

**Preferred Drug List Committee Meeting
Meeting Minutes, Open Session
June 3, 2009**

<p>Preferred Drug List Committee Meeting Minutes, Open Session EDS / Forbes Field Capital / Cedar Crest Room Topeka, KS June 3, 2009</p>	<p>Members Present: Michael Burke, M.D, Ph.D., Chair Kristen Fink, Pharm.D. Kenneth Mishler, Pharm.D. Matthew Schlotterback, M.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. Debra Quintanilla, R.N. Lisa Todd, R.Ph.</p>	<p>Representatives: Gianna Rigoni - Abbott Jeanette Sexton - Astellas Cyndee Davies - AstraZeneca Molly Skelsy - AstraZeneca Deborah Mance - Biogen Richard Mesquias - Eli Lilly Kelly Golden - Eli Lilly Ann Hartry - Endo James Lieurance - Endo Ann Gustafson - GSK Dave Walters - JnJ Barbara Belcher - Merck Lon Lowry – Novartis Todd Paulsen - Novo Nordisk Mary Shefchyk - Novo Nordisk Barnau Som – Novo Nordisk Jim Baumann - Pfizer Phil King – Pfizer Rick Learned - Pfizer Jim Tully - Sanofi-Aventis Bruce Steinberg - Sanofi-Aventis Jason Enders - Sanofi-Aventis Ervin Eaker - Takeda Joe Summers - Takeda Tony Kemmit - UCB Dave Chapman - UCB Kate Kulesher - Wyeth</p>
TOPIC	DISCUSSION	DECISION AND/OR ACTION
I. Call to Order	Dr. Burke called the meeting of the Preferred Drug List (PDL) Advisory Committee to order at 10:00 am with six members present.	
II. Announcements	Ms. Todd asked the public to fill out a conflict of interest form if they were going to speak. She said each drug has a five minute time limit.	
III. Review and Approval of December, 10 2008 Minutes	No changes to the minutes.	Dr. Sweet moved to approve the minutes. Dr. Tietze seconded the motion and it carried by a unanimous vote.

<p>IV. DUR+ Presentation</p>	<p>DUR+ Presentation</p> <p>Dr. Bell said this is a new prior authorization system implemented by KHPA/EDS. This is a presentation for informational purposes only.</p> <p><u>What is the DUR+ (Auto-PA)</u></p> <p>DUR + is an automated Prior Authorization (PA) system that is integrated within the interChange MMIS. It uses established clinical criteria and claims data from the MMIS to evaluate whether a pharmacy claim meets prior authorization criteria at the point-of-sale (POS). If the criteria is met, then a system-generated PA is created and the claim is paid.</p> <ul style="list-style-type: none"> • As with any automated PA process, some claims may not meet the automated criteria. • In these cases, the pharmacist will receive the same message that they have always received: NDC requires Prior Authorization. • At this point, the Pharmacy will contact the PA unit to obtain a Prior Authorization. The PA nurse will work with the provider using the standard PA processes currently in place today. • This new system will allow KHPA pharmacy staff to look at other drugs that may be managed through the automated PA process. • At this time there are 41 drug categories entered into the DUR+ system, these include most of the PDL drugs. • Each of these drugs have specific criteria requirements as noted in the existing PA criteria utilized by the PA nurses today. • With the addition of DUR+ - KHPA can add more drugs to the PA process without having to add administrative staff • The PA nurses can be used to evaluate more clinically and technically advanced criteria, as well as answering provider questions. • . <p><u>DUR + (Auto-PA) Panels</u></p> <ul style="list-style-type: none"> • The DUR+ (Auto-PA) subsystem is made up of 9 separate panels that each require specific data to be entered into the necessary fields to allow the claims engine to identify what to use from the existing Prior Authorization subsystem, reference subsystem and claims history. • The following panels make up the DUR+ (Auto-PA) subsystem. 	
------------------------------	--	--

- Base Information
- Grandfather Criteria
- Age Criteria
- Diagnosis Criteria – Primary
- Diagnosis Criteria – Secondary
- Other Drug Therapy 1 Criteria
- Other Drug Therapy 2 Criteria
- Co Morbid Criteria
- Provider Type/Specialty

Claims processing to DUR+ (AutoPA)

