TennCare Pharmacy Advisory Committee (TPAC Meeting)
Oct. 4, 2005

Members in Attendance:
Wendy Long, M.D., M.P.H., Chief Medical Officer (TennCare), David Beshara, R.Ph.,
Chief Pharmacy Officer (TennCare), Chairman James Powers, M.D., Co-Chairman Alan
Corley, D.Ph., Edward Capparelli, M.D., Rufus Clifford, M.D., Stanley Dowell, M.D.,
Pete Frizzell, M.D., Lynn Knott, Pharm.D., Pat McCarthy, P.A., Terry Shea, Pharm.D.,
Lisa D’Souza, J.D., Roger Zoorob, M.D.
Special Guests: Cliff Tennyson, M.D.
Non-Members Present from First Health: Nicole Charlebois, Pharm.D., Sandy Kapur,
Pharm.D.

INTRODUCTIONS:
The meeting was called to order by Dr. Powers. Dr. Powers opened the meeting by
reading the confidentiality/conflict of interest statement. Then the members of the
committee introduced themselves.

MINUTES:
The minutes from the August 3, 2005 PAC meeting were reviewed. The following
corrections were recommended:

- On p. 2, first bullet point - should read “Levaquin® for post-hospitalization
  patients” not “Levaquin® for dose optimization patients”
- On page 5, third bullet point, a portion of Dr. Powers’ statement is missing. Should be “I don’t think we talked about long-term use at the previous meeting. Perhaps we can schedule a future meeting to discuss this.”
- On page 8, second bullet point from the bottom, the comment on the A to Z trial should read “24 months” not “24 weeks”
- On page 24, the last bullet point on the page should be removed, and on page 25, the first bullet point, the statement “Therapy should be discontinued with a Mini-Mental State Exam of < 10 and/or if the recipient shows lack of improvement or becomes institutionalized due to the severity of their dementia” should be deleted.

Minutes accepted with recommended changes.

TENNCARE REFORM UPDATES:
A summary on the current state of TennCare reform was presented by Dr. Wendy Long.

- 191,000 have been disenrolled, 21,000 have appealed the disenrollment. Another
  17,000 have submitted RFIs.
- For those remaining in the program, benefit changes, including the 5 prescription
  limit, went into place on August 1st.
- TennCare continues to negotiate rebates with CMS and is in the process of
  working with their legal team to incorporate those rebates in order to re-evaluate
  their position and determine what changes will be implemented in the future.
- TennCare is also working with their legal team to interpret the Grier consent decree and determine how they will implement changes related to the Grier consent decree on January 1st.

Discussion:
- A question was posed as to what the effect of the cutbacks will be, including their impact on pharmacy costs and number of prescriptions.
  - The response indicated that TennCare is beginning to look at that data and may have something by the next meeting.
  - A comment was made that data has been provided for July and August, showing a 54% drop in number of prescriptions and a 50% decrease in prescription costs. In addition, the data showed medications such as cholesterol-lowering agents, bisphosphonates, and medicines for COPD dropping close to 70% for July to August.
  - Dr. Long stated that TennCare had not seen that data.
- A request was made for pharmacoeconomic data. The requestor cited the First Health/TennCare contract, Section 8.3.1.1, which states “The contractor will develop and present to the TennCare Pharmacy Advisory Committee the clinical and pharmacoeconomic review criteria the contractor uses to determine preferred and non-preferred drugs.”
  - Mr. David Beshara noted they have obtained legal input from their lawyers, as well as state lawyers, as to what can be shared with the committee. The legal team has stated that TennCare cannot share NMPI supplemental rebate information, and if TennCare shares CMS rebate data, they must roll-up the data and present it at category level (same as how Congress receives this data).
- A question was posed as to whether TennCare is tracking the impact to the hospitals due to discontinuations of mental health drugs?
  - Dr. Long stated that there was additional funding made available to increase payments to hospitals to help compensate for what they may experience with increased care.
- A request was made for more feedback on the impact of the decisions that the PAC has made.
  - Mr. Beshara stated that they plan on providing that information to the committee. The 1st and 2nd rounds of grandfathering are just starting to expire 10/1, so the impact of the PAC’s decisions are just beginning to be seen. A market shift won’t really be noticeable for another quarter or two, but TennCare intends to share this information with the committee.
- A question was posed as to the status of physicians being able to put diagnosis codes on prescriptions to assist with the PA process?
  - Mr. Beshara stated that TennCare has received a legal opinion stating that as long as they don’t mandate it, physicians can write the diagnosis code on the prescription. TennCare has begun working with First Health to get this up and running as an adjunct to the PA process, and hopes to have this in place by the end of the year.
Question was posed as to whether there would be a new preferred drug list to clarify what is preferred vs. non-preferred (since there are preferred agents that require prior authorization).
  - Mr. Beshara stated that they are planning on having a new format for the PDL by 12/1/05. The new PDL will have an entirely different look and feel to it, and it should be easier to determine which drugs require a PA, when an entire class requires a PA, etc.

MENTAL HEALTH PRESENTATION BY GUEST SPEAKER:
- Introduction of guest speaker, Dr. Cliff Tennyson, chief medical officer for Helen Ross McNabb Mental Health Center in Knoxville and past President of the Tennessee Psychiatric Association. He was asked to speak about atypical antipsychotic use in mental health patients.

Key Points of Dr. Tennyson’s Presentation:
- Access to the atypical antipsychotics is uniformly supported for the severe and persistently mentally ill by every algorithm, protocol, expert consensus opinion, and other guidelines produced by every professional and advocacy group (including the Tennessee Department of Mental Health, the American Psychiatric Association, the American Association of Community Psychiatrists, etc.). TMAP should not be misinterpreted to support that only some atypicals are appropriate – TMAP itself includes all atypicals to ensure flexibility.
- Non-interchangeability: While the atypicals are a heterogeneous group, they share a decreased propensity for extrapyramidal symptoms, and therefore, higher tolerability, and an ability to improve the negative symptoms. However, the atypicals are pharmacologically distinct and have significant differences in receptor affinities.
- The CATIE trial: The data published thus far is for Phase I of this trial (there are 3 phases total), and looked only at duration of treatment and tolerability. The trial considered discontinuation due to all causes. The lay press interpretation of this trial have misinterpreted and distorted the findings of the CATIE trial and ignored the findings of other studies. The results of CATIE do not support limitation of atypical antipsychotics. Compliance rates in this population have always been low. The first-generation typical antipsychotics pose significant side effects, including extrapyramidal symptoms and tardive dyskinesia, along with the persistence of negative symptoms, for which atypicals offer meaningful improvement.
- There are significant differences among the atypicals, including their target symptom effects and adverse effects.
- Cost-effectiveness of open access:
  - Mental health makes up about 6% of total healthcare costs.
  - Not treating mental illnesses increase costs in other health care cost “silos.”
  - Not treating mental illness adequately can increase costs 2-3 times. Restrictions are more costly in the long run.
• Five studies showing restricting mental health access increases costs:
  o 1998 study among 6 HMOs (5 medical conditions and 1 psychiatric condition) – This study showed the more restrictive the formulary, the higher the healthcare costs for the industry. The least restrictive formularies had the lowest usage of healthcare services overall.
  o 1994 New Hampshire study, published in the New England Journal of Medicine – This study showed that decreased drug costs were associated with increased hospitalization and emergency room costs.
  o California 2002 independently-funded study – showed improved outcomes with olanzepine, along with decreased hospitalization costs, decreased crisis costs, and increased outpatient and medication costs. Overall, mean savings of $1991/patient.
  o Virginia study 2003 – atypical antipsychotics saved costs in hospitalizations and reduced unemployment in severe and persistently mentally ill patients. Net annual inpatient savings alone were $13,677 per patient.
  o USC study 2003 – “fail-first” mechanisms cost the state over $2500 per patient over a 6 month period.

