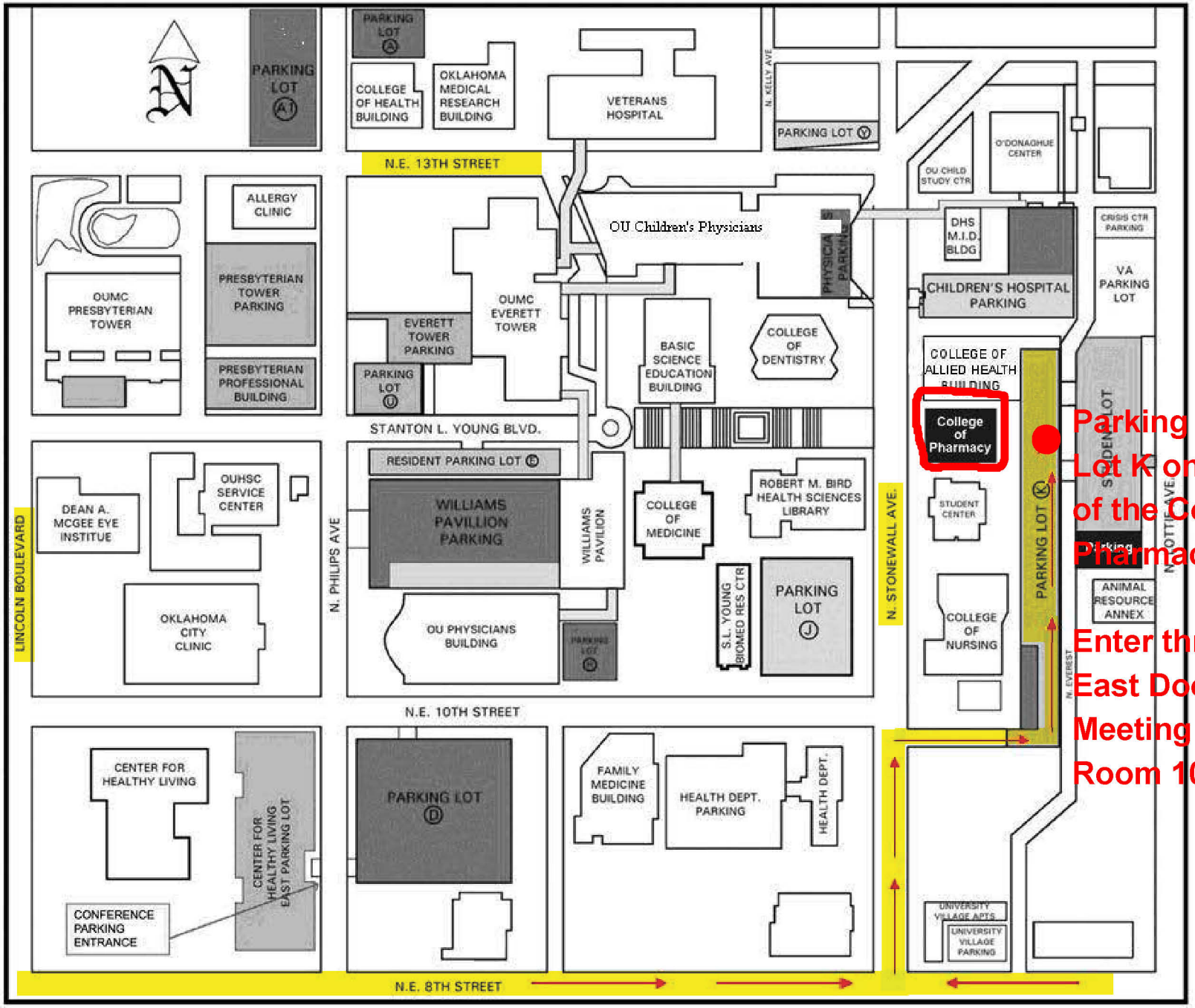
Drug Utilization Review Board

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

Wednesday
September 8, 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 – September 8, 2010**

DATE: September 2, 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 September meeting. Material is arranged in order of the Agenda.

Call to Order

Public Comment Forum

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

Update on DUR / MCAU Program – See Appendix B.

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

Action Item – Vote to Prior Authorize Qutenza® – See Appendix D.

Action Item – Vote to Prior Authorize Victoza® and Bydureon® – See Appendix E.

Action Item – Vote to Prior Authorize Special Formulation Antibiotics – See Appendix F.

Action Item – Vote to Prior Authorize Anticonvulsant Medications – See Appendix G.

Action Item – Vote to Prior Authorize ProCentra™ and Second Opinions Process for ADHD / Narcolepsy Category – See Appendix H.

Action Item – Annual Review of Synagis® – See Appendix I.

FDA and DEA Updates – See Appendix J.

Future Business

Adjournment

Oklahoma Health Care Authority
Drug Utilization Review Board
(DUR Board)
Meeting – September 8, 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. July 14, 2010 DUR Minutes – Vote
B. June 15, 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 March 2010
B. Retrospective Drug Utilization Review for April 2010
C. Retrospective Drug Utilization Review for July 2010
D. Retrospective Drug Utilization Review Response for January 2010
E. Retrospective Drug Utilization Review Response for February 2010
F. Retrospective Drug Utilization Review Response for March 2010
G. Retrospective Drug Utilization Review Response for April 2010
H. Medication Coverage Activity Audit for July 2010
I. Medication Coverage Activity Audit for August 2010
J. Help Desk Activity Audit for July 2010
K. Help Desk Activity Audit for August 2010

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

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

A. Product Summary
B. COP Recommendations

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

6. Action Item – Vote to Prior Authorize Qutenza® – See Appendix D.

A. Product Summary
B. COP Recommendations

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

7. Action Item – Vote to Prior Authorize Victoza® and Bydureon® – See Appendix E.

A. Cost Comparison
B. COP Recommendations

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

8. Action Item – Vote to Prior Authorize Special Formulation Antibiotics – See Appendix F.

A. COP Recommendations

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

9. Action Item – Vote to Prior Authorize Anticonvulsant Medications – See Appendix G.

A. COP Recommendations

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

10. Action Item – Vote to Prior Authorize ProCentra® and Second Opinions Process for ADHD / Narcolepsy Category – See Appendix H.

A. Utilization Review
B. COP Recommendations

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

11. Action Item – Annual Review of Synagis® – See Appendix I.

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

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

12. FDA and DEA Updates – See Appendix J.

13. Future Business

A. Annual Review of Growth Hormones
B. Annual Review of Narcotics
C. Annual Review of ESAs
D. New Product Reviews

14. Adjournment

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES of MEETING of JULY 14, 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): Chelsea Coates, Hillary Harwell	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:

Michael Jones, GSK	Toni Li, Strative Pharmaceuticals	John Seidenberger, Boehringer-Ingelheim
Toby Thompson, Pfizer	Paul Sparks, Neurogesx Inc.	H. David Williams, Forest
Leah S. Taylor, OHCA	Richard Ponder, J&J	Holly Preslar, OUHSC PA Student
Christian Yang, Merck	Orlando Duran, Merck	James Osborne, GSK
Vanessa Papion, UCB	Jim Dunlap, Lilly USA	Kim Greenberg, Amylin
Mark DeClerk, Lilly	Pat Trahan, Taro	Monica Iacobucci, AstraZeneca
Donna Erwin, BMS	Emily McCann, Merck	Connie Lindsey, AstraZeneca
Aaron Mays, Alcon	Russ Wilson, Johnson & Johnson	

PRESENT FOR PUBLIC COMMENT:

Agenda Item No. 8: Toni Li, Strativa Pharmaceuticals
Agenda Item No. 10: Dr. Michael Jones, GSK

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. 8: Toni Li, Strativa Pharmaceuticals

Agenda Item No. 10: Dr. Michael Jones, GSK

ACTION: NONE REQUIRED

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

3A: June 9, 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: February 2010

4B: Retrospective Drug Utilization Review Response: December 2009

4C: Medication Coverage Activity Audit: June 2010

4D: Help Desk Activity Audit: June 2010

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE PROCENTRA™**

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

Board members discussed making a physician's second opinion a PA requirement for 3-4 year age groups and requested the College of Pharmacy to present further recommendations at the next DUR Board Meeting.

Dr. Kuhls moved to table to next meeting; seconded by Dr. Bell.

ACTION: MOTION TABLED TO AUGUST 11, 2010

AGENDA ITEM NO. 6: **30-DAY NOTICE TO PRIOR AUTHORIZE AMPYRA™**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 7: **30-DAY NOTICE TO PRIOR AUTHORIZE QUTENZA®**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 8: **30-DAY NOTICE TO PRIOR AUTHORIZE SPECIAL FORMULATION ANTIBIOTICS**

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

For Public Comment, Toni Li: Good evening everyone. Thanks for the opportunity to provide public comment for a board meeting. I have a prepared statement for it from Strativa Pharmaceuticals. Strativa Pharmaceuticals, division of Par Pharmaceutical, Inc. has received approval for Oravig (miconazole) buccal tablets from the U.S. Food and Drug Administration. Oravig is indicated for the local treatment of oropharyngeal candidiasism or (OPC), more commonly known as thrush, in adults and adolescents over 16 years of age. Oravig is the first and only oral prescription formulation of miconazole approved in the U.S. for local treatment of thrush. Oravig is the first and only orally dissolving buccal tablet for oral thrush. It delivers an immediate and sustained release of miconazole directly at the local site of infection with minimal systemic absorption. The tablet is flavorless and odorless and slowly dissolves during the day. Oravig will be offered in a once daily 50 mg dose and is expected to be available in retail pharmacies in the third quarter of 2010. It is the only once daily, local treatment for oral

thrush. Oravig was studied in three clinical trials with a total of almost 900 oral thrush patients and has demonstrated efficacy. The SMiLES trial in HIV/AIDs patients is the largest worldwide clinical trial to date to evaluate a treatment for oral thrush. The efficacy of once-daily Oravig was non-inferior to clotrimazole troche dosed five times per day. Results of this trial show; at the end of 14 day treatment, 61% of patients had no signs and symptoms of OPC with Oravig versus 65% of patients treated with clotrimazole, the two products demonstrated non-inferiority; 71 % of patients were relapse free on either treatment; this study demonstrated efficacy in mild to severe oral thrush. Another study was completed in head and neck cancer patients who had undergone radiotherapy. In this study, over 90% of patients had reduced salivary flow at baseline. Results of this trial show; at the end of 14 day treatment, 53% of patients treated with Oravig had no lesions versus 47% of patients treated with miconazole oral gel, the two products demonstrated non-inferiority, note the gel is not available in the U.S.; 80% of patients treated with Oravig were relapse free at day 30 and 78% of patients were relapse free at day 60 versus 88% and 83% for the gel, respectively. These results were not statistically significantly different. Oravig is a safe first-line therapy in a convenient once-daily dose for the treatment of oral thrush. In clinical trials the most common overall adverse events which were defined as greater than or equal to 2% reported with Oravig were diarrhea at 6%, headache at 5%, nausea at 4.6%, dysgeusia at 2.9%, upper abdominal pain at 2.5%, and vomiting at 2.5%. Overall discontinuation rates due to adverse events were less than 1%. Now, the important Safety Information. 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. Discontinue Oravig immediately at the first sign of hypersensitivity. There is no information regarding cross-hypersensitivity between miconazole and other azole agents. Monitor patients with a history of hypersensitivity to azoles. Although systemic absorption of miconazole is minimal and plasma concentrations are substantially lower than when administered intravenously, the potential for interaction with drugs metabolized through CYP2C9 and CYP3A4 potential cannot be ruled out. Closely monitor patients if Oravig is administered concomitantly with warfarin. During clinical trials, the most common adverse events as discussed before. I did repeat it again here at the bottom *(of the prepared statement: diarrhea at 6%, headache at 5%, nausea at 4.6%, dysgeusia at 2.9%, upper abdominal pain at 2.5%, and vomiting at 2.5%)*.

ACTION: NONE REQUIRED

AGENDA ITEM NO. 9: **ANNUAL REVIEW OF BYETTA® AND 30-DAY NOTICE TO PRIOR AUTHORIZE VICTOZA® AND BYDUREON®**

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 10: **30-DAY NOTICE TO PRIOR AUTHORIZE ANTICONVULSANT DRUGS**

For Public Comment, Dr. Michael Jones: Good evening Dr. Graham and Board. As Shellie mentioned, I'll have to say that I'm a little bit fearful because they probably didn't even have wood out there when I was a student here and it kind of give me creeps even walking down the halls, but I'd like just to bring to the Board's attention briefly, the profile on Lamictal XR and ODT. ODT, we have no true clinical data proving efficacy over the non-ODT formulations; however, it was manufactured for the dysphasia population, and I'd just like to point out just a few, you have 23 to 35% of adults, even higher percentage in the elderly patients, suffer with this problem. Of those, 14% delay therapy, 8% skip doses, 4% discontinue. Split amongst epilepsy and bipolar patients of which the Lamictal population comprises, you've got about 8.3% suffer on the epilepsy side versus 6.3, respectively on the bipolar side. It's pleasant tasting, easy to dissolve. There's no conversion. It's a one on one conversion from a normal Lamictal, same dosage pack, same titration kits, same proven efficacy. There's one small, psychiatrists have been reporting that of course you have the increased compliance issue with the bipolar patients that they like. But that's ODT. I'm going to concentrate on a little more heavily on our Lamictal XR profile. You have both the Naritoku study and what we call the COMPASS or pharmacokinetic study in the dossier. We all realize that partial seizures are complex and a huge cost associated with the treatment of these patients. They're on approximately 2.8 meds per patient, and I'd like to focus on the COMPASS study. It was a small study that we conducted converting patients back and forth between the IDT/ID and the XR and the lower peaks and longer time periods definitely create a better pharmacokinetic profile for not having these patients switch between the medicines and having a once daily dosage form of the XR has been helping many, many patients. You have a significant reduction in seizure frequencies in patients with uncontrolled partial seizures, so I'm going to leave it at the ease of the qd dosing, the proven safety profile, direct conversion, no titration for established patients, and they're on the same, they maintain the same serum trough concentration and that they use the same titration packs as the normal Lamictal patients. Again, this is 30 days out. We're probably going to have a neurologist address the Board closer at the time, Dr. Graham, but I want to just open it up and ask you guys if you had any questions as we go into this. That's where we stand.

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

ACTION: NONE REQUIRED

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

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

ACTION: NONE REQUIRED

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

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

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 13: **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: July 15, 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 July 14, 2010

Recommendation 1: Vote to Prior Procentra™

MOTION TABLED.

The action was tabled and a request was made by the DUR Board for the College of Pharmacy to present a strategy for attaining second opinions for children under 5 years of age who require ADHD medications.

Recommendation 2: Annual Review of Byetta®

No action was required.

The College of Pharmacy does not recommend changes at this time.

NEUROLOGICAL CENTER OF OKLAHOMA, PLC.

