

**Preferred Drug List Committee Meeting
Meeting Minutes, Open Session
December 16, 2009**

<p>Preferred Drug List Committee Meeting Minutes, Open Session HP Enterprise Services Capital / Cedar Crest Room Topeka, KS</p>	<p>Members Present: Michael Burke, M.D, Ph.D., Chair Robert Haneke, Pharm.D. Glenn Harte, Pharm.D. Donna Sweet, M.D. Dennis D. Tietze, M.D. KHPA Staff Present: LeAnn Bell, Pharm.D. Aimee Grubb, Recorder Shelly Liby Margaret Smith, M.D. EDS Staff Present: Karen Kluczykowski, R.Ph. Lisa Todd, R.Ph.</p>	<p>Representatives: Mike LaFond - Abbott Jerry Clewell - Abbott Teresa Blair - Amgen Carol Curtis - AstraZeneca Mark Flynn - AstraZeneca John Stoner - AstraZeneca Neal Beasley - BMS Amanda Berge - BMS Bryon Goeckner - BMS Jim Graves - BMS John Kroeten - Boehringer-Ingelheim Susan Wood - Boehringer-Ingelheim Liz Peterson - CMFHP Jennifer Murff - CMFHP Richard Mesquias - Eli Lilly Patti Minear - Eli Lilly Don Larsen - Forest Lee Ding - Genetech Patty Laster - Genetech Ann Gustafson - GSK Dave Walters - J & J Barbara Belcher - Merck Matt Stafford - Merck Felecia Williams - Merck Lon Lowry - Novartis Todd Paulsen - Novo Nordisk Mary Shefchyk - Novo Nordisk Jim Baumann - Pfizer Phil King - Pfizer Jason Enders - Sanofi-Aventis Bruce Steinberg - Sanofi-Aventis Jim Tully - Sanofi-Aventis Tracey Gasperi - UCB Sarah Kennedy - UCB</p>
<p>TOPIC</p>	<p>DISCUSSION</p>	<p>DECISION AND/OR ACTION</p>
<p>I. Welcome and Announcements</p>	<p>Dr. Burke called the meeting of the Preferred Drug List (PDL) Advisory Committee to order at 10:02 am with five members present. Dr. Bell asked the public to fill out a conflict of interest form if they were going to</p>	

	<p>speak. She said each drug has a five minute time limit.</p>	
<p>II. Review and Approval of June 3, 2009 Minutes</p>	<p>No changes to the minutes.</p>	<p>Dr. Sweet moved to approve the minutes.</p> <p>Dr. Haneke seconded the motion and it carried with a unanimous vote.</p>
<p>III. Update on Budget and DERP</p>	<p>Dr. Bell said because of the budget reductions KHPA had to discontinue the contract with Oregon Health Sciences University who provides us with the DERP reports. We will continue to have access to the reports that have been produced over the last six years, but we will have no access to any future reports.</p>	
<p>IV. Long-Acting Insulins a. Public Comment b. Committee Discussion</p>	<p>Long acting insulins have not previously been evaluated by the PDL committee. There are two agents; insulin glargine (Lantus[®]) and insulin detemir (Levemir[®]).</p> <p>Jason Enders, Sanofi-Aventis, said data indicate differences in glargine and detemir in various clinical settings. Evidence shows that insulin requirements are consistently lower with glargine; this should be considered when selecting a basal insulin product.</p> <p>Todd Paulsen, Novo Nordisk, said Levemir[®] is a long-acting basal insulin analog. It is soluble. There is less day-to-day variability. Studies have shown less weight gain. There is less IGF-1 binding than human insulin. Hypoglycemia is lower. It has a 42 day shelf life so there is less potential wastage.</p> <p>Dr. Haneke asked about concerns raised recently regarding cardiovascular and neoplastic problems associated with detemir. Dr. Paulsen said Novo Nordisk did a complete analysis of all clinical trials, looking at NPH and glargine. When looking at detemir vs. NPH, there was a greater risk of cancer with NPH than with detemir.</p> <p>Dr. Burke said the issue is glycemic control and the effectiveness and safety of the agents.</p> <p>Dr. Sweet said Levemir[®] is usually prescribed BID whereas Lantus[®] is once daily. Dr. Harte agreed.</p> <p>Dr. Sweet said she sees no significant difference between the two agents.</p>	<p>Dr. Sweet moved that all long-acting insulins are equivalent.</p> <p>Dr. Haneke seconded the motion and it carried with a unanimous vote.</p>