• Atypical antipsychotics are truly breakthrough medications. They save lives. And all of the atypicals are gathering more data demonstrating their efficacy. Olanzepine and risperidone have been shown to be superior to Haldol® in 8 or 9 out of 10 studies.

• How Limits and Prior Approvals Present Significant Risks:
  o There are 3 means of treating severe and persistently mentally ill patients: hospitalization, comprehensive outpatient care, and medication. Access to in-patient treatment has been dramatically reduced. Outpatient psychosocial interventions also continue to be reduced. Experience has shown atypical antipsychotic medication plus intensive outpatient treatment leads to the best outcomes with the greatest savings. Our PACT program has shown that, although expensive, it saves money overall (> $1 million per year) by keeping patients out of the hospital. Reduced access to medications is another “short-term fix.” If we reduce access to medications along with hospitalizations and outpatient care, we will inevitably see increases in costs, homelessness, incarceration, and death.
  o “First fail” mechanisms are “dangerous” and “inappropriate.” With mental illness, failure is devastating. Prior approval strategies should be based on medical necessity and evidence for true therapeutic equivalence and not on cost alone. Switching antipsychotic medications is risky and should be only with significant medical rationale and with a guarantee of permanent grandfathering.
  o Problems with restricted formularies arise when patients are discharged from the hospital and cannot be continued on medications started in the hospital.
• Controlling Costs in a Medically Responsible Way:
  o Because atypical antipsychotics are not interchangeable, restrictions are not likely to result in cost-savings, and are likely to result in increased overall costs for the state. Long-term efficacy and appropriate treatment can produce indirect costs that exceed direct costs.
  o Disease management strategies can be effective.
  o Best practice guidelines and algorithms can guide treatment responsibly. Algorithms must be based on open access to medication.
  o We must be very cautious about experimental cost-containment strategies and utilization management programs imposed on vulnerable populations.
  o However, if more control is somehow inevitable, perhaps clinical criteria for antipsychotic medications should be in place. These criteria should be based on diagnosis, clinical condition, severity, levels of dysfunction or risk, and co-morbidity.
  o If we take away access to medications, severe and persistently mentally ill patients will end up in hospitals, homeless shelters, and jails.

Discussion:
• The following questions were posed regarding the HMO studies cited in the presentation:
  o Were the studies truly non-restrictive formularies (i.e., if a patient failed a preferred agent, could they get a non-preferred medication)?
    ▪ Dr. Tennyson stated that patients could get a non-preferred agent after failing under different kinds of criteria.
  o Did the studies offer any mechanism for grandfathering?
    ▪ Dr. Tennyson admitted he did not know about grandfathering in these studies.
  o Did patients have a higher copay for a non-preferred agent?
    ▪ In the 1998 HMO study, it was based on co-pay. In all the other studies, they were public sector and there was no co-pay, but you had to “jump through hoops” and meet certain criteria before you could get a non-preferred agent.
  o Were they public sector or Medicaid/Medicare?
    ▪ The 1994 New Hampshire study, the California study, the Virginia study, and the USC study were public sector.
• A question was posed as to whether there was any way a physician could choose the “right” agent the first time (and avoid “first failure”).
  o Dr. Tennyson responded that there is no way to guarantee that a physician will pick the right drug the first time. The point is that the decision should be based on medical criteria not on cost.
  o A follow-up question addressed whether there are things to guide how a physician would choose, for example, Risperdal® for Patient X, and Seroquel® for Patient Y.
    ▪ Dr. Tennyson responded that the reason he is suggesting open access is because that data does not exist. Nobody knows exactly which drug to use. The point is to make that decision based on the
physician’s experience and training, the patient’s history of response, comorbidities, tolerance of side effects, etc. The doctor must consider whether the patient needs to be sedated or activated, whether the patient can tolerate neurologic vs. anticholinergic side effects, etc.

- A question was posed as to whether Dr. Tennyson believed the development of clinical criteria could be done.
  Dr. Tennyson responded that he believed it could be done, but the data doesn’t exist right now.

- Dr. Tennyson was questioned as to how TennCare’s proposed criteria would not be clinically appropriate, given a proposal including permanent grandfathering.
  - Dr. Tennyson replied that permanent grandfathering is wonderful. The problem with not allowing all agents as first-line therapy for treatment naïve patients is that the individual agents are distinct from one another.

- A request was made for Dr. Tennyson to provide some guidelines for when he would start therapy in a treatment-naïve patient with one agent versus another.
  Dr. Tennyson responded that he could think of something for each one, but by rationing limited resources, there’s always a degree of risk at the point of service. The real problem for severe and persistently mentally ill patients is that the full continuum of care doesn’t exist. Given that they other services that are needed (psychotherapy, counseling, etc.) are being cut away, it is a problem to cut away at medication coverage.

- A request was made for Dr. Tennyson to comment on the impact of limiting patients to 3 of the available atypicals as first-line treatment.
  - Dr. Tennyson responded that there are certain adverse events he would want to avoid and certain beneficial effects that he wants to capture for certain patients. If a patient has a history of difficulty tolerating extrapyramidal side effects, he would want to avoid medications that would be more likely to cause that. If he had a patient going through puberty, he would not want to induce hyperprolactinemia. If he wanted to help someone already at risk for falling, he would want to be careful about oversedating them. If he wanted to help somebody stay alert and have good concentration at work, he would want to use an activating agent.

- Mr. Dave Beshara provided a recap of this topic for the new members of the committee.
  PAC has been discussing this topic for 2 sessions now. The Bureau, recognizing the extremely sensitive nature of this category of medications, endeavored 2 sessions ago to bring in several experts from the mental health community.
  There’s also a lot of external pressure on the Bureau to get a PDL in place for behavioral health agents. There are savings to be had, and putting a PDL in place around the behavioral health agents is actually supported by advocacy groups outside the Bureau (referenced the Tennessee Healthcare Campaign website). What TennCare has put forward today is a set of very carefully crafted criteria, based on scientific evidence.
The representative member from the Tennessee Justice Center stated that there is nothing on their website that advocates choosing among agents in this class of medications.

Mr. Beshara pointed out that their estimated savings associated with including behavioral health drugs on the PDL must include the atypicals, as there is no other way they could get that number without including the atypicals.