620 William Medical Building • 6585 South Yale • Tulsa, OK 74136-8319
(918) 481-4781 FAX (918) 481-4796

GREGORY S. CONNOR, M.D.
NEUROLOGIST
AMERICAN BOARD CERTIFIED
SPECIAL INTEREST/EMG
MOVEMENT DISORDERS
EPILEPSY

JUDY HURST
BUSINESS MANAGER

LOU ANN JENSEN, R.N.
CLINICAL COORDINATOR

CLINICAL SERVICES
GENERAL NEUROLOGY
NEUROMUSCULAR DISEASE
BOTULINUM INJECTIONS
EEG
EMG
EVOKED POTENTIALS
TRANSCRANIAL DOPPLER

July 6, 2010

Shellie Keast, Pharm D
Pharmacy Management Consultants
112 N.E. 13th St.
Ste. 4403
Oklahoma City, Ok 73117

Dear Shellie,

I am a neurologist practicing in Tulsa for the past seventeen years. We have a practice that primarily focuses on seizures and so we have seen the consequence over the years of patients having breakthrough seizures when going to generic. We understand that the pharmacy consultants are considering making it more difficult to get brand name than it already is since the government allows a range of 80% to 125% of the equivalent medication, that's a huge swing for many seizure medicines, which we require precise dosing. My patients that are easy to control we have no problem with generics but many of my more difficult patients we want to have the option of being able to use brand name. We appreciate your consideration in this matter.

Sincerely,

Gregory S. Connor, M.D.

Children's Medical Center Neurology

Helping kids get better on The Hillcrest Medical Center Campus

G. Steve Miller, M.D.

July 8, 2010

SHELLIE KEAST PHARM D
PHARMACY MANAGEMENT CONSULTANTS
1122 NE 13th ST STE 4403
OKLAHOMA CITY OK 73117

RE: Antiepileptic drugs or anticonvulsants.

Dear Dr. Keast:

A drug representative has indicated to me that Medicaid would no longer be approving name brand anticonvulsants for children and adults with epilepsy. The American Epilepsy Society feels that the therapeutic range of anticonvulsants oftentimes is so narrow that switching to generic preparations will cause loss of control. They have studies that indicate that switching from name brand medication increases cost overall by increasing emergency room visits due to recurrence of seizures or status epilepticus. Regarding XR preparations, I think it is reasonable to use twice a day dosing of non-time release medications to provide an adequate substitution for name brand time release anticonvulsants. Most anticonvulsants are now currently in generic preparations and I can understand the fiscal constraints under which Medicaid has come since the recession. From my perspective as a pediatric neurologist and epileptologist, I think that generic substitution is reasonable. It would be helpful if the state were able to have a specific generic manufacturer provide all the medications because that would limit the amount of fluctuation due to generic brand switching. In general, I try to use generic medication. The medication provided by Indian Health, for example, contracts yearly for the particular brand or generic brand of medication, therefore, it is not changed through the year. We sometimes get levels toward the end of the year and compare them with levels of the new generic that starts in the new fiscal year for the Indians. This is a simple way of attempting to maintain therapeutic levels. I did have approximately 20 patients that began having seizures after being seizure free from two to five years when they were switched from name brand Lamictal to generic Lamictal, however, this was a relatively small number compared to the number of patients that I have on Lamictal. In regards to the newer anticonvulsants for which there is no generic, I usually use those after a patient has failed two to twenty other anticonvulsants and this would also depend upon seizure type.

1145 South Utica • North Physicians Office Building, Suite 262 • Tulsa, OK • 74104-4013 • (918) 579-3070, fax (918) 579-3296

I would appreciate a response from you regarding your actual policies that are being implemented. I will look forward to working with you and the Medicaid policies regarding anticonvulsant medications. Certainly if you would like to discuss this with me further please feel free to contact me at any time at my office (918) 579-3070 or cell phone (918) 346-1977 or email at gsmtok@yahoo.com.

Sincerely yours,

G. Steve Miller, M.D. Board Certified Pediatric Neurologist and Epileptologist
GSM: hls

SOUTHWESTERN PEDIATRICS & ALLERGY CLINIC, INC.
REX R. MATTHEWS, M.D.
ALLERGY AND PEDIATRICS
8220 S. PENNSYLVANIA
OKLAHOMA CITY, OKLAHOMA 73159

TELEPHONE
682-1448

08/12/10

ATTN: Ron Graham D.Ph
1122 N.E. 13th
Oklahoma City, Ok. 73117

Dear Mr Graham.

I want to voice my opinion on changing the recommendations to only giving Synagis until the baby reaches 90 days old. I feel this would be a grave mistake and many hospitalizations would occur. I also feel the baby's with heart problems or lung problems could die.

I feel you should maintain the current dosing through RSV season until there are more guidelines available. Evidence does show Synagis is very effective throughout RSV season.

Sincerely,

Rex R. Matthews, MD.
RRM/kg

OKLAHOMA PEDIATRIC CENTER

Pediatrics & Adolescent Medicine

INDIRA SINGH, M.D., F.A.A.P.
DIPLOMATE, AMERICAN BOARD OF PEDIATRICS
FELLOW, AMERICAN ACADEMY OF PEDIATRICS

August 13, 2010

Dear Ron Graham D. PH

Please do not change the current schedule for RSV prophylaxis in premature and at risk infants. While this measure may appear to be cost saving, it is not been recommended by the FDA, or the AAP and the National Perinatal Society strongly recommends against this practice. The belief that a shortened course of Synagis may decrease cost is unproven. Pediatric providers fear that cost would actually be increased in terms of hospitalizations due to the disease. Additionally the cost of RSV in vulnerable infants in terms of human suffering can not be measured.

Sincerely,

Rose Trigg PA

Santiago Reyes, M.D.

Respiratory Diseases of Children and Adolescents

Suite 330 Baptist Medical Plaza Bldg. D
3366 N.W. Expressway
Oklahoma City, Oklahoma 73112
Telephone (405) 945-4495
Fax (405) 945-4376

August 17, 2010

Ron Graham P.h.
1122 N. 13
OKC, OK 73117

Dear Dr. Graham,

I want to remark the importance of continuing the present policy for Synagis administration to fragile children as well as infants 30-34 weeks old gestational in age through the entire RSV season.

Hopefully the board will not make any changes to this policy during the meeting on September the 8th. There is no convincing medical evidence that is beneficial for infants at high-risk to stop the Synagis therapy in the middle of the RSV season. Lets remember how expensive is a hospitalization for respiratory failure of one of these infants if they suffer a severe infection with RSV and also the consequences for the future in regard to recurrent respiratory infections and the possibility of Reactive Airway Disease.

Thank you so much one more time for your consideration.

Sincerely yours,

Santiago Reyes de la Rocha, M.D.
SR/adw

J. FIELDS, M.D.
E. FOX, M.D.
500 E. Robinson
Doctors Park Suite 2600
Norman, OK 73071
(405) 364-6432

August 16, 2010

To: Ron Graham, D Ph
1122 N E 13th
Oklahoma City, OK 73117

Re: Recommendations for RSV vaccination

Dear Dr. Graham,

I am a pediatrician who has been in practice for 28 years. During my time taking care of children, I have hospitalized numerous with RSV.

I am quite concerned with the new recommendations surrounding RSV prophylaxis. I have had several patients seriously ill who fall in the category between 32 and 34 weeks gestation and I have seen RSV out through March and April. My biggest concern is the discontinuation of the recommendation for prophylaxis in the 32 to 34-week infants once they reach three months of age, which for the most part will leave them totally unprotected during the RSV season since most of our cases occur in January, February, and March.

If these guidelines are adopted, I feel it will result in many more hospitalizations and potential long-term complications in some of these children that could have been protected and would have been protected in previous years. Also, in these patients, the cost of one hospitalization will be more than Synagis. I think the decision should be made considering the patient's ages as well as other risk factors such as daycare attendance, siblings in the household, exposure to tobacco smoke, and crowded living conditions. In my experience, these conditions have been major contributors to children with RSV and children with more severe RSV.

It would be my recommendation that the State of Oklahoma insurance companies continue to support and provide RSV prophylaxis as recommended in past years.

Should you have any questions, please notify my office.

Sincerely,

Eileen M Fox

Eileen M Fox, M.D.

EMF/cl

J. FIELDS, M.D.
E. FOX, M.D.
500 E. Robinson
Doctors Park Suite 2600
Norman, OK 73071
(405) 364-6432

August 10, 2010

To: Ron Graham, DPh
1122 NE 13th
Oklahoma City, OK 73117

Re: Recommendations for RSV vaccination

Dear Dr. Graham,

I am writing this letter in regards to the DUR review of the criteria for RSV prophylaxis. As a relatively new physician to the area, but one who treats a number of patients which qualify under the current guidelines, I ask you to keep the current policy as it stands.

Aside from protecting our premature infants from developing RSV and suffering the immediate clinical effects of this, the August 2010 issue of The Journal of Allergy and Clinical Immunology contains an article that shows RSV prophylaxis can decrease the risk of recurrent wheezing and subsequent health problems in premature infants that are otherwise non-atopic. I feel like this, combined with the decreased number of hospitalizations, validates the need for RSV prophylaxis for those who meet current criteria. I encourage you to keep the current guidelines to allow us to provide the best care for our patients.

Should you have any questions, please notify my office.

Sincerely,

Brian T. Ellis, M.D.

BTE/rv

J. FIELDS, M.D.
E. FOX, M.D.
500 E. Robinson
Doctors Park Suite 2600
Norman, OK 73071
(405) 364-6432

August 16, 2010

To: Ron Graham, DPh
1122 NE 13th
Oklahoma City, OK 73117

Re: Recommendations for RSV vaccination

Dear Dr. Graham,

I am writing this letter in regards to the DUR review of the criteria for RSV prophylaxis. I treat a number of patients which qualify under the current guidelines and ask that you keep the current policy as it stands.

Aside from protecting our premature infants from developing RSV and suffering the immediate clinical effects of this, RSV prophylaxis can decrease the risk of recurrent wheezing and subsequent health problems in premature infants. Due to this and the decreased number of hospitalizations, I feel the current criteria for RSV prophylaxis is validated. I encourage you to keep the current guidelines to allow us to provide the best care for our patients.

Should you have any questions, please notify my office.

Sincerely,

Glen Diaz, ARNP

GD/rv

Wilfred Gauthier, MD
Derek Landis, MD
Kevin Reed, MD
Gregory Spencer, MD
Toribio Velasquez, MD
Sallie Walker, ARNP

Memorial Medical Clinic

921 FOURTEENTH AVE NW
ARDMORE, OK 73401
PHONE 580-223-5311
FAX 580-223-8227

Dear, Ron Graham, D.PH

It has been brought to my attention that the DUR committee is going to be reviewing the criteria for Synagis. I am a Pediatrician that routinely cares for infants that are at an increased risk for RSV. I know there has been much controversy regarding the extended use of Synagis especially in later preterm infants. I do not understand why the prophylaxis is discontinued after 90 days of life. I have not seen any studies stating this is the best route of precautions that should be taken. After careful review of studies done by the CDC and FDA , I believe there is great benefits to using Synagis therapy throughout the entire RSV season to prevent hospitalizations to a very vulnerable portion of newborns in our communities.

Respectfully

Dr. Derek Landis M.D.

St. John Medical Center
Medical Excellence • Compassionate Care

Ricardo Miranda, M.D., FAAP
Neonatal-Perinatal Medicine

8/16/2010

Ron Graham, D.Ph.
Director of Pharmacy Management Consultants
1122 NE 13th
Oklahoma City, OK 73117

Dear Dr. Graham:

The Oklahoma DUR board will be reviewing the criteria for RSV prophylaxis on September 8, 2010. I am particularly concerned about potential changes you are considering for infants born in the 32 0/7 to 34 6/7 GA range. The 2009 AAP guidelines recommend discontinuation of therapy in this group once the infant reached 90 days of age. Clinical data shows that Synagis is very safe and effective in this highly vulnerable group. Evidenced-based medicine requires us to consider well-designed clinical studies in such matters. There is not sufficient data to support this change. The evidence overwhelmingly supports dosing these infants just prior to and throughout the entire RSV season. Additionally, truncated dosing falls outside of the FDA labeling which states, "Patients, including those who develop an RSV infection, should continue to receive monthly doses throughout the RSV season. The first dose should be administered prior to commencement of the RSV season". In fact, infants that did not receive 5 doses in the pivotal clinical trials had higher hospitalization rates than those who were dosed throughout the entire RSV season.

The CDC's Advisory Committee on Immunization Practices has established a working group that is researching and expected to develop RSV guidelines within the next year. My recommendation is to stay with the RSV prophylaxis criteria that Oklahoma established last year, especially since there is nothing new in terms of well-designed clinical studies to support further changes. The CDC's recommendation can be reviewed once they are published.

Sincerely,

Ricardo Miranda MD

Ricardo Miranda, M.D., FAAP
Neonatal-Perinatal Medicine
St. John Medical Center

Utica Park Clinic
A Service of Hillcrest HealthCare System

PEDIATRICS

University of Oklahoma College of Pharmacy

Pharmacy Management Consultants

Oklahoma Healthcare Authority

Oklahoma City, OK 73105

July 8, 2010

regarding: Intuniv

I would appreciate your consideration of adding the above named medication as a tier 1 medication for Sooner Care and Medicaid children.

Intuniv is a new medication designed to control hyperactivity, aggression, and oppositional behavior. However this medication does not seem to be particularly effective in improving attention. Therefore it is not interchangeable with other medications used for treatment of ADHD, such as stimulants and Strattera.

After using this medication for several months I have found it to be quite useful in the following situations: 1.) As an add-on to a stimulant medication to help control the above symptoms. 2.) It is very beneficial when used alone when a child's attention span/focus is not terribly important-such as during school breaks, weekends, and summer. As I'm sure you know, stimulants tend to have a suppressive effect on appetite and many children have trouble gaining weight when taking them. This allows the child to omit stimulant medication when his/her attention is not an issue. 3.) Intuniv is also very useful in preschool children in which attention span is not terribly important but symptoms of hyperactivity and oppositionality need to be controlled.

Additionally Intuniv offers 24 hour- a-day relief of symptoms as opposed to the stimulants which at best last only six or seven hours.

Please add this item to your next committee meeting. I am hopeful for a positive response.

Sincerely,

Walter J. Kan, M.D.