- Once a POS pharmacy claim is submitted for payment to the Medicaid Management Information System (MMIS)
 - It goes through the initial claims editing to ensure beneficiary number, provider number, NDC, etc. are without errors and that the claim is payable but requires a PA
 - The MMIS claims engine will then perform a PA search. Since **DUR+** is activated real-time, if an available and appropriate PA already exists on the MMIS for that beneficiary, provider and NDC, it will be used. If no active PA is found then the claim continues through the process
 - If the NDC being processed is subject to **DUR+** criteria, the claim will be processed against the **DUR+** rules set up on the panels and applicable to that NDC, GCN or these types of groups.
 - Many decision points can be evaluated based upon elements on the screens as noted in the information presented regarding the panels.
- In order to facilitate **DUR+** processing during claims adjudication
 - The claims adjudication process was modified to access expanded claims history for the beneficiary.
 - Claims engine pulls paid claims for pharmacy and professional claims in history within the past 120 days (or other date range limitations as established by KHPA);
 - For **DUR+** we have also added the pulling of inpatient, outpatient and crossover claims paid within the last 120 days. This enables more

	<p>robust diagnosis and procedure code searches to aid in the DUR+ criteria decision process.</p> <ul style="list-style-type: none"> In addition, as needed, the claims adjudication process may be modified to access and maintain specific disease profile information by beneficiary to apply to the DUR+ decision process. <p><u>The Prior Authorization Future</u></p> <ul style="list-style-type: none"> With the addition of DUR+ (Auto-PA) to the MMIS, KHPA realizes several benefits, such as: <ul style="list-style-type: none"> A more robust, cost effective pharmacy program through the placement of more drugs on prior authorization without increased administrative staff Provider satisfaction with a more cost-effective pharmacy program that eases the administrative burden Faster delivery of medications to the beneficiary An integrated solution As drugs become more expensive, sophisticated, and indicated for targeted populations (in addition to the FDA issuing more and more ‘Black Box’ warnings), this increases the need for Medicaid to assure appropriate use. <ul style="list-style-type: none"> The DUR+ automated PA solution can assist in helping KHPA maximize pharmacy benefit dollars and promote appropriate use. 	
<p>V. Proton Pump Inhibitors - Kapidex®</p> <ol style="list-style-type: none"> Public Comment Committee Discussion 	<p>Dr. Bell said there is a new agent in the class, Kapidex® (dexlansoprazole). This class was last reviewed in 2006. In addition to the package inserts for the agents in the class, included in your materials are the minutes from previous class reviews, the most recent full DERP reviews (completed in 2006), and the most recent DERP drug class scan (completed in June 2008). Dexlansoprazole was not available at the time of the scan. Full text of dexlansoprazole studies were also requested from the manufacturer (Takeda), however they were unable to provide the study in electronic form due to copyright issues. They provided a summary instead, which is included in your meeting materials.</p> <p>Ervin Eaker, Takeda, said from a clinical point of view proton pump inhibitors (PPIs) are typically classified as equivalent in terms of how they approach the average patient. His experience with PPIs has been that there are some agents that are better in some settings in some patients. This new product is interesting in a way that any product should be when entering this market, in terms of its pharmacology. From a</p>	<p>Dr. Schlotterback moved that all proton pump inhibitors are clinically equivalent.</p> <p>Dr. Sweet seconded and it carried with a unanimous vote.</p>

