Kansas Medical Assistance Program

Preferred Drug List Committee Meeting Minutes		
Preferred Drug List Committee Meeting Minutes EDS White Lakes Mall 3600 SW Topeka Blvd. Topeka, Kansas 66611 March 27, 2007 10:00 A.M.-2:00 P.M.	Members Present: Michael Burke, M.D., Ph.D., Chair Matthew Schlotterback, M.D. Brenda Schewe, M.D. Donna Sweet, M.D. Dennis D. Tietze, M.D. Kristen Fink, Pharm.D. Glenn Harte, Pharm.D. Kenneth Mishler, Pharm.D. KHPA Mary Lesperance, R.Ph. Anne Ferguson, R.Ph. Margaret Smith, M.D.	Public: AstraZeneca: Cyndee Davies; John Stoner, Pharm.D.; Carlos DaJoune, M.D. Pfizer: Jim Baumann, Phil King Graceway Pharma: Dale Johnson; Perry Johnson Schering Plough: Martin Early; Krishna Patel; Rebecca Gall Daiichi Sankyo Inc: Isabelle R. Snow Merck: Marty Mazurek; Kevin Winn Sanofi-Aventis: Wanda Stipeck, Pharm.D. GSK: Ann Gustafson, Pharm.D.; James Osborne; Michael Windheuser, Ph.D.; John Pawlowski MedImunne, Inc: Sam Smotherson King Pharmaceuticals: Jerry Gomez; Edgar Gonzalez; Mike Manale Eli Lilly: Richard Mesquias Takeda Pharmaceuticals: Don Zowader; Leah Mancini Boehringer Ingelheim: Susan Wood
I. Call to Order	Dr. Michael Burke called the Meeting of the Preferred Drug List (PDL) Advisory Committee to order at 10:04 AM with eight members present.	
II. Announcements	Mary Lesperance welcomed everyone to the PDL Advisory Committee Meeting and thanked the PDL Committee members for their continued support. Mary Lesperance introduced the new PDL Committee member; Dr. Matthew Schlotterback, M.D. Dr. Schlotterback is a native Kansan and board certified in family practice. He currently practices in Lyons, Kansas with the Hutchinson Clinic. Mary Lesperance thanked the PDL Committee for their time and support. Mary welcomed the public to the meeting. Mary stated all of the classes being reviewed today are re-reviews with the exception of the inhaled beta-agonists, and asked the public to be respectful of the Committee's time by making presentations concise and meaningful. Mary stated that anyone wishing to speak during the public comment period would need to fill out and sign a Conflict of Interest	

	Disclosure form and return the form to the Chair of the Committee, or to a State representative. Mary stated that there is a five minute time limit per drug during public comment and that speakers should provide key points outlining scientifically based evidence of comparative data on drugs in the classes being reviewed. Mary also stated that non-preferred drugs can be obtained through KMAP's streamlined, reasonable PA process when medically necessary. Lastly, Mary announced that April 17, 2007, is the deadline for submission of supplemental rebate offers.	
III. Review minutes from August 23, 2006	There were a few changes to the draft minutes of the August 23, 2006 PDL meeting. These changes involved misspelling of names and incorrect numbering. These will be revised.	A motion to approve the minutes with the minor revisions discussed was made by Dr. Sweet and seconded by Dr. Schlotterback. The motion carried unanimously by roll call of members present.
IV. Inhaled Beta 2 Agonists - albuterol, levalbuterol, pirbuterol, metaproterenol A. Public Comment B. Committee Recommendation and Action	Dr. Burke stated that the PDL Committee will look at the short-acting separate from the long-acting inhaled beta 2 agonists. Dr. Tietze reiterated that the PDL Committee is tasked with looking at the clinical efficacy of these medications and the discussion should be clinically oriented. The case for FDA approved indications does not need to be made by the speakers. The main focus is clinical equivalency and this committee is most interested in what is new, especially on the re-reviews. He said they would like to have head-to-head comparisons and statistically significant data to help make decisions on clinical efficacy. Dr. Tietze stated that the PDL Committee is on record from previous decisions made on most of the drugs in the classes being reviewed today have been found to be clinically equivalent. Therefore, the discussion process should be geared toward whether there is any new information that is significant that would make us look at one drug in a class differently than we did before. James Osborne, representing GSK, spoke about Ventolin HFA. He stated the drug offers an accurate, reliable and convenient way for the patient to track how many doses of their rescue inhaler is left. Dale Johnson, representing Graceway Pharma, spoke about Maxair Autohaler. It is CFC powered and it will remain that	Dr. Sweet made a motion that the short-acting beta 2 agonist inhalation products are clinically equivalent for the purposes of this Committee. The motion was seconded by Dr. Tietze. The motion carried unanimously by roll call vote of all members present. Dr. Sweet made a motion that the long-acting beta 2 agonist inhalation products are clinically equivalent for the purposes of this Committee's discussion. Dr. Mishler seconded the motion. The motion carried unanimously by roll call vote of all members present.

