TennCare Pharmacy Advisory Committee (PAC Meeting)
August 25, 2011

Members in Attendance:
Melvin Blevins, MD, David Collier, MD (TennCare), Edward Capparelli, MD, Chairman Alan Corley, DPh, Vice-Chair Jeri Fitzpatrick, MD, Lyn Govette, MPAS, PA-C, James Johns, MD, Lynn Knott, PharmD, CGP, FASCP, Carol Minor, Joel Phares, MD, Terry Shea, PharmD, Eleanor Twigg, PharmD, Nicole Woods, PharmD (TennCare)
Non-members present from SXC: Leslie Pittman, PharmD, Tracey Lovett, PharmD.

INTRODUCTIONS
The meeting was called to order by Chairman Alan Corley. Dr. Corley stated that committee members are volunteers, appointed according to public act (TCA 71-5-2401) establishing the Pharmacy Advisory Committee (PAC) and have signed conflict of interest statements. Dr. Corley stated no conflicts of interest had been disclosed. The members of the Committee introduced themselves.

LAST MEETING FOLLOW-UP
Dr. Pittman stated there was one follow-up item requested by Dr. Corley to check on whether the triamterene/HCTZ 50/25mg strength was still available. Dr. Pittman stated this particular product has been discontinued.

PAC MINUTES
The May 3, 2011 PAC meeting minutes were reviewed.
• Dr. Edward Capparelli motioned to approve the minutes.
• Motion seconded and carried.

TENNCARE UPDATE
Dr. David Collier gave this quarter’s TennCare update.
• The fiscal year 2012 began July 1, 2011. A couple of changes have occurred that were not mentioned at the previous meeting:
  o The Governor’s Office of Children’s Care Coordination has been dissolved; services that were previously provided by this office will now be distributed to other state agencies.
  o The TennCare Oversight & Long-Term Care Oversight Committees have been eliminated; responsibilities will now be handled by other standing legislative committees.
• In response to national credit rating agencies asking the state to present plans on how it will respond to cuts in federal funds, state agencies were asked to present 2 sets of plans to Finance Commissioner Mark Emkes, which accounted for a 15% and 30% reduction in federal aid. These plans were submitted August 24, 2011.
• TennCare has improved its standing with the National KIDS COUNT Data Book published through the Annie E Casey Foundation. This publication compares all the states on various health measures for children and adolescents.
  o Tennessee ranked 39th, the best ranking for Tennessee ever and first time ranked above 40.
  o Areas that showed improvement included infant mortality rate, child death rate, teen death rate, teen birth rate and percentage of teens not in school and not high school graduates.
The two areas that resulted in a decline were percentage of children in single-parent families and children in poverty, which is not a surprise due to the economic downturn.

The Tennessee Commission on Children and Youth stated this higher ranking is evidence of state and health department policies that have helped to improve these areas.

- **TennCare Standard Spend Down (SSD):** is designed to serve a limited number of people who are not otherwise eligible for Medicaid, but are aged, blind, disabled (as determined by social security), or the caretaker relative of a Medicaid eligible child and who have enough unreimbursed medical bills to allow them to "spend down" their income to the State's Medically Needy Income Standard (MNIS). The budget allows for a maximum of 7,000 new enrollees in this category for fiscal year 2010-2011. Two enrollments have already been offered with approximately 2,500 applicants allowed for each enrollment period.

  - TennCare and DHS plan to open the SSD call-in line to an additional 2,500 callers on September 12, 2011. Details will be announced on Monday, August 29, 2011.

- **John B. Lawsuit:** trial is scheduled for October 31, 2011 before Judge Thomas A. Wiseman, Jr. and is expected to last 4 weeks. The purpose of the trial is to determine if TennCare is in substantial compliance with the consent decree requirements.

- Questions may arise from patients regarding letters received from the state last week. Approximately, 1.2 million letters were sent out to fulfill noticing requirements set by the Grier Consent Decree. TennCare children recipients will receive a slightly different letter than adult recipients. These annual notices will review the recipients' appeal rights and any changes to the benefit. This year the adult notices will discuss the benefit limit changes for Suboxone®, sedative hypnotics, and rosacea and acne products. However, there will not be any benefit limit changes for children.

  - Dr. Capparelli inquired about the percentage amount of federal rebates and CPI penalty that will have to be shared with the federal government.
  - Dr. Woods stated that at this time no additional clarification has been received. CMS has not yet provided an explanation as to what will be considered a line extension and states are still awaiting additional guidance. So at this time there have not been any changes.
  - Dr. Capparelli asked if a major percentage of the federal rebate/CPI penalty is given back to the federal government, will this lead to significant adjustments in the availability of medications on the formulary.
  - Dr. Woods stated that to prevent major disruption in the formulary, last year’s contracts were only valid for 1 year due to the uncertainty of what portion the federal government would receive back and what effect this would have on supplemental rebates. At this point, the state feels that the pharmaceutical companies have a better understanding regarding their federal government responsibilities. Although, there are several unanswered questions regarding rebates, it was felt that many companies are now comfortable returning to our standard 2 year contract agreements. Dr. Woods stated that there were some changes to the PDL listings within the ADHD category because it was anticipated that many extended-release products in this category would eventually be classified as line extensions. However, at this time only 1 extended release agent...
has been moved to non-preferred status as a result of the higher federal recapture amount associated with the line extensions.

- Dr. Phares inquired whether the federal cuts would affect the smoking cessation grants that Tennessee will receive.
  - Dr. Collier stated that if the cuts are necessary, it is possible that smoking cessation grants could be affected. However, there has not been any specific discussions regarding limiting this benefit at this time.

**TENNCARE PHARMACY UPDATE**

Dr. Nicole Woods gave this quarter’s TennCare Pharmacy update.

TennCare Pharmacy Budget Proposals: Dr. Woods stated that a majority of the pharmacy budget cuts were approved and will go in to effect. This includes the following:

- **Adult Benefit Limit Changes** - As of July 1, 2011, benefit quantity limits for sedative hypnotics, buprenorphine and buprenorphine/naloxone products went into effect for adults (members 21 years of age or older). The quantity limits for sedative hypnotics are set at 14 tablets per month while the quantity limit for buprenorphine and buprenorphine/naloxone are set at 16 mg/day for 6 months, then 8 mg/day. Adult TennCare members who were historically receiving greater than 16mg/day will be grandfathered through 09/01/11. Initially, the plan was to grandfather members through 08/01/11. However, this was extended through 09/01/11 to allow providers an additional month to taper patients. Additionally, exclusion of acne and rosacea products for adult members began July 1, 2011 as well.

- **TennCare $4 Generic List** - On August 15, 2011, implementation of the $4 generic list began. This program was slightly delayed as to allow time for the pharmacy program to compile a drug list that we felt confident pharmacies were able to obtain specific drugs for $4 or less. The methodology that will be used involves a MAC (Maximum Allowable Cost) of $1 for an average month supply in drug ingredient cost with a dispensing fee of $3. This methodology will allow a total reimbursement of $4. As with any of our drugs that are given a MAC cost, there is a MAC dispute process for pharmacies that feel they are unable to purchase the drug for $4 or less. These disputes will be reviewed and acquisition costs will be evaluated. Adjustments will be made to the drug list as required through this dispute process.

- **Hemophilia Management Initiative** - At this time the Hemophilia Management Initiative has not been implemented. This program required hemophilia drug products to be dispensed within an upper range of no more than +2%. Typically these agents are prescribed so as to allow a dose in the range of ±10% to be dispensed. This initiative will ratchet down that allowable dose range to allow for some additional savings. The specific details are still being revised. Specialty pharmacies will receive amended contracts prior to implementation. Further details shall follow within the next 1-2 months.

- **Point of Sale Coordination of Benefit Edit** - Another change to the pharmacy program involved a POS (Point-Of-Sale) edit for coordination of benefits (COB). This edit began on July 15, 2011. The pharmacy program sent out communication prior to this edit and offered 3 training conference calls. This initiative identifies recipients with primary insurance and requires primary insurance to be billed before TennCare. SXC provides daily third party liability (TPL) files that identify recipients with primary insurance. Pharmacies are provided primary insurance information (i.e. BIN, PCN,
Group, Member ID, and Primary Insurance Help Desk Number) to assist with resolving these 41 reject (Bill Other Payor) edits. In addition the SXC Technical Call Center is available to help troubleshoot these issues. In situations, where a recipient is listed as having insurance, but after researching the pharmacy has determined this is not the case; then pharmacies are able to submit standard Other Coverage Codes (OCC) to override the reject. So far implementation of this edit has been going well. In addition to the assistance from the technical call center, SXC Provider Educators are also available to assist pharmacies with COB concerns. Ongoing tracking of the COB data is being compiled, and TennCare should have information regarding the potential savings of this edit at a future date.

