GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Georgia Department of Community Health

DRUG UTILIZATION REVIEW BOARD MEETING

Department of Community Health
2 Peachtree Street - 5th Floor Board Room
Atlanta, Georgia 30303

March 18, 2014

NorthStar
HealthCare Consulting
Let Us Be Your Guide

This page intentionally left blank

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DRUG UTILIZATION REVIEW BOARD MEETING
AGENDA
2 Peachtree Street - 5th Floor DCH Board Room
Atlanta, Georgia 30303
Tuesday, March 18, 2014
9:00 a.m. to 4:00 p.m.

CALL TO ORDER	*Joseph Bona, MD, Chair*
COMMENTS FROM THE DEPARTMENT	*Linda Wiant, PharmD, Pharmacy Director*
MINUTES FROM PREVIOUS MEETING	*Chair*
CONSUMER COMMENTS SESSION	*Chair*
ADJOURNMENT OF OPEN SESSION	*Chair*
EXECUTIVE SESSION	*Steve Liles, PharmD, Senior Director, Goold*
LUNCH	
RECONVENING OF OPEN SESSION	*Chair*
CLINICAL REVIEW AND DURB VOTES	*Emily Baker, PharmD, BCPS, NorthStar* *Tara R. Cockerham, PharmD, NorthStar*
➢ **Manufacturers' Forum**	*Lauren Ellison, PharmD, BCPS, NorthStar*

➢ **New Drug Reviews**
- ●Actemra SC
- ●Gilotrif
- ●Injectafer
- ●Mekinist
- ●Tafinlar
- ●Tivicay

➢ **Therapeutic Class Review** – Direct Inhibitors for Hepatitis C
- ●Incivek
- ●Olysio
- ●Sovaldi
- ●Victrelis

➢ **Supplemental Rebate Class Reviews**

➢ **Utilization Trends Review**

➢ **Drug Information Review**
- ●Drug Update Newsletter
- ●Horizon Watch Report
- ●Patent Expiration Report
- ●Clinical Compass Newsletter

FUTURE AGENDA ITEMS	*Chair*
ADJOURNMENT	*Chair*

NorthStar HealthCare Consulting Let Us Be Your Guide

This page intentionally left blank

Department of Community Health
Drug Utilization Review Board (DURB)
MINUTES
Tuesday, December 10, 2013

MEMBERS PRESENT

Laurel E. Ashworth, Pharm.D., Chair
Joseph R. Bona, M.D., MBA, Vice-Chair
Mia Avery, Pharm.D.
Ann R. Damon, Pharm.D.
Gurinder J.S. Doad, M.D.
Deborah W. Fincher, M.S., R.Ph.
M. Celeste Fowler, Pharm.D.
Thomas B. Gore, M.D.
Edwina L. Jones, Pharm.D.
Robyn Lorys, Pharm.D.
Osgood (Drew) A. Miller, R.Ph.
Donald A. Paul, M.D.
Brent L. Rollins, R.Ph., Ph.D.
Robert E. Shervette III, M.D.
Sandra L. White, M.D., MBA, FACR
Mary Virginia "Ginny" Yates, Pharm.D.

MEMBERS ABSENT

John Greeson, M.D., MBA
J. Russell May, Pharm.D.

Staff

Jerry Dubberly, Pharm.D., MBA, Chief Medical Assistance Plans
Heather Bond, Deputy Director, Policy and Provider Services
Linda Wiant, Pharm.D., Pharmacy Director, Pharmacy Services
Turkesia Robertson-Jones, Pharm.D., Pharmacy Operations Manager, Pharmacy Services
Gilletta Gray, R.Ph., Clinical Manager, Pharmacy Services
Lori Garner, MHS, MBA, R.Ph., Pharmacist, Pharmacy Services
Rose Marie Duncan, MBA, Program Associate, Pharmacy Services
Chala Wiam, Pharm.D. Candidate
Aderonke Adeboye, Pharm. D. Candidate

Office of General Counsel

Sharon King, J.D., Ethics Officer

NorthStar HealthCare Consulting

Emily Baker, Pharm.D., BCPS, MHA, MBA, President
Tara R. Cockerham, Pharm.D., Clinical Programs Director
Cathy Grady, Pharm.D. Candidate

Catamaran

Mark Hall, MBA, PMP, Account Manager
Talmahjia "Tami" Sweat, Pharm.D., Clinical Systems Product Manager

Goold Health Services

Steve Liles, Pharm.D., Sr. Director, Pharmacy Services
Doug Martin, Pharm.D., Pharmacy Project Manager

Call to Order

The Drug Utilization Review Board (DUR Board) held its fourth meeting for the calendar year on December 10, 2013. The Chair, Laurel E. Ashworth, Pharm.D., called the meeting to order at 9:29am.

Comments from the Department

Sharon King, J.D., Ethics Officer – Ms. King welcomed and greeted Board members on behalf of Commissioner Clyde Reese and thanked everyone for their service and participation.

Jerry Dubberly, Pharm.D., MBA, Chief Medical Assistance Plan, commented on the following items:

Affordable Care Act (ACA)

1. Non-expansion state
    a. Non-disabled, childless adults up to 138% FPL (Federal Poverty Level)
    b. 630K $4.5B state funds
2. ACA does have significant impact on GA even though non-expansion state
    a. EBNE (eligible but not enrolled) – $14.3M in FY2014 and $40.9M in FY15
    b. Federal Premium Tax - $29M
    c. ACA PCP rate increase through 12/31/2014
    d. 6-12 month eligibility FY15 $28.7M
    e. Children 6-18 100-138% FPL from PCK (PeachCare for Kids) to Medicaid (59K children)
    f. Totals
        i. SFY2014 $27M
        ii. SFY2015 $102M
3. Balancing Incentives Payment
    a. Additional 2% FMAP for LTSS
    b. Used to invest in expanding HCBS and making structural changes to the waiver programs
    c. $19M/year
4. Eligibility
    a. Enhanced federal funding (90/10) to DDI new IES
    b. Procurement
    c. Operations 50/50 to 75/25 (additional $92M)
    d. Ready for MAGI (Modified Adjusted Gross Income)

Update on Other Current Projects

1. "Foster Care"
    a. Populations: Foster Care, Adoption Assistance, and Juvenile Justice (JJ) in residential placement
    b. Multiagency approach
        i. DCH, DHS, DPH, DBHDD, DJJ, DOE, DECAL
    c. Transitioning 27K children to a single state-wide CMO (Amerigroup)
    d. March 3, 2014
    e. Strong behavioral health focus
        i. Foster Care >70 of expenditures behavioral health
        ii. JJ >80% of expenditures are behavioral health
    f. Trauma Informed Care
    g. System of care with better coordinated care and improved outcomes for the children
    h. Enhanced coordination and information sharing among state agencies
    i. Stay with Amerigroup
    j. Value based purchasing approach
        i. 5% withhold
2. Aged, Blind, and Disabled
    a. <30% of enrollment but approximately 60% of expenditures
    b. Currently in FFS environment without care coordination, case management
    c. Not moving to full risk managed care- Creating a care coordination program
    d. Features
        i. Voluntary in nature
        ii. Claims in Fee-For-Service (FFS) environment
        iii. Care coordination, case management, disease management
        iv. Strong data analytics ability to stratify population
            1. Current needs/complexity
            2. Future needs
        v. All members
            1. Care coordination call center
            2. 24/7 nurse call line
            3. Patient education regarding health care needs and disease states
        vi. Intensive Care Coordination members - individuals with the highest needs and impactful
            1. Health Risk Assessment
            2. Treatment plans utilizing interdisciplinary treatment teams
            3. PCMH and PCCM
    e. Designed to go-live 10/1/2014
3. Single Dose Vials (SDV)

a. Pay for full SDV that is the most appropriate size from which the dose can be obtained
b. Policy will be effective 1/1/2014
c. System changes to enforce the most logical size will follow

Linda Wiant, Pharm.D., Pharmacy Director, Pharmacy Services, commented on the following items:

- DUR Board Members – The following new board members were welcomed: Mia Avery, Pharm.D. (Emory Cancer Institute), Celeste Fowler, Pharm.D. (Piedmont Henry Hospital), Brent Rollins, R.Ph., Ph.D. (Philadelphia College of Osteopathic Medicine), Robert E. Shervette III, M.D. (Ogeechee Behavioral Health Services), and Gurinder J.S. Doad, M.D. (Southwest Georgia Family Medicine/Mercer University). Dr. Laurel Ashworth was thanked for her service and term as Chair. Joseph R. Bona, M.D., MBA, will move into the Chair role and Osgood (Drew) A. Miller, R.Ph., will move into the Vice-Chair role.

Laurel E. Ashworth, Pharm.D., Chair, welcomed the following pharmacy students: Cathy Grady (Mercer), Aderonke Adeboye (Mercer), and Chala Wiam (Philadelphia College of Osteopathic Medicine).

Minutes from the Previous Meeting

Dr. Ashworth asked for comments regarding the minutes from the September 19, 2013 meeting. There were no corrections. A motion was made (Joseph R. Bona, M.D., MBA, Vice-Chair) seconded (Osgood (Drew) A. Miller, R.Ph.,) and carried to approve the minutes as written.

Consumer Comments Session

There were no consumer comments.

Adjournment of Open Session

The DUR Board voted to close the open meeting pursuant to the Open Meeting Act of Georgia Section 50-14-1 – 50-14-6 and pursuant to Federal Law Section USCS1396R-8B3D. The individuals recorded in attendance were from the Department of Community Health, Goold Health Services, NorthStar HealthCare Consulting, and Catamaran. Pharmacy students, Cathy Grady (Mercer), Aderonke Adeboye (Mercer), and Chala Wiam (Philadelphia College of Osteopathic Medicine) attended the closed session with the Board members. A motion was made by Robyn Lorys, Pharm.D., and seconded by Joseph R. Bona, M.D., MBA, Vice-Chair, to adjourn the open session and approve the closed session. There was a unanimous vote approving the closed session. The Chair, Dr. Laurel Ashworth, adjourned the open session at approximately 9:55am, at which time members reconvened for the Executive (closed) Session.

Executive Session

The Executive Session was held from 9:59am to 10:47am.

Reconvening of Open Session

The DUR Board reconvened for the open session at 11:00am.

Manufacturers' Forum

Tara Cockerham, Pharm.D., reviewed information regarding the Manufacturers' Forum that was provided in the Manufacturer Information section in the DUR Board binder. A total of six (6) manufacturers participated and provided information regarding the following drugs discussed at the December 10, 2013 DUR Board meeting:

Manufacturers	Drugs
Duchesnay	Diclegis
Biogen	Tecfidera
Takeda	Nesina
Johnson & Johnson	Invokana, Sirturo
Celgene	Pomalyst
Salix	Fulyzaq

Question and comments was raised about the limited distribution of specialty pharmacy medications, incidence of pancreatitis with Nesina, and the frequency of the QT prolongation for Sirturo. The next forum will be held on Thursday, February 6, 2014 and Wednesday, February 12, 2014 from 9am-5pm at the NorthStar Healthcare Consulting office: 1121 Alderman Drive, Suite 112, Alpharetta, GA 30005.

New Drug Reviews

Clinical information for the following new drugs, in the market six months or more, was presented for discussion and recommendations. The complete detailed drug summary is in the New Drugs for Review section of the DUR Board binder.

Therapeutic Class	Drugs	Presenter
Antineoplastic	*Cometriq*	Emily Baker, Pharm.D., BCPS
Ophthalmic Miscellaneous	*Cystaran*	Emily Baker, Pharm.D., BCPS
Antiemetic	*Diclegis*	Emily Baker, Pharm.D., BCPS
Antidiarrheal	*Fulyzaq*	Emily Baker, Pharm.D., BCPS
Antidiabetics	*Invokana, Nesina*	Emily Baker, Pharm.D., BCPS
Antineoplastic	*Pomalyst*	Emily Baker, Pharm.D., BCPS
Ophthalmic Prostaglandin	*Rescula*	Emily Baker, Pharm.D., BCPS
Somatostatic	*Signifor*	Emily Baker, Pharm.D., BCPS
Antimycobacterial	*Sirturo*	Emily Baker, Pharm.D., BCPS
Multiple Sclerosis	*Tecfidera*	Emily Baker, Pharm.D., BCPS

Ganglionic Blocker	*Vecamyl*	Emily Baker, Pharm.D., BCPS

The Board discussed the drug information, provided comments, and raised questions about the following medications:

- Cometriq – prescriber restrictions
- Cystaran – cost/benefits of compounded product
- Diclegis – category status; OTC therapies
- Fulyzaq – previous therapy and PA criteria for octreotide
- Nesina – preferred status of Onglyza with highest interaction rate
- Pomalyst – reduced efficacy with cigarette smoking
- Signifor – use with other QT prolongation drugs; concerns of frequent monitoring for gallstones
- Sirturo – directly observed therapy; QT prolongation
- Tecfidera – availability through specialty pharmacies; reason for limited distribution
- Vecamyl – coverage for off-label use indications

The Board voted and made recommendations for all new drug reviews noted in the Board's Recommendations to the Department.

Utilization Trends Review
Utilization trends for Georgia Medicaid Fee-for-Service were provided in detail in the Utilization Trends section of the DUR Board binder.

Drug Information
Information from the following was provided in detail in the Drug Information section of the DUR Board binder used for this meeting:

- Drug Update Newsletter
- Horizon Watch Report
- Patent Expiration Report
- Clinical Compass Newsletter

Future Agenda Items
There were no future agenda items noted.

Upcoming Meetings
The following dates for upcoming meetings were published in the DUR Board binder (except for the revised date of the December meeting listed below):

- Drug Utilization Review Board
  2 Peachtree Street NW
  5th Floor Board Room
  Atlanta, Georgia 30303

  Tuesday, March 18, 2014
  Thursday, June 5, 2014

Thursday, September, 18, 2014
Thursday, December 4, 2014

- Manufacturers' Forum
  NorthStar Healthcare Consulting
  1121 Alderman Drive
  Suite 112
  Alpharetta, Georgia 30005

  Thursday, February 6, 2014 and Wednesday, February 12, 2014
  Thursday, May 1, 2014
  Thursday, August 7, 2014
  Thursday, November 6, 2014

Disclosure Forms
Disclosure forms were received and reviewed by the Department for completeness for all Board members attending the meeting.

Board's Recommendations to the Department
After all clinical and financial evaluations and discussions, the DUR Board voted and presented the Department with the following recommendations for changes to the Preferred Drug List (PDL). All motions and votes are noted in Attachment A.

New Drug Reviews

Antineoplastics

The DUR Board recommended ***Preferred*** status with ***Prior Authorization*** for ***Cometriq® (Oral) Capsule*** and ***Non-Preferred*** status with ***Prior Authorization*** for ***Pomalyst® (Oral) Capsule***. The DUR Board also recommended DCH restrict prescribing of antineoplastics to oncologists.

Ophthalmic Miscellaneous
The DUR Board recommended ***Preferred*** status for ***Cystaran™ (Ophthalmic) Drops***.

Antiemetic
The DUR Board recommended ***Non-Preferred*** status for ***Diclegis® (Oral) Tablet Delayed-Release***.

Antidiarrheal
The DUR Board recommended ***Non-Preferred*** status with ***Prior Authorization*** for ***Fulyzaq™ (Oral) Tablet Delayed-Release***.

Antidiabetics
The DUR Board recommended ***Non-Preferred*** status with ***Prior Authorization*** for ***Invokana™ (Oral) Tablet*** and for ***Nesina® (Oral) Tablet***.

Ophthalmic Prostaglandin

The DUR Board recommended ***Non-Preferred*** status with ***Prior Authorization*** for ***Rescula® (Ophthalmic) Drops***.

Somatostatic Agent

The DUR Board recommended ***Non-Preferred*** status with ***Prior Authorization*** for ***Signifor® (Subcutaneous) Ampule***.

Antimycobacterial Agent

The DUR Board recommended ***Preferred*** status with ***Prior Authorization*** for ***Sirturo™ (Oral) Tablet***. The DUR Board suggested requiring Sirturo to be administered under direct observation in the prior authorization criteria.

Multiple Sclerosis Agent

The DUR Board recommended ***Preferred*** status for ***Extavia® (Subcutaneous) Kit*** and ***Non-Preferred*** status with ***Prior Authorization*** for ***Betaseron® (Subcutaneous) Kit*** and ***Tecfidera® (Oral) Capsule Delayed-Release***.

Ganglionic Blocker

The DUR Board recommended ***Non-Preferred*** status with ***Prior Authorization*** for ***Vecamyl™ (Oral) Tablet***. The DUR Board suggested the Vecamyl prior authorization criteria should be similar to the Vecamyl Total Care Program criteria.

Conclusion

At the conclusion of the reconvened open session and no other business for discussion, a motion was made by Osgood (Drew) A. Miller, R.Ph., and seconded b Robyn Lorys, Pharm.D., to adjourn the meeting. Chair Ashworth adjourned the meeting at 12:43pm.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED, THIS THE _____ DAY OF _____, 2014.

_____

Joseph R. Bona, M.D., MBA, Chair

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

ANTINEOPLASTICS - (New Drug Review)

Motion:	Drug	PDL Status	DCH is to require Oncologist as the prescriber		
	Cometriq® Oral Capsule	P/PA			
Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1 Ashworth, Laurel E. Pharm.D. - Chair		√	√		
2 Avery, Mia, Pharm.D.			√		
3 Bona, Joseph R. M.D. - Co-Chair			√		
4 Damon, Ann R., Pharm.D.			√		
5 Doad, Gurinder J.S., M.D.			√		
6 Fincher, Deborah W., M.S., R.Ph.			√		
7 Fowler, M. Celeste, Pharm.D.			√		
8 Gore, Thomas B., M.D.			√		
9 Jones, Edwina L., Pharm.D., MBA		√ (Add Oncologist as prescriber to PA Criteria)	√		
10 Lorys, Robyn Pharm.D.	√ (Add Oncologist as prescriber to PA criteria)		√		
11 Miller, Osgood (Drew) A. R.Ph.			√		
12 Paul, Donald A., M.D.	√		√		
13 Rollins, Brent L., R.Ph., Ph.D.			√		
14 Shervette III, Robert E., M.D.			√		
15 White, Sandra L., M.D., MBA, FACR			√		
16 Yates, Mary Virginia "Ginny", Pharm.D.			√		
			16	0	0

Board Members - Absent
1 Greeson, John D., M.D., MBA
2 May, J. Russell (Rusty)

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

OPHTHALMIC MISCELLANEOUS - (New Drug Review)

Motion:	Drug	PDL Status
	Cystaran™ (Ophthalmic) Drop	P

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.		√	√		
9	Jones, Edwina L., Pharm.D., MBA	√		√		
10	Lorys, Robyn Pharm.D.			√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.			√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	White, Sandra L., M.D., MBA, FACR			√		
16	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				16	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

ANTIEMETICS- (New Drug Review)

Motion:	Drug	PDL Status
	Diclegis ® (Oral) Tablet DR	NP

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA			√		
10	Lorys, Robyn Pharm.D.		√	√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.	√		√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	White, Sandra L., M.D., MBA, FACR			√		
16	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				16	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)

15

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

ANTIDIARRHEALS - (New Drug Review)

Motion:	Drug	PDL Status
	Fulyzaq™ (Oral) Tablet DR	NP/PA

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.	√		√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA			√		
10	Lorys, Robyn Pharm.D.			√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.			√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	White, Sandra L., M.D., MBA, FACR			√		
16	Yates, Mary Virginia "Ginny", Pharm.D.		√	√		
				16	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)

16

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

ANTIDIABETICS - NON-INSULIN- (New Drug Review)

Motion:

	Drug	PDL Status
	Invokana™ (Oral) Tablet	**NP/PA**

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair	√		√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA			√		
10	Lorys, Robyn Pharm.D.		√	√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.			√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	White, Sandra L., M.D., MBA, FACR			√		
16	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				16	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

ANTIDIABETICS - NON-INSULIN- (New Drug Review)

Motion:	Drug	PDL Status
	Nesina ® (Oral) Tablet	NP/PA

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA			√		
10	Lorys, Robyn Pharm.D.			√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.	√		√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	Yates, Mary Virginia "Ginny", Pharm.D.		√	√		
				15	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

ANTINEOPLASTICS - (New Drug Review)

Motion:	Drug	PDL Status	DCH is to require Oncologist as the prescriber
	Pomalyst ® (Oral) Capsule	NP/PA	

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair		√	√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.	√		√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.				√	
9	Jones, Edwina L., Pharm.D., MBA		√ (Add Oncologist as prescriber to PA Criteria)	√		
10	Lorys, Robyn Pharm.D.	√ (Add Oncologist as prescriber to PA criteria)		√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.			√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				14	1	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