	way because there are no other pirbuterol inhalers on the market that offer any delivery other than CFC. The advantage is because it is breath-actuated and does not require a spacer. Krishna Patel, representing Schering-Plough, spoke about Proventil HFA. Ms. Patel also spoke about Foradil (formoterol), a long-acting beta 2 agonist. Dr. Burke asked the audience if there were any other requests for public comment on the inhaled beta 2 agonists. There were none. Dr. Burke stated the December, 2006 report from the Center for Evidence-Based Policy's position on this class of drugs is that there is no consistent, significant differences among long-acting beta agonist inhalers and no difference in efficacy or effectiveness among short-acting beta agonist inhalers. Dr. Tietze stated that he agreed with this position in regard to his clinical experience. He stated that he likes and uses all of them. There are unique circumstances when ease of use is important. Dr. Sweet agreed with Dr. Tietze that when looking at the evidence and the studies, there are no significant differences in toxicity and all of the inhalers work. Dr. Sweet also stated that the PA process is quite simple and if a non-preferred drug is medically necessary, it can be obtained. She stated that in her clinical practice she uses them all interchangeably. They are clinically equivalent. Dr. Mishler stated that he agrees that they are all clinically equivalent, including the albuterol and levalbuterol solutions for inhalation. Mary clarified that this vote means the Committee considers the short-acting beta 2 agonists to be clinically equivalent. Subsequently, the State looks at the final net cost of each drug and determines which drugs will be considered preferred and non-preferred based on cost. The PDL	

	Committee looks at the clinical aspects of the drugs, while the State does the economic analysis of drugs deemed to be clinically equivalent.	
V. Statins - atorvastatin, simvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin A. Public Comment B. Committee Recommendation and Action	The statins were last reviewed by the PDL Committee in May, 2004, and at that time the Committee found no compelling evidence for clinical differences between the drugs. There was some discussion about the potential for less drug interactions with pravastatin and rosuvastatin. Carlos Dujovne, Representing Astra Zeneca, spoke about Crestor and gave handouts to the Committee members. He stated there are differences among the statins in the amount of LDL reduction. He also stated that Crestor is not metabolized by the P450 pathway and therefore, less drug interactions. He stated that it is the only statin used as a single agent that has been shown to reverse coronary lesions. Dr. Mishler asked Dr. Dujovne if he had any insight into why the regression of plaque formation occurs. He asked if it was something unique to the molecule or is it just because of its effectiveness at lowering cholesterol levels. Dr. Dujovne stated that the effect is due to the HDL elevation. Dr. Tietze asked Dr. Dujovne if there is any outcomes data available yet. Dr. Dujovne said there is no outcomes data available currently. Phil King, representing Pfizer, spoke about Lipitor. He stated that Lipitor has received five new indications in the last two weeks. These are for reduction in the risk of non-fatal MI, fatal and non-fatal stroke, angina, prevascularization procedures, and reduction in hospitalization rate from congestive heart failure. Dr. Tietze stated that he would like to have absolute risk reduction, and numbers needed to treat. Mr. King stated that he did not have the absolute risk reduction. He stated that there was an overall 22% relative risk reduction in coronary events. Dr. Burke asked if there was any further public comment on	Dr. Sweet made a motion that atorvastatin, simvastin, and rosuvastatin are clinically equivalent. Pravastatin should be available when there is a documented drug interactions. Fluvastatin and lovastatin have lesser potency. Dr. Fink seconded the motion. The motion carried unanimously by roll call vote of all members present.

