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UNOFFICIAL TRANSCRIPT*
WASHINGTON STATE
PHARMACY AND THERAPEUTICS COMMITTEE MEETING

April 21, 2010
Sea Tac Marriott Hotel
9:00am – 4:00pm

Vyn Reese: Marian, can you wait just a minute? We need to round up one more member.

We'll go ahead and start with introductions now. I want to begin on my left. This is the Washington State Pharmacy and Therapeutics Committee and we'll begin with introductions to my left.

Amy Irwin: Amy Irwin, Health and Recovery Services.

Chuck Agte: Chuck Agte, Health and Recovery Services Administration.

Nicole Nguyen: Nicole Nguyen, Pharmacist with HRSA.

Jaymie Mai: Jaymie Mai, Labor and Industries.

Doug Tuman: Doug Tuman, Labor and Industries.

Jeff Graham: Jeff Graham, Health Care Authority.

Ken Wiscomb: Ken Wiscomb, Committee Member.

Patti Varley: Patti Varley, Committee Member.

Deb Wiser: Deb Wiser, Committee Member.

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* For copies of the official audio taped record of this meeting, please contact Regina Chacon at (206)521-2027 pdp@hca.wa.gov.

Vyn Reese: Vyn Reese, Chair.

Jason Iltz: Jason Iltz, Committee Member.

Regina Chacon: Regina Chacon, Health Care Authority.

Leta Evaskus: Leta Evaskus, Health Care Authority.

Donna Sullivan: Donna Sullivan, Health Care Authority.

Jeff Thompson: Jeff Thompson, Medicaid.

Duane Thurman: Duane Thurman, Health Care Authority and I just want to remind people to speak into the mikes and identify yourself. We're transcribing the meeting.

Thad Mick: Thad Mick, ODS.

Vyn Reese: Dr. Graham, are there announcements today? You can remind the stakeholders that you're timing.

Jeff Graham: I can do that.

Vyn Reese: All right. Jeff Graham will be timing stakeholders for three minutes. I think we should go ahead and just start with our presentation. Marian, can you begin? The slides are up.

Marian McDonagh: Okay. Thanks so much. And I would ask you certainly to ask questions at any time, but I am having a real hard time hearing you. So if I'm talking over you, please just shout and let me know. Okay. So this is the update of our report on drugs for Attention Deficit/Hyperactivity Disorder. We completed the report in September of '03. So if we go to the next slide.

This is the nice list of all the drugs that are included in this report. And of course with any new products that had come out by the time we were about halfway through the report would have been included in there.

If we go to the next slide this is a very brief search strategy and also just noting which companies did submit information to us about their drugs and about the studies.

Then we go to the next slide, slide 4 is just a quick overview of all the studies included in this report. It's a large report and we have 71 new studies added in this update.

Now the next couple slides there's nothing really new for the update. This is just summarizing some of the concerns about the evidence in general—comparative effectiveness there are no effectiveness trials. That was true in all of the previous updates and it's still true. And then there are some issues with the efficacy studies.

If we go to the next slide this is looking at the generalizability or applicability of the evidence. And while this might be improving slightly it still looks pretty much like this that the prevalence of which type of…the subtype of ADHD in the studies is not reported well and while most of the studies used DSM criteria for diagnosing ADHD not all do.

Okay. So if we move to slide 7 this is for pre-school age children. We have just a little bit of new evidence. The new evidence used an extension study of a small placebo-controlled trial that we had included previously. The trial itself did not find the difference between methylphenidate immediate release and placebo in the short-term in pre-schoolers. After that period children who had both responded and had good tolerability were enrolled in an extension study and after 10 months in the extension study only 68% were still continuing in…able to continue the drug. The others had discontinued for combinations of reasons related to tolerability and response decreasing. So not a whole lot new for our evidence on pre-schoolers.

On the next slide, slide 8, this is a slide on adolescents and really there's nothing new here. The evidence previously was pretty minimal. It looked at mostly driving skills in a simulator and they were very small studies. The drugs were superior…sorry, the methylphenidate OROS was superior to the other drugs compared to depending on the time of day that it was being studied.

So if we move to the next slide this was where we were comparing the immediate release stimulate methylphenidate to extended release formulations since there are many of those. And we still don't find differences between those products. The only new evidence, however, came from a study of a product that's available in Canada.

If we move onto the next slide this is looking at those methylphenidate sustained release drugs compared to each other and here the new evidence is related to dexmethylphenidate extended release, which is Focalin ER. Where the new drug had better response early in the day compared to methylphenidate OROS, the older product had a better response later in the day. So it depended on their pharmacokinetics. The adverse events between the drugs were not statistically significantly different.

Okay. So moving on to the next slide, slide 11, looking at some indirect evidence…because we had limited evidence for dexmethylphenidate we continued to include some placebo controlled trial evidence. As the direct evidence improves for this drug we will not be including some of these studies in the future. So the indirect evidence previously showed the results of dexmethylphenidate versus MPH OROS on the previous slide. Evidence of early onset of action versus placebo is what's added here and this is at half hour after the dose. So that's really the only evidence we have about the early onset of action. We don't have any comparison to other drugs and I would note that the other studies…studies of other drugs for ADHD haven't evaluated this early of a timepoint. So it's not clear whether those other drugs do or do not have efficacy at half an hour. And in these studies they found the adverse event rates were actually quite similar with dexmethylphenidate ER compared to placebo.

On the next slide, looking at slide 12, dextroamphetamine compared to methylphenidate we don't have new evidence and previously there had been…differences were not found between these products.

On the next slide mixed amphetamine salts again there's nothing new here. A clear difference between the mixed amphetamine salts in either the immediate release or extended release form was not found compared with methylphenidate.

