INTRODUCTIONS
The meeting was called to order by Chairman Powers, and the members of the Committee introduced themselves. Dr. Powers reminded all who were present at the meeting that all committee members are volunteers, appointed by the public act establishing the Pharmacy Advisory Committee and that they have signed both confidentiality and conflict of interest statements. The conflict of interest statement was read aloud, and Dr. Powers confirmed that no conflicts of interest had been identified.

UPDATE ON THE CONTROLLED SUBSTANCE DATABASE
David Beshara gave the update for Todd Bess who was attending the State Board of Pharmacy meeting. As of the fall, physicians could begin to apply for access to the narcotic database. It took three to four months to get the entire group of pharmacists signed up, and it may take longer to get physicians signed up since there are four times the number of physicians as pharmacists. It could take up to a year to get all of the prescribers signed up. Mr. Beshara stated that there is a form that physicians can fill out to get moved up higher on the list. A comment was made that there is only one person at the board of pharmacy responsible for signing people up. Dr. Capparelli informed the committee that he has used the system and it is fairly up to date, able to pull in multiple pharmacies and aliases. The system is able to be queried based on provider or patient. Dr. Capparelli stated that the entire process from logging on, running the query and receiving the information back can be done within 90 seconds.

Mr. Beshara also reminded the committee that TennCare rolled out the long-acting narcotic initiative on 10/1/07. He mentioned that a part of the new criteria involved a question as to whether the prescriber had consulted the Controlled Substance Database. This question is not in effect yet since all prescribers do not have access at this time, but it can be turned on in the future.

A question was raised regarding the status of the tamper-resistant prescription pad requirement. Mr. Beshara explained that CMS has delayed this process by six months. After the six month delay (April 1, 2008), only one tamper-resistant characteristic will be required. Mr. Beshara explained that three temper-resistant characteristics will have to be in place by 10/1/08. The three tamper-resistant characteristics are: (1) the prescription must prevent unauthorized copying, (2) the prescription must prevent erasure or modification, and (3) the prescription must prevent the use of counterfeit prescription forms. TennCare is currently polling different groups, including pharmacy groups, printing groups and other states, to determine what features fit into which tamper-resistant characteristic category. Within the next 3-4 months, TennCare hopes to come up with better guidelines for providers explaining what they will need for the tamper-resistant prescription pads. A question was raised as to whether physicians would be less likely to participate in the TennCare network given these prescription pad requirements, since this is
only a requirement for Medicaid and Medicare (not for private insurance). Mr. Beshara stated that with the cost being very similar to regular prescription pads, prescribers will start using tamper-resistant pads as the standard.

MINUTES
The minutes from the August 14, 2007 PAC meeting were reviewed. Dr. Capparelli stated that after reading the minutes completely, he noticed that a few things were different from the previous minutes. He pointed out that it appeared the full amount of background information, whether it was presented or not, had been cut and pasted back into the minutes. Dr. Capparelli pointed out that while there are benefits to having that information available in the minutes, it is available in the other packet, and including only the high points would be more appropriate. He also raised a concern regarding the discussion sections. He felt that these sections were very pared down and offered Ranexa® as an example of a class where the discussion section was inadequate. He expressed concern that the extensive background section would take away from focus on the Committee’s extensive discussion of each class. Dr. Capparelli made a recommendation to the committee to send the minutes back to be rewritten such that less focus would be put on the First Health presentation and more attention would be given to the actual discussion of the committee.

Dr. Woods expressed disagreement that the discussion sections were pared down. She stated that most of the Ranexa® discussion took place around the Clinical Criteria of the product and not the recommendation itself. She felt that the discussion section for the Clinical Criteria was reflective of the extensive discussion that took place around Ranexa®. She also stated that several versions of notes, as well as the recording, were consulted to produce the minutes. She stated that TennCare and First Health were under the impression that at least the main key points of the discussion were represented in the minutes.

Dr. Capparelli agreed that there was at least a summary of the key points and he felt that it is more an issue of balance. He stated that he would like the balance to reflect more committee discussion rather than the First Health presentation. Dr. Powers posed a question regarding the use of bullets in the discussion areas and wanted to make sure it was acceptable by the committee to continue this method. Dr. Powers asked Dr. Capparelli for specific direction to be given to First Health regarding changes to the minutes. Dr. Capparelli suggested that maybe the minutes just need to be shortened so that there is a more fair balance. Dr. Capparelli admitted there was noting incorrect in the minutes. He also stated that the use of bullet points was acceptable as long as the key details of the discussion were included.

Dr. Corley added that there is a lot to review for the PAC minutes, and suggested that it may be preferable to list only the recommendation and the discussion in the minutes and make the background information packet available as an attachment to the minutes. A suggestion was made to include the recommendation paragraph from the packet and then add the discussion. It was pointed out that the background information is not needed in the minutes since it is available in a separate document. Dr. Capparelli amended his recommendation to approve the minutes with the removal of the background information, and retaining the recommendation and discussion sections as the stand alone minutes. A motion was made to make these changes starting with the August minutes. Dr. Powers summarized the motion to amend the minutes, starting with the August 14th minutes, to remove the background information and refer instead to the packet, but to leave the recommendations of First Health and the Committee discussion in bullet format, as presented. The motion was seconded and approved.
TENNCARE UPDATE

