Drug Utilization Review Board

Oklahoma Health Care Authority
2401 N.W. 23rd Street, Suite 1A
Oklahoma City, Oklahoma 73107
Ponca Room

Wednesday
January 12, 2010
6:00 p.m.

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

MEMORANDUM

TO: Drug Utilization Review Board Members

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

SUBJECT: **Packet Contents for Board Meeting – January 12, 2010**

DATE: January 5, 2010

NOTE: THE DUR BOARD WILL MEET AT 6:00 P.M. THE MEETING WILL BE HELD IN THE PONCA ROOM AT THE OKLAHOMA HEALTH CARE AUTHORITY OFFICES IN SHEPHERD MALL. (NORTH ENTRANCE)

Enclosed are the following items related to the January 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 Zyflo CR® – See Appendix C.

Action Item – Vote to Prior Authorize Latuda™ – See Appendix D.

30 Day Notice to Prior Authorize Benign Prostate Hyperplasia (BPH) Products – See Appendix E.

Action Item – Annual Review of Hypnotic Medications and 30 Day Notice to Prior Authorize Silenor® – See Appendix F.

Action Item – Annual Review of Antihypertensives and 30 Day Notice to Prior Authorize Tribenzor®, Tekamlo®, Nexiclon XR®, and Catapres-TTS® – See Appendix G.

Action Item – Annual Review of ADHD Medications and 30 Day Notice to Prior Authorize Kapvay® and Xyrem® – See Appendix H.

FDA and DEA Updates – See Appendix I.

Future Business

Adjournment

Oklahoma Health Care Authority
Drug Utilization Review Board
(DUR Board)
Meeting – January 12, 2010 @ 6:00 p.m.

Oklahoma Health Care Authority
2401 N.W. 23rd Street, Suite 1-A
Oklahoma City, Oklahoma 73107
Ponca Room (North Entrance)

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. December 8, 2010 DUR Minutes – Vote
- B. December 9, 2010 DUR Recommendation Memorandum

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

4. Update on DUR / Medication Coverage Authorization Unit – See Appendix B.
- A. Retrospective Drug Utilization Review Response for September 2010
- B. Medication Coverage Activity Audit for December 2010
- C. Pharmacy Help Desk Activity Audit for December 2010

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

5. Action Item – Vote to Prior Authorize Zyflo CR® – See Appendix C.
- A. COP Recommendations

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

6. Action Item – Vote to Prior Authorize Latuda™ – See Appendix D.
- A. COP Recommendations

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

7. 30 Day Notice to Prior Authorize Benign Prostate Hyperplasia (BPH) Products – See Appendix E.
- A. COP Recommendations

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

8. Action Item – Annual Review of Hypnotic Medications and 30 Day Notice to Prior Authorize Silenor® – See Appendix F.

A. Current Authorization Criteria
B. Utilization Review
C. Prior Authorizations Review
D. Market News and Update
E. COP Recommendations
F. Utilization Details
G. Silenor® Product Details

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

9. Action Item – Annual Review of Antihypertensives and 30 Day Notice to Prior Authorize Tribenzor®, Tekamlo®, Nexiclon XR®, and Catapres-TTS® – See Appendix G.

A. Current Authorization Criteria
B. Utilization Review
C. Prior Authorizations Review
D. Market News and Update
E. COP Recommendations
F. Utilization Details
G. New Product Details

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

10. Action Item – Annual Review of ADHD Medications and 30 Day Notice to Prior Authorize Kapvay® and Xyrem® – See Appendix H.

A. Current Authorization Criteria
B. Utilization Review
C. Prior Authorizations Review
D. Market News and Update
E. COP Recommendations
F. Utilization Details
G. New Product Details

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

11. FDA and DEA Updates – See Appendix I.

12. Future Business

A. Utilization Review of Diabetes Products
B. Annual Review of Triptans
C. Annual Review of Antiemetics
D. New Product Reviews

13. Adjournment

Appendix A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES of MEETING of DECEMBER 8, 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): none		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:

Frances Bauman, Novo Nordisk	Warren Tayes, Merck	Monica Iacobucci, AstraZeneca
Jeff Himmelberg, GlaxoSmithKline	Holly Turner, Merck	Paul Davis, MHAT
Jason Ness, Sunovion	Charles Morgan, Integris/private practice	Scott Esters, Forest
John Harris, Abbott	Toby Thompson, Pfizer	Russ Wilson, OMTPI
Jim Dunlap, Eli Lilly	Donna Erwin, BMS	Linda Cantu, BMS
Bill Clark, BMS	Charlene Kaiser, Amgen	Meg Propes Sunovion
Rob Vlk, Azur	Brian Maves, Pfizer	Janie Huff, Takeda

PRESENT FOR PUBLIC COMMENT:

Agenda Item No. 6	Charles H. Morgan, M.D.	
Agenda Item No. 8	Lyle K. Laird, PharmD.; Sunovion Pharmaceuticals	Jack Putman, D.O.; Merck
	Bill Clark, PharmD.; Bristol-Myers Squibb	
Agenda Item No. 9	Michael Jones, PharmD.; GlaxoSmithKline	

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. 6	Charles H. Morgan, M.D.	
Agenda Item No. 8	Lyle K. Laird, PharmD.; Sunovion Pharmaceuticals Bill Clark, PharmD.; Bristol-Myers Squibb	Jack Putman, D.O.; Merck
Agenda Item No. 9	Michael Jones, PharmD.; GlaxoSmithKline	

ACTION: NONE REQUIRED

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

3A: November 10, 2010 DUR Minutes

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

ACTION: MOTION CARRIED

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

4A: Retrospective Drug Utilization Review: October 2010

4B: Retrospective Drug Utilization Review Response: August 2010

4C: Medication Coverage Activity Audit: November 2010

4D: Help Desk Activity Audit: November 2010

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 5: **VOTE TO PRIOR AUTHORIZE METOZOLV ODT®**

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

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

ACTION: MOTION CARRIED

AGENDA ITEM NO. 6: **VOTE TO PRIOR AUTHORIZE ALZHEIMER'S MEDICATIONS**

For Public Comment: Charles H. Morgan, M.D.: I may have misread this but I thought the decision was going to be to prior authorize under age 30. Is it 30 or 50?

Dr. Muchmore: Under 50 would have to be prior authorized.

Dr. Morgan: I don't see a lot of Medicaid patients but I see a whole lot of Alzheimer's patients. Making it more difficult to get Alzheimer's drugs. And I don't use the 23 mg Aricept. I think it's a sham. I hope somebody here doesn't sell it. Aricept is good drug and I use it, but the 23's just try to get away with the patent expiration. But Namenda really saves months of nursing home care. You look at patients that go on Namenda, or a combination of Namenda and a cholinesterase inhibitor early; the longer they're on it, the sooner they're on it, the longer before they wind up in the nursing home and all the attendant problems being in a nursing home and all the costs to the insurance providers; whether it's Medicare or Medicaid or private insurers. I think trying to limit the use of Aricept, Exelon, Reminyl and Namenda can also have its' patients, even if they're 40. I think that's pennywise and pound foolish. A year of Namenda costs about $1200 bucks. How much does a year in a nursing home cost? How much does 22 months in a nursing home cost? The average delay in nursing home placement on a new diagnosed Alzheimer's patient treated with both drugs, 22 months delay. How much does 22 months cost DHS in a nursing home?