OPHTHALMIC PROSTAGLANDINS - (New Drug Review)

Motion:	Drug	PDL Status
	Rescula ® (Ophthalmic) Drops	NP/PA

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA		√	√		
10	Lorys, Robyn Pharm.D.	√		√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.			√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				15	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

20

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

SOMATOSTATIC AGENTS - (New Drug Review)

Motion:	Drug	PDL Status
	Signifor (Sub-Q) Ampule	NP/PA

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.		√	√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA	√		√		
10	Lorys, Robyn Pharm.D.			√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.			√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				15	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

ANTIMYCOBACTERIAL AGENTS - (New Drug Review)

Motion:	Drug	PDL Status	DCH is to include direct observation therapy in its criteria for prior authorization.
	Sirturo™ (Oral) Tablet	P/PA	

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.	√		√		
9	Jones, Edwina L., Pharm.D., MBA			√		
10	Lorys, Robyn Pharm.D.		√	√		
11	Miller, Osgood (Drew) A. R.Ph.			√		
12	Paul, Donald A., M.D.			√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				15	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

MUTIPLE SCLEROSIS AGENTS - (New Drug Review)

Motion:	Drug	PDL Status
	Betaseron® (Sub-Q) Kit	**NP/PA**
	Extavia® (Sub-Q) Kit	**P**
	Tecfidera® (Oral) Capsule DR	**NP/PA**

	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA			√		
10	Lorys, Robyn Pharm.D.	√ (Betaseron® & Extavia®)		√		
11	Miller, Osgood (Drew) A. R.Ph.		√	√		
12	Paul, Donald A., M.D.	√ (Tecfidera®)		√		
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				15	0	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

Drug Utilization Review Board

Motions - Votes

New Drugs

December 10, 2013

GANGLIONIC BLOCKERS - (New Drug Review)

	Motion:	Drug	PDL Status	DCH is to ensure that the prior authorization criteria for this medication is similar to that of the Vecamyl Total Care Program		
		Vecamyl™ (Oral) Tablet	NP/PA			
	Board Members - Present	Motion Maker (√)	Seconded By (√)	VOTES YES (√)	NO (√)	ABSTAIN (√)
1	Ashworth, Laurel E. Pharm.D. - Chair			√		
2	Avery, Mia, Pharm.D.			√		
3	Bona, Joseph R. M.D. - Co-Chair			√		
4	Damon, Ann R., Pharm.D.			√		
5	Doad, Gurinder J.S., M.D.			√		
6	Fincher, Deborah W., M.S., R.Ph.			√		
7	Fowler, M. Celeste, Pharm.D.			√		
8	Gore, Thomas B., M.D.			√		
9	Jones, Edwina L., Pharm.D., MBA			√		
10	Lorys, Robyn Pharm.D.		√	√		
11	Miller, Osgood (Drew) A. R.Ph.	√		√		
12	Paul, Donald A., M.D.				√	
13	Rollins, Brent L., R.Ph., Ph.D.			√		
14	Shervette III, Robert E., M.D.			√		
15	Yates, Mary Virginia "Ginny", Pharm.D.			√		
				14	1	0

	Board Members - Absent
1	Greeson, John D., M.D., MBA
2	May, J. Russell (Rusty)
3	White, Sandra L., M.D., MBA, FACR

Drug Utilization Review Board Meeting

December 10 , 2013

Therapeutic Class	Drug Name	Current PDL Status	DCH Decisions
New Drug Reviews			
Antineoplastics			
	Cometriq (Oral) Capsule	P/PA	P/PA
	Pomalyst (Oral) Capsule	P/PA	P/PA
Ophthalmic Miscellaneous			
	Cystaran (Ophthalmic) Drops	P	P
Antiemetic			
	Diclegis (Oral) Tablet Delayed-Release	NP	NP
Antidiarrheal			
	Fulyzaq (Oral) Tablet Delayed-Release	NP/PA	NP/PA
Antidiabetics			
	Invokana (Oral) Tablet	NP/PA	NP/PA
	Nesina (Oral) Tablet	NP/PA	NP/PA
Ophthalmic Prostaglandin			
	Rescula (Ophthalmic) Drops	NP/PA	NP/PA
Somatostatic Agent			
	Signifor (Subcutaneous) Ampule	NP/PA	NP/PA
Antimycobacterial Agent			
	Sirturo (Oral) Tablet	P/PA	P/PA
Multiple Sclerosis Agent			
	Tecfidera (Oral) Capsule Delayed-Release	NP/PA	NP/PA
Ganglionic Blocker			
	Vecamyl (Oral) Tablet	NP/PA	NP/PA

PDL=Preferred Drug List; P=preferred; NP=non-preferred; PA=prior authorization

This page intentionally left blank

Manufacturers' Forum
Manufacturer Presentations

Dates: February 6, 2014 and February 19, 2014

Location: NorthStar HealthCare Consulting
1121 Alderman Drive
Suite 112
Alpharetta, Georgia 30005

Attendees
Department of Community Health
Linda Wiant, PharmD, Director, Pharmacy Services
Jessica Chen, PharmD Candidate

NorthStar HealthCare Consulting
Tara R. Cockerham, PharmD, Clinical Programs Director
Emily Baker, PharmD, BCPS, MBA, MHA, President
Dan Alday, RPh, Director, Clinical Programs & Analytics
Lauren Ellison, PharmD, BCPS, Resident
Joshua Meeks, PharmD Candidate

Catamaran Health Solutions
Talmahjia "Tami" Sweat, PharmD, Director, Clinical Management, Public Sector

Drug Summary Documents
Please note that relevant, electronic materials that were provided by manufacturers were forwarded to the Drug Utilization Review Board (DURB). For the drugs presented at the Forum that are being reviewed at the March 18, 2014 DURB meeting, the information is highlighted below. For those manufacturers that presented but their drug has been moved to be reviewed at the June meeting, the information presented will be provided for that meeting. The manufacturers presenting at the Forum referred the audience and the readers of the materials to the prescribing information for additional information on the drug, especially in regards to safety.

Drug Presentations

I. ViiV Healthcare
Cathy Schubert, PharmD, BCPS, Senior Regional Medical Scientist

Tivicay® (dolutegravir)
Pronunciation: TIV-eh-kay (doe-loo-TEG-ra-vir)

Guidelines
The Department of Human and Health Services (DHHS) Panel on Antiretroviral Guidelines for Adults and Adolescents recommends four integrase strand-transfer inhibitor (INSTI)-based regimens for use in antiretroviral (ARV)-naive patients, including: dolutegravir (DTG) 50 mg once daily (QD) plus abacavir/lamivudine (ABC/3TC) 600 mg/300 mg (in patients who are HLA-B*5701 negative), and DTG 50 mg QD plus tenofovir/emtricitabine (TDF/FTC) 300 mg/200 mg.

Description and Indication
Tivicay is an HIV-1 INSTI, available in film–coated tablets containing 50 mg DTG. Tivicay is indicated in combination with other ARV agents for the treatment of HIV-1 in adults and children ≥ 12 years and ≥ 40 kg. The following should be considered prior to initiating Tivicay: poor virologic response was observed in subjects treated with Tivicay 50 mg twice daily with an INSTI-associated resistance Q148 substitution plus two or more additional INSTI substitutions including L74I/M, E138A/D/K/T, G140A/S, Y143H/R, E157Q, G163E/K/Q/R/S, or G193E/R.

Dosing
Tivicay may be taken without regard to meals and does not require a pharmacokinetic booster.
- The recommended dose of Tivicay is 50 mg once daily in:

1. Antiretroviral-therapy (ART)-naive adults, as well as adults who are ART-experienced and INSTI-naive.
2. Pediatric patients aged 12 years and older, weighing at least 40 kg, who are INSTI-naïve.

- The recommended dose of Tivicay is 50 mg twice daily in:

1. ART-naive or ART-experienced, INSTI-naive adults or pediatric patients taking the following potent UGT1A1/CYP3A4 inducers: efavirenz (EFV), fosamprenavir/ritonavir (FPV/r), tipranavir/ritonavir (TPV/r), or rifampin.
2. INSTI-experienced adults with INSTI-associated resistance substitutions (L74I/M, E138A/D/K/T, G140A/S, Y143H/R, E157Q, G163E/K/Q/R/S, or G193E/R) or clinically-suspected INSTI resistance. Consider combinations without metabolic inducers.

Efficacy Data

- SPRING-2 randomized 822 ART-naive subjects to Tivicay 50 mg QD or raltegravir (RAL) 400 mg BID, each in combination with investigator-selected, dual-NRTI backbone (either QD ABC/3TC or TDF/FTC). The efficacy analysis included 808 subjects. At Week 48, rates of HIV-1 RNA <50 copies/mL were 88% for Tivicay plus 2 NRTIs versus 86% for RAL plus 2 NRTIs (treatment difference (TD): 2.6% [95% confidence interval (CI): -1.9%, 7.2%]).
- SINGLE randomized 833 ART-naive subjects to receive Tivicay 50 mg QD plus ABC/3TC QD, or EFV/TDF/FTC QD. Week-48 rates of HIV-1 RNA <50 copies/mL were 88% for Tivicay plus ABC/3TC versus 81% for EFV/TDF/FTC (TD: 7.4% [95% CI: 2.5%, 12.3%]).
- No ART-naive subjects receiving Tivicay 50 mg QD in SPRING-2 or SINGLE had a decrease in susceptibility to DTG or NRTIs in the resistance analysis subset (n = 6 with HIV-1 RNA >400 copies/mL at failure or last visit through Week 48 and having resistance data). An additional subject in SINGLE (275 copies/mL HIV-1 RNA) had a treatment-emergent INSTI- (E157Q/P) detected at Week 24, but no corresponding decrease in DTG susceptibility. No emergent resistance to the NRTIs was isolated in the DTG arms.
- SAILING randomized 719 ART-experienced, INSTI-naive subjects with multiclass ART resistance to receive Tivicay 50 mg QD or RAL 400 mg BID, each combined with investigator-selected background regimen (BR) (restricted to ≤2 ARVs with ≥ 1 fully-active agent). The efficacy analysis included 715 subjects. At the Week-24 pre-specified interim analysis, the rates of HIV-1 RNA <50 copies/mL were 79% for Tivicay plus BR versus 70% for RAL plus BR (TD: 9.7% [95% CI: 3.4%, 15.9%]).
- In SAILING, viruses from 5 of 15 subjects receiving Tivicay with post-baseline resistance data had evidence of treatment-emergent integrase substitutions (1 subject each with L74I/M, Q95Q/L, or V151V/I, and 2 subjects with R263K). However, none of these subjects' isolates had detectable phenotypic decreases in susceptibility to either DTG or RAL. Nine of 32 RAL subjects with post-baseline resistance data had evidence of emergent INSTI-resistance substitutions (L74M, E92E/Q, Q95Q/R, T97A, G140A/S, Y143C/R, Q148H/R, V151I, N155H, E157E/Q, and G163G/R) and RAL phenotypic resistance.
- The open-label, single-arm VIKING-3 trial enrolled 183 ART-experienced adults with multiclass ART resistance. Subjects had virological failure on, and current/historical evidence of resistance to, RAL and/or elvitegravir. Subjects received TIVICAY 50 mg BID with the current failing regimen (functional monotherapy) for 7 days, followed by TIVICAY plus optimized background therapy from Day 8. Mean reduction in HIV-1 RNA by Day 8 was 1.4 log10 (95% CI: 1.3 log10, 1.5 log10). At Week 24 in the first 114 subjects with available data; 63% had HIV-1 RNA<50 copies/mL (co-primary endpoint).
- 75% (33/44) of VIKING-3 subjects with only historic evidence of INSTI resistance at baseline achieved HIV-1 <50 copies/mL at Week 24. The response rate was 36% (13/36) when integrase substitutions at Q148 were present at baseline; Q148 was always present with additional INSTI-resistance substitutions. Diminished virologic responses (25% [7/28]) were observed when ≥3 of the following INSTI-resistance substitutions were present at baseline: L74I/M, E138A/D/K/T, G140A/S, Y143H/R, Q148H/R, E157Q, G163E/K/Q/R/S, or G193E/R.

Contraindications

Coadministration of *Tivicay* with dofetilide is contraindicated due to the potential for increased dofetilide plasma concentrations and the risk for serious and/or life-threatening events.

Warnings and Precautions

- Hypersensitivity reactions (HSR) characterized by rash, constitutional findings, and sometimes organ dysfunction, including liver injury, have been reported in <1% of subjects. Discontinue *Tivicay* and other suspect agents immediately if signs/symptoms of HSR develop. A delay in stopping therapy may result in a life-threatening reaction. *Tivicay* should not be used in patients with a previous HSR to *Tivicay*.
- Patients with underlying hepatitis B or C may be at increased risk for worsening or development of transaminase elevations with use of *Tivicay*. Appropriate laboratory testing prior to initiating therapy and monitoring during therapy with *Tivicay* is recommended.
- Redistribution/accumulation of body fat and immune reconstitution syndrome have been reported in patients treated with ART.

- Most common adverse reactions (moderate/severe intensity, incidence ≥2% in *Tivicay* arm in any one adult trial) are insomnia and headache.

Questions and Answers
Q: What were the overall results of head-to-head trials?
A: Dolutegravir was found to be noninferior to raltegravir in treatment-naïve patients; superior to raltegravir in treatment-experienced, integrase inhibitor-naïve, resistant patients; noninferior and superior when used with abacavir/lamivudine vs. efavirenz/tenofovir/emtricitabine in treatment-naïve patients; and noninferior and superior to boosted protease inhibitor.

Q: What are considered the advantages of Tivicay?
A: Once daily dosing with no pharmacokinetic booster, few drug-drug interactions, do not need to take with food, no integrase inhibitor resistance and efficacy in treatment-naïve, treatment-experienced and treatment-resistant patients.

Q: Do physicians regularly test for integrase inhibitor resistance?
A: Integrase inhibitor resistance testing is becoming regular part of testing especially if patient is not responding or responds then rebounds.

Q: How are other Medicaid plans covering Tivicay?
A: The majority of Medicaid plans cover without prior authorization (PA); a few Medicaid plans have an auto PA in place requiring a HIV diagnosis only. This means that 86% of Medicaid plans have unrestricted access ("Auto PAs" included); this covers about 94% of HIV lives. Most of the remaining 14% of Medicaid plans (6% of HIV lives) are still working through their process and the restrictions are not final.

II. Vertex

Michelle Mattox, PharmD, Managed Care Liaison II
Daniel Petty, PharmD, MBA, Regional Account Manager

Incivek® (telaprevir)
Pronunciation: In-SEE-veck (tel-A-pre-vir)

A one-page summary was not provided due to Vertex is no longer promoting Incivek.

New Information
- New dosing of 3 tablets twice daily that showed similar efficacy and safety compared to previous dosing of 2 tablets three times a day.
- New packaging with blister strips to support twice daily dosing.
- New contraindications of avoid concomitant use with carbamazepine, phenobarbital and phenytoin.

Questions and Answers
Q: Was adherence to twice daily vs. three times daily dosing evaluated?
A: Yes, a poster presentation by Sievert et al showed adherence was significantly greater with twice daily dosing compared to three times a day dosing and that higher adherence was associated with greater odds of achieving sustained virologic response at 12 (SVR12) weeks.

Q: Were adverse events increased with twice daily dosing?
A: No, twice daily dosing did not increase adverse events and incidence of rash was the same as with three times daily dosing. Less than 1% of the 65,000 patients worldwide that have received Incivek have experienced serious skin reactions. Three deaths occurred outside of the US due to therapy was not stopped when patients started experiencing serious skin reactions.

Q: How are other plans covering direct inhibitors since new agents have entered market?
A: TennCare is not pushing to Incivek or Victrelis for Sovaldi but is for Olysio; FL is holding requests for Sovaldi and Olysio due to insufficient data.

III. Purdue

Maribeth Kowalski, PharmD, MS, CPE, Director, Medical Science Liaison
Michael Packer, Senior Regional Account Executive

Charles W. Simpson, II, Western Area Manager

Butrans® (buprenorphine transdermal system)
Pronunciation: BYOO-trans (byoo pre NOR feen)

Butrans is a Schedule III, seven-day transdermal formulation of buprenorphine indicated for the management of moderate to severe chronic pain when a continuous, around-the-clock opioid analgesic is needed for an extended period of time. Butrans has been studied and is approved for use in appropriate opioid-naïve or opioid-experienced patients requiring up to 80 mg/day oral morphine equivalents (i.e., 40 mg/day of hydrocodone or oxycodone).

Cited for your review are eight articles published in 2013 and 2014 on Butrans clinical studies. Of note, two of these studies are pharmacokinetic studies, three are analyses of quality of life endpoints from Butrans pivotal studies, one is an analysis of application site reactions from 16 Butrans clinical studies, one is an analysis of patient factors associated with Butrans persistence, and one is an evaluation of dose patterns among patients using Butrans.

Butrans has limitations of use which state that Butrans is not for use as an as-needed (prn) analgesic, for pain that is mild or not expected to persist for an extended period of time, for acute pain, for postoperative pain unless the patient is already receiving chronic opioid therapy prior to surgery or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time. The Butrans Full Prescribing Information includes a Boxed Warning describing the abuse potential, risk of life-threatening respiratory depression, and risk of accidental exposure.

While the FDA approved indication and boxed warning for Butrans may be similar to or the same as other long-acting opioids, there are some distinct differences in terms of appropriate patient selection for Butrans therapy. Butrans Transdermal System is available in four dosage strengths – 5, 10, 15, and 20 mcg/hour. Butrans is intended to be worn for 7 days and may be appropriate for opioid-naive patients or opioid-experienced patients requiring up to 80 mg/day of oral morphine equivalents (e.g., up to 40 mg/day of oral oxycodone or hydrocodone). The highest dosage of Butrans 20 mcg/hour may not provide adequate analgesia for patients requiring greater than 80 mg/day of oral morphine equivalents (e.g., >40 mg/day of oral oxycodone or hydrocodone). The maximum Butrans dose is 20 mcg/hour. Do not exceed a dose of one 20 mcg/hour Butrans system due to the risk of QTc interval prolongation.

Purdue recommends adding Butrans as a preferred agent because Butrans meets an unmet need in certain patients with chronic pain. Butrans should be used in patients who require up to 80 mg per day of oral morphine equivalents and, in general, before transdermal fentanyl or other extended-release or long-acting opioids. Patients who are required to step through transdermal fentanyl or other extended-release or long-acting opioids will be at risk of inadequate or poor pain control and opioid withdrawal with Butrans. As an example, most patients who require transdermal fentanyl therapy are not appropriate for Butrans therapy because they must be 1) opioid-tolerant and 2) require 60-134 mg/day of oral morphine equivalents to meet the criteria for the lowest starting dose of 25 mcg/hour of transdermal fentanyl.

Therefore, we feel that Butrans, a 7-day, Schedule III, centrally-acting, semi-synthetic, partial mu-opioid agonist analgesic should be considered for addition to the PDL to provide an additional choice for prescribers needing a long-acting opioid analgesic delivered via a transdermal system.

Questions and Answers
Q: What issues are there with Butrans prior authorization (PA) criteria?
A: In the Butrans clinical trials, patients that had previously been on fentanyl or oral extended-release morphine were not allowed and patients that fail these therapies per criteria are not patients that should use Butrans. In addition, prescribers are not willing to go through PA or appeals process.

Q: What are considered the advantages of Butrans?
A: First and only 7-day transdermal opioid, is a schedule III and patients can be opioid-naïve or opioid-experience if they require ≤80 mg/day of oral morphine.

OxyContin® (oxycodone hydrochloride extended-release)
Pronunciation: Ox-e-KON-tin (OX-ee-KOE-dohn HIGH-droe-KLOR-ide)

OxyContin is indicated for the management of moderate to severe pain when a continuous, around-the-clock opioid

analgesic is needed for an extended period of time. OxyContin contains oxycodone, a Schedule II controlled substance with a high potential for abuse similar to other opioid agonists, legal or illicit. The OxyContin Full Prescribing Information (FPI) includes a Boxed Warning describing the abuse potential, risk of life-threatening respiratory depression, and risk of accidental exposure.

Purdue reformulated OxyContin with physicochemical properties that are intended to make the tablet more difficult to manipulate for purpose of abuse by various routes of administration (eg, snorting and intravenous injection) or misuse by inadvertent medication error (eg, crushing or cutting a tablet). In August 2010, Purdue stopped shipment of the original OxyContin and subsequently only the reformulated OxyContin has been marketed.

