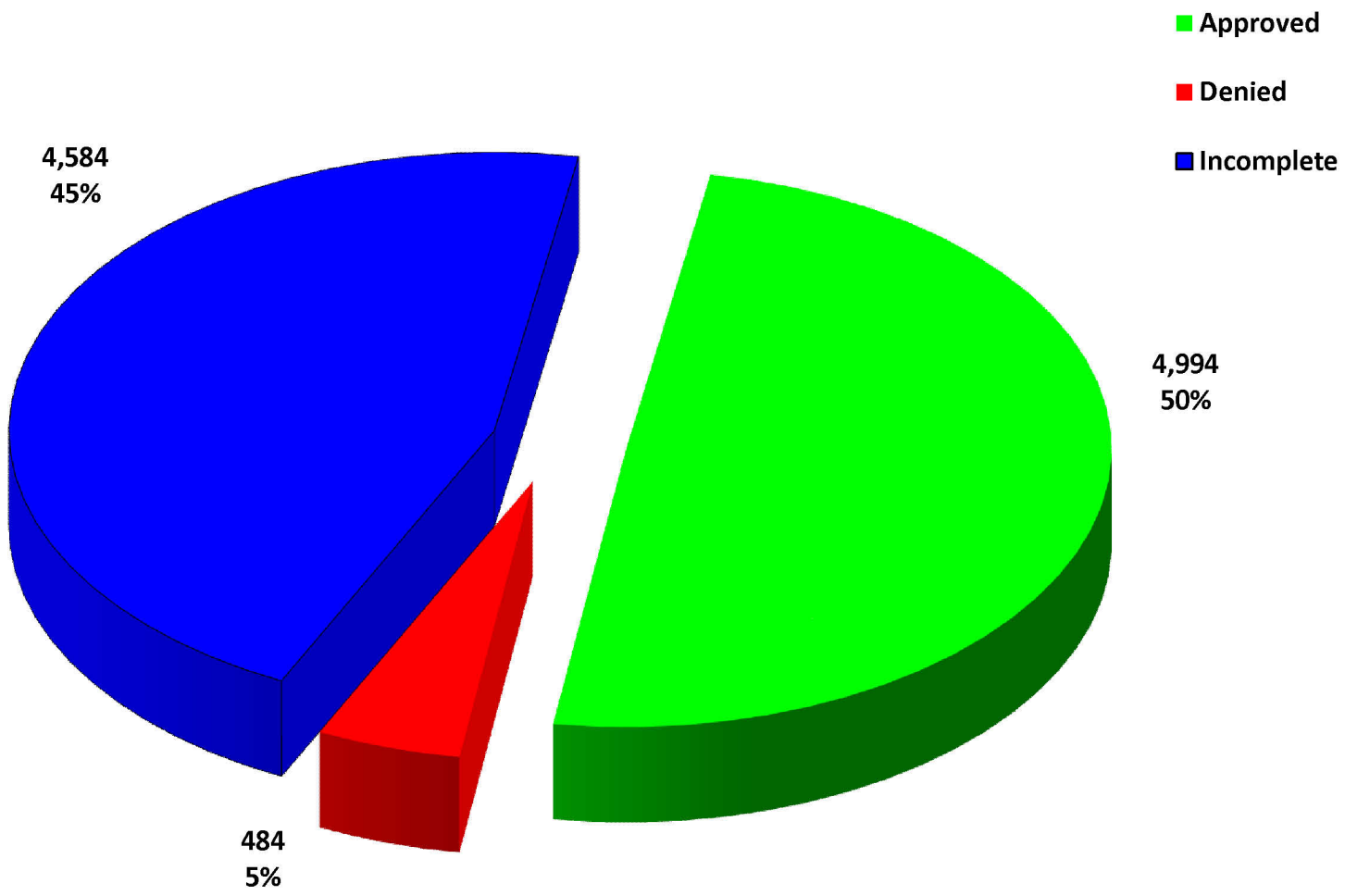
6 (10%)	*Record Error—Not my patient.*
13 (22%)	*No longer my patient.*
4 (7%)	*Medication has been changed prior to date of review letter.*
12 (21%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
14 (24%)	*I am aware of this situation and will plan to continue monitoring therapy.*
9 (16%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 22
Response Forms Returned: 14

The response forms returned yielded the following results:

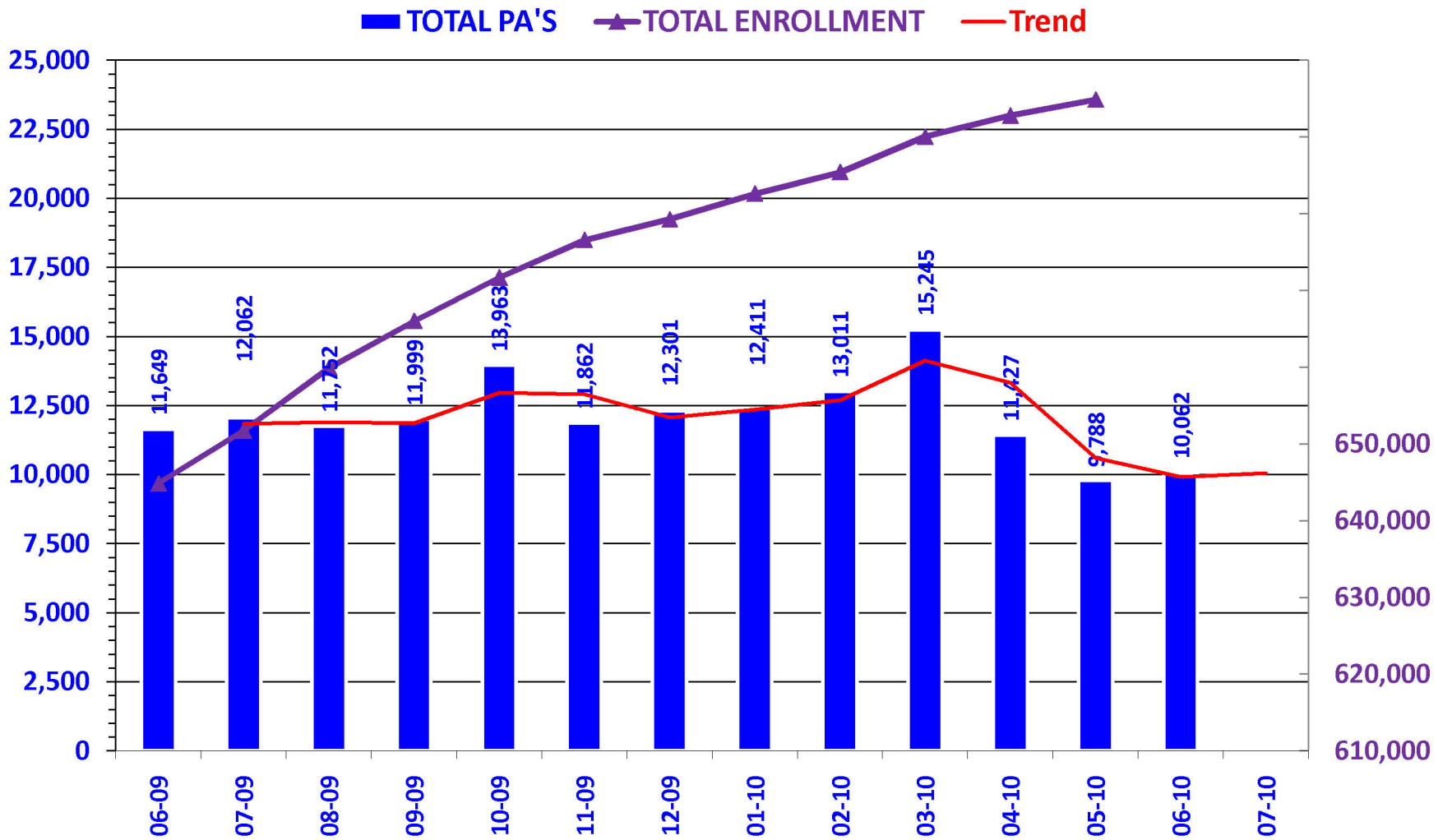
0 (0%)	*Record Error—Not my patient.*
1 (7%)	*No longer my patient.*
0 (0%)	*Medication has been changed prior to date of review letter.*
3 (21%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
3 (21%)	*I am aware of this situation and will plan to continue monitoring therapy.*
7 (50%)	*Other*

PRIOR AUTHORIZATION ACTIVITY REPORT: June 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: June 2009 – June 2010



PA totals include overrides

Prior Authorization Activity

June 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	458	209	4	245	360
Amitiza	23	8	2	13	225
Antidepressant	405	131	21	253	341
Antihistamine	411	235	15	161	319
Antihypertensives	111	36	7	68	331
Antimigraine	107	18	8	81	330
Atypical Antipsychotics	713	348	16	349	348
Benzodiazepines	135	48	2	85	280
Bladder Control	82	9	2	71	362
Brovana (Arformoterol)	1	0	0	1	0
Byetta	8	4	0	4	315
Elidel/Protopic	56	21	3	32	87
ESA	229	150	19	60	58
Fibric Acid Derivatives	5	1	0	4	364
Fibromyalgia	162	61	13	88	341
Fortamet/Glumetza	2	2	0	0	360
Forteo	2	1	0	1	364
Glaucoma	20	5	0	15	363
Growth Hormones	36	25	4	7	171
HFA Rescue Inhalers	101	35	6	60	305
Insomnia	111	30	11	70	161
Misc Analgesics	47	6	28	13	189
Muscle Relaxant	172	53	49	70	69
Nasal Allergy	345	101	36	208	129
NSAIDS	181	41	15	125	248
Ocular Allergy	37	8	3	26	94
Ocular Antibiotics	151	62	3	86	25
Opioid Analgesic	243	118	11	114	198
Other	547	170	50	327	145
Otic Antibiotic	178	86	3	89	14
Pediculicides	144	63	6	75	14
Plavix	262	179	0	83	308
Proton Pump Inhibitors	498	85	30	383	110
Qualaquin (Quinine)	3	0	2	1	0
Singulair	995	586	29	380	260
Smoking Cessation	79	23	1	55	92
Statins	119	28	2	89	351
Stimulant	1,171	746	24	401	222
Symlin	1	0	0	1	0
Topical Antibiotics	22	7	0	15	23
Topical Antifungals	22	3	0	19	40
Ultram ER and ODT	10	2	1	7	362
Xolair	8	2	4	2	362
Xopenex Nebs	48	22	1	25	300
Zetia (Ezetimibe)	22	11	1	10	360
Emergency PAs	7	7	0	0	
Total	**8,490**	**3,786**	**432**	**4,272**	

Overrides					
Brand	39	23	2	14	269
Dosage Change	490	468	1	21	8
High Dose	11	8	0	3	106
IHS - Brand	19	18	1	0	243
IHS – Brand	4	1	0	3	10
Ingredient Duplication	10	9	0	1	6
Lost/Broken Rx	107	101	4	2	4
NDC vs Age	36	35	0	1	194
Nursing Home Issue	124	120	0	4	4
Other	22	20	1	1	15
Quantity vs. Days Supply	741	435	41	265	270
Stolen	9	6	2	1	3
Overrides Total	**1,572**	**1,208**	**52**	**312**	
Total Regular PAs + Overrides	**10,062**	**4,994**	**484**	**4,584**	

Denial Reasons

Lack required information to process request.	2,369
Unable to verify required trials.	2,229
Does not meet established criteria.	366
Not an FDA approved indication/diagnosis.	38
Considered duplicate therapy. Member has a prior authorization for similar medication.	29
Member has active PA for requested medication.	19
Requested dose exceeds maximum recommended FDA dose.	7
Drug Not Deemed Medically Necessary	2
Medication not covered as pharmacy benefit.	1

Duplicate Requests: 742

Letters: 1,293

No Process: 756

Changes to existing PAs: 404

CALL VOLUME MONTHLY REPORT:
June 2009 – June 2010

Appendix C

Vote to Prior Authorize ProCentra™

Oklahoma HealthCare Authority
July 2010

ProCentra™ (dextroamphetamine sulfate) is a bubblegum flavored oral solution, 5 mg/5 ml, approved for children 3 years and older.

Indications

- Narcolepsy
- Attention Deficit Disorder with Hyperactivity

Dosing range

- ADHD (3-5 years) – 2.5-40 mg qd-tid
- ADHD (>6 years) – 5-40 mg qd-tid
- Narcolepsy (6-11) – 5-60 mg qd-tid
- Narcolepsy (>12 years) 5-60 mg qd-tid

Recommendations

The College of Pharmacy recommends adding ProCentra™ to Tier 3 of the PBPA category.

Stimulant / ADHD Medications		
Tier 1	**Tier 2**	**Tier 3**
methylphenidate SR (Ritalin® SR) amphetamine salt combo (Adderall®) dexmethylphenidate (Focalin®, Focalin® XR) methylphenidate ER (Concerta®) methylphenidate IR (Ritalin®, Methylin®)	atomoxetine (Strattera®) methylphenidate ER (Metadate® CD) methylphenidate ER (Metadate® ER) methylphenidate ER (Ritalin® LA) dextroamphetamine/amphetamine combo (Adderall® XR) lisdexamfetamine (Vyvanse®) guanfacine ER (Intuniv®)	armodafinil (Nuvigil®) methamphetamine (Desoxyn®) methylphenidate patch (Daytrana™) modafinil (Provigil®) dextroamphetamine (Dexedrine®, Dexedrine Spansules®) **dextroamphetamine (ProCentra™)**

ProCentra™ (dextroamphetamine sulfate) Product Information. Tiber Laboratories January 2009.

Appendix D

30 Day Notice to Prior Authorize Ampyra™ (dalfampridine)

Oklahoma Health Care Authority
July 2010

Manufacturer	Acorda Therapeutics
Classification	Broad Spectrum Potassium Channel Blocker
Status	Prescription Only

Ampyra™ Summary

Ampyra™ (dalfampridine) is a potassium channel blocker indicated to improve walking in patients with multiple sclerosis (MS). It exerts its effects by closing the exposed potassium channels on demyelinated axons, subsequently improving nerve impulse conduction. Ampyra™ is the first approved symptomatic treatment for MS. Ampyra™, formerly known as fampridine SR, is a tablet containing a sustained-release formulation of 4-aminopyridine, which has been evaluated in various diseases for its actions on the nerve fibers.

Dosage
Adults: 10mg twice daily (doses> 20 mg/day have no additional benefits).
Children: Safety and effectiveness in patients younger than 18 years of age have not been established.
Renal Function Impairment: Contraindicated in patients with moderate or severe renal impairment.