OHCA Staff: $4000 a month.

Dr. Morgan: So that's $4000 times 22.

OHCA Staff: $88,000.

Dr. Morgan: You'd have to save a whole lot of prescriptions to pay for one of those patients, wouldn't you? I think it's shortsighted and pennywise and pound foolish to try to inhibit the use of Alzheimer's drugs early.

Dr. Muchmore: You're thinking of it from a perspective, Dr. Morgan, using it for Alzheimer's disease. It's morphing into a lot of other uses. If I understand this PA right and you say, I've got a patient with Alzheimer's at age 42, I don't think you'd have any trouble getting it.

Dr. Morgan: No trouble getting it as in ……..?

Dr. Muchmore: The pharmacy faxes you a form and you note some items on there like the diagnosis and you know, their PET scan proved it, if you have that, you know …. whatever information you have, and you send it in for prior authorization, it would probably be approved within 24 hours.
Dr. Kuhls: But why do we need an age restriction?
Dr. Muchmore: Because it's morphing into a lot of other uses other than Alzheimer's.
Dr. Kuhls: Well I understand totally, but if you require number 2 and just say FDA approved diagnosis?
Dr. Le: Because above that age there will be no PA, that's why the age.
Dr. Kuhls: So you won't even look at a diagnosis
Dr. Le, Dr. Muchmore: Above that age, above 50.
Dr. Kuhls: Alright, okay, that makes sense.
Dr. Morgan: I'm a little, I know that some of the pediatric neurologists are using it in their patients with trisomy 21, Down Syndrome. Listen, that's Alzheimer's. Their brains have the same pathology, the same physiology and the same drugs ought to be effective and it ought to save nursing home placement. I don't see kids, but the ped neuros do and they use it. Who else would you use it?
Dr. Muchmore: It's morphing into a lot of psychiatric uses and that may be appropriate because there isn't much literature on it to justify it, but I'm thinking in the future that may be very well documented need.
Dr. Morgan: Well I think if the science comes out that shows that it helps for XYZ psychiatric diagnosis, then you'd want to use it.
Dr. Muchmore: Absolutely.
Dr. Morgan: But from the perspective of the busy neurologist, there's seven of us, going to be eight, we see 20, 25 patients a day. If you make it hard for use to see ….. harder …….. to see a Medicaid patient in our office and get the proper drugs, and we have a six-week waiting list for non-Medicaid patients, your patient's going to get short shrift and they're going to wind up seeing a group of providers that, excuse me, they're not flight A. You need to make it easy for us to take care of Medicaid patients. It's like a service we provide, it's not like you got people lining up ten deep, oh me me, I want to take care of your elderly demented Medicaid patients. I think you'd have to make it easy for us to take care of them and prior auth does not make it easy.
Dr. Muchmore: Have you ever done one?
Dr. Morgan: Yeah.
Dr. Muchmore: They're awful easy.
Dr. Preslar: Yeah but I know what he's saying about just doing one, is enough to slow you down and you're inundated with enough fax, paperwork, prescriptions, that …… I agree 100% that any, I mean, first of all, why not just put, take the age restriction out, like he had recommended and just, if you have the diagnosis of Alzheimer's ……
Dr. Kuhls: Cause then you'd have to ……..
Dr. Keast: You'd have to PA all of them.
Dr. Kuhls: That's the problem, that's the problem. That's what I was asking. I agree with you totally, but if you just put, then they'd have to go through and make sure there was an Alzheimer on all of them by putting that PA diagnosis. Which makes it more of a hassle.
Dr. Preslar: How many do you see below 50 would you say?
Dr. Morgan: With Alzheimer's?
Dr. Preslar: Yeah, I mean what population or percentage are we looking at here?
Dr. Morgan: I have a huge Alzheimer's practice. I probably write on the average five dementia scripts a day, 5% are under 50. But that's still 5%.
Dr. Preslar: I agree.
Dr. Morgan: How much pushback are the ped neuros going to get if they're going to use it for the Down Syndrome patients?
Dr. Preslar: What if we made the number 30?
Dr. Morgan: That would be a lot easier for me to live with.
Dr. Preslar: Is there a problem with making it 30?
Dr. Kuhls: Do you have a concept of our numbers in terms of less than 50 and less than 30?
Dr. Le: Yeah, the last month's packet, does anybody have it, might show you. This chart is the demographics. This is 0-9, 10-19, 20-29, 30-39, 40-49, 50 and above. As you know, this is probably Alzheimer's and this is probably not.
Dr. Preslar: But you did start seeing a bump there are 30?
Dr. Le: Yeah, right here. Right here is what we're trying to ……..
Dr. Feightner: What's the green? And the yellow?
Dr. Le: The yellow is Namenda and the blue is Aricept.
Dr. Muchmore: Most of the Namenda use is child psychiatric use.
Dr. Le: Yeah and so we thought that the age restriction would be least disruptive. It would affect the least people, the Alzheimer's population because they are here.
Dr. Morgan: So do you want to make it, these harder for your child psychiatrist to see Medicaid patients?
Dr. Kuhls: But it has to be FDA indicated, that's the problem. And Down …… I'm a pediatrician, okay? I understand what you're saying, but the fact is, is there's not an FDA indication at all for this class of medication in Down Syndrome. And actually most of it's anecdotal data, and so we're really talking two separate stories here. And I know you're trying to protect them and I would try to protect them too if I felt there was a strong enough data in the literature and that they're really helped that much, but I don't think the data's there. And we're talking about, you know, FDA, you know, we really have to go by FDA approved indications.

Dr. Morgan: Did you try to use FDA approved indications to limit use? Then you can't use Namenda for early Alzheimer's. If your mother had early Alzheimer's, she'd be on Namenda. The best study came out of Harvard, NIA sponsored trial, not a drug company sponsored trial, 4-year study, no treatment, cholinesterase inhibitor only, Namenda plus cholinesterase inhibitor. You had a significant slowing of memory loss and more important, the slowing of behavioral abnormalities. That's, you don't put mom in a nursing home because she doesn't remember dad's name. You put mom in a nursing home because she walks away in the middle of the night and leaves the stove on and beats the cat and scolds your kid. And Namenda has a much more powerful effect on that, and the sooner you start it the better it works. And that literature is solid but it's not an FDA approved indication. And the company's not likely to go through the hoops to get an FDA approved indication.
Dr. Muchmore: We don't require an FDA approved indication. We have to make it available for an FDA approved indication, but we don't say you can't have it because it doesn't have an FDA. We just need some kind of evidence.
Dr. Le: There is an explanation that goes along with the posted data. If I could go through it maybe it would answer some of these questions.
Materials included in agenda packet; presented by Dr. Le.
Dr. Kuhls moved to approve as submitted; seconded by Dr. Feightner.
ACTION: MOTION CARRIED

AGENDA ITEM NO. 7: **ANNUAL REVIEW OF SINGULAIR® AND 30-DAY NOTICE TO PRIOR AUTHORIZE ZYFLO CR®**
Materials included in agenda packet; presented by Dr. Le.
ACTION: NONE REQUIRED