So on the next slide, slide 14 for lisdexamfetamine we have very little direct evidence so we are continuing to include placebo-controlled trial

evidence. And while there is not a new study we have a post hoc analysis was published and we included that simply showing that the drug is superior to placebo at various times of day and probably the more important point was that it continues to be more effective than placebo as late as 10 hours after the dose at 6:00 p.m. Next slide.

Okay. Slide 15 is modafinil. Previously we had indirect evidence from five trials. Now we have one head to head study. It's very small however. But this study did find similar response between methylphenidate and modafinil, but that methylphenidate had more…higher rates of side effects. So it's a small study and it would need to be confirmed with the larger study with a more…a larger N.

Okay. The next slide is looking at the transdermal formulation of methylphenidate and the new evidence is a direct comparison to Concerta. Similar efficacy was found and also similar rates of adverse events. But the measurement of effect did not start until four hours after the application. So this was very different to some of the studies we just talked about with early measurements. We also have new indirect evidence with placebo-controlled trials. This was looking at shorter time periods of wearing the patch. So wearing it for four to six hours and indicating that at both of those time points the patch is superior to placebo and also showing that four hours after the patch is removed there's no difference between placebo and patch.

Okay. On the next slide, slide 17, we're looking at evidence for non-stimulants which is atomoxetine in this report. In this the new evidence compares methylphenidate OROS to atomoxetine and here OROS was found to be superior to atomoxetine based on response rate. And then overall we looked at adverse events from all of the studies looking at atomoxetine versus methylphenidate and here we find that atomoxetine consistently causes more vomiting and somnolence than the stimulant comparator in four trials. And all the differences were statistically significant. Rates of vomiting were 12 to 13% with atomoxetine, which is about three times greater than the rates found for immediate release methylphenidate or mixed amphetamine salts. Rates of somnolence ranged from 6 to 26% with atomoxetine, which is about three to four times greater than the rates seen with methylphenidate OROS and again mixed amphetamine salts. Sorry, the methylphenidate OROS and mixed amphetamine salts extended release do cause higher rates of insomnia

compared with atomoxetine based on two trials with the rates being 7% with atomoxetine, 13% with methylphenidate OROS and 28% with mixed amphetamine salts extended release.

So the next slide, slide 18 we were looking at how well the effects of the stimulant response is maintained over time and this is based primarily on the multi-modal treatment of ADHD study and this was a study that originally randomized children to medication plus behavior therapy or community care or behavior therapy alone. And the original study did find that the arms that included a drug had superior outcomes and now we're just looking at after the trial ended what happened to the children based on the groups they were randomized to. So in this time period between our last update and now we have a publication reporting three-year follow up and then another one reporting six- and eight-year follow up. So at three years the difference between the groups that had previously favored the medication group had dissipated. At six to eight years there was no difference found between groups on efficacy or other measures. They were looking at some more effectiveness sort of functional kinds of outcomes in the six- to eight-year follow up.

So moving on to the next slide looking at the evidence in adults, we really don't have a lot to add here. We still don't have more than…we have one small study for head-to-head direct comparison and the rest are placebo-controlled trials and we've added a few new trials there.

So the next slide, slide 20, there's nothing new to add since there are no new head-to-head trials, direct comparisons.

On slide 21 an indirect meta-analyses so based on the placebo-controlled trial evidence indicates that methylphenidate immediate release is superior to longer acting stimulants in short-term efficacy measures with a relative risk of 3.26 based on response.

On the next slide, slide 22, we have some additional evidence for each of these drugs—new placebo-controlled trial evidence indicates that atomoxetine was not superior to placebo on quality of life or driving measures. Methylphenidate immediate release was better in reducing anxiety and on driving outcomes, but not on sleep outcomes. There was no difference between placebo and methylphenidate in sleep outcomes. And then mixed amphetamine salts extended release improved driving

skills compared to placebo. Methylphenidate OROS was better than placebo in a small study of parenting skills. So I guess I would just simply comment that all of these studies were small and so these results could change with larger studies.

Now on slide 23 we're looking at the adverse events in adults and again the indirect meta-analyses that we did found no difference in appetite loss or insomnia between the long-acting and short-acting stimulants in adults.

So then on the next slide we're moving into the evidence on harms. It's a long-term serious harms related to these drugs. We do have some new evidence here so we'll move to the next slide, slide 25.

Sudden cardiac death. There's some conflicting evidence, but evidence is leaning more towards an increase in risk. The largest study, the Case-Control Study that looked at state vital statistics records and also parent…they interviewed parents and the risk of sudden cardiac death was found to be significantly greater in children who were taking stimulants at the time of their death with an odds ratio of 7.4. The concern about this study would be that because the exposure was determined by questioning the parents years later that there may be a recall bias problem. A smaller study did not find a relationship for example. So further research is needed here to determine if the association is strong.

And on the next slide, slide 35 [meant to say slide 26], this is some evidence we had presented previously based on the FDA Office of Drug Safety, their publication on the harms related to cardiovascular adverse events. So there's nothing new on this slide.

On slide 27 we do have some new evidence about atomoxetine's risk for increased risk of suicidal behaviors. Previously we had an FDA meta-analyses that they had done based on placebo-controlled trials that had been submitted to them by the manufacturer and now we have new evidence that the manufacturer went through their own data and produced their own meta-analyses both based on short-term trials as well as longer term extension studies, follow up studies. So in the short term there is an increased risk of both suicidal ideation and completed suicide with a Mantel-Haenszel incidence difference of .52%. It's very similar to what the FDA found. It's a little bit higher. And then in the longer term it looks like the risk is actually even higher. So the risk of the combination

of suicidal ideation behavior or attempts was 2% looking at the five studies that had at least three years duration of exposure. So those are some new evidence. They are based on placebo-controlled trials and then extension studies. So probably further work is needed to look at the…what is the risk in populations that are more broadly defined?