- David Beshara discussed that the TennCare waiver was approved by CMS. TennCare has a month to accept this approval. Once this has taken place, the standard spend down population will be opened up to enrollment, with a cap of 100,000 persons. The population that was in the “limbo period” from the previous enrollment will be given first opportunity to re-enroll, followed by new members.
- The RFP for the new TennCare PBM is circulating through the internal state process. First Health’s contract goes through 6/30/2008. TennCare is hoping to get an RFP out for PBM services sometime in December. The PBM will be selected in the spring and be up and running by 7/1/2008. Because of the potential for a new vendor, most changes to the pharmacy program will be on hold until the new PBM is in place. Because the state may need to change vendors and contracts, the state will be revisiting high utilization and/or cost drug categories where general recommendations for the category have not been obtained. This has cause a change in the review schedule for the next three meetings. Dr. Woods stated that the revised schedule will be updated and posted in the coming weeks.
  - Dr. Capparelli asked if the categories coming back for re-review would include those where the committee did not agree all were the same and recommended specific drugs, or only those classes where the committee voted on the formulary list.
    - David Beshara explained that with the new RFP, the PBM will share some risk as far as contracting goes. The PAC committee votes on the clinical efficacy of drugs. In categories where the committee feels a drug is superior to its competitors in that category, that drug will be on PDL regardless of the financial constraints or concerns of that drug. In these situations, TennCare will not hold the PBM accountable for that drug or category (i.e., the drug will be removed from the rebate contract equations for that category). As an example, Mr. Beshara described a hypothetical situation where the PAC committee voted that penicillin had to be on the formulary. At the time the PBM does not have a contract for penicillin, but does have one with amoxicillin. TennCare would tell the PBM that they want penicillin on the PDL, therefore TennCare would remove penicillin out of the rebate equation. So at the end of the year when TennCare holds the PBM accountable for the rebate contracts, anything this committee disagrees with, from a clinical standpoint, will then be out of that equation.
    - Mr. Beshara further stated that the categories coming back for re-review would mostly be older categories where a preferred/non-preferred list was approved. The upcoming reviews will be based on utilization. In case a new PBM is chosen, TennCare would need to be ready for this change and therefore must review the classes that would have the most impact.
    - Dr. Capparelli asked if there would be a grandfathering for these potential changes if a new PBM is chosen. Mr. Beshara stated that each proposed PBM would have to submit a disruption analysis and that will play a role in the selection process.
- Dr. Capparelli raised a question regarding whether TennCare would consider adding Chantix® to the PDL. He stated that twenty-nine states cover Chantix® in their Medicaid programs. Since it seems it would have cost savings up front, Dr. Capparelli wanted to know if a discussion of Chantix® could be added to this meeting or to a subsequent meeting.
Mr. Beshara stated that there is no plan to add smoking cessation products to the list of covered categories for TennCare. Smoking cessation agents are considered an allowable exclusion which means Medicaid gives the state the authority to either include them or exclude them. They have always been excluded historically. Last year TennCare made a recommendation to include them, but it did not make it through the budgetary process. TennCare cannot increase its budget without approval of the lawmakers. He reiterated that smoking cessation agents did not make it through last year and he did not believe that it would be reviewed again this year.

Dr. Capparelli stated that Chantix® has a forty-four percent cure rate, so it would take treating slightly over two people to get one cure. Dr. Capparelli stated that treatment with Chantix® would cost approximately $681 to achieve one cure. He also explained that the direct medical cost savings in the first twelve months from one person quitting smoking, according to the American Lung Association, would be $1700. He emphasized that spending $681 to save $1700 seems like a “no-brainer”. Mr. Beshara agreed with Dr. Capparelli that there may be the potential for long term savings, but stated that he did not have the authority to add this category to the list of covered classes.

Dr. Powers brought up another question about adding the inhaled corticosteroids to the short-list. Mr. Beshara stated that there are no plans on making changes to the auto-exemption list at this time. He stated that there has been little use of the attestation process and little feedback has been given. Dr. Powers stated that this is a continued request and asked Mr. Beshara to consider this as feedback.

Dr. Capparelli stated that he has not used the attestation process very much because it is an extremely time consuming process. Dr. Capparelli stated that for some reason he and Dr. Powers get a lot of feedback from prescribers regarding the process. Mr. Beshara did agree that the process is time consuming, but this is what the prescriber community asked for when prescription limits were added. There are two processes in place, one for the acute requests that do not require attesting to the other agents and one for the long term requests. PA Govette stated that she has used the process a couple of times and she confirmed that it is a very time consuming process that can take up to ninety minutes to complete and that she would only do it in extreme situations. She did confirm that it is a useful system, but an incredible effort to incorporate into the day.

Dr. Capparelli stated that the short list is heavily weighted for cardiovascular and diabetes agents, but the only asthma products are the short acting beta agonists. Mr. Beshara stated that the list started out as mainly generic items and when other respiratory agents become generic, he hopes to add them to this list.

Dr. Dowell brought up the topic of BiDil® that was discussed at the prior meeting. He stated that he understood that the committee would review some additional information and after that they would provide some feedback. He stated that he has not heard anything yet.

Dr. Woods stated that she was unable to get the full text of the guidelines, but she did send out the citation to the entire committee.

Dr. Dowell stated that his concern was that in order for patients to get this drug, they would have to fail therapy. He thought that this criteria was very problematic and thought that it should be addressed.

Since it had been 2 meetings since this drug was reviewed, the Chair recommended that this issue be revisited after lunch to give TennCare some time to review.
• Dr. Corley asked for a quick update on the long acting narcotic process that was started 10/1/07. Mr. Beshara stated that the process requires a PA for those patients that have a narcotic dose exceeding 200mg per day of morphine or morphine equivalent. Also, when the patient reaches 400mg/day, the prescriber will receive a notice through the RetroDUR program. Dr. Woods stated that the forms and materials for this program are located on the First Health website for reference. She explained that a long-acting narcotic PA fax form is available, and briefly described its content and intended use.

DRUG CLASS REVIEWS

The drug class review section of the meeting consisted of a First Health Services presentation of background information and an overall recommendation for each therapeutic class, as well as any proposed clinical criteria, step therapy, or quantity limits. This presentation was followed by the committee’s discussion and vote on the recommendation and any proposed restrictions.

For the purpose of the minutes, the section below reflects First Health’s proposed recommendations, the committee’s discussion, and the committee’s votes on each recommendation and criteria reviewed. For the complete background information provided by First Health Services, please refer to the November 8, 2007 PAC packet at: https://tennessee.fhsc.com/Downloads/provider/TNRx PAC 20071108 Review Packet.pdf.

Respiratory Agents, First Generation Antihistamines:
⇒ The first generation antihistamines are commonly used to treat both skin and nasal allergy, insomnia, and for symptomatic relief of the common cold. Diphenhydramine is also used in Parkinson’s disease. Doxylamine and triprolidine are the only first generation antihistamines not available generically; however, these agents offer no unique indication or side effect profile over the other first generation antihistamines. While the agents in this class vary slightly in approved indications and side effect profiles, they can all be considered therapeutic alternatives to one another. Therefore, it is recommended that at least 4 agents be available, one of which should be diphenhydramine. [Of note, promethazine will not be counted among the 4 agents that must be available within this category; although, it will be listed here as well as in the antiemetic class.]