Ampyra™ 10mg extended-release tablets (#60 tablets per bottle)

EAC/tablet	AWP/tablet	Estimated monthly cost	Estimated yearly cost
$18.59	$21.12	$1,115	$13,385

Ampyra™ must be distributed in compliance with the FDA's Risk Evaluation and Mitigation Strategy (REMS) Program which has the following goals:

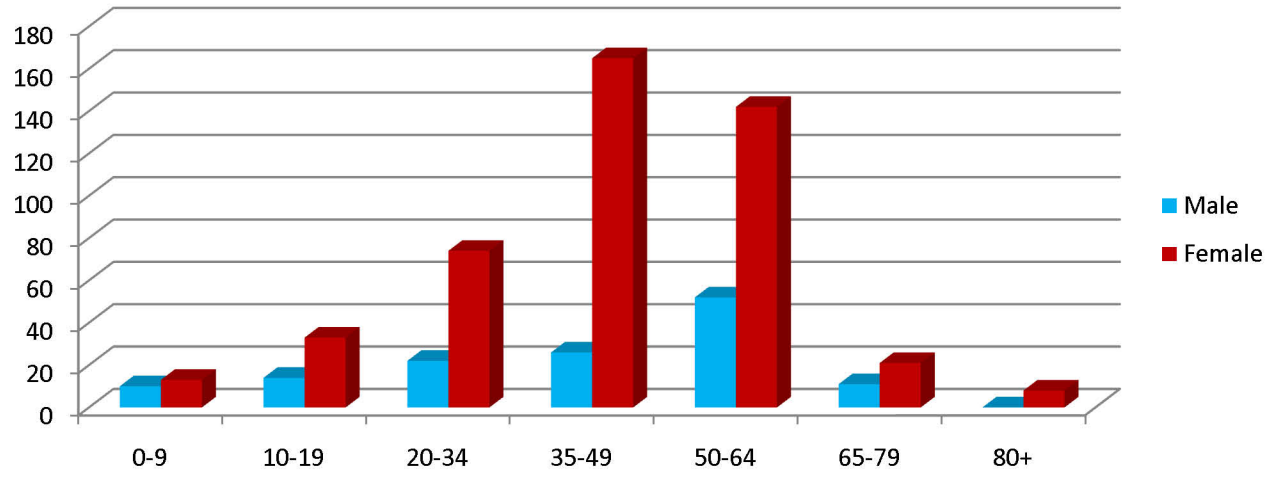
- To inform healthcare providers about the risk of drug-associated seizures in patients treated with Ampyra™.
- To inform healthcare providers about the change of the established name from fampridine to dalfampridine.
- To inform patients about the serious risks associated with Ampyra™ therapy.

Utilization

There are currently 3 members on Ampyra ™.

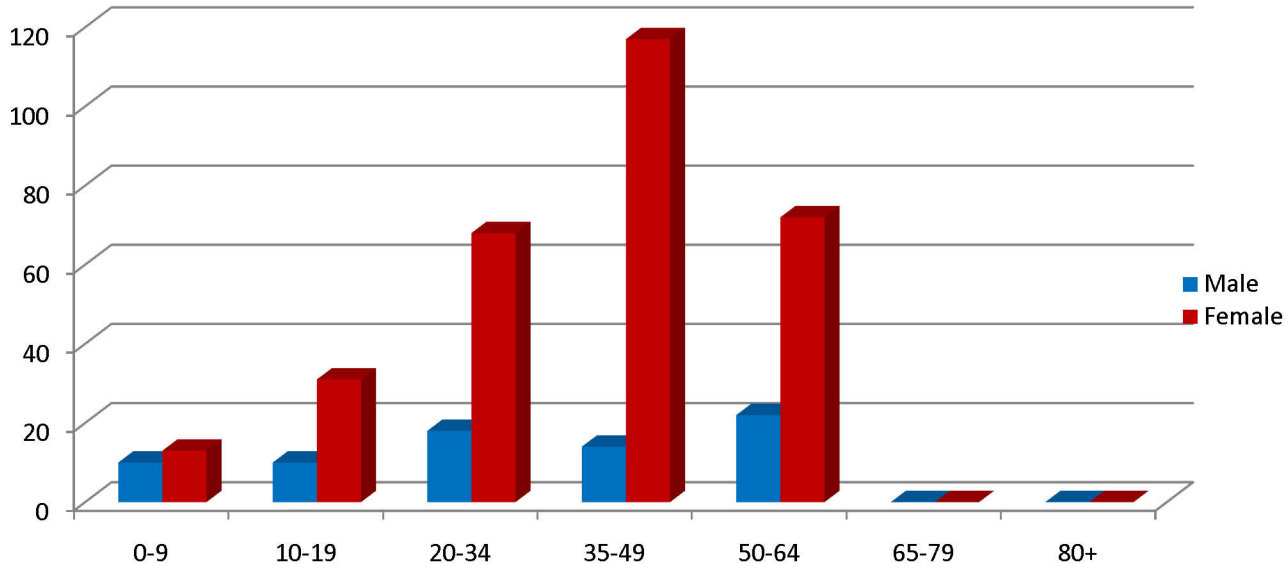
BRAND NAME	CLAIMS	UNITS	DAYS	MEMBERS	COST	UNITS/ DAY	COST/ DAY
AMPYRA TAB 10MG	4	210	120	3	$3,913.63	1.75	$32.61

Members with a Diagnosis of MS between April 09 to Mar10



Age Category	0-9	10-19	20-34	35-49	50-64	65-79	80+	Total
Male	10	14	22	26	52	11	0	135
Female	13	33	74	165	142	21	8	456
Total	23	47	96	191	194	32	8	591

Non Dual Members with a Diagnosis of MS between April 09 and March 10



Age Category	0-9	10-19	20-34	35-49	50-64	65-79	80+	Total
Male	10	10	18	14	22	0	0	74
Female	13	31	68	117	72	0	0	301
Total	23	41	86	131	94	0	0	375

Prescriber Specialty:

	Number of Claims	Total Amount Paid
Neurologist	2	$1,674.99
Psychiatrist	2	$2,238.64

Clinical Trials

The effectiveness of Ampyra™ in improving walking in patients with multiple sclerosis was evaluated in two controlled trials involving 540 patients. Patients in these two clinical trials had a mean disease duration of 13 years and a mean Kurtzke Expanded Disability Status Scale (EDSS) score of 6 (Intermittent or unilateral constant assistance (cane, crutch, brace) required to walk about 100 meters with or without resting).

Trial 1:

- Randomized, placebo-controlled, parallel group
- 21-week study (one week post screening, two-week, single-blind placebo run-in, 14-week double-blind treatment, and 4-week no treatment follow-up)
- 301 patients with multiple sclerosis at 33 centers in the U.S. and Canada
- 229 patients assigned to Ampyra™ 10 mg twice daily and 72 patients assigned to placebo.
- Total of 283 patients (212 Ampyra™ and 71 placebo) completed all study visits
- Inclusion criteria: ability to walk 25 feet in 8–45 seconds
- Exclusion criteria: a history of seizures or evidence of epileptiform activity on a screening EEG, and onset of an MS exacerbation within 60 days.

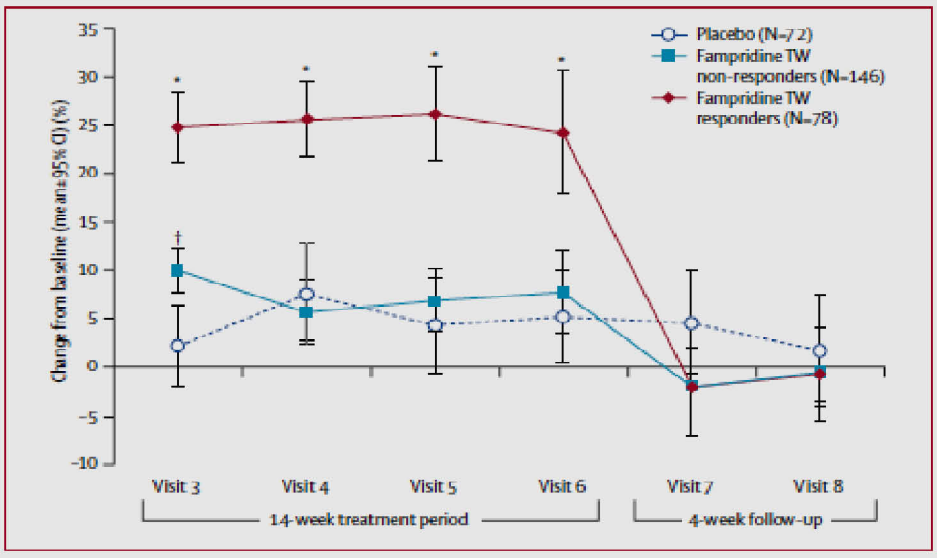


Figure 3: **Percent change in walking speed at each visit after randomisation**
The fampridine-treated timed walk responders showed a sustained improvement during the treatment period that was completely reversed at 2-week and 4-week follow-up visits. The fampridine-treated timed walk non-responders showed a significant improvement compared with the placebo group only for visit 3 (2 weeks after randomisation). TW=timed walk. *Means fampridine TW responders are greater than placebo and fampridine TW non-responders ($p<0.001$). †Means fampridine TW non-responders are greater than placebo only ($p<0.001$).

Goodman AD, Brown TR, Krupp LB, et al. Sustained-release oral fampridine in multiple sclerosis: a randomized, double-blinded, controlled trial. Lancet 2009; 373:732-738

The primary measure of efficacy in both trials was walking speed (in feet per second) as measured by the Timed 25-foot Walk (T25FW), using a responder analysis. A responder was defined as a patient who showed faster walking speed for a least three visits out of a possible four during the double-blind period than the maximum value achieved in the five non-double-blind no treatment visits (four before the double-blind period and one after).

Results:

- The number of patients who met the responder criterion—i.e. timed walk responders—was 78 of 224 (35%) in the fampridine-treated group and 6 of 72 (8%) in the placebo group ($p<0.0001$; Mantel-Haenszel odds ratio [OR] 4.75; 95% CI 2.08 to 10.86)
- Average change from baseline in walking speed for the fampridine-treated timed walk responders during the treatment period was 25.2% (95% CI 21.5% to 28.8%) or 0.51 feet/s (0.41 to 0.61), and 4.7% (1.0% to 8.4%) or 0.10 feet/s (0.03 to 0.17) in the placebo group.
- For the fampridine-treated timed walk non-responders, the average change during treatment was 7.5% (5.0% to 10.0%) or 0.16 feet/s (0.11 to 0.21). Increase in walking speed in non-responders was small but significant compared with that in the placebo group at the earliest double-blind treatment visit, but no difference existed at any subsequent visit

Trial 2[2]:

- Randomized, placebo-controlled, parallel group
- 14-week study (one week post-screening, two weeks of single-blind, placebo run-in, nine weeks of double-blind treatment, and two weeks of no-treatment follow-up)
- 239 patients with multiple sclerosis at 39 centers in the U.S. and Canada
- 120 patients assigned to 10 mg twice daily and 119 assigned to placebo.
- Total of 227 patients (113 AMPYRA™ and 114 placebo) completed all study visits
- Inclusion and exclusion criteria used in Trial 1 were employed in Trial 2, and in addition patients with severe renal impairment were also excluded

Results[2]:

A significantly greater proportion of patients taking Ampyra™ 10 mg twice daily were responders, compared to patients taking placebo, as measured by the T25FW 51/119 (42.9%) vs. 11/118 (9.3%). The increased response rate in the Ampyra™ group was observed across all four major types of MS disease course.

During the double-blind treatment period, a significantly greater proportion of patients taking Ampyra™ 10 mg twice daily had increases in walking speed of at least 10%, 20%, or 30% from baseline, compared to placebo in both trials

In Trial 1 and Trial 2, consistent improvements in walking speed were shown to be associated with improvements on a patient self-assessment of ambulatory disability, the 12-item Multiple Sclerosis Walking Scale (MSWS-12), for both drug and placebo treated patients. However, a drug-placebo difference was not established for that outcome measure.

Prior Authorization by Other State Medicaid Programs

Wyoming:

- Member must have a gate disorder associated with Multiple Sclerosis
- Member may receive an 8 week trial of Ampyra
- If after 8 week trial, the physician states on PA form that the member has showed improvement or the drug was effective, member may receive authorization for 1 year

Recommendations

The College of Pharmacy recommends prior authorizing Ampyra™ with the following criteria:

- Member must have a diagnosis of Multiple Sclerosis, and
- Kurtzke Expanded Disability Status Scale (EDSS) score between 4 and 7.
- A 12 week trial will be approved. If member has responded well to treatment and physician states that the member has shown improvement or the drug was effective, member may receive authorization for one year

REFERENCE

[1] Goodman AD, Brown TR, Krupp LB, et al. Sustained-release oral fampridine in multiple sclerosis: a randomized, double-blinded, controlled trial. Lancet 2009; 373:732-738

[2] Ampyra(TM) (dalfampridine) Product Information. Acorda Pharmaceuticals. June 10, 2010.

Appendix

Medication Product Details

Indication

Ampyra™ is indicated to improve walking in patients with multiple sclerosis. Improved walking can be demonstrated by an increase in walking speed.

Dosage Forms

10 mg extended release tablets

Contraindications

Ampyra™ is contraindicated in patients with a history of seizures and patients with moderate to severe renal impairment (CrCl ≤50 mL/min). Ampyra™ is also contraindicated in patients with known hypersensitivity to the drug or its ingredients.

Pregnancy Risk Factor C

Precautions

- **seizures**-Increased incidence of seizures has been observed at dalfampridine 20 mg twice daily in controlled clinical studies. Dalfampridine should be discontinued and not restarted in patients who experience a seizure while on treatment
- **urinary tract infections-**UTIs were reported more frequently as adverse reactions in patients receiving dalfampridine 10 mg twice daily compared with placebo.
- **geriatric patients** –Dalfampridine clearance modestly decreased with increasing age, but not sufficiently to necessitate a modification of dose. Because elderly patients are more likely to have decreased renal function, and dalfampridine is substantially renally excreted, elderly are at a higher risk of adverse effects. It is important to know the estimated CrCl in these patients.
- **renal impairment**-mild renal impairment (CrCl 51-80 ml/min) may be associated with increased risk of seizures. If unknown, CrCl should be estimated prior to initiating treatment with dalfampridine.
- **children-**Safety and effectiveness of dalfampridine in patients younger than 18 years of age have not been established
- **4-aminopyridine**-dalfampridine should not be taken with other forms of 4-aminopyridine (fampridine).

Common Adverse Effect

☑ UTI	☑ Insomnia	☑ Asthenia
☑ Dizziness	☑ Somnolence	☑ Nausea

Less Common Adverse effects

☑ Back Pain	☑ MS Relapse	☑ Balance Disorder	☑ Constipation
☑ Paresthesia	☑ Dyspepsia		

Drug Interactions

Ampyra™ does not have any significant drug interactions.