New Information
On April 16, 2013, the FDA approved a supplemental application for reformulated OxyContin, approving updates to the OxyContin FPI, which describe the abuse deterrent characteristics of OxyContin as demonstrated by *in vivo* and *in vitro* studies. This updated information can be found in section 9.2, titled Abuse, of the FPI. Briefly, this section describes data from *in vitro* testing and a clinical study demonstrating that OxyContin has properties that are expected to reduce abuse via injection or the intranasal routes, respectively. However, abuse of OxyContin by these and the oral route is still possible. Additionally, the FPI states that additional data, including epidemiological data, when available, may provide further information on the abuse liability of the product. Cited for your reference are seven recently published articles on *in vitro* abuse deterrence testing, human pharmacokinetic and epidemiologic studies evaluating the impact of reformulated OxyContin on abuse, diversion, and unintentional medication errors.

In addition, the Committee should be aware that continued support for the development and approval of abuse deterrent formulations for opioids was recently demonstrated by the submission of a document, signed by the Attorneys General for 46 states, to include Sam Olens, then Attorney General for Georgia. In a letter to FDA commissioner Margaret Hamburg, the attorneys general, writing on behalf of the National Association of Attorneys General, wrote that people who abuse opioid painkillers are increasingly using those that lack tamper-resistant features, and applauded the FDA for proposing guidelines establishing clear standards for manufacturers who develop and market tamper- and abuse-resistant opioid products.

If pain medications that incorporate abuse-deterrent properties are developed at considerable time and effort and are approved by FDA under stringent standards but, in practice, are unavailable to many patients, the product's full benefits to society including any cost savings that can be gained by reducing prescription drug abuse will never be realized. Therefore, given all of the concerns of opioid abuse, misuse, and diversion, it would seem inherent upon this Committee to consider reformulated OxyContin for addition to the PDL to provide an additional choice for prescribers in the State of Georgia needing an appropriate prescription of a long-acting opioid analgesic.

Questions and Answers
Q: How are other Medicaid plans covering abuse-deterrent OxyContin?
A: States are starting to look at due to data becoming available. Legislation has been filed to look at abuse-deterrent products nationally and 46 states have signed on to abuse-deterrent.

Q: Is there completed data on outcomes of abuse-deterrent products?
A: Yes, approximately 8 studies have been published since 2013 and 15 studies are in progress. Studies have shown significant decreased rates in abuse, routes of abuse and diversion with the abuse-deterrent formulation.

IV. Gilead

Ray E. Lancaster, BS, PharmD
Robert Firnberg, Senior Manager, National Accounts
Eric Kimelblatt, Director, National Accounts

Sovaldi® (sofosbuvir)
Pronunciation: Soh-VAHL-dee (soe fos' bue vir)

SOVALDI is a hepatitis C virus (HCV) nucleotide analog NS5B polymerase inhibitor (chain terminator) indicated for the treatment of chronic hepatitis C (CHC) infection as a component of a combination antiviral treatment regimen.

- SOVALDI efficacy has been established in subjects with HCV genotype (GT) 1, 2, 3 or 4 infection, including those with hepatocellular carcinoma (HCC) meeting Milan criteria (awaiting liver transplantation) and those with HCV/HIV-1 coinfection.

Simplified dosing regimen: The recommended dose of SOVALDI is one 400 mg tablet, taken orally, once daily with or without food for 12 or 24 weeks.

- SOVALDI should be used in combination with ribavirin (RBV) or in combination with pegylated interferon (PegIFN) and RBV for the treatment of CHC in adults. No response guided algorithm for SOVALDI-based regimens.
- SOVALDI in combination with RBV for 24 weeks can be considered as a therapeutic option for CHC patients with GT 1 infection who are ineligible to receive an interferon-based regimen. Treatment decision should be guided by an assessment of the potential benefits and risks for the individual patient.
- For patients with HCC awaiting liver transplantation, SOVALDI in combination with RBV is recommended for up to 48 weeks or until the time of liver transplantation, whichever occurs first, to prevent post-transplant HCV reinfection.
- No dose adjustment of SOVALDI is required for patients with mild, moderate or severe hepatic impairment (Child-Pugh Class A, B or C). Safety and efficacy of SOVALDI have not been established in patients with decompensated cirrhosis.

Potent Efficacy with High SVR Rates: Table 2 presents the SVR results from each of the key clinical studies with SOVALDI. SVR rates were consistent across ages (19 – 77 years), race, and BMI (17 – 56 kg/m^2).

Table 2. SOVALDI Key Studies[a]: SVR Results

Study	**Primary Efficacy Endpoint: SVR12**		
NEUTRINO: treatment naïve	**Overall**	**Genotype 1**	**Genotypes 4, 5, 6**
SOVALDI + PegIFN/RBV × 12 weeks	90% (cirrhotics- 80%)	89%	96%
FISSION: treatment naïve	**Overall**	**Genotype 2**	**Genotype 3**
SOVALDI + RBV × 12 weeks	67%	95% (cirrhotics- 83%)	56%
PegIFN/RBV × 24 weeks	67%	78%	63%
POSITRON: IFN not-an-option	**Overall**	**Genotype 2**	**Genotype 3**
SOVALDI + RBV × 12 weeks	78%	93% (cirrhotics- 94%)	61%
Placebo	0%	0%	0%
FUSION: treatment experienced	**Overall**	**Genotype 2**	**Genotype 3**
SOVALDI + RBV × 12 weeks	50%	82% (cirrhotics- 60%)	30%
SOVALDI + RBV × 16 weeks	71%	89%	62%
VALENCE: treatment-naïve and treatment-experienced		**Genotype 2 12 weeks**	**Genotype 3 24 weeks**
SOVALDI + RBV, overall		93%	84%
treatment-naive		97% (cirrhotics- 100%)	93% (cirrhotics- 92%)
treatment-experienced		90% (cirrhotics- 88%)	77% (cirrhotics- 60%)
PHOTON-1: HIV/HCV coinfection, treatment-naïve and treatment-experienced	**Genotype 1 24 weeks Treatment-naïve**	**Genotype 2 12 weeks Treatment-naïve**	**Genotype 3 24 weeks Treatment-experienced**
SOVALDI + RBV, overall	76%	88%	92%

[a] Treatment duration is not guided by patients' on-treatment HCV RNA levels (i.e., no response-guided algorithm is necessary).

Drug-drug interaction profile: Drugs that are potent P-gp inducers in the intestine (e.g., rifampin, St. John's wort) may significantly decrease sofosbuvir plasma concentrations and may lead to a reduced therapeutic effect of SOVALDI. There are no significant drug interactions with cyclosporine, darunavir/ritonavir, efavirenz, emtricitabine, methadone, raltegravir, rilpivirine, tacrolimus, or tenofovir disoproxil fumarate.

High Barrier to Resistance: No patients developed resistance to SOVALDI when used in combination with RBV ± PegIFN and no baseline resistance screening is required.

Low Discontinuation Rates: Across the SOVALDI phase 3 studies; there were low rates of treatment discontinuations (1.5-3%) due to adverse events.

Adverse Reactions: SOVALDI was generally safe and well-tolerated in clinical studies to date (>3000 patients). Reported adverse events with SOVALDI-based regimens were consistent with the expected profiles of PegIFN/RBV and RBV treatments. Most common (≥20%, all grades) adverse reactions for SOVALDI + PegIFN/RBV combination therapy were fatigue, headache, nausea, insomnia, and anemia and SOVALDI + RBV combination therapy were fatigue and headache.

Questions and Answers
Q: Which prescribers are Gilead marketing Sovaldi to?
A: Gilead is marketing Sovaldi to gastroenterologists, hepatologists and infectious disease; Gilead is not marketing Sovaldi to primary care physicians.

Q: Will indication in genotypes 5 and 6 be pursued?
A: Most likely not in the US since genotype 5 is primarily found in Africa and genotype 6 is primarily found in Asia.

V. UCB

Erica Werts, PharmD, Immunology Medical Science Liaison
Ashley Mikles, MBA, Regional Account Executive

Cimzia® (certolizumab pegol)
Pronunciation: CIM-zee-uh (SER-toe-LIZ-oo-mab PEG-ol)

CIMZIA (certolizumab pegol) is approved for reducing signs and symptoms of Crohn's disease (CD) and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy; the treatment of adult patients with moderate to severely active Rheumatoid Arthritis (RA); and the treatment of active psoriatic arthritis (PsA) and active ankylosing spondylitis (AS). CIMZIA is available as pre-filled syringes and as lyophilized powder.

New Information
Recently, updates have been made to the following sections of the approved prescribing information: Specific Populations, Warning and Precautions, Clinical Studies, and Post-Marketing Experience. These include Hepatitis B Virus Reactivation and Immunizations (Section 5.5 and 5.10), and the addition of clinical data to Use in Specific Populations (Section 8), Psoriatic Arthritis (Section 14.3) and Ankylosing Spondylitis (Section 14.4). The post-marketing section has been updated to include sarcoidosis (Section 6.2) as a reported adverse event.

The updated sections provide information regarding testing for HBV infection before beginning an anti-TNF, vaccine responses in patients receiving CIMZIA, placental transfer of CIMZIA in pregnant women, and clinical trial data in patients with active PsA and active AS.

- Periodic skin examinations are recommended for all patients, particularly those with risk factors for skin cancer.
- Hepatitis B virus reactivation – test for HBV infection before starting CIMZIA. Monitor HBV carriers during and several months after therapy. If reactivation occurs, stop CIMZIA and begin anti-viral therapy.
- In a placebo-controlled clinical trial of patients with RA, no difference was detected in antibody response to vaccine between CIMZIA and placebo treatment groups when the pneumococcal polysaccharide vaccine and influenza vaccine were administered concurrently with CIMZIA.
- In an independent clinical study conducted in 10 pregnant women with CD treated with Cimzia, concentrations were measured in maternal blood as well as in cord and infant blood (n=12) at the day of birth. Plasma Cimzia concentrations were lower (by at least 75%) in the infants than in mothers, suggesting low placental transfer of Cimzia. In one infant, the plasma concentration declined from 1.02 to 0.84 µg/mL over 4 weeks suggesting that CIMZIA may be eliminated at a slower rate in infants than adults.
- Cimzia remains Pregnancy Category B.
- The efficacy and safety of CIMZIA were assessed in a Phase III trial in 409 patients (≥18 years) with active PsA of at least 6 months' duration despite DMARD therapy. Previous treatment with one anti-TNF biologic therapy was allowed. Patients were evaluated for signs and symptoms (ACR20 response) at Week 12 and structural damage (modified Total Sharp Score) at Week 24.
- The efficacy and safety of CIMZIA were assessed in one multicenter, randomized, double-blind, placebo-controlled study in 325 patients ≥18 years of age with adult-onset active axial spondyloarthritis for at least 3 months. The majority of patients in the study had active AS. Patients were evaluated for signs and symptoms (ASAS 20 response) at Week 12.

Serious and sometimes fatal side effects have been reported with CIMZIA, including tuberculosis (TB) and other serious infections. Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients. CIMZIA is not indicated for use in pediatric patients. The risks and benefits of treatment with CIMZIA should be carefully considered prior to initiating therapy in patients.

With over 10 years of clinical experience and over 110,000 patient-years of cumulative market exposure with CIMZIA, I

respectfully ask you to considering adding CIMZIA on the Georgia Pharmacy PDL.

Questions and Answers
Q: Are there any head-to-head trials?
A: An ongoing trial of certolizumab pegol compared to adalimumab in rheumatoid arthritis is ongoing.

Q: How are other Medicaid plans covering Cimzia?
A: Most states have PA except 5-6 states. Cimzia is preferred for about 50% of fee-for-service lives.

Q: Why is placental transfer important?
A: If patient has exposure to TNF therapy in utero, there is concern with exposure to live virus vaccinations after birth so will not immunize child within certain time period if exposed to TNF therapy in utero. Cimzia does not have Fc component and thus has low transfer across the placenta.

VI. AstraZeneca

Kathy J. Berkowitz, APRN, FNP-BC, CDE, Senior Regional Scientific Manager
Negelle Y. Green, LCSW, Account Director

Kombiglyze® XR (saxagliptin and metformin hydrochloride extended-release)
Pronunciation: sax-a-GLIP-tin and met-FOR-min hye-droe-KLOR-ide

Indications and Limitations of Use
- KOMBIGLYZE XR is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus when treatment with both saxagliptin and metformin (met) is appropriate.
- KOMBIGLYZE XR should not be used for the treatment of type 1 diabetes mellitus or diabetic ketoacidosis.
- KOMBIGLYZE XR has not been studied in patients with a history of pancreatitis.

Clinical Trial Efficacy
There have been no clinical efficacy or safety studies conducted with Kombiglyze XR to characterize its effect on A1C reduction. Bioequivalence of Kombiglyze XR with coadministered saxagliptin and met HCl XR tablets has been demonstrated; however, relative bioavailability studies between Kombiglyze XR and coadministered saxagliptin and met immediate-release (IR) tablets haves not been conducted. The met XR tablets and met IR tablets have a similar extent of absorption (as measured by AUC) while peak plasma levels of XR tablets are ~20% lower than those of IR tables at the same dose.
Saxagliptin Add-On Combination Therapy with Metformin plus Sulfonylurea
- A 24-week, randomized, double-blind, placebo-controlled trial in T2DM patients inadequately controlled (A1C ≥7% to ≤10%) for at least ≥8 weeks on Metformin (≥1500 mg) plus a sulfonylurea (≥50% of the maximum recommended dose) was conducted. Patients (n=257) were randomized 1:1 to double-blind treatment with either Saxagliptin 5mg + Metformin + Sulfonylurea (n=129) or Placebo + Metformin + Sulfonylurea (n=128).
- The percentage of patients who discontinued for lack of glycemic control was 6% in the Saxagliptin + Metformin + Sulfonylurea group and 5% in the Placebo + Metformin + Sulfonylurea group.
- Saxagliptin + Metformin + Sulfonylurea provided significant mean reductions from baseline in A1C vs. Placebo + Metformin + Sulfonylurea (-0.7% vs. -0.1%, respectively; P<0.0001).

Important Safety Information
WARNING: LACTIC ACIDOSIS
Contraindications
- Renal impairment (eg, serum creatinine levels ≥1.5 mg/dL for men, ≥1.4 mg/dL for women, or abnormal creatinine clearance)
- Hypersensitivity to metformin hydrochloride
- Acute or chronic metabolic acidosis, including diabetic ketoacidosis
- History of a serious hypersensitivity reaction to KOMBIGLYZE XR or saxagliptin (eg, anaphylaxis, angioedema, or exfoliative skin conditions)

Warnings and Precautions
- The reported incidence of lactic acidosis in patients receiving metformin is very low (approximately 0.03 cases/1000 patient-years). When it occurs, it is fatal in approximately 50% of cases. Reported cases of lactic acidosis have occurred primarily in diabetic patients with significant renal insufficiency.

- Patients with congestive heart failure requiring pharmacologic management, in particular those with unstable or acute congestive heart failure who are at risk of hypoperfusion and hypoxemia, are at increased risk of lactic acidosis.
- Lactic acidosis risk increases with the degree of renal dysfunction and patient age. The risk may be significantly decreased by use of minimum effective dose of metformin and regular monitoring of renal function. Careful renal monitoring is particularly important in the elderly. KOMBIGLYZE XR should not be initiated in patients ≥80 years of age unless measurement of creatinine clearance demonstrates that renal function is not reduced.
- Withhold KOMBIGLYZE XR in the presence of any condition associated with hypoxemia, dehydration, or sepsis.
- There have been postmarketing reports of acute pancreatitis in patients taking saxagliptin. After initiating KOMBIGLYZE XR, observe patients carefully for signs and symptoms of pancreatitis. If pancreatitis is suspected, promptly discontinue KOMBIGLYZE XR and initiate appropriate management. It is unknown whether patients with a history of pancreatitis are at increased risk of developing pancreatitis while using KOMBIGLYZE XR.
- Before initiation of KOMBIGLYZE XR, and at least annually thereafter, renal function should be assessed and verified as normal.
- KOMBIGLYZE XR is not recommended in patients with hepatic impairment.
- Metformin may lower vitamin B12 levels. Measure hematological parameters annually.
- Warn patients against excessive alcohol intake.
- KOMBIGLYZE XR should be suspended for any surgical procedure (except minor procedures not associated with restricted intake of food and fluids), and should not be restarted until patient's oral intake has resumed and renal function is normal.
- Hypoglycemia with Concomitant Use of Sulfonylurea or Insulin - Saxagliptin: When saxagliptin was used in combination with a sulfonylurea or with insulin, medications known to cause hypoglycemia, the incidence of confirmed hypoglycemia was increased over that of placebo used in combination with a sulfonylurea or with insulin. Therefore, a lower dose of the insulin secretagogue or insulin may be required to minimize the risk of hypoglycemia when used in combination with KOMBIGLYZE XR.
- Metformin: Hypoglycemia does not occur in patients receiving metformin alone under usual circumstances of use, but could occur when caloric intake is deficient, when strenuous exercise is not compensated by caloric supplementation, during concomitant use with other glucose-lowering agents (such as sulfonylureas or insulin), or with use of ethanol. Elderly, debilitated, or malnourished patients and those with adrenal or pituitary insufficiency or alcohol intoxication are particularly susceptible to hypoglycemic effects.
- Intravascular contrast studies with iodinated materials can lead to acute alteration of renal function and have been associated with lactic acidosis in patients receiving metformin. KOMBIGLYZE XR should be temporarily discontinued at the time of or prior to the procedure, and withheld for 48 hours after the procedure and reinstituted only after renal function is normal.
- There have been postmarketing reports of serious hypersensitivity reactions in patients treated with saxagliptin, including anaphylaxis, angioedema, and exfoliative skin conditions. Onset of these reactions occurred within the first 3 months after initiation of treatment with saxagliptin, with some reports occurring after the first dose. If a serious hypersensitivity reaction is suspected, discontinue KOMBIGLYZE XR, assess for other potential causes for the event, and institute alternative treatment for diabetes. Use caution in patients with a history of angioedema to another DPP-4 inhibitor as it is unknown whether they will be predisposed to angioedema with KOMBIGLYZE XR.
- There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with KOMBIGLYZE XR or any other anti-diabetic drug.

Questions and Answers
Q: Is there any new information on Kombiglyze XR?
A: No.

Onglyza® (saxagliptin)
Pronunciation: sax-a-GLIP-tin

Indication
- ONGLYZA is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus in multiple clinical settings.

Clinical Trial Efficacy
- A total of 4148 patients with T2DM were randomized in 6, double-blind, controlled clinical trials conducted to evaluate the safety and glycemic efficacy of Saxagliptin. A total of 3021 patients in these trials were treated with Saxagliptin. In these trials, the mean age was 54 years, and 71% of patients were Caucasian, 16% were Asian, 4% were black, and 9% were of other racial groups.

- In these six, double-blind trials, ONGLYZA was evaluated at doses of 2.5 mg and 5 mg once daily. Three of these trials also evaluated a saxagliptin dose of 10 mg daily. The 10 mg daily dose of saxagliptin did not provide greater efficacy than the 5 mg daily dose. The 10 mg dosage is not an approved dosage.
- **Saxagliptin Add-On Combination Therapy with Metformin plus Sulfonylurea**

- A 24-week, randomized, double-blind, placebo-controlled trial in T2DM patients inadequately controlled (A1C ≥7% to ≤10%) for at least ≥8 weeks on Metformin (≥1500 mg) plus a sulfonylurea (≥50% of the maximum recommended dose) was conducted. Patients (n=257) were randomized 1:1 to double-blind treatment with either Saxagliptin 5mg + Metformin + Sulfonylurea (n=129) or Placebo + Metformin + Sulfonylurea (n=128).
- The percentage of patients who discontinued for lack of glycemic control was 6% in the Saxagliptin + Metformin + Sulfonylurea group and 5% in the Placebo + Metformin + Sulfonylurea group.
- Saxagliptin + Metformin + Sulfonylurea provided significant mean reductions from baseline in A1C vs. Placebo + Metformin + Sulfonylurea (-0.7% vs. -0.1%, respectively; P<0.0001).

Pharmacoeconomics - New Information

Cost and Resource Utilization of Select DPP-4 Inhibitors (Saxagliptin vs. Sitagliptin): A retrospective claims analysis of type 2 diabetes patients initiating treatment with saxagliptin or sitagliptin compared healthcare resource use and costs in the 6 months following treatment initiation. After controlling for baseline characteristics‡ saxagliptin was associated with statistically significant lower total costs vs. sitagliptin ($7,802 vs $8,302 respectively; p<0.05) § and diabetes-related costs vs. sitagliptin ($2,510 vs $2,772, respectively; p<0.001) ‖. Prior to risk adjustment, saxagliptin patients had statistically significant lower total and diabetes-related rates of inpatient stay than sitagliptin (total rates 7.2% vs 10.6% and diabetes-related rates 4.0% vs 6.6%, respectively; both p<0.05). After controlling for baseline characteristics‡, saxagliptin patients were less likely than sitagliptin patients to have an overall or diabetes-related inpatient stay. The overall inpatient resource use odds ratio for saxagliptin was 0.80 vs. sitagliptin (p<0.001). The diabetes-related inpatient resource use odds ratio for saxagliptin was 0.74 vs. sitagliptin (p<0.001).