1245 South Utica Avenue, Suite 130 • Tulsa, OK 74104
918/560-3832
A Service of Hillcrest HealthCare System

Appendix B

RETROSPECTIVE DRUG UTILIZATION REVIEW REPORT
March 2010

MODULE	DRUG INTERACTION	DUPLICATION OF THERAPY	DRUG-DISEASE PRECAUTIONS	DOSING & DURATION
Total # of messages	52,241	65,319	974,587	32,726
Limits applied	Established, Major, Males and Females, Age 58-65	Males and Females, Anti-platelet Agents(non-Aspirin), Age 0-150	Contraindicated, Diabetes Mellitus, Males and Females Age 59-150	High Dose, Low Dose & Duration, Males and Females Aged 0-18, Misc Antibiotics
Total # of messages after limits were applied	99	29	230	31
Total # of members reviewed	99	15	212	31

LETTERS

Category	Prescribers	Pharmacies	Total Letters
Drug Interaction	16	1	17
Duplication of Therapy	16	9	25
Drug-Disease Precautions	48	20	68
Dosing & Duration	5	5	10
Total Letters Sent	85	35	120

RETROSPECTIVE DRUG UTILIZATION REVIEW REPORT
April 2010

MODULE	DRUG INTERACTION	DUPLICATION OF THERAPY	DRUG-DISEASE PRECAUTIONS	DOSING & DURATION
Total # of messages	50,291	63,123	931,309	30,004
Limits applied	Established, Major, Males and Females, Age 66-150	Males and Females, Inter-feron Beta Agents (Avonex, Rebif, Betaseron, Extavia), Age 0-150	Contraindicated, Alcohol Dependence, Males and Females Age 0-150	High Dose, Low Dose & Duration, Males and Females Aged 19-150, Misc Antibiotics
Total # of messages after limits were applied	14	1	35	56
Total # of members reviewed	14	1	33	56

LETTERS

Category	Prescribers	Pharmacies	Total Letters
Drug Interaction	0	0	0
Duplication of Therapy	0	0	0
Drug-Disease Precautions	11	0	11
Dosing & Duration	32	13	45
Total Letters Sent	43	13	56

RETROSPECTIVE DRUG UTILIZATION REVIEW REPORT
July 2010

MODULE	DRUG INTERACTION	DUPLICATION OF THERAPY	DRUG-DISEASE PRECAUTIONS	DOSING & DURATION
Total # of messages	48,367	58,182	1,010,044	25,044
Limits applied	Established, Major, Males and Females, Age 0-18	Males and Females, Anorexiants/Stimulants, Age 0-4	Contraindicated, Alcohol Dependence, Males and Females Age 0-150	High Dose, Low Dose & Duration, Males and Females Aged 19-150, Misc Antibiotics
Total # of messages after limits were applied	14	13	168	18
Total # of members reviewed	14	1	35	18

LETTERS

Category	Prescribers	Pharmacies	Total Letters
Drug Interaction	9	5	14
Duplication of Therapy	2	3	5
Drug-Disease Precautions	3	2	5
Dosing & Duration	4	14	18
Total Letters Sent	18	24	42

Retrospective Drug Utilization Review Report

Claims Reviewed for January 2010

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females, Age 22-50	Narcotics, Males and Females, Age 38-40	Contraindicated, Diabetes Mellitus, Males and Females, Age 46-52	High Dose & Low Dose, Biguanides, Males and Females, Age 0-40

Response Summary (Prescriber)
Letters Sent: 219
Response Forms Returned: 127

The response forms returned yielded the following results:

10 (8%)	*Record Error—Not my patient.*
18 (14%)	*No longer my patient.*
6 (5%)	*Medication has been changed prior to date of review letter.*
24 (19%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
40 (31%)	*I am aware of this situation and will plan to continue monitoring therapy.*
29 (23%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 22
Response Forms Returned: 10

The response forms returned yielded the following results:

0 (0%)	*Record Error—Not my patient.*
0 (0%)	*No longer my patient.*
0 (0%)	*Medication has been changed prior to date of review letter.*
3 (30%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
4 (40%)	*I am aware of this situation and will plan to continue monitoring therapy.*
3 (30%)	*Other*

Retrospective Drug Utilization Review Report

Claims Reviewed for February 2010

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females, Age 51-57	Bupropion Products, Males and Females, Age 0-150	Contraindicated, Diabetes Mellitus, Males and Females, Age 53-58	High Dose & Duration, Emergency Contraceptives, Males and Females, Age 0-150

Response Summary (Prescriber)
Letters Sent: 65
Response Forms Returned: 30

The response forms returned yielded the following results:

0 (0%)	*Record Error—Not my patient.*
4 (13%)	*No longer my patient.*
2 (7%)	*Medication has been changed prior to date of review letter.*
8 (27%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
14 (47%)	*I am aware of this situation and will plan to continue monitoring therapy.*
2 (7%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 17
Response Forms Returned: 11

The response forms returned yielded the following results:

1 (9%)	*Record Error—Not my patient.*
2 (18%)	*No longer my patient.*
0 (0%)	*Medication has been changed prior to date of review letter.*
1 (9%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
3 (27%)	*I am aware of this situation and will plan to continue monitoring therapy.*
4 (36%)	*Other*

Retrospective Drug Utilization Review Report

Claims Reviewed for March 2010

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females, Age 58-65	Anti-platelet Agents, Males and Females, Age 0-150	Contraindicated, Diabetes Mellitus, Males and Females, Age 59-150	High Dose, Low Dose, Duration, Miscellaneous Antibiotics, Males and Females, Age 0-18

Response Summary (Prescriber)
Letters Sent: 85
Response Forms Returned: 54

The response forms returned yielded the following results:

6 (11%)	*Record Error—Not my patient.*
4 (7%)	*No longer my patient.*
3 (6%)	*Medication has been changed prior to date of review letter.*
9 (17%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
28 (52%)	*I am aware of this situation and will plan to continue monitoring therapy.*
4 (7%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 35
Response Forms Returned: 20

The response forms returned yielded the following results:

1 (5%)	*Record Error—Not my patient.*
0 (0%)	*No longer my patient.*
5 (25%)	*Medication has been changed prior to date of review letter.*
1 (5%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
9 (45%)	*I am aware of this situation and will plan to continue monitoring therapy.*
4 (20%)	*Other*

Retrospective Drug Utilization Review Report

Claims Reviewed for April 2010

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females, Age 66-150	Interferon Beta Agents, Males and Females, Age 0-150	Contraindicated, Alcohol Dependence, Males and Females, Age 0-150	High Dose, Low Dose, Duration, Miscellaneous Antibiotics, Males and Females, Age 19-150

Response Summary (Prescriber)
Letters Sent: 43
Response Forms Returned: 21

The response forms returned yielded the following results:

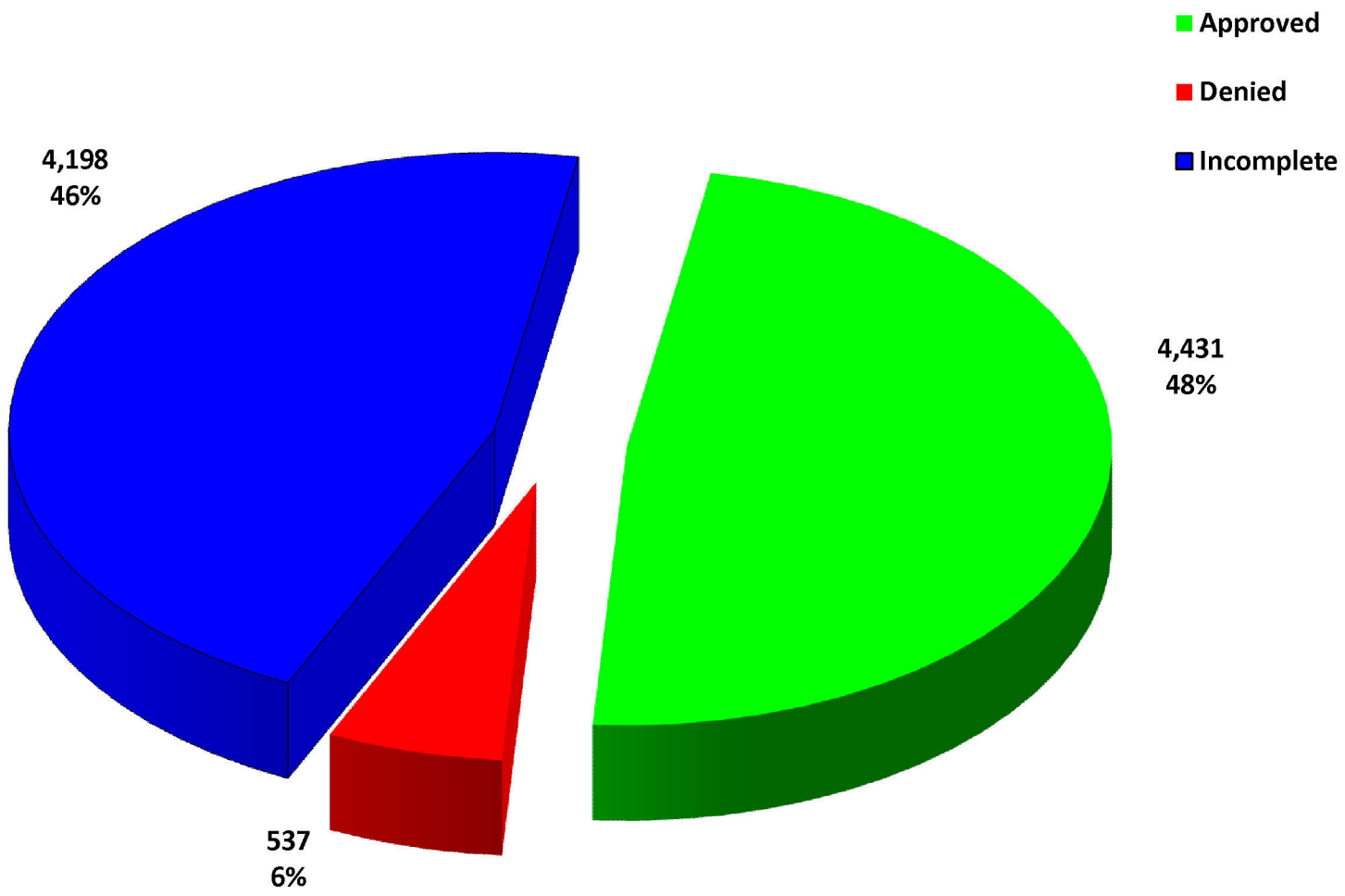
0 (0%)	*Record Error—Not my patient.*
3 (13%)	*No longer my patient.*
0 (0%)	*Medication has been changed prior to date of review letter.*
4 (19%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
12 (57%)	*I am aware of this situation and will plan to continue monitoring therapy.*
2 (10%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 13
Response Forms Returned: 6

The response forms returned yielded the following results:

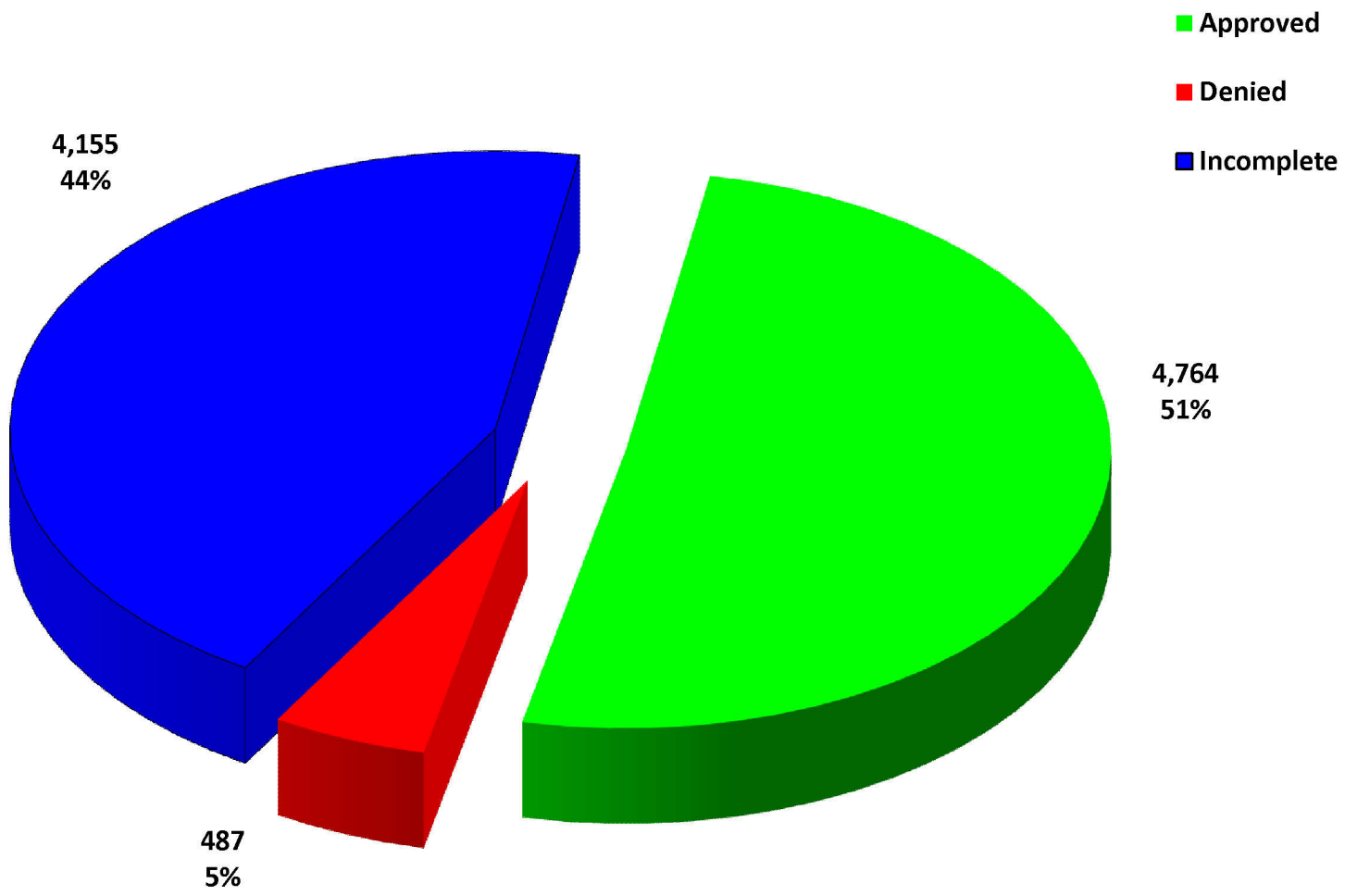
1 (17%)	*Record Error—Not my patient.*
1 (17%)	*No longer my patient.*
1 (17%)	*Medication has been changed prior to date of review letter.*
0 (0%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
3 (50%)	*I am aware of this situation and will plan to continue monitoring therapy.*
0 (0%)	*Other*