<p>V. Targeted Immune Modulators (Biologics) a. Public Comment b. Committee Discussion</p>	<p>See the attached reference designating first line and second line monotherapies and combination therapies status. The biologics have not previously been reviewed for inclusion on the Kansas Medicaid PDL. They have been reviewed by The Oregon Health Science University Drug</p>	<p>Dr. Sweet moved that targeted immune modulators are equivalent within disease class (except adult RA) with the caveat that if only one agent is designated as</p>

	<p>Effectiveness Review Project (DERP) twice; once in 2005 and again in November 2009. There are 11 agents in the class; six have multiple indications, five have only one FDA labeled indication. All are on PA except for Tysabri[®], Rituxan[®], and Stelara[®]; these three agents will be reviewed by the DUR Board in January 2010. All indications except for ulcerative colitis have multiple agents approved for use in that disease state. KHPA is proposing the creation of drug classes based on approved indications. Placement of the biologics on the PDL would result in designation of a preferred agent only if the preferred agent has the appropriate indication (i.e. if the request is for Ankylosing spondylitis, Cimzia[®] would not be designated as a preferred agent because it is not indicated for that disease state).</p> <p>Enbrel[®] Theresa Blair, Amgen, said Enbrel[®] has five indications and is the only anti tumor necrosis factor (TNF) inhibitor indicated for pediatric patients down to age two. It has long term clinical and safety experience. It is available in a prefilled syringe and it is a fully human soluble protein.</p> <p>Humira[®] Jerry Clewell, Abbott, said Humira[®] is an anti TNF that is fully human monoclonal antibody. It has five indications and over 12 years of clinical trials experience. It is indicated for use with or without Methotrexate.</p> <p>Rituxan[®] Lee Ding, Genetech, said Rituxan[®] is indicated for use in combination with Methotrexate. The package insert was updated in October 2009 with more radiographic data and new treatment data.</p> <p>Cimzia[®] Sarah Kennedy, UCB, said Cimzia[®] is unique in that it is the first PEGylated fab fragment, not a full antibody. PEGylation may prolong circulation time and reduce dosing frequency. It offers flexible administration options. In Rheumatoid Arthritis (RA) it may be given as monotherapy or in combination with Methotrexate. It has stable dosing in RA and Crohn's Disease, very low injection site reactions, and rapid and sustained clinical improvements.</p> <p>Dr. Burke said the DERP report concludes that the data shows no difference in efficacy.</p>	<p>preferred for an indication, that it shouldn't be one with only a second-line indication.</p> <p>Dr. Harte seconded the motion. The motion passed with a 4 to 1 vote. Dr. Haneke voted against.</p> <p>Dr. Sweet moved that for adult RA, Enbrel[®], Humira[®], Kineret[®], Orencia[®], and Cimzia[®] are clinically equivalent with the caveat if only one agent is designated as preferred for an indication, that it shouldn't be one with only a second-line indication. Remicade[®], Simponi[®], and Rituxan[®] are not clinically equivalent to the other biologics approved for the treatment of adult RA because they require use in combination with methotrexate or DMARD therapy.</p> <p>Dr. Tietze seconded. The motion passed with a 4 to 1 vote. Dr. Haneke voted against.</p>
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	<p>Dr. Haneke said there are a number of different mechanisms of action. Dr. Sweet said those mechanisms of action lead to the same effect. She said there is no good data that says one is better than the other. Dr. Haneke compared this to oral contraceptives that didn't make it onto the PDL because of differences in mechanisms of action. He said there are variances in limitations or requirements with this class. The end result is the same but getting to that end result is different. Dr. Sweet said she's not concerned so much with the mechanism of action, but she is concerned with how they are administered. Dr. Burke said his recommendation is to stay focused on clinical