- Lastly, TennCare typically requests 2 year rebate contracts. However, due to the recent Health Care Reform, rebate contracts requested last year were only given a 1 year term. This year the pharmacy program is returning to the standard 2 year contract agreements as TennCare and pharmaceutical companies now have a better feel of the impact of Health Care Reform. Rebate contract notices were sent to pharmaceutical companies and SXC is currently compiling the new bid information and evaluating the numbers. The new contracts will cover October 1, 2011 through September 30, 2013. Notices regarding PDL (Preferred Drug List) changes will be sent to providers on September 1, 2011. At this time only a few changes are anticipated, and when necessary grandfathering will be offered to ensure adequate transition time for patients and providers.
  - Dr. Capparelli inquired as to whether TennCare termination letters have been sent out recently. On 3 separate occasions, mothers have indicated a letter was received stating their child will be terminated from TennCare if information regarding the father and/or father’s insurance information is not provided. In each incident the mother has stated that she has notified TennCare that she is unaware of the father’s residence or any other information that may assist TennCare in locating the father to obtain insurance information. Dr. Capparelli asked if the new COB edit would affect patients that fall in this category.
  - Dr. Woods stated that this particular edit would not result in termination of any TennCare patients. However, there may be some TennCare eligibility rules that apply. If the father did have insurance coverage for the child, this information would be identified on the TPL file and the specific insurance information will be sent to the dispensing pharmacy, such as ID number, BIN number, group number, etc that would allow the pharmacy to process the claim with that primary insurance. Approximately 80% or more of the claims that reject return back this primary insurance information. In situations in which the ID number, etc is not returned to the pharmacy, the message returned provides the help desk 1-800 number specific to the primary insurance company on file. If for some reason the primary insurance on file is not valid per pharmacist verification, then an override may be placed by the pharmacy with the use of the OCC codes.
  - Dr. Woods stated that in the situations Dr. Capparelli cited, this POS edit should not prevent them from receiving their medication.
  - Dr. Collier stated he was unaware of any communication being sent regarding this issue. However, he would check to confirm if any correspondence regarding this issue had been dispersed.
  - Dr. Fitzpatrick inquired as to why the edit for the sedative hypnotics was placed. Dr. Woods stated that placing quantity limits on the sedative
hypnotics was primarily a financial decision; however, it was supported by the current insomnia guidelines. Utilization of sedative hypnotics within the TennCare population was reviewed and the numbers showed that our members were receiving an average of 29 tablets per month and most patients were remaining on this quantity indefinitely. The guidelines state you should use daily sedative hypnotics for short-term use and if used for chronic insomnia, then an intermittent dosing schedule should be utilized. Dr. Woods stated that there was concern that many patients were placed on these medications for an indefinite time frame without re-evaluating for behavior modifications.

- Dr. Fitzgerald voiced her concern involving formulary decisions being made primarily on a value-judgment for specific drug categories and if the quantity limits set were able to be appealed. Dr. Woods stated, no this would be considered a benefit limit similar to the 5 scripts per month limit and reiterated that this was truly a budgetary driven decision.

- Lynn Govette stated that encouragement and counseling has helped eased the transition to the new quantity limit. She stated that many of her patients have done well with transitioning to the new quantity limits.

- Dr. Capparelli stated that on previous meetings, the committee had voted to cover Lunesta® for 30 tablets per month due to the long-term studies that were available compared to studies available for Ambien® at the time. Additionally, a drug limitation was set for Ambien® as a result of these studies at 14 tablets per month. Interestingly, this limit was taken away when Ambien® became available generically. Dr. Capparelli stated that this scenario has occurred repeatedly and expressed discontentment regarding the Bureau’s policing of brand name products.

- Dr. Woods stated that within the scope of this committee, clinical recommendations have always been utilized to help guide formulary decisions, so that decisions are made foremost on a clinical basis with cost being secondary. In regards to the quantity limit removal on the zolpidem product; this decision was made by the committee as a whole to allow utilization greater than 14 per month. However, if the board felt strongly about safety issues with daily use of this agent, and there was clinical data to support this, the higher quantity limit would not have been implemented. Dr. Woods stated that there were also examples where the board has recommended that a more costly product be preferred due to clinical evidence of the product exhibiting superiority and/or better safety profile, and TennCare had listed that product as preferred.

- Dr. Corley expressed concerns over the $4 generic list that is currently in place. Dr. Corley stated that many of the $4 generic lists available are primarily utilized for customers with no insurance. These transactions do not include eligibility confirmation, coordination of benefits, delivery services, etc. So this pricing is based primarily on the intention that this will be a cash transaction. Many of the agents listed on the TennCare $4 generic list are not available from McKesson, a major wholesaler at the $4 rate being reimbursed. Dr. Corley stated he has plenty of information to support these findings if needed. Dr. Corley stated that, while the committee does not deal with reimbursement issues, part of the committee’s job is to maintain the integrity of our pharmacy network. He expressed concern that the current $4 generic list may threaten to disrupt that integrity. Dr. Corley stated this is a radical change in reimbursement. The MAC process that has previously been in place allowed providers to submit an invoice
as evidence that the agent could not be obtained at the listed MAC price. Since the implementation of the $4 generic list this MAC dispute process for the $4 generic list in place has been modified so that providers are now asked to prove they cannot obtain the drug at the $4 reimbursement rate; no allowance is made for any percentage of profit to account for overhead cost. Dr. Corley stated that since 2004, when the program was struggling with cost, many of the program changes that have occurred have been successful with the help of pharmacists increasing the generic utilization rate from 68% to about 82% today. A 1% move in generic utilization rate is approximately a 20 million savings to the state. In the past as an incentive for pharmacist to increase the generic utilization rate an additional 50 cent dispensing rate per prescription was implemented. However, with the implementation of over 200 drugs on the $4 generic list, there is not much incentive to continue in that direction. In order for pharmacies to make a profit to maintain their business, generic utilization may decrease.

- Dr. Corley asked if the $4 generic list also applies to long-term care pharmacies or just strictly retail pharmacies. Dr. Woods stated that this would apply to both retail and long-term care pharmacies. Dr. Knott stated that a long-term care setting is not able to operate receiving a $4 reimbursement rate in a setting where pharmacies are required to have special packaging, provide delivery and provide 24/7 pharmacist staffing coverage. Dr. Woods stated that long-term care pharmacies receive a higher dispensing fee to offset some cost. Dr. Knott stated that the current dispensing fee does not offset or cover the money that will be lost with receiving the $4 reimbursement rate. Dr. Knott stated that many pharmacists are unable to obtain many of the drugs on the list at the $4 reimbursement rate. In some instances the cost of obtaining the drug was 400% higher than what is currently listed on the acquisition cost list.

- Dr. Woods stated this was a budgetary move. TennCare had proposed a 7% reduction in reimbursement rates for all providers. For pharmacy providers, TennCare had considered a reduction to AWP (Average Wholesale Price) -20% plus a dispensing fee but thought that the $4 generic list would be more palatable. Many pharmacy chains were already submitting a U & C (Usual & Customary) cost of $4 to TennCare for the drugs on their $4 lists. Approaching a $4 generic list as a MAC process allows TennCare to ensure maximum reimbursement of $4. to give the pharmacist a smaller reduction versus a 7% reduction across the board. Although, the profit margin is small on $4 generic list agents, there are other agents that do not have such an aggressive MAC and substantial profit may be gained from those agents. Dr. Corley pointed out that a 7% reduction across the board in AWP would not necessarily mean a move from AWP-13% to AWP-20% as the reduction would come off the total price.

- Dr. Twigg stated that she works for a chain that has a $4 generic list and there are several agents on TennCare’s $4 generic list, such as pravastatin and levothyroxine (doses above the 100mcg), that were not placed on her pharmacy’s $4 list due to the pricing received from their wholesaler. Another point she made is that TennCare has typically paid on the lower end of the generic effective rate compared to other state medicaid payers. Looking at a week’s worth of data, this payment has been cut in half based on the drugs typically dispensed. This basically
averages to about a decrease of $2 or more. Dr. Twigg asked that the pharmacy program re-evaluate this plan.

- Dr. Woods stated that TennCare’s $4 Generic List was compiled based on the $4 generic lists of several major chain pharmacies.
- Dr. Twigg also pointed out that monies lost at the major chain pharmacies due to certain drugs being placed on a $4 drug list, are covered or accounted for in other departments of the store, such as the grocery department. Many pharmacies initially look to decreasing staff, to account for deceased profits. This decrease in staff leads to a decrease in services or patient care secondary to the staff shortage. These are all factors that should be considered when implementing such a change.
- Dr. Woods expressed the State would be willing to discuss specific concerns and would re-evaluate that products on the $4 list.

**AE SUBCOMMITTEE**

Dr. Leslie Pittman reported to the PAC committee there were 5 additions of new drugs to existing categories on the Auto-Exemption List for 2Q2011. These 5 additions included Yervoy®, vandetanib, Sylatron®, Victrelis®, and Incivek®.

**DRUG CLASS REVIEWS**

The drug class review section of the meeting consisted of an SXC 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 a vote on the recommendation and any proposed restrictions.

For the purpose of the minutes, the section below reflects SXC’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 SXC, please refer to the August 25, 2011 PAC review packet at: https://tnm.providerportal.sxc.com/rxclaim/TNM/PAC%20packet%20082511.pdf

**CNS Agents**

**Agents for RLS (Restless Leg Syndrome)**

- Gabapentin enacarbil is a prodrug of gabapentin, and is FDA-approved for the treatment of moderate to severe primary RLS. Clinical trials demonstrate gabapentin enacarbil is effective for the treatment of RLS compared to placebo; however there are no head-to-head trials comparing this agent to other treatment options for RLS. First-line treatment options for RLS include the dopamine agonists, pramipexole and ropinirole, with gabapentin listed as a second-line treatment option in primary RLS for daily symptoms. Therefore, in order to ensure appropriate use as a second line agent, it is recommended gabapentin enacarbil should be subject to clinical criteria.

**Discussion:**
- Dr. Capparelli asked why clinical criteria was needed that basically reiterates the general criteria for non-preferred agents that requires trial/failure of 2 preferred agents, unless there is a contraindication and/or intolerance to preferred agents
Dr. Pittman stated that the difference in this case is the criteria require a diagnosis of RLS due to the concern of off label use. Dr. Capparelli felt the second bullet point should be removed as this was redundant given the fact, general non-preferred criteria is already in place. Dr. Pittman explained that the second bullet point was listed to provide clarification on the public documents as to the exact requirements for receiving the drug.