PRIOR AUTHORIZATION ACTIVITY REPORT: July 2010



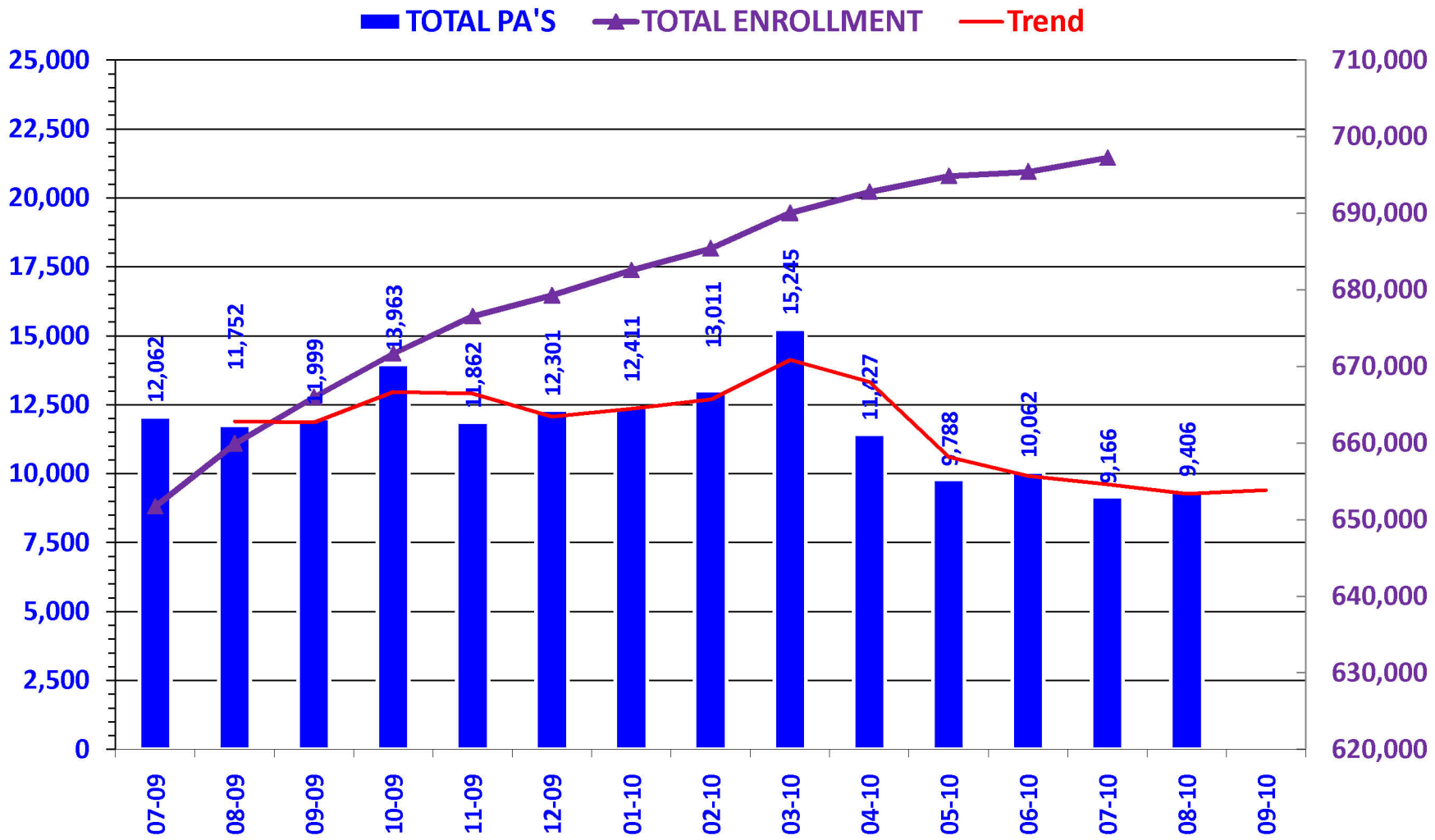
PA totals include overrides

PRIOR AUTHORIZATION ACTIVITY REPORT: August 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: July 2009 – August 2010



PA totals include overrides

Prior Authorization Activity

July 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	336	154	5	177	355
Amitiza	18	8	0	10	222
Anti-Ulcer	427	90	53	284	101
Antidepressant	409	115	18	276	350
Antihistamine	293	157	13	123	332
Antihypertensives	106	51	9	46	338
Antimigraine	100	16	13	71	246
Atypical Antipsychotics	723	323	21	379	345
Benzodiazepines	125	38	8	79	268
Bladder Control	85	13	9	63	341
Brovana (Arformoterol)	5	3	1	1	364
Byetta	17	8	1	8	295
Elidel/Protopic	64	29	12	23	91
ESA	215	122	18	75	59
Fibric Acid Derivatives	7	1	0	6	361
Fibromyalgia	130	49	6	75	341
Fortamet/Glumetza	7	3	0	4	301
Forteo	6	2	1	3	364
Glaucoma	22	9	0	13	343
Growth Hormones	26	18	2	6	171
HFA Rescue Inhalers	48	17	2	29	296
Insomnia	103	18	7	78	161
Misc Analgesics	40	5	19	16	150
Muscle Relaxant	150	43	46	61	65
Nasal Allergy	231	79	22	130	152
NSAIDS	137	27	16	94	315
Ocular Allergy	33	3	2	28	42
Ocular Antibiotics	118	58	3	57	23
Opioid Analgesic	234	83	18	133	187
Other	510	160	48	302	162
Otic Antibiotic	176	92	3	81	18
Pediculicides	148	72	6	70	15
Plavix	219	143	2	74	320
Singulair	703	398	19	286	249
Smoking Cessation	61	17	1	43	72
Statins	116	31	11	74	361
Stimulant	1,395	822	45	528	212
Symlin	3	1	0	2	360
Synagis	1	0	1	0	0
Topical Antibiotics	11	3	0	8	130
Topical Antifungals	14	4	0	10	28
Ultram ER and ODT	8	0	0	8	0
Xolair	2	1	0	1	360
Xopenex Nebs	56	24	1	31	267
Zetia (Ezetimibe)	20	6	3	11	346
Emergency PAs	8	8	0	0	
Total	**7,666**	**3,324**	**465**	**3,877**	

Overrides					
Brand	39	15	5	19	254
Dosage Change	508	475	4	29	7
High Dose	6	5	0	1	138
IHS - Brand	6	6	0	0	242
IHS – Brand	2	1	0	1	360
Ingredient Duplication	5	5	0	0	6
Lost/Broken Rx	87	84	3	0	5
NDC vs Age	25	25	0	0	267
Nursing Home Issue	102	96	0	6	5
Other	23	20	1	2	24
Quantity vs. Days Supply	715	392	59	264	263
Stolen	8	8	0	0	6
Wrong D.S. on Previous Rx	1	1	0	0	3
Overrides Total	**1,500**	**1,107**	**72**	**321**	
Total Regular PAs + Overrides	**9,166**	**4,431**	**537**	**4,198**	

Denial Reasons

Unable to verify required trials.	2,692
Lack required information to process request.	1,482
Does not meet established criteria.	500
Not an FDA approved indication/diagnosis.	14
Member has active PA for requested medication.	7
Considered duplicate therapy. Member has a prior authorization for similar medication.	6

Duplicate Requests: 667

Letters: 860

No Process: 887

Changes to existing PAs: 566

Prior Authorization Activity

August 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	435	203	5	227	358
Amitiza	21	11	0	10	144
Anti-Ulcer	431	95	45	291	111
Antidepressant	359	108	26	225	339
Antihistamine	299	160	10	129	345
Antihypertensives	152	71	3	78	357
Antimigraine	87	14	14	59	243
Atypical Antipsychotics	734	330	29	375	354
Benzodiazepines	109	28	3	78	205
Bladder Control	70	10	4	56	330
Brovana (Arformoterol)	2	2	0	0	364
Byetta	9	1	1	7	365
Elidel/Protopic	28	15	2	11	91
ESA	230	148	3	79	59
Fibric Acid Derivatives	12	1	1	10	365
Fibromyalgia	116	53	8	55	348
Fortamet/Glumetza	1	1	0	0	360
Forteo	15	2	3	10	364
Glaucoma	18	9	1	8	339
Growth Hormones	59	40	6	13	173
HFA Rescue Inhalers	125	44	6	75	293
Insomnia	100	24	10	66	172
Misc Analgesics	37	4	21	12	234
Muscle Relaxant	145	49	37	59	94
Nasal Allergy	258	112	27	119	171
NSAIDS	141	35	8	98	305
Ocular Allergy	23	7	1	15	120
Ocular Antibiotics	96	43	5	48	33
Opioid Analgesic	283	127	17	139	216
Other	592	183	49	360	173
Otic Antibiotic	144	80	2	62	13
Pediculicides	143	74	3	66	12
Plavix	215	151	0	64	334
Qualaquin (Quinine)	2	0	1	1	0
Singulair	732	396	16	320	266
Smoking Cessation	48	15	0	33	59
Statins	121	24	8	89	329
Stimulant	1,439	914	50	475	229
Synagis	1	0	0	1	0
Topical Antibiotics	14	3	1	10	20
Topical Antifungals	16	4	0	12	23
Ultram ER and ODT	2	0	0	2	0
Xopenex Nebs	24	9	0	15	300
Zetia (Ezetimibe)	26	15	2	9	360
Emergency PAs	3	3	0	0	
Total	**7,917**	**3,618**	**428**	**3,871**	

Overrides					
Brand	35	20	1	14	214
Dosage Change	497	475	2	20	6
High Dose	4	1	0	3	92
IHS - Brand	17	17	0	0	183
IHS – Brand	5	1	0	4	11
Ingredient Duplication	8	6	0	2	8
Lost/Broken Rx	114	103	1	10	5
NDC vs Age	23	21	0	2	180
Nursing Home Issue	171	151	4	16	5
Other	40	30	0	10	21
Quantity vs. Days Supply	563	311	50	202	268
Stolen	12	10	1	1	4
Overrides Total	**1,489**	**1,146**	**59**	**284**	
Total Regular PAs + Overrides	**9,406**	**4,764**	**487**	**4,155**	

Denial Reasons

Unable to verify required trials.	2,555
Lack required information to process request.	1,544
Does not meet established criteria.	507
Not an FDA approved indication/diagnosis.	10
Drug Not Deemed Medically Necessary	2
Considered duplicate therapy. Member has a prior authorization for similar medication.	2

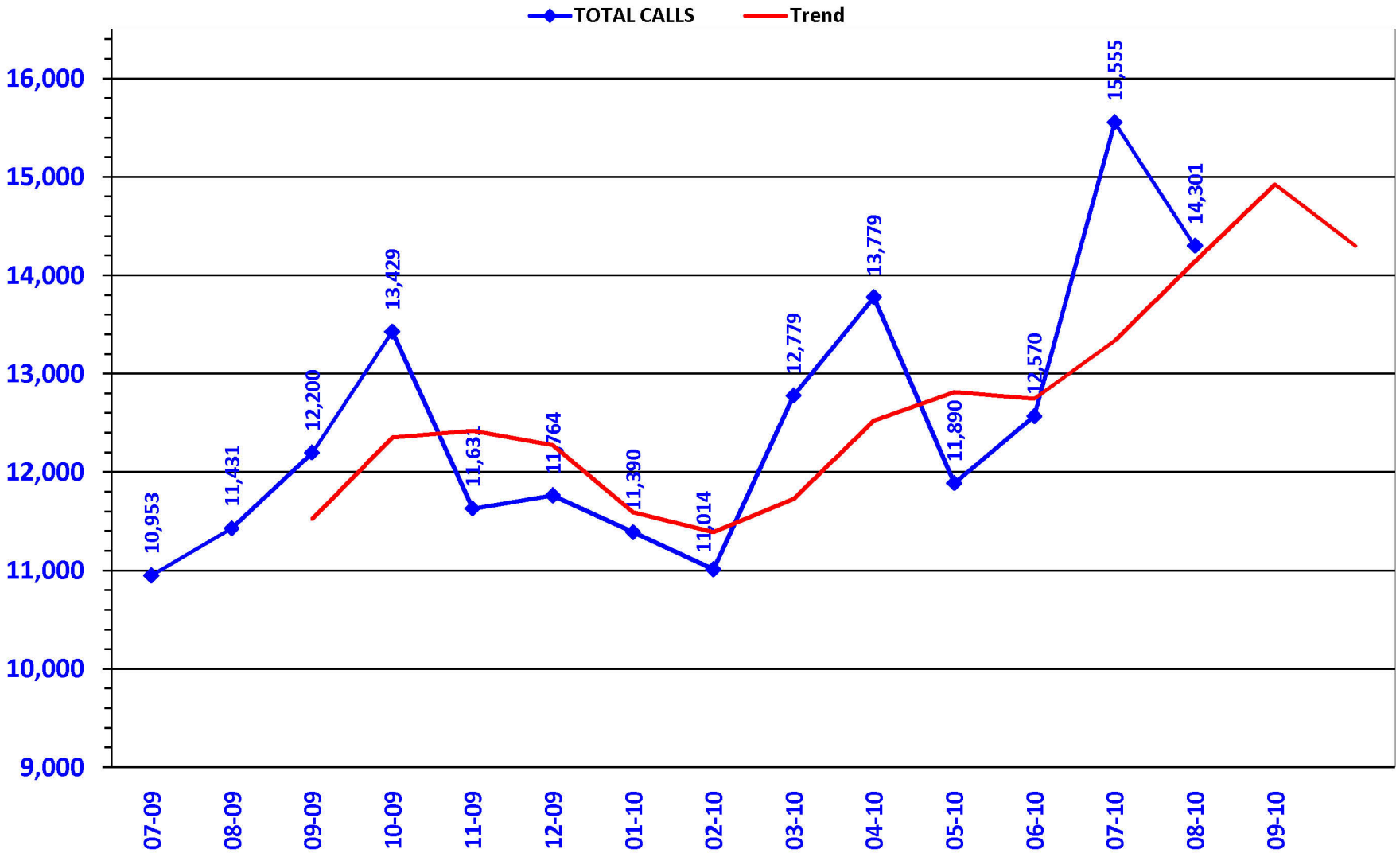
Duplicate Requests: 797

Letters: 1,015

No Process: 1,051

Changes to existing PAs: 440

CALL VOLUME MONTHLY REPORT:
July 2009 – August 2010



Appendix C

Vote to Prior Authorize Ampyra™ (dalfampridine)

Oklahoma Health Care Authority
September 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.

Recommendations

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

- Member must have a diagnosis of Multiple Sclerosis
- Kurtzke Expanded Disability Status Scale (EDSS) score between 4 and 7.5
- A 90 day 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
- Quantity limit of 60 for 30 days

Appendix

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 D

Vote to Prior Authorize
Qutenza® (capsaicin) 8 % Patch

Oklahoma Health Care Authority, September 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.

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 each of the following drug classes:
    a. Tricyclic antidepressants
    b. Anticonvulsants
    c. Topical lidocaine
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 and is 14 cm x 20 cm (280 cm^2) in size.

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 clinical drug interaction studies have been performed with the use of Qutenza®. In vitro cytochrome P450 inhibition and induction studies show that capsaicin does not inhibit or induce liver cytochrome P450 enzymes at concentrations which far exceed those measured in blood samples therefore Qutenza® is expected to have a very low potential for drug-drug interactions.

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 E

Vote to Prior Authorize Victoza®(liraglutide) and Bydureon® (exenatide LAR)

Oklahoma HealthCare Authority
September 2010

Cost Comparison of Available Products

Product[#]	AWP/ Unit	EAC / Unit	Monthly Cost*^
Victoza®(liraglutide) 0.6mg/0.1ml	$48.16	$42.38	$381.42(3pen)
Victoza®(liraglutide) 0.6mg/0.1ml	$48.16	$42.38	$254.28(2pen)
Byetta®(exenatide) 10mcg/0.04ml	$120.40	$105.95	$254.28
^maintenance dose 1.2mg/day ,*max dose 1.8mg/day Victoza®(liraglutide); max dose 20 mcg/day Byetta®(exenatide) # Victoza®(liraglutide) 2 pen pack (6ml) or 3 pen pack (9ml), Byetta®(exenatide) 10mcg Pen (2.4ml)			

Recommendations

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

1. Diagnosis of Type 2 Diabetes.
2. Therapy with metformin, sulfonylurea, thiazolidinediones, or a combination, for at least 90 days within the last 180 days, that has not yielded adequate glycemic control.
3. Clinical exception may be allowed if medication is prescribed by an endocrinologist.