• Discussion:
  o It was noted that some of these agents have OTC strengths available such as chlorpheniramine and diphenhydramine.
  o It was also noted that hydroxyzine is widely used for anxiety and muscle spasms; therefore it was recommended that, in addition to the diphenhydramine, hydroxyzine be included as a “must have” agent.
  o The Committee was asked how they felt about the need to have dexchlorpheniramine available on the PDL, given that it is significantly more expensive compared to other agents and it has very low utilization. The committee commented that utilization of this agent is mostly in the liquid form, therefore it is probably being given to children. It was pointed out that, based on recent FDA safety concerns regarding the use of certain cough and cold medications and antihistamines in children, it may be appropriate for this agent to be non-preferred. The Committee concluded that since there are other agents that are available in a liquid form, dexchlorpheniramine was not required.
A comment was made regarding the price difference between hydroxyzine pamoate versus hydroxyzine HCL. It was noted that there are minimal differences between these products except that one comes in a lower dose of 10mg that may be beneficial for those patients who have sedation side effects from the higher doses. It was pointed out that prescriptions written for “hydroxyzine” can be filled with either salt; while the branded products must be substituted with the specific salt associated with that brand.

A motion was made to accept the recommendations with the following modifications:
- Move dexchlorpheniramine to the non-preferred side.
- At least one liquid formulation needs to be available.
- Of the four available products, one should be diphenhydramine and one should be hydroxyzine.

Motion seconded and passed.

Respiratory Agents, Minimally sedating antihistamines:
⇒ All of the minimally sedating antihistamines are effective at reducing the symptoms of allergic rhinitis (AR) and chronic idiopathic urticaria (CIU). While comparative data show mixed results, some studies indicate cetirizine may be more effective than loratadine or fexofenadine at providing symptomatic relief; however, cetirizine is associated with more sedation (up to 14% incidence). According to the AAAAI guidelines, there is similar efficacy among the agents in this class. Therefore, it is recommended that at least one minimally sedating antihistamine and one minimally sedating antihistamine/pseudoephedrine combination product be available for use in patients with AR or CIU. In order to meet the needs of pediatric patients, it is recommended that at least one oral solution or syrup formulation be available.

- Discussion:
  - It was recommended that the first sentence be deleted because only cetirizine and desloratadine have FDA-approved indications for CIU.
  - Since loratadine was the only generic agent available when this class was reviewed last time, it was recommended that TennCare consider adding the generic fexofenadine, and cetirizine once it becomes available.
  - It was also noted that some patients that use these agents long term may become tolerant to the effects, and therefore, being able to switch a patient to another agent without requiring a PA would be beneficial.
  - It was also stated that it would be beneficial for the prescriber to be able to have more preferred choices for the patient if possible for those who are not responsive to loratadine.
  - Since these changes would not be effective until early spring, it was suggested that the wording of the recommendation be changed to require that at least 2 generic products be available, with TennCare able to choose which ones.
  - David Beshara pointed out that if and when all these agents become OTC, there would be a much different dynamic than is present today. Right now, since the least expensive product is OTC, what happens is TennCare actually foregoes the federal financial funding on that product. That means that the OTC product needs to be that much cheaper than the other products in the category. TennCare does this because they don’t want to prefer a brand over something that is that much cheaper. However, when all the products go OTC, they become not covered for adults. TennCare would need to cover the category only if there are prescription items in the category. If there are no prescription
products to prefer, there is a much different dynamic in the future depending on how the category looks like.

- A motion was made to approve the recommendation with the following changes:
  - Strike the last four words of the first sentence in the recommendation – “and chronic idiopathic urticaria (CIU)”.
  - Require that at least two minimally sedating antihistamines and two minimally sedating antihistamine combinations be available.

- The motion was seconded.
  - Further discussion about the motion
    - A question was raised as whether the PAC really wants to require a second agent. Dr. Shea voiced support for the original recommendation to have one agent and combination available based on Mr. Beshara’s comments regarding the possibility of loosing federal funding for the category.
    - Dr. Woods stated that in the past general recommendations had allowed First Health and TennCare to monitor the cost of the products within a class, and add a second agent when it becomes cost effective to do so. The Committee responded that they could support that idea.

- The motion was rephrased as follows:
  - Strike the last four words of the first sentence in the recommendation – “and chronic idiopathic urticaria (CIU)”.
  - Add a statement at the end recommending that a second agent be added to the preferred list, when it is financially feasible to do so.
  - Motion was seconded.
  - Motion carried.

- Quantity Limits Discussion
  - Motion was made to accept the recommendation of the quantity limits.
  - Motion was seconded and carried.

**Respiratory Agents, Intranasal Steroids:**

⇒ According to the AAAAI, the intranasal corticosteroids are the most effective single agents for controlling allergic rhinitis symptoms. In addition, the intranasal steroids are among the agents of choice for non-allergic rhinitis, as well. While differences in approved indications, dosing regimens, and patient preference may exist, clinical trials have shown the intranasal corticosteroids to be similar in efficacy and the AAAAI makes no differentiation between the agents. In order to allow for patient and prescriber choice, it is recommended that at least three intranasal corticosteroids be available.

- Discussion:
  - A question was raised regarding the reasoning for having flunisolide preferred over fluticasone. Dr. Hawkins clarified that the overall cost profile was the determining factor in how the preferred and non-preferred lists for this category were produced.
  - A question was raised to clarify if a generic agent is non-preferred on the PDL, do the brand name preferred agents count as a generic for patients with script limits. Mr. Beshara stated that all the preferred agents must be brand products, with no generic agents available, in order for the brand name preferred agents to
count as generics towards script limits. If there is a generic on the preferred side, then the brand name preferred agents count as brands.

- A question was posed as to whether HFA products would be phased in over the next year for this category. **TennCare was unsure of the status of HFA products within this category, and responded that they would look into this topic and follow-up with the Committee at a later date.**

- It was noted that the indications for these agents are somewhat different. Fluticasone has the better mix of indications. Dr. Hawkins clarified that the current guidelines do not differentiate between the different products even though the FDA indications are different. Dr. Hawkins asked for feedback as far as practical use of these agents and their differences. One committee member stated that intranasal steroids are a hard sell in both kids and adults; however clinically, they felt the differences between these products were not significant.

- A motion was made to accept the recommendation with the addition of fluticasone as a preferred agent.

- Motion was seconded.
  - It was clarified that the fluticasone should be one of three preferred agents in this class.

- Motion passed.

- **Quantity Limits Discussion**
  - Motion made and seconded to approve recommendations for the QLs.
  - Motion carried.