On slide 28 the first slide looking at impact on weight in children of these drugs and the first slide has…there's no new evidence for these drugs. On slide 29, however, we do have new evidence for atomoxetine. For durations of one to three years exposure the weight of the child does seem to be decreased with atomoxetine exposure and at three to five years duration the expected weight is not different to what was…sorry, the weight of the children is not different to what is expected for their age. So similar to some of the findings we have found with the stimulants as well.

Now on the next slide, slide 30 we're looking at the same studies but looking at height and very similar findings here. The decrease in expected height…there is a decrease in expected height at both 18 months and 2 years depending on which study you're looking at. But then another study found that two years and then again at five years the children's height was actually not different to what was expected. So it does seem similar again to the weight findings and to findings with other drugs, but the impact is in the first year or two and then it does tend to dissipate after that.

On slide 31 we have no new evidence for the impact of these drugs on treatment emergent tics.

On slide 32 we had previously been asked to look at the evidence…the connection between these drugs, exposure to these drugs as children, and later misuse, abuse and diversion of drugs. So we'll go into that evidence. The last time we didn't have a lot of evidence here and now we do have better evidence.

So on slide 33 here we see that…previously this was really mixed evidence, but now we can see that with nicotine dependence when the confounder of conduct disorder is controlled for in the analysis the studies indicate no association. So no increased risk for nicotine dependence. And the same with alcohol abuse – no association was found in five studies.

On the next slide looking at substance abuse here again studies that control for conduct disorder did not find statistic…significant association between earlier stimulant exposure and later substance abuse.

So if we look at rates of misuse of ADHD medications based on surveys of people who were prescribed a stimulant for ADHD the findings on children and college students come from a systematic review of 21 survey type studies. So it's numerator data and it's not comparative. It does increase…I'm sorry, these studies do indicate that the rate of misuse increases with age up to young adulthood.

Looking at diversion on the next slide, slide 36, based on small studies or a systematic review of surveys, again similar to what we saw with misuse we find that the rates of diversion do increase from childhood to teenage years and then into the early adult years. This indicates just the degree of the problem. The risk appears to be highest among young adults. The effective of the type of stimulant…so any differences among the drugs is really not clear from these studies, these surveys.

On slide 37 looking at…going into some of the effects in different subgroups of the population with ADHD, looking at rates or ethnicity new evidence indicates the similar efficacy with atomoxetine in Latino and Caucasian patients and no difference there. Some differences found there as you can see in adverse events, but again probably those data are a little bit shaky because of the number of patients included.

On the next slide looking at gender, atomoxetine we have new evidence with a pooled analysis. So this is a simple pooled analysis of placebo-controlled trials. This is in adults. So it indicates that atomoxetine is superior to placebo in both sexes. However, they also found that women did respond better on some subscale items. So looking at the ADHD ratings symptom scale the women responded better on a subscale item called emotion disregulation and then on the Sheehan disability scale they found that the social life subscale item women did better on. But no differences in the total score for either of those scales. It's a little unclear what the value of those subscale assessments are and particularly what the power…what the statistical power was. It is probably inadequate so it could be different if a larger group of studies had been pooled.

Looking at the next slide, looking at ADHD subtypes, which was an area that we had mentioned early on as being not well studied. So we do have some new evidence here in a pooled analysis of data from three placebo-controlled trials of modafinil. The results indicate a statistically significant improvement on the ADHD rating scale for both the combined and in attentive subtypes but not…so no statistically significant difference for the hyperactive impulsive subtype. But again the subgroup numbers are pretty small. So the statistical power behind these findings are certainly in question. So a larger study needs to be done to determine if that…if those results are robust.

On the next slide, slide 40, looking at comorbidity we have no new evidence.

And then looking at slide 41 this is looking at some subpopulations. So comorbidities. We do have just a little bit of new evidence – in adolescents the methylphenidate sodas was superior to placebo in reducing ADHD symptoms in teens who have substance use disorder and there was no significant treatment effect on their drug use or their substance abuse. And in adults' atomoxetine was found superior to placebo in improving ADHD symptoms in adults who had comorbid alcohol use disorders. Neither immediate release methylphenidate nor methylphenidate sustained release was superior to placebo in improving ADHD symptoms in adults with comorbid cocaine dependence, methadone maintenance or general alcohol and drug dependence in a single study.

That's the summary of the new evidence. I'd be glad to take your questions.

Vyn Reese: This is Dr. Reese. Are there questions from the committee?

Patti Varley: I just want to clarify that to the best of my knowledge modafinil is still not FDA approved for the use of ADHD. Is that correct?

Marian McDonagh: That is correct, yes.

Patti Varley: Sorry. That was Patti Varley.

Barak Gaster: This is Barak Gaster. Going back to slide 36, can you tell us anything more about how that survey was conducted? Do you have any methodology?

Marian McDonagh: This is based a number of different surveys and I think that the methodology probably varied somewhat. But what they described is simply sending out fliers to children who had…they had identified through clinics who had been treated. So it was like a mail out survey contact with them and I think that there may have been one of these that did follow up phone calls, but for the most part these were mailed out surveys and then people would send them back with their response or whatever. So whatever they wrote in is all they got.

Barak Gaster: Right. Barak Gaster again. My main sort of question is how anonymous they were? I mean we're asking people if they've sold their drugs illicitly. So we're going to get a really different response regarding…dependent on how anonymous of a survey it was. It's very possible that this is a dramatic under estimate depending on how anonymous of a survey it was.