	<p>therapeutic point of view it is very similar to the other products. The theoretical advantage to this product is its application in patient care. It eliminates many of the limitations in the way the drug is administered and the way the drug works throughout the day. PPIs must be given, for the most part, before a meal on an empty stomach and then be given a stimulating meal in order for the drug to work. This product, because of the way it has been manipulated as an isomer with dual coating, has two peaks in absorption that are independent of meals. The patient will not have to take the drug with regard to meals and therefore can likely be more compliant.</p> <p>Dr. Mischler asked how this drug will impact adherence. Dr. Eaker said if the patient misses a dose the drug will lose efficacy.</p> <p>Dr. Sweet said the company said because the company chose to compare is against placebo instead of another PPI, clinical superiority can't be determined based on the data shown.</p> <p>Dr. Fink said there are other products that have different dosage forms; dissolvable tablets, and this is only available in capsule form. There is no approval to use this drug in children 18 and younger. Some of the products in this class do.</p> <p>Dr. Tietze said there is no proven superiority. We need clinical things like need to treat numbers or need to harm numbers to help pass onto the DUR Board any issue of superiority. He has no issue with including in group.</p>	
<p>VI. Antiemetics - Sancuso Patch[®]</p> <p>a. Public Comment</p> <p>b. Committee Discussion</p>	<p>Dr. Bell said there is a new agent in the class, Sancuso[®] (granisetron transdermal patch). This class was last reviewed in December 2008 for inclusion of another new agent, Aloxi[®] (palonsetron). Sancuso[®] is the first transdermal dosage form in this class, but does contain the same drug as Kytril[®] (granisetron oral). Minutes from previous reviews, package inserts, and DERP class review from January 2009 are included in your materials.</p> <p>No public comment.</p> <p>Dr. Burke said the new agent is available in a patch. We do have parenteral formulations and disintegrating tabs available in this class. There doesn't appear to be a difference in tolerability, effectiveness, or safety.</p> <p>Dr. Sweet said it is the same drug as one that has already been deemed</p>	<p>Dr. Sweet moved that all antiemetics are clinically equivalent.</p> <p>Dr. Fink seconded and it carried with a unanimous vote.</p>

	equivalent.	
<p>VII. Urinary Incontinence Drugs - Toviaz[®], Gelnique[®]</p> <p>a. Public Comment</p> <p>b. Committee Discussion</p>	<p>Dr. Bell said there are two new agents in the class, Toviaz[®] (fesoterodine) and Gelnique[®] (oxybutynin gel). This class was last reviewed in 2005. DERP reviewed this class in early 2009; neither was available at the time of review; however Oxytrol[®] (oxybutynin patch) is in the review and was compared to oral forms of oxybutynin. Minutes from previous class reviews and package inserts are also in your materials.</p> <p>Phil King, Pfizer, said Toviaz[®] is the latest entry in the overactive bladder (OAB) class. It is indicated for treatment of OAB with symptoms of urge, urge urinary incontinence, and frequency. The efficacy, tolerability, and safety of Toviaz[®] has been established in two clinical trials. Both of these studies looked at placebo, Toviaz[®] 4mg, and Toviaz[®] 8mg over a 12 week treatment period. Urge urinary incontinence rates were reduced by 40% in the placebo group, 67% in Toviaz[®] 4mg, and 82% in Toviaz[®] 8mg. Micturitions per 24 hours were reduced by 7% in the placebo group, 15% in Toviaz[®] 4mg, and 16% in the Toviaz[®] 8mg. From a safety and tolerability standpoint the primary adverse events are consistent with the anticholinergic properties of the agents in the class including dry mouth and constipation. Dosing is a once a day preparation recommended start at 4mg, titrated to 8mg as tolerated, giving it an advantage of having two efficacious doses. It is recommended to not exceed 4mg in patients with severe renal impairment. This focuses on the behavioral component. He asked the committee to consider placing Toviaz[®] in the preferred position for equivalency with other products that are currently available.</p> <p>Dr. Burke said the PDL committee does not determine which agents are preferred. That is determined between the manufacturers and the State of Kansas.</p> <p>Dr. Sweet asked if there is any comparison with Detrol LA. Mr. King said not at this time.</p> <p>Dr. Burke said the March 2009 Oregon Health Sciences University report found that transdermal oxybutynin did not offer any patient quality of life or patient perception difference versus extended or immediate release formulations.</p> <p>Dr. Tietze pointed out that in preparation for the meeting the committee has reviewed clinical trial data and meta-analyses that have been presented for FDA approval. Dr. Burke told the audience that if there is</p>	<p>Dr. Sweet moved that all urinary incontinence drugs are clinically equivalent.</p> <p>Dr. Tietze seconded and it carried with a unanimous vote.</p>