Discussion took place regarding whether supporting a “PDL” implies having preferred and non-preferred agents, and whether having non-preferred agents can be considered a “fail-first” approach. TennCare suggested that “PDL” does imply preferred vs. non-preferred agents, but having non-preferred agents within the same class is not a “fail-first” approach. TennCare argued instead that a step-therapy program requiring failure of a different class of medications before a certain class of drugs could be obtained would be considered a “fail-first” approach.

- Dr. Long pointed out that in classes other than the atypicals, access to a non-preferred drug is based on scientific evidence indicating that drug X is superior for a certain patient population. The problem with the atypicals is that it is difficult for physicians to articulate that if certain criteria are true, than drug X is indicated for an individual. Mr. Beshara reminded the physicians of the committee that if they could provide rationale for why they would choose one agent over another, TennCare would gladly build this into the criteria for the non-preferred products.
  - The committee responded that it comes down to clinical judgment. The provider needs the flexibility to make that choice.

- Dr. Tennyson was asked to describe a patient for whom he would choose Abilify® or Zyprexa® over the other agents as first-line treatment, and to comment on what percent of the population would require these agents first-line over the others.
  - Dr. Tennyson stated that he had no idea about what percentage of the population would require these agents first-line over the others.
    - Dr. Tennyson stated that he had no idea about what percentage of the population would require these agents first-line. If a patient comes to him and can’t sleep, he would use a sedating drug. If the patient is oversleeping, we would use an activating agent such as aripiprazole. If a patient has a family history of diabetes or already has diabetes, he may want to be more cautious with agents associated with more weight gain, such as clozapine and olanzepine. Abilify® has been shown to be very useful in people with “rageful discontrol” and “behavioral outbursts.” Also, it is safe in teens (not much hormonal disturbance). Olanzepine has been shown to be extremely useful in long-term improvement in cognitive and negative symptoms of psychosis. It is also very good at “community readiness.”

- A question was posed as to why the Texas algorithm was changed in July of this year for bipolar disorder to allow open access.
  - Dr. Tennyson stated that the TMAP schizophrenia algorithm always included all of the atypicals. Opening up the bipolar algorithm probably
had something to do with the atypicals one by one getting approval as anti-manic drugs.

- Mr. Beshara stated that this too was their understanding. When the bipolar algorithm was developed, olanzepine was the only agent approved for bipolar. As other agents were approved, they were added to the algorithm.

- A comment was made that since none of the treatment algorithms have restricted any of the atypicals, if TennCare were to restrict this class, they would be setting an “unprecedented precedent.”
  - Clarification was provided stating that it would not be unprecedented for public sources to set these kinds of restrictions, but it would be unprecedented if this group were developing an evidence-based, independent, academically-oriented, research-based algorithm.

- A question was posed to Dr. Tennyson regarding how much the proposed recommendations would impair his ability to treat patients.
  - Dr. Tennyson responded that if any of the 5 non-clozapine atypicals were among the 2 that were going to be left out, for each one that’s left out 5-10% of his patients would not respond adequately.

- The question was posed as to whether open-access for psychiatrists would be an acceptable alternative.
  - Dr. Tennyson pointed out that one of the problems with this is there are not enough psychiatrists available to treat all of the mental illness in the state. We have to use primary care doctors. He stated that if we cannot have open access to the atypicals, then we should probably have some clinical criteria. He stated that clinical criteria would result in more savings than leaving two agents out. Criteria should address that the patient has an appropriate diagnosis – this will help with misuse/overuse.

- Dr. Tennyson was thanked for his presentation and remarks.

**DRUG CLASS REVIEWS:**

*(Morning Session)*

**ATYPICAL ANTIPSYCHOTICS:**

**Introduction:**

- The clinical literature, as well as treatment guidelines from APA and IPAP, suggest that the agents in this class have similar efficacy, with the exception of clozapine, which has been shown to have superior efficacy in patients with suicidal ideation. The major differences between agents are their side effect profiles (olanzepine associated with weight gain, clozapine associated with risk of agranulocytosis, risperidone associated with increased prolactin levels, etc.).

First Health’s recommendations were presented:

CLOZAPINE, GEODON®, RISPERDAL®, SEROQUEL®, and FAZACLO® ODT preferred with the following criteria:
**Atypical antipsychotics will only be authorized for the following diagnoses:**

### BIPOLAR MANIA-ACUTE, BIPOLAR DEPRESSION, BIPOLAR MAINTENANCE, BIPOLAR MIXED STATES
- Patients should have documented in their medical record a diagnosis of bipolar disorder.
- For patients in a manic episode with psychotic features, e.g. delusions, hallucinations, bizarre behavior, one of the preferred atypical agents will be approved.
- For partial or non-response after a 4-week trial of an appropriate dose of a preferred atypical at the highest recommended or tolerated dose, approval will be granted for an alternative preferred atypical.
  - Patients not on a mood stabilizer (lithium, divalproex, lamotrigine, oxcarbazepine, or carbamazepine) will be required to try addition of a mood stabilizer before an alternative preferred atypical will be approved.
  - Patients currently receiving a mood stabilizer will be approved for an alternative preferred atypical.
- For partial or non-response after a 4-week trial of an appropriate dose of a second preferred atypical and a mood stabilizer, the patient should be recommended to receive clozapine if it has not yet been tried.
- For partial or non-response after trials of high doses of the three preferred atypicals, then a non-preferred atypical will be approved.

### SCHIZOPHRENIA
- Patient should have documented in their medical record a diagnosis of schizophrenia or schizoaffective disorder
- For the first episode or for patients with a history of response of positive symptoms to an antipsychotic drug, one of the preferred agents should be tried. If schizoaffective and currently in an excited state, a mood stabilizer may be used. If depressed at the end of four weeks, an antidepressant may be used.
- If psychosis persists after a trial of 4 weeks at an appropriate dose of a preferred atypical, then a second preferred newer generation atypical should be tried as monotherapy for a period of four weeks. If schizoaffective, a mood stabilizer may be used.
- If psychosis persists or if moderate to severe tardive dyskinesia is present despite two trials with two different drugs from the preferred list, a trial of clozapine must be strongly recommended to the patient if not already tried. If refused, this should be documented in the medical record and a trial of a third preferred atypical agent, using high doses, is recommended. Clozapine is also recommended in patients that have made a medically serious suicide attempt.
- For partial or non-responsive patients after a 4 week trial of an appropriate dose of the third preferred atypical, then a non-preferred atypical will be approved.

### SCHIZOAFFECTIVE DISORDER
- DELUSIONAL DISORDER
- PSYCHOTIC DEPRESSION
- TOURETTES/SEVERE TICS
- PSYCHOTIC DISORDER NOS
- AGITATION OF DEMETIA
- PSYCHOSIS SECONDARY TO A MEDICAL CONDITION
- AGITATION/AGGRESSION IN MENTAL RETARDATION/AUTISM
- AGGRESSION/IMPULSE CONTROL DISORDERS
- BRIEF PSYCHOTIC DISORDER
- SUBSTANCE-INDUCED PSYCHOTIC DISORDER (including SUBSTANCE-INDUCED WITHDRAWAL PSYCHOTIC DISORDER)
- SEVERE REFRACTORY DEPRESSION
- SEVERE REFRACTORY OBSESSIVE COMPULSIVE DISORDER
- SEVERE REFRACTORY POST-TRAUMATIC STRESS DISORDER
**† Risperdal M-tab® and Zyprexa Zydis®**

Risperdal M-tab® and Zyprexa Zydis® will only be authorized if the recipient is unable to swallow tablets, but is able to absorb PO medications.