Dr. Capparelli asked if this specific recommendation could be merged with the general RLS recommendation. Dr. Pittman stated this was possible; however, the category is currently listed as Dopamine Agonists. It was felt that a new category, Agents for RLS, could be created to include the dopamine agonists along with gabapentin enacarbil. If this new category were added, then all the RLS agents could be listed in one category for completeness, and the Dopamine Agonists category could remain on the PDL with pramipexole and ropinirole.

Dr. Capparelli stated that he felt that if the PAC was reviewing a recommendation for the Agents for RLS category, it would be valuable to have all the information for the other agents added as well. Dr. Pittman stated that information for all agents in this category will be listed, such as quantity limits.

Dr. Capparelli inquired as to why gabapentin was not included in this category, but was included in the general recommendation. Dr. Pittman stated that gabapentin was not included because this agent was not FDA approved for RLS. The agent was included in the general recommendation because gabapentin enacarbil is a prodrug of gabapentin. Dr. Capparelli stated he understood that additional studies would not be done on a generic product to receive a FDA approval. But he pointed out that it provides confusion when gabapentin is included in the general recommendation and not included in the drug listing. Dr. Pittman stated that because gabapentin is an anticonvulsant, it is listed on the PDL under that category and would not be included in this category as this is an off label use that is utilized as a second-line treatment.

Dr. Woods asked the committee what the major concern was with the current presented recommendation. Dr. Capparelli stated that the general recommendation presented does not include the other agents used for RLS. Additionally, a second-line agent is included in the recommendation, but is not included in the drug listing. He felt the recommendation needed to be tweaked. Dr. Pittman stated the proposed recommendation is only to represent gabapentin enacarbil. A footnote was included that explains the other agents were included in this category for completeness and were already approved by PAC under the non-ergot dopamine agonists category. Dr. Woods stated that the guidelines specifically mention gabapentin and the recommendation includes the information regarding gabapentin enacarbil as a prodrug of gabapentin to clarify that the agent therapeutic effects are due to gabapentin.

Dr. Johns asked if non-FDA approved agents were prohibited from being included in a recommendation. Dr. Pittman stated they could be included. Dr. Johns stated that it is reasonable to consider including gabapentin within the recommendation. Dr. Pittman stated that logistically it becomes confusing mentioning drugs in other categories and what is required based on the different category listing. Therefore, typically we try to stick
with the categorizing of the drug based on the listing in the drug file to prevent confusion.
  o Dr. Blevins felt that this agent would probably be used infrequently as the other agents show good efficacy.
  o Dr. Corley proposed that this category be revisited after lunch to allow time for TennCare and SXC to modify the recommendation to incorporate other agents used in RLS.

• Dr. Pittman presented the following revised recommendation to the committee following lunch for approval:

RECOMMENDATION
- Pramipexole, ropinirole and gabapentin enacarbil are FDA-approved for the treatment of RLS. Gabapentin enacarbil is a prodrug of gabapentin. Clinical trials demonstrate the efficacy of all agents; however there are no head-to-head trials comparing the available treatment options for RLS. Per AASM guidelines, first-line treatment options for RLS include the dopamine agonists, pramipexole and ropinirole. Therefore, it is recommended gabapentin enacarbil should be subject to clinical criteria requiring initial treatment with first line agents.

Discussion:
• Motion made to approve the revised recommendation
• Motion seconded and carried.

Clinical Criteria for Horizant®
Horizant® will be approved for patients meeting ALL of the following criteria:
• Diagnosis of Restless Leg Syndrome
• Trial and failure, contraindication or intolerance to BOTH pramipexole AND ropinirole

Discussion:
• Dr. Blevins motioned to approve.
• Motion seconded and carried.

Quantity Limits

| Horizant® | 1 tablet/day |

Discussion:
• Dr. Blevins motioned to approve.
• Motion seconded and carried.

CNS Agents

ANTIHYPERTKINESIS AGENTS
• Dr. Pittman presented modified criteria including both diagnosis and documentation of shift work sleep disorder for Provigil® and Nuvigil® to address concerns by the committee at the last meeting. Additionally, Dr. Fitzpatrick asked for some research on the use of these agents in Anergic Depression and the use of these agents in Multiple Sclerosis patients with fatigue. Handouts summarizing results from clinical
trials on the use of these drugs for these specific indications were given to the committee for review.

- **Provigil® in the use of MS fatigue** - two small trials were identified:
  - **Trial 1:** 72 patients: improvement in fatigue with doses of 200 mg. The 400 mg dose was found to be no different than placebo.
  - **Trial 2:** 115 patients: This study found no improvement in fatigue with either dose.

- **Provigil® in the use of Anergic Depression** - two small trials were identified:
  - **Trial 1:** showed modafanil significantly improved atypical depression symptoms at 12 weeks.
  - **Trial 2:** This trial compared 2 doses and both doses showed improvement in symptoms.

**Dr. Woods** presented information received from Dr. Ronald Wilson, a neurologist who works extensively with MS patients, in regards to these agents being used for fatigue in the MS patients. She also presenting information received from Dr. Karen Rhea, a psychiatrist with CenterStone who solicited responses from colleagues in regards to use in Anergic Depression.

- **Dr. Ronald Wilson on fatigue in MS patients:** Has utilized modafanil in several MS patients to treat fatigue; however, he has discontinued this use based on a study that did not show a significant benefit in MS patients. He noted that patients with traumatic brain injuries, brain tumors or who have experienced strokes, may show responsiveness to this agent as a result of their current brain pathology and utility of this agent may be needed in this subset of patients. However, he was unaware of any class I evidence to support this use. In general, he would not support use of modafanil in MS patients for fatigue, but suggested requests for this indication should be handled through the appeal process with reassessment of efficacy following a month trial approval.

- **Dr. Rhea and colleagues:**
  - Generally does not use modafanil in Anergic Depression and addressed concerns with use of the drug without thoroughly exploring the underlying cause of depression. However, once underlying causes have been ruled out and activating medications have not been found to be successful; addition of modafanil may be considered in these patients.
  - Modafanil is useful for both Anergic Depression and Bipolar Depression. However, cost and insurance coverage of these agents for this indication are limiting factors. Studies were provided which showed a benefit of these agents for these specific indications.
  - Occasionally prescribes in patients with resistant depression who remain sluggish or tired from antidepressant therapy. Caution was given to monitor that the agents were not being used in excess.
  - Provider has not used the products on a regular basis. However, a professor of psychiatry that has done extensive research in this area, recommends modafanil augmentation with SSRIs, bupropion, and venlafaxine for fatigue, sleepiness and lack of concentration. Also believes modafanil is a better
alternative to stimulants for fatigue and lack of concentration in depressed patients.

- Dr. Woods stated that in general there did not appear to be enough data to support use of modafanil in MS patients with fatigue; however, there were a number of studies that supported the use of this agent in Anergic Depression and Bipolar Depression.
  - Dr. Capparelli stated he did not feel this was a highly utilized drug. He has only had 2 patients on this drug, one of whom had been switched to a stimulant as a result of insurance loss and had done very well. He expressed concern in requiring documentation of a work schedule, especially from people who work in a factory setting.
  - Dr. Fitzpatrick stated she felt the documentation requirement was somewhat excessive. Dr. Fitzpatrick also voiced to the committee the value she placed on Dr. Shelton's comments, as this provider sees primarily a large group of refractory patients and has more experience as to what therapies are effective. Dr. Fitzpatrick felt having some internal criteria to address these patients may be helpful. Dr. Pittman stated that if these drugs would be used in only a small subset of patients, having these requests come through the appeals process may be appropriate. If the committee wanted, internal criteria could be put together for the call center to ensure these agents were approved for refractory patients.
  - Dr. Woods stated these agents should be reserved for those patients who are truly refractory. Dr. Fitzpatrick stated that she felt some type of avenue should be available for these type of patients. Dr. Pittman felt that since these agents are used for this indication infrequently, a better outcome will be to process these through the appeal board. Dr. Lovett reiterated that the appeal board would be a good process, as many of these patients may be seen by multiple providers due to the nature of their medical condition and the lack of clinical information from a requesting provider may cause the request to become pended or denied.

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**Clinical Criteria for Provigil®:**

Will be approved for recipients meeting ONE of the following criteria:

- Diagnosis of obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, PLUS
  - Trial and failure (minimum duration of 3 months with documented compliance) OR contraindication to Continuous Positive Airway Pressure (CPAP) or BiPAP device
- Diagnosis of Shift work sleep disorder, PLUS
  - Documentation of patient’s work schedule showing a minimum of 6 hours work between the hours of 10 pm and 8 am
- Diagnosis of Narcolepsy
- Diagnosis of ADD/ADHD, PLUS
  - Trial and failure of, or contraindication to, 2 preferred agents, OR
  - Contraindication to stimulant therapy
Clinical Criteria for Nuvigil®:

Will be approved for recipients meeting ONE of the following criteria, PLUS trial and failure, contraindication or intolerance to Provigil:

- Diagnosis of Obstructive sleep apnea/hypopnea syndrome supported by a documented sleep study, PLUS
  - Trial and failure (minimum duration of 3 months with documented compliance) OR contraindication to Continuous Positive Airway Pressure (CPAP) or BiPAP device
- Diagnosis of Shift Work Sleep Disorder, PLUS
  - Documentation of patient’s work schedule showing a minimum of 6 hours work between the hours of 10 pm and 8 am
- Diagnosis of Narcolepsy
- Diagnosis of ADD/ADHD, PLUS
  - Trial and failure of, or contraindication to, 2 preferred agents, OR
  - Contraindication to stimulant therapy

Discussion:

- Dr. Capparelli suggested that documentation of work schedule be modified to simply request details of the patient’s current work schedule. Dr. Pittman agreed this could be changed to request a statement of the patient’s work schedule.
- Dr. Blevins moved that the criteria be approved with modification from “documentation of” to “statement of” patient’s work schedule for both Provigil® and Nuvigil®.
- Motion seconded and carried.
- Dr. Pittman clarified that requests for treatment of Anergic Depression and fatigue in MS would be handled through the Appeals process. It would be noted in the internal criteria to refer these requests to the Appeal Board for review.

