



**Pharmacy and Therapeutics Committee  
Meeting Summary  
November 12, 2009**

Dr. Jack Walker started the meeting by discussing the Plan's pharmacy statistics for the last fiscal year. The retail cost of medications increased 11%, while the Plan's cost only increased 5.8% primarily due to utilization management programs and increased generic utilization. The generic dispensing rate increased to 65.5% at the end of the fiscal year and has increased to 68% in September 2009 due to benefit changes. Dr. Walker also shared the concern over members' increased utilization of services in June prior to the July 1<sup>st</sup> benefit changes. That increased utilization is impacting the 1<sup>st</sup> Quarter FY 2009-10 financials.

Dr. Sally Morton then addressed changes to four of the State Health Plan's pharmacy coverage management rules. The antinarcotic prior authorization rule for Nuvigil now requires that the patient be 18 years of age or older. Extavia, a new Beta interferon, for the treatment of multiple sclerosis has been added to the multiple sclerosis agent prior authorization criteria. Stelara (ustekinumab) an injectable for moderate to severe psoriasis will be added to the psoriasis agent criteria. Also, Onsolis (fentanyl buccal soluble film) will be added to the Actiq and Fentora criteria.

Dr. Jennifer Smith reviewed the formulary status of PrandiMet (Repaglinide/metformin) and the other currently preferred oral diabetes agents. Dr. Smith stated that this combination of medications is not ideal clinically, and since Prandin will be available as a generic soon that it was not recommended to add PrandiMet to the preferred drug list. Also, she recommended that Avandia, Avandament, Avandaryl, Duetact, Januvia, and Janumet remained on the preferred drug list since they are all effective diabetes medications and all had a place in diabetes therapy. The committee agreed with her recommendations.

Dr. Jennifer Burch reviewed the formulary status of Toviaz (fesoterodine extended-release oral tablets) and other oral urinary incontinence agents. Dr. Burch stated that Toviaz is a prodrug which its active metabolite is Tolterodine (Detrol), a preferred product. Toviaz and the other orally available urinary incontinence agents (Enablex, Ditropan XL, Vesicare, Sanctura XR) do not appear to offer any major clinical advantages over the preferred agents including the generic oxybutynin. Toviaz was recommended to be a "May Add". It was also agreed that there was not a strong need to add any of the other agents.

Dr. Morton reviewed the opportunities to cover the new over-the-counter proton pump inhibitors, Prevacid 24HR (lansoprazole 15mg capsules) and Zegerid OTC (omeprazole 20mg/sodium bicarbonate), for a \$5 copay for a 42 day supply as the Plan currently covers Prilosec OTC and omeprazole OTC. With recent legislation the Plan has the authority to block coverage of prescription products when an over-the-counter equivalent is available pending P&T approval. A financial analysis of the coverage options was presented which showed the most cost effective option was to cover the OTC

medications and exclude coverage of the prescription products that have an OTC equivalent. It was recommended to continue to provide the \$5 Prilosec OTC benefit and add the OTC benefit for Prevacid 24HR on 1/1/10 and Zegerid OTC when available. It was also recommended to block coverage of prescription Prevacid 15mg capsules and generic, Zegerid 20mg and generic and brand prescription Prilosec 20mg capsules by 2/1/10, but continue coverage of prescription generic omeprazole. The committee agreed with these recommendations.

Dr. Morton also presented an opportunity for the Plan to encourage the use of generic Cozaar and Hyzaar, angiotensin receptor blockers (ARB) used for the treatment of hypertension, when they are available as generics in April 2010. In order to maximize savings for the Plan in this therapeutic class, it was recommended to add Diovan/HCT, and delete Atacand/HCT and Benicar/HCT from the preferred drug list on 4/1/10. The implementation of a step therapy program will ensure the Plan's preferred agents are used. The step therapy program will allow for the use of Atacand/HCT for patients with heart failure due to the clinical data to support the reduced risk of death from cardiovascular causes and decreased hospitalizations from heart failure with the use of Atacand/HCT. The committee agreed with the preferred drug list changes and the implementation of the ARB step therapy program on 4/1/10.

Another step therapy opportunity was shared for the use of Forteo (teriparatide) for osteoporosis. The program would provide coverage immediately in situations where there is a prescription for a bisphosphonate in claims history during the previous 18 months. The program would ensure that a bisphosphonate is used first line if the patient is able, and that the member does not use the medication longer than 2 years per package labeling. The committee agreed with the implementation of this step therapy program on 4/1/10.

Dr. Sheila Marshall, Dr. John Engemann, Dr. John Anderson, Dr. Jeffrey Tingen (pharmacy resident) and Dr. Morton reviewed the new medications for formulary consideration. Fenofibric acid (TriLipix<sup>®</sup>) for reducing triglycerides, Amoxicillin Pulsys (Moxatag<sup>®</sup>) for the treatment of tonsillitis and/or pharyngitis, Dexlansoprazole (Kapidex<sup>®</sup>) for gastroesophageal reflux disease, Febuxostat (Uloric<sup>®</sup>) for chronic management of hyperuricemia in patients with gout, Dapsone gel 5% (Aczone<sup>™</sup>) and Adapalene/benzoyl peroxide topical gel (Epiduo<sup>™</sup>) for acne and mesalamine extended-release capsules (Apriso<sup>™</sup>) for maintenance of remission of ulcerative colitis were considered "may add" medications due to their lack of significant clinical advantages over existing products. The Plan will add TriLipix due to its unique indication in the combination use with statins and Apriso due to its once daily dosing.

A provider requested a review of the Plan's current proton pump inhibitor utilization management program. The provider felt there should be a provision for the long term suppression of asymptomatic peptic ulcer disease after initial treatment; however, this is not a labeled indication for PPIs. The committee agreed that if there is a provision for the long term use of a PPI in the symptomatic patient then the criteria did not need to be changed.