AGENDA ITEM NO. 8: **POST-IMPLEMENTATION UTILIZATION REVIEW OF ATYPICAL ANTIPSYCHOTICS AND 30-DAY NOTICE TO PRIOR AUTHORIZE LATUDA™**
For Public Comment: Lyle K. Laird, PharmD.: Good evening, I'm Dr. Lyle Laird. I'm a clinical psychopharmacologist by training and I'm Senior Area Medical Specialist for Sunovion Pharmaceuticals, formerly Sepracor. Thank you for the opportunity to let us speak to you tonight. I want to review lurasidone hydrochloride, which is known at Latuda and it comes as a tablet. Latuda is a newly FDA approved atypical antipsychotic that went through on the first cycle with the FDA and this is unparalleled in the history of atypical antipsychotics. It was approved in October 28th of this year and is for the treatment of schizophrenia in adults. And as you are aware, schizophrenia is a chronic and progressive neurodegenerative disorder and requires lifelong treatment and there is no cure and there is no one medication or two medications that works in everyone. Latuda offers a proven efficacy and safety profile for schizophrenic patients. Efficacy was established in four randomized double blind placebo for six weeks' studies in adults with schizophrenia and the safety database consists of more than 2,100 patients and this number is growing as we speak. Latuda demonstrated superiority over placebo in both primary and secondary efficacy measures. This was the PANSS and the BPRS-derived scale, as well as the CGI severity scale. It's available in 40 and 80 mg tablets. It's dosed once a day. Recommended starting dose is 40 mg, recommended maximum daily dose is 80 mg and dosage titration is not necessary. It's contraindicated in those individuals who are hypersensitive to it or those individuals who are on very powerful cytochrome P450 3A4 inducers or inhibitors so that the two, rifampin as the inducer and ketoconazole, the antifungal drug as an inhibitor. Latuda showed safety and tolerability in the clinical studies. Average weight gain in short term studies was 0.75 kg over six weeks, this is 1.65 pounds, versus .26 kg in placebo group. In the uncontrolled longer term study which went out full 52 weeks, there was a mean decrease in weight that was 0.71 kg at 52 weeks. It's associated with no clinically relevant mean changes in the metabolic parameters, serum glucose, total cholesterol and triglycerides. This was borne out in the short term and the longer term extension studies. Latuda is associated with no clinically relevant changes. The median change is in prolactin. There was a higher change in woman versus males, however. Latuda is a pregnancy category B drug. Its most commonly observed after six events of somnolence, akathisia, nausea, Parkinsonism and agitation. This is at the level 5% and twice of the placebo. The dose related adverse events were somnolence and akathisia. Discontinuation secondary to adverse events was 9.4% in Latuda and 6% in the placebo treated group. Latuda carries similar class warnings of precautions of the other atypicals such as the box warning, increased mortality in elderly patients with dementia related psychosis, cerebral vascular adverse events, NMS, TD, metabolic changes, including hyperglycemia, diabetes mellitus, dyslipidemias and weight gains. There is no warning for QTC prolongation whatsoever on the label. I'd like to direct you to the PI for any further questions. So in summary, Latuda offers an option for the treatment of schizophrenia in adults. This is a disorder with significant unmet needs and I've given you the efficacy and the safety numbers. We'd like you to consider putting Latuda as a Tier 2 drug, a Tier 2 option for your patients with schizophrenia. Thank you.
Dr. Kuhls: You realize how drugs go from Tier 3 to Tier 2 in our process? Because there's supplemental rebate programs and so on. It's not just us picking …. just want you to know that it's not us picking a Tier 2.
Dr. Laird: Sure and I understand the supplemental contract.
Dr. Kuhls: I just want to make sure. You realize that we aren't going to recommend it as a Tier 2 drug because we don't chose Tier 2's versus Tier 3's.
For Public Comment: Jack Putman, D.O.: Good evening. I'm a regional medical director with Merck. So Saphris is an atypical antipsychotic with indications in adults for the acute and maintenance treatment of schizophrenia and in bipolar I disorder as monotherapy or as adjunctive therapy with either lithium or valproate. Saphris is the first atypical antipsychotic with dual indications at launch for both schizophrenia and bipolar. Dosage of Saphris is either 5 or 10 mg sublingual tablets. Sublingual

administration prevents cheeking of doses that many people in these disease categories do and allows for bypassing of first pass metabolism. This accounts for peak plasma concentrations to occur in 30 to 90 minutes. Following a dose of Saphris, patients are advised not to eat or drink anything for ten minutes. Saphris has a black box warning as do other atypical antipsychotics in this class about not using in patients with dementia related psychosis. Saphris has no contraindications. In a dedicated QTC interval study in 151 patients with schizophrenia, at doses of up to two to four times recommended doses, Saphris was associated with an increased QTC of just 2 to 5 milliseconds, which is clinically insignificant. Saphris should be avoided in combination with other drugs that might increase the QTC interval. A dedicated smoking study showed that smoking had no effect on the pharmacokinetics of Saphris. In a longer term trial, 52 weeks, in people with schizophrenia or schizoaffective disorder, Saphris demonstrated the following: weight gain, only 0.9 kg in 52 weeks; an increase in blood sugar of 2.4 mg/dL on a baseline of 89, that's clinically insignificant; a decrease in total cholesterol; a decrease in triglycerides; as well as a decrease in prolactin levels of 27 ng/dL. There are no dosage adjustments necessary for age, sex, race or renal function. Saphris should not be used in patients with severe hepatic impairment. These two disease states, schizophrenia, bipolar, are incredibly difficult to treat. I've had an opportunity to interact with several psychiatrists recently, and it's quite a challenge. It's unlike about anything else I can imagine, maybe with the exception of cancer. One medicine will work well for one patient but not another. But when there's a treatment failure in these medications and patients change medicines frequently, it's not just a matter of not getting to a blood pressure goal or an A1C goal. These patients end up in the hospital and an average admission cost of $10,000 to $27,000 per admission. They commit crimes, they hurt people, they attempt or commit suicide, they end up in jail. Huge costs to society. In consideration of the unique characteristics of Saphris is efficacy, side effect profile, rapid onset and the attributes around lipids, weight, blood glucose and prolactin, I respectfully request that you give strong consideration to having Saphris at Tier 2 or Tier 3. Any questions?

For Public Comment: Bill Clark, PharmD.: Thank you. My name is Bill Clark. I am the medical science liaison for Bristol-Myers Squibb and was trained as a pharmacologist by Dr. Laird in that school south of the Red River. In any case, thank you for allowing the opportunity to provide testimony on the Abilify brand of aripiprazole. Safety and efficacy of aripiprazole has been studied in multiple indications in adult and pediatrics, resulting in 14 FDA approved indications, including treatment of schizophrenia in adults and adolescents 13 to 17 years old, acute and maintenance treatment of bipolar mania in adults and pediatric patients age 10 to 17. Also as adjunctive therapy for adults treated for major depressive disorder who have had as adjunctive therapy, have had inadequate response to other antidepressant therapy. Treatment of irritability associated with autistic disorder in patients age 6 to 17 and finally, there is an IM formulation of course used for the acute treatment of agitation with people who are treated for schizophrenia or bipolar illness. According to the surveillance data incorporated for anonymous PD patient level data or the SDI APLD, 75% of prescriptions for aripiprazole are written for FDA indications, so most of the use is on label. I would like to suspend my comments at this point and ask if there are any questions about the utilization of this drug since it is well known and see if there's any questions. In fair balance, I would remind you there are two boxed warnings, one for the treatment of patients with Alzheimer's disease, psychosis associated with Alzheimer's disease, increased mortality as with all antipsychotic agents and finally, any drug indicated for the treatment of depression carries increased suicidal ideation and behavior, especially in younger patients.