	data that shows their product is superior to the other products in the class they should focus on that information in their presentations.	
VIII. Fibrin Acid Derivatives - Trilipix® a. Public Comment b. Committee Discussion	<p>Dr. Bell said there is a new agent in the class, Trilipix® (fenofibric acid). This class was last reviewed in 2006. Fenofibric acid is the active metabolite of fenofibrate, which is rapidly converted to fenofibric acid by esterases, with no unchanged fenofibrate detected in plasma. Trilipix® is indicated for use with statins. Along with minutes and package inserts, your meeting materials contain a presentation regarding co-administration of statins with fenofibrate and gemfibrozil.</p> <p>Gianna Rigoni, Abbott, said Trilipix® is the only FDA approved drug that is indicated to be used in combination with a statin. No other fibrin acid on the market has gone through the rigorous clinical trial testing. It has been in clinical trials for over two years with 2800 patients. Dr. Sweet asked Dr. Rigoni if there is evidence of more toxicity with other fenofibrates and statins. Dr. Rigoni said there have been no head-to-head studies, so they are unsure at this time. Dr. Sweet said she believes they are clinically equivalent, but she does know that there are physicians who feel uncomfortable putting things together because of the liability issue. She asked if this agent is more expensive than the others. Dr. Tietze said it is a lot more expensive. Dr. Burke asked when Trilipix® became available. Dr. Rigoni said December 2008.</p> <p>Dr. Burke referenced the PowerPoint that was in the committee's materials. It contained data from pharmacokinetics studies of fenofibrate versus gemfibrozil in 2002-2003. It appears that gemfibrozil inhibited metabolism of statins and fenofibrate had minimal effect on metabolism of statins. The absence of the effect of fenofibrates generalizes to the class.</p> <p>Dr. Sweet asked if currently gemfibrozil and fenofibrate are clinically equivalent. Dr. Bell said yes. Dr. Mishler said they may be clinically equivalent, but there are also safety issues to consider. Dr. Bell said when this was previously discussed there was a stipulation that fenofibrate could not be a non-preferred agent. The committee wanted to make sure there was a fenofibrate product available because of the danger with gemfibrozil. Dr. Burke said the motion from the meeting in 2006 was all formulations of fenofibrate are clinically equivalent.</p>	<p>Dr. Mishler moved that all fibrin acid derivatives are equivalent.</p> <p>Dr. Fink seconded and it carried with a unanimous vote.</p> <p>Dr. Mishler suggested a recommendation is made to the DUR that when combination therapy with a statin is being used that fenofibrates are safer than gemfibrozil combinations.</p>
IX. Insulin Pens - Lantus®, Levemir®, Apidra® a. Public Comment b. Committee Discussion	Dr. Bell said the committee has previously reviewed short acting insulins, most recently in 2005. This review is related to determining clinical equivalence of the vial/syringe vs. pen delivery devices of Lantus®, Levemir®, and Apidra®. All pen devices are currently non-preferred	<p>Dr. Tietze moved that all delivery methods are clinically equivalent.</p> <p>Dr. Schlotterback seconded and it carried</p>

	<p>except for the three listed as they have not previously been reviewed by the Committee. Comparison of Lantus[®] and Levemir[®] for long-acting insulin equivalence is not the intention of this agenda item.</p> <p>Todd Paulsen, NovoNordisk, said in other countries about 90% of utilization is through a pen device. The United States is slowly catching up as far as the utilization of pens. One of the benefits of pens is patients are more adherent when using the pens. There is some health economics data showing some reduced overall health system costs by using a pen device. There are some data showing improved accuracy and reduced instances of hypoglycemia. Patients prefer using a pen device. There are five pens per box and 300 units per pen. Dr. Tietze asked if he could site his data. Dr. Paulsen said he has the data. Dr. Tietze asked how many patients he has to treat with a pen to avoid a diabetic complication. Dr. Paulsen said he doesn't have that exact answer. He said there was one large study by Lee that he can give the reference to. Hypoglycemic events are hard to tease out of head-to-head clinical trials, but there are large health economic outcomes. Dr. Sweet said that she was told there was a cut off in terms of the number of units of Lantus[®] used per day in terms of cost efficiency. If it was more than 30 units per day it would be much more cost efficient to use the vial. Dr. Paulsen said he does not have those numbers for his product. Dr. Burke asked how long the pen can be stored. Dr. Paulsen said Levemir[®] can sit out for 42 days after the patient opens it and it does not have to be refrigerated. Dr. Burke asked about how you put the needle on and take it off in terms of dexterity. Dr. Paulsen said what it comes down to is the patient no longer has to carry a vial and syringe. He then gave a demonstration on how to change the needle. Dr. Mishler asked if there is any data on waste. Dr. Paulsen said he does not have direct data on waste. Dr. Mishler said he doesn't know if there is a good way to measure how much insulin ends up in the trash can when people end up with more than one vial open.</p> <p>Jason Enders, Sanofi Aventis, said pens have the potential to overcome the barriers of insulin delivery. There is published data on patient preference and usability of the Solostar[®] pen.</p> <p>Dr. Sweet said she still believes that the agents of this class are clinically equivalent, but they do not improve the overall quality of care.</p> <p>Dr. Tietze said there is more than one issue. Pens are a good thing and diabetes educators are well sold on the pen devices. The diabetes educators asked that the committee make the pen devices easily available.</p>	<p>with a unanimous vote.</p>
--	--	-------------------------------