**Respiratory Agents, Nasal Antihistamines:**

⇒ Azelastine is effective in the symptomatic treatment of seasonal allergic rhinitis and can be considered an alternative to oral antihistamine therapy. Although an alternative therapy, azelastine offers advantages over systemic antihistamines with regards to lessened systemic adverse effects such as sedation, and it may be beneficial in those intolerant to, or not well-controlled on, intranasal corticosteroids. Therefore, it is recommended that azelastine be available for use in allergic rhinitis patients.

- **Discussion:**
  - A comment was made that many patients complain about the terrible taste of Astelin®. It was noted that Dr. Bob Overholt in East Tennessee is a major proponent of Astelin® in his practice. This product does not increase blood pressure or cause urinary retention as can be seen with the oral antihistamines.
  - Motion was made and seconded to approve the recommendation of First Health as proposed.
  - Further discussion about the motion.
    - It was noted that the wording in the recommendation “be available for use in allergic rhinitis patients” could be construed as meaning clinical criteria could be created.
  - The motion was amended by the original contributor to accept the recommendation with the removal of the words “for use in allergic rhinitis patients”.
  - The motion was seconded and carried.
• Quantity Limit discussion:
  o A question was posed regarding the number of actuations in the unit. It was determined that there are 120 actuations in each bottle.
  o A question was posed regarding what the max daily dose is for this agent. First Health responded that the max dose is 2 sprays per nostril twice daily.
  o Dr. Hawkins agreed to double check the QL and see if it needs to be changed.
  o A motion was made to approve the QL to be for the max daily dose which may be 2 bottles per month instead of 3.
  o Motion seconded and carried.

Respiratory Agents, Nasal Anticholinergics:
⇒ Nasal anticholinergics represent a reasonable option for patients with rhinorrhea symptoms associated with either allergic rhinitis, non-allergic rhinitis, or the common cold. While current clinical guidelines recommend antihistamines and nasal steroids as first line treatments for allergic rhinitis, nasal anticholinergics are effective at reducing rhinorrhea symptoms with few side effects. Therefore, it is recommended that at least one nasal anticholinergic be available.

• Discussion:
  o Motion was made to approve the recommendation and move this class to the list of obscure drug categories.
  o Motion seconded.
  o Motion carried.

• Quantity Limits discussion:
  o Motion to approve the recommendation as proposed.
  o Motion seconded and carried.

Respiratory Agents, Non-narcotic Antitussives:
⇒ Benzonatate and dextromethorphan are effective prescription options to codeine for the treatment of cough. Benzonatate should not be used in children less than 10 years old; therefore, dextromethorphan must be available. In order to ensure adequate prescriber choice, it is recommended that both benzonatate and dextromethorphan products be available for use.

• Discussion:
  o It was pointed out by the committee that only utilization of benzonatate was four claims and that there were no claims for the dextromethorphan product.
    ▪ Mr. Beshara responded that the OTC dextromethorphan products are covered for children; however, these are not listed on the PDL so as not to cause confusion regarding adult coverage.
    ▪ A question was posed as to whether benzonatate is covered by TennCare. It was pointed out that most people pay cash for benzonatate. 
      TennCare/ First Health agreed to investigate this question.
  o A recommendation was made to include a comment on the PDL stating that OTC dextromethorphan products are available for children. Mr. Beshara asked the Committee what they felt that best way to present this information on the PDL would be. The Committee suggested that the best way to present these in the PDL may be to list them with Clinical Criteria (CC).
A motion was made to accept the recommendation as presented with the following changes:
- Eliminate the second sentence of the recommendation
- Change the third sentence to read: "In order to ensure adequate prescriber choice, it is recommended that at least one agent be available as preferred.
Motion seconded and carried.

Clinical Criteria discussion:
- A suggestion was made to place clinical criteria around benzonatate to prevent its use in children 10 and under. It was pointed out that this was because the capsule causes a local anesthesia effect when sucked or chewed, presenting a choking risk in young children.
- A comment was made that an additional hoop was not needed for this class.

Respiratory Agents, Expectorants:
⇒ While guaifenesin is more commonly used, both guaifenesin and potassium iodide are reasonable options when an expectorant is needed. Since potassium iodide is used as a disinfectant and to prevent thyroid injury during radiation therapy, it is recommended that both guaifenesin and potassium iodide products be available. In order to best meet patient and prescriber needs, it is recommended that at least one liquid formulation be available.

Discussion:
- A question was raised as to whether the statement at the top of each list which says, "All generic, prescription guaifenesin products" was truly needed. It was pointed out that this may be helpful for internal use, but not for external use.
- A motion was made to accept the recommendation of First Health as proposed.
- Motion was seconded.
- Motion carried.

Respiratory Agents, Mucolytics:
⇒ There are currently two FDA approved mucolytic agents. Acetylcysteine has utility as an antidote for acetaminophen toxicity, in the treatment of bronchopulmonary disease, chronic bronchitis, and cystic fibrosis, as a diagnostic agent for lower respiratory tract illness, and for tracheostomy care. Some data suggest that dornase alfa may be superior; however, acetylcysteine serves as a reasonable alternative for those patients who have a contraindication to, intolerance to, or failure with dornase alfa therapy. The FDA-Approved indications and safety profiles vary between the agents as well; therefore, it is recommended that both acetylcysteine and dornase alfa products be available for use.

Discussion:
- A concern was raised by Dr. Capparelli regarding the large price difference between acetylcysteine and dornase alfa. The concern was that prescribers may see that both agents are preferred and prescribe dornase alfa inappropriately since there is no clinical criteria associated with its use.
- Dr. Woods stated that the intent was to not make the process more cumbersome for prescribers. She did not feel this product was being overused based on current utilization data.
Dr. Capparelli stated that it was important to have clinical criteria in place to prevent misuse of dornase alfa by physicians who do not treat patients with cystic fibrosis.

A motion was made to approve the recommendation with the addition that dornase alfa have established clinical criteria limiting its use to patients with cystic fibrosis.

Motion seconded and carried.

- Quantity Limit discussion for dornase alfa:
  - Move to accept the recommendation of First Health for QL for dornase alfa.
  - Motion seconded and carried.

-Lunch Break-

A discussion of the BiDil® issue brought up by Dr. Dowell was revisited.

- Dr. Dowell stated that First Health submitted information from one consensus group. What Dr. Dowell has submitted was another recommendation from another consensus group to show that there are some differences on what people are recommending. Dr. Dowell stated that now that the product is out and the use of BiDil® has increased, utilization data from other states and Medicare should be looked at.