Patient Information

- Ampyra™ should be taken twice a day, approximately 12 hours apart.
- Do not break, crush, chew, or dissolve Ampyra tablets.
- Ampyra™ can be taken with or without food.
- If you miss a dose, do not make up the missed dose and do not take 2 doses at the same time. Take your next dose at the scheduled time.
- Ampyra™ may have the potential to cause seizures. The medication must be discontinued if a seizure occurs.
- Ampyra™ can only be purchased through a specialty pharmacy by following these steps:
    - The physician and patient must complete the enrollment form.
    - The physician's office faxes the completed enrollment form to Ampyra™ Patient Support Services at 1-888-883-3053.
    - An individual from Ampyra™ Patient Support Services confirms the patient's insurance and eligibility for co-pay mitigation and forwards the prescription to a specialty pharmacy.
    - A staff member from the specialty pharmacy contacts the patient to set up delivery of Ampyra™ and will also contact the patient prior to each refill date to coordinate the next shipment.

Kurtzke Expanded Disability Status Scale	
0.0	Normal neurological examination
1.0	No disability, minimal signs in one FS
1.5	No disability, minimal signs in more than one FS
2.0	Minimal disability in one FS
2.5	Mild disability in one FS or minimal disability in two FS
3.0	Moderate disability in one FS, or mild disability in three or four FS. Fully ambulatory
3.5	Fully ambulatory but with moderate disability in one FS and more than minimal disability in several others
4.0	Fully ambulatory without aid, self-sufficient, up and about some 12 hours a day despite relatively severe disability; able to walk without aid or rest some 500 meters
4.5	Fully ambulatory without aid, up and about much of the day, able to work a full day, may otherwise have some limitation of full activity or require minimal assistance; characterized by relatively severe disability; able to walk without aid or rest some 300 meters.
5.0	Ambulatory without aid or rest for about 200 meters; disability severe enough to impair full daily activities (work a full day without special provisions)
5.5	Ambulatory without aid or rest for about 100 meters; disability severe enough to preclude full daily activities
6.0	Intermittent or unilateral constant assistance (cane, crutch, brace) required to walk about 100 meters with or without resting
6.5	Constant bilateral assistance (canes, crutches, braces) required to walk about 20 meters without resting
7.0	Unable to walk beyond approximately five meters even with aid, essentially restricted to wheelchair; wheels self in standard wheelchair and transfers alone; up and about in wheelchair some 12 hours a day
7.5	Unable to take more than a few steps; restricted to wheelchair; may need aid in transfer; wheels self but cannot carry on in standard wheelchair a full day; May require motorized wheelchair
8.0	Essentially restricted to bed or chair or perambulated in wheelchair, but may be out of bed itself much of the day; retains many self-care functions; generally has effective use of arms
8.5	Essentially restricted to bed much of day; has some effective use of arms retains some self care functions
9.0	Confined to bed; can still communicate and eat.
9.5	Totally helpless bed patient; unable to communicate effectively or eat/swallow
10.0	Death due to MS

Appendix E

30 Day Notice to Prior Authorize Qutenza® (capsaicin) 8 % Patch

Oklahoma Health Care Authority, July 2010

Manufacturer NeurogesX, Inc.
Classification TRPV1 Channel Agonist
Status Prescription Only

Product Summary

Qutenza® is a TRPV1 channel agonist with an FDA approved indication for neuropathic pain associated with postherpetic neuralgia (PHN). The transient receptor potential vanilloid 1 receptor (TRPV1) is an ion channel-receptor complex expressed on nociceptive nerve fibers in the skin. Topical administration of capsaicin causes an initial enhanced stimulation of the TRPV1-expressing cutaneous nociceptors that may be associated with painful sensations. This is followed by pain relief thought to be mediated by a reduction in TRPV1-expressing nociceptive nerve endings. Over the course of several months, there may be a gradual re-emergence of painful neuropathy thought to be due to TRPV1 nerve fiber reinnervation of the treated area requiring re-application of the patch.

Qutenza® is applied by a physician, or other health care professional under close physician supervision, and left in place for one hour. Up to four patches may be used per treatment and may be repeated after three months. A topical anesthetic should be applied to the area prior to placing the Qutenza® patch. Cleansing gel is included with the patch to clear any residue once the patch has been removed.

Cost Comparison

Product	EAC (unit)	90 day Supply	Cost per Day
Qutenza® 8% Patch	**$712.80 (1 patch)** **$1,425.60 (2 patches)**	**$712.80 (1 patch)** **$1,425.60 (2 patches)** **$2,851.20 (4 patches)**	**$7.92** **$15.84** **$31.68**
Lidoderm® 5% Patch	**$6.79 (1 patch)**	**$611.10 (1 patch qd)** **$1833.30 (3 patches qd)**	**$6.79** **$20.37**
Lyrica® 300 mg	**$2.38 (1 capsule)**	**$428.40 (1 cap BID)**	**$4.76**
Amitriptyline 25 mg	**$0.10 (1 tablet)**	**$9.00 (1 tablet qd)**	**$0.10**

Recommendations

The College of Pharmacy recommends pharmacy and medical prior authorization of Qutenza® with the following criteria.

1. FDA approved diagnosis (Postherpetic Neuralgia)
2. Provide documented treatment attempts at recommended dosing or contraindication to at least one agent from two of the following drug classes:
    a. Tricyclic antidepressants
    b. Anticonvulsants
    c. Topical or Oral Analgesics
3. Quantity limit of no more than 4 patches per treatment every 90 days.

Product Details

Indication

Qutenza® is a TRPV1 channel agonist indicated for the management of neuropathic pain associated with postherpetic neuralgia (PHN).

Dosage Forms

Qutenza® patch contains 8% capsaicin (640 mcg/cm^2). Each patch contains a total of 179 mg of capsaicin.

Contraindications

There are no contraindications to this medication.

Pregnancy Risk Factor B

Precautions

Eye and Mucous Membrane Exposure

Do not apply Qutenza® to the face or scalp to avoid risk of exposure to the eyes or mucous membranes.

Aerosolization of Capsaican

Inhalation of airborne capsaicin can occur upon rapid removal of Qutenza® patches. This can result in coughing and sneezing. Therefore, remove Qutenza® patches gently and slowly by rolling adhesive side inward.

Increase in Blood Pressure

Transient increases in blood pressure may occur in patients during and shortly after the Qutenza® treatment. These changes averaged less than 10 mm Hg, although some patients had greater increases which lasted for approximately 2 hours after patch removal. Blood pressure should be monitored during and following treatment. Patients with unstable or poorly controlled hypertension or a recent history of cardiovascular or cerebrovascular events may be at an increased risk of adverse cardiovascular effects. These factors should be considered prior to initiating Qutenza® treatment.

Common Adverse Effect

- Nausea
- Hypertension
- Application Site Pain
- Application Site Papules
- Application Site Erythema
- Application Site Pruritis

Less Common Adverse Effects

- Vomiting
- Dry Skin
- Application Site Edema
- Nasopharyngitis
- Headache
- Dizziness
- Abnormal Skin Odor

Drug Interactions

No drug interaction studies have been performed with the use of Qutenza®. However, caution is advised when using the combination of Qutenza® and ACE Inhibitors. The concomitant use of these may cause or exacerbate coughing associated with angiotensin-converting enzyme inhibitor treatment and vice versa. If a severe cough develops in patients, one or both medications may need to be discontinued.

Patient Information

- Exposure of the skin to Qutenza® may result in transient redness and burning. Do not touch the patch. If accidentally touched, burning or stinging may occur.
- If irritation of eyes or airways occurs, or if any of the side effects become severe, notify a healthcare professional immediately.
- The treated area of skin may be sensitive to heat (hot showers/baths, direct sunlight, vigorous exercise) for a few days following treatment.
- As a result of treatment-related pain, small transient increases in blood pressure may occur during and shortly after Qutenza® treatment. Blood pressure should be monitored during and after treatment.

REFERENCE

Qutenza® (capsaicin) Product Information. NeurogesX, Inc. June 21, 2010.

Appendix F

30-day Notice to Prior Authorize Special Formulation Antibiotics

Oklahoma Health Care Authority
July 2010

Moxatag® (amoxicillin)

Manufacturer	MiddleBrook Pharmaceuticals, Inc.
Classification	Antibiotic
Status	Prescription Only

Summary

Moxatag® is an extended-release form of amoxicillin indicated for the treatment of tonsillitis and/or pharyngitis secondary to *Streptococcus pyogenes* in adults and pediatric patients 12 years or older. Moxatag® is available as a 775 mg extended release tablet and is meant to be taken once daily with a meal for 10 days. The extended release tablet is made up of three components, one immediate-release and two delayed-release, all containing amoxicillin. The immediate release component is designed to be released in the stomach, while the delayed-release components are released separately at different points in the gastrointestinal tract, triggered by pH levels at specific regions.

A prospective, double-blind, multicenter, randomized trial of Moxatag® 775 mg once daily for 10 days demonstrated noninferiority to penicillin VK 250 mg 4x/day for 10 days in adult and pediatric patients 12 years of age and older. Moxatag® achieved a clinical cure rate of 91.8% at a test-of-cure visit (Day 14 through 18, or 4 to 8 days post-therapy). This cure rate was comparable to penicillin VK dosed 4x/day (93.5%). The most common drug-related adverse reactions associated with Moxatag® observed in clinical studies were vulvovaginal mycotic infection (2.0%), diarrhea (1.7%), nausea (1.3%), vomiting (0.7%), abdominal pain (0.3%) and headache (1.0%).

The total cost of therapy for 10 days of Moxatag® is approximately $90.35, compared to approximately $12.00 for amoxicillin (#30), or $23.00 for amoxicillin/clavulanate (#20).

Recommendations

The College of Pharmacy recommends prior authorization of Moxatag® with the following criteria:

1. FDA-approved diagnosis of tonsillitis and/or pharyngitis secondary to *Streptococcus pyogenes,* confirmed by clinical testing, in members 12 and older.
2. Must provide a clinical reason why the member cannot take immediate-release forms of amoxicillin or other penicillin medications.

Augmentin XR® (amoxicillin/clavulanate potassium)

Manufacturer	GlaxoSmithKline
Classification	Antibiotic
Status	Prescription Only

Summary

Augmentin XR® is an extended-release form of amoxicillin indicated for the treatment of patients with community-acquired pneumonia or acute bacterial sinusitis due to confirmed or suspected β-lactamase-producing pathogens (i.e. *H. influenza, M. catarrhalis, H. parainfluenzae, K. pneumoniae*, or methicillin-susceptible *S. aureus*) and *S. pneumoniae* with reduced susceptibility to penicillin (i.e. penicillin MICs = 2

mcg/mL, but not indicated if MICs ≥ 4 mcg/mL). Augmentin XR® is supplied as a 1,000/62.5 mg tablet. The recommended dose is 4,000/250 mg daily (2 tablets q12h for 7-10 days).

In a multicenter, double-blind, parallel group, noninferiority study (n=436), twice-daily amoxicillin/clavulanate 2000/125 mg was at least as effective as thrice-daily amoxicillin/clavulanate 875/125 mg for the treatment of community-acquired pneumonia in adults. For the primary efficacy outcome, clinical success rates at test of cure (TOC; day 21 to 28 post-therapy) in the clinical per-protocol population (n=436) were similar between the 2 groups (92.4% and 91.2% for experimental and control groups, respectively; difference, 1.2%; 95% CI, -4.4% to 6.6%). Drug-related adverse events were reported with similar frequency in each treatment group, with diarrhea being the most common adverse event (10.2% in experimental group and 9.9% in control group). Elevations in ALT and AST levels occurred in more patients in experimental group (ALT 4.3% and AST 2.6%) compared with the control group (ALT 0.5% and AST 0.5%).

The total cost of therapy for 10 days of Augmentin XR® (#40) is $149.66, compared to approximately $12.00 for amoxicillin (#30), or $23.00 for amoxicillin/clavulanate (#20).

Recommendations

The College of Pharmacy recommends prior authorization of Augmentin XR® with the following criteria:

1. FDA-approved diagnosis of community-acquired pneumonia or acute bacterial sinusitis due to confirmed or suspected β-lactamase-producing pathogens (i.e. *H. influenza, M. catarrhalis, H. parainfluenzae, K. pneumoniae*, or methicillin-susceptible *S. aureus*) and *S. pneumoniae* with reduced susceptibility to penicillin (i.e. penicillin MICs = 2 mcg/mL, but not indicated if MICs ≥ 4 mcg/mL).
2. Must provide a clinical reason why the member cannot take immediate-release forms of amoxicillin/clavulanate or other penicillin medications.

Oracea® (doxycycline)

Manufacturer	Catalent Pharma Solutions, LLC
Classification	Antibiotic
Status	Prescription Only

Summary

Oracea® is a tetracycline-class antibiotic indicated for the treatment of only inflammatory lesions (papules and pustules) of rosacea in adult patients. Oracea® has not been evaluated for the treatment of the erythematous, telagiectatic, or ocular components of rosacea. Oracea® is supplied as a 40 mg hard gelatin capsule shell filled with two types of doxycycline beads (30 mg immediate release and 10 mg delayed release). Oracea® should not be used to treat microbial infections, and should be used only as indicated.

In a non-inferiority comparison of safety and effectiveness of once daily Oracea® (40 mg extended release capsules) vs. 100 mg doxycycline (in the presence of once-a-day topical metronidazole gel 1%) in the treatment of moderate to severe rosacea (N= 91), Oracea® was found to have equivalent efficacy. In clinical trials, the most common adverse events reported were gastrointestinal upsets, nasopharyngitis/pain, and nasal congestion/sinusitis.

The total cost of therapy for 30 days of Oracea® is $319.62, and for doxycycline 100 mg given twice daily is approximately $10.77.

Recommendations

The College of Pharmacy recommends prior authorization of Oracea® with the following criteria:

1. FDA-approved diagnosis of rosacea with inflammatory lesions in adults 18 and older.
2. Must provide a clinical reason why the member cannot take immediate-release forms of doxycycline.

Doryx® (doxycycline hyclate)

Manufacturer	Mayne Pharma International Pty Ltd
Classification	Antibiotic
Status	Prescription Only

Summary

Doryx® is a tetracycline-class antibiotic indicated for rickettsial infections, sexually transmitted infections, respiratory tract infections, specific bacterial infections, ophthalmic infections, anthrax (including inhalational anthrax post-exposure), alternative treatment for selected infections when penicillin is contraindicated, adjunctive therapy in acute intestinal amebiasis, adjunctive therapy in severe acne, and prophylaxis of malaria. Doryx® is supplied as a delayed-release formulation of 75 mg, 100 mg and 150 mg tablets. The usual adult dose of Doryx® is 200 mg on the first day followed by a maintenance dose of 100 mg/day. In the management of more severe infections, 100 mg every 12 hours is recommended.