REFERENCES

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

Appendix F

Vote to Prior Authorize Special Formulation Anti-Infectives

Oklahoma Health Care Authority, September 2010

Recommendations:

The College of Pharmacy recommends pharmacy prior authorization of these special formulation antibiotics with the criteria as follows:

Moxatag® (extended-release amoxicillin) 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 penicillin, amoxicillin, or amoxicillin/clavulanate.

Augmentin XR® (amoxicillin/clavulanate potassium) 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 penicillin, amoxicillin, or other forms of amoxicillin/clavulanate.

Oracea® (extended-release doxycycline) 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® (extended-release doxycycline) criteria:

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

Oravig® (miconazole buccal tablets) criteria:

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

The College of Pharmacy also recommends the prior authorization of drugs on the market that are reformulations of existing anti-infectives. Member must have a clinically significant reason why the existing formulation and/or other cost effective therapeutic equivalent medication(s) cannot be used.

Appendix G

Vote to PA Anticonvulsant Drugs under the Scope/Utilization PA Program

Oklahoma Health Care Authority, September 2010

Recommendations:

The College of Pharmacy recommends prior authorization of the anticonvulsant category under the scope/utilization PA program.

1. Anticonvulsants will be included in the current mandatory generic plan.
    a. All brand-name anticonvulsants will require prior authorization
        i. Brand-name medications will be approved for all members who are currently stable on these medications and have a seizure diagnosis
2. Prior authorization will be required for certain non-standard dosage forms of medications 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
        iii. Clinically significant reason why member cannot use the short-acting formulation
    c. Dosepacks will not be approved if standard dosage forms are available.
3. Quantity limit restrictions will be placed on lower strength tablets and capsules. The highest strengths will continue to have no quantity restrictions unless a maximum dose is specified for a particular medication.
4. Felbamate will require prior authorization with the following criteria:
    a. Initial prescription written by a neurologist
    b. Member has failed therapy with at least three other medications commonly used for seizures

Implementation plan:

1. **Prior authorization of felbamate will begin immediately. Current users will be grandfathered and proactive prior authorizations will be put into the system for those members.**
2. **Brand-name, dosage form, and quantity limit restrictions will be gradually implemented in batches over a 3-month period to ensure that each petition will be processed quickly and efficiently.**
3. **Prescribers will be notified and educated about these new changes before the implementation period begins.**
4. **Proposed restrictions are outlined in the following table included for your review.**

Anticonvulsants and Applicable Restrictions

Drug Name	Proposed Quantity Limits	Other Limits	Normal Daily Dosing	Max Dose
Barbiturates				
Mephobarbital (Mebaral)	32, 50 mg: 120 tablets per 30 days		400-600 mg daily divided TID or QID, or given hs Adults: 50-100 mg BID to TID Children 3-6mg/kg/day 60-200 mg/day 100-320 mg/day	600 mg/day
	100 mg: no restriction			
Phenobarbital (Luminal)	15, 16.2, 30, 32.4 mg: 90 tablets per 30 days			
	60, 64.8, 97.2, 100 mg: no restriction			
Phenobarbital elixir	20 mg/mL: 1,500 mL per 30 days	Age		
Phenobarbital injection	65 mg/mL: 277 mL per 30 days			
Hydantoins				
Fosphenytoin (Cerebyx)	100 mg/2 mL: 3 mL PE/min IV		LD: 10-20 mg PE/kg given IV or IM MD: 4-6 mg PE/kg/day	
Phenytoin (Dilantin)	50 mg chewable: 180 tablets per 30 days	Age	ID: 5mg/kg/day BID-TID MD: 4-8 mg/kg/day BID-TID LD: 15-20 mg/kg MD: 2 mL IV Q 6-8 hrs 100 mg BID-QID 100 mg TID	PED: 300 mg/day ADULT: 600 mg/day
	100 mg/4mL, 125 mg/5mL suspension: 360 mL per 30 days	Age		
	50 mg/mL injection: 1 mL/min IV in adults or 0.02-0.06 mL/kg/min in neonates			
	100 mg: 120 capsules per 30 days			
	200 mg: 90 capsules per 30 days			
	300 mg: 60 capsules per 30 days			
	100 mg EX: 180 capsules per 30 days			
Succinamides				
Ethosuxamide (Zarontin, Celontin)	250 mg: 180 capsules per 30 days		Individualized, starting dose is 500 mg/day	1500 mg daily in divided doses
	300 mg: 150 capsules per 30 days			
Valproic acid and derivatives				
Valproic acid (Depakene)	250 mg/5 mL syrup: 900 mL per 30	Age	ID: 10-15 mg/kg/day, doses >250 mg/day should be given in divided doses	60 mg/kg/day 75 kg (165 lb)= 4,500 mg/day 25 kg (55 lb)=1,500 mg/day
Valproic acid (Stavzor)	125 mg: 120 capsules per 30 days			
	250 mg: 120 capsules per 30 days			
	500 mg: 270 capsules per 30 days			
Divalproex sodium (Depakote)	125 mg sprinkle: 360 caps per 30 days	Age		
	125 mg DR: 90 tablets per 30 days			
	250 mg DR: 90 tablets per 30 days			
	500 mg DR: 270 tablets per 30 days			
	250 mg ER: 90 tablets per 30 days			
	500 mg ER: 270 tablets per 30 days			
Valproate inj (Depacon)	100 mg/mL: 1,350 mL per 30 days			

Drug Name	Proposed Quantity Limits	Other Limits	Normal Daily Dosing	Max Dose
Carbamazepine derivatives				
Carbamazepine (Tegretol)	100 mg chew: 300 tablets per 30	Age	ID: 400 mg/day (BID for ER, TID-QID for others) PED <6: 10-20 mg/kg/day PED 6-12: 100 mg BID for tabs or 2.5 mL QID for susp	PED: 1,000 mg/day ADULT: 1,600 mg/day
	100 mg/5 mL susp: 1,500 mL per 30	Age		
	200 mg: 240 tablets per 30 days			
	100 mg XR: 90 tablets per 30 days			
	200 mg XR: 90 tablets per 30 days			
	400 mg XR: 120 tablets per 30 days			
Carbamazepine (Carbatrol)	100 mg: 150 capsules per 30 days			
	200 mg: 150 capsules per 30 days			
	300 mg: 150 capsules per 30 days			
Carbamazepine (Equetro)	100 mg: 90 capsules per 30 days		200 mg BID	1,600 mg/day, given BID
	200 mg: 120 capsules per 30 days			
	300 mg: 150 capsules per 30 days			
Oxcarbazepine (Trileptal)	300 mg/5 mL susp: 1,200 mL per 30	Age	1,200 mg/day, given BID	2,400 mg/day
	150 mg: 90 tablets per 30 days			
	300 mg: 90 tablets per 30 days			
	600 mg: 120 tablets per 30 days			
Lamotrigine				
Lamotrigine (Lamictal)	5 mg chew: 240 tablets per 30 days	Age	Ranges from 100-600 mg/day in divided doses	
	25 mg chew: 120 tabs per 30 days	Age		
	25 mg: 120 tablets per 30 days			
	100 mg: 60 tablets per 20 days			
	150 mg: 90 tablets per 30 days			
	200 mg: 90 tablets per 30 days			
	25 mg ODT: 90 tablets per 30 days	Age		
	50 mg ODT: 90 tablets per 30 days	Age		
	100 mg ODT: 90 tablets per 30 days	Age		
	200 mg ODT: 90 tablets per 30 days	Age		
	25 mg XR: 30 tablets per 30 days	Form		
	50 mg XR: 30 tablets per 30 days	Form		
	100 mg XR: 30 tablets per 30 days	Form		
	200 mg XR: 90 tablets per 30 days	Form		
	Start kits: #35, #49, #98	Age, Form		
	ODT kits: #28, #35, #56	Age, Form		
	XR kits: #21, #35 (100mg), #35 (200 mg)	Form		
Levetiracetam				
Levetiracetam (Keppra)	100 mg/mL soln: 900 mL per 30	Age	3000 mg/day	3000 mg/day
	500 mg/5mL soln: 900 mL per 30	Age		
	250 mg: 60 tablets per 30 days			
	500 mg: 60 tablets per 30 days			
	750 mg: 90 tablets per 30 days			
	1000 mg: 90 tablets per 30 days			
	500 mg XR: 60 tablets per 30 days	Form		
	750 mg XR: 120 tablets per 30 days	Form		

Drug Name	Proposed Quantity Limits	Other Limits	Normal Daily Dosing	Max Dose
Topiramate				
Topiramate (Topamax)	15 mg spr: 120 capsules per 30 days	Age	200-400 mg/day divided BID	400 mg/day
	25 mg spr: 120 capsules per 30 days	Age		
	25 mg: 60 tablets per 30 days			
	50 mg: 60 tablets per 30 days			
	100 mg: 60 tablets per 30 days			
	200 mg: 60 tablets per 30 days			
Other anticonvulsants				
Felbamate (Felbatol)	400 mg: 240 tablets per 30 days		1200-3600 mg/day divided TID-QID	3200 mg/day
	600 mg: 150 tablets per 30 days			
Gabapentin (Neurontin)	250 mg/5 mL soln: 2,250 mL per 30 days	Age	900-1800 mg/day in divided doses	3600 mg/day
	100 mg: 90 capsules per 30 days			
	300 mg: 90 capsules per 30 days			
	400 mg: 90 capsules per 30 days			
	600 mg: 180 capsules per 30 days			
	800 mg: 120 capsules per 30 days			
Lacosamide (Vimpat)	50 mg: 60 tablets per 30 days		200-400 mg/day	400 mg/day
	100 mg: 60 tablets per 30 days			
	150 mg: 60 tablets per 30 days			
	200 mg: 60 tablets per 30 days			
Primidone (Mysoline)	50 mg: 120 tablets per 30 days		250 mg TID-QID	500 mg QID (2000 mg/day)
	250 mg: 240 tablets per 30 days			
Rufinamide (Banzel)	200 mg: 90 tablets per 30 days		3200 mg/day divided BID	3200 mg/day
	400 mg: 240 tablets per 30 days			
Zonisamide (Zonegran)	25 mg: 90 capsules per 30 days		100-600 mg/day divided QD-BID	600 mg/day
	50 mg: 90 capsules per 30 days			
	100 mg: 180 capsules per 30 days			
Pregabalin (Lyrica)	25 mg: 90 capsules per 30 days		150-600 mg/day, divided BID-TID	600 mg/day
	50 mg: 90 capsules per 30 days			
	75 mg: 90 capsules per 30 days			
	100 mg: 90 capsules per 30 days			
	150 mg: 90 capsules per 30 days			
	225 mg: 60 capsules per 30 days			
	300 mg: 60 capsules per 30 days			

Appendix H

Vote to Prior Authorize ProCentra™ and Second Opinion Process for ADHD/Narcolepsy Category

Oklahoma HealthCare Authority
September 2010

Utilization of ADHD/Narcolepsy Medications in the SoonerCare Population

Utilization data was separated into two categories and demographics data is shown for each category:

Demographics of Members Utilizing Stimulant Medications during Fiscal Year 2010

Age Groups	Male	Female	Totals
0-2	5	0	5
3	15	6	21
4	98	29	128
5	376	134	510
6-10	7,901	3,057	10,958
11-18	9,906	4,054	13,960
19-21	486	326	812
22-50	241	553	794
51-65	31	80	111
> 66	1	1	2

Demographics of Members Utilizing Non-Stimulant Medications during Fiscal Year 2010

Age Groups	Male	Female	Totals
0-2	0	0	0
3	1	0	1
4	6	4	10
5	56	16	72
6-10	1,041	391	1,432
11-18	1,477	537	2,014
19-21	84	46	130
22-50	71	159	230
51-65	19	53	72
> 66	0	2	2

Utilization of Stimulants in the Very Young

Age	Sex	Possible Diagnosis detected from Med/Hosp Claims	Medication of Interest
1	M	Attention Deficit Disorder Of Childhood With Hyperactivity, Oppositional Disorder Of Childhood Or Adolescence, Other Speech Disturbance, Unspecified Disturbance Of Conduct	Concerta
1	M	Attention Deficit Disorder Of Childhood With Hyperactivity	Focalin XR
2	M	None in Claims Hx	Amphetamine Salt Combo
2	M	Malignant Neoplasm Of Kidney Except Pelvis, Secondary Malignant Neoplasm Of Lung, Malignant Neoplasm Of Connective And Other Soft Tissue Site Unspecified, Encounter For Palliative Care, Anemia Unspecified	Methylphenidate (#20 for 14 days)
2	M	Developmental Language Disorder, Disorders Relating To Other Preterm Infants Unspecified Weight	Concerta , then Amphetamine Salt Combo

Utilization of Non-Stimulants in the Very Young

Age	Sex	Possible Diagnosis detected from Med/Hosp Claims	Medication of Interest
3	M	Oppositional Disorder Of Childhood Or Adolescence Problems With Hearing Attention Deficit Disorder Of Childhood With Hyperactivity Unspecified Lack Of Normal Physiological Development Other Child Abuse And Neglect Developmental Speech Or Language Disorder Developmental Coordination Disorder	Intuniv then Intuniv + Vyvanse

Conclusion and Recommendations

The College of Pharmacy recommends inclusion of the ADHD/Narcolepsy PBPA category in the Second Opinion Program for all SoonerCare members aged 0-4. The current Second Opinion Process, which provides a response to both the pharmacy and the prescriber within 24 hours of receipt of the petition, will be utilized.

The College of Pharmacy also recommends the addition of ProCentra™ to Tier 3 of the PBPA category. The current criteria for the category will apply. In addition, a clinical statement of medical necessity for the liquid formulation must be provided.

Appendix I

Annual Review of Synagis® - Fiscal Year 2010

Oklahoma Health Care Authority
September 2010

Prior Authorization of Synagis® during FY '10

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

Current Criteria for Prior Authorization of Synagis

A. Member Selection. Members must be included in one of the following age groups at the beginning of the RSV season:*

1) Infants and children less than 24 months old with Chronic Lung Disease (CLD) (formerly bronchopulmonary dysplasia) who have required medical treatment (O2, bronchodilator, corticosteroid, or diuretic therapy) for CLD in the 6 months prior to RSV season.
2) Infants up to 24 months old with moderate to severe pulmonary hypertension, cyanotic heart disease, or those on medications to control congestive heart failure.
3) Infants less than 12 months of age, born at 28 weeks gestation or earlier
4) Infants less than 6 months of age, born at 29-31 weeks gestation.
5) Infants less than 12 months of age, born before 35 weeks gestation, with congenital abnormalities of the airway
6) Infants less than 12 months of age, born before 35 weeks gestation, with severe neuromuscular disease
7) Infants, up to 3 months old at the start of RSV season, born at 32-34 weeks gestation, who have one of the following risk factors:
    a. Child care attendance
    b. Siblings younger than 5 years of age

* Treatment should continue through the entire RSV season.