	the statins. There was none. Dr. Schlotterback stated that at maximum doses all of these products lower the LDL's, some to differing degrees, but this does not guarantee differences in clinical outcomes. Dr. Sweet agreed that you can't go from a low LDL to a clinical outcome and the degree of LDL lowering can be considered but would not be used from a clinical efficacy standpoint. Dr. Tietze said that this is a miracle class of drugs but there are no blockbuster clinical differences based on the evidence. Dr. Sweet said she looked at how the statins compare in the reduction in risk of cardiovascular disease with the data that is available. The problem is that the studies do not compare equipotent doses so it is not helpful. All of these drugs have their problems if you push the dose. There are no good head to head studies that prove that clinically one of these is better than another. Furthermore, the prior authorization process is not overly burdensome if a specific one is necessary. Dr. Tietze agrees that the drugs can be used interchangeably. Dr. Burke stated that Dr. Haneke submitted comments to say that there was no compelling evidence that there are clinically significant differences among the statins. Mary stated that on May 26, 2004, the PDL Advisory Committee made the following motion: Atorvastatin, simvastatin, pravastatin and rosuvastatin are clinically equivalent and that fluvastatin and lovastatin have lesser potency in lowering LDL and that pravastatin should be available for at risk populations, i.e. people who have potential 3A34 drug interactions. Dr. Burke stated that the issue is whether the potency in reducing LDL is equivalent to a favorable cardiovascular outcome.	

VI. Calcium Channel Blockers - all oral forms of nifedipine, micapdipine, amlodipine, isradipine, nimodipine, felodipine, nisolidipine, diltiazem, verapamil A. Public Comment B. Committee Recommendation and Action	Dr. Burke stated that the calcium channel blockers were last reviewed in June, 2004 and decided that the class needed to be separated into the sub-classes of dihydropyidines and non-dihydropyridines. All of the drugs in each of the sub-classes were found to be clinically equivalent. There was no public comment on this drug class. Dr. Haneke's comment (read by Dr. Burke) was that he sees no significant new information in the Oregon Health Sciences University report and he would recommend that both the dihydropyridines and the non-dihydropyridines are clinically equivalent.	Dr. Sweet made a motion that the dihydropyridines are clinically equivalent and the non-dihydropyridines are clinically equivalent. Dr. Tietze seconded the motion. The motion carried unanimously by roll call vote of all members present.
VII. Beta-Blockers - all oral forms of acebutolol, atenolol, carvedilol, metoprolol tartrate, metoprolol succinate, pindolol, propranolol, sotalol, betaxolol, bisoprolol, nadolol, penbutolol, timolol A. Public Comment B. Committee Recommendation and Action	Dr. Burke reminded the Committee that this is the third review of beta-blockers. They were reviewed in November, 2002 and again in October, 2004. In 2004, the PDL Committee found clinical equivalence with a preference for Coreg and Toprol for use in congestive heart failure. John Pawloswki, representing GSK, spoke about new information on Coreg. The COMET study, which was a head to head study between Coreg and metoprolol, demonstrated a 17% mortality reduction with Coreg vs. metoprolol. Further analysis demonstrated a 20% relative risk reduction in cardiovascular death, a 19% relative risk reduction in sudden death and a 67% relative risk reduction in death due to stroke. Coreg CR has recently been approved for the same indications as Coreg. Dr. Burke commented that the COMET study was included in the OHSU report. John Stoner, representing Astra Zeneca, spoke about Toprol XL. He stated that the reductions in mortality and hospitalizations attributable to the use of Toprol XL is well documented and is widely prescribed by cardiologists. Dr. Haneke's comment (read by Dr. Burke) was that he would vote to maintain the current position of the beta-blockers with the caveat that there is some advantage to using more B1 selective agents in patients with reactive	Dr. Mishler made a motion that the beta-blockers are clinically equivalent and that carvedilol and metoprolol are preferred agents for congestive heart failure. Dr. Schlotterback seconded the motion. The motion carried unanimously by roll call vote of all members present.