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

ACTION: NONE REQUIRED

AGENDA ITEM NO. 9: **60-DAY NOTICE TO PRIOR AUTHORIZE BENIGN PROSTATE HYPERPLASIA (BPH) PRODUCTS**

For Public Comment: Michael Jones, PharmD.: Thank you for letting me come speak to the Board. It's great coming last because I'd like to reemphasize some of the points we made tonight about maybe even grandfathering or considering populations that may not take that big of a slice out of the Medicaid population; specifically BPH men. There is so much right now in the data with this cancer thing going on and what I'd like to contrast just briefly and I'm not going to fight the generic Proscar war or anything like that because I think there are appropriate patients for the appropriate drugs. But what I'd like you to consider is when we look at head-to-head studies starting out, and there's not a true good head-to-head study between Proscar and Avodart for example, which are our five ARI representatives to that class. You can treat the symptoms until you're blue in the face with the alpha blockers, etc., etc., get them peeing better and not getting up at night, all that. That's there. The five ARI's enter that class at a totally different regime, in that they take over those symptoms after awhile because they're actually shrinking the prostate, not just relaxing the muscles and things and hence, just one brief commercial for the combo that we just introduced that's got the Flomax and Avodart. Your urologists have been doing that for 15 years, putting men on both drugs at the same time. It gives you a little bit more flexibility, they can start them on both, but then they can still always come in on an older alpha blocker and you can add Avodart or something. That's not the main issue that I'm bringing up. It's long term versus short term. In the short term, you trained me well here. You can look at side effects, good time to look at side effects, as the drug they're both prospectively starting out, you ask patients how they feel on the drug, you get a better report of what side effects are actually happening in those two drugs. We went head-to-head with Proscar. There were very little differences in the side effects and there was a very little difference in shrinking of the prostate in one year. But when you go now, of all these men that we've been watching and waiting and looking at for eight, ten, and now fifteen years, do they have cancer, do they not have cancer. We're monitoring your PSAs, we're looking at other things. You've got a drug with a 3-day half life inhibiting enzymes at two different levels and it's actually doing a better job of shrinking that prostate and producing that end result in the men to the tune when you look at retrospective studies over all those years and you do pull the charts, the Avodart men have far less AURs, far less repeat TURP surgeries, check it out. I'm not just telling you this. Your urologist will

confirm this. So what I'd like to leave you with is I understand possibly having someone get generic, starting out having their symptoms of BPH controlled, etc., but the real proof of the pudding to this BPH conundrum is not short term looking. It's a long term disease. A lot goes on after we control their getting up at night, their irritating and their obstructive symptoms. What I would like to suggest and again, for these few men that are on Avodart, possibly if the Board would consider grandfathering them so they could stay on their Avodart and continue the continuum that we're about to break through with REDUCE and REDEEM trials and all the studies that will maybe prove someday that this dual enzyme and 3-day half life way to shrink the prostate is a better way to come around than a 6-hour half life and more AURs and surgeries when we're talking about the whole concept that has been brought up earlier tonight, of you can pay me now or pay me later. I'd like to answer any questions and entertain … if it's possible if you might consider grandfathering some of the patients that are presently receiving Avodart. Thank you.
Materials included in agenda packet; presented by Dr. Keast.
ACTION: NONE REQUIRED

AGENDA ITEM NO. 10: **FDA & DEA UPDATES**
Materials included in agenda packet; presented by Dr. Graham.
ACTION: NONE REQUIRED

AGENDA ITEM NO. 11: **FUTURE BUSINESS**
Materials included in agenda packet; submitted by Dr. Graham.
A: Annual Review of Advair® / Symbicort®
B: Annual Review of Antihypertensives
C: Annual Review of Hypnotics
D: New Product Reviews
ACTION: NONE REQUIRED

AGENDA ITEM NO. 12: **ADJOURNMENT**
The meeting was adjourned at 7:56 p.m.

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

Memorandum

Date: December 14, 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 December 8, 2010

Recommendation 1: Vote to Prior Authorize Metozolv® (metoclopramide) ODT

MOTION CARRIED by unanimous approval.

The College of Pharmacy recommends prior authorization of Metozolv® (metoclopramide) ODT with the following criteria:

1. FDA-approved diagnosis of gastroesophageal reflux disease in adults not responding to conventional therapy, or acute and recurrent diabetic gastroparesis in adults.
2. Must provide a clinical reason why the member cannot use the regular formulation of metoclopramide tablets.
3. Therapy will be approved for a period of not more than 12 weeks.
4. Quantity limit of 120 tablets for 30 days.

Recommendation 2: Vote to Prior Authorize Alzheimer's Medications

MOTION CARRIED by unanimous approval.

1. Prior Authorization of special formulation products including oral solutions, patches, extended release formulations, or other convenience formulations with the following approval criteria:
    a. Member must have a documented reason why the special formulation is clinically necessary over the regular formulation

2. Application of Age Restriction for ages 0-50 with the following approval criteria
    a. FDA approved diagnosis

Recommendation 3: Annual Review of Singulair

NO ACTION REQUIRED.

The COP does not recommend any changes to the Singulair PA.

Recommendation 4: Utilization Review of Atypical Antipsychotics

NO ACTION REQUIRED.

Appendix B

Retrospective Drug Utilization Review Report

Claims Reviewed for September 2010

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Limits which were applied	Established, Major, Males and Females, Age 36-50	Acne Antibiotics, Males and Females, Age 0-150	Contraindicated, Pregnancy, Females, Age 36-150	High & Low Dose, Oxazolidinediones (Zyvox®), Males and Females, Age 0-150

Response Summary (Prescriber)
Letters Sent: 29
Response Forms Returned: 13

The response forms returned yielded the following results:

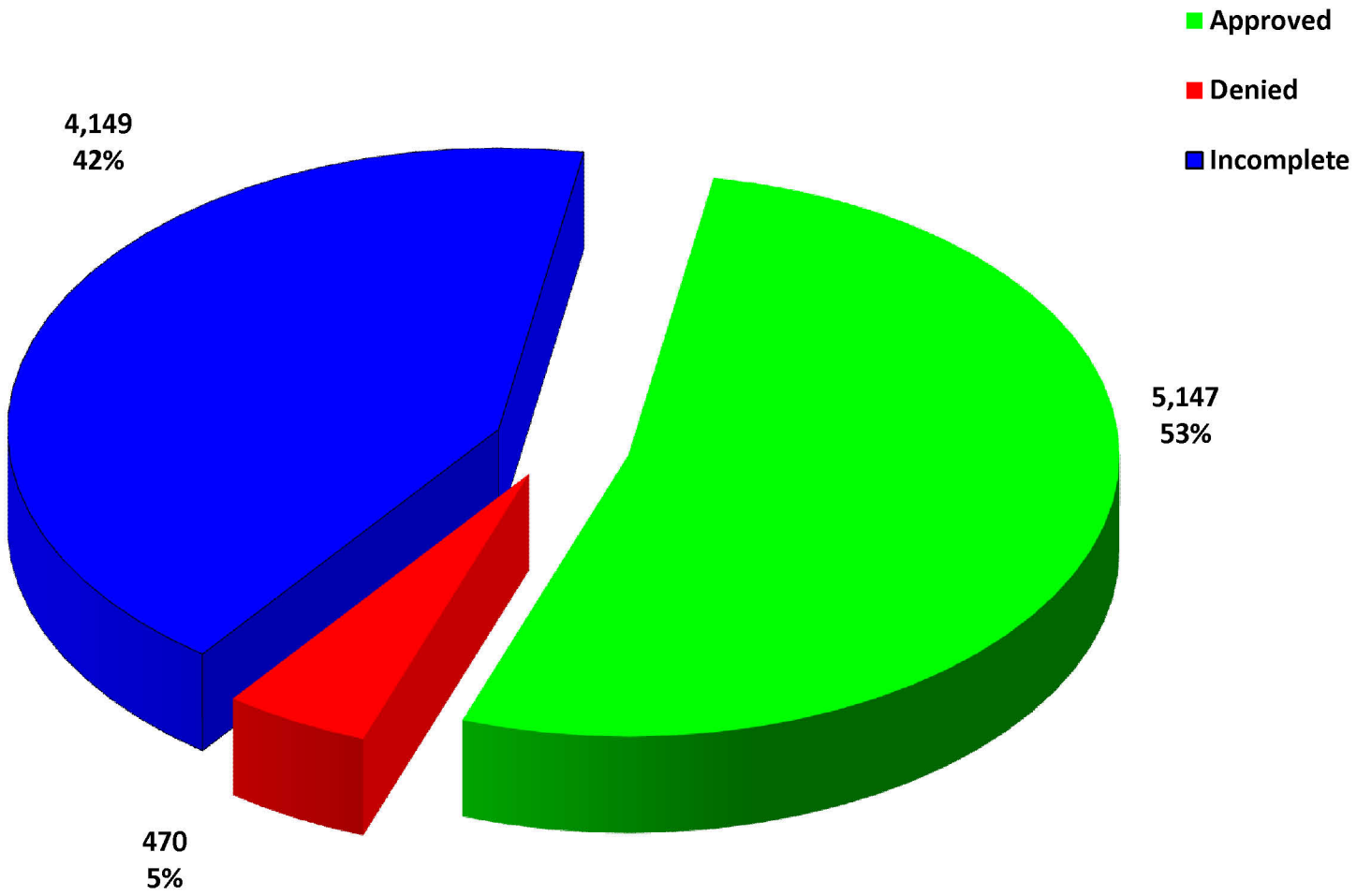
0 (0%)	*Record Error—Not my patient.*
4 (31%)	*No longer my patient.*
2 (15%)	*Medication has been changed prior to date of review letter.*
1 (8%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
4 (31%)	*I am aware of this situation and will plan to continue monitoring therapy.*
2 (15%)	*Other*

Response Summary (Pharmacy)
Letters Sent: 10
Response Forms Returned: 5

The response forms returned yielded the following results:

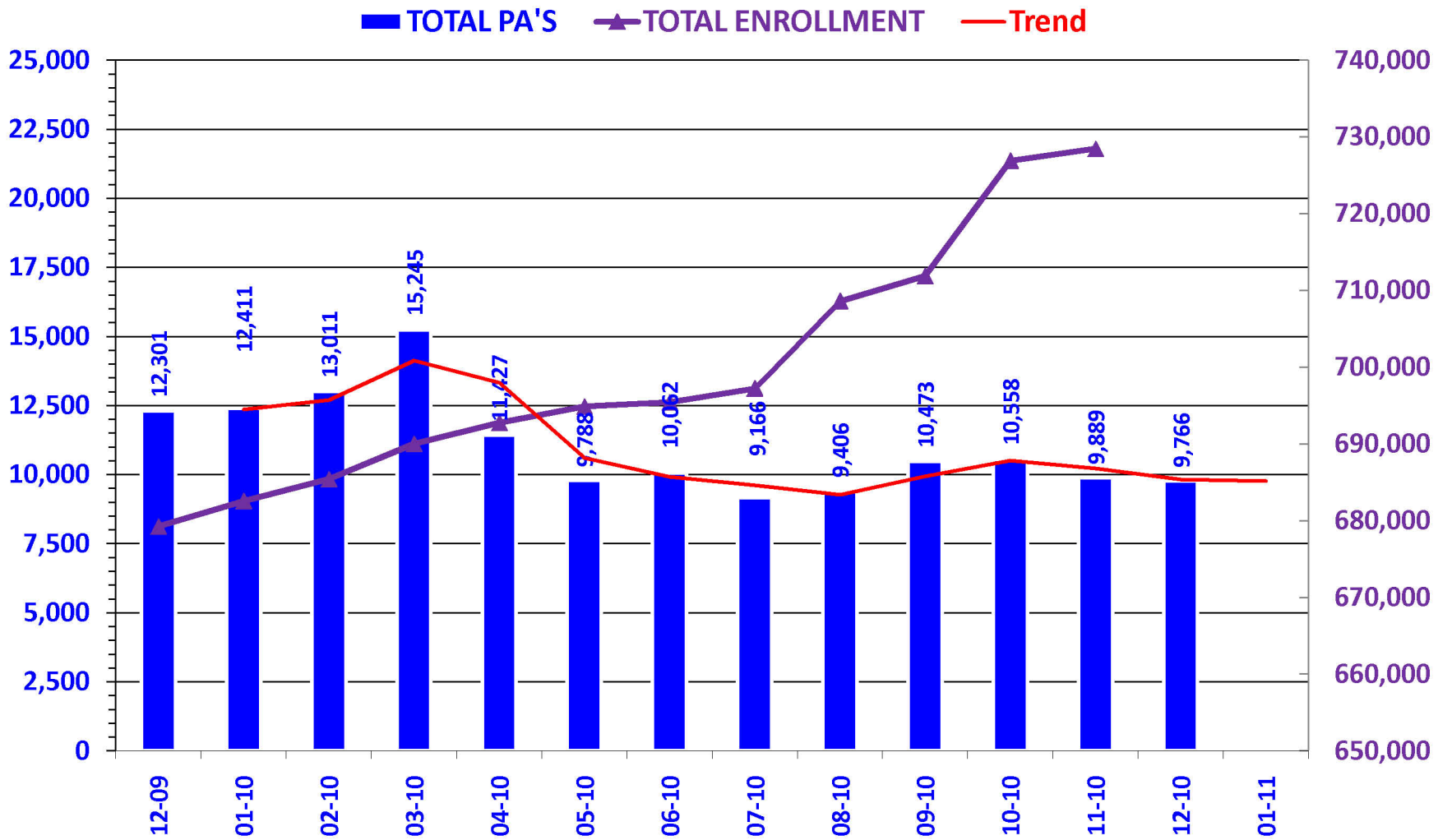
0 (0%)	*Record Error—Not my patient.*
0 (0%)	*No longer my patient.*
1 (20%)	*Medication has been changed prior to date of review letter.*
1 (20%)	*I was unaware of this situation & will consider making appropriate changes in therapy.*
3 (60%)	*I am aware of this situation and will plan to continue monitoring therapy.*
0 (0%)	*Other*