**‡ Risperdal Consta®**

Risperdal Consta® will only be authorized if the recipient has documented non-compliance with PO atypicals or non-response due to non-compliance.

**Symbyax® (H7Z) (olanzapine/fluoxetine)**

All of the following must apply:

- The recipient is unable to tolerate the medications given separately
- The diagnosis must be depressive episodes associated with bipolar disorder
- The recipient is > 18 years of age and < 65 years of age

**Discussion:**

- Comment made advising TennCare and the committee not to accept these recommendations. The Tennessee Psychiatric Association, CMS, and APA all support open access. The TMAP algorithm was created after long consultations with psychiatrists across the state of Texas, and does NOT have preferred agents.
- It was pointed out that in manic patients, it’s not a matter of psychosis, it’s a matter of severity. For a severe manic episode, an atypical should be used.

**Motion:**

- Reject the concept of preferred agents in this category and leave the category open.

**Motion seconded.**

**Discussion on the motion:**

- Comment made by a committee member that, given the savings from the cuts already made to the TennCare, limiting this class of medications is not necessary.
- Comment made by committee members that this would place tremendous burden on psychiatrists, and patients on atypicals may not inform their physician if the medication is not working.
- The committee members voiced agreement over the need to look at Seroquel® 25 mg for sleep.
  - First Health clarified that low-dose Seroquel® will not be grandfathered in order to rule out its use for sleep.
- Question posed as to where it was stated that there would be permanent grandfathering for all atypicals (other than low dose Seroquel®)?
  - First Health pointed out that in the past this information has not been included with the clinical criteria. TennCare remarked that they would be more than happy to specify permanent grandfathering in the criteria.
- Question was posed as to whether all dosage forms are included?
  - TennCare confirmed that all dosage forms would be included, based on the drug.
- Concern was voiced over patients not coming back to pick up their drugs in instances where they needed to wait for a PA.
• TennCare admitted they need to educate physicians to seek PAs for patients from an in-patient setting. The need for physician education will increase even more post-Grier.
• Comment was made stressing the importance of having Abilify® available for overweight teenage girls.

Vote:
• Motion passed unanimously.

Mr. Beshara voiced disappointment in the committee for making their decision based on individual practice patterns rather than the medical literature. Mr. Beshara stated that the medical literature did not offer any reason why one atypical should be selected over another in a therapy-naïve patient, and that several experts have gone on the record saying that treatment algorithms are the proper way to treat.

Dr. Frizzell made a rebuttal stating that when one considers the opinions of the American Psychiatric Association, the Tennessee Psychiatric Association, and the experts that were consulted, “to construct what you constructed here to ram down our throats is contemptible.”

SKELETAL MUSCLE RELAXANTS:
Introduction:
• First Health reviewed the new format for drug class review. Committee members were asked to assess agents within each category while considering the following three questions:
  1) Are any of the products less effective or associated with concerning safety issues compared to the others?
  2) Do any of the products show superior efficacy or have a special niche in a certain population?
  3) Are the products considered therapeutically equivalent?
    o Concern was expressed that the new format would be too time-consuming. The suggestion was made to return to the old format in which First Health recommends preferred vs. non-preferred agents.
    ▪ First Health replied that if the new method was found to be more time-consuming or did not appear to be working, they could go back to the old method for future PAC meetings.

Overview of agents used for spasticity:
• Baclofen – gaba-B agonist, predominant side effect is sedation
• Zanaflex® (tizanidine) – alpha-2 agonist
• Dantrium® (dantrolene) – works peripherally by inhibiting the release of calcium from the sarcoplasmic reticulum
  Based on treatment guidelines and available clinical literature, all agents are more effective than placebo. Baclofen and tizanidine are considered equivalent in treating spasticity, whereas there is insufficient data for dantrolene.
Discussion of agents for spasticity:

- Inquiry made as to whether all three agents are currently available generic?
  - First Health affirmed they are.
- Comment made by committee members that there has been lots of clinical experience with baclofen.
- Question posed as to whether there are any differences in side effects among the agents?
  - First Health responded that baclofen and tizanidine have greater sedation than dantrolene; however dantrolene has a risk of hepatotoxicity.
- Comment was made that there is little utilization of dantrolene and it appears to be significantly more expensive than the other agents. Baclofen appears to be least expensive.

Motion:
- Since all 3 agents are available generically, recommend that baclofen and tizanidine be preferred.

Motion seconded.

Discussion on the motion:
- Question as to whether it would be possible to put PA criteria in place for dantrolene to allow its use for spasticity in patients for whom sedation is a problem.
  - First Health stated that the baseline criteria for the class should accommodate this (non-preferred agents are approved if there is a history of unacceptable/toxic side effects with agents not requiring prior approval).

Vote:
- Motion passed unanimously.

Overview of agents for skeletal muscle pain:

- Flexeril® (cyclobenzaprine) – 5 mg tablet available brand only, 10 mg available brand and generic. Limiting side effect is sedation.
- Norflex® (orphenadrine) – available brand and generic, used off-label for Parkinson’s disease.
- Norgesic Forte®/Orphengesic® (orphenadrine/ASA/caffeine)
- Robaxin® (methocarbamol) – available brand and generic
- Skelaxin® (metaxolone) – available brand only
- Parafon Forte® (chlorzoxazone) – available brand and generic. Associated with some risk of hepatotoxicity.
- Soma® (carisoprodol) – available brand and generic. The active metabolite of Soma is meprobamate, an anti-anxiety agent with high abuse potential.
- Soma compound® (carisoprodol/ASA)
- Soma compound with codeine® (carisoprodol/ASA/codeine)

First Health proposed the following criteria for agents within this class:

`Flexeril® 5mg tablets will only be authorized if the recipient has tried and failed a 1 month therapy of two preferred agents, where one of the agents must be generic cyclobenzaprine, and the recipient is unable to split tablets.`
Due to lack of efficacy for chronic use and potential for abuse, suggest decreasing the quantity level limits for carisoprodol to 56 tabs (14 days of therapy) every 90 days.

- The Soma® criteria allows for a quantity of 3/day for 14 days. A tapering schedule will be made available for those patients receiving greater than 3/day to avoid withdrawal or serotonergic effects.
- Flexeril® currently has the greatest clinical evidence supporting its use. Limited data exists for Skelaxin®, Robaxin®, and Parafon Forte®. Skelaxin® has a short half-life and little potential for abuse. Soma® has great abuse potential, and some states have moved it to a Schedule IV status.