The total cost of therapy for 30 days of Doryx® 75 mg is $226.42, 100 mg is $265.70, and 150 mg is $448.41. The cost of therapy for 30 days of doxycycline 100 mg twice daily is approximately $10.77.

Recommendations

The College of Pharmacy recommends prior authorization of Doryx® with the following criteria:

1. FDA-approved diagnosis as listed above.
2. Must provide a clinical reason why the member cannot take immediate-release forms of doxycycline.

Oravig® (miconazole buccal tablets)

Manufacturer	Catalent Germany Shorndorf GmbH
Classification	Azole antifungal
Status	Prescription Only

Summary

Oravig® (miconazole) is an azole antifungal agent indicated for the local treatment of oropharyngeal candidiasis (OPC) in adults. Oravig® is available as a 50 mg buccal tablet which is placed to the gum region once daily for 14 consecutive days. The tablet should be held in place against the gum above the canine fossa until it adheres; the tablet stays in place and gradually dissolves. Subsequent applications of Oravig® should be made to alternate sides of the mouth. Oravig® is contraindicated in patients with a known hypersensitivity to miconazole, milk protein concentrate, or any other component of the product. Allergic reactions, including anaphylactic reactions and hypersensitivity, have been reported with the administration of miconazole.

In a multicenter, randomized, double-blind, double-dummy, comparative trial (n=577), Oravig® demonstrated favorable clinical and mycological cure rates in human immunodeficiency virus-infected patients with OPC. In another multicenter, randomized, open-label trial (n=294), the success rate observed with Oravig® was

noninferior to miconazole oral gel in head and neck cancer patients with OPC. Common adverse events to Oravig in clinical trials were diarrhea (6%), nausea (4.6%), headache (5%), dysgeusia (2.9%), upper abdominal pain (2.5%), and vomiting (2.5%).

Current clinical practice guidelines for the management of candidiasis published by the Infectious Disease Society of America include a section on oropharyngeal candidiasis. The recommendation states that for mild disease, clotrimazole troches at a dosage of 10 mg 5 times daily, nystatin suspension at a concentration of 100,000 U/mL and a dosage of 4-6 mL 4 times daily for 7-14 days is recommended. For moderate to severe disease, oral fluconazole at a dosage of 100-200 mg (3 mg/kg) daily for 7-14 days is recommended.

The total cost of therapy for 14 days of Oravig® is $241.60. In comparison, the cost of 14 days of clotrimazole 10 mg troches (given 5 times daily) is $52.68, fluconazole 100 mg tablets is $6.63, fluconazole 200 mg tablets is $8.98, and nystatin suspension (24 mL/day) is $31.64.

Recommendations

The College of Pharmacy recommends prior authorization of Oravig® with the following criteria:

1. FDA-approved diagnosis of oropharyngeal candidiasis in adults age 18 and older.
2. Recent trials (within the last month) of two of the following medications at recommended dosing and duration of therapy:
    a. Clotrimazole troches
    b. Nystatin suspension
    c. Fluconazole tablets, or
3. Contraindication(s) to all available alternative medications.

Moxatag® Product Information[i]

Indication

Moxatag® is a penicillin-class antibacterial indicated for the treatment of tonsillitis and/or pharyngitis secondary to *Streptococcus pyogenes* in adults and pediatric patients 12 years or older.

Dosage Forms: 775 mg Tablets

Contraindications

Moxatag® is contraindicated in patients with known serious hypersensitivity to amoxicillin or to other drugs in the same class or patients who have demonstrated anaphylactic reactions to beta-lactams.

Pregnancy Risk Factor B

Precautions

- Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. Serious anaphylactic reactions require immediate emergency treatment with epinephrine. Oxygen, intravenous steroids, and airway management, including intubation, should also be administered as indicated.
- *Clostridium difficile* associated diarrhea (ranging from mild diarrhea to fatal colitis): Evaluate if diarrhea occurs.

Special Allergy Precaution

Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy, it has occurred in patients on oral penicillins. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity that have experienced severe reactions when treated with cephalosporins. Before initiating therapy with Moxatag®, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, or other allergens. If an allergic reaction occurs, Moxatag® should be discontinued and appropriate therapy instituted.

Common Adverse Effects

- ☑ Vulvovaginal mycotic infection
- ☑ Diarrhea
- ☑ Nausea
- ☑ Headache

Less Common Adverse effects

- ☑ Vomiting
- ☑ Abdominal pain

Drug Interactions

Probenecid decreases the renal tubular secretion of amoxicillin. Concurrent use of Moxatag® and probenecid may result in increased and prolonged blood levels of amoxicillin. The clinical relevance of this finding has not been evaluated. Chloramphenicol, macrolides, sulfonamides, and tetracyclines may interfere with the bactericidal effects of penicillin. This has been demonstrated *in vitro;* however, the clinical significance of this interaction is not well documented. As with other antibiotics, amoxicillin may affect the gut flora, leading to lower estrogen reabsorption and potentially resulting in reduced efficacy of combined oral estrogen/progesterone contraceptives

Patient Information

- Take Moxatag® exactly as prescribed by your healthcare provider.
- Moxatag® should be taken by mouth within one hour after eating a meal.
- Take Moxatag® around the same time every day for 10 days.
- Moxatag® should not be chewed or crushed.

- Complete the full 10-day course of therapy for effective treatment with Moxatag®.
- Do not skip any doses or stop taking Moxatag® until you finish your prescribed treatment, unless:
  - o You have a serious allergic reaction
  - o Your doctor tells you to stop
- If you miss a dose of Moxatag®, take it as soon as you remember. Do not take more than one Moxatag Tablet a day, even if you miss a dose.
- If you take too much, call your doctor or get medical help immediately.

Augmentin XR® Product Information[ii]

Indication

Augmentin XR® is an extended-release form of amoxicillin indicated for the treatment of patients with community-acquired pneumonia or acute bacterial sinusitis due to confirmed or suspected β-lactamase-producing pathogens (i.e. *H. influenza, M. catarrhalis, H. parainfluenzae, K. pneumoniae*, or methicillin-susceptible *S. aureus*) and *S. pneumoniae* with reduced susceptibility to penicillin (i.e. penicillin MICs = 2 mcg/mL, but not indicated if MICs ≥ 4 mcg/mL)

Dosage Forms: 1000/62.5 mg tablet

Contraindications

- History of allergic reactions to any penicillin
- Previous history of cholestatic jaundice/hepatic dysfunction associated with treatment with amoxicillin/clavulanate potassium
- Severe renal impairment (creatinine clearance < 30 mL/min.) and in
- Hemodialysis patients

Pregnancy Risk Factor B

Precautions

- Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. Serious anaphylactic reactions require immediate emergency treatment with epinephrine. Oxygen, intravenous steroids, and airway management, including intubation, should also be administered as indicated.
- *Clostridium difficile* associated diarrhea (ranging from mild diarrhea to fatal colitis): Evaluate if diarrhea occurs.

Special Allergy Precaution

Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. Although anaphylaxis is more frequent following parenteral therapy, it has occurred in patients on oral penicillins. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens. There have been reports of individuals with a history of penicillin hypersensitivity that have experienced severe reactions when treated with cephalosporins. Before initiating therapy with Augmentin XR®, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, or other allergens. If an allergic reaction occurs, Moxatag should be discontinued and appropriate therapy instituted.

Common Adverse Effects

- ☑ Vulvovaginal mycotic infection
- ☑ Diarrhea
- ☑ Nausea
- ☑ Headache

Less Common Adverse effects

- ☑ Vomiting
- ☑ Abdominal pain

Drug Interactions

Probenecid decreases the renal tubular secretion of amoxicillin. Concurrent use of Augmentin XR® and probenecid may result in increased and prolonged blood levels of amoxicillin. The clinical relevance of this finding has not been evaluated. Chloramphenicol, macrolides, sulfonamides, and tetracyclines may interfere with the bactericidal effects of penicillin. This has been demonstrated *in vitro;* however, the clinical significance of this interaction is not well documented. As with other antibiotics, amoxicillin may affect the gut flora, leading to lower estrogen reabsorption and potentially resulting in reduced efficacy of combined oral estrogen/progesterone contraceptives.

Patient Information

- Take Augmentin XR® exactly as prescribed by your healthcare provider.
- Augmentin XR® should be taken by mouth every 12 hours with a meal or snack.
- Take Augmentin XR® around the same time every day.
- Augmentin XR® should not be chewed or crushed.
- Complete the full 10-day course of therapy for effective treatment with Augmentin XR.
- Do not skip any doses or stop taking Augmentin XR® until you finish your prescribed treatment, unless:
  - o You have a serious allergic reaction
  - o Your doctor tells you to stop
- If diarrhea develops and is severe or lasts more than 2 or 3 days, call your doctor.
- If you miss a dose of Augmentin XR®, take it as soon as you remember, but do not take two doses at the same time,
- If you take too much, call your doctor or get medical help immediately.

Doryx® Product Information[iii]

Indication

Doryx® Delayed-Release Tablets, a tetracycline-class oral antibiotic, is indicated for adjunctive treatment of severe acne.

Dosage Forms: 75, 100, 150 mg Tablets

Contraindications

Doryx® is contraindicated in persons who have shown hypersensitivity to any of the tetracyclines.

Pregnancy Risk Factor D

Precautions

- The use of drugs of the tetracycline-class during tooth development (last half of pregnancy, infancy and childhood to the age of 8 years) may cause permanent discoloration of the teeth (yellow-gray-brown).
- *Clostridium difficile*-associated diarrhea: Evaluate patients if diarrhea occurs.
- Photosensitivity manifested by an exaggerated sunburn reaction has been observed in some individuals taking tetracyclines. Limit sun exposure.
- Overgrowth of non-susceptible organisms, including fungi, may occur. Re-evaluate therapy if superinfection occurs.

Common Adverse Effects

- ☑ Headache
- ☑ Common cold
- ☑ Flu symptoms
- ☑ Toothache
- ☑ Nausea
- ☑ Diarrhea
- ☑ Dyspepsia
- ☑ Photosensitivity

Less Common Adverse effects

- ☑ Muscle pain
- ☑ Gum pain
- ☑ Backache
- ☑ Infection
- ☑ Esophagitis

Drug Interactions

- Patients who are on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
- Avoid coadministration of tetracyclines with penicillin.
- Absorption of tetracyclines is impaired by antacids containing aluminum, calcium, or magnesium, bismuth subsalicylate and iron-containing preparations.
- Concurrent use of tetracycline may render oral contraceptives less effective.
- Barbiturates, carbamazepine and phenytoin decrease the half-life of doxycycline.

Patient Information

- Take this medication by mouth as directed.
- Do not crush or chew the tablets.
- Doxycycline is best taken on an empty stomach with a full glass of water, 1 hour before or 2 hours after meals. Some manufacturers state it can be taken with food or milk if you develop an upset stomach, however doxycycline might be less effective if taken with food or milk (or other products high in calcium).
- Do not lie down for 30 minutes after taking this medication.
- Take this medication 2-3 hours before or after taking any medications containing magnesium, aluminum, calcium, iron, or zinc.
- The dosage is based on your medical condition and response to therapy.
- Take this medication as prescribed for full course of treatment. It is important you not miss any doses and that you take the drug on a regularly scheduled basis. Remember to take at the same time each day until the full prescribed amount is finished, even if symptoms disappear after a few days.

Oracea® Product Information[iv]

Indication

Oracea® is indicated for the treatment of only inflammatory lesions (papules and pustules) of rosacea in adult patients. This formulation of doxycycline has not been evaluated as an antibacterial in the treatment of infections.

Dosage Forms: 40 mg Capsules

Contraindications

Oracea® is contraindicated in persons who have shown hypersensitivity to doxycycline or any of the other tetracyclines.

Pregnancy Risk Factor D

Precautions

- Safety of Oracea® beyond 9 months has not been established.
- As with other antibiotic preparations, use of Oracea® may result in overgrowth of non-susceptible microorganisms, including fungi. If superinfection occurs, Oracea® should be discontinued and appropriate therapy instituted.

- Although not observed in clinical trials with Oracea®, the use of tetracyclines may increase the incidence of vaginal candidiasis.
- Oracea should be used with caution in patients with a history of or predisposition to candidiasis overgrowth.
- Bacterial resistance to tetracyclines may develop in patients using Oracea®. Because of the potential for drug-resistant bacteria to develop during the use of Oracea®, it should be used only as indicated.
- Tetracyclines have been associated with the development of autoimmune syndromes. Symptoms may be manifested by fever, rash, arthralgia, and malaise. In symptomatic patients, liver function tests, ANA, CBC, and other appropriate tests should be performed to evaluate the patients. Use of all tetracycline-class drugs should be discontinued immediately.
- Tetracycline class antibiotics are known to cause hyperpigmentation. Tetracycline therapy may induce hyperpigmentation in many organs, including nails, bone, skin, eyes, thyroid, visceral tissue, oral cavity (teeth, mucosa, alveolar bone), sclerae and heart valves. Skin and oral pigmentation has been reported to occur independently of time or amount of drug administration, whereas other pigmentation has been reported to occur upon prolonged administration. Skin pigmentation includes diffuse pigmentation as well as over sites of scars or injury.
- Bulging fontanels in infants and benign intracranial hypertension in adults have been reported in individuals receiving tetracyclines. These conditions disappeared when the drug was discontinued.

Common Adverse Effects

- ☑ Nasopharyngitis
- ☑ Hypertension
- ☑ Sinusitis
- ☑ Nausea
- ☑ Diarrhea
- ☑ Dyspepsia
- ☑ Stomach Discomfort
- ☑ Photosensitivity

Less Common Adverse effects

- ☑ Sinus Headache
- ☑ Pain
- ☑ Back pain
- ☑ Stomach Discomfort
- ☑ Esophagitis

Drug Interactions

- Because tetracyclines have been shown to depress plasma prothrombin activity, patients who are on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
- Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, it is advisable to avoid giving tetracycline-class drugs in conjunction with penicillin.
- The concurrent use of tetracycline and methoxyflurane has been reported to result in fatal renal toxicity.
- Absorption of tetracyclines is impaired by bismuth subsalicylate, proton pump inhibitors, antacids containing aluminum, calcium or magnesium and iron-containing preparations.
- Doxycycline may interfere with the effectiveness of low dose oral contraceptives. To avoid contraceptive failure, females are advised to use a second form of contraceptive during treatment with doxycycline.
- There have been reports of pseudotumor cerebri (benign intracranial hypertension) associated with the concomitant use of isotretinoin and tetracyclines. Since both oral retinoids, including isotretinoin and acitretin, and the tetracyclines, primarily minocycline, can cause increased intracranial pressure, the concurrent use of an oral retinoid and a tetracycline should be avoided.