‡Adjustments were made for baseline resource use or log of costs corresponding to each outcome, age, gender, region, baseline comorbidities such as cardiovascular events, dyslipidemia, stroke, atherosclerosis, hypertension, nephropathy, diabetic foot problems, neurological complications, subtypes of diabetes, and CCI without diabetes.
§ Total Prescription Drug Costs plus Total Medical Costs
‖ Diabetes-related Prescription Drug Costs plus Diabetes-related Medical Costs

Important Safety Information

Contraindications: History of a serious hypersensitivity reaction to ONGLYZA (eg, anaphylaxis, angioedema, or exfoliative skin conditions)

Warnings and Precautions:

- **Pancreatitis:** There have been postmarketing reports of acute pancreatitis in patients taking ONGLYZA. After initiating ONGLYZA, observe patients carefully for signs and symptoms of pancreatitis. If pancreatitis is suspected, promptly discontinue ONGLYZA and initiate appropriate management. It is unknown whether patients with a history of pancreatitis are at increased risk of developing pancreatitis while using ONGLYZA.
- **Hypoglycemia with Concomitant Use of Sulfonylurea or Insulin**: When ONGLYZA was used in combination with a sulfonylurea or with insulin, medications known to cause hypoglycemia, the incidence of confirmed hypoglycemia was increased over that of placebo used in combination with a sulfonylurea or with insulin. Therefore, a lower dose of the insulin secretagogue or insulin may be required to minimize the risk of hypoglycemia when used in combination with ONGLYZA.
- **Hypersensitivity Reactions:** There have been postmarketing reports of serious hypersensitivity reactions in patients treated with ONGLYZA, including anaphylaxis, angioedema, and exfoliative skin conditions. Onset of these reactions occurred within the first 3 months after initiation of treatment with ONGLYZA, with some reports occurring after the first dose. If a serious hypersensitivity reaction is suspected, discontinue ONGLYZA, assess for other potential causes for the event, and institute alternative treatment for diabetes. Use caution in patients with a history of angioedema to another DPP-4 inhibitor as it is unknown whether they will be predisposed to angioedema with ONGLYZA.

Most Common Adverse Reactions:

- Most common adverse reactions reported in ≥5% of patients treated with ONGLYZA and more commonly than in patients treated with control were upper respiratory tract infection (7.7%, 7.6%), headache (7.5%, 5.2%), nasopharyngitis (6.9%, 4.0%) and urinary tract infection (6.8%, 6.1%).
- When used as add-on combination therapy with a thiazolidinedione, the incidence of peripheral edema for ONGLYZA 2.5 mg, 5 mg, and placebo was 3.1%, 8.1% and 4.3%, respectively.
- Confirmed hypoglycemia was reported more commonly in patients treated with ONGLYZA 2.5 mg and ONGLYZA 5 mg compared to placebo in the add-on to glyburide trial (2.4%, 0.8% and 0.7%, respectively), with ONGLYZA 5 mg compared to placebo in the add-on to insulin (with or without metformin) trial (5.3% and 3.3%, respectively), with ONGLYZA 2.5 mg compared to placebo in the renal impairment trial (4.7% and 3.5%, respectively), and with

ONGLYZA 5 mg compared to placebo in the add-on to metformin plus sulfonylurea trial (1.6% and 0.0%, respectively).

Questions and Answers
No questions and answers followed.

Bydureon® (exenatide extended-release for injectable suspension)
Pronunciation: ex EN a tide

Indication and Important Limitations of Use
- BYDUREON is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus in multiple clinical settings.
- Not recommended as first-line therapy for patients inadequately controlled on diet and exercise.
- Use with insulin has not been studied and is not recommended
- Has not been studied in patients with history of pancreatitis. Consider other antidiabetic therapies in patients with a history of pancreatitis.

BOXED WARNING: RISK OF THYROID C-CELL TUMORS

Warnings and Precautions
Pancreatitis: Based on postmarketing data, exenatide has been associated with acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. After initiation of BYDUREON, observe patients carefully for pancreatitis (persistent severe abdominal pain, sometimes radiating to the back, with or without vomiting). If pancreatitis is suspected, BYDUREON should be discontinued promptly and should not be restarted if pancreatitis is confirmed.

Clinical Trial Efficacy
The clinical effectiveness of BYDUREON (Exenatide Once-weekly, ExQW) has been demonstrated in 6 head-to-head randomized controlled clinical trials (N = 3223) in which A1C reductions ranged from 1.3% to 1.9% in patient with baseline A1C values of 8.3% to 8.6%. Direct comparative trials showed that A1C reductions with BYDUREON were significantly greater than A1C reductions with BYETTA (Exenatide Twice-Daily, ExBID), sitagliptin, pioglitazone or insulin glargine, but significantly less than with liraglutide in T2DM patients on 1 or more other glucose-lowering therapies. In treatment naïve-patients, BYDUREON was shown to be more effective than sitagliptin, as effective as metformin, and not as effective as pioglitazone in controlling A1C. In a head to head comparator study with Byetta, Bydureon had a significantly greater reduction in fasting plasma glucose compared to Byetta at the end of the study, -35mg/dl vs -12mg/dl respectively. Although Bydureon did not provide a greater reduction in 2 hour post prandial plasma glucose compared to Byetta, Bydureon showed significant improvement from baseline to endpoint (-95.4 mg/dl p =0.0124). The risk of hypoglycemia was increased when Bydureon was used in combination with a sulfonylurea. The incidence of minor hypoglycemia without concomitant sulfonylurea was 0.0% for Bydureon and Byetta. Overall, 52% to 77% of patients treated with BYDUREON achieved an A1C of 7% and no major hypoglycemia events were observed. In extension trials, patients treated with BYDUREON for 5 years achieved A1C.

Clinical Trial Safety
An analysis of the safety of BYDUREON in 4328 patients demonstrated that BYDUREON was generally well-tolerated; head-to-head trials provided information on the adverse events observed with BYDUREON and comparators (BYETTA, insulin, liraglutide, metformin, pioglitazone, sitagliptin). The most frequent adverse event observed with BYDUREON was mild-to-moderate nausea, with an incidence lower than BYETTA or liraglutide. Most nausea events with BYDUREON were transient and occurred within the first 2 weeks of treatment then were less common over time, with only 1.4% of patients discontinuing treatment due to gastrointestinal AEs. Injection-site reactions were also observed more frequently with BYDUREON than with BYETTA (7.1% vs 2.6%). BYDUREON increased heart rate (1 to 3 beats per minute), but no increased cardiovascular risk has been observed. BYDUREON is renally excreted, so BYDUREON is contraindicated in patients with severe renal impairment. An increased incidence of thyroid C-cell tumors was observed in rats compared to controls, and BYDUREON is not indicated for use in patients with a personal or family history of thyroid C-cell tumors or Multiple Endocrine Neoplasia syndrome type 2 (MEN 2).

Real-world Adherence – New Information
Adherence to GLP-1 receptor agonists (ExQW, ExBID, and liraglutide) in were measured in adult patients with type 2 diabetes in a retrospective cohort study, using administrative claims data from the Truven Health MarketScan databases. Adherence was measured by the proportion of days covered (PDC) measure, calculated as the total number of days covered with GLP-1 supply during the post-index period divided by 180 days. Patients with a PDC ≥

80% were classified as adherent. A significantly higher proportion of patients initiating ExQW achieved a PDC ≥80% during the 6-month follow-up compared with ExBID (48.6% vs 30.3%, P<0.0001) and liraglutide (48.6% vs 44.2%, P<0.0001), respectively. After adjusting for potential confounders, adherence was significantly higher among patients initiating ExQW than patients initiating ExBID (OR=0.41, 95% CI=0.34, 0.45) and among patients initiating liraglutide (OR=0.80, 95% CI=0.75, 0.86) during the 6-month follow-up period.

Real-World A1C Outcome – New Information
Similar treatment effects were observed in a retrospective cohort study using ambulatory electronic medical record (EMR) data to evaluate A1c outcome at six-month in adult patients with type 2 diabetes initiating either ExQW or liraglutide. After adjusting for potential confounders (e.g., baseline patient and clinical characteristics), the least-squares mean change in A1C from baseline were -0.68% for ExQW compared with -0.61% for liraglutide (P=0.2751). Similarly, among the subgroup of patients with suboptimum glycemic control (A1C ≥7.0%) and no prescription for insulin during the 12-month pre-index period, the adjusted mean change in A1C at 6-month did not differ between ExQW and liraglutide (-0.94% vs -0.85%, respectively, P=0.3728).

Questions and Answers
Q: What are the key points of Bydureon?
A: Once weekly dosing, decreased GI adverse events, increased adherence, comparable reduction in A1c as Victoza, robust clinical program, consistent A1c reduction (overall -1.5), greater reduction in A1c compared to Byetta and consistent weight loss.

VII. Cornerstone
Archie Stone, PhD, Senior Director, Medical Affairs
Lee Stout, National Account Executive
Gary Golby, Senior National Account Manager

Bethkis® (tobramycin for inhalation solution)
Pronunciation: Beth kis (TOE-bra-MYE-sin)

Background
BETHKIS (Tobramycin Inhalation Solution) is indicated for the management of cystic fibrosis patients with *Pseudomonas aeruginosa.* Safety and efficacy have not been demonstrated in patients under the age of six years, patients with FEV1 less than 40% or greater than 80% predicted, or patients colonized with *Burkholderia cepacia.* Prior to approval for marketing in the US in 2012, a formulation similar to BETHKIS has been available in Europe for over 7 years. These non-US formulations are branded as BRAMITOB, Tobrineb, and Actitob. The clinical trials summarized in this document were conducted using BRAMITOB. Because of the similarity of BRAMITOB and BETHKIS, the results described below with the BRAMITOB product are applicable to BETHKIS.

Clinical Trials
- In a randomized, double-blind, 3-cycle, placebo-controlled trial by Chuchalin and colleagues, a total of 247 patients with cystic fibrosis (CF) were randomized 2:1 to receive three cycles of BETHKIS (n=161) or placebo (n=86). All subjects enrolled in this efficacy study were at least 6 years of age with a baseline FEV1 ≥ 40% and ≤80% predicted and colonized with *P. aeruginosa*. Each cycle comprised 28 days on treatment followed by 28 days off treatment. BETHKIS significantly improved lung function compared with placebo as measured by the absolute change in FEV1 % predicted from baseline to the end of the Cycle 3 "ON" period, the primary outcome measure for the study. Treatment with BETHKIS and placebo resulted in absolute increases in FEV1% predicted of 7% and 1%, respectively (LS mean difference = 6%; 95% CI: 3, 10; p<0.001). Median density of *P. aeruginosa* in sputum decreased throughout the study for subjects receiving BRAMITOB, from – 0.98 $\log_{10}$ CFU/g sputum at 4 weeks to – 1.0 $\log_{10}$ CFU/g sputum at the end of 20 weeks. At week 20, 52/156 (33.3%) of BRAMITOB recipients had a negative sputum culture for *P. aeruginosa* compared with 13/70 (16.5%) of subjects treated with placebo.
- More patients in the placebo group discontinued/dropped out of the study than patients in the BETHKIS group (9.4% [8/85] vs 4.3% [7/161], respectively). Of these, 3 patients in the BETHKIS group (1.9%) compared to 2 patients in the placebo group (2.4%) withdrew due to a treatment-emergent adverse events (TEAE). The most common TEAEs causing patients treated with BETHKIS to discontinue from the study were respiratory, thoracic, and mediastinal disorders.
- The study described above confirmed and extended previous findings in a double-blind, single cycle study that randomized 59 patients with CF and *P. aeruginosa* colonization to receive BETHKIS (n=29) or placebo (n=30) for one cycle of treatment. BETHKIS significantly improved lung function compared with placebo as measured by the absolute change in FEV1 % predicted from baseline to the end of Cycle 1. Treatment with BETHKIS and placebo

resulted in absolute increases in FEV1% predicted of 16% and 5%, respectively (LS mean difference = 11%; 95% CI: 3, 19; p=0.003).

Important Safety Information

- Bethkis is contraindicated in patients with a known hypersensitivity to any aminoglycoside.
- Bronchospasm can occur with inhalation of Bethkis. Bronchospasm and wheezing should be treated as medically appropriate.
- Caution should be exercised when prescribing Bethkis to patients with known or suspected auditory, vestibular, renal, or neuromuscular dysfunction. Audiograms, serum concentration, and renal function should be monitored as appropriate.
- Avoid concurrent and/or sequential use of Bethkis with other drugs with neurotoxic or ototoxic potential.
- Bethkis should not be administered concurrently with ethacrynic acid, furosemide, urea, or mannitol.
- Aminoglycosides may aggravate muscle weakness because of a potential curare-like effect on neuromuscular function.
- Fetal harm can occur when aminoglycosides are administered to a pregnant woman. Apprise women of the potential hazard to the fetus.
- The most common adverse reactions (more than 5% occurring more frequently in Bethkis patients are forced expiratory volume decreased, rales, red blood cell sedimentation rate increased, and dysphonia.

Questions and Answers

Q: What are considered the advantages of Bethkis?
A: More concentrated so less volume to be inhaled, more efficient nebulization and more isotonic.

Q: Are there any outcomes or adherence studies comparing Bethkis (4mL) vs. Tobi (5mL)?
A: No.

Q: How much nebulized administration time is reduced by the 1mL less volume of Bethkis?
A: Approximately 15-20 minutes.

VIII. Amgen

Lori Arrington, PA, PharmD, Senior Regional Medical Liaison
Janet K. Gusmerotti, Corporate Account Manager

Enbrel® (etanercept)

Pronunciation: En-brel (ee TAN er sept)

- ENBREL is indicated for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active RA. ENBREL can be initiated in combination with MTX or used alone.
- ENBREL is indicated for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in patients ages 2 and older.
- ENBREL is indicated for reducing signs and symptoms, inhibiting the progression of structural damage of active arthritis, and improving physical function in patients with psoriatic arthritis. ENBREL can be used in combination with MTX in patients who do not respond adequately to MTX alone.
- ENBREL is indicated for reducing signs and symptoms in patients with active ankylosing spondylitis.
- ENBREL is indicated for the treatment of adult patients (18 years or older) with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.
- ENBREL has been evaluated in clinical studies over the past 20 years in RA.
- ENBREL has a known and consistent safety profile that was evaluated in an open-label extension trial in RA over 10 years.
- IMPORTANT SAFETY INFORMATION: Patients treated with ENBREL are at increased risk for developing serious infections that may lead to hospitalization or death. Patients should be closely monitored for the development of signs and symptoms of infection during and after treatment with ENBREL, including the possible development of TB in patients who tested negative for latent TB prior to initiating therapy. Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, including ENBREL.

New Information

- The RACAT study4 was a 48-week, double-blind, noninferiority trial of 353 patients with RA with active disease despite MTX treatment. Patients were assigned to either a triple regimen of DMARDs (MTX, sulfasalazine, and hydroxychloroquine) or to ETN plus MTX. Patients with no improvement at 24 weeks were blindly switched to the other regimen. Improvement in DAS28 at 48 weeks was similar in the two groups. A larger percentage of ETN + MTX patients had an ACR 70 response at 24 weeks, but the difference was not maintained at 48 weeks. Based on these results, the strategy of starting triple therapy was found to be noninferior versus ETN + MTX. Limitations of RACAT include the target study sample size not being reached, which resulted in a protocol change to a different primary outcome (primary outcome was changed to compare DAS28 reduction of 1.2 at week 48), a noninferiority margin of 0.6 reduction of DAS28 analyzed without adequate support, a study population consisting of more males than females and a study design that allowed a between-cohorts crossover rate of > 25% that may have affected data interpretation. Additionally, using a 95% CI instead of 97.5% for one-sided analyses is unconventional.
- The British Society of Rheumatology Biologic Register is a national prospective observational study following biologic and nonbiologic DMARD use. It is estimated that more than 80% of patients treated with anti-TNF therapy are included in the register, which began in 2001 and included a comparison cohort of conventional DMARDs since 2002. To be included in the study, both cohorts had to have a diagnosis of RA and a minimum of one follow-up visit after registration; these criteria were met by 3529 patients on ETN and 2864 patients on conventional DMARDs. The results indicated no statistical differences between the groups with regard to serious infections and cancers. The ETN cohort had lower all-cause mortality, lymphoproliferative malignancies, serious adverse events, and cardiac events ($P < 0.05$).
- A total of 2,071 patients with RA in the CORRONA database were studied to compare the effectiveness of nonbiologic DMARDs versus biologic DMARDs using two analytical approaches: multivariable regression (MV) and propensity score (PS) matching.6 Patients who failed a nonbiologic DMARD were given either another nonbiologic DMARD or a biologic DMARD. These groups were compared at 5, 9, and 24 months after treatment change. After 5 months, both analyses showed that patients who were switched to biologic DMARDs exhibited greater improvement than those switching to nonbiologic DMARDs. The MV analysis also showed this advantage for biologic DMARDs at 9 and 24 months, but the PS analysis did not. Limitations of matching-based studies include data potentially regressing to the mean and lack of adherence measurement. Authors concluded that the study showed how different research methodologies applied to comparative research can lead to different results.

ACR = American College of Rheumatology; AHR = adjusted hazard ratio; CI = confidence interval; CORRONA = Consortium of Rheumatology Researchers of North America; DAS28 = Disease Activity Score for 28 joints; DMARD = disease-modifying antirheumatic drug; ETN = etanercept; MTX = methotrexate; RA = rheumatoid arthritis; RACAT = RA: Comparison of Active Therapies; TB = tuberculosis; TNF = tumor necrosis factor.

Questions and Answers

Q: What are the key points on Enbrel?
A: Patients with RA have increased lymphoma, the medications do not increase lymphoma; has been shown to be safer vs. monoclonal antibodies due to differences in binding as Enbrel does not bind to transmembrane TNF; no neutralizing antibodies develop; and Enbrel binds and releases so physicians like from a safety perspective since monoclonal antibody binding is irreversible.

IX. Boehringer Ingelheim

Patricia Grossman, PharmD, MBA, Associate Director, Health Economics and Outcomes Research
Jay Moore, Account Manager

Gilotrif® (afatinib)
Pronunciation: JEE-loh-trif (a fa' ti nib)

A one-page summary on the Gilotrif presentation was not provided. The safety and efficacy of the drug was presented and will be discussed with the new drug evaluation monograph.

Questions and Answers

Q: Is there a limited distribution?
A: Approximately 400 oncology clinics have and Accredo is the only specialty pharmacy.

Q: Are Medicaid patients eligible for dosage exchange program?
A: Yes. If patient does not fill 2nd prescription, payer is reimbursed for 1st fill.

Q: Do other Medicaid plans require PA?

A: Some plans do not; approximately 60-70% of plans have automatic PA to ensure appropriate use for patients with EGFR mutation.

Q: Is a study being conducted that evaluates overall survival as primary efficacy endpoint?
A: No due to difficulty in conducting.

Tradjenta® (linagliptin)
Pronunciation: LIN-a-GLIP-tin

Indication and Important Limitations of Use
- TRADJENTA is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.
- TRADJENTA should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis.
- TRADJENTA has not been studied in patients with a history of pancreatitis.

Contraindications
TRADJENTA is contraindicated in patients with a history of hypersensitivity reaction to linagliptin, such as urticaria, angioedema or bronchial hyperreactivity.

Warnings and Precautions
- **Pancreatitis** - There have been postmarketing reports of acute pancreatitis, including fatal pancreatitis, in patients taking TRADJENTA. Take careful notice of potential signs and symptoms of pancreatitis. If pancreatitis is suspected, promptly discontinue TRADJENTA and initiate appropriate management. It is unknown whether patients with a history of pancreatitis are at increased risk for the development of pancreatitis while using TRADJENTA.
- **Use with Medications Known to Cause Hypoglycemia -** Insulin secretagogues and insulin are known to cause hypoglycemia. The use of TRADJENTA in combination with an insulin secretagogue (e.g., sulfonylurea) was associated with a higher rate of hypoglycemia compared with placebo in a clinical trial. Therefore, a lower dose of the insulin secretagogue or insulin may be required to reduce the risk of hypoglycemia when used in combination with TRADJENTA.
- **Macrovascular Outcomes -** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with TRADJENTA or any other antidiabetic drug.