Marian McDonagh: Yeah, I think you're right and I think the reports of the surveys were not that clear on that point. So they might indicate that they were in some way anonymized but not clear on how. So that would have a big impact on as you're saying, how the person might choose to respond.

Patti Varley: This is Patti Varley. What's not on there are the children who are prescribed meds whose parents use them. Because I will say that that is much more common in my clinical experience.

Marian McDonagh: And we haven't found studies on that yet.

Jason Iltz: Marian, this is Jason Iltz. Question…a follow up to slide number 27 about suicidal ideation and suicide. Was the population there a simple diagnosis of ADHD or were there co-occurring disorders that are also present in that population that was studied? Co-occurring meaning other mental health disorders.

Marian McDonagh: That's very good and I think that in particular the answer is…because these are people who all came from trials, so even in the extension studies they would have been people who had been enrolled in a trial originally that the comorbidity list is much smaller. So while it might include some

things like the conduct disorder it didn't include other sorts of psychological diagnoses. So I think, yes, it did, but not large…one of the problems is that they weren't able to do a lot of subgroup analysis because of not having enough patients with those comorbidities in this group.

Patti Varley: This is Patti Varley and I think in some ways for me reinforces the fact that when you're looking at the group of meds for ADHD that atomoxetine is a different substance in regard to it. It is a norepinephrine reuptake inhibitor similar to the antidepressants and therefore would have the same risk that they would and I think this supports that and I think most people protocol wise are following that and I'm not sure that the data I've seen anyway both clinically and in evidence based indicates necessarily that they had to have a diagnosed comorbid anxiety or depression to necessarily be at risk. It doesn't mean they don't have it, it just means they may not have been formally assessed or diagnosed. But I do think this clarifies that this is a different class of medication.

Vyn Reese: Any other questions from the committee? Marian, can I ask you to stay on the line while the stakeholders speak?

Marian McDonagh: Sure.

Vyn Reese: And I want to remind the stakeholders that they have three minutes to speak. The first stakeholder is Steven Cheng from Eli Lilly and on deck is Fred Amberger from Novartis.

Steven Cheng: My name is Steven Cheng.

Vyn Reese: Just a second. We're not hearing you very well.

Steven Cheng: Hello?

Vyn Reese: There you go.

Steven Cheng: Okay. Thank you for the time. My name is Steven Cheng. I'm a Health Outcomes Liaison with Eli Lilly and Company. I would like to support keeping Strattera as a preferred drug for patients in Washington. Strattera is the first non-controlled, non-stimulant ADHD agent FDA indicated for children, adolescents and adults. Strattera is the first ADHD agent indicated for the maintenance treatment of ADHD in children and

adolescents. Strattera offers continuous efficacy and has been proven effective in both hyper active, impulsive and inattentive symptoms of ADHD. Strattera provides long-term control of ADHD symptoms with proven maintenance, extended treatment in children and adolescents. Strattera appears to be safe in the treatment of ADHD in patients with ADHD and coexisting chronic, motor, tic or anxiety disorders as it does not worsen anxiety or tics in these patients.

The American Academy of Child and Adolescent Psychiatry treatment guidelines suggested initial treatment plan that includes, "Strattera, amphetamine or methylphenidate preparations". The guidelines also suggest that Strattera may be considered as a first medication for ADHD in persons with an active substance abuse problem, comorbid anxiety or tics and is preferred if the patient experiences severe side effects of stimulants such as mood, [inaudible] or tics.

Regarding safety Strattera has a proven safety and tolerability profile in children, adolescents and adults. It is not a scheduled substance. It has not shown a pattern or response that suggests any stimulant properties and may be a viable option of ADHD patients with a history of alcohol or drug abuse or those residing in a substance abusing environment.

Availability of Strattera may help address current unmet medical needs in the treatment of ADHD and again I would like to ask that the P&T consider keeping Strattera as a preferred agent. Thank you for your time.

Vyn Reese: Thank you. Are there questions from the committee? Okay. Next up is Fred Amberger. On deck is Allen Wu from OMP Janssen.

Fred Amberger: Good morning. I'm Dr. Fred Amberger. I'm a scientific director with Novartis Pharmaceuticals and I've got a few comments relative to Focalin XR. Focalin XR is an extended release formulation of dexmethylphenidate with a bimodal release profile. Focalin XR is indicated for the treatment of ADHD in patients' age six years and older. Focalin XR is a single isomer technology product and is formulated with the active d'isomer of methylphenidate, a stimulant that's been used to treat the symptoms of ADHD for more than 40 years.

Focalin XR contains only the more active isomer which is responsible for the effective management of the symptoms of ADHD. In addition, as part

of a total treatment program Focalin XR helps manage ADHD symptoms rapidly with the convenience of a once daily dose.

Clinical experience has shown that patients may benefit from a greater efficacy in the later hours of the day. In an effort to address this identified patient need Novartis has developed a 30 mg dose of Focalin XR that demonstrates statistically significant improvement in ADHD for up to 12 hours versus placebo.

A recent randomized double blind crossover trial re-evaluated the safety and efficacy of Focalin XR 30 mg versus 20 mg in children with ADHD in a 12-hour laboratory classroom setting. The clinical study involving 165 children age 6 to 12 demonstrated significantly greater improvement in ADHD symptoms with the 30 mg dose compared with the 20 mg at hours 10 through 12. Adverse events with Focalin XR 30 mg were consistent with those observed with the Focalin XR 20 mg dose but were more frequent at the higher dose.

In concluding just a short comment that the capsules should be swallowed whole. However for children the capsules can be broken apart and the beads sprinkled on something like applause for ease of administration. So I thank you for considering continuing to maintain Focalin XR on the Washington State PDL. Thank you.