B. Length of treatment. Synagis® is approved for use only during RSV season, which is generally November 1 through April 30, as determined by Oklahoma State Dept. of Health. Approval dates were from October 15, 2008 through March 31, 2009

C. Units authorized. The maximum duration of therapy is six (6) doses, with a dose to be administered no more often than every 30 days. Members given doses more frequently than every 30 days will not be authorized for additional doses. Doses administered prior to the member's discharge from a hospital will be counted as one of the six.

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

Utilization

For the period of October 15, 2009 through March 31, 2010, a total of 804 SoonerCare members received Synagis® from a pharmacy provider or a physician's office.

RSV Season	Members	Claims	Cost	Total Doses	Cost/Dose	Units	Days
2008 - 09	945	4,872	$7,539,574.82	3,530	$2,135.86	4,262	143,383
2009 - 10	804*	3,566	$5,926,396.14	2,739	$2,163.71	3,099	106,850
Percent Change	**-14.90%**	**-26.80%**	**-21.40%**	**-22.4%**	**1.3%**	**-27.30%**	**-25.50%**
Change	**-141**	**-1,306**	**-$1,616,843.59**	**-791**	**$27.85**	**-1,163**	**-36,563**

*One member had pharmacy and outpatient claims

Claim Type	EAC per Vial/Increment
Synagis® 50 mg/0.5 ml vial	$1,008.12
Synagis® 100 mg/ml vial	$1,903.43
Synagis® 50 mg increments - 90378	$916.23

EAC = Estimated Acquisition Cost

Pharmacy Claims

Product	# of Claims	Total Units	Total Days	Total Cost	Total Members
Synagis® 50 mg/0.5 ml vial	1,171	588	35,101	$1,174,985.18	570
Synagis® 100 mg/ml vial	2,394	2,511	71,719	$4,747,746.05	719
Total	**3,565**	**3,099**	**106,820**	**$5,922,731.23**	**804****

**Total unduplicated members for 09-10

Physician Office Claims – CPT code 90378

Product	# of Claims	Total Units	Total Days	Total Cost	Total Members
Synagis® 50 mg increments	1	4†	30	$3,664.91	1

† One unit = 0.5 mls

PA Activity

Total petitions - RSV Season 09-10
A total of 1,597 petitions were submitted for consideration of Synagis®.

Approved 939
Denied 237
Incomplete 420

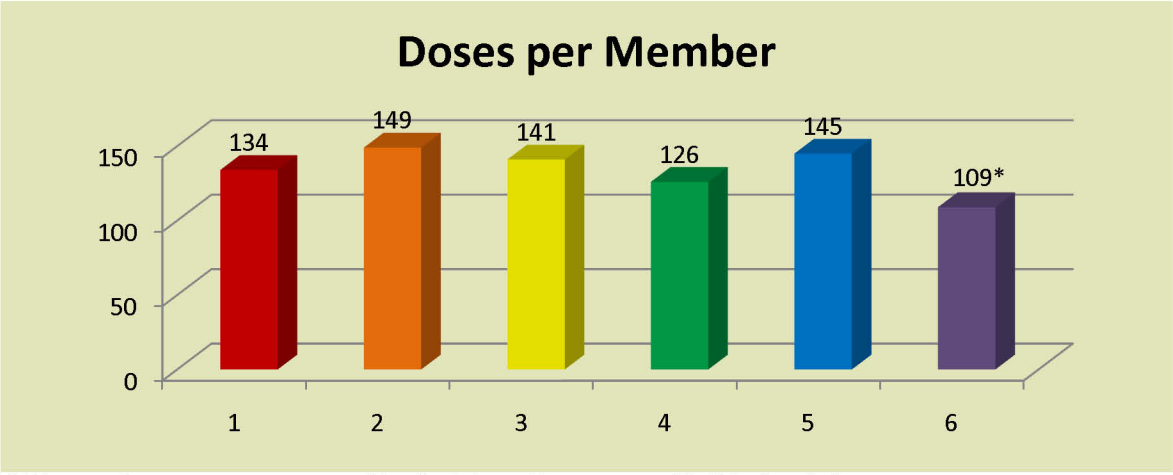
Demographics

Claims were reviewed to determine the age/gender of the members. The 2-year olds were under 24 months at the time of approval.

Age	Female	Male	Totals
0	354	345	699
1	52	45	97
2	2	6	8
Totals	**408**	**396**	**804**

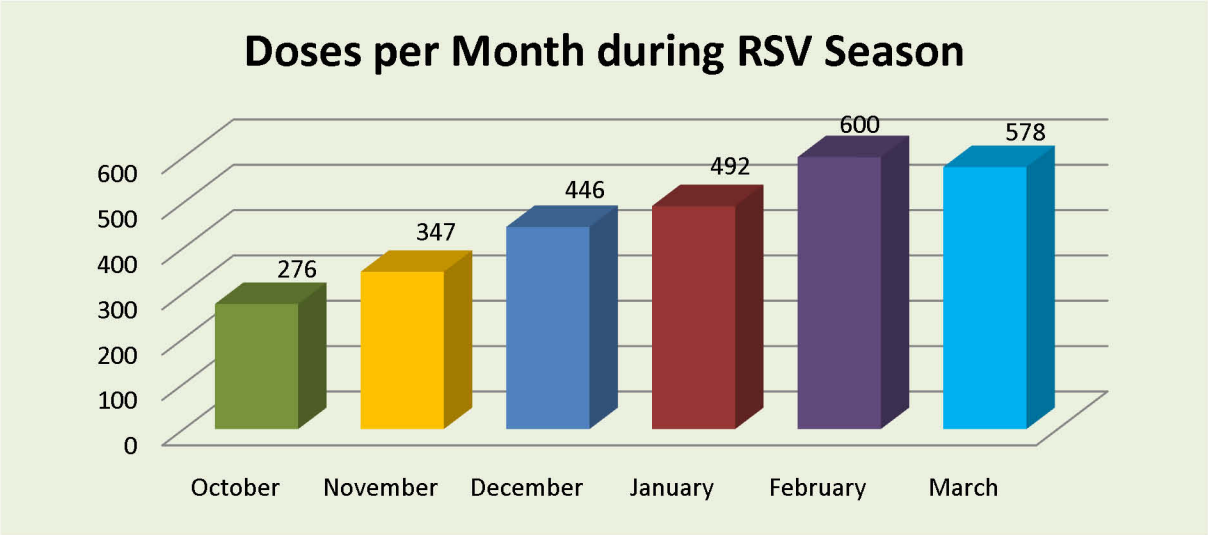
Dose Data

A total of **2,738 doses** were given through the season. The average cost per dose was **$2,163.71**. Synagis was limited to 6 doses for the season. None of the members had more than the six approved doses.

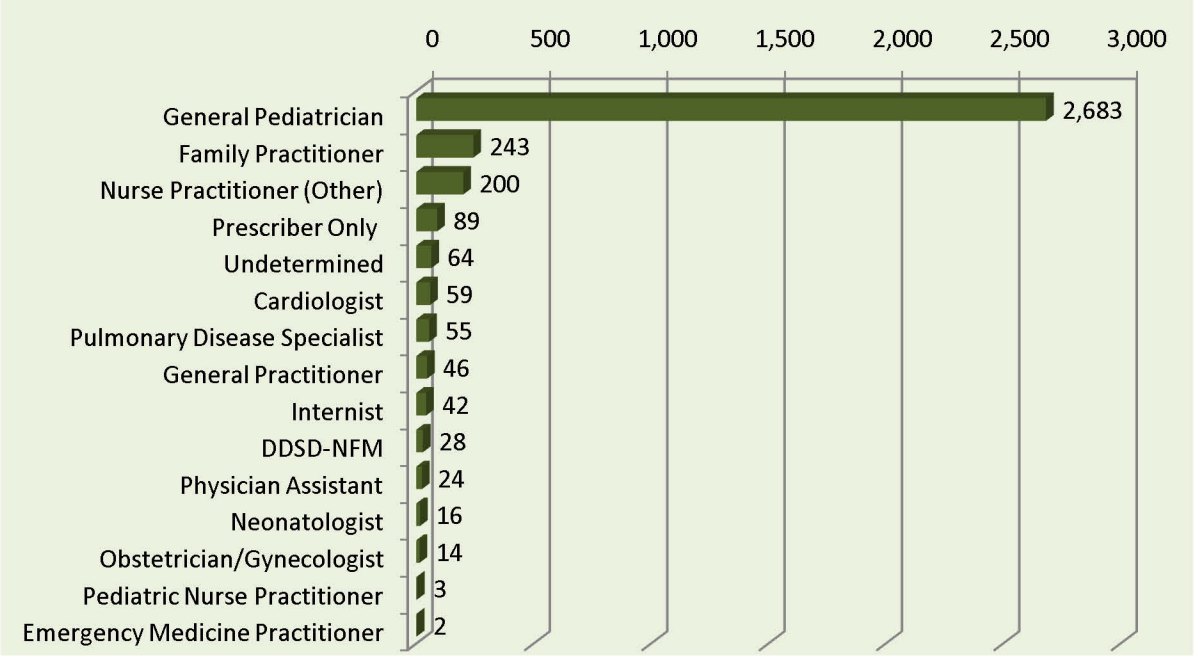


***354 members were approved in October, thus were eligible for 6 doses.**

Dosing

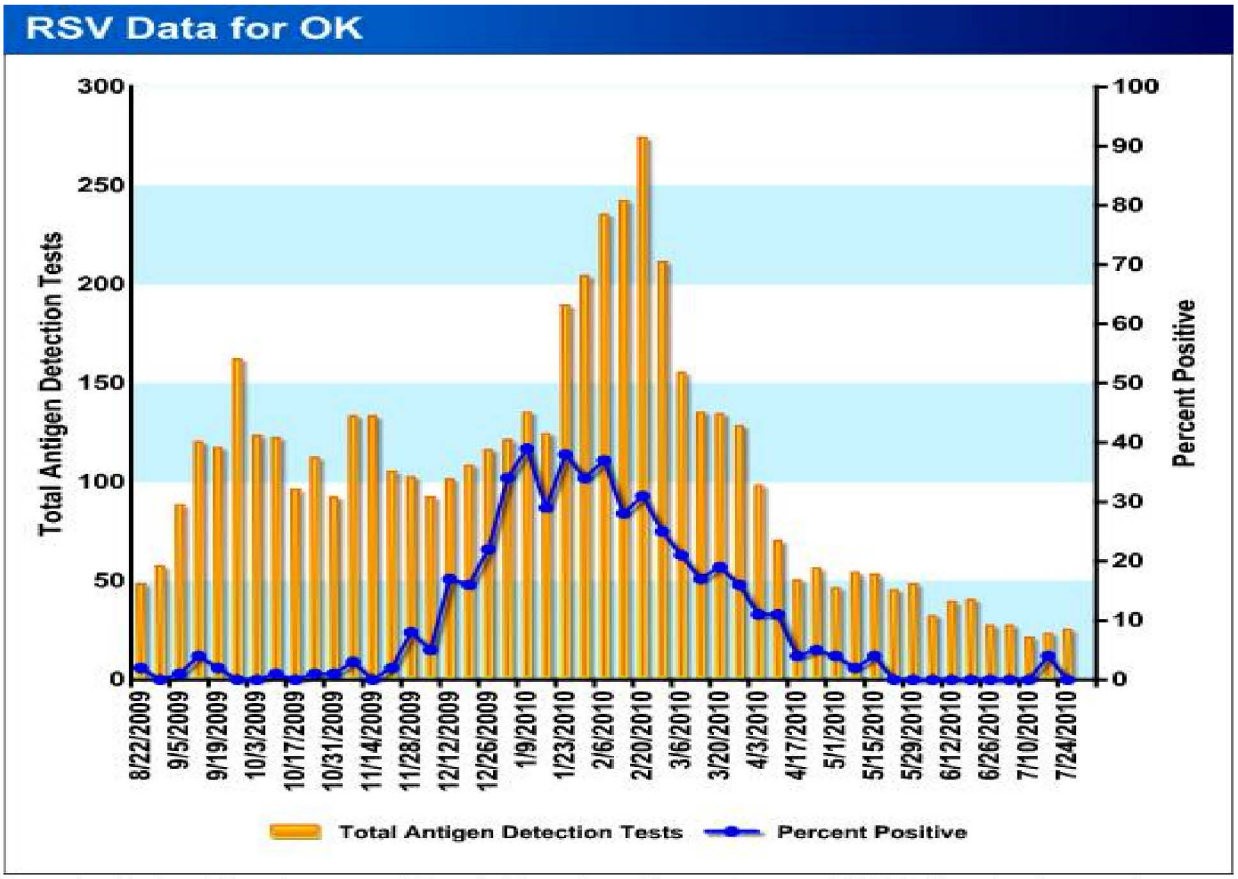


Prescriber Specialty



Discussion

- The 2009-10 RSV season did not reach the epidemic threshold until the first two weeks of December. After the peak in January, there was a gradual decline in cases into March. There was a slight increase in reported cases in mid-March, which corresponds to a winter storm that occurred in the state. By the second week of April, the number of cases had decreased to below the10% threshold. Considering the increase in lab tests due to the H1N1 pandemic, the incidence of RSV cases was similar to previous seasons.



From the National Respiratory and Enteric Virus Surveillance System (NREVSS) at the Centers for Disease Control website: http://www.cdc.gov/surveillance/nrevss/rsv/state.html

- The National Perinatal Association has published a guideline statement for immunoprophylaxis with palivizumab. These guidelines are available on the association's website: www.nationalperinatal.org.

Recommendations

The College of Pharmacy recommends modification of the existing palivizumab authorization criteria to concur with the guidelines published by the American Academy of Pediatricians (AAP) in 2009.

Recommended Criteria for Prior Authorization of Synagis®

A. Member Selection. Members must be included in one of the following age groups at the beginning of the RSV season:*

1. Infants and children less than 24 months old with Chronic Lung Disease (CLD) (formerly bronchopulmonary dysplasia) who have required medical treatment (O2, bronchodilator, corticosteroid, or diuretic therapy) for CLD in the 6 months prior to RSV season.
2. Infants up to 24 months old with moderate to severe pulmonary hypertension, cyanotic heart disease, or those on medications to control congestive heart failure.
3. Infants less than 12 months of age, born at 28 weeks gestation or earlier
4. Infants less than 6 months of age, born at 29-31 weeks gestation.
5. Infants less than 12 months of age, born before 35 weeks gestation, with congenital abnormalities of the airway
6. Infants less than 12 months of age, born before 35 weeks gestation, with severe neuromuscular disease
7. Infants, up to 3 months old at the start of RSV season, born at 32-34 weeks gestation, who have one of the following risk factors: (up to three doses only)
    a. Child care attendance
    b. One or more siblings or other children younger than 5 years living permanently in the same household

* Treatment should continue through the entire RSV season as indicated, except #7 (only up to 3 months of age).