	airway disease. Dr. Schlotterback stated that they all work well and he likes the way the formulary is currently. Dr. Sweet stated that the formulary we currently have is appropriate. She is not convinced that Coreg CR is any great addition. Dr. Harte said that he thinks that compliance may be better with once a day dosing versus twice daily dosing. Dr. Burke stated that the PDL Committee's position in 2004 was that beta-blockers are clinically equivalent and that carvedilol and metoprolol are preferred agents for patients with congestive heart failure.	
VIII. Angiotensin II Receptor Antagonists - irbesartan, irbesartan/HCTZ, losartan, losartan/HCTZ, telmisartan, telmisartan/HCTZ, valsartan, valsartan/HCTZ, candesartan, candesartan/HCTZ, eprosartan, eprosartan/HCTZ, olmesartan, olmesartan/HCTZ A. Public Comment B. Committee Recommendation and Action	Dr. Burke stated the ARBS have been reviewed twice before, in November, 2002 and October, 2004. In 2004, the PDL Committee's position was that the ARBs were clinically equivalent and that the ARB/HCTZ combinations were clinically equivalent and equivalent to the single agents used in combination. John Stoner, representing Astra Zeneca, spoke about Atacand. He gave the Committee a handout and discussed the CHARM trial. He stated that language in the package insert states that Atacand reduces blood pressure more significantly than losartan. Dr. Sweet clarified that the CHARM trial did not look at any other ARB and that it was in comparison to placebo. Mr. Stoner agreed. Mary pointed out that the CHARM trial was included in the OHSU report on ARBs. Dr. Isabelle Shaw, representing Diiachi Sankyo, spoke about Benicar. Dr. Shaw gave a brief summary of the drug's monograph. Wanda Stipeck, representing Sanofi-Aventis, spoke about	Dr. Mishler made a motion that all formulations of ARBs are clinically equivalent and that all combination formulation ARBs are clinically equivalent to single agents and HCTZ when taken in combination. Dr. Harte seconded the motion. The motion carried unanimously by roll call vote of all members present.

	Avapro. She stated that hypertensive patients using Avapro had less progression of type 2 diabetic nephropathy. Dr. Burke stated that the study on Avapro was included in the OHSU report. Kevin Winn, representing Merck, spoke about Cozaar. Mr. Winn gave a brief summary of the drug's monograph. Dr. Susan Wood, representing Boehringer-Ingelheim, spoke about Micardis. A brief summary of the drug was provided to the Committee. Dr. Tietze stated that the OHSU report found no significant compelling differences in these drugs. He was disappointed that the speakers educated them on primary indications. There is inadequate data to compare the drugs. Placebo controlled studies are not helpful in comparing the drugs. He said he struggles with 2 to 4 mmHg drops in blood pressure as this is not able to be measured in the office. Controlling high blood pressure is a huge issue and KHPA needs to look at this because when looking at the national statistics, Kansas is about 40% in terms of adequately controlling blood pressure. It is not as important as what we use, but that we get to the goal of controlling blood pressure. Dr. Sweet agreed with Dr. Tietze that the drugs are very important in treating hypertension but after reading all of the evidence there is no data that shows that one is superior than another. If any company wants to prove that their drug is better, they need to do head to head clinical trials that make a difference. Mary stated that the recommendation when last reviewed was that all formulations of ARBs are clinically equivalent and that all combination ARBs are clinically equivalent to their single agents.	
IX. ACE Inhibitors - benzapril, captopril, enalapril, lisinopril, quinapril, fosinopril, meoxipril, perindopril, ramipril, trandolopril	Dr. Burke stated that the ACE Inhibitors were last reviewed by the PDL Committee in June, 2004. Dr. Edgar Gonzalez, representing King Pharmaceuticals, spoke about Altace and distributed a handout. Dr. Gonzalez	Dr. Sweet made a motion that all the ACE inhibitors are clinically equivalent. Dr. Tietze seconded the motion. The motion carried unanimously by roll call vote of all members present.