Vyn Reese: Thank you. Questions? Next speaker is Allen Wu. On deck is Harlan Gephard.

Allen Wu: Good morning. My name is Allen Wu and I'm with the Medical [inaudible] Department at Janssen. In the next few minutes I'm going to review results from several studies that could potentially be generalizable to patients in everyday clinical practice. The studies were not included in the OHSU review and I would like to bring it to your attention.

The first study is titled ABC Trial. It assessed the effectiveness of Concerta in ADHD children with comorbid learning disability. It is estimated that 25% to 35% of patients with ADHD also have comorbid learning disability yet these patients are often excluded in clinical trials and data are often quite limited. Results from the study are the following: Concerta demonstrated a significant improvement in behavior, attention and math problem attempted in ADHD children with and without

comorbid learning disability. Also Concerta demonstrated a significant improvement in behavior and attention in one hour and through 12.5 hours in all patients.

So in summary, past studies have demonstrated effectiveness of Concerta in ADHD patients with comorbid [inaudible] disorder and connect disorder. Now we can include learning disability and hopefully this will help clinicians include it in their practice.

I would also like to move to the next discussion topic which is abuse liability of ADHD medication. Abuse liability of ADHD medications are of great concern and interest to practicing clinicians and is a topic with limited data. I would like to highlight some findings that provide signals that the oral delivery system of Concerta may be an advantage.

Two studies compared the relative abusability of Concerta to methylphenidate immediate release formulation and concluded that the slower, longer rate of delivery of methylphenidate via the oral delivery system may lower the abuse liability of Concerta. Also, results from a survey of more than 20,000 college students between age 18 and 24 reviewed that Concerta was less frequently…was used less frequently for non-medical purposes compared to other forms of methylphenidate. This was published in the American Journal of Addiction in 2008.

Last, the National Poison database compared medication exposure and abuse of amphetamine, dexamphetamine to methylphenidate in children age 10 to 19. Rates of amphetamine, dexamphetamine exposure and abuse [inaudible] both increased approximately 140%. At the same time methylphenidate exposure increased 57%, but abuse [inaudible] decreased by 55%.

In summary, this data could signal a potential advantage of methylphenidate delivered in a long-acting oral delivery system. I want to emphasize that there are numerous limitations to these studies, but they do provide a signal that clinicians could hopefully apply to their practice. Also these can be provided upon request. Thank you for your time.

Vyn Reese: Thank you. Are there questions from the committee? Next up is Dr. Harlan Gephart.

Harlan Gephart: Good morning. I'm Harlan Gephart. I practice behavioral pediatrics privately at Pediatric Associates. I spent 34 years at Group Health. I'm a Clinical Professor. I helped develop the Academy of Pediatrics Guidelines on ADHD, edited their online course, developed their toolkit, currently serve on the Reach Institute along with the Hall of Fame bunch like Mark Walrike(?) and Peter Jensen in which we're trying to teach psychopharmacology to primary care doctors. I say this not to talk about my career, but I think what is absent often from these discussions, and I've been to two or three of these panels in the last few years, and I'm not bashing evidence-based research, but a lot of it is impractical and I think what is lacking from these discussions is the experience and wisdom from older clinicians like myself. I prescribed my first dose of stimulant in 1964 when I finished residency and started practice. So I have 40 something years of experience and thousands of kids and ran an ADHD center that had 600 referrals a year at Group Health.

Why I came here today is I have a concern because of a drift towards generic only medications and I think that's wrong. Medications have to be individualized to a patient. Even if you look at brand names compare Ritalin LA to Metadate CD. The amount of immediate acting and longer acting granules in each capsule is different. So Metadate CD and Ritalin LA are two different medications. They are apples and oranges and yet often we get requests from pharmaceuticals and by the way I don't know if I mentioned this but I have no association financial or otherwise with any pharmaceutical. But we get requests from health providers that we have to give a certain preparation and it's apples and oranges. The other day received and said, you know, "You need to generic Concerta." There is no generic Concerta. There is no 12-hour methylphenidate. And if there is one that comes out generically I would have to look at the pharmacokinetics because years ago I did participate in developing Concerta and it was very important that we develop what was called an ascending profile. We duplicated what happened when methylphenidate was given three times a day where each successive dose was stronger than the original dose because there was some leftover. And if you don't incorporate that into the capsule then you're not really duplicating Concerta. So I know there's this drift toward generic medications and I came here just because I want you to stop and think about that and don't just rely on evidence based.

Jeff Graham: Please conclude your remarks.

Harlan Gephart: Okay. Last remark, the decision you make are very important because eyeball-to-eyeball with Peter Jensen in just the last month, data that's not even reported yet, the major cause of poor outcomes in kids with ADHD is socioeconomic factors, which certainly make sense, substance abuse, maternal depression and whether or not they used medications. And it's very important that we get this right about what medications are available and I hope you use people like myself and others in the community who have great experience in making some of these decisions. Thank you.

Vyn Reese: Thank you. Any questions from the committee? All right. I'd like to open it up for discussion. Can we look at our…Marian, are you still one?

Marian McDonagh: Yes I am.

Vyn Reese: Okay. I think you can probably be excused.

Marian McDonagh: All right.

Vyn Reese: Yeah. Can we look at our last motion on the same topic?

Barak Gaster: This is Barak Gaster and I think looking at our last motion it's first amazing how quickly a year goes by. It seems like just yesterday that we were doing this. I guess the main decision for us as a committee is…I mean the main drug that was not in our past motion that we did see…that we did review today was still modafinil and I guess I would judge that the data is still not sufficient to warrant including a statement of efficacy on modafinil in our motion.