B. Length of treatment. Synagis® is approved for use only during RSV season. Approval dates will be November 1 through March 31, 2009.

C. Units authorized. The maximum duration of therapy is five (5) doses, with a dose to be administered no more often than every 30 days. Infants born at 32-34 weeks gestation will receive a maximum of three doses; prophylaxis to be administered only up to 3 months of age. Members given doses more frequently than every 30 days will not be authorized for additional doses. Doses administered prior to the member's discharge from a hospital will be counted as one of the approved total.

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

Appendix J

U.S. Food and Drug Administration

Safety

Lamictal (lamotrigine): Label Change - Risk of Aseptic Meningitis

[Posted 08/12/2010]

AUDIENCE: Pediatrics, Neurology, Psychiatry

ISSUE: FDA notified healthcare professionals and patients that Lamictal (lamotrigine), a medication commonly used for seizures in children two years and older, and bipolar disorder in adults, can cause aseptic meningitis. Symptoms of meningitis may include headache, fever, stiff neck, nausea, vomiting, rash, and sensitivity to light. In cases of meningitis, it is important to rapidly diagnose the underlying cause so that treatment can be promptly initiated.

BACKGROUND: The decision to revise the Lamictal label is based on FDA's identification of 40 cases of aseptic meningitis in patients taking Lamictal (from December 1994 to November 2009). See the Data Summary section of the Drug Safety Communication for additional information.

RECOMMENDATION: Patients should be advised to contact their healthcare professional immediately if they experience signs and symptoms of meningitis while taking Lamictal. If meningitis is suspected, patients should be evaluated for other causes of meningitis and treated as indicated. Discontinuation of Lamictal should be considered if no other clear cause of meningitis is identified.

Healthcare professionals and patients are encouraged to report adverse events or side effects related to the use of this product to the FDA's MedWatch Safety Information and Adverse Event Reporting Program:

- Complete and submit the report Online: www.fda.gov/MedWatch/report.htm[1]
- Download form[2] or call 1-800-332-1088 to request a reporting form, then complete and return to the address on the pre-addressed form, or submit by fax to 1-800-FDA-0178

[08/12/2010 - Drug Safety Communication [3]- FDA]

Links on this page:

1. http://www.fda.gov/MedWatch/report.htm
2. http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm
3. http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm221847.htm

U.S. Food and Drug Administration

Safety

Midodrine hydrochloride: FDA Proposes Withdrawal of Low Blood Pressure Drug

[Posted 08/16/2010]
AUDIENCE: Cardiology and Nephrology

ISSUE: FDA proposed to withdraw approval of the drug midodrine hydrochloride, used to treat the low blood pressure condition, orthostatic hypotension, because required post-approval studies that verify the clinical benefit of the drug have not been done. To date, neither the original manufacturer nor any generic manufacturer has demonstrated the drug's clinical benefit, for example, by showing that use of the drug improved a patient's ability to perform life activities.
BACKGROUND: The drug, marketed as ProAmatine by Shire Development Inc. and as a generic by others, was approved in 1996 under the FDA's accelerated approval regulations for drugs that treat serious or life-threatening diseases. That approval required that the manufacturer verify clinical benefit to patients through post-approval studies.
RECOMMENDATION: Patients who currently take this medication should not stop taking it and should consult their health care professional about other treatment options.

[08/16/2010- News Release[1] - FDA]

Links on this page:

1. http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm222580.htm

U.S. Food and Drug Administration

Drugs

FDA Drug Safety Communication: New boxed warning for severe liver injury with arthritis drug Arava (leflunomide)

Safety Announcement

[07-13-2010] The U.S. Food and Drug Administration (FDA) is adding information on severe liver injury to the Boxed Warning of Arava (leflunomide) – a drug used to treat rheumatoid arthritis - to highlight the risk of severe liver injury in patients using this drug and how this risk may be reduced. FDA previously required a Boxed Warning stating that leflunomide was contraindicated in pregnant women, or women of childbearing potential who were not using reliable contraception.

The information on severe liver injury now being added to the Boxed Warning states:

- Patients with pre-existing liver disease should not receive leflunomide.
- Patients with elevated liver enzymes (ALT greater than two times the upper limit of normal) should not receive leflunomide.
- Caution should be used in patients who are taking other drugs that can cause liver injury.
- Liver enzymes should be monitored at least monthly for three months after starting leflunomide and at least quarterly thereafter.
- If the ALT rises to greater than two times the upper limit of normal while the patient is on leflunomide – leflunomide should be stopped, cholestyramine washout begun to speed the removal of leflunomide from the body and follow-up liver function tests conducted at least weekly until the ALT value is within normal range.

Although a bolded warning statement on severe liver injury was added to the leflunomide drug label in 2003, FDA determined that information on severe liver injury should be included in the Boxed Warning to highlight the importance of appropriate patient selection before starting treatment, and monitoring once treatment has begun.

The decision to add information on severe liver injury to the Boxed Warning was based on FDA's 2010 review of adverse event reports which identified 49 cases of severe liver injury, including 14 cases of fatal liver failure, between August 2002 and May 2009. In this review, the greatest risk for liver injury was seen in patients taking other drugs known to cause liver injury, and patients with pre-existing liver disease (see Data Summary below).

Healthcare professionals should be aware of the risk for severe liver injury with this drug, and ensure appropriate patient selection and monitoring (see Additional Information for Healthcare Professionals below).

Patients should know that severe liver injury is a rare, but serious side effect of this drug. Patients who experience itching, yellow eyes or skin, dark urine, loss of appetite, or light-colored stools should contact their healthcare professional right away—these may be signs of severe liver injury (see Additional Information for Patients below).

Additional Information for Patients

- Be aware that cases of severe liver injury have been reported in people taking leflunomide.
- Contact your healthcare professional if you develop itching, yellow eyes or skin, dark urine, loss of appetite, or light-colored stools. These may be signs of liver injury.
- Talk to your healthcare professional about any concerns you have with this medication.
- Report any side effects with leflunomide to FDA's MedWatch program using the information at the bottom of the page in the "Contact Us" box.

Additional Information for Healthcare Professionals

- Cases of severe liver injury, including fatal liver failure, have been reported in patients using leflunomide.
- Only patients for whom the anticipated therapeutic benefit is expected to outweigh the risk of severe liver injury should be considered for leflunomide treatment.
- Patients with pre-existing liver disease (acute or chronic infection with hepatitis B or C virus), or those with serum ALT greater than 2 times the upper limit of normal before initiating treatment, should not be treated with leflunomide.
- Caution should be used when leflunomide is given with other drugs that have the potential to cause liver injury.
- ALT levels should be monitored at least monthly for three months after starting leflunomide and at least quarterly thereafter.
- If the ALT rises to greater than 2 x the upper limit of normal while the patient is being treated with leflunomide – leflunomide should be stopped, cholestyramine washout begun, and follow-up liver function tests conducted at least weekly until normalization.

Data Summary

In 2003, a bolded warning statement about the risk of severe liver injury and a recommendation to monitor liver function tests every 6 to 8 weeks were included in the professional prescribing information for leflunomide. In 2009, based on continued reports of severe liver injury, FDA conducted an updated review of severe liver injury and leflunomide and identified 49 cases, 36 which required hospitalization, reported between August 2002 and May 2009.

The estimated duration of leflunomide treatment before the occurrence of severe liver injury ranged from 9 days to 6 years, with the majority of patients developing severe liver injury within the first 6 to 12 months of treatment.

Of the 49 cases, there were 14 deaths. An additional five patients required a liver transplant and nine patients experienced a life-threatening event. Twenty-three reports described jaundice at the time of diagnosis, 11 reported coagulopathy (clotting disorder), and five reported encephalopathy.

Other presenting symptoms in these cases included vomiting, rash and or itching, abdominal pain, and fever. Seventeen cases reported normal liver enzymes prior to starting leflunomide.

Forty-six of the 49 patients were also taking other medications that have been associated with liver injury, including methotrexate, TNF-α blockers, hydroxychloroquine, acetaminophen, non-steroidal anti-inflammatory drugs, and statins. In addition, 14 patients had pre-existing liver disease such as active or chronic hepatitis, and/or a history of alcohol abuse. Although many patients who developed severe liver injury were also taking other drugs that can damage the liver, or had pre-existing liver disease, FDA concluded that use of leflunomide was associated with the development of severe liver injury in these patients.

To highlight the importance of appropriate patient selection and monitoring in reducing the risk of severe liver injury, the agency decided that specific recommendations to ensure safe use of leflunomide needed to be added to the Boxed Warning.

Related Information

- Leflunomide (marketed as Arava) Information[1]
- FDA Drug Safety Podcast for Healthcare Professionals: New boxed warning for severe liver injury with arthritis drug Arava (leflunomide)[2] 7/13/2010

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1. http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm218691.htm
2. http://www.fda.gov/Drugs/DrugSafety/DrugSafetyPodcasts/ucm219584.htm
3. http://www.fda.govhttps://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm
4. http://www.fda.gov/downloads/Safety/MedWatch/DownloadForms/UCM082725.pdf

U.S. Food and Drug Administration

Drugs

FDA Drug Safety Communication: Eosinophilic pneumonia associated with the use of Cubicin (daptomycin)

Safety Announcement

[07-29-2010] The U.S. Food and Drug Administration (FDA) is informing patients and healthcare professionals about the potential for developing eosinophilic pneumonia during treatment with Cubicin (daptomycin), an intravenous antibacterial drug.

Cubicin was first approved in September 2003 to treat serious skin infections. In 2006, it was approved to treat bloodstream infections.

Eosinophilic pneumonia is a rare, but serious condition where a type of white blood cell (eosinophil) fills the lungs. Symptoms of eosinophilic pneumonia include fever, cough, shortness of breath, and difficulty breathing.

Healthcare professionals should closely monitor patients being treated with Cubicin for eosinophilic pneumonia (see Additional Information for Healthcare Professionals). Patients receiving Cubicin should immediately contact their healthcare professional if they develop a new or worsening fever cough, shortness of breath, or difficulty breathing.

In 2007, pulmonary eosinophilia was added to the *Adverse Reactions, Post-Marketing Experience* section of the Cubicin product label. Since then, the Agency has reviewed published case reports of Cubicin-associated eosinophilic pneumonia,[1-4] and conducted a review of post-marketing adverse event reports from the FDA's Adverse Event Reporting System (AERS). FDA's review identified 7 cases of eosinophilic pneumonia between 2004 and 2010 that were most likely associated with Cubicin (see Data Summary below).

Based on these reviews, FDA determined that eosinophilic pneumonia can be associated with Cubicin use and requested that the manufacturer of Cubicin include this information in the *Warnings and Precautions* and *Adverse Reactions, Post-Marketing Experience* sections of the drug label.

Additional Information for Patients

- Be aware that eosinophilic pneumonia has been reported in patients receiving Cubicin.
- If you experience a new or worsening fever, cough, shortness of breath, or have difficulty breathing while receiving Cubicin, contact your healthcare professional immediately.
- Talk to your healthcare professional about any concerns with Cubicin.
- Report any side effects from the use of Cubicin to the FDA MedWatch program, using the information in the "Contact Us" box at the bottom of the page.

Additional Information for Healthcare Professionals

- Be aware that eosinophilic pneumonia has been reported in patients receiving Cubicin.
- Discuss with patients the clinical benefits and potential risks of Cubicin, including the risk of eosinophilic pneumonia, prior to beginning treatment.
- Monitor patients for signs and symptoms of eosinophilic pneumonia, including new onset or worsening fever, dyspnea, difficulty breathing, and new infiltrates on chest imaging studies.
- In patients exhibiting signs and symptoms of eosinophilic pneumonia, discontinue Cubicin and consider treating as clinically indicated.
- Report adverse events involving Cubicin to the FDA MedWatch program using the information in the "Contact Us" box at the bottom of this page.

Data Summary

FDA identified six cases of eosinophilic pneumonia reported to AERS between 2004 and 2010 that were most likely associated with Cubicin. One additional case of eosinophilic pneumonia most likely associated with Cubicin was identified in the medical literature.[2]

For FDA's review, a case of eosinophilic pneumonia most likely associated with Cubicin was defined as meeting all of the following criteria:

- Concurrent exposure to Cubicin
- Fever
- Dyspnea with increased oxygen requirement or requiring mechanical ventilation
- New infiltrates on chest x-ray or computed tomography scan
- Bronchoalveolar lavage with > 25% eosinophils
- Clinical improvement following Cubicin withdrawal

Of the seven cases identified using the above definition:

- Cubicin was prescribed for non-FDA approved indications, including osteomyelitis (n=4), prosthetic hip infection (n=1), enterococcal endocarditis (n=1), and aortic valve endocarditis (n=1).
- The ages of patients ranged from 60 to 87 years.
- Eosinophilic pneumonia developed 2-4 weeks after initiating Cubicin treatment.
- All seven cases reported improvement or resolution of symptoms after Cubicin was discontinued. Five of the seven cases were also treated witl systemic corticosteroids.

- Two cases reported recurrence of eosinophilic pneumonia after Cubicin was restarted.

FDA also identified 36 possible cases of eosinophilic pneumonia associated with Cubicin use. Although these cases did not meet the full criteria for a likely case of eosinophilic pneumonia associated with Cubicin, they do provide additional support for an association between use of Cubicin and development of eosinophilic pneumonia.

Based on FDA's review, there appears to be a temporal association between Cubicin administration and the development of eosinophilic pneumonia. Eosinophilic pneumonia may lead to progressive respiratory failure and is potentially fatal if not quickly recognized and appropriately managed. FDA requested that Cubist, the manufacturer of the product, revise the *Warnings and Precautions and Adverse Reactions, Post-Marketing Experience* sections of the Cubicin product label to further inform healthcare professionals of this association.

References:

1. Lal Y, Assimacopoulos AP. Two cases of daptomycin-induced eosinophilic pneumonia and chronic pneumonitis. *Clin Infect Dis.* 2010;50:737-40.

2. Hayes D Jr, Anstead MI, Kuhn RJ. Eosinophilic pneumonia induced by daptomycin. *J Infect.* 2007;54:e211-3.

3. Miller BA, Gray A, Leblanc TW, Sexton DJ, Martin AR, Slama TG. Acute eosinophilic pneumonia secondary to daptomycin: a report of three cases. *Clin Infect Dis.* 2010;50:e63-8.

4. Kakish E, Wiesner AM, Winstead PS, Bensadoun ES. Acute respiratory failure due to daptomycin induced eosinophilic pneumonia. *Respir Med CME.* 2008;1:235-7.