PRIOR AUTHORIZATION ACTIVITY REPORT: December 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: December 2009 – December 2010



PA totals include overrides

Prior Authorization Activity

12/1/2010 Through 12/31/2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	377	195	4	178	358
Amitiza	19	6	1	12	149
Anti-Ulcer	454	148	40	266	101
Antidepressant	451	149	19	283	347
Antihistamine	345	197	9	139	334
Antihypertensives	127	54	10	63	327
Antimigraine	71	22	2	47	252
Atypical Antipsychotics	709	339	19	351	352
Benzodiazepines	75	38	0	37	214
Bladder Control	58	8	9	41	362
Brovana (Arformoterol)	4	0	1	3	0
Byetta	16	7	0	9	309
Elidel/Protopic	56	16	2	38	86
ESA	152	120	1	31	97
Fibric Acid Derivatives	10	1	0	9	359
Fibromyalgia	135	47	11	77	356
Fortamet/Glumetza	1	0	0	1	0
Forteo	2	1	0	1	365
Glaucoma	12	6	0	6	362
Growth Hormones	49	32	5	12	157
HFA Rescue Inhalers	85	28	4	53	284
Insomnia	67	11	7	49	230
Misc Analgesics	45	3	26	16	157
Muscle Relaxant	127	40	37	50	70
Nasal Allergy	248	88	23	137	128
NSAIDS	143	26	11	106	263
Ocular Allergy	18	2	1	15	90
Ocular Antibiotics	57	12	0	45	22
Opioid Analgesic	623	321	8	294	246
Other	722	195	91	436	166
Otic Antibiotic	77	50	0	27	28
Pediculicides	106	48	3	55	15
Plavix	161	113	0	48	328
Singulair	789	479	19	291	234
Smoking Cessation	40	11	1	28	60
Statins	126	29	6	91	342
Stimulant	1,241	804	39	398	245
Symlin	2	1	0	1	365
Synagis	262	176	23	63	94
Topical Antibiotics	9	1	0	8	19
Topical Antifungals	25	4	2	19	30
Ultram ER and ODT	8	0	0	8	0
Xolair	5	2	0	3	179
Xopenex Nebs	22	14	0	8	349
Zetia (Ezetimibe)	30	17	0	13	358
Emergency PAs	10	10	0	0	
Total	**8,171**	**3,871**	**434**	**3,866**	

Overrides					
Brand	59	36	4	19	257
Dosage Change	516	496	0	20	4
High Dose	1	1	0	0	360
IHS-Brand	168	148	0	20	55
Ingredient Duplication	9	7	0	2	4
Lost/Broken Rx	108	104	1	3	8
NDC vs Age	38	38	0	0	169
Nursing Home Issue	57	56	0	1	4
Other	22	19	0	3	24
Quantity vs. Days Supply	612	366	31	215	258
Stolen	5	5	0	0	3
Overrides Total	**1,595**	**1,276**	**36**	**283**	
Total Regular PAs + Overrides	**9,766**	**5,147**	**470**	**4,149**	

Denial Reasons	
Unable to verify required trials.	2,484
Lack required information to process request.	1,687
Does not meet established criteria.	426
Drug Not Deemed Medically Necessary	1

Duplicate Requests: 768

Letters: 1,626

No Process: 708

Changes to existing PAs: 482

CALL VOLUME MONTHLY REPORT:
December 2009 – December 2010

Appendix C

VOTE TO PRIOR AUTHORIZE ZYFLO CR® (ZILEUTON)

OKLAHOMA HEALTH CARE AUTHORITY
JANUARY 2011

Recommendations

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

Children age 12 and older and adults:

- Diagnosis of mild or moderate persistent asthma, AND
- Trial of inhaled corticosteroid AND corticosteroid/LAB_2A therapy within the previous 6 months and reason for trial failure, AND
- Recent trial with at least one other available leukotriene modifier that did not yield adequate response.

Appendix D

Vote to Prior Authorize Latuda™ (lurasidone HCl)

Oklahoma Health Care Authority, January 2011

Recommendations

The College of Pharmacy has the following recommendations:

1. Placement of Latuda® (lurasidone) into Tier 3 of the PBPA category.
2. Addition of Symbyax® (olanzapine/fluoxetine) to the following section of criteria: For **aripiprazole, quetiapine extended release and olanzapine/fluoxetine**: a diagnosis of depression requires current use of an antidepressant, and previous trials with at least two other antidepressants. Tier structure still applies.
3. Perform an additional class review in six months to ensure that the goals of this PBPA category are being met.
4. For 2011* only, change the item 2 of the criteria for Tier 3 to read: A trial of ~~all available~~ two Tier 2 medications, at least 14 days in duration, titrated to recommended dose, that did not yield adequate response or resulted in intolerable adverse effects.

*For 2011, four products were recommended for Tier 2 status by the psychiatric workgroup based on a combination of cost effectiveness and clinical consideration. They further recommend allowing movement to Tier 3 after an adequate trial of at least 2 Tier 2 products.

New Tiers for 2011 after Supplemental Rebates

Atypical Antipsychotics*

Tier 1	Tier 2	Tier 3†
risperidone (Risperdal®)[Ŧ] **clozapine (Clozaril®)**	aripiprazole **(Abilify®)** iloperidone **(Fanapt™)** ziprasidone **(Geodon®)** quetiapine ER **(Seroquel XR®)**	olanzapine **(Zyprexa®)** quetiapine **(Seroquel®)** paliperidone **(Invega®)** asenapine **(Saphris®)** clozapine **(Fazaclo®)** olanzapine/fluoxetine **(Symbyax®)** lurasidone **(Latuda®)**

Appendix E

30-day Notice to Prior Authorize Benign Prostate Hyperplasia Medications

Oklahoma HealthCare Authority
January 2011

Recommendations

The College of Pharmacy recommends the addition of the BPH class of medications to the Product Based Prior Authorization program. The Tier 1 drug list has been reviewed and determined to be an acceptable combination for use as initial therapy for the majority of members. The College of Pharmacy recommends this list to the Drug Utilization Review Board based on cost and clinical effectiveness for approval before referral to the Oklahoma Healthcare Authority.

Tier 1	Tier 2
Hytrin® (Terazosin)	Uroxatrol® (Alfuzosin)
Cardura® (Doxazosin)	Rapaflo® (Silodosin)
Flomax® (Tamsulosin)	Cardura XL® (Doxazosin)
Proscar® (Finasteride)	Avodart® (Dutasteride)
	Jalyn® (Dutasteride/Tamsulosin)

Prior Authorization Criteria:

1. FDA approved diagnosis
2. Recent 4-week trial of at least two Tier-1 medications from different pharmacological classes within the last 90 days
3. Documented adverse effect, drug interaction, or contraindication to all available Tier-1 products.

Appendix F

Annual Review of Hypnotic Medications - Fiscal Year 2010
Oklahoma Health Care Authority
January 2011

Current Prior Authorization Criteria

Current Prior Authorization Criteria

1. In order to receive a Tier 2 product (or a Tier 3 product if no Tier 2 products exists) a minimum trial of 30 days with at least two Tier 1 products (including zolpidem) should be attempted. Also, clinical documentation of attempts to correct any primary cause for insomnia should be provided.
2. In order to receive a Tier 3 product, all available Tier 2 products should be attempted for a minimum of 30 days each. All other Tier 2 criteria should also be met.
3. FDA approved diagnosis (Ambien CR® only covered for sleep maintenance insomnia).
4. No concurrent anxiolytic benzodiazepine therapy greater than TID dosing and no concurrent ADHD medications.
5. Approvals granted for 6 months.