Respiratory Agents

Phosphodiesterase 4 inhibitor

- Roflumilast is a phosphodiesterase 4 (PDE 4) inhibitor which is FDA-approved to reduce the risks of COPD exacerbations in patients with severe COPD associated with chronic bronchitis and a history of exacerbations. Placebo-controlled trials have demonstrated reduced COPD exacerbations and improved lung function when added to first line COPD maintenance therapy; however, treatment has been associated with a significant increase in adverse events, including psychiatric events and weight loss. This class of drugs is indicated for a targeted patient population and treatment guidelines do not include PDE4 inhibitors as first line therapy for COPD; therefore, it is recommended roflumilast be subject to clinical criteria.

Discussion:

- Dr. Blevins agreed with the recommendation to have this agent subject to clinical criteria. Dr. Blevins stated that if this drug is effective, a definite benefit that should be seen is a reduction in the number of hospital admissions in the COPD population which are a very complicated and sickly group of patients to treat. However, he agreed that it should not be used as a first line treatment.
- Dr. Blevins motioned to approve the recommendation as presented.
- Motion seconded and carried.
Clinical Criteria for Daliresp

Daliresp® will be approved for recipients meeting the following criteria:

- Diagnosis of COPD associated with chronic bronchitis, **AND**
- Trial and failure, contraindication or intolerance to long-acting beta agonist
- Patient is currently receiving standard of care COPD treatments, unless contraindicated (short acting β agonists **OR** short acting anticholinergics **PLUS** long acting β agonists **OR**
  long acting anticholinergics ), **AND**
- Patient has a documented history of continued COPD exacerbations on their current COPD treatment regimen.

Discussion:

- Dr. Capparelli stated looking at the studies there are some concerns with the drug as the trials did not compare the drug with other standards of care including long-acting beta-agonists and steroids. Since, roflumilast is the first oral agent available to the COPD population, Dr. Capparelli requested an allowance be made for those patients who experience laryngospasms with inhaled products secondary to the propellant, and/or who have intolerance to inhaled agents.
- Dr. Capparelli asked for an additional bullet point to allow for intolerance of inhaled agents.
  - Dr. Woods stated that this agent should not be used as a sole agent and adding the intolerance may open this up as a sole agent being used.
  - Dr. Pittman asked what agents are typically used for these patients. Dr. Capparelli stated that these patients may use oral theophylline agents or intermittent steroids, neither of which are viewed as good options for long-term therapy.
  - Dr. Pittman stated the bullet point regarding a contraindication to the bronchodilator agents would cover those patients who experience laryngospasms due to intolerance to propellants.
- Dr. Blevins motioned to accept the criteria as presented, with the inclusion of laryngospasm as an allowable contraindication within the call center documents.
- Motioned seconded by Dr. Capparelli and carried.

Smoking Cessation Agents

Smoking is a significant public health problem that causes many preventable diseases including cancers, cardiovascular disease and complications during pregnancy. Smoking cessation treatment, including the use of medications, is effective in helping smokers quit. Bupropion hydrochloride (HCl) sustained-release, the nicotine replacement products and varenicline tartrate are all FDA approved for smoking cessation. Based on results from clinical trials and meta-analyses, all of the smoking cessation agents are effective. Abstinence rates with varenicline appear to be significantly higher compared with either bupropion HCl sustained release or nicotine replacement therapy; however, the use of varenicline is associated with significant adverse reactions including neuropsychiatric events, cardiovascular effects, skin reactions, and angioedema. Guidelines from the US DHHS and NICE recommend bupropion sustained-release, nicotine replacement therapies and varenicline tartrate as first-line agents for smoking cessation and state the agents are more effective when used in combination with counseling. The ACOG Opinion statement recommends non-pharmacological methods should be utilized as first line therapy in pregnant women before pharmacological therapy due to lack of sufficient
efficacy and safety information for smoking cessation agents. ACOG recommends if nicotine replacement agents are utilized, agents with intermittent dosing may reduce fetal nicotine exposure. Therefore, it is recommended at least three smoking cessation agents be available, one of which should have an intermittent dosing schedule and one of which should be a non-nicotine replacement therapy. Additionally, given that the combination of counseling and medications are more effective for smoking cessation than either therapy alone, it is recommended that the class be subject to clinical criteria to ensure behavioral therapy is offered in combination with pharmacotherapy.

<table>
<thead>
<tr>
<th>Clinical Criteria for Smoking Cessation Agents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A combination of counseling and medication is more effective for smoking cessation than either therapy alone.</td>
</tr>
<tr>
<td>Preferred smoking cessation agents will be approved for patients meeting the following criteria:</td>
</tr>
<tr>
<td>o The physician has provided the patient with information on available non-pharmacological treatments, including counseling services and the Quit Line (1-800-QUIT-NOW).</td>
</tr>
<tr>
<td>o For approval of bupropion sustained release, the recipient must not be on any other concomitant bupropion agent.</td>
</tr>
</tbody>
</table>

Discussion:
- Dr. Capparelli stated his understanding was $10 million was specifically set aside for smoking cessation. This money was appropriated as a separate budget item and if not utilized would go back into the general state fund to be used elsewhere.
  o Dr. Woods stated this was correct; this money was appropriated to TennCare for smoking cessation.
  o Dr. Capparelli stated this money should be utilized to the fullest. The grant is a recurring appropriation; therefore this category should be opened with no clinical criteria restrictions.
  o Dr. Woods pointed out that the TennCare pharmacy program has higher utilization of medications compared to other states and stressed the importance of being cautious that the State’s spend not exceed this appropriated amount. The criteria were set to prevent exceeding the allotted budget.
  o Dr. Capparelli expressed his opinion as to why the funds should be utilized to the fullest degree. This is a wonderful intervention that could affect multiple disease states. This category should have open access; if it appears the utilization of this category is growing inappropriately, clinical criteria can be added back.
  o Dr. Phares stated that varenicline data clearly shows this agent is effective, yet it has been listed as non-preferred. The mortality risk of a smoker is 3 times higher than that of a non-smoker. The risks of adverse events associated with this agent are small compared to the benefits a patient would receive by cessation of smoking.
  o Dr. Blevins stated the media coverage of varenicline has been negative; however it has been shown to be successful.
Ms. Minor expressed to the committee that lung cancer has the highest mortality of all cancers and felt the appropriated funds should be utilized to provide comprehensive coverage. Additionally, a communication initiative should be implemented to inform providers/patients that this benefit is available. Ms. Minor stated providers should be allowed to make the decision as to what agent would be appropriate for each patient.

Dr. Phares stated if money was a major concern, this category could be revisited in a few months to determine at that time if changes or restrictions may be needed.

Dr. Capparelli asked that the recommendation be modified to read “all unique smoking agents be available” and remove the requirement for clinical criteria.

Dr. Woods thanked the board for their feedback. She agreed that an educational piece would be helpful to inform providers as to what agents are available and to encourage use of non-pharmacological strategies to educate patients and to provide ongoing counseling. However, she expressed concerns on having a recommendation that is based solely on the idea that money has been allotted via a recurring fund, which may not be available in the future due to federal cuts. Dr. Woods asked for a recommendation that would allow wording for open access as long as the recurring funds are available, perhaps a 2 tier recommendation that may be utilized as well if the recurring fund becomes unavailable.

Dr. Capparelli and Dr. Knott stated that in the past whenever things changed, the committee was asked to revisit a category if circumstances changed. Dr. Blevins stated the committee has processes in place to make changes if necessary.

Dr. Capparelli stated that even with a 30% decrease that would bring us from 10 million to 7 million and on a per patient/per month basis, this will still put us well above the national average for smoking programs. Dr. Capparelli expressed his gratitude that these funds were made available for this use and felt the program should make the best use of these funds.

Dr. Woods asked for additional feedback on varenicline. She expressed that although the efficacy data on this product appears very promising, she was troubled by a report submitted by the Institute for Safe Medication Practices, which stated in 4Q2006, varenicline had 100 or more reports of serious injuries, in 2Q2007, it was ranked as the drug with the 3rd highest number of reports of serious injuries, and by 4Q2007, it had more reports than any other drug. She asked the board to discuss these concerns.

Dr. Blevins stated that the board is aware of the risks, but felt the benefits outweighed the risks. He recommended moving varenicline to the preferred side. Dr. Phares stated that if the money is taken away, then this category could be addressed at that time.

Dr. Corley stated that we already have some self-imposed limits in place, with the 2 brands per month limit.

Dr. Fitzpatrick felt that if changes in funding occur in the future, the class should come back to the committee for re-review.

Dr. Capparelli stated that this class specifically had money appropriated for this use and appears to be a separate budget item set aside from the TennCare
funds and should not be subject to prescription limits, assuming there are no rules to prevent this limit. Several committee members agreed these medications should not be subject to script limits. Dr. Woods stated she will have to check on whether script limits would still apply to this class.

- The committee asked that the minutes reflect that if any financial funding is removed, this category will be re-reviewed by the committee.
- Dr. Capparelli asked that the last 3 lines of the recommendation be removed. Dr. Johns suggested changing the wording be changed to indicate that all unique entities should be available.
- Motion made to accept the recommendation modified to remove the last 3 lines and read “Therefore it is recommended all unique chemical entities in the smoking cessation category be available for use, with at least one of the nicotine replacement agents having intermittent dosing for pregnant patients”.
- Dr. Woods asked if they could add a reason as to why all agents should be available. Dr. Corley stated that most of the guidelines refer to removing all barriers to improve success rates. Ms. Govette stated that for members who have tried one formulation, having other options available may assist the patient in being successful.
- Motion seconded and carried.
- Dr. Corley stated that although a recommendation to exempt these from prescription limits may not be appropriate, it should however, be appropriate to make a motion as a committee to ask TennCare to consider removing the script limits on the smoking cessation category.
- Dr. Phares motioned for TennCare to consider removal of script limits for the smoking cessation agents due to monies being appropriated as a separate budgeted line item.
- Motion seconded and carried.