Adverse Reactions
- Adverse reactions reported in ≥5% of patients treated with TRADJENTA and more commonly than in patients treated with placebo included nasopharyngitis.
- Hypoglycemia was more commonly reported in patients treated with the combination of TRADJENTA and sulfonylurea compared with those treated with the combination of placebo and sulfonylurea. When TRADJENTA was administered in combination with metformin and a sulfonylurea, 181 of 792 (22.9%) patients reported hypoglycemia compared with 39 of 263 (14.8%) patients administered placebo in combination with metformin and a sulfonylurea. In patients receiving TRADJENTA as add-on therapy to a stable dose of insulin severe hypoglycemic events were reported in 11 (1.7%) patients compared with 7 (1.1%) for placebo.
- In the clinical trial program, pancreatitis was reported in 15.2 cases per 10,000 patient-years of exposure while being treated with TRADJENTA compared with 3.7 cases per 10,000 patient-years of exposure while being treated with comparator (placebo and active comparator, sulfonylurea). Three additional cases of pancreatitis were reported following the last administered dose of linagliptin.

Drug Interactions
The efficacy of TRADJENTA may be reduced when administered in combination with a strong P-glycoprotein or CYP3A4 inducer (e.g., rifampin). Therefore, use of alternative treatments to TRADJENTA is strongly recommended.

Use in Special Populations
- There are no adequate and well-controlled studies in pregnant women. Therefore, TRADJENTA should be used during pregnancy only if clearly needed.
- It is not known whether linagliptin is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when TRADJENTA is administered to a nursing woman.
- The safety and effectiveness of TRADJENTA in patients below the age of 18 have not been established.

Questions and Answers
Q: Is there any new information on Tradjenta?

A: No, there are no PI updates.

Jentadueto® (linagliptin and metformin hydrochloride)
Pronunciation: LIN-a-GLIP-tin and met-FOR-min hye-droe-KLOR-ide

Indication and Important Limitations of Use
- JENTADUETO tablets are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus when treatment with both linagliptin and metformin is appropriate.
- JENTADUETO should not be used in patients with type 1 diabetes or for the treatment of diabetic ketoacidosis, and has not been studied in combination with insulin.
- JENTADUETO has not been studied in patients with a history of pancreatitis.

Important Safety Information
WARNING: RISK OF LACTIC ACIDOSIS
Contraindications - JENTADUETO is contraindicated in patients with:
- Renal impairment (e.g., serum creatinine ≥1.5 mg/dL for men or ≥1.4 mg/dL for women, or abnormal creatinine clearance).
- Acute or chronic metabolic acidosis, including diabetic ketoacidosis.
- History of hypersensitivity reaction to linagliptin (such as urticaria, angioedema, or bronchial hyperreactivity) or metformin.

Warnings and Precautions
- Patients with congestive heart failure requiring pharmacologic management, particularly when accompanied by hypoperfusion and hypoxemia due to unstable or acute failure, are at increased risk of lactic acidosis.
- The risk of lactic acidosis increases with the degree of renal impairment and the patient's age. The risk of lactic acidosis may be significantly decreased by regular monitoring of renal function in patients taking metformin. Treatment of the elderly should be accompanied by careful monitoring of renal function. Metformin treatment should not be initiated in any patients unless measurement of creatinine clearance demonstrates that renal function is not reduced.
- Metformin should be promptly withheld in the presence of any condition associated with hypoxemia, dehydration, or sepsis.
- There have been postmarketing reports of acute pancreatitis, including fatal pancreatitis, in patients taking linagliptin. Take careful notice of potential signs and symptoms of pancreatitis. If pancreatitis is suspected, promptly discontinue JENTADUETO and initiate appropriate management. It is unknown whether patients with a history of pancreatitis are at increased risk for the development of pancreatitis while using JENTADUETO.
- Before initiation of therapy with JENTADUETO and at least annually thereafter, renal function should be assessed and verified as normal. In patients in whom development of renal impairment is anticipated (e.g., elderly), renal function should be assessed more frequently and JENTADUETO discontinued if evidence of renal impairment is present.
- Impaired hepatic function has been associated with cases of lactic acidosis with metformin therapy. JENTADUETO tablets should generally be avoided in patients with clinical or laboratory evidence of hepatic impairment.
- Insulin secretagogues are known to cause hypoglycemia. The use of linagliptin in combination with an insulin secretagogue (e.g., sulfonylurea) was associated with a higher rate of hypoglycemia compared with placebo in a clinical trial. A lower dose of the insulin secretagogue may be required to reduce the risk of hypoglycemia when used in combination with JENTADUETO.
- Cardiovascular collapse (shock) from whatever cause (e.g., acute congestive heart failure, acute myocardial infarction, and other conditions characterized by hypoxemia) has been associated with lactic acidosis and may also cause prerenal azotemia. When such events occur in patients on JENTADUETO therapy, the drug should be promptly discontinued.

Adverse Reactions
- In a 24-week factorial design study, adverse reactions reported in ≥5% of patients treated with JENTADUETO and more commonly than in patients treated with placebo were nasopharyngitis and diarrhea.
- In a 24-week factorial design study, hypoglycemia was reported in 4 (1.4%) of 286 subjects treated with linagliptin + metformin, 6 (2.1%) of 291 subjects treated with metformin and 1 (1.4%) of 72 subjects treated with placebo. In the placebo-controlled studies, hypoglycemia was more commonly reported in patients treated with the combination of linagliptin and metformin with SU (22.9%) compared with those treated with the combination of placebo and metformin with SU (14.8%).
- In the clinical trial program, pancreatitis was reported more often in patients randomized to linagliptin (1 per 538 person-years versus 0 in 433 person-years for comparator). Three additional cases of pancreatitis were reported following the last administered dose of linagliptin.

Questions and Answers
Q: Is there any new information on Jentadueto?
A: No, there are no PI updates.

X. GlaxoSmithKline

Ann M. Adams, PharmD, Scientific Account Liaison
Tejal Vishalpura, PharmD, Regional Vice President, Specialty
Rick M. Smith, MBA, CMR, Account Manager

Mekinist™ (trametinib)
Pronunciation: MEK-in-ist (tru-MEH-tih-nib)

Indication

- *Mekinist* is a kinase inhibitor indicated as a single agent and in combination with dabrafenib for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. The use in combination is based on the demonstration of durable response rate. Improvement in disease-related symptoms or overall survival has not been demonstrated for *Mekinist* in combination with dabrafenib.
- **Limitation of use:** *Mekinist* as a single agent is not indicated for treatment of patients who have received prior BRAF-inhibitor therapy.

Dosing

- The recommended dosage regimens of *Mekinist* are 2 mg orally QD as a single agent or in combination with dabrafenib 150 mg orally BID. Take *Mekinist* at least 1 hour before or at least 2 hours after a meal.

Efficacy Data

- Trial 1 (randomized [2:1], open-label) (N = 322)322 with BRAF V600E or V600K mutation-positive, unresectable or metastatic melanoma. Patients were randomized to receive *Mekinist* 2 mg orally QD (N = 214) or chemotherapy (N = 108) consisting of either dacarbazine 1,000 mg/m2 IV every 3 weeks or paclitaxel 175 mg/m2 IV every 3 weeks. The median (95% CI) investigator-assessed PFS was 4.8 (4.3, 4.9) and 1.5 (1.4, 2.7) months for *Mekinist* and chemotherapy, respectively (HR [95% CI]: 0.47 [0.34, 0.65]; $P < 0.0001$). The confirmed objective response rate (95% CI) was 22% (17, 28) and 8% (4, 15), respectively. The median duration of response for *Mekinist* was 5.5 months and not reached for group receiving chemotherapy.
- Trial 2 (randomized [1:1:1], open-label) evaluated the efficacy of *Mekinist* plus dabrafenib and to compare the safety with dabrafenib as a single agent in 162 patients with BRAF V600E or V600K mutation-positive, unresectable or metastatic melanoma. Patients were randomized to receive *Mekinist* 2 mg orally QD with dabrafenib 150 mg orally BID (n = 54), *Mekinist* 1 mg orally once daily with dabrafenib 150 mg orally BID (n = 54), or dabrafenib 150 mg orally BID (n = 54). The following data summarizes the efficacy outcomes for the arm receiving *Mekinist* 2 mg QD in combination with dabrafenib 150 mg BID and the arm receiving dabrafenib monotherapy. The investigator-assessed ORR (95% CI)) was 76% (62, 87) and 54% (40, 67) for *Mekinist* plus dabrafenib and dabrafenib monotherapy, respectively. The independent radiology review committee (IRRC) assessed ORR (95% CI) was 57% (43, 71) and 46% (33, 60) for *Mekinist* plus dabrafenib and dabrafenib monotherapy, respectively. The investigator-assessed median duration of response for *Mekinist* plus dabrafenib and dabrafenib monotherapy was 10.5 and 5.6 months, respectively. The IRRC assessed median duration of response for *Mekinist* plus dabrafenib and dabrafenib monotherapy was 7.6 months for each.
- The clinical activity of *Mekinist* as a single agent was evaluated (Trial 3) in 40 patients with BRAF V600E or V600K mutation-positive, unresectable or metastatic melanoma who had received prior treatment with a BRAF inhibitor. All patients received *Mekinist* at a dose of 2 mg orally QD until disease progression or unacceptable toxicity. No patient in Trial 3 achieved a confirmed partial or complete response as determined by the clinical investigators.

Warnings and Precautions

- New primary malignancies, cutaneous and non-cutaneous, can occur when *Mekinist* is used in combination with dabrafenib. Monitor patients for new malignancies prior to initiation of therapy while on therapy, and following discontinuation of the combination treatment.
- Hemorrhage: Major hemorrhagic events can occur in patients receiving *Mekinist* in combination with dabrafenib. Monitor for signs and symptoms of bleeding.
- Venous Thromboembolism: Deep vein thrombosis and pulmonary embolism can occur in patients receiving *Mekinist* in combination with dabrafenib.

- Cardiomyopathy: Assess LVEF before treatment, after 1 month of treatment, then every 2 to 3 months thereafter.
- Ocular Toxicities: Perform ophthalmologic evaluation for any visual disturbances. For Retinal Vein Occlusion (RVO), permanently discontinue *Mekinist*.
- Interstitial Lung Disease (ILD): Withhold *Mekinist* for new or progressive unexplained pulmonary symptoms. Permanently discontinue *Mekinist* for treatment-related ILD or pneumonitis.
- Serious Febrile Reactions can occur when *Mekinist* is used in combination with dabrafenib.
- Serious Skin Toxicity: Monitor for skin toxicities and for secondary infections. Discontinue for intolerable Grade 2, or Grade 3 or 4 rash not improving within 3 weeks despite interruption of *Mekinist*.
- Hyperglycemia: Monitor serum glucose levels in patients with pre-existing diabetes or hyperglycemia.
- Embryofetal Toxicity: Can cause fetal harm. Advise females of reproductive potential of potential risk to the fetus.

Questions and Answers
No questions and answers followed.

Tafinlar® (dabrafenib)
Pronunciation: TAFF-in-lar (duh-BRA-feh–nib)

Indication
- *Tafinlar* is a kinase inhibitor indicated as a single agent for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E mutation as detected by an FDA-approved test. *Tafinlar* in combination with trametinib is indicated for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test. The use in combination is based on the demonstration of durable response rate. Improvement in disease-related symptoms or overall survival has not been demonstrated for *Tafinlar* in combination with trametinib.
- **Limitation of use:** *Tafinlar* is not indicated treatment of patients with wild-type BRAF melanoma.

Dosing
- The recommended dose of *Tafinlar* is 150 mg orally BID as a single agent or in combination with trametinib 2 mg orally QD. Take *Tafinlar* at least 1 hour before or at least 2 hours after a meal.

Efficacy Data
- Trial 1 (randomized, open label) evaluated *Tafinlar* (N = 250) in untreated BRAF V600E mutation-positive, unresectable or metastatic melanoma. Patients were randomized to receive *Tafinlar* 150 mg by mouth BID (n = 187) or dacarbazine 1,000 mg/m2 IV every 3 weeks (n = 63). The median (95% CI) investigator-assessed PFS was 5.1 (4.9, 6.9) and 2.7 (1.5, 3.2) months for *Tafinlar* and dacarbazine, respectively (HR [95% CI]: 0.33 [0.20, 0.54]; $P < 0.0001$). The confirmed ORR (95% CI) was 52% (44, 59) and 17% (9, 29), respectively.
- Trial 2 (open-label, randomized) (N = 162) evaluated *Tafinlar* plus trametinib and compared the safety with *Tafinlar* monotherapy in BRAF V600E or V600K mutation-positive, unresectable or metastatic melanoma. Patients were randomized to receive *Tafinlar* 150 mg BID with trametinib 2 mg QD (n = 54), *Tafinlar* 150 mg BID with trametinib 1 mg BID (n = 54), or *Tafinlar* 150 mg BID (n = 54). The following summarizes the efficacy outcomes for the arm receiving *Tafinlar* 150 mg BID in combination with trametinib 2 mg daily and the arm receiving *Tafinlar* monotherapy. The investigator-assessed ORR, (95% CI) was 76% (62, 87) and 54% (40, 67) for *Tafinlar* plus trametinib and *Tafinlar* monotherapy, respectively. The IRRC assessed ORR (95% CI) was 57% (43, 71) and 46% (33, 60) for *Tafinlar* plus trametinib and *Tafinlar* monotherapy, respectively.
- The activity of *Tafinlar* in BRAF V600E mutation-positive melanoma, metastatic to the brain was evaluated in Trial 3. All patients received *Tafinlar* 150 mg BID. Patients in Cohort A (n = 74) had received no prior local therapy for brain metastases, while patients in Cohort B (n = 65) had received at least 1 local therapy for brain metastases. The IRRC assessed OIRR (95% CI) for patients with the V600E mutation was 18% (9.7, 28.2) and 18% (9.9, 30) for Cohort A and Cohort B, respectively. The median (95% CI) duration of OIRR for Cohorts A and B was 4.6 (2.8, not reached) and 4.6 (1.9, 4.6) months, respectively.

Warnings and Precautions
- New primary malignancies, cutaneous and non-cutaneous, can occur when *Tafinlar* is administered as a single agent or in combination with trametinib. Monitor patients for new malignancies prior to initiation of therapy, while on therapy, and following discontinuation of *Tafinlar* or the combination therapy.
- Tumor Promotion in BRAF Wild-Type Melanoma: Increased cell proliferation can occur with BRAF inhibitors.
- Hemorrhage: Major hemorrhagic events can occur in patients receiving *Tafinlar* in combination with trametinib. Monitor for signs and symptoms of bleeding.

- Venous Thromboembolism: Deep vein thrombosis and pulmonary embolism can occur in patients receiving *Tafinlar* in combination with trametinib.
- Cardiomyopathy: Assess LVEF before treatment with *Tafinlar* in combination with trametinib, after 1 month of treatment, then every 2 to 3 months thereafter.
- Ocular Toxicities: Perform ophthalmologic evaluation for any visual disturbances.
- Serious Febrile Reactions: Incidence and severity of pyrexia are increased with *Tafinlar* in combination with trametinib.
- Serious Skin Toxicity: Monitor for skin toxicities and for secondary infections. Discontinue for intolerable Grade 2, or Grade 3 or 4 rash not improving within 3 weeks despite interruption of *Tafinlar*.
- Hyperglycemia: Monitor serum glucose levels in patients with pre-existing diabetes or hyperglycemia.
- Glucose-6-Phosphate Dehydrogenase Deficiency: Closely monitor for hemolytic anemia.
- Embryofetal Toxicity: Can cause fetal harm. Advise females of reproductive potential of potential risk to a fetus. *Tafinlar* may render hormonal contraceptives less effective and an alternative method of contraception should be used.

Questions and Answers
Q: How are other Medicaid plans covering Mekinist and Tafinlar?
A: Some states do not PA; others PA for indication.

Q: Will physicians start with monotherapy or combination therapy?
A: Most likely combination therapy due to efficacy.

Q: What is the purpose of combination therapy with Mekinist and Tafinlar?
A: Combination therapy increases efficacy and helps to overcome BRAF mutations.

Q: Is there a limited distribution of Mekinist and Tafinlar?
A: Yes, limited to approximately 18 specialty pharmacies.

Q: Are other indications being sought?
A: Studies are being conducted in non-small cell lung cancer, endocellular pancreas cancer, colon cancer and in conjunction with other medications for melanoma.

XI. Novartis

Julia Compton, PharmD, Regional Account Scientific Director
Fred McClellan, Senior Regional Account Manager

Tobi™ Podhaler™ (tobramycin inhalation powder)
Pronunciation: TOE-bee (TOE-bra-MYE-sin)

Indications and Usage: TOBI Podhaler is an antibacterial aminoglycoside indicated for the management of cystic fibrosis (CF) patients with *Pseudomonas aeruginosa (Pa)*.

Clinical Studies
- **Study 2:** In this 24 week, randomized, two-arm, three-cycle trial, in which each cycle comprised of 28 days on then 28 days off treatment, patients were randomized 1:1 to TOBI Podhaler (4 x 28 mg capsules BID: n=46) or placebo (n=49) in cycle 1. The primary endpoint was change in FEV1 predicted from baseline to day 28 of Cycle 1. After completion of the first cycle, patients in the placebo group received TOBI Podhaler for cycles 2 and 3. All patients were less than 22 years of age (mean 13.3 years) and had not received inhaled anti-pseudomonal antibiotics within 4 months prior to screening. The study was stopped early for demonstrated benefit. This resulted in a total of 61 patients, 29 in the TOBI Podhaler group and 32 in the placebo group included for the primary analysis.
    - This analysis adjusted for the covariates of baseline FEV1% predicted, age, and region, and imputed for missing data. At the end of Cycle 1, treatment with TOBI Podhaler significantly improved lung function compared with placebo which resulted in relative increases in FEV1% predicted (primary endpoint) of 12.54% and 0.09%, respectively (LS mean difference = 12.44%, 95% CI: 4.89, 20.00; p=0.002). Absolute changes in FEV1% predicted showed LS means of 6.38% and -0.52% (TOBI Podhaler vs placebo, respectively) with a difference of 6.90 (95% CI: 2.40, 11.40). Improvements in lung function were achieved during the subsequent cycles of treatment with TOBI Podhaler, although the magnitude was reduced.

- New antipseudomonal antibiotics in Cycle 1 was greater in the placebo treatment group (18.4%) compared with the TOBI Podhaler treatment group (13.1%). During the first cycle, 8.7% of TOBI Podhaler patients and 10.2% of placebo patients were treated with parenteral antipseudomonal antibiotics.
- Respiratory related hospitalizations in Cycle 1: two patients (4.4%) in the TOBI Podhaler treatment group vs six patients (12.2%) in the placebo treatment group.

- **Study 3:** In this randomized, double-blind, placebo-controlled study, the primary efficacy endpoint was absolute change in FEV1% predicted. Patients were randomized 1:1 to receive TOBI Podhaler (4 x 28 mg capsules BID; n=32) or placebo (n=30) for one cycle (28 days on treatment and 28 days off treatment). All patients were less than 22 years of age (mean 12.9 yrs), 64.5% were female, 98.4% were Caucasian, and had not received inhaled anti-pseudomonal antibiotics within 4 months prior to screening.
  - Results were not statistically significant for the primary lung function endpoint when adjusting for the covariates of age (<13 years, ≥13 years) and FEV1% predicted at screening (<50%, ≥50%) and imputing for missing data. Improvement in lung function for TOBI Podhaler compared with placebo was evaluated using the relative change in FEV1% predicted from baseline to the end of Cycle 1 dosing. Treatment with TOBI Podhaler (8.19%) compared to placebo (2.27%) failed to achieve statistical significance in relative change in FEV1% predicted (LS mean difference 5.91%; 95% CI: -2.54, 14.37; p=0.167).
  - Absolute changes in FEV1% predicted showed LS means of 4.86% for TOBI Podhaler and 0.48% for placebo with a difference of 4.38 and (95% CI:-0.17, 8.94).
- **Study 1:** In this randomized, open-label, active-controlled parallel arm, 24-week trial, eligible patients were randomized 3:2 to TOBI Podhaler (4 x 28 mg capsules twice daily) or TOBI (300 mg/5 mL twice daily). Treatment was administered for 28 days, followed by 28 days off therapy (1 cycle) for 3 cycles. A total of 517 patients were randomized and received TOBI Podhaler (n=308) or TOBI (n=209). Patients were predominantly 20 years of age or older (mean age 25.6 years) with no inhaled antipseudomonal antibiotic use within 28 days prior to study drug administration; 45% were female and 91% were Caucasian.
  - The number (%) of patients with missing values for FEV1 % predicted at Weeks 5 and 25 in the TOBI Podhaler treated group were 40 (13.0%) and 86 (27.9%) compared to 15 (7.2%) and 40 (19.1%) in the TOBI treated group. Using imputation of the missing data, the mean differences (TOBI Podhaler minus TOBI) in the percent relative change from baseline in FEV1% predicted at Weeks 5 and 25 were -0.87 (95% CI: -3.80, 2.07) and 1.62 (95% CI: -0.90, 4.14), respectively.
  - Respiratory related hospitalizations occurred in 24% of TOBI Podhaler treated patients and 22% of TOBI treated patients.
  - New usage of antipseudomonal antibiotics increased in the TOBI Podhaler arm (65% TOBI Podhaler vs 55% TOBI), this included, new usage of oral antibiotics (55% TOBI Podhaler vs 40% TOBI) and IV antipseudomonal antibiotic (35% TOBI Podhaler vs 33% TOBI). Median time to first antipseudomonal usage was 89 days in the TOBI Podhaler arm and 112 days in the TOBI arm.
  - Administration time ranged from 2-7 and 2-6 minutes at the end of the dosing period for Cycle 1 and Cycle 3, respectively.