- Dr. Woods replied that BiDil® utilization is something that could be looked at going forward and that clinical literature is continuously reviewed for all drug classes. She also stated that a head to head study of the fixed dose combination and the individual generic components would be helpful, but until that is done, TennCare will continue with the current recommendation on this agent.

- Dr. Dowell expressed concern over the clinical criteria for this agent that states that failure of the preferred agent must occur. Since these patients are classified as class IV heart failure, documented failure of the preferred agent may be difficult. Dr. Woods clarified that the call center is instructed to take subjective information provided from the prescriber as far as failure is concerned. She stated that if the prescribers states that the patient is having a worsening of symptoms or is not responding in the manner the prescriber is wanting, that would constitute a treatment failure. Dr. Woods concluded by stating that the clinical literature will be monitored for any information that would prove that the fixed dose combination is superior to the individual components.

Dr. Powers announced that the CNS agents would be moved up to this point in the meeting. Upon the request of several of committee members, a consult had been obtained from a neurologist and sleep specialist, Dr. Beth Mala. Dr. Mala is the associate professor of neurology at Vanderbilt and fellow of the Society of Sleep Medicine. Due to scheduling difficulties, Dr. Mala was unable to present at the meeting; however she had provided written comments. The questions that were posed to her are as follows:

1. Regarding the agent Rozerem®, has there been any experience with this agent and has the agent been found helpful and is it safer than other sleep medications?
   - Dr. Mala response: “It is relatively safe, but I have not been that impressed with its efficacy compared with Lunesta® and Ambien® which unfortunately have more side effects.”

2. With regard to pediatric use of Rozerem® and safety issues.
Dr. Mala response: “The biggest concern is that melatonin agonists may affect reproductive hormones, so I would recommend this agent be used with caution.”

Dr. Mala refers quotes a study that was published in Sleep last year, first author is Richardson, “the melatonin agonist, ramelteon, recently approved by the FDA for the treatment of insomnia in adults exhibited a small, within the reference and normal range, but statistically significant transient increase in prolactin levels in women without clinical sequelae when 16mg was given, which is twice the normal dose.”

3. With respect to generic medications use in epilepsy.

Dr. Mala response: “Generic antiepileptic drugs are a terrible idea for epilepsy - although they may be okay to use for mood or pain syndromes. The reason is that you cannot guarantee that patients will get the same generic consistency. So, while generic one may have bioavailability that is higher than brand, while generic two has lower bioavailability than brand, then the patient can seize with the drop in levels or get toxic if it is the other way around. So, in general epilepsy specialists recommend against the use of generics.”

Discussion regarding Dr. Mala’s Response:

- Dr. Woods pointed out that her understanding of the AB-rating for generic equivalents was that the variation allowed for the generic was the same as the variation allowed between batches of a drug from the same manufacturer.
  - Discussion took place around the allowable variation. David Beshara explained that the allowed variation is a specified logarithmic deviation from the mean.

- Concern was voiced over switching patients from Tegretol to the generic. Anecdotal experiences were mentioned where patients' drug levels had changed following a change from a brand name to a generic agent.

Anticonvulsants, Hydantoins:

⇒ Phenytoin is the most commonly prescribed agent in the hydantoin class due to its availability in multiple dosage forms and pediatric indication. Ethotoin possesses no advantage over phenytoin and is not mentioned in the current treatment guidelines; therefore, it is recommended that at least phenytoin and all of its available dosage forms be available for use.

- Discussion:
  - A question was raised as to why this class of medication was separated out from the other anti-seizure medications. Dr. Hawkins stated that the attempt was to separate agents by their mechanism of action. Dr. Woods added that splitting the anticonvulsant class was for facilitation of discussion during the PAC meeting, and for the PDL listing it would be more appropriate to have the agents listed together.
  - A question was posed as to what was meant by “all of its available dosage forms” in the recommendation for this class. Dr. Hawkins stated that the intent it to have both the free acid and salt form available as well as the tablet, capsule and suspension.
  - A motion was made to accept the recommendation as proposed.
  - The motion was seconded.
  - Discussion about the motion:
• Dr. Capparelli asked that Dr. Hawkins clarify “all of its available dosage forms” in the recommendation.
• Dr. Woods asked the committee for feedback regarding whether they saw any problems with having the multi-source brand products listed as non-preferred. Dr. Powers stated that he has used a lot of generic phenytoin without any problems. His only problems have been from switching formulations, such as capsules to liquid. He stated that consistency of the formulation is very important.
  o Motion carried.

**Anticonvulsants, Succinimides:**

⇒ Succinimides are effective in the treatment of absence seizures by suppressing the paroxysmal three cycles per second spike and wave activity associated with lapses of consciousness and depressing the seizure threshold. Current clinical guidelines identify ethosuximide as a first line agent for the treatment of absence seizures in children and adults and as a second line agent for the treatment of Lennox-Gastaut syndrome. Succinimides are also beneficial in the treatment of mixed seizure types as an adjunctive therapy. Therefore, it is recommended that at least ethosuximide be available for use in patients with these seizure types.

• Discussion:
  o A motion was made and seconded to approve the recommendation as proposed.
  o Dr. Powers noted that there seems to be much more use of the generic ethosuximide than Zarontin®.
  o Dr. Woods again asked for input from the Committee regarding having the branded product non-preferred. The Committee expressed that they did not see this as a problem. Dr. Powers stated that he usually writes for the generic.
  o Motion carried.

**Anticonvulsants, Miscellaneous:**

⇒ Given the differences in mechanism of action, side effect profiles, and FDA approved indications between the different agents in this category, these agents cannot be deemed therapeutic alternatives to one another. Due to the safety concerns (aplastic anemia, hepatotoxicity) and lack of endorsement by current treatment guidelines, felbamate can be considered an inferior agent in this class. Patient responses may vary from agent to agent; therefore, it is necessary to have multiple agents for each seizure type. For this reason, it is recommended that the various unique chemical entities and dosages forms included in the miscellaneous anticonvulsant class all be made available with the exception of felbamate which will be reserved for patients with refractory seizures in which the benefits of therapy outweigh the risks.

• Discussion:
  o A question was raised regarding the listing of lamotrigine in chart 2 as being used for absence seizures, since it is not listed in chart 1 as an approved indication. Dr. Hawkins clarified that this is correct; the NICE guidelines do recommend its use in absence seizures even though it does not have the FDA approved indication.
Another concern was raised regarding the need for use of more than one of these agents for treatment. Will this be a problem with the call center and the therapeutic duplication edit? Dr. Woods stated that there are only certain classes of medications where the therapeutic duplication edit is turned on and this class is not one of those classes.