Discussion of agents used for skeletal muscle pain:
- Recommendation made to not to cover Soma® or its compounds.
- Concern expressed over withdrawal symptoms in patients currently taking Soma®. Request to make a tapering schedule available to physicians.
  - First Health stated that there are tapering schedules out there, which will be made available.
- Recommendation to have Robaxin® (methocarbamol) preferred because it is non-sedating, which is especially important for school-age children/teens. Additional comment made that Robaxin® is also very inexpensive.
- Recommendation made to have Flexeril® (cyclobenzaprine) preferred, as well.
- Question posed as to whether the 10 mg Flexeril® (cyclobenzaprine) tablet can be split, since it wouldn’t make sense to cover the 5 mg brand Flexeril® tablet if the 10 mg tablet can be split.
  - First Health stated that the 5 mg Flexeril® criteria should take this into account. (It requires the patient to be unable to split tablets.)
  - The Committee pointed out that the PA criteria wouldn’t be needed if the 5 mg Flexeril® were just non-preferred.
- Recommendation made to have an all-generic preferred list for this category.
  - First Health pointed out that the generic Norflex® is still very expensive.
  - The Committee stated it would not have a problem with generic Norflex® being non-preferred.
- Question posed as to why we are still seeing such high brand medication use in this category?
  - TennCare responded that if the physician writes, “Dispense as Written” then the brand is filled.
  - TennCare asked whether they are following up on this to ensure that pharmacies are not just filling the brand medication on their own (without a DAW1).
  - TennCare stated that there is a pharmacy auditing process.

Motion:
- To have an all-generic preferred list within this class, with the exception of orphenadrine, which should be non-preferred because it is significantly more expensive. All brands, including Flexeril® brand, Soma®, and Soma® compounds
recommended to be non-preferred, with tapering schedules to be made available for Soma®.

Motion seconded.

Vote:
- Motion passed unanimously.

(Afternoon Session)

ACKNOWLEDGEMENT OF FORMER PAC MEMBERS:
- The Chairman recognized the contributions of Dr. Diane Pace, Dr. Shana Bush, and Dr. Bill Terrell.
- Letters of appreciation will be sent.
- TennCare stated that they will be recognizing these PAC members’ contributions with a plaque. The plaques are to be forwarded to Dr. Powers and sent along with the thank you letters.

DRUG CLASS REVIEWS CONTINUED:

PLATELET INHIBITORS:
Introduction:
- The following agents are used in cardiovascular disease, coronary artery disease (CAD), and stroke:
  - Aggrenox® (dipyridamole/ASA)
  - Persantine® (dipyridamole) – available generic
  - Plavix® (clopidogrel)
  - Ticlid® (ticlopidine) – available generic
- The following agent is used in peripheral vascular disease and intermittent claudication:
  - Pletal® (cilostazol)
- The role of Ticlid® has been questioned given its side effect profile, the lack of head-to-head trials with Plavix®, and the lack of data in acute coronary syndrome (ACS).
- In CAD and ACS, Plavix® has the most clinical evidence. Ticlid® and Aggrenox® have not been studied in ACS.
- In stroke/TIA, Plavix®, Aggrenox®, and aspirin are all considered appropriate therapy. ACCP has a weak statement supporting the use of Aggrenox® or Plavix® over aspirin in stroke patients based upon data from the European Stroke Prevention Trial. The American Heart Association guidelines state that Aggrenox®, aspirin, and Plavix® are all reasonable options for secondary prevention of stroke, while aspirin should be first line for primary prevention of stroke.
- For peripheral vascular disease, Pletal® is the only agent with an FDA-approved indication for PVD; however the data supports use of aspirin and Plavix®, as well.
Discussion:

- Comment made that Plavix® is an extremely important drug – its use post-MI and in PAD is unparalleled.
- Comment made that dipyridamole must be taken 5 times a day (q4h) in order to be used effectively, and it is not terribly well tolerated.
- Discussion regarding the clinical data for Aggrenox®:
  - In terms of stroke, the ESPSII data has shown a 22% risk reduction whereas the CAPRI trial doesn’t show as much; however it’s difficult to compare the ESPSII study with the CAPRI trial because they used different strengths of aspirin (ESPSII = 50 mg ASA, CAPRI = 325 mg ASA).
- Point made that Aggrenox® is only indicated for prevention of a second stroke, and thus, is unlikely to be abused.
- Opinion voiced that it is worth the cost of Aggrenox® to have this agent available for prevention of a second stroke.
- Comment made that Ticlid® has a strong Beers severity rating, and is thought to be no better than aspirin and more toxic.
- Question posed as to when physicians would use Aggrenox® if Plavix® were available?
  - Response made stating that the data for secondary stroke prevention is statistically significant for Aggrenox® but not for Plavix®. Also, personal anecdote related describing a patient stable on Aggrenox® for 2 years, who was then switched to Plavix® and had several repeated strokes and died.
- Comment made that, in terms of clinical use, having more than one alternative is useful.
- Comment made that in all the guidelines, the use of Ticlid® has been questioned given the availability of Plavix®.
- Question posed as to whether Plavix® is associated with higher bleed rates than Aggrenox®.
  - Claim made that there seems to be more bleeding with Plavix® alone than with Aggrenox® alone.
- Comment made that they are coming out with a new device to assist in monitoring the antiplatelet effects of Plavix® (called Verify Now P2Y2).

Motion:

- To keep Plavix®, cilostazol, dipyridamole, and Aggrenox® preferred, with Ticlid®, ticlopidine, Pletal®, and Persantine® non-preferred (i.e., all agents except Ticlid® and multi-source brands).

Motion seconded.

Discussion on the motion:

- Question voiced as to whether dipyridamole should be preferred.
  - Recommendation made that, given it is not very expensive, and there are some people who are doing well on this drug, it should be included as preferred.
  - Disagreement voiced for this recommendation stating there is no reason to list dipyridamole as preferred.
Comment made that dipyridamole has been available for years and none of the studies have ever shown that it has done any better than aspirin.

Question posed as whether Aggrenox® would be considered a generic if dipyridamole were non-preferred.
- TennCare stated that Aggrenox® would not be considered a generic because the two drugs, although related, have different mechanisms.

- Question posed as to whether there would be no generics available as preferred agents if dipyridamole were non-preferred.
- TennCare confirmed this; however they pointed out that the issue is that the generics that are available are not as effective as the brands.

Vote:
- Motion carried (all ayes, with one voter absent).

**ESTROGENS/PROGESTINS:**

Introduction:
- First Health clarified that the oral contraceptives will NOT be reviewed at this meeting. Only the hormone replacement products will be reviewed.
  - Inquiry made as to when the oral contraceptives will be reviewed?
    - First Health stated that they are on the roll-out schedule for 2006-2007. While not sure of the exact date, they confirmed the oral contraceptives will not be reviewed at the next PAC meeting.
  - Question posed as to whether the oral contraceptives are going to be available up until the time they are reviewed?
    - TennCare stated that this class has not been reviewed, so they will all continue to be covered for now.