Vyn Reese: I think it's not FDA approved. This is Dr. Reese so I would agree with that. I'm more concerned about atomoxetine and the risks involved with it. It looks like every time we review this there are more risks with atomoxetine and I know we have it reserved for patients for special populations. It's clearly…it's probably a safer drug on someone who has got an active substance abuse problem. In that subgroup there's no question and the question is do we have a way of making sure it's going to that population only? It looks like it has a suicide risk associated with it that's worrisome and I want to make sure I talk…know how we focus that drug to the people who have substance abuse issues and is it being limited to that group?

Patti Varley: This is Patti Varley and I would say that you can't limit it to just that group because there are non-stimulant responder ADHD patients who need an alternative. There are kids with comorbid or adults with comorbid anxiety or tic disorders where that's a safer, better drug. I think we're back into our system of…absolutely appropriate concerns that clinicians who are using these meds understand these meds, how they work, the risks associated with them. But I would argue too that there has been a wax-and-wane of the concerns of growth with kids on stimulants, cardiac risk with kids on stimulants, and I just think all of that is important to look at that. We all need to keep updated on the risks associated with any medication we use and know what they are. So doing vital signs, getting cardiac histories on kids on stimulants I would say is equally concerning to me as is the suicide risk with atomoxetine. I don't see them necessarily as different. I think everything has their risks.

While I'm on the microphone I guess I would like to clarify that Harlan, I've known you forever, I struggle too being on this committee and being a clinician is an expert in this area with the fact of…and I teach that too, the lack of similarity between administration of stimulants amongst different preparations. On the other hand we are in an incredibly difficult economic time where having to provide coverage to a greater number of people I think that it is of our need to also look at where to start. We know, all of us who work in this area, there is no way to predict what medication a patient will respond to the best. And I think starting with something that is on the preferred list that is generic, that is less expensive to see if that fits…I want to make sure people always understand that we, especially if you're an endorsing prescriber, we have the ability to continue to look to match for a patient what is most efficacious for them and what is the best fit, but I think we have to do that with a mindfulness about economy in this day and age. And it's been a switch for me as well. But I think that it is…it's still looking at within what we have in our toolkit what can we best treat patients with, but in treatment naïve patients, which is what the generic first is all about it's not about destabilizing stable patients. It's just looking at those alternatives and looking at whether for some people that's a way to match it. So I just want to be clear that we're not saying you can never move to those things, it's just that when we're starting we're trying to look at ways of making more available for everyone and it's within every class. But I agree, I struggle with there is no Ritalin LA generic. And there are no Concerta generics

and there…so it is tough, but it's trying to, with what we have, look at that.

That was a longwinded answer to…I think everything has more risks now than when we thought. I wouldn't take it off in my opinion because I think I need that alternative of a non stimulant still available.

Vyn Reese: Thank you. Is there any other comment? This is Dr. Reese.

Alvin Goo: Hi. It's Alvin. Comparatively as far as the number of prescriptions of atomoxetine compared to the other stimulants do you have a sense of what that is?

Chuck Agte: This is Chuck Agte with HRSA and we are not prepared with that data at this time unless Dr. Thompson might have something.

Jeff Thompson: This is Jeff Thompson. This would be a year dated and this would be including…this would be for all of the state purchasing fee for service. The data supplied for Strattera would be 795,000 days of supply and you would benchmark that against let's say something like Concerta which would be 1.2 million days supply. I'd have to add up all the numbers but it's not insignificant, 795,000 days supplied with Concert, 1.2 million days supplied.

Vyn Reese: You meant the reverse.

Jeff Thompson: I'm sorry.

Vyn Reese: Yeah. Any other discussion?

Barak Gaster: This is Barak Gaster and I just want to thank Vyn Reese for his thoughtful comments about the huge safety concerns with just about every drug in this class and there's no question that there's a huge potential cause…potential for harm. Probably none of the safety concerns rise to the level that we would state that they are not safe and that they are safe enough and balanced against their efficacy. And also thank you Patti Varley for your really thoughtful important comments as well, which I think sort of starts getting us into more of a drug utilization discussion that I think would be very useful for us to have in our afternoon session at

some point because of what a huge potential there is for harm with these drugs as well as potential for diversion and inappropriate use.

That said though I think probably looking at the motion that we made one year ago it probably is reasonable to restate that motion with the same working we did a year ago since we're…it sounds like we're all in agreement that modafinil would still not be included in that statement and that we still don't have good head-to-head trials that would suggest that one agent is more effective than another.

Vyn Reese: So are you going to make that a motion Barak?

Barak Gaster: I think I would like to make the motion that we carry forward the motion of April 15, 2009 as it was worded then.

Patti Varley: This is Patti Varley. I second.

Vyn Reese: All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed same sign. It's passed unanimously. Let's move on to the next item on the agenda.

Susan Rowe: May I make one quick comment?

Vyn Reese: Go ahead.

Susan Rowe: This is Susan Rowe and I would like to second the idea that we bring this up as a drug utilization review topic because drug treatment is such a…it's one part of the treatment but we really need to, you know, I'd like to know what's available to parents in terms of parenting skills and finding the right, you know, tools for finding the correct dose and developing a routine. So it is so multi-faceted that I do recommend it for the future.

Vyn Reese: Thank you for your comments. The next item on the agenda is a break. So that's welcomed. So we'll have a 15-minute break and we'll get back here at 10 after.

This is Dr. Reese. I'd like to try to call the committee to order again. Please take your seats. This is Dr. Reese. I'd like to call the committee to order and state representative Christopher Hurst is going to be addressing the committee on ADHD drugs.

Christopher Hurst: Thank you very much.