<table>
<thead>
<tr>
<th>Quantity Limits:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bupropion SR (Zyban®) 2 per day</td>
</tr>
<tr>
<td>Chantix® 2 per day</td>
</tr>
<tr>
<td>Duration limit of 24 weeks per year for all smoking cessation agents. NOTE: exceptions will be made for pregnant women to allow for use throughout pregnancy. For children, larger quantities may be approved as medically necessary.</td>
</tr>
</tbody>
</table>

Discussion:
- Dr. Capparelli stated the 24 week duration allows some flexibility for patients and agreed that it was reasonable. He moved that the committee accept the quantity limits.
- Motion seconded and carried.

The Committee was dismissed for Lunch break.

Attendance after lunch: all committee members returned.
Anti-infective Agents

Hepatitis C Protease Inhibitors

- Boceprevir and telaprevir are direct acting antivirals that inhibit the replication of hepatitis C virus (HCV) host cells by binding to the protease of HCV genotype 1. The hepatitis C protease inhibitors are indicated, to be used in combination with peginterferon alfa and ribavirin, for the treatment of adults with genotype 1 chronic hepatitis C. Both agents are indicated in patients who are treatment naïve or who have previously been treated with interferon-based treatment. Telaprevir is the only hepatitis C protease inhibitor indicated in treatment experienced patients who are prior null responders; however, boceprevir has been studied in this population as well. Current clinical guidelines recommend the use of peginterferon alfa and ribavirin as the standard of care for chronic HCV; however, infection with HCV genotype 1 is the least responsive to treatment, with forty-eight weeks of combination therapy needed for an optimal response. Clinical trials demonstrate that use of the hepatitis C protease inhibitors, in combination with the standard therapy, results in a significantly higher proportion of patients with chronic HCV genotype 1 infection to achieve sustained virologic response. Additionally, in select patients with satisfactory early virologic responses, treatment may be significantly shortened. However, due to limited clinical experience, concerns regarding emergence of drug resistance, and response guided treatment algorithms, it is recommended that the hepatitis C protease inhibitors be subject to clinical criteria.

Discussion:

- Dr. Woods presented to the committee a handout that included input/responses received from gastroenterology experts regarding the new protease inhibitor agents for Hepatitis C.
  - Drs. Porayko and Perri both stated that they initiate all treatment naïve patients on a triple regimen with peg-interferon, ribavirin, and a protease inhibitor. They monitor patients on PI therapy according to the recommendations in the package insert, and do not use these products off-label, as there is not sufficient data to justify off-label use at this time. They stated that, thus far, all of their patients had been responding very well to the triple therapy regimen. They both preferred to use telaprevir due to its easier dosing schedule. Dr. Porayko pointed out that telaprevir looked like it might have better numbers than boceprevir, but head to head data was not available at this time. Dr. Perri stated that if one agent were prohibitively expensive, he did not think there would be an issue to have one of these two agents non-preferred. But he pointed out the importance of taking the entire cost of treatment into consideration, including costs of adverse events and additional therapies, such as epoietin.

- Dr. Capparelli asked for clarification on the term dysguesia. Dr. Pittman clarified that this referred to an alteration in taste.

- Dr. Capparelli asked about the cost differential between the two treatments – it appeared there was a 4:1 cost differential. Dr. Pittman responded that it was necessary to consider the cost of a full course of treatment (telaprevir has a shorter treatment course than boceprevir). Although there still is a cost differential between the two agents, it is not as great as it appears.
• Dr. Capparelli stated these agents are used to treat a non-benign disease and the proposed recommendation is reasonable.
• Dr. Blevins stated the agents are very expensive, and for a long time there were no medications available to treat this disease, so to have another drug to treat this disease is reason enough to have these agents available.
• Dr. Capparelli motioned to accept the recommendation as presented.
• Motion seconded and carried.

<table>
<thead>
<tr>
<th>Clinical Criteria for Incivek®:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incivek® will be approved for patients with chronic hepatitis C who meet ALL of the following criteria:</td>
</tr>
<tr>
<td>o Genotype 1</td>
</tr>
<tr>
<td>o Taking in combination with BOTH peginterferon alfa AND ribavirin</td>
</tr>
<tr>
<td>o After 4 weeks of therapy, patients with a HCV-RNA level of ≤ 1000 will be approved for an additional 8 weeks of Incivek®.</td>
</tr>
</tbody>
</table>

Discussion:
• Dr. Pittman stated this is the initial interim criteria implemented. However, we have had a few patients who have run into issues with the initial duration of approval, due to delays in obtaining laboratory results. Dr. Woods reached out to the gastroenterology experts to get their input on an appropriate initial approval duration that would allow providers adequate time to obtain laboratory results.
  o Dr. Pittman stated that currently we are allowing a 1 week supply to allow providers a grace period to obtain laboratory results secondary to missed appointments, rescheduling, etc.
  o Dr. Blevins also stated that it takes several days to receive lab work.
  o Dr. Johns voiced concern regarding the risk of resistance and recommended allowing an initial 2 month approval.
  o Dr. Woods asked if an initial approval for 6 weeks would be acceptable due to the expense of the drug. She pointed out that Drs. Perri and Porayko had thought 6 weeks was reasonable.
  o Dr. Corley asked if these agents were placed on the auto-exemption list. Dr. Pittman stated they were indeed on the list. Dr. Corley stated that allowing the additional 2 weeks should not cause problems with their script limits.
  o Dr. Johns made a motion to allow for an initial 6 week approval for the agent; then patients with HCV-RNA levels ≤ 1000 at treatment week 4 would be approved for an additional 6 weeks of therapy.
  o Motion seconded and carried.
<table>
<thead>
<tr>
<th>Clinical Criteria for Victrelis&lt;sup&gt;®&lt;/sup&gt;:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Victrelis&lt;sup&gt;®&lt;/sup&gt;</strong> will be approved for patients chronic hepatitis C who meet ALL of the following criteria:</td>
</tr>
<tr>
<td>- Genotype 1</td>
</tr>
<tr>
<td>- Taking in combination with BOTH peginterferon alfa AND ribavirin</td>
</tr>
<tr>
<td>- Has completed (or will have completed at time of initiation of therapy) 4 weeks of ribavirin PLUS peginterferon alfa</td>
</tr>
<tr>
<td>- Patients meeting above criteria will be approved for 8 weeks of Victrelis&lt;sup&gt;®&lt;/sup&gt; (through treatment week 12), except for patients with compensated cirrhosis and patients documented to be historical “null responders” who will be approved for 40 weeks of Victrelis (through treatment week 44)</td>
</tr>
<tr>
<td>- After treatment week 12, patients with a HCV-RNA level of &lt; 100 will be approved for additional therapy as outlined below:</td>
</tr>
<tr>
<td>- Treatment naïve patients with undetectable HCV-RNA level at treatment week 8: approved for additional 16 weeks of Victrelis&lt;sup&gt;®&lt;/sup&gt; (through treatment week 28)</td>
</tr>
<tr>
<td>- Treatment naïve patients with detectable HCV-RNA level at treatment week 8: approved for additional 24 weeks of Victrelis&lt;sup&gt;®&lt;/sup&gt; (through treatment week 36)</td>
</tr>
<tr>
<td>- Treatment failure patients (previous partial responder or relapser): approved for additional 24 weeks of Victrelis&lt;sup&gt;®&lt;/sup&gt; (through treatment week 36)</td>
</tr>
</tbody>
</table>

**Discussion:**
- Dr. Pittman stated the same concern would apply here just like telaprevir with the initial approval duration. Dr. Pittman pointed out if we allow an additional 2-week grace period for the initial duration approval as given with telaprevir, as well as a decrease for the subsequent approval duration by 2 weeks, then boceprevir’s criteria would be in line with the approval criteria guidelines for telaprevir.
- Dr. Blevins motioned to approve the criteria with the 2 week modification in approval duration.
- Motion seconded and carried.

<table>
<thead>
<tr>
<th>Quantity Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Incivek&lt;sup&gt;®&lt;/sup&gt;</strong></td>
</tr>
<tr>
<td><strong>Victrelis&lt;sup&gt;®&lt;/sup&gt;</strong></td>
</tr>
</tbody>
</table>

**Discussion:**
- Dr. Corley stated that as long as the quantity limit is based on a rolling 28 days, it should not pose a problem with set approval durations.
- Dr. Capparelli motioned to accept quantity limits as presented.
- Motion seconded and carried.

**Cardiovascular Agents**
- Dr. Corley asked the committee, if no one objects to go straight to the recommendation and to omit the clinical background information for the remaining cardiovascular agents, as these categories have previously received a full class review.
Committee agreed to review only the recommendation for the cardiovascular classes.

- Dr. Phares asked if the committee could move to the antiarrhythmics, to allow Dr. George Crossley, Director of Electrophysiology at St. Thomas Heart and President of the American College of Cardiology for Tennessee, as well as a nationally recognized atrial fibrillation expert, to speak on antiarrhythmics agents.
  - Dr. Crossley presented the committee with his conflict of interest statement. He disclosed that he had been involved in the Sanofi-Aventis RELY and ATHENA trials over 5 years ago and had served on a couple of speaker’s panels. He confirmed that he was not receiving any money to speak today.