Patient Information

- Take Oracea® exactly as prescribed by your doctor. Do not change your dose unless told to do so by your doctor. Taking more than the prescribed dose may increase your chance of having side effects.
- The usual dose of Oracea® is one capsule in the morning.
- Do not take Oracea® with or right after a meal. It may not work as well. If you take Oracea® close to meal times, you should take it at least one hour before your meal or two hours after your meal.

- Take Oracea® with a full glass of water while sitting or standing. To prevent irritation to your throat, do not lay down right after taking Oracea®.
- Do not take Oracea® with or right after taking antacids or products that contain calcium, aluminum, magnesium, or iron. Oracea® may not work as well.
- If you take too much Oracea®, or overdose, stop taking Oracea® and talk to your doctor.
- If you miss a dose of Oracea®, skip that dose and take the next dose at your regular time.
- Do not take Oracea® to treat infections caused by bacteria germs or viruses.
- Your doctor may do blood tests from time to time to check for side effects of Oracea.

Oravig® Product Information[v]

Indication

Oravig® is indicated for the local treatment of oropharyngeal candidiasis (OPC) in adults.

Dosage Forms: 50 mg buccal tablets

Contraindications

Oravig® is contraindicated in patients with known hypersensitivity (e.g., anaphylaxis) to miconazole, milk protein concentrate, or any other component of the product.

Pregnancy Risk Factor C

Precautions

- Allergic reactions, including anaphylactic reactions and hypersensitivity, have been reported with the administration of miconazole products, including Oravig®. Discontinue Oravig® immediately at the first sign of hypersensitivity.
- Monitor patients with a history of hypersensitivity to azole antifungals.
- Oravig is metabolized in the liver. While systemic absorption is limited, Oravig® should be administered with caution in patients who have hepatic impairment.

Common Adverse Effects

- ☑ Diarrhea
- ☑ Nausea
- ☑ Headache
- ☑ Rash/Skin Irritation

Less Common Adverse effects

- ☑ Vomiting
- ☑ Dry Mouth
- ☑ Anemia
- ☑ Fatigue
- ☑ Taste distortion
- ☑ Cough
- ☑ Abdominal Pain
- ☑ Pruritis

Drug Interactions

- Warfarin
  - Concomitant administration of Oravig® and warfarin has resulted in enhancement of anticoagulant effect. Cases of bleeding and bruising following the concomitant use were reported. Prothrombin time, bleeding, and International Normalized Ratio (INR) should all be monitored closely if Oravig is concomitantly administered with warfarin.
- Drugs Metabolized Through CYP2C9 and 3A4
  - Oravig® is a known inhibitor of CYP2C9 and CYP3A4. Although the systemic absorption is minimal and plasma concentrations of miconazole are substantially lower than when given intravenously, the potential for interaction with medications metabolized through 2C9 and 3A4 (such as oral hypoglycemics, phenytoin, or ergot alkaloids) cannot be ruled out.

Patient Information

- Use medication for full treatment time, even if symptoms improve. Notify health care provider if there is no improvement in 2 weeks.
- With topical therapy, if condition worsens or if burning, itching, or redness occurs, discontinue use and notify health care provider.
- Oravig® should not be crushed, chewed, or swallowed.
- Food and drink can be taken normally while Oravig® is in place, but chewing gum should be avoided.
- If Oravig® does not adhere or falls off within the first 6 hours, the same tablet should be repositioned immediately. If the tablet still does not adhere, a new tablet should be placed.
- If Oravig® is swallowed within the first 6 hours, the patient should drink a glass of water and a new tablet should be applied only once.
- If Oravig® falls off or is swallowed after the first 6 hours or more, a new tablet should not be applied until the next regularly scheduled dose.
- Subsequent applications of Oravig® should be made to alternate sides of the gum.

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[i] ***Moxatag® (amoxicillin extended-release)*** Package Insert. MiddleBrook Pharmaceuticals. June, 2008.

[ii] ***Augmentin XR® (amoxicillin/clavulanate potassium extended-release tablets)*** Package Insert. GlaxoSmithKline. September, 2009.

[iii] ***Doryx® (Doxycycline hyclate delayed-release)*** Package Insert. Warner Chilcott Company, LLC. August, 2009.

[iv] **Oracea® (Doxycycline, USP)** Package Insert. Catalent Pharma Solutuions, LLC. May, 2008.

[v] **Oravig® (miconazole buccal tablets)** Package Insert. Catalent Germany Shordorf GmbH. April, 2010.

Appendix G

Annual Review of Byetta® (exenatide) and 30-day Notice to Prior Authorize Victoza® (liraglutide) and Bydureon® (exenatide LAR)

Oklahoma HealthCare Authority
July 2010

Current Prior Authorization Criteria

For exenatide, a step therapy edit detects metformin, sulfonylurea, or thiazolidinedione usage for at least 30 days within the previous 120 days. Members without sulfonylurea, thiazolidinedione or metformin claims within previous 120 days require manual prior authorization.

Authorization is based on the following criteria:

1. Diagnosis of Type 2 Diabetes.
2. Current therapy with metformin, sulfonylurea, thiazolidinediones, or a combination, for at least 90 days within the last 180 days, and have not achieved adequate glycemic control.
3. Clinical exception may be allowed if Byetta® is prescribed by an endocrinologist.

GLP-1 Products	Quantity Limit
Byetta®(exenatide) 5mcg/0.02ml	3.6ml per 90 days
Byetta®(exenatide) 10mcg/0.02ml	7.2ml per 90 days

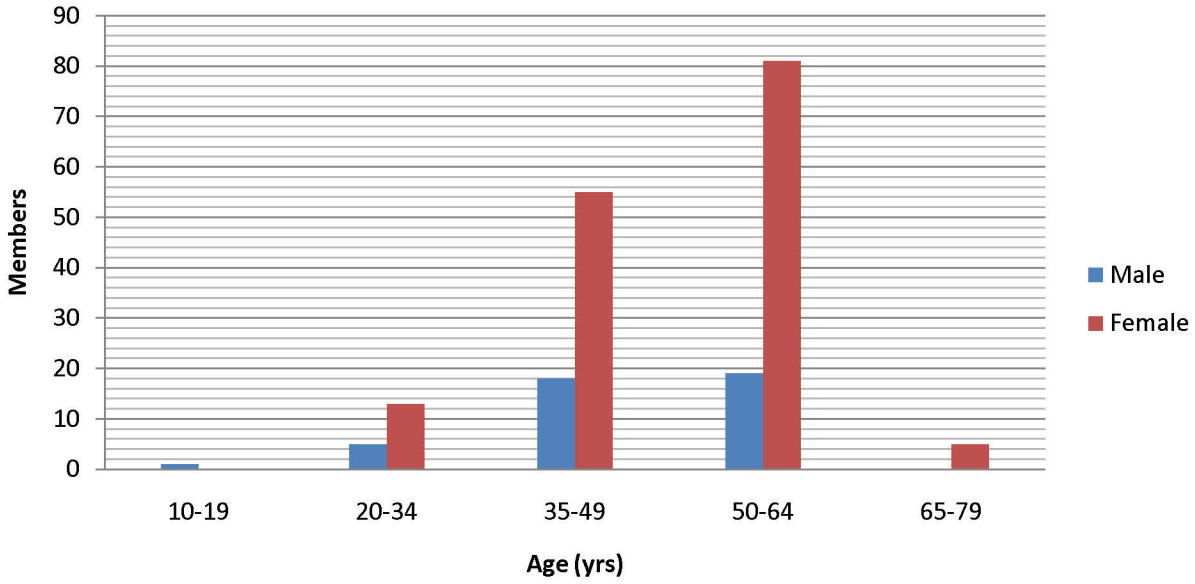
Utilization and Comparison: Byetta® (exenatide) CY 08 vs CY 09

Calendar Year	Total Members	Total Claims	Total Cost	Cost / Claim	Per-Diem	Total Units	Total Days
2008	209	938	$229,848.82	$245.04	$7.39	2,114	31,101
2009	197	820	$231,235.14	$281.99	$8.16	1,926	28,337
% Change	-5.7%	-12.6%	0.6%	15.1%	10.4%	-8.9%	-8.9%
Change	-12	-118	$1,386.32	$36.95	$0.77	-188	-2,764

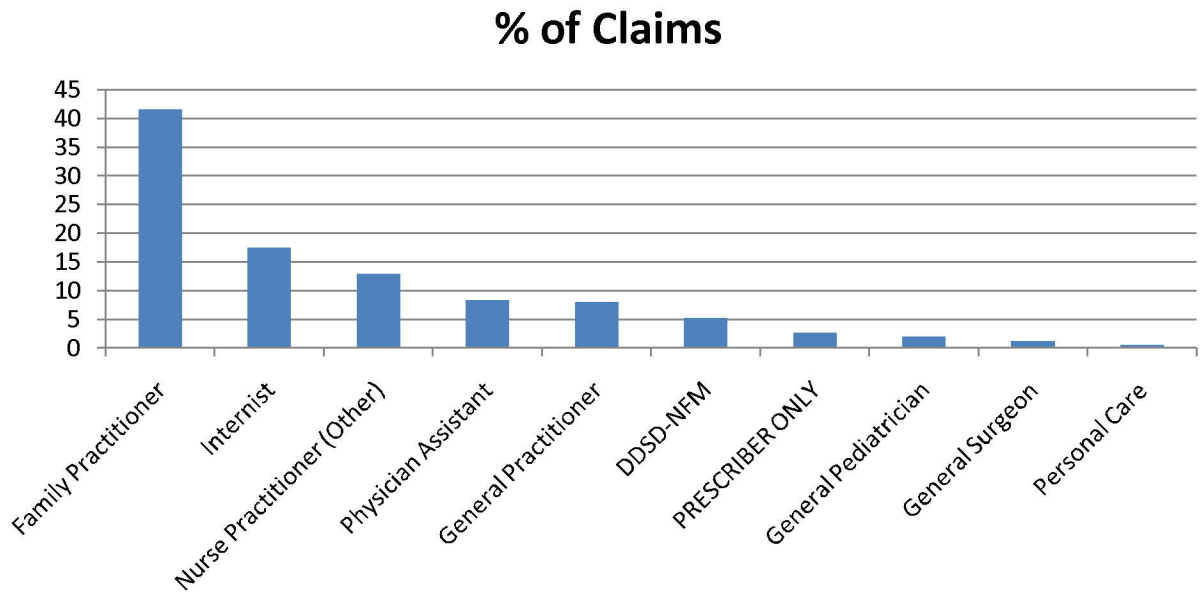
Calendar Year 2009 Utilization Details

CHEMICAL NAME	BRAND NAME	CLAIMS	UNITS	DAYS	MEMBERS	COST	CLAIMS/ MEMBER	COST/ DAY	PERCENT COST
Exenatide	BYETTA INJ 10MCG	586	1,598	20,148	135	$171,786.83	4.34	$8.53	74.29%
Exenatide	BYETTA INJ 5MCG	234	327	8,189	98	$59,448.31	2.39	$7.26	25.71%
	Totals	820	1,925	28,337		$231,235.14	4.16	$8.16	100.00

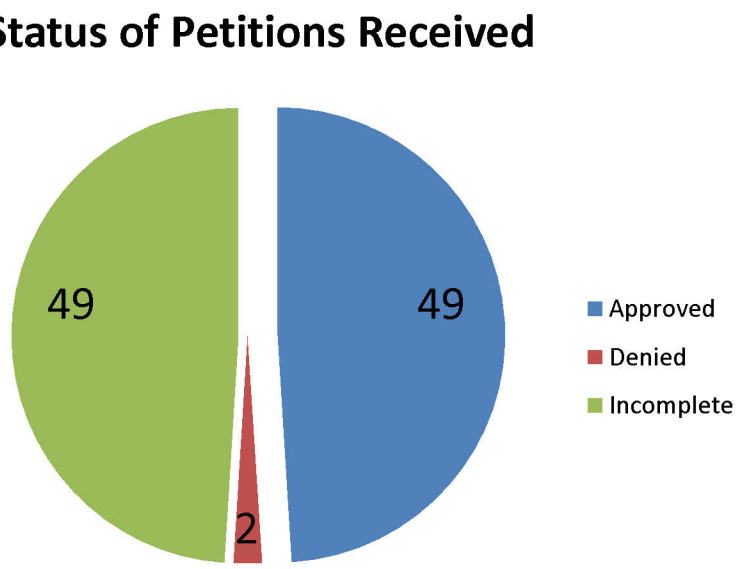
Age and Gender CY 2009



Prescriber Specialty CY 2009



Prior Authorization Totals



Market Update

Victoza® (liraglutide) was approved by the FDA in January 2010 for Type 2 Diabetes. Victoza® is dosed once daily.

Bydureon® (exenatide LAR) is a once-weekly dosing product. Its approval has been delayed due to need for additional product labeling regarding risk evaluation and mitigation strategy and product manufacturing processes. The anticipated FDA action date is October 2010.

DURATION-4 is a 26-week double-blind study comparing monotherapy Bydureon® (exenatide) versus other oral anti-diabetic medications to achieve lower HgA1c. Preliminary results revealed slightly higher percent reduction in HgA1c with the Bydureon® group. A recent study published in *The Lancet* reveals preliminary results of a 26-week clinical study comparing Lantus and Bydureon® with slightly better outcomes in drop in HgA1c and weight loss in the Bydureon® group. However, there was a higher dropout rate due to adverse effects with the Bydureon® group, and study patients were also on concomitant oral anti-diabetic therapy.

Taspoglutide is an investigational GLP-1 analog by Roche. Its development is currently delayed due to safety issues.

Cost Comparison of Available Products

Product[#]	AWP/ Unit	EAC / Unit	Monthly Cost*
Victoza®(liraglutide)6mg/1ml	$48.16	42.38	$254.28
Byetta®(exenatide)10mcg/0.04ml	$120.40	$105.95	$254.28
*max dose 1.8mg/day Victoza®(liraglutide); max dose 20 mcg/day Byetta®(exenatide) # Victoza®(liraglutide) 3 pen pack (9ml), Byetta®(exenatide) 10mcg Pen (2.4ml)			

Recommendations

The College of Pharmacy recommends prior authorization of Victoza® (liraglutide) and Bydureon® (exenatide long-acting) when it becomes available. Approval would be based on prior authorization criteria similar to that required for Byetta® (exenatide).