Vyn Reese: Can you pull your mike up? I want to make sure it's…

Christopher Hurst: How about that? Or is it turned on?

Vyn Reese: That's better.

Christopher Hurst: Very good. Folks, thanks for hearing me here today. I was stuck for about an hour in traffic coming up on I-5. I had hoped to be here about an hour earlier but it's a little bit of a mess out there today. I wanted to just speak real briefly and I'll only take a couple minutes of your time in relation to the stimulant drugs. I'm a member of the House of Representatives, but I'm also the Chair of the Public Safety Committee in the House. But probably more importantly I spent 14 years in narcotics and actually taught all of the narcotics law enforcement training classes here in Washington State for many, many years. I was a guest instructor. Washington sent me back to the Federal Law Enforcement Training Center where we worked for quite a number of years to create a standardized model of teaching narcotics law enforcement throughout the country and I actually worked with some of the top experts in the world literally as we worked for several years to put together a program that now is actually taught not just in all 50 states, but throughout the United States and did a great deal of research in my career on the area of substance abuse.

One of the things I want you to think about very carefully, and I know you may have already made your decision, but I want to tell you that I have some significant concerns about the use of stimulants and talking just briefly historically the processes that we've through in this country before and the experiences we've used with stimulants or we have learned with using stimulants in many different ways—recreationally a long time ago when cocaine was a very popular substance and we put it in everything from pop to wine to all these different types of things back in the 30s to the experiences that we went back and replicated again when we decided

that we were going to put most of the women in America on stimulants as weight control things. And the mechanism, and I wish I had about an hour to go over this with you, but the mechanism of abuse with stimulants is very nefarious and one of the reasons that we have this tendency to repeat history and go back and make the same mistakes over and over and over again is after we fix the mistake and we go back and we say, "Well, it's all new now it's going to be different," we forget the mechanism and how long it takes a person to get addicted to a stimulant and then what the catastrophic consequences are once they become addicted.

And I will tell you after working for 14 years as a narcotics detective and actually at the end of my career I was supervising these units and I can tell you I've been in contact in the last few days with folks that are working narcotics on the street. The problem that we're having with Ritalin, the problem that we're having with substance abuse, with prescription drugs is growing at a rate that it never has in Washington State's past, absolutely never. Today more people are going to die from oxycodone overdoses than they are from traffic accidents in Washington State. That's a statistical fact and I will tell you that one of the ways in which people get involved in very dangerous drugs is starting with Ritalin. It is a psychologically addicting drug as opposed to a physically addicting drug, but the power of that psychological addiction, once you get hooked on it, will ultimately lead you to use other drugs; specifically methamphetamine. It will also cause you to change after a while your pattern of how you use that drug.

The most powerful way in which people use drugs is to crush them up and smoke them and that's what a majority of the deaths you're seeing today from OxyContin are. Now I know that OxyContin is a depressant and this is a stimulant we're talking about, but whenever you put a person on a drug, especially a young person while their brain is developing, and they get addicted to that drug at some point in time when they can't get it anymore or you take it from them they will still have that psychological addiction. The social cost to that is absolutely enormous. Now I'm the Chair of the Public Safety Committee in the House and we have spent years trying to deal with methamphetamine and methamphetamine labs. We've been very successful in dealing with labs, but not with methamphetamine as a whole because as we cut down on the number of labs we now have methamphetamine being imported in much higher

quality and much larger volumes by Mexican organized crime families from out of state.

And here's my problem with saying we're going to make somebody exhaust a cheaper drug before we use something else. I can promise you from my experience on the street, from the people that I work with, from the studies that I've done, and once again I wish I had more time, and I'm going to cut this short, we are going to turn a lot of kids into drug addicts and when they can no longer get that drug no matter what you put them on, they will self-medicate with other drugs and this is a disaster. The use of prescription drugs, the overdoses and the abuses that are leading from starting with one type of a prescription drug to another are catastrophic today. I've had people calling me that I worked with years ago that are in narcotics that are saying, "Chris, you've gotta do something about this. You're the chair of the Public Safety Committee in the House. Do people really realize how many kids are dying every single day and how bad the abuse of prescription drugs is getting in the state of Washington today?" And I go, "You know, I understand that." This is a decision and respectfully, very respectfully I have to tell you it's an ill conceived decision. This is a bad idea. The social costs of putting kids on Ritalin that shouldn't be on Ritalin and you look at the money that you're going to save from doing that compared to the social costs we're going to pay later for substance abuse, very difficult addiction to break psychological addictions, the problems it's going to create in families, the problems it's going to create within the criminal justice systems is enormous. It really is a poor decision and I know you've made the decision, but I'm hoping that you'll think about it. And if you have the time I'd like to come back and maybe go into more depth and more detail and I will tell you I am concerned enough about that that I believe that it such a poor decision that if you continue on this path I think it will be important maybe for the legislature to take a look at it and say legislatively we may want to look at changing it. I hope it doesn't come to that. So I implore you, I beg you—talk to me. I'll be happy to sit down with any of you who want additional information. If you want real life stories or what I've seen on the street, and this is not just antidotal information. I actually did this for 14 years and I understand what's happening. I supervised other people that did as well, but also in my capacity as a member of the House of Representatives and Chair of the Public Safety Committee I have a moral obligation to try to get you to reconsider and realize that this is creating a disaster. It may save a few dollars, but for every dollar you save I'm going to tell you

we're going to spend $100 in taxpayer money down the road. It really is a problem and I hope you consider that.

Vyn Reese: This is Dr. Reese.

Christopher Hurst: Yes, sir.

Vyn Reese: You missed the whole presentation of the committee. So you're telling us that we should not allow…

Christopher Hurst: I understand.