A question was raised if Trileptal® would be counted as a brand or generic. Dr. Hawkins stated that this agent is currently on the brand as generic list. Therefore, the brand name will count as a generic for script limits and copays.

There was a question raised regarding the law that was passed that requires pharmacists to dispense generic medications when available. The concern was that if TennCare has a preferred brand over the generic, legally the pharmacist is required to dispense the generic agent. Mr. Beshara stated that he would check the law, but that he understood there was an exemption for managed care or Medicaid programs that require brand name medications. Dr. Shea clarified that the law was amended to add that exception.

It was noted by looking at the utilization data that the two agents that would be affected the most would be the Lamictal® (lamotrigine) chewable/dispersible tablets, and Zonegran® (zonisamide). It appears that there is more use of these brand name items then the generics.

First Health mentioned that Carbatrol® and Equetro® should be moved over to the preferred side of the list, since they do not have generics available.

It was pointed out that phenobarbital was noticeably missing from the list. Dr. Capparelli asked whether there was any possibility of phenobarbital coming back on the formulary since most of the Medicare patients are no longer dual eligible. Mr. Beshara stated that phenobarbital is covered for children but not for adults. He clarified that there is an exemption for children because it is considered an allowable exclusion. TennCare has to treat all adults the same. If allowable exclusions are covered for adults, they have to be covered for both dual-eligible members and non-dual eligible members. Some Medicare plans allow additional coverage for medications not covered by Medicare, but the risk falls on the plan and not on CMS.

A question was raised regarding the need to have clinical criteria stating that phenobarbital is covered for children. Mr. Beshara stated that it could be listed in the PDL. It maybe that a different abbreviation than used for clinical criteria, such as CO (Children only) or AL (age limited).

It was noted that there is a high utilization of Lamictal chewable, especially in children. It was proposed to the committee to have clinical criteria on this item to allow for use in children only.

○ Dr. Woods asked the committee if it would be acceptable to have this branded product available for those patients that are currently on this medication, but to have the new patients start on the generic chewable tablet.

○ Dr. Capparelli asked Dr. Woods to clarify if she was stating that the generic lamotrigine chewable would be preferred and the brand name would be non-preferred but have a note stating that it would be grandfathered for those patients. Dr. Woods stated that the notation may not be listed on the PDL, but the system would perform an automatic look back and it would be listed in the provider notice. Dr. Capparelli stated that most pharmacists and doctors look at the PDL and not the letter. So when a change is made, even thought the letter states that it will be grandfathered, the pharmacy will send it back and say that it’s not
covered and that it needs to be switched to another product. He assumed that this is because they have to pay every time a claim is submitted and if the product is not listed as preferred they tell the doctor that it is not covered without trying to submit the claim. Dr. Corley stated that this does not happen that much. He stated that most pharmacists submit the claim.

- Mr. Beshara stated that when drugs are grandfathered, you see a steady decline in the use of the medication over time, which is consistent with population turnover.

A motion was made to accept the recommendation with the following changes:
- Carbatrol® and Equetro® be moved to the preferred side, since they do not have generics available
- Phenobarbital be listed for children

- A motion was seconded.
- Discussion on the motion
  - Dr. Powers stated that the Lamictal® and Zonegran® may present issues with switching patients over to the generic products.
  - It was stated that if a prescriber writes for Lamictal®, the pharmacist will dispense the generic product unless DAW is written.

- Motion carried with one opposing vote from Dr. Powers.

- Proposed Felbatol® Step Therapy Criteria:
  - Felbatol® will be approved if **ONE** of the following criteria have been met:
    1. Used as adjunctive therapy in Lennox-Gastaut Syndrome **AND** there has been a contraindication to, or trial and failure of all of the following medications:
      - Lamotrigine; **AND**
      - Topiramate
    2. Used for the treatment of partial seizures **AND** there has been a contraindication to or trial and failure of **ALL** of the following medications:
      - Carbamazepine; **AND**
      - Gabapentin; **AND**
      - Lamotrigine; **AND**
      - Topiramate; **AND**
      - Valproic acid/divalproex sodium
  - Of note, Felbatol® will not be approved for patients with a history of blood dyscrasia or liver disease unless the prescriber can make a compelling clinical case demonstrating that the benefits of the drug outweigh the risks.

- Discussion on Felbatol® Step Therapy Criteria:
  - A question was posed regarding how patients with a history of blood dyscrasia would be identified. Dr. Hawkins stated that the claim would deny at the POS for the required clinical criteria and the call center would ask these questions when the provider sought the PA.
  - A motion was made to accept the recommendation as proposed.
  - Motion seconded.
  - Discussion on the motion
    - Dr. Woods mentioned that the agents most commonly used for Lennox-Gastaut Syndrome are lamotrigine, divalproex sodium, and topiramate. Therefore, she recommended that a trial and failure of two out of these three agents (lamotrigine, topiramate or divalproex sodium) be required in
order to be approved for Felbatol®. In addition, Dr. Woods referred to an article that defined refractory epilepsy as failure to respond to 3 or more anti-epileptic drugs. Based on this idea, she proposed that for treatment of partial seizures, a trial and failure of three out of the five agents listed should be required in order for Felbatol® to be approved.

- It was noted that this agent may only be available through a specialty pharmacy.
- The motion was amended to approve recommendation with the following changes:
  - Investigate to see if this agent is only available through specialty pharmacy and if so, see if they have criteria in place already.
  - If not available solely through a specialty pharmacy, require trial and failure of two out of the three agents listed for Lennox-Gastaut Syndrome and the three out of the five agents listed for partial seizures.
- Motion seconded and carried.