Approval will be based on the following criteria:

1. Patients must have a diagnosis of Type 2 diabetes and current therapy of metformin, sulfonylurea, thiazolidinediones, DPP-IV Inhibitors, or a combination, for at least 90 days within the last 180 days, and have not achieved adequate glycemic control.
2. Clinical exception may be allowed if prescribed by an endocrinologist.

REFERENCES

1. Product Information Byetta® (exenatide) Package Insert.
2. Product Information Victoza® (liraglutide) Package Insert.

VICTOZA® (LIRAGLUTIDE) PRODUCT INFORMATION

Manufacturer	Novo Nordisk
Classification	Glucagon-Like Peptide-1 (GLP-1)
Status	Prescription Only

Dosage Forms: 6mg/ml (3ml) multidose pen that delivers 0.6mg, 1.2mg or 1.8mg dose

Dosing and Administration:

- Initial dose is intended to reduce well recognized GI symptoms with GLP-1 analogs; does not provide effective glycemic control. The starting dose is 0.6mg/day for 1 week
- Maintenance dose may increase to 1.2mg/day or further to 1.8mg/day
- No dosing adjustment recommended for geriatric patients or patients with renal or hepatic impairement
- Use only if clear, colorless and free of particulate
- Administered via subcutaneous injection in upper arm, thigh or abdomen.
- Store away from excessive heat and light in refrigerator or at room temperature
- Pen should be discarded after 30 days
- Take other oral medications one hour before administering this medication.

Contraindications:

- History of medullary thyroid carcinoma (MTC)
- History of multiple endocrine neoplasia syndrome type 2 (MEN2)

Warning:

- [U.S. Boxed Warning] Dose- and duration- dependent thyroid C-cell tumors have developed in animal studies with liraglutide therapy; relevance in humans unknown.
- GI symptoms: Most common reactions are gastrointestinal related; these symptoms may be dose-related and may decrease in frequency/severity with gradual titration and continued use.
- Pancreatitis: Cases of acute pancreatitis (including one case of fatal necrotizing pancreatitis) have been reported; monitor for unexplained severe abdominal pain, and if pancreatitis is suspected, discontinue use. Don't resume unless alternative etiology of pancreatitis is confirmed. Caution in patients with a history of pancreatitis, cholelithiasis, and/or alcohol abuse.
- Weight loss: Use may be associated with weight loss (likely due to reduced intake) independent of the change in hemoglobin A1c.
- Insulin secretagogues: Concomitant use of an insulin secretagogue (eg, sulfonylurea, meglitinide) may increase the risk of hypoglycemia; dosage reduction of secretagogues may be required during initiation of liraglutide.
- Oral medications: Due to its effects on gastric emptying, liraglutide may reduce the rate and extent of absorption of orally-administered drugs; use with caution in patients receiving medications with a narrow therapeutic window or require rapid absorption from the GI tract. Administer medications 1 hour prior to the use of liraglutide when optimal drug absorption and peak levels are important to the overall therapeutic effect (eg, antibiotics, oral contraceptives).

Pregnancy Risk Factor: C

Adverse Reactions:

- Most common: nausea, diarrhea, vomiting, headache, dizziness, constipation, urinary tract infection, upper respiratory infection, anti-liraglutide antibodies.

Drug Interactions:

- Sulfonylureas: GLP-1 Agonists may enhance the hypoglycemic effect of Sulfonylureas. Management: Consider sulfonylurea dose reductions when used in combination with GLP-1 agonists. Risk D: Consider therapy modification
- Somatropin: May diminish the hypoglycemic effect of Antidiabetic Agents. Risk D: Consider therapy modification
- Corticosteroids: May diminish the hypoglycemic effect of Antidiabetic Agents. In some instances, corticosteroid-mediated HPA axis suppression has led to episodes of acute adrenal crisis, which may manifest as enhanced hypoglycemia, particularly in the setting of insulin or other antidiabetic agent use. Risk C: Monitor
- Luteinizing Hormone-Releasing Hormone Analogs: May diminish the therapeutic effect of Antidiabetic Agents. Risk C: Monitor
- Pegvisomant: May enhance the hypoglycemic effect of Antidiabetic Agents. Risk C: Monitor
- Thiazide Diuretics: May diminish the therapeutic effect of Antidiabetic Agents. Risk C: Monitor

Pharmacokinetics:

- Volume of Distribution: 13 L
- Protein Binding: >98%
- Bioavailability: ~55%
- Half-life: ~13 hours
- Cp Max: 8-12 hours
- Excretion: Urine 6%; feces 5%

REFERENCES

Lexicomp Online. Accessed June 2010. http://online.lexi.com/crlsql/servlet/crlonline?siteid=721.

Appendix H

30-Day Notice to PA Anticonvulsant Drugs under the Scope/Utilization PA Program
Oklahoma HealthCare Authority
July 2010

Current Anticonvulsant Policies

The anticonvulsant/antiepileptic category of medications is currently available to members without restriction or limitation. Unlike most therapeutic categories, members are not required to take the generic form of medications, and there is no upper limit as to the quantity that can be dispensed. Members are not required to use immediate release or tablet formulations before receiving extended-release, oral disintegrating tablets, or sprinkle formulations. A utilization review of this category suggests changes to this policy could provide cost-effective therapy.

Generic Utilization

Many products in this category have recently become available in generic formulations. Divalproex sodium (Depakote®) entered the market in 2008, and in 2009 generic versions of Lamictal®, Topamax®, and Keppra® became available. All of these generics are AB rated and available as multi-source products. Current OHCA rules mandate generic substitution of all drugs that are available from three or more manufacturers and subject to pricing under the Federal Upper Limit or the State Maximum Allowable Cost program.

A limited number of drugs are considered to be Narrow Therapeutic Index (NTI) drugs and are exempt from the general rule of mandatory generic substitution. Currently, all anticonvulsants are included as NTI drugs.

Special Dosage Formulations

Another issue to consider is the use of non-standard packaging and/or formulations. Several medication categories include restrictions for multiple daily dosing of extended-release formulations, prior authorization for special packaging, and prior authorization for non-standard dose forms (e.g., orally dissolving tablets, sublingual sprays, liquids, and trans-dermal delivery systems). Generally, the prescriber is required to give a clinical rationale for the use of these non-standard products, with an explanation as to why the member cannot use the standard dosage form. OHCA currently has a general policy permitting prior authorization of non-standard dosage forms.

This category of medication includes products available as standard tablets as well as orally dissolving tablets, special packaging, extended release formulations, and other non-standard items that should be reviewed for inclusion in the prior authorization program.

Quantity Limits

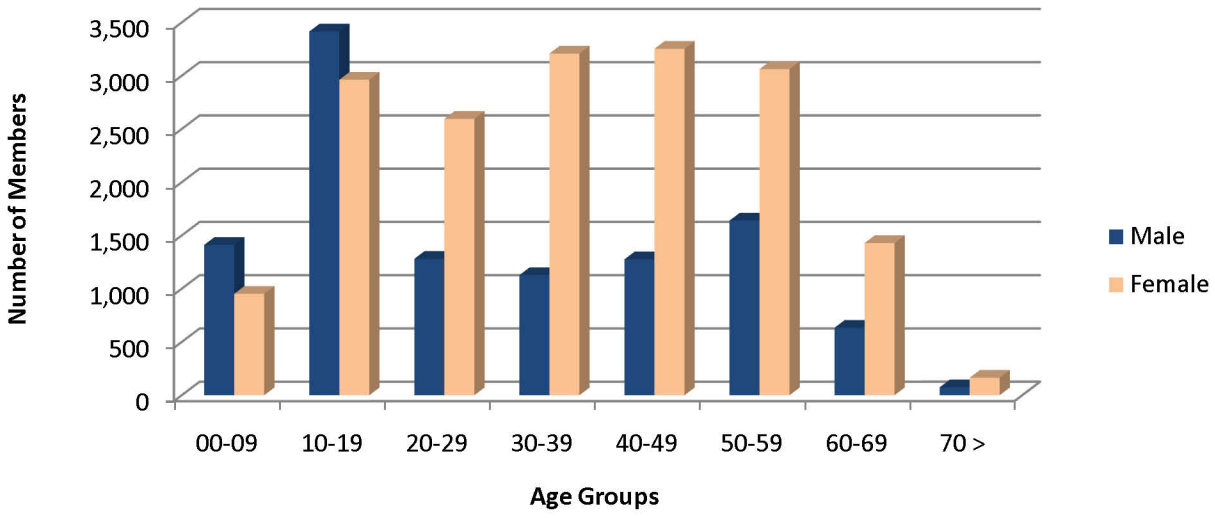
Finally, the issue of quantity limits should be reviewed. For this category, it is accepted that there are very often no dosage limits imposed in treating certain conditions, such as seizures. However, dosing can be optimized by achieving the desired daily dose in as few tablets as possible, relieving patient pill burden and reducing waste.

Utilization of Anticonvulsants

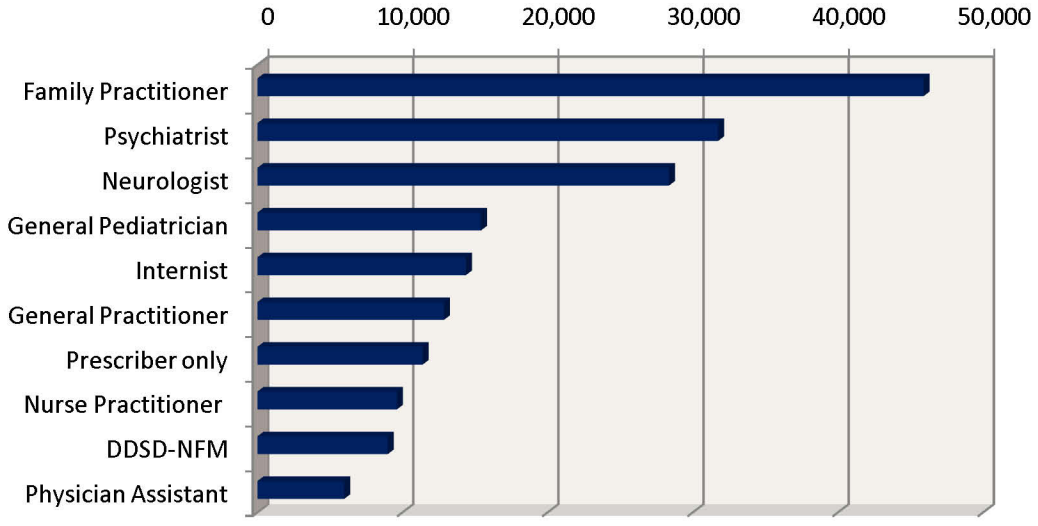
Comparison of Fiscal Years

Fiscal Years	Total Members	Total Claims	Total Cost	Cost per Claim	Per-Diem	Total Units	Total Days
2008	26,606	199,360	$27,133,754.21	$136.10	$4.52	22,378,624	6,005,057
2009	28,470	200,831	$16,942,390.07	$84.36	$2.81	22,063,464	6,025,391
Percent Change	7.00%	0.70%	-37.60%	-38.00%	-37.80%	-1.40%	0.30%
Change	1,864	1,471	($10,191,364.14)	($51.74)	($1.71)	-315,160	20,334

Demographics of Members Utilizing Anticonvulsants: CY 2009



Top Ten Prescriber Specialties of Anticonvulsants by Number of Claims: CY 2009



Brand/Generic

Based on figures from 2009, OHCA could potentially save an estimated $1.5 million simply by implementing a mandatory generic plan. All generic medications in this category are safe, effective, AB-equivalent formulations with good therapeutic efficacy.

Special Dosage Forms

The following chart provides just a few examples of how allowing open access to all dosage forms has led to increased use of resources.

Member*	**Special dosage form**	**Cost of special dosage form**	**Cost of equivalent regular dosage form**	**Savings**
Female, age 18	Lamictal ODT 200mg #30/30 days	$183.44	$5.94	$177.50
Male, age 19	Lamictal ODT 100mg #30/30 days	$153.74	$5.25	$148.49
Female, age 41	Lamictal ODT 200mg #30/30 days	$183.44	$5.94	$177.50
Female, age 38	Lamictal XR 50mg #120/30 days	$1,076.77	$5.94	$1070.83
Female, age 38	Lamictal XR 100mg #60/30 days	$576.68	$5.94	$570.74
Male, age 34	Topiramate 25mg sprinkle #450/30 days	$158.45	$17.72	$140.73
Male, age 25	Topamax 25mg sprinkle #180/30 days	$493.44	$9.02	$484.42
Male, age 25	Divalproex sodium 125mg sprinkle #300/30 days	$172.53	$15.92	$156.61
	Totals:	**$2,998.49**	**$71.67**	**30 days- $2,913.53**
				12 months- $34,962.36

*note: all members were screened for the presence of other regular oral medications in their profiles

Quantity Limits

Again, many examples exist in this category of potential savings.

Member	**High quantity medication**	**Cost of high quantity**	**Cost of same dose, lower quantity**	**Savings**
Female, age 2	Lamictal® 5mg chewable tablet #270/30 days	$1,162.84	$55.69	$1,107.15
Female, age 4	Lamictal® 5mg chewable tablet #300/30 days	$1,292.04	$22.81	$1,269.23
Female, age 20	Lamictal® 25mg #120/30 days	$565.31	$5.25	$560.06
Male, age 38	Topamax® 50mg #180/30 days	$984.80	$15.82	$968.98
Male, age 25	Topamax® 25mg #180/30 days	$493.44	$6.65	$486.79
	Totals:	**$4,498.43**	**$106.22**	**30 days- $4,392.21**
				12 months- $52,706.52

Recommendations

The College of Pharmacy recommends the following:

1. Inclusion of the Anticonvulsants medications in the current mandatory generic plan.
2. Prior authorization of certain non-standard dosage forms when the drug is available in standard dosage forms.
    a. Members 12 and older must have a documented medical reason demonstrating need for non-standard dosage forms.
    b. Criteria for approval of extended-release formulations:
        i. Previously stabilized on the short-acting formulation
        ii. Dosing is not more than once daily
    c. Dosepacks will not be approved if standard dosage forms are available.
3. Placement of Quantity Limit restrictions on lower strength tablets and capsules. The highest strengths will continue to have no quantity restrictions.