	<p>He is comfortable with saying they are clinically equivalent.</p> <p>Short Acting Insulins</p> <p>Dr. Burke said since there is a new short acting insulin the committee should discuss whether it is clinically equivalent.</p> <p>No public comment.</p>	<p>Dr. Sweet moved that short acting insulins are clinically equivalent including Apidra®.</p> <p>Dr. Schlotterback seconded and it carried with a unanimous vote.</p>
<p>X. Inhaled Corticosteroids - Alvesco®</p> <p>a. Public Comment</p> <p>b. Committee Discussion</p>	<p>Dr. Bell said there is a new agent in the class, Alvesco® (ciclesonide). The most recent DERP review of Controller drugs for Asthma (which include inhaled corticosteroids, leukotriene modifiers, 5-lipoxygenase inhibitor, long-acting beta agonists, anti-IgE, and combination products) was completed in February 2009. Inhaled ciclesonide was not available at the time of review, but the DERP documents are included in your materials. Also included are the minutes from past reviews of this class by the PDL Committee and package inserts for the new agent and the rest of this class.</p> <p>No public comment.</p> <p>Dr. Burke said this class was reviewed in 2005 and 2006.</p>	<p>Dr. Sweet moved that all inhaled corticosteroids are clinically equivalent.</p> <p>Dr. Fink seconded and it carried with a unanimous vote.</p>
<p>XI. NSAIDs - Flector®, Voltaren Gel®</p> <p>a. Public Comment</p> <p>b. Committee Discussion</p>	<p>Dr. Bell said there are two new agents in this class, both of which are topical formulations of diclofenac – Flector® 1.3% patch and Voltaren® 1% gel. An additional topical formulation of diclofenac (Solaraze® 3% gel) is also available but is indicated only for actinic keratoses and is therefore not included in this review. This class was last reviewed in 2004. There were no topical products available at that time in the U.S., although a variety of topical NSAIDs have been available outside of the U.S. for a number of years. Minutes from previous reviews of NSAIDs and package inserts for the two new products and a few key representative members of the NSAID class are included in your materials. Additional, materials include the executive summary of the last DERP review on NSAIDs (July 2006), the DERP NSAID Drug Class Scan (September 2008), which includes abstracts from two studies on topical NSAIDs, a meta-analysis and systematic review of topical NSAIDs, the AHRQ report on Analgesics for Osteoarthritis, and the protocol of a Cochrane Review currently underway which provides some background on the use of topical NSAIDs inside and outside the U.S.</p> <p>Ann Hartry, Endo Pharmaceuticals, said Voltaren Gel® is a topical diclofenac. It is indicated for chronic use in relieving the pain of osteoarthritis. The side effects were relatively low. The number needed</p>	<p>Dr. Schlotterback moved that all NSAIDs are clinically equivalent.</p> <p>Dr. Mishler seconded and it carried with a unanimous vote.</p>