A. Public Comment B. Committee Recommendation and Action	stated that he is a member of the HOPE trial investigators group. He discussed the "ARB paradox" and that the ACE inhibitors outperform the ARB's in many studies. The ACE inhibitors are not all identical. He believes that Altace is superior relative to the other ACE inhibitors because it is the strongest at producing bradykinin release at the cellular level. He also discussed the anti-diabetic effect. Dr. Burke asked Dr. Gonzalez to comment on the mechanism whereby an ACE inhibitor is having an anti-diabetic effect. Dr. Gonzalez stated that the function of insulin on the endothelium and the way insulin mediates both vasodilatation and islet cell function, part of it has to do with the ability of insulin to strike the insulin receptor on the endothelium to generate nitric oxide synthesis. This is the mechanism for insulin-mediated dilatation. Dr. Haneke sent the comment that there is no compelling new information any drug in the class has significant clinical superiority. Mary read the motion from the last review of the ACE inhibitors: All formulations of ACE inhibitors are clinically equivalent.	
X. ACE Inhibitor/Calcium Channel Blockers A. Public Comment B. Committee Recommendation and Action	Dr. Burke stated that the PDL Committee last reviewed this class in June, 2005. At that time, the distinction was made that the Committee would focus only on the indication for hypertension. The Committee evaluated the drugs to be clinically equivalent to each other and to the single agents in combination. No public comment. Dr. Sweet stated that there is no evidence that the drugs are not clinically equivalent and would suggest no change to our previous recommendation.	Dr. Harte made a motion that all formulations of ACE inhibitor/calcium channel blockers are clinically equivalent for the treatment of hypertension with the recommendation to use generic substitutions of individual components when available. Dr. Tietze seconded the motion. The motion carried unanimously by roll call vote of all members present.
XI. Oral Hypoglycemics A. 2nd Generation Sulfonylureas - glipizide, glipizide XL, glyburide, glyburide micronized, glimeperide, glipizide/metformin,	No public comment Dr. Burke read the previous recommendation of the PDL Committee back in October, 2004. The recommendation was there is clinical equivalence among the Sulfonylureas. There are no significant clinical differences among single	Dr. Sweet made a motion that the 2nd generation Sulfonylureas are clinically equivalent. The combination agents are clinically equivalent to single agents taken together. Dr. Tietze seconded the motion. The motion carried unanimously by roll call vote of all members present.

glyburide/metformin 1. Public Comment 2. Committee Recommendation and Action	agents, and the combination agents are clinically equivalent to single agents taken together.	
B. Meglitinides - nateglinide, repaglinide 1. Public Comment 2. Committee Recommendation and Action	The PDL Committee's position at the last review in October, 2004, was all formulations are clinically equivalent. There was no public comment. Dr. Sweet commented there is no new evidence that would suggest a change in the Committee's position.	Dr. Schlotterback made a motion that the meglitinides are clinically equivalent. Dr. Mishler seconded the motion. The motion carried unanimously by roll call vote of all members present.
C. TZDs - pioglitazone, rosiglitazone, pioglitazone/glimepiride, piolitazone/metformin, rosiglitazone/metformin 1. Public Comment 2. Committee Recommendation and Action	Leah Mancini, representing Takeda Pharmaceuticals, spoke about Actos and distributed a handout which addressed new data regarding an outcomes study. Dr. Michael Windheuser, representing GSK, spoke about Avandia. He discussed the ADOPT trial which was a comparative study comparing glyburide, metformin and Avandia. Dr. Burke asked Dr. Windheuser if there are any comparative studies between the two TZD's. Dr. Windheuser said no. Anne asked Dr. Windheuser if he could comment on the newest release on bone fractures with the use of TZD's. He stated that this has been reported as an adverse event and the incidence of fracture rates for women is lower for glyburide, intermediate for metformin, and higher for Avandia. He stated this can be attributable to the fact that diabetic women fracture more easily than non-diabetic women. Causality has not been proven and there is a need for prospective trials. Dr. Burke asked if there was any further discussion and if not, he would entertain a motion.	Dr. Mishler made a motion that the TZD's are clinically equivalent. Dr. Schewe seconded the motion. The motion carried unanimously by roll call vote of all members present.
D. Biguanides - metformin, metformin extended release	Dr. Edgar Gonzalez, representing King Pharmaceuticals, spoke about Glumetza which is a sustained release	Dr. Schewe made a motion that all formulation of metformin, including the extended release, are clinically