Utilization Details of Medication or Class: Calendar Year 2009

BRAND NAME	CLAIMS	UNITS	DAYS	MEMBERS	PAID	UNITS/ DAY	CLAIMS/ MEMBER	PER DIEM
MEBARAL TAB 32MG	45	4,605	1,350	4	$3,841.47	3.41	11.25	$2.85
MEBARAL TAB 50MG	54	4,476	1,659	6	$4,785.51	2.7	9	$2.88
MEPHOBARB TAB 50MG	5	450	150	1	$302.55	3	5	$2.02
MEBARAL TAB 100MG	29	2,550	870	3	$4,048.28	2.93	9.67	$4.65
MEPHOBARB TAB 100MG	1	90	30	1	$80.37	3	1	$2.68
PHENOBARB TAB 15MG	408	35,631	11,272	63	$1,815.02	3.16	6.48	$0.16
PHENOBARB TAB 16.2MG	249	22,961	7,517	34	$1,465.23	3.05	7.32	$0.19
PHENOBARB TAB 30MG	2,330	212,729	69,722	316	$12,869.85	3.05	7.37	$0.18
PHENOBARB TAB 32.4MG	1,584	139,311	47,275	208	$8,683.31	2.95	7.62	$0.18
PHENOBARB TAB 60MG	1,200	79,560	36,381	159	$7,106.40	2.19	7.55	$0.20
PHENOBARB TAB 64.8MG	2,177	148,411	68,228	278	$13,208.32	2.18	7.83	$0.19
PHENOBARB TAB 97.2MG	781	38,483	25,203	111	$5,152.41	1.53	7.04	$0.20
PHENOBARB TAB 100MG	382	20,972	12,188	59	$2,574.06	1.72	6.47	$0.21
PHENOBARB ELX 20MG/5ML	2,742	1,384,169	70,326	395	$37,037.03	19.68	6.94	$0.53
PHENOBARB INJ 65MG/ML	1	25	8	1	$41.55	3.13	1	$5.19
Category Totals:	**11,988**	**2,094,423**	**352,179**	**1,639**	**$103,011.36**	**5.95**	**7.31**	**$0.29**
FELBATOL TAB 400MG	116	14,415	3,480	15	$31,588.22	4.14	7.73	$9.08
FELBATOL TAB 600MG	267	32,365	8,002	31	$76,124.67	4.04	8.61	$9.51
FELBATOL SUS 600/5ML	190	80,433	5,611	20	$90,912.20	14.33	9.5	$16.20
Category Totals:	**573**	**127,213**	**17,093**	**66**	**$198,625.09**	**7.44**	**8.68**	**$11.62**
FOSPHENYTOIN INJ 100/2ML	10	130	13	5	$138.74	10	2	$10.67
DILANTIN CHW 50MG	963	107,058	28,835	155	$43,294.46	3.71	6.21	$1.50
PHENYTOIN SUS 125/5ML	873	283,235	21,035	132	$36,320.59	13.46	6.61	$1.73
DILANTIN-125 SUS 125/5ML	86	33,052	1,887	11	$7,145.17	17.52	7.82	$3.79
PHENYTOIN SUS 100/4ML	54	5,636	710	3	$994.61	7.94	18	$1.40
PHENYTOIN INJ 50MG/ML	1	10	1	1	$9.43	10	1	$9.43
DILANTIN CAP 30MG	133	9,163	4,426	24	$3,607.19	2.07	5.54	$0.82
PHENYTOIN EX CAP 100MG	9,355	1,070,423	277,724	1,646	$304,230.90	3.85	5.68	$1.10
DILANTIN CAP 100MG	2,150	259,847	64,002	367	$108,989.97	4.06	5.86	$1.70
PHENYTEK CAP 200MG	134	8,301	4,024	26	$6,440.48	2.06	5.15	$1.60
PHENYTEK CAP 300MG	123	5,053	3,881	32	$5,762.44	1.3	3.84	$1.48
Category Totals:	**13,882**	**1,781,908**	**406,538**	**2,402**	**$516,933.98**	**4.38**	**5.78**	**$1.27**
ETHOSUXIMIDE CAP 250MG	364	33,085	11,052	65	$34,915.94	2.99	5.6	$3.16
ZARONTIN CAP 250MG	39	4,020	1,175	7	$5,542.09	3.42	5.57	$4.72
ETHOSUXIMIDE SOL 250/5ML	354	112,891	10,028	55	$8,130.35	11.26	6.44	$0.81
CELONTIN CAP 300MG	66	5,744	2,102	9	$7,584.82	2.73	7.33	$3.61
Category Totals:	**823**	**155,748**	**24,357**	**136**	**$56,173.20**	**6.39**	**6.05**	**$2.31**
DIVALPROEX TAB 125MG DR	1,273	109,964	38,302	310	$23,990.79	2.87	4.11	$0.63
DEPAKOTE TAB 125MG DR	156	14,540	4,510	55	$13,751.30	3.22	2.84	$3.05
DIVALPROEX TAB 250MG DR	6,035	503,013	182,071	1,526	$112,114.79	2.76	3.95	$0.62

BRAND NAME	CLAIMS	UNITS	DAYS	MEMBERS	PAID	UNITS/ DAY	CLAIMS/ MEMBER	PER DIEM
DEPAKOTE TAB 250MG DR	739	74,308	22,469	213	$132,507.28	3.31	3.47	$5.90
DIVALPROEX TAB 500MG DR	7,128	558,950	220,695	1,474	$164,567.96	2.53	4.84	$0.75
DEPAKOTE TAB 500MG DR	454	41,696	13,981	132	$137,762.31	2.98	3.44	$9.85
DIVALPROEX CAP 125MG	2,551	444,604	74,151	482	$260,553.23	6	5.29	$3.51
DEPAKOTE SPR CAP 125MG	1,466	250,979	42,469	395	$215,795.92	5.91	3.71	$5.08
DIVALPROEX TAB 250MG ER	2,030	121,225	60,804	614	$122,515.68	1.99	3.31	$2.01
DEPAKOTE ER TAB 250MG	1,245	80,032	36,910	417	$130,429.05	2.17	2.99	$3.53
DIVALPROEX ER 250MG TAB	95	5,689	2,776	60	$3,443.41	2.05	1.58	$1.24
DIVALPROEX TAB 500MG ER	5,993	415,637	181,710	1,396	$715,758.53	2.29	4.29	$3.94
DEPAKOTE ER TAB 500MG	2,550	181,757	76,728	924	$517,255.49	2.37	2.76	$6.74
VALPROIC ACD SYP 250/5ML	2,221	1,187,734	60,611	316	$38,247.74	19.6	7.03	$0.63
VALPROIC ACD SYP 250/5ML	48	23,803	1,223	14	$796.72	19.46	3.43	$0.65
DEPAKENE SYP 250/5ML	35	18,750	1,046	5	$9,313.02	17.93	7	$8.90
DEPACON INJ 100MG/ML	5	1,350	150	1	$4,170.09	9	5	$27.80
VALPROATE INJ 100 MG/M	4	1,120	136	1	$1,668.48	8.24	4	$12.27
VALPROATE INJ 100MG/ML	2	475	60	2	$1,026.37	7.92	1	$17.11
VALPROIC ACD CAP 250MG	2,256	293,360	67,375	497	$83,828.51	4.35	4.54	$1.24
STAVZOR CAP 125MG	7	480	210	3	$456.43	2.29	2.33	$2.17
STAVZOR CAP 250MG	21	1,340	755	7	$2,503.79	1.77	3	$3.32
STAVZOR CAP 500MG	37	2,800	1,113	15	$9,320.10	2.52	2.47	$8.37
Category Totals:	**36,351**	**4,333,606**	**1,090,255**	**8,859**	**$2,701,776.20**	**3.97**	**4.10**	**$2.48**
CARBAMAZEPIN TAB 200MG	5,486	548,229	166,291	997	$81,662.88	3.3	5.5	$0.49
EPITOL TAB 200MG	862	85,167	26,271	227	$4,897.95	3.24	3.8	$0.19
TEGRETOL TAB 200MG	258	31,590	7,954	44	$25,280.40	3.97	5.86	$3.18
CARBAMAZEPIN CHW 100MG	1,664	208,629	49,703	351	$37,468.00	4.2	4.74	$0.75
TEGRETOL CHW 100MG	123	17,956	3,661	16	$8,344.13	4.9	7.69	$2.28
CARBAMAZEPIN SUS 100/5ML	638	408,895	17,051	93	$36,798.48	23.98	6.86	$2.16
TEGRETOL SUS 100/5ML	167	180,921	4,856	20	$23,207.42	37.26	8.35	$4.78
CARBATROL CAP 100MG	112	8,792	3,345	21	$12,444.96	2.63	5.33	$3.72
CARBATROL CAP 200MG	736	77,155	22,145	101	$105,251.28	3.48	7.29	$4.75
CARBATROL CAP 300MG	726	59,981	22,203	101	$84,023.15	2.7	7.19	$3.78
TEGRETOL XR TAB 100MG	364	37,054	11,120	68	$16,310.31	3.33	5.35	$1.47
TEGRETOL XR TAB 200MG	896	98,012	27,628	157	$88,103.65	3.55	5.71	$3.19
CARBAMAZEPIN TAB 200MG ER	292	27,309	9,050	97	$23,690.20	3.02	3.01	$2.62
TEGRETOL XR TAB 400MG	647	45,737	19,997	100	$82,041.79	2.29	6.47	$4.10
CARBAMAZEPIN TAB 400MG ER	173	11,660	5,262	46	$20,285.98	2.22	3.76	$3.86
Category Totals:	**13,144**	**1,847,087**	**396,537**	**2,439**	**$649,730.08**	**4.66**	**5.39**	**$1.64**
GABAPENTIN CAP 100MG	4,040	363,640	118,216	1,484	$42,911.62	3.08	2.72	$0.36
GABAPENTIN CAP 300MG	15,730	1,428,460	477,434	4,782	$193,927.02	2.99	3.29	$0.41
NEURONTIN CAP 300MG	20	3,760	618	2	$6,186.29	6.08	10	$10.01
GABAPENTIN CAP 400MG	2,481	262,690	73,735	589	$39,172.96	3.56	4.21	$0.53

BRAND NAME	CLAIMS	UNITS	DAYS	MEMBERS	PAID	UNITS/ DAY	CLAIMS/ MEMBER	PER DIEM
GABAPENTIN TAB 100MG	1	120	30	1	$19.64	4	1	$0.65
GABAPENTIN TAB 400MG	7	1,941	125	4	$227.87	15.53	1.75	$1.82
GABAPENTIN TAB 600MG	6,296	583,990	194,591	1,549	$189,865.31	3	4.06	$0.98
NEURONTIN TAB 600MG	6	440	220	1	$1,470.10	2	6	$6.68
GABAPENTIN TAB 800MG	2,282	218,707	68,711	475	$73,932.07	3.18	4.8	$1.08
NEURONTIN TAB 800MG	30	4,440	900	3	$17,645.71	4.93	10	$19.61
NEURONTIN SOL 250/5ML	289	155,959	8,416	58	$41,642.87	18.53	4.98	$4.95
Category Totals:	**31,182**	**3,024,147**	**942,996**	**8,948**	**$607,001.46**	**3.21**	**3.48**	**$0.64**
VIMPAT TAB 50MG	155	17,367	4,440	57	$60,833.24	3.91	2.72	$13.70
VIMPAT TAB 100MG	139	9,721	4,107	51	$55,295.47	2.37	2.73	$13.46
VIMPAT TAB 150MG	26	1,560	780	8	$10,090.20	2	3.25	$12.94
VIMPAT TAB 200MG	22	1,350	660	11	$7,878.41	2.05	2	$11.94
Category Totals:	**342**	**29,998**	**9,987**	**127**	**$134,097.32**	**3.00**	**2.69**	**$13.43**
LAMOTRIGINE TAB 25MG	3,243	272,298	96,553	1,149	$203,252.21	2.82	2.82	$2.11
LAMICTAL TAB 25MG	259	25,451	7,318	103	$111,023.47	3.48	2.51	$15.17
LAMOTRIGINE TAB 100MG	5,886	350,773	184,494	1,465	$297,624.56	1.9	4.02	$1.61
LAMICTAL TAB 100MG	619	52,251	18,506	165	$262,782.07	2.82	3.75	$14.20
LAMOTRIGINE TAB 150MG	1,943	103,746	58,414	427	$87,246.07	1.78	4.55	$1.49
LAMICTAL TAB 150MG	232	15,133	6,976	57	$77,870.50	2.17	4.07	$11.16
LAMOTRIGINE TAB 200MG	5,010	260,659	160,035	1,035	$231,197.31	1.63	4.84	$1.44
LAMICTAL TAB 200MG	629	38,268	20,058	139	$226,289.98	1.91	4.53	$11.28
LAMICTAL KIT START 35	23	805	594	21	$3,631.26	1.36	1.1	$6.11
LAMICTAL KIT START 49	486	23,750	13,965	455	$111,801.01	1.7	1.07	$8.01
LAMOTRIGINE KIT START 49	1	49	35	1	$184.79	1.4	1	$5.28
LAMICTAL KIT START 98	17	1,666	518	17	$7,422.23	3.22	1	$14.33
LAMICTAL ODT KIT	11	308	253	11	$1,595.19	1.22	1	$6.31
LAMICTAL ODT KIT	2	112	52	2	$938.92	2.15	1	$18.06
LAMICTAL ODT KIT	67	5,852	1,792	63	$15,479.97	3.27	1.06	$8.64
LAMICTAL XR KIT	1	35	35	1	$237.82	1	1	$6.79
LAMOTRIGINE CHW 5MG	340	45,092	9,774	96	$30,826.12	4.61	3.54	$3.15
LAMICTAL CHW 5MG	29	5,219	877	12	$22,014.80	5.95	2.42	$25.10
LAMOTRIGINE CHW 25MG	744	86,510	22,345	174	$64,336.93	3.87	4.28	$2.88
LAMICTAL CHW 25MG	66	14,324	1,893	16	$68,135.14	7.57	4.13	$35.99
LAMICTAL ODT TAB 25MG	22	1,665	657	11	$4,744.31	2.53	2	$7.22
LAMICTAL ODT TAB 50MG	12	450	360	9	$2,218.50	1.25	1.33	$6.16
LAMICTAL ODT TAB 100MG	57	2,340	1,710	33	$9,378.53	1.37	1.73	$5.48
LAMICTAL ODT TAB 200MG	32	1,080	910	24	$6,084.03	1.19	1.33	$6.69
LAMICTAL XR TAB 25MG	4	210	146	2	$981.23	1.44	2	$6.72
LAMICTAL XR TAB 50MG	8	224	224	3	$2,054.37	1	2.67	$9.17
LAMICTAL XR TAB 100MG	15	814	454	8	$7,730.29	1.79	1.88	$17.03
LAMICTAL XR TAB 200MG	51	2,760	1,530	17	$28,483.39	1.8	3	$18.62