Adverse Event Profile

- **Study 1**: Adverse events (AEs) reported in ≥13% of TOBI Podhaler patients included cough (48.4% [45% discontinued due to cough]), lung disorder (including AEs of pulmonary or CF exacerbations) (33.8%), productive cough (18.2%), dyspnea (15.6%), pyrexia (15.6%), oropharyngeal pain (14.0%), dysphonia (13.6%), and hemoptysis (13.0%).
- **Study 2**: AEs reported more frequently by TOBI Podhaler patients than in placebo patients in Cycle 1 were: pharyngolaryngeal pain (10.9 %vs. 0%); dysphonia (4.3% vs. 0%); and dysgeusia (6.5% vs. 2.0%).
- **Study 3**: AEs reported more frequently by TOBI Podhaler patients than placebo patients were: cough (10% vs. 0%) and hypoacusis (10% vs. 6.3%).

Questions and Answers

Q: Is there any compliance data of Tobi Podhaler compared to Tobi Neb?
A: There is not compliance data available from study conducted by Novartis in the US. An independent study in Ireland found that in a real-life clinical setting, new inhaled antibiotic therapy demonstrated improved tolerability, improved adherence, lower discontinuation rates, a reduction in exacerbation rate and stable lung function when compared with nebulised antibiotic therapy.

Gilenya® (fingolimod)

Pronunciation: Je-LEN-yah (fin GOE li mod)

Overview
Gilenya (fingolimod) is the first once-daily oral disease-modifying therapy (DMT) indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS) to reduce the frequency of clinical relapses and to delay the accumulation of physical disability. Gilenya has a novel mode of action that has the potential to fulfill unmet needs for an effective treatment for MS in an oral formulation. Gilenya offers a novel mode of action, targeting the inflammatory components of MS through sphingosine-1-phosphate receptor (S1PR) modulation on lymphocytes, which reversibly sequesters lymphocytes in lymph nodes.

Clinical Efficacy
Gilenya is the only MS treatment with Phase 3 clinical trial evidence demonstrating significant efficacy in a randomized, double-blind, double-dummy study vs IM IFNβ-1a, a current standard of care (TRANSFORMS; N=1,292). Gilenya demonstrated efficacy across all clinical measures of inflammatory disease activity compared with IM IFNβ-1a in this 1-year study and with placebo in a 2-year study (FREEDOMS; N=1,272).

Gilenya was effective in patients with relapsing forms of MS as it significantly reduced relapse frequency compared with placebo and in a head-to-head clinical trial vs IM IFNβ-1a.

- In FREEDOMS, the annualized relapse rate (ARR) was significantly lower in patients treated with Gilenya 0.5 mg than in patients who received placebo (0.18 vs 0.40; *P*<0.001), representing a relative reduction of 54%. There was a significantly higher percentage of Gilenya-treated patients without relapse after 24 months of therapy compared to placebo (70% vs 46%; *P*<0.001).
- In TRANSFORMS, the ARR was significantly lower in patients treated with Gilenya 0.5 mg than in patients who received IM IFNβ-1a (0.16 vs 0.33; *P*<0.001), representing a relative reduction of 52%. Gilenya reduced the frequency time to first confirmed relapse. The proportion of patients who were relapse-free vs IM IFNβ-1a (83% vs 70%, respectively; *P*<0.001).

- **Gilenya delayed the accumulation of physical disability in patients with relapsing forms of MS.**
  - In FREEDOMS, Gilenya 0.5 mg significantly delayed the time to onset of 3-month confirmed disability progression compared with placebo (hazard ratio [HR] 0.70; 95% confidence interval [CI] 0.52, 0.96; *P*=0.024).
  - In TRANSFORMS, confirmed disability progression over 12 months was infrequent in the Gilenya 0.5 mg and IM IFNβ-1a groups. There were no significant differences in the time to 3-month confirmed disability progression between treatments.
- **Gilenya improved magnetic resonance imaging (MRI) measures in patients with relapsing forms of MS.**
  - In FREEDOMS, Gilenya 0.5 mg significantly reduced the mean number of new or newly enlarging lesions on T2-weighted images (a sign of active inflammation) compared with placebo over 24 months (2.5 vs 9.8 lesions; *P*<0.001). The mean of T1-Gd enhancing lesions at 24 months (0.2 vs 1.1; *P*<0.001).
  - In TRANSFORMS, Gilenya 0.5 mg significantly reduced the mean number of new or newly enlarging lesions on T2-weighted images compared with IM IFNβ-1a (1.6 vs 2.6 lesions; *P*=0.002). The mean number of T1 Gd enhancing lesions at 12 months (0.2 vs 0.5; *P*<0.001).

New Information
Gilenya - TRANSFORMS Extension Trial - Overview

- The TRANSFORMS extension trial analyzed within group comparisons the efficacy and safety of fingolimod during Months 13-24 compared with Months 0-12 in patients who had switched from interferon beta-1a (IFNβ-1a) at Month 12. In addition, analyses compared groups of patients receiving fingolimod for up to 2 years with patients who switched to fingolimod treatment to assess the effect of delayed onset of fingolimod.
- Patients who switched from IFNβ-1a in the core study to fingolimod 0.5 mg had a relative reduction in ARR of 30% during the extension phase (Months 13-24). Patients on continuous fingolimod treatment maintained an ARR similar to the core study.
- During treatment with fingolimod (Months 13-24) the incidence of adverse events in the fingolimod 0.5 mg group was 86% and 91% in the fingolimod 1.25 mg group.

Gilenya - FREEDOMS Extension Trial - Overview

- The FREEDOMS extension study evaluated within group comparisons of the core study phase (Month 0-24) and the extension phase (Month 24-48), in which patients from the core study phase had been re-randomized to receive fingolimod in the extension phase. Efficacy outcomes included annualized relapse rate (ARR), Expanded Disability Status Scale (EDSS) evaluated every 3 months, and standardized MRI scans at Months 36, 48, end of study and follow-up visits.
- The ARR was significantly reduced in those patients who were in the continuous fingolimod treatment group verses patients in the placebo-fingolimod group. Throughout the study, a larger proportion of patients in the continuous fingolimod groups than in the placebo–fingolimod group remained free of 3-month and 6-month confirmed disability progression (p<0.05, respectfully). Significant efficacy benefits were observed for inflammatory MRI measures in the placebo–fingolimod groups during months 24–48 compared with the core phase; inflammatory MRI markers remained low in the extension phase in continuous fingolimod groups.

- Mild increases of blood pressure (BP) were seen in patients who switched from placebo to fingolimod. Adverse events of hypertension were observed to be slightly less frequent in the continuous fingolimod group than in the switched treatment group. During first-dose monitoring in the patients who were switched from placebo to fingolimod, a decrease in mean pulse rate was noted 1 hour post-first dose of fingolimod, and reached a maximal decrease from pre-dose values of 7 beats per minute (bpm) (5 hours after dosing) and 10.37 bpm (4 hours after dosing) in the placebo–fingolimod 0.5 mg group and the placebo–fingolimod 1.25 mg group, respectively.

Questions and Answers
No questions and answers followed.

XII. Takeda

Faisal Riaz, MD, Senior Manager, Clinical Sciences and Health Outcomes
Keely S. Gilroy, PhD, Executive Clinical Science Liaison
Jennifer Hooks, Regional Account Manager

Nesina® (alogliptin tablets)
Pronunciation: Nes-see′-na (al-oh-GLIP-tin)

Indication: NESINA is a dipeptidyl peptidase-4 inhibitor (DPP-4) indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Dosage and Administration: Recommended dose: 25 mg once daily, as monotherapy or combination therapy. Adjust dose for patients with moderate renal impairment (CrCl ≥ 30 to < 60 mL/min; 12.5 mg/day), and severe renal impairment or end-stage renal disease (CrCl > 15 to < 30 mL/min or CrCl < 15 mL/min or requiring hemodialysis, respectively; 6.25 mg/day).

Contraindications: NESINA is contraindicated in patients with a history of serious hypersensitivity reaction to alogliptin-containing products, such as anaphylaxis, angioedema or severe cutaneous adverse reactions.

Warnings and Precautions:
- There have been postmarketing reports of acute pancreatitis in patients taking NESINA. If pancreatitis is suspected, promptly discontinue NESINA.
- There have been postmarketing reports of serious hypersensitivity reactions in patients treated with NESINA such as anaphylaxis, angioedema and severe cutaneous adverse reactions. In such cases, promptly discontinue NESINA, assess for other potential causes, institute appropriate monitoring and treatment, and initiate alternative treatment for diabetes.
- Postmarketing reports of hepatic failure, sometimes fatal. Causality cannot be excluded. If liver injury is detected, promptly interrupt NESINA and assess patient for probable cause, then treat cause if possible, to resolution or stabilization. Do not restart NESINA if liver injury is confirmed and no alternative etiology can be found.
- A lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with NESINA.
- There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with NESINA or any other antidiabetic drug.

Efficacy: A total of 8673 patients with type 2 diabetes were randomized in 10 double-blind, placebo- or active-controlled clinical safety and efficacy studies conducted to evaluate the effects of NESINA on glycemic control. In patients with type 2 diabetes, treatment with NESINA produced clinically meaningful and statistically significant improvements in glycosylated hemoglobin A1C (A1C) compared to placebo in pivotal studies (Table). As is typical for trials of agents to treat type 2 diabetes, the mean reduction in A1C with NESINA appears to be related to the degree of A1C elevation at baseline. Improvements in A1C were not affected by gender, age, or baseline body mass index.

Table: Baseline and Mean Change From Baseline in A1C (%) at Week 26

Study	Parameter	Mean Baseline A1C (%)	Adjusted Mean Change from Baseline A1C (%)
Monotherapy Study	NESINA 25 mg (n = 128)	7.9	- 0.6
	Placebo (n = 63)	8.0	0
Combination Study 1	NESINA 25 mg + metformin (n = 203)	7.9	- 0.6
	Placebo + metformin (n = 103)	8.0	- 0.1

Combination Study 2	NESINA 25 mg + pioglitazone ± metformin ± sulfonylurea (n = 195)	8	- 0.8
	Placebo + pioglitazone ± metformin ± sulfonylurea (n = 95)	8	- 0.2
Combination Study 3	NESINA 25 mg + glyburide (n = 197)	8.1	- 0.5
	Placebo + glyburide (n = 97)	8.2	0
Combination Study 4	NESINA 25 mg + insulin ± metformin (n = 126)	9.3	- 0.7
	Placebo + insulin ± metformin (n = 126)	9.3	- 0.1

Abbreviation: A1C, glycosylated hemoglobin A1C. [a] Least squares mean values.

Most Common Adverse Reactions: Approximately 8500 patients with type 2 diabetes have been treated with NESINA in randomized, double-blind controlled clinical trials. The most common adverse reactions reported in ≥ 4% of patients treated with NESINA 25 mg and more frequently than in patients who received placebo were: nasopharyngitis (4.4%), headache (4.2%) and upper respiratory tract infection (4.2%).

Questions and Answers
Q: Is there any new information on Nesina since last presented?
A: Not with Nesina but there are two new combination formulations with alogliptin, Oseni and Kazano.

Oseni® (alogliptin and pioglitazone)
Pronunciation: OH-senn-ee (AL-oh-GLIP-tin and PYE-oh-GLI-ta-zone)

Indication: OSENI is a dipeptidyl peptidase-4 inhibitor and thiazolidinedione combination product indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Dosage and Administration: Individualize the starting dose of OSENI based on the patient's current regimen and concurrent medical condition but do not exceed a daily dose of alogliptin 25 mg and pioglitazone 45 mg. Limit initial dose of pioglitazone to 15 mg once daily in patients with New York Heart Association (NYHA) Class I or II heart failure. Adjust dose for patients with moderate renal impairment (CrCl ≥ 30 to < 60 mL/min; 12.5 mg/15 mg, 12.5 mg/30 mg or 12.5 mg/45 mg once daily). OSENI is not recommended for patients with severe renal impairment or end-stage renal disease requiring dialysis. The maximum recommended dose of pioglitazone is 15 mg once daily in patients taking strong CYP2C8 inhibitors (eg, gemfibrozil).

Contraindications: OSENI is contraindicated in patients with a history of a serious hypersensitivity reaction to alogliptin or pioglitazone, components of OSENI, such as anaphylaxis, angioedema or severe cutaneous adverse reactions. Do not initiate OSENI in patients with established NYHA Class III or IV heart failure.

Warnings and Precautions:
- **Boxed Warning:** Thiazolidinediones, including pioglitazone, which is a component of OSENI, cause or exacerbate congestive heart failure in some patients. After initiation of OSENI, and after dose increases, monitor patients carefully for signs and symptoms of heart failure (eg, excessive, rapid weight gain, dyspnea, and/or edema). If heart failure develops, it should be managed according to current standards of care and discontinuation or dose reduction of pioglitazone in OSENI must be considered. OSENI is not recommended in patients with symptomatic heart failure. Initiation of OSENI in patients with established NYHA Class III or IV heart failure is contraindicated.
- There have been postmarketing reports of acute pancreatitis. If pancreatitis is suspected, promptly discontinue OSENI.
- There have been postmarketing reports of serious hypersensitivity reactions in patients treated with alogliptin such as anaphylaxis, angioedema and severe cutaneous adverse reactions. In such cases, promptly discontinue OSENI, assess for other potential causes, institute appropriate monitoring and treatment, and initiate alternative treatment for diabetes.
- There have been postmarketing reports of hepatic failure, sometimes fatal. Causality cannot be excluded. If liver injury is detected, promptly interrupt OSENI and assess patient for probable cause, then treat cause if possible, to resolution or stabilization. Do not restart OSENI if liver injury is confirmed and no alternative etiology can be found. Use with caution in patients with liver disease.
- Dose-related edema may occur.
- There is increased incidence of fractures in female patients. Apply current standards of care for assessing and maintaining bone health.
- Preclinical and clinical trial data, and results from an observational study suggest an increased risk of bladder cancer in pioglitazone users. The observational data further suggest that the risk increases with duration of use.

Do not use in patients with active bladder cancer. Use caution when using in patients with a prior history of bladder cancer.
- A lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with OSENI.
- There have been postmarketing reports of macular edema. Recommend regular eye exams in all patients with diabetes according to current standards of care with prompt evaluation for acute visual changes.
- There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with OSENI or any other antidiabetic drug.

Efficacy: The coadministration of alogliptin and pioglitazone has been studied in patients with type 2 diabetes inadequately controlled on either diet or exercise alone or on metformin alone. There have been no clinical efficacy studies conducted with OSENI; however, bioequivalence of OSENI with coadministered alogliptin and pioglitazone tablets was demonstrated, and efficacy of the combination of alogliptin and pioglitazone has been demonstrated in four Phase 3 efficacy studies. In patients with type 2 diabetes, treatment with OSENI produced clinically meaningful and statistically significant improvements in A1C compared to either alogliptin or pioglitazone alone in pivotal studies (Table). As is typical for trials of agents to treat type 2 diabetes, the mean reduction in A1C with OSENI appears to be related to the degree of A1C elevation at baseline. Improvements in A1C were not affected by gender, age, or baseline body mass index. Efficacy in clinical trials of reducing mean A1C from baseline ranged from -0.7 to -1.7 with alogliptin + pioglitazone vs. -0.3 to -1.2 with active-comparator vs. -0.1 to -0.2 with placebo.

Most Common Adverse Reactions: Over 1500 patients with type 2 diabetes have received alogliptin coadministered with pioglitazone in 4 large randomized, double-blind controlled clinical trials. Common adverse reactions reported in ≥4% of pts. treated with coadministration of alogliptin 25 mg or 12.5 mg and pioglitazone 15 mg, 30 mg or 45 mg were: nasopharyngitis (4.9%), back pain (4.2%) and upper respiratory tract infection (4.1%).

Questions and Answers
Q: How are other Medicaid plans covering Oseni?
A: Kentucky added Oseni to PDL.

Kazano® (alogliptin and metformin hydrochloride)
Pronunciation: Kah-ZAHN-oh (AL-oh-GLIP-tin and met-FORE-min HYE-droe-KLOR-ide)

Indication: KAZANO is a dipeptidyl-peptidase-4 inhibitor and a biguanide combination product indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Dosage and Administration: Individualize the starting dose of KAZANO based on the patient's current regimen. KAZANO should be taken twice daily with food. May adjust the dosing based on effectiveness and tolerability, while not exceeding the maximum recommended daily dose of 25 mg alogliptin and 2000 mg metformin HCl.

Contraindications: KAZANO is contraindicated in patients with renal impairment; metabolic acidosis, including diabetic ketoacidosis; and those with a history of a serious hypersensitivity reaction to alogliptin or metformin, components of KAZANO, such as anaphylaxis, angioedema or severe cutaneous adverse reactions.

Warnings and Precautions:
- **Boxed Warning:** Lactic acidosis can occur due to metformin accumulation. The risk increases with conditions such as sepsis, dehydration, excess alcohol intake, hepatic impairment, renal impairment, and acute congestive heart failure. Symptoms include malaise, myalgias, respiratory distress, increasing somnolence, and nonspecific abdominal distress. Laboratory abnormalities include low pH, increased anion gap and elevated blood lactate. If acidosis is suspected, KAZANO should be discontinued and the patient hospitalized immediately.
- Warn against excessive alcohol intake. KAZANO is not recommended in hepatic impairment and is contraindicated in renal impairment. Ensure normal renal function before initiating and at least annually thereafter.
- There have been postmarketing reports of acute pancreatitis. If pancreatitis is suspected, promptly discontinue KAZANO.
- There have been postmarketing reports of serious hypersensitivity reactions in patients treated with alogliptin such as anaphylaxis, angioedema and severe cutaneous adverse reactions. In such cases, promptly discontinue KAZANO, assess for other potential causes, institute appropriate monitoring and treatment, and initiate alternative treatment for diabetes.
- There have been postmarketing reports of hepatic failure, sometimes fatal. Causality cannot be excluded. If liver injury is detected, promptly interrupt KAZANO and assess patient for probable cause, then treat cause if

possible, to resolution or stabilization. Do not restart KAZANO if liver injury is confirmed and no alternative etiology can be found.
- Temporarily discontinue in patients undergoing radiologic studies with intravascular administration of iodinated contrast materials or any surgical procedures necessitating restricted intake of food and fluids.
- Metformin may lower Vitamin B12 levels. Monitor hematologic parameters annually.
- A lower dose of insulin or insulin secretagogue may be required to minimize the risk of hypoglycemia when used in combination with KAZANO.
- There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with KAZANO or any other antidiabetic drug.

Efficacy: The coadministration of alogliptin and metformin has been studied in patients with type 2 diabetes inadequately controlled on either diet or exercise alone, on metformin alone or metformin in combination with a thiazolidinedione. There have been no clinical efficacy studies conducted with KAZANO; however bioequivalence of KAZANO with coadministered alogliptin and metformin tablets was demonstrated, and efficacy of the combination of alogliptin and metformin has been demonstrated in three Phase 3 efficacy studies. A total of 4716 patients with type 2 diabetes were randomized in 4 double-blind, placebo- or active-controlled clinical safety and efficacy studies conducted to evaluate the effects of KAZANO on glycemic control. In patients with type 2 diabetes, treatment with KAZANO produced clinically meaningful and statistically significant improvements in A1C versus comparator in pivotal studies (Table). As is typical for trials of agents to treat type 2 diabetes, the mean reduction in A1C with KAZANO appears to be related to the degree of A1C elevation at baseline. Improvements in A1C were not affected by gender, age, race, or baseline body mass index. Efficacy in clinical trials of reducing mean A1C from baseline ranged from -0.6 to -1.6 with alogliptin + metformin vs. -0.3 to -1.1 with active-comparator vs. -0.1 with placebo.