- Proposed Clinical Criteria for Topamax®
  - Topamax® is unrestricted in patient \( \leq 20 \) years old for all indications.
  - For those \( > 20 \) years old, Topamax® is unrestricted in the treatment of seizures. The patient must have in their medication history (a past 3 month computer review) prior use of an antiepileptic medication.
  - For migraine prophylaxis:
    - Patients requesting Topamax® for treatment of migraines must meet all of the following criteria:
      - Diagnosis of frequent migraines (defined as 4 or more migraines per month) that fail typical abortive therapy or are so severe that having one leads to debility (hemiplegic migraine, seizure, etc.); AND
      - Has tried and failed migraine prophylaxis with a beta-blocker and amitriptyline
      - Approval may also be given if the prescriber has a reason not to try both classes of medications prior to prescribing Topamax®. Reasons not to try both classes of medications may include
        1. Intolerance to one or more medications.
        2. Failure of a similar medication within the class.
        3. History of seizure and would like to combine therapy.
  - For Bipolar Disorder:
    - Patients requesting Topamax® for treatment of bipolar disorder must meet the following criteria:
      - Has tried and failed treatment with lithium, AND lamotrigine OR valproate (NOTE: failure on valproate due to weight gain would be indicated by an increase in baseline weight by \( \geq 10 \) pounds or \( > 7\% \)).
      - Use of Topamax® therapy must be in combination with an atypical antipsychotic (unless the recipient has a history of intolerance or contraindication to atypical antipsychotics)

- Clinical criteria for Topamax® - discussion around use in seizures
  - A comment was made that the wording of the criteria regarding use for seizures in adult patients may cause confusion. It states that Topamax® is unrestricted for those \( > 20 \) years old in the treatment of seizures, but then the automatic lookback statement makes it sound like the patient must have tried something else for seizures first.
Dr. Hawkins clarified that the intent was for Topamax® to be unrestricted for seizures in patients of all ages. She suggested that the wording regarding the look-back could be removed on the posted criteria.

- A question was raised regarding the ability to use the POS ICD-9 override process in this case. Dr. Hawkins stated that the system is capable of doing this.
- There was a discussion regarding pharmacist and physician awareness of the ICD-9 process. Mr. Beshara stated that TennCare is always looking for ways to improve communication. He also stated that TennCare is partnering with the UT College of pharmacy for the spring pharmacy CE meetings held across the state. This would be a TennCare “back to basics” session for pharmacists.
- A request was made to have a link in the First Health website for directions on how to do an ICD-9 bypass. The committee stated that the problem with this suggestion is that pharmacy systems are all different. The specific directions could not be listed, but the field codes could be listed and the pharmacy software company could help with this process.
- A motion was made to change the wording to say “Topamax® is unrestricted in patients less than or equal to 20 years old for all indications. For those greater than 20 years old, Topamax® is unrestricted in the treatment of seizures”. In addition, it was recommended to remove the sentence regarding the automatic look back.
- Motion was seconded.
- Motion carried.

- Clinical criteria for Topamax® - discussion around use in migraine prophylaxis
  - Dr. Capparelli explained that he had had a long talk with a Dr. Brandes, a neurologist at Vanderbilt who is also a headache specialist. She suggested that another bullet point be added for migraine prophylaxis for pregnant women. She also stated that when speaking of intolerance, specific disease states should be listed as well. Examples of this would be that patients with diabetes or asthma should not be required to try and fail on a beta blocker. She also had a concern about the requirement of amitriptyline because this agent is not FDA indicated for use in migraines.
  - It was noted by the Committee that the use of amitriptyline as an agent for migraines has been established for some time. It may not be FDA indicated, but this use was one of the first off label uses.
  - It was noted that sometimes the patient may not have intolerance, but the prescriber may not feel that trial and failure of these agents is clinically appropriate. A suggestion was made to add “unless clinical indications prevent use of these agents” to the second bullet point requiring that the patient has tried and failed a beta-blocker and amitriptyline.
  - A motion was made to accept the criteria as proposed, with the addition of pregnancy as a reason to approve Topamax®
  - Motion seconded and carried.

- Clinical criteria for Topamax® - discussion around use in bipolar disorder:
  - A concern was voiced regarding the lack of an FDA indication for Topamax® in the use of bipolar disorder.
    - Dr. Fitzpatrick responded that Topamax® is used often for bipolar, but is usually reserved until patients have tried other agents first. She stated that it is generally not a first line agent.
Dr. Woods cited a study supporting use of this agent in refractory bipolar mania. She also stated that the guidelines have not been updated since 2002 and several trials have been done since then.

A question was raised from the committee to ask if this agent should be made unrestricted altogether since it has many uses and is a fairly safe agent.

- It was noted that there are a lot of other off label requests that are made for this agent that are not supported by clinical studies.
- A comment was made that a common off-label use is for weight loss.

A motion was made to accept the criteria as proposed.

Motion seconded and carried, with one opposing vote from Dr. Capparelli.

Sedative Hypnotics:

The ideal sedative hypnotic would induce sleep within 30 minutes, maintain a normal pattern of sleep for 6-8 hours, have no residual effects the next morning, be safe upon overdose, and not induce tolerance, abuse or dependence. Chloral hydrate can be considered an inferior agent in this class, because it is associated with tolerance, dependence, GI effects, drug interactions and fatalities in overdose. Although it is the only agent in this class approved for children, the current guidelines do not recommend it over any other sedative hypnotic. The other sedative hypnotics seem to be equally effective and tolerated, and thus can be considered therapeutic alternatives to one another. In order to best meet patient needs, it is recommended that at least one agent with the following characteristics be available: indication for long term use, a quick onset (≤30 minutes), and a long duration of action (up to 8 hours).

- Discussion:
  - Dr. Capparelli disagreed with the statement that all agents are equally effective and tolerated. He stated that some agents last longer than others, some agents have a faster onset of action than others, and some have data supporting chronic use while others do not. He stated that while the lists of preferred and non-preferred agents are reasonable, Lunesta® is the only agent to have a published 12-month long term use study. He pointed out that the Ambien CR study supporting chronic use involved intermittent use of 4 to 7 days per week. In addition, he voiced concerns over decreased effectiveness of this agent over time.
  - Dr. Capparelli voiced support for having generic zolpidem available for short term use; however, he argued that Lunesta® should be considered a superior agent in the class at this time due to its long-term data.
  - Dr. Fitzpatrick stated that several psychiatrists have pointed out to her when you have a patient with past substance abuse; it is beneficial to have Rozerem® available.
    - Mr. Beshara stated that this is something the state has been looking at internally to determine if clinical criteria should be added to Rozerem® to allow access without trial and failure of the preferred agent for those patients with a history of drug abuse or the need to avoid drugs that can be abused.
  - Dr. Fitzpatrick also discussed the use of sedative hypnotics in children. She stated that most child psychiatrists are interested in determining the underlying cause of the insomnia rather than just prescribing a sedative hypnotic; however, she pointed out that especially in some children with neurodevelopmental disorders, a sedative hypnotic may be needed. Mr. Beshara asked which agent Dr. Fitzpatrick would choose for pediatrics if a sedative hypnotic were needed.
She stated that some of the first choices would include diphenhydramine and trazadone. Clonidine is also used in the ADHD population, and Remeron® in children with anxiety disorders. In cases where you may not want to use any of the above agents, a short acting agent such as zolpidem may be used.