- Dr. Crossley gave a brief overview of the role of currently available antiarrhythmics in the treatment of atrial fibrillation.
  - A physician statement provided by both the Heart Rhythm Society and American College of Cardiology 2011 provided drug recommendations based on the origin of A-fib (atrial fibrillation).
    - A-fib with normal heart: flecainide and propafenone work very well. These agents should be used as first-line therapy.
    - A-fib with left ventricular HF, cardiovascular disease, etc.: This category is a little more difficult as there are limitations that prevent the use in specific conditions, and the efficacy of these agents typically does not go above a 60-70% efficacy rate. However, the logical approach to selecting an agent includes the following:
      - Amiodarone has been used for years in this category where there are other heart issues involved. However, the use of this agent is limited by the toxicity of the drug. Additionally, this agent is not labeled for A-fib.
      - Other drug choices include sotalol, dofetilide and dronedarone.
    - Sotalol use is limited by its non-cardioselective beta-blocker properties. Many patients do not tolerate greater than 40-80mg of the drug. Additionally, studies show that doses greater than 120mg are limited in effectiveness.
    - Dofetilide is a pure class III antiarrhythmic. This drug is a potent QT prolonging drug and moderately effective. Many pharmacies do not supply this agent due to the cost and it has a limited distribution to physician providers. Physicians must receive additional training and are placed on an approved list prior to dispensing. The major concerns associated with this agent are the black box warning regarding hospitalizations of 72 hours during initiation of the drug and enormous QT prolongation risks. Patients on concomitant drug therapy must be treated as if they have QT prolongation syndrome.
    - Dronedarone is viewed structurally as amiodarone absent the iodine. It does not work as well as amiodarone, but compared to other drugs has good efficacy in suppressing a-fib. and preventing hospitalizations. Additionally, patients may be started on therapy as an outpatient. Major side effects include gastrointestinal
(limiting in 3-4% of patients). Dr. Crossley felt this was a safer drug compared to dofetilide and the role of this drug may be as a step before moving to amiodarone due to a better safety/toxicity profile.

- During Dr. Crossley’s term as chairman of the Pharmacy & Therapeutics Committee at Baptist Hospital, a cost projection study was conducted that evaluated the cost of therapy for amiodarone versus dronedarone over the duration of 1 year. This cost projection study was not a randomized controlled study, but primarily evaluated the cost of amiodarone, including costs of monitoring, labs, etc. This study showed very similar costs to the retail cost of dronedarone.

- Dr. Phares asked if there would ever be a situation where a patient would fail amiodarone and move to dronedarone.
  - Dr. Crossley stated the only instance he would see this scenario was if a patient failed amiodarone due to toxicity. However, he stated that in no scenario would he move a patient that clinically failed amiodarone over to dronedarone, as these two agents are electrophysiological very similar with dronedarone having weaker effects.

- Dr. Johns asked Dr. Crossley to speak to the safety concerns of dronedarone found during the PALLAS (Permanent Atrial fibrillation outcome Study using Dronedarone on top of standard therapy) trial. The PALLAS trial was a multinational, randomized, double-blind, parallel-group, placebo-controlled, multicenter Phase IIIb trial comparing the efficacy of Multaq® 400mg twice-daily with placebo in more than 10,000 patients with permanent atrial fibrillation.
  - An analysis of the ATHENA trial found, in patients who progressed to “permanent” AF and stayed in AF throughout the course of the study, a consistent trend towards a decrease in cardiovascular hospitalization or death for patients who received dronedarone. The PALLAS looked at a group that behaved similarly to assess the impact of dronedarone on major cardiovascular events or cardiovascular hospitalization or death from any cause, among patients with permanent atrial fibrillation.
  - The study found an excess mortality in patients treated with dronedarone. However, there was also an increase in strokes in these patients. So a full review of the PALLAS study will have to review the information on which patients were anticoagulated to get a full understanding of the results received thus far from the trial.
  - Definitely dronedarone should not be used in patients with unstable heart failure.

- Dr. Woods asked Dr. Crossley thoughts on the current criteria proposed and if any other criteria should be placed.
  - Dr. Crossley agreed with the current criteria, but suggested adding restrictions for patients who fall in the class 3B category, a subcategory of Class III patients.

- Dr. Johns asked for clarification on the use of extended release propafenone.
  - Dr. Crossley stated that at this time the extended release propafenone is very expensive. However, clinical trials show that the product is better, but this is primarily due to improved compliance with the longer acting
agent. In practice there is solid data that indicates in patients greater than 70 years of age, the metabolism of short-acting propafenone, following hepatic metabolism extends to the point that twice a day dosing works well in older patients.

- Dr. Crossley discussed the role of metoprolol succinate versus metoprolol tartrate. When beta-blockers are used primarily for rate control in a-fib, patients who are on short-acting metoprolol tartrate typically show 2 short peaks and 2 short troughs throughout the day. With the use of metoprolol succinate, the patient will typically show 1 big peak and 1 big trough per day. In patients with arrhythmias, the use of metoprolol succinate is worth the cost to maintain a steady drug level versus metoprolol tartrate.

**Antiarrhythmics**

- The antiarrhythmics class contains a wide variety of agents with differing indications, mechanisms of actions and adverse event profiles. Given these differences, these agents cannot be deemed therapeutic alternatives. Even within the sub-classes of anti-arrhythmics, there are distinct differences in effect and adverse event profiles. For this reason, it is recommended that the various unique chemical entities included in the anti-arrhythmic class all be made available. However, given the increased risk of mortality with dronedarone in specified populations, it is recommended dronedarone should be subject to clinical criteria.

**Discussion:**
- Dr. Capparelli motioned to accept the recommendation presented.
- Motion seconded and carried.

<table>
<thead>
<tr>
<th>Clinical Criteria for Multaq®</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multaq will be approved for patients meeting ALL of the following criteria:</td>
</tr>
<tr>
<td>- Not on concurrent Class I or III anti-arrhythmic agent</td>
</tr>
<tr>
<td>- Not hospitalized for exacerbation of heart failure in past 30 days</td>
</tr>
<tr>
<td>- Patient does not have NYHA class IV heart failure</td>
</tr>
<tr>
<td>- Trial and failure, contraindication, intolerance or drug-drug interaction to at least TWO of the following preferred antiarrhythmic agents:</td>
</tr>
<tr>
<td>- amiodarone</td>
</tr>
<tr>
<td>- flecainide</td>
</tr>
<tr>
<td>- propafenone</td>
</tr>
<tr>
<td>- sotalol</td>
</tr>
</tbody>
</table>

**Discussion:**
- Dr. Phares stated he was not sure how to amend the criteria as there are instances you would not go to a different drug if a patient failed on another. Dr. Phares recommended adding the restriction of class IIIB patients to bullet point 3 of the criteria. Dr. Phares also indicated that amiodarone is not FDA approved for atrial-fibrillation and used primarily off label.
  - Dr. Johns asked if the last bullet point was necessary. Dr. Phares suggested if the bullet point remained, perhaps it could be changed to read failure of 1 preferred agent.
  - Dr. Phares stated that patients with structural heart disease are unable to use Class I anti-arrhythmic agents, and this is where the problem arises, which prevents use of propafenone and flecainide. Dr. Pittman stated that scenario would count as a contraindication to two preferred agents and would be approved.
Dr. Pittman stated the structural heart disease could be listed as a contraindication to class I antiarrhythmics in the internal criteria.

Committee suggested the criteria read trial/failure of these agents will be waived if patient has structural heart disease.

- Dr. Phares motioned that the criteria is accepted with the modification that class IIIB patients are added to bullet point 3 and the bullet point 4 be modified to state trial/failure is waived for patients with structural heart disease.
- Motion seconded and carried.

**Beta Blockers**

- The beta-blockers differ in their effects on adrenergic receptors, sympathomimetic activities and lipophilicity, thus resulting in differences in pharmacologic and pharmacokinetic properties. Cardioselective beta-blockers primarily exert their effects on beta-1 receptors located in the heart and kidney. Cardioselective beta blocker agents may be safer for use in patients with certain concomitant conditions due to less inhibition of beta-2 receptors, resulting in less vasoconstriction and bronchospasm, while non-cardioselective beta blockers inhibit beta-2 receptor sites, located in smooth muscle of the lungs, blood vessels, and other organs. Non-cardioselective agents differ in their FDA-approved indications and in the presence or absence of intrinsic sympathomimetic activity (ISA). In the treatment of unstable angina and Non-ST-segment elevation myocardial infarction, the American College of Cardiology and American Heart Association prefer beta-blockers without ISA to manage patients. Additionally, The American College of Cardiology and the American Heart Association specifically recommend metoprolol succinate, bisoprolol, or carvedilol for the management of CHF. It is recommended that at least 5 beta-blockers be available for use with both cardioselective and non-cardioselective agents available. In addition, due to its unique indication for heart failure and recommendation by the current guidelines for the treatment of CHF, metoprolol succinate should be available for patients with heart failure.

Discussion:

- Dr. Johns recommended that the recommendation allow for patients with prolonged QT intervals to have available nadolol, as this agent is preferred in this group of patients. Dr. Phares also recommended adding a sentence to allow metoprolol succinate for patients with paroxysmal atrial fibrillation due to its use for heart rate control, in addition to allowing its use in heart failure patients.

- Dr. Phares motioned to accept the recommendation with the modifications to include use of nadolol for patients with prolonged QT interval and metoprolol succinate for patients with paroxysmal atrial fibrillation due to its use for heart rate control.

- Motion seconded and carried.

<table>
<thead>
<tr>
<th>Clinical Criteria for metoprolol succinate (Toprol XL®)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metoprolol succinate ER will be approved for recipients with a diagnosis of heart failure or LVEF ≤ 40%.</td>
</tr>
</tbody>
</table>

Discussion:

- Dr. Phares made a motion to approve the clinical criteria with the modification that metoprolol succinate will also be available for patients with a diagnosis of paroxysmal atrial fibrillation.