BRAND NAME	CLAIMS	UNITS	DAYS	MEMBERS	PAID	UNITS/ DAY	CLAIMS/ MEMBER	PER DIEM
LEVETIRACETA TAB 250MG	1,078	84,902	31,952	271	$44,696.77	2.66	3.98	$1.40
Category Totals:	**20,887**	**1,396,746**	**642,410**	**5,787**	**$1,930,260.70**	**2.17**	**3.61**	**$3.00**
KEPPRA TAB 250MG	311	24,009	8,949	78	$69,375.47	2.68	3.99	$7.75
LEVETIRACETA TAB 500MG	5,320	473,031	158,104	1,082	$300,513.32	2.99	4.92	$1.90
KEPPRA TAB 500MG	947	92,581	28,406	238	$311,916.54	3.26	3.98	$10.98
LEVETIRACETA TAB 750MG	1,484	121,864	43,599	262	$96,467.88	2.8	5.66	$2.21
KEPPRA TAB 750MG	235	21,815	6,705	61	$103,186.64	3.25	3.85	$15.39
LEVETIRACETA TAB 1000MG	1,181	87,059	34,032	205	$90,096.62	2.56	5.76	$2.65
KEPPRA TAB 1000MG	369	30,092	11,043	133	$210,368.08	2.72	2.77	$19.05
LEVETIRACETA SOL 100MG/ML	3,324	985,940	95,644	591	$158,317.18	10.31	5.62	$1.66
KEPPRA SOL 100MG/ML	1,836	512,233	52,939	492	$343,240.32	9.68	3.73	$6.48
LEVETIRACETA SOL 500/5ML	3	480	64	2	$77.02	7.5	1.5	$1.20
KEPPRA INJ 500/5ML	1	5	1	1	$40.12	5	1	$40.12
KEPPRA XR TAB 500MG	1,034	89,417	31,034	221	$299,226.98	2.88	4.68	$9.64
KEPPRA XR TAB 750MG	74	5,058	2,242	27	$25,770.48	2.26	2.74	$11.49
Category Totals:	**16,119**	**2,443,584**	**472,762**	**3,393**	**$2,008,596.30**	**5.17**	**4.75**	**$4.25**
OXCARBAZEPIN TAB 150MG	3,439	220,972	103,066	1,023	$102,965.21	2.14	3.36	$1.00
TRILEPTAL TAB 150MG	70	4,326	2,103	37	$7,321.08	2.06	1.89	$3.48
OXCARBAZEPIN TAB 300MG	6,423	502,206	193,048	1,498	$340,292.06	2.6	4.29	$1.76
TRILEPTAL TAB 300MG	251	20,696	7,338	73	$59,040.43	2.82	3.44	$8.05
OXCARBAZEPIN TAB 600MG	4,333	309,570	130,801	829	$422,710.03	2.37	5.23	$3.23
TRILEPTAL TAB 600MG	157	12,235	4,893	44	$70,150.56	2.5	3.57	$14.34
TRILEPTAL SUS 300MG/5M	2,401	850,694	66,801	352	$517,752.48	12.73	6.82	$7.75
OXCARBAZEPIN SUS 300MG/5M	8	3,000	228	8	$1,678.67	13.16	1	$7.36
Category Totals:	**17,082**	**1,923,699**	**508,278**	**3,864**	**$1,521,910.30**	**3.79**	**4.42**	**$2.99**
LYRICA CAP 25MG	173	11,551	4,963	62	$25,098.12	2.33	2.79	$5.06
LYRICA CAP 50MG	2,510	186,026	73,840	899	$429,608.61	2.52	2.79	$5.82
LYRICA CAP 75MG	5,501	380,499	165,832	1,668	$882,357.88	2.29	3.3	$5.32
LYRICA CAP 100MG	2,406	188,788	72,807	678	$438,348.38	2.59	3.55	$6.02
LYRICA CAP 150MG	3,627	256,932	110,376	896	$597,990.14	2.33	4.05	$5.42
LYRICA CAP 200MG	541	43,322	16,721	115	$99,335.40	2.59	4.7	$5.94
LYRICA CAP 225MG	233	14,433	7,421	53	$32,659.18	1.94	4.4	$4.40
LYRICA CAP 300MG	653	41,795	19,934	126	$98,376.48	2.1	5.18	$4.94
Category Totals:	**15,644**	**1,123,346**	**471,894**	**4,497**	**$2,603,773.90**	**2.38**	**3.48**	**$5.52**
PRIMIDONE TAB 50MG	469	39,965	14,397	100	$11,027.30	2.78	4.69	$0.77
MYSOLINE TAB 50MG	14	2,910	420	2	$1,700.52	6.93	7	$4.05
PRIMIDONE TAB 250MG	500	40,712	15,921	64	$13,082.98	2.56	7.81	$0.82
MYSOLINE TAB 250MG	7	680	250	2	$2,657.55	2.72	3.5	$10.63
Category Totals:	**990**	**84,267**	**30,988**	**168**	**$28,468.35**	**2.72**	**5.89**	**$0.92**

BRAND NAME	CLAIMS	UNITS	DAYS	MEMBERS	PAID	UNITS/ DAY	CLAIMS/ MEMBER	PER DIEM
BANZEL TAB 200MG	220	24,929	6,381	47	$57,843.61	3.91	4.68	$9.06
BANZEL TAB 400MG	252	32,208	7,504	50	$150,685.53	4.29	5.04	$20.08
Category Totals:	**472**	**57,137**	**13,885**	**97**	**$208,529.14**	**4.12**	**4.87**	**$2.28**
TOPIRAMATE TAB 25MG	3,111	247,834	91,316	1,265	$167,356.67	2.71	2.46	$1.83
TOPAMAX TAB 25MG	1,593	131,253	46,831	746	$321,219.57	2.8	2.14	$6.86
TOPIRAMATE TAB 50MG	2,742	178,368	83,215	922	$196,067.44	2.14	2.97	$2.36
TOPAMAX TAB 50MG	1,329	87,937	40,153	563	$424,815.45	2.19	2.36	$10.58
TOPIRAMATE TAB 100MG	3,501	226,725	108,657	868	$344,177.10	2.09	4.03	$3.17
TOPAMAX TAB 100MG	2,271	147,180	71,280	739	$961,820.65	2.06	3.07	$13.49
TOPIRAMATE TAB 200MG	1,384	97,484	43,720	291	$171,464.40	2.23	4.76	$3.92
TOPAMAX TAB 200MG	1,030	73,520	32,214	285	$547,246.98	2.28	3.61	$16.99
TOPAMAX SPR CAP 15MG	276	28,752	8,283	74	$59,257.15	3.47	3.73	$7.15
TOPIRAMATE CAP 15MG	203	20,153	6,059	80	$38,195.70	3.33	2.54	$6.30
TOPAMAX SPR CAP 25MG	319	53,596	8,783	74	$149,781.29	6.1	4.31	$17.05
TOPIRAMATE CAP 25MG	202	32,454	5,845	67	$68,986.94	5.55	3.01	$11.80
Category Totals:	**17,961**	**1,325,256**	**546,356**	**5,974**	**$3,450,389**	**2.43**	**3.01**	**$6.32**
ZONISAMIDE CAP 25MG	1,120	124,391	31,602	212	$25,078.25	3.94	5.28	$0.79
ZONEGRAN CAP 25MG	20	2,760	600	5	$1,089.53	4.6	4	$1.82
ZONISAMIDE CAP 50MG	328	24,094	9,761	72	$6,133.97	2.47	4.56	$0.63
ZONISAMIDE CAP 100MG	1,756	152,577	50,971	280	$40,443.10	2.99	6.27	$0.79
ZONEGRAN CAP 100MG	81	10,941	2,598	11	$31,474.37	4.21	7.36	$12.11
Category Totals:	**3,305**	**314,763**	**95,532**	**580**	**$104,219.22**	**3.30**	**5.70**	**$1.09**
Grand Totals:	**200,745**	**22,062,920**	**6,022,067**	**28498***	**$16,823,579.16**	**3.66**	**7.04**	**$2.79**

*Total number of unduplicated members

FDA-Approved Indications for Oral Anticonvulsants

*indicates approval for adjuvant therapy only

Drug	Manufacturer	Seizure Disorders				Neuropathic Pain	Lennox-Gastraut Syndrome	Migraine Prophylaxis	Bipolar Disorder
		Absence	Myoclonic	Partial	Tonic-clonic				
Carbamazepine Derivatives									
carbamazepine (Tegretol®)	generic			X	X	X[1]			
carbamazepine extended-release (Tegretol® XR)	generic								
carbamazepine extended-release (Carbatrol®)	Shire								
carbamazepine (Equetro®)									X
oxcarbazepine (Trileptal®)	generic, Novartis			X					
Valproic Acid and Derivatives									
valproic acid (Depakene®)	generic	X	X	X	X				
valproic acid delayed-release (Stavzor®)	Noven Therapeutics	X		X	X			X	X
divalproex delayed-release (Depakote®)	generic	X	X	X	X			X	X
divalproex sodium extended-release (Depakote® ER)	generic	X		X				X	X
Other Anticonvulsants									
felbamate (Felbatol®)	Meda			X			X*		
gabapentin (Neurontin®)	generic, Pfizer			X*		X			
lacosamide (Vimpat®)	UCB Pharma			X*					
lamotrigine (Lamictal®)	generic			X	X*		X*		X
lamotrigine (Lamictal® XR)	GSK			X*					
levetiracetam (Keppra®)	generic		X*	X*	X*				
pregabalin (Lyrica®)	Pfizer			X*		X[2]			
rufinamide (Banzel®)	Eisai						X*		
tiagabine (Gabitril®)	Cephalon			X*					
topiramate (Topamax®)	generic			X	X		X*	X	
zonisamide (Zonegran®)	generic			X*					

[1] associated with trigeminal neuralgia

[2] associated with diabetic peripheral neuropathy or post-herpetic neuralgia

OTHER INDICATIONS

Pregabalin (Lyrica) is also indicated for treatment of fibromyalgia

Vigabatrin (Sabril) is also indicated for treatment of infantile spasms

Appendix I

U.S. Food and Drug Administration

News & Events

FDA Press Release

For Immediate Release: May 11, 2010
Media Inquiries: Shelly Burgess, 301-796-4651, shelly.burgess@fda.hhs.gov
Consumer Inquiries: 888-INFO-FDA

FDA: 'Bad Ad Program' to Help Health Care Providers Detect, Report Misleading Drug Ads

The U.S. Food and Drug Administration today launched a program designed to educate health care providers about their role in ensuring that prescription drug advertising and promotion is truthful, and not misleading.

The Bad Ad Program is an FDA-sponsored educational outreach effort administered by the agency's Division of Drug Marketing, Advertising, and Communications (DDMAC), in the FDA's Center for Drug Evaluation and Research.

"The Bad Ad Program will help health care providers recognize misleading prescription drug promotion and provide them with an easy way to report this activity to the agency," said Thomas Abrams, director of DDMAC.

The program will be rolled out in three phases. In Phase 1, DDMAC will engage health care providers at specifically-selected medical conventions and partner with specific medical societies to distribute educational materials. Phases 2 and 3 will expand the FDA's collaborative efforts and update the educational materials developed for Phase 1.

The FDA's traditional regulatory activities for monitoring prescription drug promotion primarily rely on review of promotional pieces submitted to the agency by sponsoring drug companies, industry complaints, and field surveillance at large medical conventions. Although these efforts are effective, the agency has limited ability to monitor promotional activities that occur in private.

Health care professionals are encouraged to report a potential violation in drug promotion by sending an email to badad@fda.gov or calling 877-RX-DDMAC. Reports can be submitted anonymously; however, the FDA encourages providers to include contact information so that DDMAC officials can follow-up, if necessary.

For more information:

- The FDA's Bad Ad Program[1]
- The FDA's Division of Drug Marketing, Advertising, and Communications[2]

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RSS Feed for FDA News Releases[3] [what is RSS?[4]]

Links on this page:

1. http://www.fda.gov/badad
2. http://www.fda.gov/AboutFDA/CentersOffices/CDER/ucm090142.htm
3. http://www.fda.gov/AboutFDA/ContactFDA/StayInformed/RSSFeeds/PressReleases/rss.xml
4. http://www.fda.gov/AboutFDA/ContactFDA/StayInformed/RSSFeeds/ucm144575.htm

U.S. Food and Drug Administration

News & Events

FDA NEWS RELEASE

For Immediate Release: June 29, 2010
Media Inquiries: Sandy Walsh, 301-796-4669, sandy.walsh@fda.hhs.gov
Consumer Inquiries: 888-INFO-FDA

FDA Approves First Generic Effexor Extended Release Capsules to Treat Major Depressive Disorder

On June 28, the U.S. Food and Drug Administration approved the first generic version of Effexor XR capsules (venlafaxin hydrochloride) to treat major depressive disorder.

Venlafaxine hydrochloride extended-release capsules in 37.5 milligram, 75 milligram and 150 milligram strengths have been approved to be manufactured by TEVA Pharmaceuticals, North Wales, Pa.

"The approval of this widely used antidepressant is another example of the FDA's efforts to increase access to safe and effective generic drugs," said Keith Webber, Ph.D., deputy director of the Office of Pharmaceutical Science in the FDA's Center for Drug Evaluation and Research. "Access to treatments for depression is important because depression can interfere with a person's daily life and routine, which can significantly affect relationships with family and friends."

Symptoms of depression can include feelings of sadness, anxiety, emptiness, hopelessness, guilt, worthlessness or helplessness. Irritability and restlessness are also common symptoms of depression. Many people with depression lose interest in activities or hobbies and feel tired all the time.

The prescribing information (label) for the generic drug may differ from that of Effexor XR capsules because some uses c the drug and parts of the label are protected by patents and/or exclusivity held by the Effexor manufacturer, Wyeth Pharmaceuticals Inc.

Generic venlafaxine hydrochloride will have the same safety warnings as Effexor XR.

The drug has a boxed warning indicating that antidepressant medicines may increase suicidal thoughts or actions in som children, teenagers, and young adults within the first few months of treatment. The warning also notes that depression and other serious mental illnesses are the most important causes of suicidal thoughts and actions. Some people may have a particularly high risk of having suicidal thoughts or actions. These include people who have or have a family history of bipolar illness (also called manic-depressive illness) or suicidal thoughts or actions.

For more information:

- Generic Drugs[1]
- Depression (from the National Institute of Mental Health)[2]

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Links on this page:

1. http://www.fda.gov/Drugs/ResourcesForYou/ucm167906.htm
2. http://www.nimh.nih.gov/health/publications/depression-easy-to-read/index.shtml
3. http://www.fda.gov/AboutFDA/ContactFDA/StayInformed/RSSFeeds/PressReleases/rss.xml
4. http://www.fda.gov/AboutFDA/ContactFDA/StayInformed/RSSFeeds/ucm144575.htm