outcome. In terms of superiority, just because a drug is monotherapy doesn't mean it is superior. Dr. Sweet said she would not feel comfortable having a preferred drug that has to be used in combination. Dr. Bell said if an agent that is recommended to be used in combination with methotrexate/DMARD therapy became preferred, and a first line/monotherapy agent was non-preferred, then the PA criteria would give the prescriber the option to choose a first line/monotherapy agent for the patient if the prescriber did not want the patient to use methotrexate/DMARD. Basically, that statement would be treated like a trial of a preferred agent.</p> <p>Dr. Sweet said she has trouble saying that all agents for adult RA are clinically equivalent when some of them don't work as well unless you put them with methotrexate. Dr. Burke said he would agree that if an agent has to be used in combination then it isn't the same as an agent that can be used as monotherapy. Second line agents can be used as monotherapy so they are equivalent with first line agents. Agents that must be used in combination with Methotrexate/DMARD therapy are different. Dr. Sweet asked what happens if a second line agent becomes the preferred drug and a first line is non-preferred. Dr. Burke said a caveat can be added to the motion saying that a second line agent cannot be an exclusive preferred drug.</p>	
<p>VI. DPP-4 Inhibitors (Gliptins)</p> <ul style="list-style-type: none"> a. Public Comment b. Committee Discussion 	<p>This class has not previously been reviewed. The class contains two agents; sitagliptin (Januvia[®]), approved in October 2006, and saxagliptin (Onglyza[®]), approved in July 2009. No head-to-head trials are available; however Bristol-Myers Squibb was required to do a non-inferiority study for Onglyza[®] to be approved in Europe.</p> <p>Felicia Williams, Merck, said Januvia[®] is indicated as adjunct to diet and exercise in patients with Type 2 diabetes. The benefits of Januvia[®] are efficacy, safety, weight neutrality, decreased risk of hypoglycemia, and the ability to use across a broad spectrum of patients.</p>	<p>Dr. Haneke moved that all DPP-4 inhibitors are clinically equivalent.</p> <p>Dr. Sweet seconded and it carried with a unanimous vote.</p>

	<p>Dr. Tietze asked how Januvia® compares to Onglyza®. Ms. Williams said there are no head-to-head studies, but Januvia® has been on the market since 2006 so there is significant safety and efficacy data.</p> <p>Amanda Berge, Bristol Myers Squibb, said Onglyza® is indicated as adjunct to diet and exercise to improve glycemic control in adults with Type 2 diabetes. Pancreatitis has not been reported in the Onglyza® label.</p> <p>No board discussion.</p>	
<p>VII. Angiotensin Receptor Blocker/Calcium Channel Blocker (ARB/CCB) Combos</p> <p>a. Public Comment</p> <p>b. Committee Discussion</p>	<p>Angiotensin II Receptor Blockers/Calcium Channel Blocker combination products have not previously been reviewed for inclusion on the PDL; however both ARBs and CCBs have been reviewed and determined to be equivalent. Both ARBs and CCBs were previously reviewed in 2002, 2004, and 2007. There are three ARB/CCB products available: valsartan/amlodipine (Exforge®), olmesartan/amlodipine (Azor®), and telmisartan/amlodipine (Twynsta®).</p> <p>Susan Wood, Boehringer-Ingelheim, said Twynsta® is indicated for the treatment of hypertension alone or with other anti-hypertension agents. It may be used as initial therapy in patients who are likely to need multiple drugs to achieve blood pressure goals. It is not recommended for initial therapy for patients 65 years or older or with hepatic impairment.</p> <p>Dr. Tietze asked if there is a comparison looking at the advantage of putting the two agents into one pill. Dr. Wood said she doesn't have that data.</p> <p>Dr. Burke said when the committee reviewed the ACE Inhibitor/Calcium Channel Blocker the position was that the combination formulations were clinically equivalent and not superior to co-prescribed individual components.</p>	<p>Dr. Sweet moved that all ARB/CCB combos are clinically equivalent and not superior to the individual agents.</p> <p>Dr. Tietze seconded and it carried with a unanimous vote.</p>