- Motion seconded and carried.
### Clinical Criteria for propranolol solution

- No PA required for 6 years old & younger.
- For recipients above age 6, approval will be granted if documented difficulty swallowing

**Discussion:**
- Dr. Johns approved clinical criteria as presented.
- Motion seconded and carried

### Quantity Limits

<table>
<thead>
<tr>
<th>Product</th>
<th>Limit(s)</th>
</tr>
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<tbody>
<tr>
<td>InnoPran XL®</td>
<td>80mg (2/day)</td>
</tr>
<tr>
<td></td>
<td>120mg (1/day)</td>
</tr>
<tr>
<td>Levatol®</td>
<td>2/day</td>
</tr>
<tr>
<td>Metoprolol succinate ER</td>
<td>1/day</td>
</tr>
<tr>
<td>Toprol XL®</td>
<td>1/day</td>
</tr>
</tbody>
</table>

**Discussion:**
- Dr. Phares motioned to accept the quantity limits as presented.
- Motion seconded and carried.

### Beta Blockers & Diuretic

- All of the beta-blocker combination products are approved for the treatment of hypertension and contain a beta-blocker and a thiazide diuretic. The available beta-blockers differ in their receptor selectivity (non-selective β-blockers and cardioselective β-blockers) and the presence or absence of intrinsic sympathomimetic activity (ISA). Clinical data indicates thiazide diuretics can be considered therapeutic alternatives to one another with regards to safety and efficacy. There are currently no head-to-head trials comparing the combination beta-blocker/diuretic products with the individual components given concurrently. However, the JNC-7 guidelines state that most patients with stage 2 hypertension will require initial therapy with medications from two drug classes. Additionally, if a single drug in adequate doses fails to achieve the blood pressure goal, then a second agent from a different class should be added to the treatment regimen, one of which should be a thiazide diuretic. Furthermore, initial treatment with two antihypertensive agents should be considered for patients with a baseline blood pressure of more than 20/10 mm Hg above goal. Treatment guidelines do not specifically address fixed dose combination products, but these combination products may simplify drug regimens and increase compliance. Therefore it is recommended that that at least one cardioselective beta-blocker/diuretic combination product and at least one non-selective beta-blocker/diuretic combination be available.

**Discussion:**
- Dr. Phares motioned to accept the recommendation as presented.
- Dr. Capparelli asked if there was a need to have nadolol available in a combination product as mentioned in the sole beta blocker category. Dr. Phares stated that from an adult standpoint, the combination product may cause more electrolyte disturbances and increase the risk of arrhythmias. Dr. Johns concurred.
- Motion seconded and carried.
**Alpha/Beta Blockers**

- Carvedilol and labetalol are the two nonselective $\alpha/\beta$-blockers available within the larger $\beta$-blocker class. The additional $\alpha 1$-adrenergic blocking activity of carvedilol and labetalol blunts the pressor effect of phenylephrine, causes vasodilation and reduces peripheral vascular resistance. The available alpha/beta-blockers exhibit similar efficacy and safety and thus can be considered therapeutic alternatives to one another for the treatment of hypertension. Both agents in this class are indicated for the treatment of hypertension; however, carvedilol has additional indications for treatment of heart failure and for use in patients with left ventricular dysfunction following a myocardial infarction. Additionally, guidelines from the American College of Cardiology/American Heart Association for the treatment of heart failure specifically recommend carvedilol due to its proven effect to reduce mortality in patients with heart failure. Therefore, it is recommended that at least carvedilol be available for use.

**Discussion**

- Dr. Johns asked if the phenylephrine should be changed to read norepinephrine. Dr. Pittman agreed this was a typo.
- Dr. Capparelli motioned to accept the recommendation with the modification of phenylephrine being changed to read norepinephrine.
- Motion seconded and carried.

<table>
<thead>
<tr>
<th>Quantity Limits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Carvedilol</td>
<td>2/day</td>
</tr>
<tr>
<td>Coreg®</td>
<td>2/day</td>
</tr>
<tr>
<td>Coreg CR®</td>
<td>1/day</td>
</tr>
</tbody>
</table>

**Discussion:**

- Dr. Capparelli motioned to approve the quantity limits.
- Motion seconded and carried.

**ACE Inhibitors**

- The ACE Inhibitors are FDA approved for the treatment of hypertension, and most agents are also approved for the treatment of heart failure. Additionally, ramipril and perindopril are FDA-approved to reduce the risk of cardiovascular morbidity and mortality. Evidence-based guidelines recognize the important role ACE inhibitors play in the treatment of hypertension and other cardiovascular and renal diseases. ACE inhibitors are recommended as a first-line option for patients with hypertension complicated by comorbidities, such as cerebrovascular disease, chronic kidney disease, diabetes, heart failure, and myocardial infarction. ACE inhibitors are also recommended as first-line agents for patients with acute myocardial infarction, diabetic nephropathy, heart failure, and left ventricular dysfunction unless otherwise contraindicated. The current treatment guidelines do not establish a preference for one ACE inhibitor over another. Therefore, it is recommended at least 4 ACE inhibitors should be available for use. Given the additional FDA-approved indications as well as evidence showing decreased mortality with ramipril and perindopril in patients post-myocardial infarctions, either ramipril or perindopril should be available for use in patients determined to be at high-risk for cardiovascular complications.
Discussion:
- Dr. Capparelli stated that in previous discussions, PAC had unanimously voted to have ramipril available. It would seem appropriate, based on similar pricing of the agent compared to the other agents, to state ramipril must be available in the recommendation and to allow removal of the clinical criteria currently in place as data supports the use of this agent in various FDA approved indications. Dr. Phares stated he primarily uses lisinopril and ramipril. Lisinopril has been the most studied ACE-inhibitor agent; while ramipril has a lot of data to support its use. He agreed if there was not a huge cost difference that it should be available for use with no restrictions or criteria.
- Dr. Pittman stated the perindopril was added due to a retrospective analysis that showed decreased mortality for both ramipril and perindopril, with no significant difference between the two agents. The committee agreed that the perindopril is not a widely used agent.
- Dr. Capparelli motioned to approve the recommendation with the modification that perindopril is removed from the recommendation and it reads “Given the additional FDA approved indications, as well as evidence showing decreased mortality with ramipril in patients post-myocardial infarctions, ramipril should be available for use.”
- Motion seconded and carried.

### Clinical Criteria for ramipril (Altace®):

<table>
<thead>
<tr>
<th>Will be authorized, without trial and failure, contraindication or intolerance to preferred agents, only if a history of any of the following are present:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coronary Artery Disease (CAD) / Post MI</td>
</tr>
<tr>
<td>• History of Stroke</td>
</tr>
<tr>
<td>• Peripheral Vascular Disease</td>
</tr>
<tr>
<td>• Diabetes</td>
</tr>
<tr>
<td>• Chronic renal disease (CrCl defined as &lt; 40ml/min)</td>
</tr>
</tbody>
</table>

Discussion:
- Motion made to disapprove recommendation, and have no clinical criteria on ramipril.
- Motion seconded and carried.

### Clinical Criteria for perindopril (Aceon®):

<table>
<thead>
<tr>
<th>Will be authorized, without trial and failure, contraindication or intolerance to preferred agents, only if a history of any of the following are present:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Coronary Artery Disease (CAD) / Post MI</td>
</tr>
<tr>
<td>• History of Stroke</td>
</tr>
<tr>
<td>• Peripheral Vascular Disease</td>
</tr>
<tr>
<td>• Diabetes</td>
</tr>
<tr>
<td>• Chronic renal disease (CrCl defined as &lt; 40ml/min), PLUS</td>
</tr>
</tbody>
</table>

| Trial and failure, contraindication or intolerance to ramipril |

Discussion:
- Motion made to disapprove recommendation and have no specific clinical criteria on perindopril.
- Motion seconded and carried.
Quantity Limits

<table>
<thead>
<tr>
<th>Drug</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>perindopril (Aceon®)</td>
<td>1/day</td>
</tr>
<tr>
<td>moexipril (Univasc®)</td>
<td>7.5 mg: 1/day, 15 mg: 2/day</td>
</tr>
<tr>
<td>ramipril (Altace®)</td>
<td>1.25 mg, 2.5 mg: 1/day, 10 mg: 2/day</td>
</tr>
<tr>
<td>trandolapril (Mavik®)</td>
<td>1/day</td>
</tr>
</tbody>
</table>

Discussion:
- Motion made to accept quantity limits
- Motion seconded and carried.

ACE Inhibitor & Diuretic Combos

All of the ACE inhibitor-diuretic combination products are approved for the treatment of hypertension; however, only captopril/hydrochlorothiazide is approved for use as an initial agent. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure states that most patients with stage 2 hypertension will require initial therapy with medications from two drug classes and recommends that thiazide diuretics should be used in most patients with uncomplicated hypertension as monotherapy or combination therapy. ACE inhibitors are recommended as a first-line option for patients with hypertension complicated by comorbidities, such as cerebrovascular disease, chronic kidney disease, diabetes, heart failure, and myocardial infarction. ACE inhibitor-diuretic combination products are intended to maximize the antihypertensive effect of each individual agent and minimize the potential for dose-related adverse effects. While several retrospective analyses have reported improved compliance with the fixed-dose combination products, there is insufficient evidence to conclude that combination products are significantly more effective than administration of the separate components. Therefore, it is recommended at least three ACE Inhibitor-diuretic combinations, or their individual components, should be available.

Discussion:
- Dr. Phares motioned to accept the recommendation as presented.
- Motion seconded and carried.