1. Public Comment 2. Committee Recommendation and Action	formulation of metformin. He discussed average doses and gastrointestinal intolerance with high doses of immediate release metformin. Dr. Burke stated at the last review, the PDL Committee decided the drugs within this class, including the extended release formulations, were clinically equivalent. The discussion at the time was that if a person could not tolerate a short acting preferred agent, they would have access to the extended release formulation through the prior authorization process. Dr. Tietze stated he sees no reason to change the position of the previous recommendation from the PDL Committee.	equivalent. Dr. Tietze seconded the motion. The motion carried unanimously by roll call vote of all members present.
E. Alphaglucosidase Inhibitors - miglitol, acarbose 1. Public Comment 2. Committee Recommendation and Action	Dr. Burke stated these were last reviewed in October, 2004 and judged to be clinically equivalent. There was no public comment. Dr. Sweet stated that there is no new data and the current recommendation of clinical equivalence should stand.	Dr. Sweet made a motion that the alphaglucosidase inhibitors are clinically equivalent. Dr. Harte seconded the motion. The motion carried unanimously by roll call vote of all members present.
XII. Muscle Relaxants A. Skeletal Muscle - carisoprolol, carisoprolol/aspirin, carisoprolol/aspirin/codeine, orphenadrine, orphenadrine/aspirin/caffeine, chlorzoxazone, cyclopenzaprine, metaxalone 1. Public Comment 2. Committee Recommendation and Action B. Spasticity - baclofen, tizanidine, dantrolene 1. Public Comment 2. Committee Recommendation	At the request of Dr. Burke, Mary stated at the last review in 2003, the PDL Committee divided this class into skeletal muscle relaxation and spasticity. The PDL Committee deemed tizanidine and baclofen to be clinically equivalent as antispasmodics. All of the other muscle relaxants were deemed to be clinically equivalent for treating musculoskeletal discomfort with the exception of carisoprolol and carisoprolol combination products. It was recommended that arisoprolol and carisoprolol combinations be non-preferred because there is little data to support efficaciousness and carries the potential for abuse and addiction. Jerry Gomez, representing King Pharmaceuticals, spoke about Skelaxin. He discussed the efficacy and safety of Skelaxin. Dr. Burke stated that according to the OHSU report from May, 2005, there is insufficient evidence to prove that	Dr. Sweet made a motion that the musculoskeletal relaxants are clinically equivalent with the exception of carisoprolol and carisoprolol combinations. Dr. Tietze seconded the motion. The motion carried unanimously by roll call vote of all members present. Dr. Mishler stated that dantrolene is used on rare occasions and should be included with the antispasticity agents. Dr. Schlotterback made a motion that the antispasticity muscle relaxants (tizanidine, dantrolene, and baclofen) are clinically equivalent. Dr. Tietze seconded the motion. The motion carried unanimously by roll call vote of all members present.

and Action	different skeletal muscle relaxants are associated with different efficacy or safety. The best available evidence suggests that tizanidine is roughly equivalent to baclofen for most clinical outcomes regarding spasticity.	
XIII. Adjournment	With no further discussion, a motion to adjourn was placed before the Committee.	Dr. Mishler made a motion to adjourn and this was seconded by Dr. Harte. The motion carried unanimously by roll call vote of all members present.