<p>VIII. HMG-CoA Reductase Inhibitors (Statins)</p> <p>a. Public Comment</p> <p>b. Committee Discussion</p>	<p>There is a new agent in this class, Livalo® (pitavastatin). It is not yet on the market in the U.S. but is expected to be released in early 2010. The statins were previously reviewed in 2002, 2004, and 2007; all agents were determined equivalent on review.</p> <p>John Stoner, representing Astra Zeneca, the manufacturer of Crestor®, presented information on the STELLAR and METEOR studies. He also presented information on the JUPITER Trial. No board discussion.</p>	<p>Dr. Haneke moved that atorvastatin, simvastatin, rosuvastatin, and pitavastatin are clinically equivalent. Pravastatin should be available when there is a documented drug interaction. Fluvastatin and lovastatin have lesser potency.</p> <p>Dr. Sweet seconded and it carried with a unanimous vote.</p>
<p>IX. Proton Pump Inhibitors</p>	<p>This class was last reviewed in June 2009 to evaluate a new agent in the</p>	<p>Dr. Sweet moved to continue class as is.</p>

<p>a. Public Comment b. Committee Discussion</p>	<p>class, dexlansoprazole (Kapidex[®]). All agents were determined to be equivalent. The class is now being presented for evaluation due to new evidence related to the class. Debate on safety of PPI use with clopidogrel has been ongoing for several months, and recently the FDA issued an alert regarding the combination of clopidogrel and omeprazole. Also recently released were preliminary results of a prospective trial (COGENT trial) comparing clopidogrel+placebo to clopidogrel+omeprazole. The trial was discontinued due to sponsor bankruptcy.</p> <p>No public comment.</p> <p>Dr. Sweet said the data isn't good enough to change anything now. Dr. Haneke said that this is a drug-drug interaction.</p>	<p>Dr. Haneke seconded and it carried with a unanimous vote.</p> <p>Dr. Burke said this should be referred to the DUR board.</p>
<p>X. Drugs for Insomnia a. Public Comment b. Committee Discussion</p>	<p>There is a new agent in the class, Edluar[®], which is a sublingual form of zolpidem. Newer drugs for insomnia were reviewed by the PDL Committee in June 2005 and February 2006. Eszopiclone (Lunesta[®]), zaleplon (Sonata[®]), and zolpidem (Ambien, Ambien CR) were reviewed in 2005 and determined to be equivalent. Ramelteon (Rozerem[®]) was evaluated in 2006 for possible equivalence with the other non-benzodiazepine sleep agents, however was determined, in a divided vote, to not be equivalent. DERP has reviewed this class three times: 2005, 2006, and 2008.</p> <p>Lon Lowry, Novartis, questioned this class being on the agenda. Dr. Bell said it is listed on the agenda that is posted online. He asked if it was updated after it was originally posted. Dr. Bell said yes there was a revision to it two days after the original posting. There was a question about the rules and when the agenda is to be posted. It was determined that the rule is seven days. Jim Baumann, Pfizer, said that since it was posted after that seven day period it shouldn't be discussed. Dr. Bell said it was posted 12 days prior to the meeting. Dr. Tietze voiced concern about tabling the discussion because the next meeting isn't June 2010.</p>	<p>Dr. Haneke moved to table until the next meeting.</p> <p>Dr. Sweet seconded. All but Dr. Tietze voted in favor. The motion passed with a 4 to 1 vote.</p> <p>Jim Baumann, Pfizer, requested that the drugs that are to be discussed be listed on the agenda.</p> <p>Dr. Sweet suggested a "this agenda is subject to change" message be added to the agenda when it is posted online, up to eight days prior to the meeting. Carol Curtis, Astra Zeneca, asked for that to be added to the rules of public forum.</p>
<p>XI. Adjourn</p>		<p>Dr. Sweet moved to adjourn the meeting.</p> <p>Dr. Schlotterback seconded and it carried with a unanimous vote.</p>