ACE Inhibitors & CCB Combos

All of the ACE inhibitor-CCB combination products are approved for the treatment of hypertension. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure states that most patients with stage 2 hypertension will require initial therapy with medications from two drug classes. ACE inhibitors are recommended as a first-line option for patients with hypertension complicated by comorbidities, such as cerebrovascular disease, chronic kidney disease, diabetes, heart failure, and myocardial infarction. ACE inhibitor-CCB combination products are intended to maximize the antihypertensive effect of each individual agent and minimize the potential for dose-related adverse effects. While there are no head-to-head trials comparing the ACE inhibitor-CCB combination products, available data from clinical trials for the individual products suggest that they provide similar blood pressure reduction and thus can be
considered therapeutic alternatives to one another. While several retrospective analyses have reported improved compliance with the fixed-dose combination products, there is insufficient evidence to conclude that combination products are significantly more effective than administration of the separate components. Therefore, it is recommended at least one ACE inhibitor-CCB combination, or its individual components, should be available.

Discussion:
- Motion made to accept the recommendation as presented
- Motion seconded and carried.

<table>
<thead>
<tr>
<th>Clinical Criteria for ACEI +CCB combos</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Will be authorized in patients who are unable to take the two components separately</td>
</tr>
</tbody>
</table>

Discussion:
- Motion made to accept the criteria as presented
- Motion seconded and carried.

<table>
<thead>
<tr>
<th>Quantity Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>benazepril/amiodipine (Lotrel®)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>trandolapril/verapamil (Tarka®)</td>
</tr>
</tbody>
</table>

Discussion:
- Motion made to accept quantity limits as presented
- Motion seconded and carried.

**Pulmonary Arterial Hypertension Agents**

- Pulmonary arterial hypertension (PAH) is a life-threatening disorder with a poor prognosis. The goals of treatment include improvement in the patient's symptoms, quality of life, and survival. There are no head to head trials comparing the available treatments; however, clinical trials have demonstrated the safety and efficacy of sildenafil, tadalafil, bosentan, iloprost, ambrisentan, and treprostinil for the treatment of PAH. The ACCP (The American College of Chest Physicians) guidelines for PAH support sildenafil as first line therapy for WHO Functional Class II patients, whereas sildenafil, bosentan, iloprost, ambrisentan, and treprostinil are recommended for WHO Functional class III patients, and prostacyclin agents are reserved for critically ill class III and IV patients. Given the impact of functional status on recommended treatments, as well as the different mechanisms of action and side effect profiles of available therapies, and the need for combination therapy in select patients, it is recommended that at least one phosphodiesterase-5 enzyme (PDE-5) inhibitor agent, one endothelin receptor antagonist (ERA), and 1 prostanoid agent be available for use for patients with a diagnosis of Pulmonary Arterial Hypertension. However, due to concerns regarding off-label use or misuse of agents within this class, as well as the potential for serious adverse events, it is recommended that agents within this class be subject to clinical criteria in order to ensure use for PAH.
Discussion

- Dr. Phares voiced to the committee that due to a conflict of interest, he would excuse himself from the vote. However, he did want to address with the committee his concerns regarding the dosing of iloprost. Dr. Phares stated the packaging states that iloprost has to be dosed 9 times/day. This is an inhaled medication that requires a separate device to be purchased in order to take the medicine. This device is classified as a durable medical equipment purchase that is billed on the medical side. The dosing is basically every 2 hours; the patient must hold the breathing device at a 90 degree angle to properly receive the correct dose. After each dose the patient is required to clean the machine versus the alternative prostaglandin medication, treprostinil, which is dosed 4 times/day. The breathing device is included with the drug for treprostinil and does not have to be cleaned after each dose. Dr. Phares stated that reviewing the cost utilization it is very clear that patients are not being compliant with the medications based on the recommended packaging dosing. Dr. Phares stated he did not feel based on the significantly different dosing of the agents that iloprost should be listed as preferred, and treprostinil listed as non-preferred. Dr. Phares recommended that based on the dosing recommendations and previous factors listed, treprostinil should be listed as preferred and iloprost should be moved to non-preferred status. Dr. Phares stated that based on the 6 minute walking distance (6MWD) test, treprostinil was shown to be superior.

- Dr. Capparelli noted that the black box warning had been removed from ambrisentan. Dr. Capparelli stated that from a safety perspective, it would appear that ambrisentan is the safer product compared to bosentan.
  - Dr. Woods stated at the time this class was previously brought to PAC, it was felt that most of the providers were comfortable using bosentan and to the recommendation was to leave it preferred. Dr. Woods asked the committee if the use of the drug had shifted since that time.
  - Dr. Phares stated the PDE-5 agents are pretty much first line, with prostacyclin agents being second line. He stated he was not really sure where the ERAs fit in, but thought they were viewed as 3rd line agents. Dr. Lovett noted that most of the FDA approvals were based on the specific study groups that participated in the clinical trials. Dr. Capparelli stated that this disease has a bad prognosis and it would seem appropriate to have at least one agent from the 3 classes available that seemed to have a better profile. Dr. Phares stated that only a small subset of providers will prescribe these medications.
  - Dr. Capparelli wasn’t sure if financial reasons played any role in the drug selection, however suggested adding a sentence to the recommendation that allows use of treprostinil and ambrisentan.

- Dr. Capparelli motioned to accept the recommendation with the addition of the following: “Based on the clinical literature, treprostinil has been shown to be superior due to ease of administration and frequency of dosing. Additionally, ambrisentan is associated with less risk of liver toxicity compared to bosentan. Therefore if financially feasible it is recommended that treprostinil and ambrisentan be available for use.”
- Motion seconded and carried. Dr. Phares abstained from the vote.
Clinical Criteria for Pulmonary Arterial Hypertension Agents

This class will be approved only for the treatment of Pulmonary Arterial Hypertension (PAH)/Primary Pulmonary Hypertension (PPH).

Discussion:

- Dr. Johns recommended adding “Elevated Pulmonary Vascular Resistance” to the acceptable diagnoses, as the pediatric/young adult population, may not necessarily have a diagnosis of PAH, but have elevated vascular resistance that requires use of the medications.
- Motion seconded and carried. Dr. Phares abstained from the vote.

<table>
<thead>
<tr>
<th>Quantity Limits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Letairis® (ambrisentan)</td>
<td>1 tablet/day</td>
</tr>
<tr>
<td>Tracleer® (bosentan)</td>
<td>2 tablets/day</td>
</tr>
<tr>
<td>Ventavis® (iloprost)</td>
<td>3 ampules/day</td>
</tr>
<tr>
<td>Revatio® (sildenafil)</td>
<td>3 tablets/day</td>
</tr>
<tr>
<td>Adcirca® (tadalafil)</td>
<td>2 tablets/day</td>
</tr>
<tr>
<td>Tyvaso® (treprostinil)</td>
<td>1 ampule/day</td>
</tr>
</tbody>
</table>

Discussion:

- Dr. Johns asked that the dosing for sildenafil be double checked and Dr. Phares voiced concern on the listed quantity limit for iloprost. Dr. Phares stated the quantity limit should read 4 ampules/day. Dr. Lovett stated she would double check the quantity limits to ensure they are appropriate. The listed quantity limit for sildenafil was verified as an appropriate quantity limit.
- Dr. Capparelli motioned to accept the quantity limits with a request to check the listed quantity limit on iloprost based on the recommended dosing.
- Motioned seconded and carried. Dr. Phares abstained from the vote.

REVIEW OF MAY PAC MEETING DECISIONS

SXC reviewed TennCare’s decisions from the May 3, 2011 meeting. In the interest of time, decisions were presented only for those classes in which TennCare did not accept the Committee’s recommendations. There were no classes where TennCare did not accept PAC’s recommendations; however, one change was made for clarification on page 12 regarding the Xyrem® clinical criteria. The criteria wording was changed slightly to clarify that only one approvable diagnosis was needed.
SPEAKERS FOR PUBLIC TESTIMONY

<table>
<thead>
<tr>
<th>Name</th>
<th>Company</th>
<th>Product(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ron Rideman, Pharm.D.</td>
<td>United Therapeutics</td>
<td>Adcirca®</td>
</tr>
<tr>
<td>Tracy Smith, Pharm.D.</td>
<td>Actelion Pharmaceuticals</td>
<td>Tracleer®, Ventavis®</td>
</tr>
<tr>
<td>Ray Lancaster</td>
<td>Gilead</td>
<td>Letairis®</td>
</tr>
<tr>
<td>Lurtysia Britton</td>
<td>Nashville Pulmonary Hypertension Support Group</td>
<td>Letairis®</td>
</tr>
<tr>
<td>Pauline Patrick</td>
<td>Forest Pharmaceuticals</td>
<td>Daliresp®, Bistolic®</td>
</tr>
<tr>
<td>Sheila Alizadeh</td>
<td>Next Wave Pharmaceuticals</td>
<td>NexiClon®</td>
</tr>
</tbody>
</table>

- Representative for United Therapeutics thanked the committee for the time and decisions and yielded time for public testimony.
- Representative from Actelion Pharmaceuticals providing brief information regarding Tracleer® and Ventavis®. Clarification on the recommended dosing for Ventavis® was also provided.
- Representative from Gilead thanked the committee and yielded time for public testimony.
- Representative for Nashville Pulmonary Hypertension Support Group gave public testimony regarding use Letairis® and thanked the committee for their decisions.
- Representative for Forest Pharmaceuticals yielded time for public testimony.
- Representative for NextWave Pharmaceuticals gave public testimony regarding NexiClon®, an extended release formulation for clonidine.

An announcement was made that the next PAC meeting will be Tuesday, November 8, 2011 at the Franklin Cool Springs Marriott.
- Dr. Corley recognized Dr. Terry Shea for his years of service on the committee and wished him well on behalf of the committee.

Meeting Adjourned.