All members under the age of 18 will require a petition for use of hypnotic medications.
Quantity limit of #30 per 30 days apply for all medications in this category.

Tier 1	Tier 2	Tier 3
Estazolam **(ProSom®)** Temazepam **(Restoril®) 15 and 30mg** Flurazepam **(Dalmane®)** Triazolam **(Halcion®)** zolpidem **(Ambien®)** Zaleplon **(Sonata®)**		Eszopiclone **(Lunesta®)** Temazepam **(Restoril®) 7.5 and 22.5 mg** Ramelteon **(Rozerem®)** Zolpidem **(Ambien CR®)** Zolpidem† Oral Spray **(Zolpimist™)** Zolpidem† SL Tabs **(Edular®)** Zolpidem† SL Tabs **(Intermezzo®)**

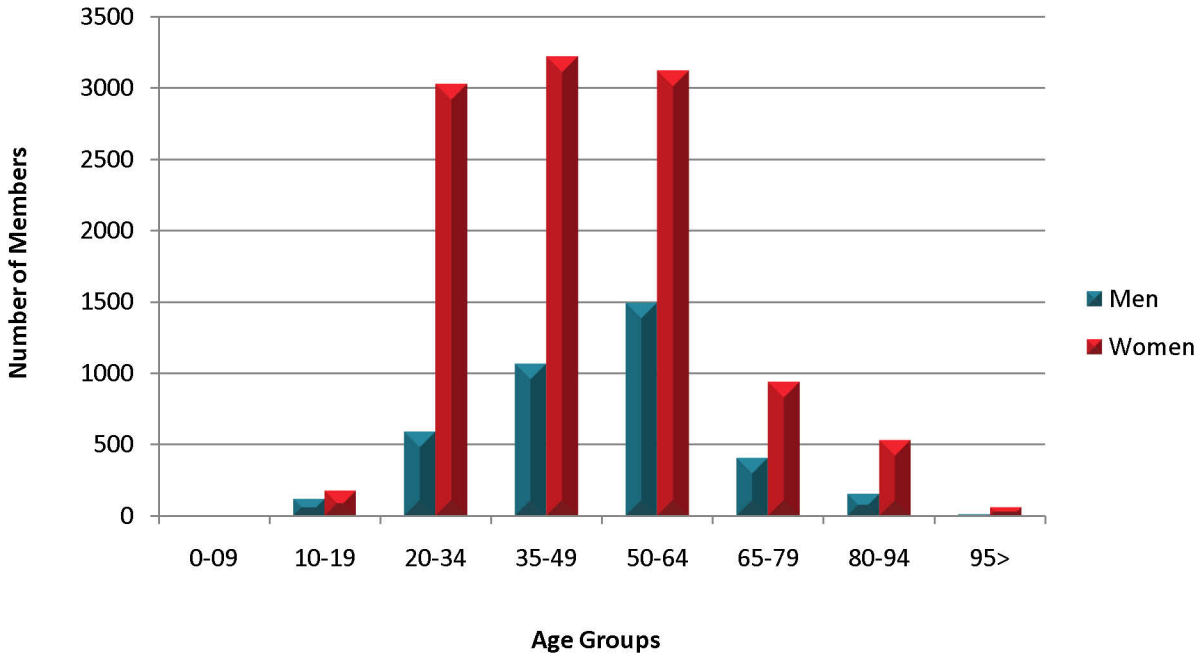
Mandatory Generic Plan Applies.
†Requires special reason for use.

Utilization of Hypnotic Medications

Comparison of Fiscal Years

Fiscal Year	Members	Claims	Paid Amount	Paid/Claim	Perdiem	Units	Days
2009	14,107	59,590	$1,683,539.97	$28.25	$0.98	1,735,785	1,711,142
2010	14,966	64,320	$1,270,102.23	$19.75	$0.68	1,854,882	1,856,275
% Change	6%	7.9%	-24.5%	-30.1%	-32.6%	6.86%	8.48%
Change	859	4,730	-$413,437.74	-$8.50	-$0.30	119,097	145,133

Demographics of Members Utilizing Hypnotic Medications: FY 2010



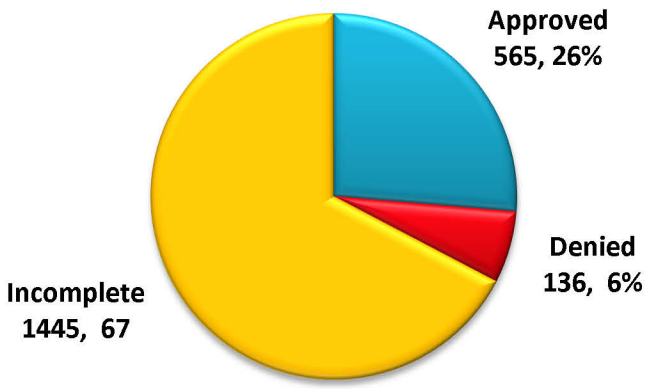
Prescribers of Hypnotic Medications by Number of Claims: FY 2010

Specialty	Number of Claims	Total Cost
Family Practitioner	22,411	$400,333.34
Psychiatrist	10,267	$239,061.85
Internist	8,712	$149,285.16
General Practitioner	5,847	$114,653.08
Nurse Practitioner (other)	2,524	$57,430.61
Physician Assistant	2,483	$47,789.74
DDSD-NFM	2,045	$47,348.52
Prescriber Only	1,868	$30,489.10
Obstetrician/Gynecologist	1,646	$13,738.00
General Pediatrician	770	$18,125.25
General Surgeon	719	$8,868.07
Geriatric Practitioner	544	$13,386.42
Anesthesiologist	521	$12,434.61
Cardiologist	516	$11,362.79

Prior Authorization of Hypnotic Medications

There were a total of 2,146 petitions submitted for the Hypnotic Medications category during fiscal year 2010. For this category there is a computerized step edit implemented at the point of sale to detect two Tier 1 agents. If Tier 1 agents are detected, the claim is allowed to run without a prior authorization. All members under the age of 18 are required to submit a petition. The following chart shows the status of the submitted petitions.

Status of Petitions for Hypnotic Medications: FY 2010



Market News and Update

Patent Expirations

- Patent for Ambien CR® 6.25mg expired October 2010 and 12.5mg expired in December. The generic formulation is currently available in pharmacies, however, there is currently no maximum allowable cost applied.
- Lunesta-2012
- Rozerem-2017

New Products

- Transcept Pharmaceuticals, Inc. plans to resubmit Intermezzo® (their version of low dose (3.5mg) zolpidem sublingual tablets) NDA in the first quarter of 2011 and expects a six month review by the FDA.
- Silenor® (doxepin) was approved in March 2010 for the treatment of insomnia characterized by difficulties with sleep maintenance. Silenor® is available in 3mg and 6mg non-scored tablets indicated to be taken once daily 30 minutes before bedtime. The maximum recommended dose is 6mg.