Most Common Adverse Reactions: Over 2700 patients with type 2 diabetes have received alogliptin coadministered with metformin in four large randomized, double-blind controlled clinical trials. Common adverse reactions reported in ≥ 4% of patients treated with coadministration of alogliptin with metformin were: upper respiratory tract infection (8.0%), nasopharyngitis (6.8%), diarrhea (5.5%), hypertension (5.5%), headache (5.3%), back pain (4.3%) and urinary tract infection (4.2%).

XIII. Novo Nordisk

Leonard Bennett, PharmD, Senior Medical Liaison
Mary Cooper, PharmD, Account Manager
Joe Spano, Account Executive II

Norditropin® (somatropin [rDNA origin] injection)
Pronunciation: NOR-dee-TROE-pin (soe ma TROE pin)

Norditropin is a growth hormone for growth hormone deficiencies.
- **Fine Dosing Increments and Maximum Dose**
  - GH therapy in children is a weight-based dosing regimen; therefore, dosing as close to the prescribed dose is important. The smallest dose you can dial with FlexPro® 5 mg pen is 0.025 mg. This allows the pediatric endocrinologist to adjust doses in small increments versus a pen that would require the physician to increase in higher dosing increments because of increment limitations. [FlexPro®: 5 mg Pen-0.025mcg-2mg/10mg Pen-0.05mg-4mg/15 mg Pen-0.1mg- mg/NordiFlex®: 30 mg Pen-0.1mg-6mg].
  - When a child on GH therapy begins to require higher doses after reaching pre-pubertal stage, the child may have to administer multiple injections per day if using a pen device that only allows a maximum of 2 mg or 4 mg.
- **Ease of Use**

Norditropin® FlexPro® was rated by patients (n=110) as easiest to use overall and associated with the fewest errors compared with 4 other devices (easypod®, Genotropin® pen, Nutropin AQ® NuSpinTM pen, and Omnitrope® pen). An easy and less error-prone device may help improve treatment adherence.
- **Room Temperature Storage – New Information**

In October 2013, the Prescribing Information for Norditropin® was revised to include an additional storage option for Norditropin® FlexPro® 15 mg and NordiFlex® 30 mg. Norditropin® is the only growth hormone product where all dosage forms have stability data to support storage out of refrigeration (up to 77°F) after first use for up to three weeks. This offers patients storage flexibility for all pen strengths.

Questions and Answers
Q: What are considered the advantages of Norditropin?

A: Preloaded, prefilled, disposable pens that require no mixing and all pens can be left at room temperature for 21 days (28 days if refrigerated).

Q: How many days supply are the pens packaged in?
A: Generally 30 days but depends on patient's weight for dosing.

Victoza® (liraglutide [rDNA origin] injection)
Pronunciation: VICK-toe-ZA (LIR-a-GLOO-tide)

Victoza is for the treatment of type 2 diabetes mellitus in combination with diet and exercise
New Information

- A retrospective cohort study compared the cost of achieving glycemic goals between Victoza® once-daily (n=234) and exenatide twice daily (n=182) over a 6-month follow-up period in adult patients with type 2 diabetes. The adjusted predicted diabetes-related pharmacy costs per patient over the 6-month post-index period were noted to be higher for Victoza®. However, a greater adjusted predicted proportion of patients receiving Victoza® achieved A1c<7% (64.4% vs 53.6%; *P*<.05) resulting in lower average diabetes-related pharmacy costs per successfully treated patient with Victoza® compared to exenatide ($3,108 vs. $3,354; *P*<.0001).
- Another retrospective claims database study evaluated the adherence rates between patients initiating Victoza® 1.8 mg once-daily and exenatide 10 mcg twice daily over a 12-month follow-up period. After adjusting for confounding factors, patients receiving Victoza® 1.8 mg were ~11% more adherent than patients receiving exenatide 10 mcg twice-daily (95% CI, 7–14; *P*<.0001).
- Compared with exenatide, fewer than seven patients need to be treated with Victoza® 1.8 mg for one additional patient to achieve a composite endpoint of A1c <7%, no weight gain, and no hypoglycemia.

Questions and Answers
Q: What are considered the advantages of Victoza?
A: Improved efficacy portfolio, more patients get to goal and adverse events are similar to comparators.

Q: What percentage of Medicaid patients were in the studies?
A: Approximately 0.7-1.4%.

Q: What cost was used in the study?
A: Wholesale acquisition cost (WAC).

Q: Has risk of rat medullary thyroid cancer with Victoza been extrapolated to humans?
A: Medullary thyroid cancer is being continually monitored. Rats have many for glucagon-like peptide receptors than humans. When monkeys, which are more similar to humans, were exposed to Victoza, the risk for medullary thyroid cancer was not increased.

XIV. Pfizer

Tom Heard, PharmD, CGP, Associate Director, Medical Outcomes
Brian K. Gillespie, Account Manager

Chantix® (varenicline)
Pronunciation: CHANT-iks (var-EN-i-kleen)

Clinical Background and Burden of Illness

- Nicotine addiction is a chronic, relapsing medical condition, which is the most common form of chemical dependence in the United States (US), with an increasing prevalence among young adults (aged 18-24 years). Smoking is the number one preventable cause of premature death in the US. Approximately 1 out of every 5 deaths in the United States is attributed to smoking, resulting in over 400 000 smoking-related deaths reported annually. Smoking is responsible for 90% of all lung cancers, 75% of chronic bronchitis and emphysema, and 25% of heart disease cases. There is a high economic burden associated with smoking. According to the Centers for Disease Control and Prevention, the average societal burden of smoking in the US exceeded $167 billion annually from 1997 to 2001. Almost $76 billion of the total societal cost was related to direct medical costs and $92 billion was related to years of potential life lost and productivity losses.
- Weigh the risks of CHANTIX against benefits of its use. CHANTIX has been demonstrated to increase the likelihood of abstinence from smoking for as long as one year compared to treatment with placebo. The health benefits of quitting smoking are immediate and substantial.

Indications and Usage

- Chantix is a nicotinic receptor partial agonist indicated for use as an aid to smoking cessation treatment for patients ≥18 years of age.
- Smoking cessation therapies are more likely to succeed for patients who are motivated to stop smoking and who are provided additional advice and support. Provide patients with appropriate educational materials and counseling to support the quit attempt.
- The patient should set a date to stop smoking. Begin Chantix dosing one week before this date. Alternatively, the patient can begin Chantix dosing and then quit smoking between days 8 to 35 of treatment. Chantix should be taken after eating and with a full glass of water.
- The recommended dose of Chantix is 1.0 mg twice daily following a 1-week titration as follows: Days 1 - 3: 0.5 mg once daily; Days 4 - 7: 0.5 mg twice daily; Day 8 – end of treatment: 1.0 mg twice daily.
- Consider dose reduction for patients who cannot tolerate adverse effects.
- Another attempt at treatment is recommended for those who fail to stop smoking or relapse when factors contributing to the failed attempt have been addressed.
- An additional 12 weeks of treatment is recommended for successful quitters to increase likelihood of long-term abstinence.
- Patients with impaired renal function: No dosage adjustment is necessary for patients with mild to moderate renal impairment. For patients with severe renal impairment (estimated creatinine clearance <30mL/min), the recommended starting dose of Chantix is 0.5 mg once daily. The dose may then be titrated as needed to a maximum dose of 0.5 mg twice a day. For patients with end-stage renal disease undergoing hemodialysis, a maximum dose of 0.5 mg once daily may be administered if tolerated

Clinical Efficacy

- The efficacy of CHANTIX in smoking cessation was demonstrated in six clinical trials in which a total of 3659 chronic cigarette smokers (≥10 cigarettes per day) were treated with CHANTIX.
- An independent meta-analysis of 17 Pfizer-sponsored RCT's (n=8,027) showed that varenicline was significantly more effective for SC than bupropion or placebo. Varenicline did not increase rates of adverse neuropsychiatric events in patients with or without a history of a psychiatric disorder compared to placebo.
- An independent, observational, real world cohort study (n=119,546) showed that varenicline did not increase the risk of depression or suicidal behavior compared with NRT.
- An independent Cochrane network meta-analysis evaluated the relative efficacy and safety of SC therapies. Varenicline was found to be more effective than bupropion and single NRT, and equally effective to combination NRT when compared with placebo. There was no increase of serious AE's, neuropsychiatric AE's and a marginal, non-significant increase in cardiovascular AE's in varenicline users.
- An RCT (n=525) of varenicline in patients with stable treated depression or past major depression within 2 years showed that varenicline was significantly more effective for SC than placebo (OR 3.35 at 12w, p<0.001; OR 2.36 at 52w, p=0.01) without exacerbating depression, anxiety, or suicidal behavior.
- An RCT evaluated the safety of varenicline in patients with stable schizophrenia (n=127) and found varenicline to be well tolerated with no evidence of exacerbations of psychiatric symptoms compared with placebo, with significantly higher quit rates at 12 weeks.
- In a randomized, double-blind, placebo-controlled trial of patients with mild-to-moderate COPD (postbronchodilator FEV1/FVC <70% and FEV1 ≥50% of predicted normal value), subjects treated with varenicline had a superior rate of CO-confirmed abstinence during weeks 9 through 12 (41%) compared to subjects treated with placebo (9%) and from week 9 through 52 (19%) compared to subjects treated with placebo (6%). Adverse events were similar.
- In a randomized, double-blind, placebo-controlled trial of patients aged 35 to 75 years with stable, documented cardiovascular disease (diagnoses other than, or in addition to, hypertension) that had been diagnosed for more than 2 months, subjects treated with varenicline had a superior rate of co-confirmed abstinence during weeks 9 through 12 (47%) compared to subjects treated with placebo (14%) and from week 9 through 52 (20%) compared to subjects treated with placebo (7%). Additionally, varenicline- and placebo-treated patients did not differ in adjudicated cardiovascular events, cardiovascular deaths, and all-cause mortality.

Clinical Safety

- Most common adverse reactions (>5% and twice the rate seen in placebo- treated patients) were nausea, abnormal (e.g., vivid, unusual, or strange) dreams, constipation, flatulence, and vomiting.
- **There is a boxed warning regarding serious neuropsychiatric events that have been reported in patients treated with Chantix.**
- Other warnings/precautions include angioedema, hypersensitivity reactions, serious skin reactions, cardiovascular events, accidental injury and nausea.

Questions and Answers
Q: How many courses of treatment do patients need?
A: Some patients may need 2 courses of 12-weeks of therapy.

Toviaz® (fesoterodine extended-release)
Pronunciation: TOH-vee-as (FES oh TER oh deen)

Toviaz is indicated for the treatment of overactive bladder (OAB) with symptoms of urinary incontinence, urinary urgency, and urinary frequency. **New information includes the AFTER study:**

- The AFTER study was A 14-week randomized, double-blind, placebo-controlled, parallel-group, multicenter study to determine the efficacy of fesoterodine 8 mg on urgency urinary incontinence (UUI) reduction in patients with overactive bladder (OAB) with sub-optimal response to tolterodine 4 mg extended-release (ER compared to placebo. Following a 2-week, open-label tolterodine ER 4 mg run-in period, patients who were non-responders (defined as subjects who had ≤50% change in UUI episode frequency during open-label run-in phase) were randomized to fesoterodine 4 mg daily for 1 week followed by 8 mg daily or placebo, for a 12-week treatment period. Secondary objectives were to determine the efficacy of fesoterodine 8 mg on the frequency, urgency and quality of life patients reported outcomes and to determine the tolerability and safety of fesoterodine 8 mg in OAB subjects with sub-optimal response to tolterodine. Eligible patients included those who were aged ≥18 years with OAB symptoms for ≥6 months, ≥8 micturitions and ≥2 and ≤15 UUI episodes/24 hours on screening bladder diary, and at least moderate bladder-related problems on the Patient Perception of Bladder Condition (PPBC).
- A total of 2217 subjects were screened, of which 990 subjects took open-label tolterodine in the run-in period. Of the 642 patients (non-responders) randomized to double-blind medication, 322 were assigned to FESO and 320 were assigned to placebo. Of those patients, 308 patients were treated with at least one dose of fesoterodine and 301 patients with placebo. Demographics were similar for both treatment groups.
- At Week 12, the decrease in the mean number of UUI episodes per 24 hours was statistically significantly greater in the fesoterodine group compared to the placebo group (p-value=0.0079), the primary endpoint of the study. The least square (LS) mean decrease from Baseline was -2.37 episodes in the fesoterodine group versus -1.87 in the placebo group (treatment difference at Week 12 was -0.50). The decrease from Baseline to Week 4 in the mean number of UUI episodes and micturitions (frequency) was also statistically significantly greater in the fesoterodine group (p-value=0.0031 and p-value=0.0463 respectively); however, the change from Baseline to Week 12 in the mean number of micturitions was not statistically significantly different with fesoterodine treatment compared to placebo (p-value=0.0931). The change from Baseline to Week 4 in the mean number of micturition-related urgency episodes was not statistically significantly different with fesoterodine treatment compared to placebo (p-value=0.2172); however it was statistically significantly different from Baseline to Week 12 (p-value=0.0438). The LS mean decrease from the Baseline was -3.49 episodes in the fesoterodine group versus -2.79 in the placebo group (treatment difference at Week 12=-0.70). Additionally, statistically significant improvements in change from Baseline to Week 12 were seen in the fesoterodine group compared to placebo in scores on the PPBC, Urgency Perception Scale (UPS), OAB-q symptom bother scores, total, and each domain (coping, concern, sleep, and social interaction).
- Fesoterodine was generally well tolerated and the safety and tolerability profiles were consistent with previous studies. The most commonly reported adverse events included dry mouth and constipation in the fesoterodine group (16.6% and 3.9%) and placebo group (6.2% and 1.1%), respectively.

Questions and Answers
No questions and answers followed.

XV. Bristol-Myers Squibb

Manan Shah, PharmD, PhD, Director, Health Services & Outcomes Research
Greg Ives, State Access Manager

Atripla® (efavirenz/emtricitabine/tenofovir disoproxil fumarate)
Pronunciation: Uh-TRIP-luh (eh-FAH-vih-rehnz/em-tri-SIT-uh-bean/teh-NOE-foh-veer)

Indication

- ATRIPLA is a once-daily single tablet regimen (STR) indicated for use alone as a complete regimen, or in combination with other antiretroviral agents for the treatment of HIV-1 infection in adults and pediatric patients 12 years of age and older

- The regimen in ATRIPLA is preferred by both the Department of Health and Human Services (DHHS) and International Antiviral Society (IAS)-USA guidelines as an initial treatment for HIV-1 infection in adults and adolescents.

Boxed Warning: Lactic acidosis and severe hepatomegaly with steatosis, including fatal cases, have been reported with the use of nucleoside analogs, including tenofovir disoproxil fumarate, a component of ATRIPLA. ATRIPLA is not approved for the treatment of chronic hepatitis B virus (HBV) infection. Severe acute exacerbations of hepatitis B have been reported in patients coinfected with HBV and HIV-1 who have discontinued EMTRIVA or VIREAD, two of the components of ATRIPLA. Hepatic function should be monitored closely in these patients. If appropriate, initiation of anti-hepatitis B therapy may be warranted

New phase 3 clinical data that compared ATRIPLA (or its components) to other ARV agents and regimens:
- Stribild (elvitegravir/cobicistat/emtricitabine/tenofovir disoproxil fumarate, EVG/cobi/FTC/TDF) was non-inferior to ATRIPLA in treatment naive patients in Study 102: 84% on ATRIPLA vs. 88% on Stribild achieved HIV-1 RNA <50 copies/mL at week 48, and 82% on ATRIPLA vs. 84% on Stribild at week 96 (both by Snapshot analysis)
    - Compared to Stribild, ATRIPLA demonstrated a lower rate of nausea (Grade 1), higher rates of rash, dizziness, and abnormal dreams, and a similar rate of discontinuation due to adverse events (6.8% vs. 4.6%) by week 96.
    - Virologic failure by week 96: 8% in ATRIPLA, 6% in Stribild.
    - Resistance development through 96 weeks: 10 patients in each arm developed resistance mutations. Among them, 3 patients on ATRIPLA and 10 patients on Stribild developed resistance to backbone NRTI.
- Components of Complera (emtricitabine/ rilpivirine /tenofovir disoproxil fumarate) were non-inferior to components of ATRIPLA in treatment naive patients in the ECHO and THRIVE Studies: 77% patients on each arm achieved HIV-1 RNA <50 copies/mL at week 96 (by Snapshot analysis). Compared to rilpivirine (RPV)+Truvada: Components of ATRIPLA (efavirenz +Truvada) observed:
    - lower rates of virologic failure, especially in patients with baseline HIV-1 RNA >100,000 copies/mL (12% vs. 22%), and in patients with baseline CD4+ cells <200 cells/mm3 (12% vs. 27%), with a lower rate of both NNRTI and NRTI resistance and cross-resistance to the NNRTI class.
    - higher rates of rash (5% vs. 1%), abnormal dreams (3% vs. 1%), and dizziness (7% vs. 1%). The discontinuation rate due to adverse drug reactions was 5% (efavirenz + Truvada) vs. 2% by week 96.
- Tivicay (dolutegravir) + Epzicom (abacavir sulfate/lamivudine) was shown to be statistically superior to ATRIPLA on virologic response rate by Snapshot analysis in treatment naive patients in the SINGLE Study: 81% patients on ATRIPLA vs. 88% on Tivicay + Epzicom achieved HIV-1 RNA <50 copies/mL at week 48.
    - Compared to Tivicay + Epzicom, ATRIPLA demonstrated a similar virologic non-response rate (6% vs. 5%), but had a higher rate of discontinuations due to adverse events or death (10% vs. 2%).
    - Resistance development through 48 weeks was similar between arms (4% for both).

New Pharmacoeconomic/Cost Effectiveness Data
- ATRIPLA showed improved adherence and a reduction in hospitalization costs vs. multi-pill regimens in several analyses.
- An analysis of Medicaid data from 15 states (n = 3593) demonstrated that compared to patients initiating non-preferred ART, those initiating the 2012 DHHS guideline-preferred ART regimens had: 37.4% greater adjusted odds of ART adherence ≥ 80% (P = .014), 25.9% greater adjusted odds of ART adherence ≥ 95% (P = .014), 51.9% lower adjusted hazards of non-persistence (P < .001), and $341 lower adjusted mean per patient per month (PPPM) all-cause total healthcare expenditures (this difference did not reach statistical significance).
- A subanalysis of the DHHS-preferred regimens showed that relative to patients initiating ATRIPLA, adjusted odds of adherence ≥ 80% were significantly lower in patients treated with ritonavir boosted darunavir + TDF/FTC (adjusted odds ratio = .561, P = .045), and adjusted PPPM total healthcare expenditures were significantly higher for ritonavir-boosted darunavir + TDF/FTC (by $2,155), ritonavir-boosted atazanavir + TDF/FTC (by $1,379), and raltegravir + TDF/FTC (by $1,479) versus ATRIPLA, all P values < .01.
- A cost-effectiveness analysis based on pooled clinical trial data demonstrated that EFV-based regimen was dominant relative to RPV-based regimen at 3, 5, and 10 years; The majority (80%) of patients in both groups were taking the TDF/FTC backbone, i.e. the same components as ATRIPLA and Complera.
- A lifetime cost-effectiveness analysis of ATRIPLA and EVG/cobi/FTC/TDF estimated an incremental cost-effectiveness ratio of $166,287/ quality-adjusted life-year (QALY) for EVG/cobi/FTC/TDF relative to ATRIPLA, which at a societal willingness-to-pay of $100,000/QALY is not considered cost-effective.

Questions and Answers
No questions and answers followed.

Reyataz® (atazanavir sulfate)
Pronunciation: RAY-ah-taz (ah-TAZ-ah-nah-veer)

Indication and Usage
- REYATAZ (ATV) is indicated in combination with other antiretroviral agents for the treatment of HIV-1 infection.
- This indication is based on analyses of plasma HIV-1 RNA levels and CD4+ cell counts from controlled studies of 96 weeks duration in antiretroviral-naive and 48 weeks duration in antiretroviral-treatment-experienced adult and pediatric patients at least 6 years of age.
- The following points should be considered when initiating therapy with REYATAZ:
    - In Study 045, REYATAZ/ritonavir and lopinavir/ritonavir were similar for the primary efficacy outcome measure of time-averaged difference in change from baseline in HIV RNA level. This study was not large enough to reach a definitive conclusion that REYATAZ/ritonavir and lopinavir/ritonavir are equivalent on the secondary efficacy outcome measure of proportions below the HIV RNA lower limit of detection.
    - The number of baseline primary protease inhibitor mutations affects the virologic response to REYATAZ/ritonavir.