Related Information

- Daptomycin (marketed as Cubicin) Information[1]
- FDA Drug Safety Podcast for Healthcare Professionals: Eosinophilic pneumonia associated with the use of Cubicin (daptomycin)[2]

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3. http://www.fda.govhttps://www.accessdata.fda.gov/scripts/medwatch/medwatch-online.htm
4. http://www.fda.gov/downloads/Safety/MedWatch/DownloadForms/UCM082725.pdf

U.S. Food and Drug Administration

Drugs

FDA Drug Safety Communication: Ongoing safety review of Evamist (estradiol transdermal spray) and unintended exposure of children and pets to topical estrogen

Safety Announcement

[07-29-2010] The U.S. Food and Drug Administration (FDA) is reviewing reports of adverse effects from Evamist in children who may have been unintentionally exposed to the drug through skin contact with women using this product. FDA has also received reports of inadvertent exposure in pets

Evamist contains estradiol, an estrogen hormone. It is used in women to reduce hot flashes during menopause. Evamist is a topical product, sprayed on the skin on the inside of the forearm between the elbow and the wrist.

Patients should make sure that children are not exposed to Evamist and that children do not come into contact with any skin area where the drug was applied. Women who cannot avoid contact with children should wear a garment with long sleeves to cover the application site.

Children unintentionally exposed to Evamist may experience premature puberty. Female children may experience nipple swelling and breast development. Male children may experience breast enlargement.

Pets exposed to Evamist may exhibit signs such as mammary/nipple enlargement and vulvar swelling.

FDA is currently reviewing these reported adverse events and is working with the company to identify any factors that may contribute to unintended exposure. FDA and the company are also evaluating ways to minimize the risk.

This communication is in keeping with FDA's commitment to inform the public about its ongoing safety review of drugs. The Agency will update the public when this review is complete.

Additional Information for Patients

- Do not allow children to make contact with the area of the arm where Evamist was sprayed. If contact with children cannot be avoided, it is recommended that you wear a garment with long sleeves to cover the application site.
- If a child comes in direct contact with the arm where Evamist was sprayed, wash the child's skin with soap and water as soon as possible.
- Contact the child's healthcare professional if the child begins to have any of the following signs or symptoms: nipple or breast swelling or breas tenderness in females, or breast enlargement in males. Be sure to tell the healthcare professional that the child may have been exposed to Evamist.
- If you are using Evamist and have questions concerning the possibility of drug transfer to a child, you should consult your healthcare professional.
- Do not allow pets to lick or touch the arm where Evamist was sprayed. Small pets may be especially sensitive to the estrogen in Evamist. Contact your pet's veterinarian if your pet exhibits signs of nipple and/or vulvar enlargement, or any other signs of illness.
- Read the Patient Package Insert when picking up a prescription for Evamist.
- Report any side effects from the use of Evamist to the FDA MedWatch program, using the information in the "Contact Us" box at the bottom of the page.

Additional Information for Healthcare Professionals

- Be aware that unintentional exposure by children to Evamist can result in signs and symptoms of premature puberty and breast development i females, as well as gynecomastia in males.
- Advise patients to cover the application site if direct contact with children or pets cannot be avoided.
- Continue to counsel patients on how to apply Evamist properly.
- Encourage patients to read the Patient Package Insert when picking up their prescription for Evamist.
- Be aware that inadvertent exposure to Evamist was reported in household pets and alert patients to this potential.
- Report adverse events involving Evamist to the FDA MedWatch program using the information in the "Contact Us" box at the bottom of this page.

Data Summary

Evamist was approved by FDA in July 2007. Since then through June 2010, FDA has received 8 postmarketing cases of unintended exposure of childre to Evamist. The children ranged in age from three to five years.

The reported adverse effects were consistent with premature puberty in females, including development of breast buds and breast mass. For males, reported adverse effects were consistent with gynecomastia. The signs and symptoms appeared several weeks to months after the adult patient initiated therapy with Evamist. Some cases reported symptom resolution after the Evamist user discontinued the drug or used preventive measures to avoid unintentional exposure of children to the drug.

Reports of secondary exposure to Evamist in two spayed female dogs have been received by FDA's Center for Veterinary Medicine since 2007 and include signs of mammary/nipple enlargement, vulvar swelling, and liver failure in one case, and vaginal prolapse and elevated estrogen levels in the other. In both cases, secondary exposure occurred through licking of the owner's arms or by the dog being held by the owner.

FDA does not have information to assess the potential of topical Evamist transfer from adult users to children. It is not feasible to conduct such studies

FDA is continuing to review adverse event reports and evaluate ways to reduce unintended exposures with Evamist.

Related Information

- Estradiol Transdermal Spray (marketed as Evamist) Information[1]
- Keep Kids, Pets Away From Skin Sprayed With Evamist[2]
  7/29/2010
- FDA Drug Safety Podcast for Healthcare Professionals: Ongoing safety review of Evamist (estradiol transdermal spray) and unintended exposure of children and pets to topical estrogen[3]
- FDA Drug Safety Podcast: Avoid Unintentional Exposure of Children and Pets to Evamist[4]

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6. http://www.fda.gov/downloads/Safety/MedWatch/DownloadForms/UCM082725.pdf

U.S. Food and Drug Administration

Drugs

FDA Drug Safety Communication: Ongoing safety review of the angiotensin receptor blockers and cancer

Safety Announcement

[7-15-2010] The U.S. Food and Drug Administration (FDA) is conducting a review of the class of medications known as angiotensin receptor blockers (ARBs) after a recently published study suggested they may be associated with a small increased risk of cancer.

- **FDA's review is ongoing and the Agency has not concluded that ARBs increase the risk of cancer.**
- **At this time, FDA believes that the benefits of these medicines continue to outweigh their potential risks.**
- **FDA recommends that these drugs continue to be used as recommended in their approved labels.**

ARBs are used in patients with high blood pressure and other conditions. Brand names include Atacand, Avapro, Benicar, Cozaar, Diovan, Micardis, and Teveten. ARBs are also sold in combination with other medications (see Approved Angiotensin Receptor Blockers below).

The Agency plans to review the available data on these medications, and evaluate additional ways to better assess a possible link between use of ARBs and cancer. FDA will update the public when this review is complete.

The published study was a meta-analysis combining cancer-related findings from several clinical trials. The study found a small increased risk of reported new cancers in patients taking an ARB compared to those not taking an ARB.[1] No statistically significant difference in the number of cancer deaths was observed (see Data Summary below).

These clinical trials were not designed to study the effects of ARBs on cancer risk. The findings need close examination for more detailed information about the patients who were reported to have cancer so that it can be determined whether this cancer was in fact new. ARBs have been shown to provide significant benefit in many patients with certain heart-related conditions such as high-blood pressure and heart failure.

Additional Information for Patients

- FDA has not concluded that angiotensin receptor blockers (ARBs) increase the risk of cancer. FDA is evaluating this safety concern and will update the public when additional information is available.
- FDA believes the benefits of ARBs in patients with high blood pressure and certain heart-related conditions continue to outweigh their potential risks.
- Do not stop taking your ARB unless told to do so by your healthcare professional.
- Talk to your healthcare professional if you have concerns about your medicine.
- Report any side effects you experience to the FDA MedWatch program, using the information in the "Contact Us" box at the bottom of the page

Additional Information for Healthcare Professionals

- The meta-analysis by Sipahi et al. concluded that there was an increase in new cancer diagnoses in patients randomized to an ARB.[1]
- FDA has not concluded that angiotensin receptor blockers (ARBs) increase the risk of cancer. The Agency is reviewing information related to this safety concern and will update the public when additional information is available.
- FDA believes the benefits of ARBs continue to outweigh their potential risks.
- Report adverse events involving ARBs to the FDA MedWatch program using the information in the "Contact Us" box at the bottom of this page.

Data Summary

The meta-analysis included data from over 60,000 patients in several long-term, randomized, controlled clinical trials evaluating angiotensin receptor blockers (ARBs) for which adverse events related to cancer were captured during the study. The mean duration of follow-up ranged from 1.7 to 4.8 years.

The study reported the frequencies of new cancer occurrence to be 7.2% for patients receiving ARBs compared to 6.0% for those not receiving ARBs (risk ratio = 1.08, 95% Confidence Interval: 1.01-1.15). No statistically significant difference in cancer deaths was noted.

The meta-analysis had several limitations that make it difficult to determine the validity of the findings without further examination of the underlying data. The limitations include:

- The analysis included data from trials where there was no adjudication of cancer-related adverse events. In these trials, there was no way to determine whether the events represented new diagnoses of cancer, or events related to a preexisting cancer. Thus, the actual number of new cancer occurrences is unknown.
- The analysis may not have included all relevant clinical trials of ARBs.
- The analysis is not based on patient-level data. Knowledge of the specific timing and nature of events in individual patients would aid in interpretation of the findings.
- The majority of patients included in the studies reviewed were receiving the ARB telmisartan; therefore the applicability of the cancer-related findings to all ARBs is uncertain.

- The meta-analysis was planned to examine a hypothesis raised by cancer-related trends in three outcome studies. Because the meta-analysis included two of these studies, the results of the meta-analysis do not provide a fully independent confirmation of the hypothesis raised by the earlier studies.

Once complete, FDA's review will provide additional information about the possible link between ARB use and development of cancer. At this time, FDA recommends that healthcare professionals continue to use ARBs as recommended in their product labels. Patients should not stop taking their medication unless told to do so by their healthcare professional.

Approved Angiotensin Receptor Blockers

Single Ingredient Angiotensin Receptor Blockers

Brand Name	Generic Name
Atacand	candesartan
Avapro	irbesartan
Benicar	olmesartan
Cozaar	losartan
Diovan	valsartan
Micardis	telmisartan
Teveten	eprosartan

Combination Angiotensin Receptor Blockers

Brand Name	Generic Names
Atacand HCT	candesartan and hydrochlorothiazide
Avalide	irbesartan and hydrochlorothiazide
Azor	olmesartan and amlodipine
Benicar HCT	olmesartan and hydrochlorothiazide
Diovan HCT	valsartan and hydrochlorothiazide
Exforge	valsartan and amlodipine
Exforge HCT	valsartan, amlodipine, and hydrochlorothiazide
Hyzaar	losartan and hydrochlorothiazide
Micardis HCT	telmisartan and hydrochlorothiazide
Teveten HCT	eprosartan and hydrochlorothiazide
Twynsta	telmisartan and amlodipine
Valturna	valsartan and aliskiren

References:

1. Sipahi I, Debanne SM, Rowland DY, Simon DI, Fang JC. Angiotensin-receptor blockade and risk of cancer: meta-analysis of randomised controlled trials. *The Lancet Oncology* 2010;11(7), 627-36.

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PRESS RELEASE

FOR IMMEDIATE RELEASE: Thursday, July 15, 2010

CONTACT: ONDCP Public Affairs
202-395-6618

- **New Data Reveal 400% Increase in Substance Abuse Treatment Admissions for People Abusing Prescription Drugs**

- WASHINGTON—Today, Gil Kerlikowske, Director of National Drug Control Policy (ONDCP), and Thomas McLellan, Deputy Director of ONDCP, joined Peter Delany, Director of Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies, and Michele M. Leonhart, Acting Administrator of the Drug Enforcement Administration (DEA), to release a new study showing a 400 percent increase in substance abuse treatment admissions for prescription pain relievers. Governor Jack Markell of Delaware and Chris Kennedy Lawford were also in attendance.

- The study, *Substance Abuse Treatment Admissions Involving Abuse of Pain Relievers: 1998-2008,* conducted by the SAMHSA, and based on the agency's Treatment Episode Data Set (TEDS) reveals a 400 percent increase between 1998 and 2008 of substance abuse treatment admissions for those aged 12 and over reporting abuse of prescription pain relievers. The increase in the percentage of admissions abusing pain relievers spans every age, gender, race, ethnicity, education, employment level, and region. The study also shows a more than tripling of pain reliever abuse among patients who needed treatment for opioid dependence.

- "The TEDS data released today highlights how serious a threat to public health we face from the abuse of prescription drugs", said Gil Kerlikowske, National Drug Policy Director. "The spikes in prescription drug abuse rates captured by this study are dramatic, pervasive, and deeply disturbing."

- "The non-medical use of prescription pain relievers is now the second-most prevalent form of illicit drug use in the Nation, and its tragic consequences are seen in substance abuse treatment centers and hospital emergency departments throughout our Nation" said SAMHSA Administrator Pamela S. Hyde, J.D. "This public health threat demands that we follow the President's National Drug Control Strategy's call for an all-out effort to raise awareness of this risk and the critical importance of properly using, storing, and disposing of these powerful drugs."

- "The data released today is alarming and shows the tremendous damage being caused by prescription drug abuse all across this country each and every day," said DEA Acting Administrator Michele M. Leonhart. "The effective enforcement of laws regulating the distribution of controlled substances, coupled with their lawful disposal are essential parts of a comprehensive strategy to reduce drug abuse. DEA is committed to being part of the solution, however it will take all of us working together to prevent the tragedies that inevitably come with drug abuse."
- "This rise in prescription drug abuse is no surprise to the doctors and law enforcement professionals who see its effects in our communities," said Governor Markell. "We have been focused on making sure that health care professionals have the best tools available to detect and prevent this kind of abuse before it ruins lives. Delaware's new legislation to authorize a prescription monitoring program is one of those tools and an important component of the President's National Drug Control Strategy."
- "Our national prescription drug abuse problem cannot be ignored. I have worked in the treatment field for the last 35 years, and recent trends regarding the extent of prescription drug abuse are startling," said A. Thomas McLellan, Deputy Director of ONDCP. "We must work with prescribers, the pharmaceutical industry, law enforcement, and families to help us fight this scourge."
- The National Drug Control Strategy, released in May, outlines several steps to address what Director Kerlikowske calls "the fastest-growing drug problem in the United States"—prescription drug abuse.
- They include:
  - Increasing prescription drug return, take-back, and disposal programs. Prescription drugs that are commonly abused are often found in the family medicine cabinet, and individuals should get rid of unused or expired prescription drugs to prevent diversion and abuse.
  - Educating physicians about opiate painkiller prescribing. The Administration's FY 2011 Budget request proposes funding for a program to train prescribers on how to instruct patients in the use and proper disposal of painkillers, to observe signs of dependence, and to use prescription drug monitoring programs to detect when an individual is going from doctor to doctor in search of prescriptions (also called "doctor shopping").
  - Expanding prescription drug monitoring programs. Currently, these programs are operating in 34 states. The Administration supports establishment of these programs in every state, and is seeking to ensure new and existing monitoring programs effectively use the data they acquire

- Assisting states in addressing doctor shopping and pill mills. Criminal organizations have established thriving businesses of transporting people to states with little regulation to obtain prescription drugs from multiple doctors or from pill mills, which distribute drugs indiscriminately. Federal, state, local, and tribal authorities are working together to address this problem.
- Driving illegal Internet pharmacies out of business.
- Cracking down on rogue pain clinics that do not follow appropriate prescription practices.

- The National Drug Control Strategy provides a blueprint for reducing prescription drug abuse. Parents, law enforcement, the medical community, and all levels of government have a role to play in reducing prescription drug abuse.
- Later today, Director Kerlikowske will travel to Delaware to attend Governor Markell's bill signing for the Delaware Prescription Drug Monitoring Program.

  - www.whitehousedrugpolicy.gov

- *The Office of National Drug Control Policy seeks to foster healthy individuals and safe communities by effectively leading the Nation's effort to reduce drug use and its consequences.*

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