- Dr. Corley stated that he sees chloral hydrate used often for group home patients that may need it prior to a dental procedure. Since this is the only liquid formulation available, it is good for those patients who have trouble swallowing. He requested that maybe this agent be left as preferred with quantity limits. Dr. Fitzpatrick agreed with Dr. Corley.

- Dr. Hawkins asked the committee if both the liquid and capsule formulations of chloral hydrate would need to be made available, given that the capsules are only available as a brand product. The committee voiced the need for the liquid formulation only.

- A motion was made to modify the recommendation as follows:
  - Strike the sentence that states that all the sedative hypnotics are equally effective and tolerated
  - Mention that Lunesta® is the only drug in this category that has a long term daily use indication
  - Recommend that generic zolpidem, generic chloral hydrate liquid, and Lunesta® be available

  - Motion seconded.
  - Motion carried.

- **Discussion Regarding the Need for Clinical Criteria for Rozerem®**
  - The committee discussed the benefits and drawbacks of Rozerem® compared to the other sedative hypnotic agents. The benefits included the fact that it is not a controlled substance, has a quick onset, and has low residual effects. However, the major drawback is that data suggests it is not as effective as the other agents.
  - It was pointed out that a person cannot overdose on Rozerem®, so this product is often favored in patients with a history of polysubstance abuse.
  - A suggestion was made to create clinical criteria for Rozerem® such that it will be available for patients with a history of substance abuse.
  - A motion was made to have Rozerem® subject to clinical criteria which states: “Rozerem® will be approved for any patient for which there is a risk of substance abuse or overdose.”

  - Motion seconded and carried.

- **Discussion of the quantity limits for the sedative hypnotics.**
  - A question was raised regarding why the quantity for zolpidem was set at 14/month when Ambien CR was approved for a quantity of 1/day.
  - Dr. Hawkins stated that this was the original quantity approved for short term use in the Ambien package insert.
  - A comment was made that in clinical practice, zolpidem is often used on a daily basis.
  - After much discussion among the group, a motion was made to remove the 14/day QL on zolpidem and Ambien® and change it to 1/day.

  - Motion seconded.
  - Motion carried.
REVIEW OF MAY PAC MEETING DECISIONS
First Health reviewed TennCare’s decisions from the August 14, 2007 PAC meeting. In the interest of time, decisions were presented only for those classes in which TennCare did not accept the Committee’s recommendations. The classes where TennCare’s decisions differed from the recommendations of the Committee are as follows:

- **Cardiovascular Agents: Intermittent Claudication (Page #18)**
  - PAC: Approved the proposed recommendation as stated.
  - TennCare: Accepted the PAC’s recommendation, but added a statement pointing out pentoxifylline’s utility in patients with CHF.
  - The following statement was added to the recommendation. However, cilostazol is contraindicated in patients with congestive heart failure, as it has been shown to decrease survival in these patients. For this reason, both cilostazol and pentoxifylline should be available.

- **Endocrine Agents: Non-oral contraceptives (Page #26)**
  - PAC: Approved the proposed recommendation.
  - TennCare: Accepted the PAC’s recommendation, but decided to move Nuvaring® to preferred, while keeping Ortho-Evra® non-preferred due to its side effect profile (i.e., greater estrogen exposure and potential for increased risk of blood clots). An additional sentence was added to the recommendation stating that Ortho Evra® can be considered an inferior agent in this class.

- **Endocrine Agents: Non-oral contraceptives – Criteria (Page #26-27)**
  - PAC: Approved the proposed criteria without any changes.
  - TennCare: Revised the criteria slightly to clarify that a step through an oral contraceptive was required, with demonstrated non-compliance or intolerance to the oral contraceptive before approval of the non-oral contraceptive would be granted.

- **Endocrine Agents: Oral Glucocorticoids (Page #38)**
  - PAC: Approved the proposed recommendation.
  - TennCare: Accepted the PAC’s recommendation; however, based on discussion of this class, the recommendation was modified to ensure that at least one oral solution, syrup, and tablet formulation be available on the PDL.

- **Endocrine Agents: Bisphosphonates (Page #47)**
  - PAC: Approved the proposed recommendation, but asked that the various agents be split out into their individual categories on the PDL (e.g., bisphosphonates, SERMs, calcitonins, and parathyroid hormone agents). In addition, the PAC requested that the cost of Miacalcin and Fortical be investigated to ensure that Miacalcin is least costly of the two products.
  - TennCare: Accepted the PAC’s recommendations, but included verbiage in the recommendation pointing out the limited outcomes data available for teriparatide. In addition, TennCare did verify that Miacalcin® is indeed the more cost effective agent.
SPEAKERS FOR PUBLIC TESTIMONY

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<td>Rita Lakamp, Pharm.D.</td>
<td>sanofi-aventis/UCB</td>
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<td>Laura Fye Moore, DHSc, PA-C</td>
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<td>Nigel Isaacs, PharmD, JD</td>
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Additional Discussion:

Dr. Capparelli revisited the discussion regarding coverage of Chantix®. He recommended that the Committee send back a straw vote for TennCare to take to the legislators reflecting PAC support for coverage of this product. He stated that Chantix® is the first agent available for smoking cessation that has proven to be this effective, and as such, it would be both a clinically-effective and cost-effective medication for TennCare to cover for smoking cessation. He added that the American Lung Association states that smoking cessation is the hallmark of therapy for COPD and lung diseases. Therefore, he encouraged the committee to take a vote reflecting their stance that it would be important for Chantix® to be available to TennCare patients.

- A motion was made that the TennCare Pharmacy Advisory Committee recommends to TennCare that Chantix® is both cost effective and a very clinically effective medication for smoking cessation. The committee feels that it would be very helpful to have that available for TennCare patients and that this information be carried forward to the legislature for their consideration.
- Motion seconded.
- A comment was made that some of the committee members had already left the meeting, and at least eight members of the committee would need to be present to represent a quorum. Although a quorum was not present for this vote, Dr. Powers suggested that a vote should still be taken for the record. Dr. Powers, acting as the chair, allowed the vote.
- Motion carried. Votes were five in favor, one opposed.

Meeting Adjourned.