Overview of the estrogen class:
- Estrogens have been shown to be effective at reducing post-menopausal symptoms (night sweats, hot flashes, etc.).
- The 2002 Women’s Health Initiatives study showed an increased risk of CHD, stroke, and breast cancer; therefore treatment guidelines recommend that the lowest dose of these agents be used for the shortest duration.
- Guidelines do not recommend these agents as first line for treatment of osteoporosis due to their potential risks.
- Women with an intact uterus should receive an estrogen/progestin combination product rather than estrogen alone to prevent endometrial hyperplasia.
- Oral and transdermal formulations are thought to be equally effective; however transdermal formulations may result in lower elevations in triglycerides and less interpatient variability.
- Vaginal products are preferred in patients with predominantly urogenital symptoms due to their lower systemic absorption.

Agents in the Oral Estrogen Class:
- Estrace®/Gynodiol® (Estradiol) – generic available
- Cenestin® (estrogens, conjugated synthetic A)
Discussion:

- Comment made that there is a lot of personal choice involved in this class. Some women prefer the patches to the tablets. However, the products are equivalent in terms of efficacy and side effects.
- Comment made that there is some evidence to support fewer thromboembolic phenomena with the transdermal products versus the oral agents.
- Comment made that the vaginal estrogens do have some systemic absorption but are mainly used for local symptoms.
- Comment made that there is not any major differences among the oral estrogens.

Motion:

- To give First Health the ability to negotiate for any of these agents.

Motion seconded.

Vote:

- Motion approved unanimously.

Agents in the Vaginal Estrogen Class:

- Premarin® (estrogens, conjugated equine)
- Menest® (esterified estrogens)
- Ogen®/Ortho-Est® (Estropipate) – generic available

First Health proposed the following criteria for the Vaginal Estrogen Class:

<table>
<thead>
<tr>
<th>Estring®, Femring®</th>
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<td>Due to the high cost of vaginal estradiol rings and their similar efficacy to other vaginal estrogen products, patients will be required to try and fail two preferred vaginal estrogen products before they will be approved for a vaginal estradiol ring.</td>
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Discussion:

- None.

Motion:

- To allow First Health to negotiate to have one or two preferred vaginal preparations and to approve the criteria for the vaginal ring formulations.

Motion seconded.

Vote:

- Motion approved unanimously.
Agents in the Transdermal Estrogen Class:

- Alora® (estradiol)
- Esclim® (estradiol)
- Estraderm® (estradiol) – “reservoir-type,” where drug is dissolved in alcohol solvent
- Estrasorb® (estradiol) – topical emulsion formulation
- Estrogel® (estradiol) – topical gel formulation (flammable)
- Vivelle® (estradiol)
- Vivelle-Dot® (estradiol)
- Climara® (estradiol)
- Estradiol TDS® (estradiol)
- Menostar® (estradiol)

(Note: some generic estradiol patches available; however it is only certain strengths.)

Overall, studies have shown similar efficacy among transdermal products. Studies have shown better tolerability of the matrix patch compared to the reservoir-type patch.

First Health recommended the following criteria for the Transdermal Estrogen Class:

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**Estrogel®**

Due to the high cost and inconvenient administration of Estrogel, this product will only be authorized for individuals who have tried and failed an adequate trial of two preferred transdermal estrogens.

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Discussion:

- Comment made that there are not any major differences among the patches. Request just to have at least one transdermal patch available.
- Agreement voiced that if one agent is significantly more expensive than the others, as is the case with Estrogel®, then it should not be preferred.

Motion:

- To allow First Health to decide which of these agents to have preferred.

Motion seconded.

Vote:

- Motion approved unanimously.

Agents in the Oral Progestin Class:

- Provera® (medroxyprogesterone) – generic available
- Aygestin® (norethindrone acetate) - generic available
- Prometrium® (progesterone)

First Health pointed out that these agents are indicated for the treatment of secondary amenorrhea, abnormal uterine bleeding, and endometrial hyperplasia.

Discussion:

- Question posed as to why injectable estrogens were not listed here.
  - First Health responded that the injectable estrogens are not mentioned because they are point of service in the doctor’s office.
Comment made that there is equivalency in this class.

Motion:
- To allow First Health to decide on the preferred agents for this class.
Motion seconded.
Vote:
- Motion unanimously approved.

Agents in the Oral Estrogen/Progestin Combination Class;
- Activella® (estradiol/norethindrone acetate)
- Ortho-Prefest®/Prefest® (estradiol/norgestimate)
- Premphase®/Prempro® (estrogen, conj./medroxyprogesterone acetate)
- FemHRT® (ethinyl estradiol/norethindrone acetate)

Discussion:
- Comment made that due to the cardiovascular risks associated with these agents, fewer are being used. However, the different agents can be considered equivalent.
- Question posed as to whether Prempro® includes all of the different doses?
  - First Health clarified that this would include all strengths of Prempro®.
- Comment made that with the Prempro® family, there is more flexibility due to the many different strengths available.

Motion:
- To include Prempro® as preferred and let First Health decide on other agents to be preferred.
Motion seconded.
Vote:
- Motion unanimously approved.

Agents in the Transdermal Estrogen/Progestin Combination Class:
- Climara-Pro® (estradiol/levonorgestrel)
- CombiPatch® (estradiol/norethindrone acetate)

- First Health pointed out that there are currently no head to head studies, and the agents have similar pricing.

Discussion:
- Comment made that the agents in this class appear to be equivalent.

Motion:
- To allow First Health to decide on the preferred agent.
Motion seconded.
Vote:
- Motion approved unanimously.

REVIEW OF CLINICAL CRITERIA:
- The Committee voiced concern over criteria for agents that have not yet received FDA-approval. Comment made that the general approach in most Medicaid
programs is to require a drug to be out for roughly 6 months before considering the agent.

- TennCare stated that for these new drugs, they are looking for a preliminary recommendation by the committee. Depending on when a drug is released, there might be 3 months of utilization of a drug before the committee reviews it. TennCare’s aim is to have preliminary recommendations for how to treat a drug when it first becomes available, and then the drug can be reconsidered after 3-6 months of data are available.

- TennCare further pointed out that one benefit of reviewing these agents proactively is that if the decision is made not to prefer a drug, there won’t be patients who have been on the drug for 6 months needing to be taken off the drug or switched to something else.

**MEGACE ES®:**

**Introduction:**

- Megace ES® is a concentrated oral suspension indicated for the treatment of anorexia, cachexia, or unexplained weight loss in patients with AIDS.
- Megace ES® has been found to be therapeutically equivalent to megestrol acetate.
- The major difference between Megace ES® and megestrol acetate is in viscosity. Megace ES® is 16 times less viscous, and therefore requires a much smaller volume.

First Health recommended the following criteria for Megace ES®:

- Megace ES® will be approved for patients who cannot take the original formulation due to any of the following:
  1. Inability to swallow the 10ml (400mg) or 20ml (800mg) dose
  2. Intolerance to the original formulation (aversion to taste, viscosity, etc.)
  3. Recipients who are fluid restricted

**Discussion:**

- Comment made that the difference between 5 ccs and 20 ccs is negligible in patients who are severely fluid restricted; therefore the 3rd bullet point can be omitted.
- Question posed as to whether Megace® is currently on the PDL.
  - First Health replied that it is currently covered, but not on the PDL.
- Question posed as to whether it is reasonable to discuss new drugs in categories where the old drugs have not been discussed yet.
  - TennCare stated that they could table Megace ES® until the entire category is brought back for review.