New Information
- **Study 103 -** The elvitegravir (EVG) single-tablet regimen (STR) comprises the integrase strand transfer inhibitor EVG, cobicistat (a pharmacoenhancer that does not have activity against HIV) and the nucleoside/nucleotide reverse transcriptase inhibitors emtricitabine/tenofovir disoproxil fumarate (FTC/TDF). Study 103 is a Gilead Sciences phase 3 clinical trial evaluating the efficacy and safety of EVG STR to ritonavir-boosted atazanavir (ATV/r) plus FTC/TDF in treatment naïve HIV-1 infected patients.2-4 Non-inferiority assessment of the EVG STR to ATV/r plus FTC/TDF was performed with a two-sided 95% CI and a pre-specified non-inferiority margin of 12%. The primary endpoint was the proportion of patients with HIV RNA < 50 copies/mL at 48 weeks; efficacy results for both 48 and 144 weeks are presented below:
    - At week 48, 89.5% of patients in the EVG STR arm achieved HIV RNA of < 50 copies/mL and 86.8% in the ATV/r+ FTC/TDF arm with 95% CI of –1.9% to 7.8%.
    - At week 144, 77.6% (274/353) of patients in the EVG STR arm and 74.6% (265/355) in the ATV/r arm achieved a viral load < 50 copies/mL. The 95% CI for the difference was –3.2% to 9.4%.
    - At week 48, rates of grade 3 or 4 adverse events (AEs) for EVG STR and ATV/r + FTC/TDF were 13% and 14%, respectively. The rates of drug-related AEs in the EVG STR arm and ATV/r + FTC/TDF arm were 45% and 57%, respectively. Safety findings at 144 weeks were generally consistent with the week 48 results.
    - At week 48, the mean CD4 cell increase was + 207 cells/mm3 in EVG STR and + 211 cells/ mm3 in ATV/r arm.
    - Virologic failure rates at week 144 were 7.9% and 7.3% in the EVG STR and ATV/r arms, respectively. Eight patients (2.3%) in the EVG STR arm had resistance to the antiretroviral (ARV) regimen; 8 patients with primary integrase resistance mutations and 8 patients with primary nucleoside reverse transcriptase inhibitor resistance mutations, including M184V/I and K65R. Two patients analyzed in the ATV/r + FTC/TDF arm had emergent M184V/I in reverse transcriptase.
- **Pharmacoeconomic Data**
    - A retrospective analysis was conducted in Medicaid administrative healthcare claims extracted from the 2002-2010 Truven Health MarketScan® Multi-State Medicaid Database to determine 6-month incidence and health care costs of medically attended adverse effects in patients receiving atazanavir- versus darunavir-based ART in routine HIV care.
    - Patients treated with ATV and DRV were propensity score matched (ratio = 3:1), multivariable models adjusted for covariates lacking post-match statistical balance.
    - Compared with ATV-treated patients (n=1,848 post-match), DRV-treated patients (n=616) had:
        - Significantly greater hazards of medically attended gastrointestinal symptoms (HR=1.25, p=0.043)
        - Insignificantly greater hazards of medically attended lipid abnormalities (HR=1.38, p=0.072) and rash (HR=1.11, p=0.233)
        - Insignificantly lower hazards of medically attended diabetes/hyperglycemia (HR=0.84, p=0.552)
        - Significantly greater adjusted PPPM all-cause health care costs (difference=$1,086, p<0.001) and insignificantly different PPPM health care costs for each specific medically attended AE

Questions and Answers
No questions and answers followed.

XVI. Genentech

Sapna S. McManus, MD, MHA, Senior Medical Science Liaison
D. Christopher Kennedy, Regional General Manager

Actemra® Subcutaneous (tocilizumab)
Pronunciation: Ac tEm ra (TOE si LIZ ue mab)

Overview: Actemra is the first humanized monoclonal antibody directed against the IL-6 receptor which is FDA-approved for 1) adult patients with moderately to severely active rheumatoid arthritis (RA) who had an inadequate response (IR) to one or more disease-modifying antirheumatic drugs (DMARDs), 2) active systemic juvenile idiopathic arthritis (SJIA) in patients > 2 yrs of age, and 3) active polyarticular juvenile idiopathic arthritis (PJIA) in patients > 2 yrs of age.

Efficacy and Safety: The global clinical efficacy and safety program for Actemra in RA was assessed in seven randomized, double-blind, multicenter studies in patients >18 yrs with active RA diagnosed according to ACR criteria across the following scenarios: as monotherapy (MT), in combination with MTX, or other DMARDs in patients with an inadequate response (IR) to those drugs, or in combination with MTX in patients with an inadequate response to TNFi (TNFi-IR). Pooled analyses of open-label, long-term treatment with Actemra, following double-blind treatment in these trials, continue with more than 4 years of treatment.

Highest Level of Head to Head Comparison: Recent data have demonstrated superiority of Actemra to adalimumab in the monotherapy treatment of MTX-IR patients with RA2. The ADACTA study compared Actemra MT (8 mg/kg IV q4 wks) vs adalimumab MT (40 mg SC q2 wks) in MTX intolerant patients or patients in whom MTX was considered ineffective or intolerant and found significantly greater reduction in the mean change from baseline in disease activity score (DAS28) score at 24 wks in the Actemra group (n=163) vs the adalimumab group (n=162) (primary endpoint, Actemra (-3.3) vs adalimumab (-1.8): difference -1.5 (95% CI -1.8 to -1.1; p<0.0001))3. Statistical significance was also achieved in favor of Actemra on key secondary endpoints including DAS28 <2.6% and ACR20/50/70. Safety analyses showed that AE rates were similar between the two groups; changes in laboratory values were consistent with previously reported data.

Safety

- In a pooled safety analysis of the intravenous Actemra Phase III trials and their long-term, open-label extension studies with mean treatment duration of 3.7 yrs (total observation time of 14,994 patient-years (PY), N=4,009), the rates of SAEs/100 PY over 12-month intervals were 16.1 during 0 to12 months and 13.5 for >36 months. In the same analysis, the rates of serious infections/100 PY over 12-month intervals were 4.6 during 0 to 12 months and 4.2 for >36 months.
- Most commonly reported AEs with Actemra IV or SC in clinical trials up to 24 wks (incidence ≥ 5%) were upper respiratory tract infections, nasopharyngitis, headache, hypertension, increased ALT, and injection-site reactions. The all-exposure population includes patients treated with ≥ 1 dose of Actemra IV in registration trials. Of 4,009 patients in this population, 3,577 received treatment for ≥ 6 months, 3,309 for ≥ 1 yr; 2,954 for ≥ 2 yrs, and 2,189 for 3 yrs. Overall rate of infections and serious infections in the all-exposure population remained consistent with rates in the controlled portion of the clinical trials.
- The safety observed for Actemra SC was consistent with the known safety profile of IV Actemra, with the exception of injection site reactions, which were more common with SC Actemra compared with placebo SC injections (IV arm).

Actemra SC has been evaluated in double-blind RCTs including DMARD-IR patients (approximately 20% of patients in each study had previously failed TNFi treatment). These studies are summarized below.

- The SUMMACTA study compared the efficacy and safety of Actemra 162 mg SC weekly to Actemra 8 mg/kg IV q4 wks (both in combination with traditional DMARDs) and demonstrated non-inferiority of Actemra SC to Actemra IV for the proportion of patients achieving ACR20 response at Week 24 (69.4% [95% CI: 65.5 to 73.2] vs 73.4% [95% CI 69.6 to 77.1], respectively). To claim non-inferiority, the lower bound of the 95% CI for the difference in ACR responses (tocilizumab-SC 162 mg weekly minus tocilizumab-IV 8 mg/kg) had to be greater than −12%. The difference between groups was -4% (95% CI:-9.2 to 1.2)8. ACR50/70 responses and DAS28 and physical function (HAQ-DI) improvements were also comparable between groups. The safety profiles of the different formulations were also similar in this study; however, injection site reactions occurred more frequently in the Actemra SC arm.
- The BREVACTA study evaluated Actemra 162 mg SC q2 wks relative to placebo (both in combination with traditional DMARDs) and demonstrated superiority of Actemra SC to placebo: at Week 24, significantly more patients in the Actemra SC group vs the placebo group achieved ACR20 response (60.9% vs 31.5%,respectively

[p<0.0001]). In addition, patients treated with Actemra SC were significantly less likely to experience worsening joint damage vs those treated with placebo in this study and AE profiles were consistent with previous findings.
- The MUSASHI study compared the efficacy and safety of Actemra 162 mg SC q2 wks to Actemra 8 mg/kg IV q4 wks (both monotherapy) and demonstrated non-inferiority of Actemra SC to Actemra IV for the proportion of patients achieving ACR20 response at Week 24 (79.2% [95% CI: 72.9 to 85.5] vs 88.5% [95% CI: 83.4, 93.5], respectively). ACR50/70 responses, change in DAS28, and rates of Boolean remission were also similar between groups. Safety profiles were comparable between SC and IV with the exception of injection site reactions, which occurred more commonly in the SC group.

Conclusions: Actemra has a distinct mechanism of action of inhibiting IL-6 mediated signaling, and therefore represents a unique therapeutic option and the only FDA-approved therapy for the treatment of RA, SJIA, and PJIA that acts on the IL-6 pathway. Actemra has demonstrated safety and efficacy in the treatment of RA across diverse subpopulations of patients and under varied treatment conditions, including as monotherapy and in combination with DMARDs.

Questions and Answers
Q: Did the MUSASHI study include US patients?
A: No, it was a Japanese study.
Q: Why not a subcutaneous formulation upon launch of Actemra?
A: A manufacturer in Japan developed Actemra IV and this was the formulation that had already launched in Japan so the rights to were acquired by Genentech.

Q: How are other Medicaid plans covering?
A: Coverage and PA criteria are generally similar to Orencia.

Q: What are considered the advantages of Actemra SC?
A: Unique mechanism of action, effective as monotherapy and effective in patients that need to switch, consistent efficacy data and evidence of ACR guidelines.

Q: How was nonresponse handled in clinical trials?
A: If patient did not respond, they could be switched to other arm but were not allowed to increase dosing.

XVII. Johnson & Johnson

Megan L. Jones, PharmD, MPA, Senior Liaison, Health Economics & Outcomes Research
J. Leigh Faircloth, Strategic Market Director
Samantha Ramos, Strategic Market Director

Olysio™ (simeprevir)
Pronunciation: Oh li' see oh (sim e' pre vir)

OLYSIO (simeprevir) is a hepatitis C virus (HCV) NS3/4A protease inhibitor indicated for the treatment of chronic hepatitis C infection as a component of a combination antiviral treatment regimen. Efficacy has been established in combination with peginterferon alfa (PegIFN alfa) and ribavirin (RBV) in HCV genotype 1 infected patients with compensated liver disease (including cirrhosis). OLYSIO must not be used as monotherapy. Efficacy in combination with PegIFN alfa and RBV is influenced by baseline host and viral factors and is substantially reduced in patients infected with HCV genotype 1a with an NS3 Q80K polymorphism at baseline compared to those patients without the Q80K polymorphism. Screening patients for the presence of virus with the NS3 Q80K polymorphism at baseline is strongly recommended. Alternative therapy should be considered for patients infected with HCV genotype 1a containing the Q80K polymorphism. Efficacy has not been studied in patients who have previously failed therapy with a treatment regimen including OLYSIO or other HCV protease inhibitors. OLYSIO is available as 150-mg oral capsules. The recommended dose is 150 mg taken orally once daily with food. The recommended duration of treatment is 12 weeks in combination with PegIFN alfa and RBV. All treatment-naïve and prior relapser patients, including those with cirrhosis, should receive an additional 12 weeks of PegIFN alfa and RBV (total treatment duration, 24 weeks). All prior non-responder patients (including partial and null-responders), including those with cirrhosis, should receive an additional 36 weeks of PegIFN alfa and RBV (total treatment duration, 48 weeks).

Efficacy studied in 3 phase 3 and 1 phase 2 pivotal study enrolling patients with HCV genotype 1 infection
Treatment-naïve Studies:
In a pooled analysis of 2 phase 3 studies (QUEST-1 and QUEST-2), administration of a 150-mg dose of OLYSIO daily in combination with PegIFN and RBV resulted in a significantly higher rate of sustained virologic response (SVR) at 12 weeks following the end of planned treatment (SVR12) (80%; 419/521) than did administration of placebo (50%; 132/264) with PegIFN and RBV (P<0.001). In patients with genotype 1a virus, rates of SVR12 were 75% (191/254) for patients who received OLYSIO and 47% (62/131) for patients who received placebo. In patients with genotype 1b virus, rates of SVR12 were 85% (228/267) for patients who received OLYSIO and 53% (70/133) for patients who received placebo.

Treatment-experienced Studies:
In a phase 3 study (PROMISE) in patients who had previously relapsed after IFN-based therapy, administration of a 150-mg dose of OLYSIO daily in combination with PegIFN and RBV resulted in a significantly higher rate of SVR12 (79%; 206/260) than did administration of placebo with PegIFN and RBV (37%; 49/133) (P<0.001).6 In patients with genotype 1a virus, rates of SVR12 were 70% (78/111) for patients who received OLYSIO and 28% (15/54) for patients who received placebo. In patients with genotype 1b virus, rates of SVR12 were 86% (128/149) for patients who received OLYSIO and 43% (34/79) for patients who received placebo. In a phase 2 study (ASPIRE) in patients who had no response to previous PegIFN and RBV treatment, significantly higher rates of SVR at 24 weeks following the end of planned treatment (SVR24) were seen with OLYSIO 150 mg in combination with PegIFN and RBV (67% [44/66] to 80% [52/65]) than with placebo in combination with PegIFN and RBV (23%; 15/66) when dose durations were pooled (all P<0.001 vs placebo).

Overall Safety
In 3 pooled trials, adverse events (AEs) which occurred with ≥3% higher frequency among patients receiving OLYSIO 150 mg once daily with PegIFN alfa and RBV than in patients receiving placebo with PegIFN alfa and RBV during the first 12 weeks of treatment were rash (including photosensitivity), pruritus, nausea, myalgia, and dyspnea. The majority of AEs reported during 12 weeks of treatment with OLYSIO with PegIFN alfa and RBV were grade 1 to 2 in severity. Grade 3 or 4 AEs occurred in 23% of patients receiving OLYSIO with PegIFN alfa and RBV and in 25% of patients receiving placebo with PegIFN alfa and RBV. Serious AEs were reported in 2% of patients receiving OLYSIO with PegIFN alfa and RBV and in 3% of patients receiving placebo with PegIFN alfa and RBV. Discontinuation of OLYSIO or placebo due to AEs occurred in 2% and 1% of patients receiving OLYSIO with PegIFN alfa and RBV and patients receiving placebo with PegIFN alfa and RBV, respectively.

Questions and Answers
Q: Is there any data in patients with HIV?
A: There is a trial ongoing.

Q: Are there any interferon-free studies?
A: There are phase 3 interferon-free trials in progress.

Q: Is the COSMOS study in phase 3 yet?
A: The COSMOS study is in phase 3 and not sure when data will be available.

This page intentionally left blank

Manufacturers' Forum

ANNOUNCEMENT

NorthStar HealthCare Consulting
Georgia Department of Community Health

On behalf of the Georgia Department of Community Health (DCH) and in service to the Georgia Medicaid Fee-for-Service (FFS) Drug Utilization Review Board (DURB), NorthStar HealthCare Consulting (NHC), in conjunction with Catamaran, announces the Manufacturers' Forum occurring on Thursday, May 1, 2014.

Date: **Thursday, May 1, 2014 from 9am-5pm EST**

Location: **NorthStar HealthCare Consulting**
1121 Alderman Drive
Suite 112
Alpharetta, GA 30005

Appointments: The Manufacturers' Forum is by appointment only. Appointments may be requested and will be scheduled ***after*** the Drugs Under Review are posted to the DCH website at **http://dch.georgia.gov/durb-meeting-information** approximately 30 days prior to the Forum. Manufacturers with drugs up for review at the current DURB meeting will be granted preference when seeking appointments. All requests for appointments must be made in writing to **GAMedicaid@nhc-llc.com** and include the drug name.

Guidelines for Participation:

- To ensure equitable treatment of all manufacturers, individual manufacturer participation shall be limited to one 30-minute time segment per Forum. The presentation shall be limited to 20 minutes with 10 minutes for questions and answers.
- Manufacturer presentations may be audio-recorded for review after the Forum and the associated information shall be presented by NHC in summary fashion at regularly scheduled DURB meetings.
- For new drugs, manufacturers are highly encouraged to present all clinical information pertinent and relevant to current NHC clinical presentations to the DURB, to DCH drug benefit plan design as posted on the DCH website, and to other drugs within the class.
- For existing drugs, manufacturers are highly encouraged to present new clinical information since the drug was last reviewed by the DURB, especially clinical information related to comparisons of other drugs within the class.
- An electronic **one-page** summary (front only, font 10, not including references) of the presentation should be provided one week prior to the presentation via email to **GAMedicaid@nhc-llc.com** and please include a pronunciation guide of the drug's brand and generic names. The one-page summary along with relevant questions and answers related to the presentation will be provided to the DURB as well as published in the DURB meeting handout that is provided to the public at the meetings and on the DCH website at **http://dch.georgia.gov/durb-meeting-information**.

Comments and Inquiries:

- Manufacturers with comments or inquiries related to Georgia Medicaid FFS **Preferred Drug List, Prior Authorization Criteria, Manufacturers' Forum or DURB** should submit these in writing to **GAMedicaid@nhc-llc.com**.
- Manufacturers with comments or inquiries related to Georgia Medicaid FFS **supplemental rebates** should submit these in writing to **GAOffers@ghsinc.com**.
- Manufacturers with comments or inquiries related to Georgia Medicaid FFS **claims processing** or **drug benefit plan design** should submit these to the address or phone number below:

Catamaran, Inc.
Georgia Department of Community Health
Windward Fairways I, 3025 Windward Plaza Suite 200, Alpharetta, Georgia 30005
Phone: 770-776-2000 Fax: 770-776-2050

This page intentionally left blank

Georgia Department of Community Health (GDCH)

Opportunities for Pharmaceutical Manufacturer Input on Clinical Recommendations and Clinical Management Strategies by the Drug Utilization Review Board

Clinical Information and Clinical Management Strategies relevant to the GDCH Medicaid Fee-For-Service program will be presented to the Drug Utilization Review Board (DURB) at each meeting through Catamaran by its vendor NorthStar HealthCare Consulting (NHC). Manufacturer input on recommendations is welcomed and appreciated using these opportunities. **Please note that new drug entities are not reviewed by the DURB until the drug has been on the market for at least 6 months.**

Ongoing Opportunity:

DUR Board Meeting Process: Drugs, therapeutic classes and/or supplemental rebate classes under review will be posted to the DCH website at **http://dch.georgia.gov/durb-meeting-information** approximately 30 days prior to the Manufacturers' Forum. Input specific to the drugs under review from manufacturers are made directly to NHC via **GAMedicaid@nhc-llc.com** and reported as appropriate by NHC at subsequent DURB meetings. NHC will pass relevant manufacturer-submitted electronic materials to the DURB members via a secure FTP site.

Upon review of information, and based on its expertise and discussions, the DURB makes recommendations to GDCH.

Presentation Opportunity:

Manufacturers' Forum: A forum prior to each relevant DURB meeting whereby manufacturers may present:

1) Clinical information relevant to a new drug on the market or a drug that is part of a therapeutic or supplemental rebate class under review by the DURB at the next meeting.

2) Clinical information relevant to ongoing NHC/Catamaran clinical management strategies (e.g. review of drug benefit plan designs, new drugs coming to market, new drug indications, etc.) as deemed necessary by NHC/Catamaran.

Please see the Manufacturers' Forum Announcement at **http://dch.georgia.gov/durb-meeting-information**.

Opportunity to Appeal to GDCH:

GDCH Review Process: DURB recommendations are reviewed by GDCH for final decisions. Manufacturers may request an appeal meeting for review directly with GDCH within 10 business days following DURB meetings. **Contact: Shirmary Hodges at (404) 656-4044 or shodges@dch.ga.gov**

Questions not addressed in this document may be sent to NorthStar HealthCare Consulting by e-mail: GAMedicaid@nhc-llc.com

This page intentionally left blank

2014

Upcoming Meetings

Drug Utilization Review Board Meeting

2 Peachtree Street, N.W.

5th Floor Board Room

Atlanta, Georgia 30303

Thursday, June 5, 2014:	9:30am – 2:30pm
Thursday, September 18, 2014:	9:30am – 1:30pm
Thursday, December 4, 2014:	9:30am – 1:30pm

Manufacturers' Forum

NorthStar HealthCare Consulting

1121 Alderman Drive

Suite 112

Alpharetta, Georgia 30005

Thursday, May 1, 2014:	9:00am – 5:00pm
Thursday, August 7, 2014:	9:00am – 5:00pm
Thursday, November 6, 2014:	9:00am – 5:00pm