	<p>to treat was 13 to avoid discontinuation due to adverse effect. Dr. Fink asked if there is any information on compliance as it requires frequent application. Ms. Hartry said there have been no compliance issues in the clinical trials. Real world data is still coming in. Dr. Mishler asked if there is any data comparing side effects of topical to oral. Ms. Hartry said just European data.</p> <p>Dr. Burke said the last time this class was reviewed it was deemed that all NSAIDs are clinically equivalent.</p>	
<p>XII. Adjunct Antiepileptics - Vimpat[®], Banzel[®], Keppra XR[®]</p> <p>a. Public Comment</p> <p>b. Committee Discussion</p>	<p>Dr. Bell said there are two new chemical entities to the class, Vimpat[®] (lacosamide) and Banzel[®] (rufinamide), and a new extended release formulation of levetiracetam (Keppra XR[®]), which is already listed on the PDL. This class was last reviewed in 2006, and includes only antiepileptics that do not have an indication for use as monotherapy in epilepsy; their only indication for epilepsy is as adjunctive. An inter-agent comparison was unable to be located so a comparison chart was drafted using drug information adapted from Facts and Comparisons Online. Dr. Bell explained the three different spreadsheets presented; they contain dosage forms and indications, pharmacology and pharmacokinetics, and common adverse effects. Also included in your meeting materials are the minutes from previous reviews and package inserts for all the agents.</p> <p>Dave Chapman, UCB, said over 1,000,000 patients in the U.S. still suffer from epilepsy despite the current treatments. Vimpat's mechanism of action is distinct from other anticonvulsants that act on sodium channels from a pivotal trials perspective we looked at patients who were still suffering from seizures despite being on 1-3 medications. In this population 84% were on two or more AEDs. There are no significant drug to drug interactions. The only adverse events that did occur with a frequency greater than 10% were dizziness, headache, and nausea. Dr. Burke asked if risk of suicide is unique to Vimpat[®] or the whole class. Dr. Chapman said it will be for the whole class.</p> <p>Dr. Chapman said Keppra XR[®] does not have head to head data. There is a meta-analysis looking at tolerability. There was no adverse event seen with a frequency greater than 10%.</p> <p>Dr. Burke said these agents are approved as adjunctive therapy, but there is a trend toward using them as monotherapy. Dr. Chapman said most Neurologists and Epileptologists believe that, when possible, monotherapy is better than polytherapy. Dr. Burke asked if monotherapy</p>	<p>Dr. Sweet moved that the adjunct antiepileptics, including Vimpat[®], Banzel[®], and Keppra XR[®] are clinically equivalent and can be used interchangeably.</p> <p>Dr. Fink seconded and it carried with a unanimous vote.</p>

	is something the manufacturers would try to pursue. Dr. Chapman said yes, but the challenge is the FDA wants to see superiority data.	
XIII. Long-Acting Opioids – Re-review a. Public Comment b. Committee Discussion	<p>Dr. Bell said this class has been previously reviewed, but not placed on the PDL. It was last reviewed in 2004. DERP updated their drug class review in April 2008, and new agents have entered the market since the last review by the PDL Committee. The DERP review, package inserts, and minutes from previous meetings are included in your meeting materials.</p> <p>No public comment.</p> <p>Dr. Burke said this class was not added previously because they are regulated in a variety of ways. He said the DERP report is helpful because it shows there was no evidence of superior efficacy and no evidence of difference in safety and tolerability. Patients on fentanyl patches had more ER visits. Long acting agents were not found to be superior to short acting agents.</p>	<p>Dr. Sweet moved to add the class to the PDL and that all agents are clinically equivalent.</p> <p>Dr. Tietze seconded and it carried with a unanimous vote.</p>
XIV. Xanthine Oxidase Inhibitors - New Review a. Public Comment b. Committee Discussion	<p>This is a new class review. A new agent, Uloric[®] (febuxostat) was recently approved by the FDA. Allopurinol was previously the only xanthine oxidase inhibitor on the market. The package inserts are included in your meeting materials as well as two clinical studies. Uloric[®] is indicated for the treatment of hyperuricemia in patients with gout and the recommended dose is 40mg or 80mg once daily. The clinical studies compared allopurinol 300mg to 80mg, 120mg, and 240mg of febuxostat.</p> <p>No public comment.</p> <p>Dr. Burke said he did not see anything in regard to efficacy that separated Uloric[®] from Allopurinol.</p> <p>Dr. Sweet said the only advantage she saw is that some people are allergic to allopurinol and there is nothing else left to put them on.</p>	<p>Dr. Sweet moved that all xanthine oxidase inhibitors are clinically equivalent including Uloric[®].</p> <p>Dr. Schlotterback seconded and it carried with a unanimous vote.</p>
XV. Adjourn	<p>Dr. Burke complimented Dr. Bell on well prepared background information.</p> <p>Carol Curtis asked if we could post the DUR+ presentation on the web. Dr. Bell said we can post the presentation given by Ms. Quintanilla.</p>	<p>Dr. Sweet moved to adjourn the meeting.</p> <p>Dr. Schlotterback seconded and it carried with a unanimous vote.</p>