Recommendations

The College of Pharmacy recommends the placement of Silenor® in Tier 3 of the Hypnotics Medications PBPA Category and placement of Ambien CR® in Tier 2 when a state maximum allowable cost is applied. The existing criteria will apply.

Tier 1	Tier 2	Tier 3
Estazolam **(ProSom®)** Temazepam **(Restoril®) 15 and 30mg** Flurazepam **(Dalmane®)** Triazolam **(Halcion®)** zolpidem **(Ambien®)** Zaleplon **(Sonata®)**	Zolpidem **(Ambien CR®)**	Eszopiclone **(Lunesta®)** Temazepam **(Restoril®) 7.5 and 22.5 mg** Ramelteon **(Rozerem®)** Zolpidem† Oral Spray **(Zolpimist™)** Zolpidem† SL Tabs **(Edular®)** Zolpidem† SL Tabs **(Intermezzo®)** Doxepin **(Silenor®)**

Utilization Details of Hypnotic Medications: Fiscal Year 2010

Medication	Claims	Members	Units	Days	Paid Amount	Claims/ Member	Perdiem	% Paid
ZOLPIDEM TAB 10MG	26,920	7,532	773,083	778,282	$123,000.88	3.57	$0.16	10.08%
TEMAZEPAM CAP 30MG	15,381	3,323	453,229	454,472	$114,412.31	4.63	$0.25	9.38%
TEMAZEPAM CAP 15MG	9,473	2,843	274,725	272,477	$63,331.89	3.33	$0.23	5.19%
ZOLPIDEM TAB 5MG	4,227	1,733	114,256	115,936	$20,589.87	2.44	$0.18	1.69%
AMBIEN CR TAB 12.5MG	2,775	501	81,492	81,642	$437,009.73	5.54	$5.35	35.82%
TRIAZOLAM TAB 0.25MG	1,353	517	33,734	31,115	$11,004.83	2.62	$0.35	0.87%
LUNESTA TAB 3MG	1,274	260	37,810	37,810	$212,403.98	4.9	$5.62	16.72%
TEMAZEPAM CAP 7.5MG	615	154	17,471	17,447	$123,952.52	3.99	$7.10	9.76
ROZEREM TAB 8MG	492	98	14,333	14,618	$59,884.51	5.02	$4.10	4.71
FLURAZEPAM CAP 30MG	442	118	13,508	12,943	$2,776.01	3.75	$0.21	0.22%
ZALEPLON CAP 10MG	355	177	11,047	10,417	$5,420.06	2.01	$0.52	0.43%
LUNESTA TAB 2MG	328	96	9,522	9,634	$52,878.00	3.42	$5.49	4.16%
ESTAZOLAM TAB 2MG	148	30	4,505	4,205	$2,141.38	4.93	$0.51	0.17%
AMBIEN CR TAB 6.25MG	147	44	4,229	4,229	$22,841.82	3.34	$5.40	1.80%
FLURAZEPAM CAP 15MG	114	36	3,208	3,325	$640.17	3.17	$0.19	0.05%
TRIAZOLAM TAB 0.125MG	96	39	2,489	2,489	$827.16	2.46	$0.33	0.07%
ZALEPLON CAP 5MG	63	41	2,504	1,842	$954.98	1.54	$0.52	0.08%
ESTAZOLAM TAB 1MG	40	12	1,106	1,106	$442.48	3.33	$0.40	0.03%
LUNESTA TAB 1MG	30	9	885	900	$4,756.36	3.33	$5.28	0.37%
RESTORIL CAP 7.5MG	30	10	876	876	$8,745.27	3	$9.98	0.69%
HALCION TAB 0.25MG	12	1	720	360	$1,288.98	12	$3.58	0.10%
TEMAZEPAM CAP 22.5MG	3	2	90	90	$779.66	1.5	$8.66	0.06%
TRIAZOLAM 0.25MG TAB	2	2	60	60	$19.38	1	$0.32	0.00%
Totals	**64,320**	**14,966***	**1,854,882**	**1,856,275**	**$1,270,102.23**	**4.30**	**$0.68**	**100%**

*Total number of unduplicated members

PRODUCT DETAILS OF SILENOR™ (DOXEPIN)

FDA-APPROVED IN MARCH 2010, INITIAL U.S. APPROVAL: 1969

INDICATIONS : Silenor® tablets are indicated for the treatment of insomnia characterized by difficulties with sleep maintenance.

DOSAGE FORMS :

- 3 mg and 6 mg tablets.
- Tablets not scored.

ADMINISTRATION:

- Initial dose: 6 mg, once daily for adults and 3 mg, once daily for the elderly.
- Take within 30 minutes of bedtime. Total daily dose should not exceed 6 mg.
- Should not be taken within 3 hours of a meal.

CONTRAINDICATIONS:

- Hypersensitivity to doxepin hydrochloride, inactive ingredients, or other dibenzoxepines.
- Co-administration with Monoamine Oxidase Inhibitors (MAOIs): **Do not administer if patient is taking MAOIs or has used MAOIs within the past two weeks.**
- Untreated narrow angle glaucoma or severe urinary retention.

SPECIAL POPULATIONS:

- **Pregnancy Category C**: Based on animal data, may cause fetal harm.
- **Nursing Mothers:** Infant exposure via human milk.
- **Pediatric Use:** Safety and effectiveness have not been evaluated.
- **Geriatric Use:** The recommended starting dose is 3 mg. Monitor prior to considering dose escalation.
- **Use in Patients with Comorbid Illness:** Initiate treatment with 3 mg in patients with hepatic impairment or urinary retention.

WARNINGS & PRECAUTIONS:

- **Need to Evaluate for Co-morbid Diagnoses**: Re-evaluate if insomnia persists after 7 to 10 days of use.
- **Abnormal thinking, behavioral changes, complex behaviors:** May include "Sleep-driving" and hallucinations. Immediately evaluate any new onset behavioral changes.
- **Depression:** Worsening of depression or suicidal thinking may occur. Prescribe the least amount feasible to avoid intentional overdose.
- **CNS-depressant effects:** Use can impair alertness and motor coordination. Avoid engaging in hazardous activities such as operating a motor vehicle or heavy machinery after taking drug. Do not use with alcohol. Potential additive effects when used in combination with CNS depressants or sedating antihistamines. Dose reduction may be needed.
- **Patients with severe sleep apnea:** Silenor® is ordinarily not recommended for use in this population.

ADVERSE REACTIONS (reported in ≥ 2% of patients treated):

- somnolence/sedation
- nausea
- upper respiratory tract infection

DRUG INTERACTIONS:

- **MAO inhibitors**: Silenor should not be administered in patients on MAOIs within the past two weeks.
- **Cimetidine:** Increases exposure to doxepin.

- **Alcohol:** Sedative effects may be increased with doxepin.
- **CNS Depressants and Sedating Antihistamines:** Sedative effects may be increased with doxepin.
- **Tolazamide:** A case of severe hypoglycemia has been reported.

PATIENT INFORMATION:

Prescribers or other healthcare professionals should inform patients, their families, and their caregivers about the benefits and risks associated with treatment with hypnotics, should counsel them in appropriate use, and should instruct them to read the accompanying Medication Guide.

REFERENCES

Silenor® Label Information. Somaxon Pharmaceuticals, Inc. Available online at: http://silenor.com/pub/download.ashx?key=%2fwECFQ%3d%3d. Last revised March 2010.