**Motion:**

- To table Megace ES® until the entire category is brought back for review.

Motion seconded.

**Vote:**

- Motion approved.
**BIDIL®**:
- Dr. Dowell announced that he was one of the co-investigators in some studies with BiDiI®; therefore he refrained from voting on this criteria.

**Introduction:**
- BiDiI® is indicated for the treatment of heart failure as an adjunct to standard therapy in self-identified black patients to improve survival, to prolong time to hospitalization for heart failure, and to improve patient-reported functional status.

First Health recommended the following criteria for BiDiI®:
- BiDiI® will be approved for patients who meet all of the following criteria:
  1. Cannot take the two products individually
  2. Non-compliance with a four times daily regimen is documented.
  3. Patients with heart failure - patient must also be on standard therapy for heart failure (loop diuretic, ACE Inhibitor/ARB, and beta blocker)

**Discussion:**
- Question asked regarding how the computer system will know a patient has a history of use of the two medications individually, if the patient is not receiving the medicines through TennCare.
  - TennCare responded that the computer would not know, but a conversation with the prescriber would take care of this.
- Request made to indicate that this study was performed strictly in African-Americans somewhere within the criteria.
  - First Health pointed out that while the study was performed in African-Americans, one cannot overlook the fact that these two individual agents have been used for years in all populations to decrease preload and afterload.
  - Comment added that while initially this drug was used only in African-Americans, they are now using it across the board.
- Comment made that these agents are usually add-on therapy for patients who are already taking a beta-blocker, a loop diuretic, an ACE inhibitor, aldosterone, and digoxin. To add 2 more medications, may be a major problem, especially given the script limits.
- Comment made that these medications are available generically, and available for $18 for a 3-month supply through RxOutreach.
- Comment made that it would be difficult to find someone who could take BiDiI® but not the two individual agents. Additionally, moving from a four-times-a-day to a three-times-a-day regimen would not result in a significant increase in compliance.
  - TennCare commented that occasionally they see situations where a patient has a caregiver who comes by 3 times a day, so they wouldn’t be able to take the four-times-a-day regimen, but the three-times-a-day regimen is OK.
- General consensus that, given the high cost of BiDiI®, use of the generic products should be encouraged first.
- Point made that use of the two individual agents as opposed to BiDiI® makes it easier to adjust patients’ doses because it is not a fixed dose combination.
• Question posed to clarify whether both isosorbide dinitrate and hydralazine are preferred.
  o TennCare responded that isosorbide is preferred and hydralazine has not been reviewed.
• Comment made that BiDil® seems to be an issue of convenience, and we need to decide whether we are willing to pay $300 for convenience.

Motion:
• To accept criteria as is.
Motion seconded.

Vote:
• Motion approved – 1 abstention.

**BYETTA™:**

Introduction:
• Byetta™ improves glycemic control in people with type 2 diabetes mellitus by:
  o Enhancing insulin secretion from the pancreatic beta cells
  o Suppressing inappropriately elevated glucagon secretion
  o Slowing gastric emptying
• Byetta™ is FDA-approved for patients with type 2 diabetes who are already receiving metformin, a sulfonylurea, or both, and have sub-optimal glycemic control.

First Health recommended the following criteria for Byetta™:
Byetta™ will be approved for patients who meet all of the following criteria:
1. Diagnosis of type 2 diabetes mellitus
2. Current use of metformin, a sulfonylurea, or both.
3. Failure to achieve goal glycemic control despite an appropriate trial of metformin and/or a sulfonylurea.
4. No history of hypersensitivity to Byetta™ or any of its components.

Discussion:
• Inquiry made as to whether a patient needs to be on both metformin and a sulfonylurea or will one suffice.
  o TennCare responded that it is either a sulfonylurea OR metformin (or both).
• Question as to whether it is necessary to define what “goal glycemic control” is within the criteria.
  o First Health responded that it is up to the physician to determine how they will assess goal.
• Question posed regarding patients with slowed gastric emptying. (Concern over whether this is a contraindication for this product.)
  o First Health clarified that Byetta is not contraindicated in slowed gastric emptying - Symlin® is.

Motion:
• To accept criteria as is.
Motion seconded.
Vote:
- Motion approved unanimously.

**SYMLIN®:**

Introduction:
- Symlin® is a synthetic analog of the human hormone amylin, which is made in the beta cells of the pancreas and co-secreted with insulin after meals to help to control glucose levels. As an amylinomimetic agent, Symlin® is responsible for the following effects:
  - Slowing of gastric emptying, reducing the rate at which glucose appears in the bloodstream
  - Decreased post-prandial glucagon secretion, thus reducing hepatic glucose output after meals
  - Reduced caloric intake secondary to a centrally-mediated modulation of the appetite

First Health recommended the following criteria for Symlin®:
- Patients meeting all of the following criteria may be approved for Symlin®:
  1. Diagnosis of Type 1 or 2 diabetes
  2. Failure to achieve adequate glycemic control despite optimal, individualized insulin regimen
  3. Undergoing regular monitoring by a health care professional

- Patients meeting any of the following will not be approved for Symlin®:
  - Poor compliance with current insulin regimen and/or self blood glucose monitoring
  - Recurrent, severe hypoglycemia requiring assistance during the past 6 months
  - Confirmed diagnosis of gastroparesis
  - Requiring the use of drugs that stimulate gastrointestinal motility
  - Age < 15 years
  - History of hypersensitivity to Symlin® or any of its components, including metacresol

Discussion:
- Question as to whether hypoglycemic unawareness should be part of the criteria for not approving Symlin.
  - Comment made that there are already 6 bullet points under the criteria, and adding an additional bullet point would make it even longer. General feeling expressed by the committee that this can be left up to the physician’s discretion.
  - Additional comment made that these patients would most likely meet the criteria for recurrent, severe hypoglycemia.

Motion:
- To accept the original criteria as is.

Motion seconded.

Vote:
- Motion approved unanimously.
LEVEMIR®:
Introduction:
- Levemir® is a long-acting basal insulin analog, with duration of action up to 24 hours. It can be used as monotherapy, added to oral anti-diabetic agents, or in combination with a rapid-acting insulin.

First Health recommended the following criteria for Levemir®:
Levemir® will be approved for patients with a diagnosis of Type 1 or 2 Diabetes who require basal (long-acting) insulin in order to control hyperglycemia AND who have tried and failed an adequate trial of either NPH insulin or Lantus® (insulin glargine). Failure of NPH or Lantus® may include, but is not limited to, inadequate control of blood glucose levels, hypoglycemia, or intolerance/hypersensitivity reactions.

Discussion:
- Comment made that Levemir® is not a novel agent. There is currently another basal insulin available.
- Comment made that we do not know anything about the pricing of this agent.
- Question posed as to why we would want to set criteria, rather than just placing this agent as non-preferred?
  o TennCare asked whether the Committee agreed that as long as a long-acting basal insulin is on the PDL they would be comfortable from a clinical standpoint.
  o The general consensus expressed by the Committee was that they saw this as a “me too” drug and would be comfortable having it non-preferred. Putting clinical criteria around it would encourage usage.
- Question posed as to, if another basal insulin were to come to market, would it be brought to PAC for review, or would it automatically be placed as non-preferred?
  o TennCare responded that if another basal insulin came out and it was decided clinically that it was a superior product, then the entire category (all 3 agents) would come back to PAC for re-review.

Motion:
- To reject the criteria and make Levemir® non-preferred on the PDL.
Motion seconded.
Vote:
- Motion approved unanimously.

EXUBERA®:
Introduction:
- Exubera® is an inhaled short-acting insulin preparation indicated for the treatment of Type 1 and 2 diabetes. It closely mimics the body’s normal physiologic insulin response to meals.
First Health recommended the following criteria for Exubera®:

Exubera® may be approved for patients with a diagnosis of Type 1 diabetes, or Type 2 diabetes unresponsive to treatment with diet and/or oral hypoglycemics, who meet one of the following criteria:
1. History of treatment failure with SC insulin due to non-compliance
2. Inability to self-administer injections of SC insulin
3. Intolerance to SC insulin (i.e., injection site reactions)

Exubera® will NOT be approved for any patients with a contraindication to this product, including hypersensitivity to Exubera® or any of its components.

Discussion:
- Recommendation to omit bullet point #1 because it is too broad.
- Recommendation to change “self-administer” to “receive” in the second bullet point since there may be situations where a caregiver administers the medication.

Motion:
- To approve the criteria with the omission of bullet point #1 and the change of “self-administer” to “receive” in the second bullet point.

Motion seconded.

Vote:
- Motion approved unanimously.

ROZEREM™:

Introduction:
- Rozerem™ is a highly selective melatonin receptor type 1 (MT1) and type 2 (MT2) agonist indicated for the treatment of insomnia characterized by difficulty with sleep onset.

First Health recommended the following criteria for Rozerem™:

Rozerem™ will be approved for patients who meet all of the following criteria:
1. Diagnosis of insomnia characterized by difficulty with sleep onset
2. Do not have any of the following conditions: severe sleep apnea, severe COPD, or severe hepatic impairment
3. Have tried and failed an appropriate trial of one preferred sedative/hypnotic

Discussion:
- Comment made that Rozerem™ is a “me too” agent.
  - Response indicated that this is not a “me too” agent, as it has a different mechanism of action compared to the other available sedative hypnotics.

Motion:
- To reject this criteria and place Rozerem™ as non-preferred until re-reviewed along with the sedative-hypnotic class.

Motion seconded.

Vote:
- Motion approved unanimously.
XYREM®:
Introduction:
- Xyrem® is the first and only FDA-approved medication for the treatment of cataplexy associated with narcolepsy.
- It is the sodium salt of gamma hydroxybutyrate (GHB), a known drug of abuse. Abuse of this agent has been associated with CNS adverse events and even death.
- Xyrem® is available only through a single central pharmacy, and patients must enroll in the Xyrem® Success Program in order to receive this medication. However, even with this controlled distribution, patients are still receiving this medication for off-label indications.

First Health proposed the following criteria for Xyrem®:
- Xyrem® (sodium oxybate) will be approved only for patients meeting all of the following criteria:
  1. Enrolled in the Xyrem® Success Program
  2. Diagnosis of cataplexy associated with narcolepsy
  3. Currently receiving treatment with a CNS stimulant
  4. No current use of alcohol, sedative hypnotics, or other CNS depressants
  5. Age > 16 years

Discussion:
- None.

Motion:
- To accept the criteria as is.

Motion seconded.

Vote:
- Motion approved unanimously.

PROPOSED CRITERIA FOR SEDATIVE HYPNOTICS:
Introduction:
- A request was previously made by the committee to present more uniform criteria for the sedative hypnotic agents.

First Health proposed the following criteria for the sedative hypnotics:

- A quantity limit of 1 tablet/day will be applied to all sedative/hypnotics.
- A duration limit of 1 month will be applied to all sedative/hypnotics.*
- In order for a patient to receive more than 1 month of any sedative/hypnotic, a prior authorization (PA) will be required.

PA Criteria:
Greater than 4 weeks of therapy with a sedative hypnotic will be approved in patients meeting the following 2 criteria:
1. Presence of an underlying medical or psychiatric cause of insomnia, which is currently being addressed/treated.
   - Acceptable medical/psychiatric causes of insomnia include but are not
limited to: anxiety disorder, depression, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), restless legs syndrome (RLS), periodic limb movement disorder (PLMD), shift work sleep disorder, and cancer pain associated with hospice patients. Please note, sleep apnea is NOT an appropriate medical condition indicating use of a sedative/hypnotic.

OR Unknown cause of insomnia for which the physician has ruled out differential medical and psychological diagnoses, and for which the patient has tried and failed behavioral modification.
- Behavioral modification may include decreasing caffeine intake, eliminating afternoon naps, performing relaxation exercises, etc.

2. Patient has failed adequate trial of being weaned off the sedative/hypnotic medication.

Length of authorization = Up to 1 year.

* According to the National Institutes of Health and the American Psychiatric Association, chronic insomnia is defined as inadequate or poor quality sleep for at least 3 nights/week for 1 month or more.

Discussion:
- Comment made that a 15-day restriction on Ambien® was previously recommended by the committee, and the 15-day limit on chloral hydrate is necessary due to its abuse potential.
- Point made that the average quantity per Ambien® prescription is 28.
- Question posed as to what Ambien® use is like in the community.
  - Reply indicated that commercial plans usually limit use to 14-days, but physicians can request an override. Quantities over the limit are approved when other causes of insomnia have been ruled out. The average quantity is about 20 tablets per month for Ambien® and Sonata®.
- Recommendation made to reject the criteria and leave the current sedative hypnotic criteria as is.
  - Reply expressed disagreement with this recommendation, stating that the category needs control and the proposed criteria are appropriate.
- Comment made that many of these scripts will take care of themselves with the script limits.
  - TennCare pointed out that less than 25% of patients who are subject to the prescription limit have hit the limit in the last 2 months.
  - Comment made that pharmacies may just not be attempting to submit greater than 5 claims for a patient.
  - TennCare responded that they are encouraging pharmacies to go ahead and try to process claims even if they know a patient has received 5 scripts already.

Motion:
- To reject the proposed criteria, leave the category as it currently is (with a 15-day limit on Ambien® and chloral hydrate) and revisit this category later.

Motion seconded.

Vote:
- 1 opposed, rest in favor
MISCELLANEOUS DISCUSSION:

- Question was posed as to when the Xopenex MDI will be available, and whether it will have criteria similar to that of Xopenex nebulized solution.
  - TennCare responded that the Xopenex MDI is expected to become available around the end of 2005, and it will have criteria in place similar to that of the nebulized solution.

Pharmaceutical Manufacturer Representatives for Testimony Bill

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<td>Robin Stanley, Marjan Massoudi,</td>
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Next PAC meeting: February 16, 2006

MEETING ADJOURNED