Vyn Reese: …methylphenidate to be prescribed in the state? Is that your recommendation?

Christopher Hurst: No. I think…

Vyn Reese: I'm not sure what you mean.

Christopher Hurst: I think there are times when it should be, but the problem that I have is saying that this is going to be a drug that we must exhaust first. In other words, we've going to try this, we're going to use this first because we move to more expensive drugs. I am under the understanding that this is done as a cost-saving measure at least in part and I'm going to tell you that the danger of these drugs is seriously misunderstood and is being understated by some folks. Now there are going to be people that are going to disagree with me, but I will tell you that I'm talking to folks all the time and they're saying the level at which we're seeing abuse of these drugs is continuing to grow. Now remember because it's a psychologically addicting drug this isn't something you see the results of immediately. It takes some period of time. The average person even using cocaine or any other stimulant is going to sometimes use that drug to up to three years—sometimes before they see measurable symptoms of substance abuse or of addiction to that. Sometimes it's much quicker depending upon how they use it.

Vyn Reese: This is Dr. Reese. Patti Varley is an expert on pharmacology in kids and how to treat ADHD. Could she have a chance to respond to that?

Christopher Hurst: Oh sure. Absolutely.

Patti Varley: And this is Patti Varley and I'm not sure I agree that there may be a missing point here that we need to clarify, but the first thing I want to say is along the lines of…I'll say what I say to the kids. The pill itself is not good or bad. It's how that pill is used whether it becomes a drug or a medication.

Christopher Hurst: True.

Patti Varley: We clearly know as far as long term outcome not treating ADHD kids and not treating them well increases the risks of substance abuse, increases the risks of criminal problems and costs to society as a whole.

Christopher Hurst: And I agree with that as a whole.

Patti Varley: Many…I would say many and most of the patients that are treated appropriately with this medication there is data evidence showing that they are less likely to be substance abusers. But clearly what I think I'm hearing and you can clarify is that having those stimulants out there where people who aren't prescribed them or people who don't need them take them is the concern. Then they become addicted and I do think that's a concern, which is why these are scheduled drugs and if somebody calls for an extra refill I look at why that is, etc.

I need to clarify for the record that not treating ADHD kids and not treating them well is actually a danger similar to what you're describing in regard to substance abuse, criminal behavior, etc. What I'm not clear on is whether your concern is that by having a generics first policy that the generics being out there would be abused more than a higher cost non-generic med and I couldn't tell from your statement if that was your concern.

Christopher Hurst: No. And I'll clarify for you. And you bring up a couple of excellent points. I'm not saying don't treat people. And you're also correct in that the diversion is a significant portion of the problem because we find that a lot of kids, the parents don't manage the medications quite as well as they should, they allow the kids to manage the medications themselves. But I know you tell folks not to do that and a lot of these drugs do get sold on the street. I'm telling you it would take me a very short amount of time out here on Pacific Highway South, probably about 10 minutes, I could

probably come back with a large quantity of all different types of prescription meds that are being sold just right on the street corners out there today. But the problem that you speak of relates not to not treating, because I agree 100%. You must treat this and I'm not saying don't treat the condition. I'm saying if there are alternatives, even if they are more expensive alternatives that are not stimulants, they're a wiser course of action and therein lies my concern.

Patti Varley: So therein lies the misunderstanding though that if you look at any data from many, many, many years of data being collected, if you have an individual who truly has diagnosed ADHD, the treatment of choice whether we like it or not, whether it's comfortable or not is appropriate prescribing of stimulant medications. And all of the alternatives being looked at to date do not have any of the clinical or research evidence showing equal efficacy. So in that realm I understand the dilemma, but in order to treat to avoid that stimulants are still the number one drugs of choice that are most efficacious for this population.

Christopher Hurst: And I guess I thank you for your thoughts. But I guess I'd have to say that I would…I would say that it must be treated. I think that it is over treated and I think that the medical community has realized that and has significantly cut back and has made different diagnosis. But I think there are other alternatives and using that as a starting point is causing problems that maybe are not fitting into the data that you're seeing. And I'd have to disagree with some of that.

Patti Varley: I'd have to refer you to the MTA studies, which are headed by Peter Jensen which is an NIH funded multi-site longitudinal study of this disorder and the data repeatedly supports the fact that stimulants for this condition are the clinical efficacious and safe medications for our patients.

Vyn Reese: And this is Dr. Reese and the other option, we just talked about this…we had a big review just before you came in. Atomoxetine, the drug that is a non-stimulant in this drug has serious other risks associated with it including suicide risk, nausea, drowsiness, it has multiple side effects and they don't respond as well to that drug as they do to the stimulants. So to say that the whole state should use just that drug is going to subject a lot of people to other medical risks that are quite serious. It does have its place in somebody who already has a problem where the stimulants don't work. But it's a drug that has its own set of side effects, its own risk profile, and

I'm very concerned about that drug right now. So if you do that and you divert everybody to that drug you're going to be denying people a lot of, you know, people the necessary treatment they need and you're also going to be subjecting to risks that the stimulants don't have. So you have to remember this is not something that's easy to just say, "Oh no you're not going to prescribe stimulants. You're only going to prescribe this drug." That drug is not without its own problems.

Christopher Hurst: And I understand that. Let me clarify once again. I'm not giving you absolutes here. I'm not saying don't ever use it. I'm saying that if you simply say that everyone must exhaust this before we use a different step I think that's an error. And that's different than saying don't use it at all. I also think that the data that the other good doctor spoke about misses the fact of what's happening in the area of diversion. So even for our folks that are using this the area of diversion is extraordinary and there is no measurement in your statistical data that deals with the folks that are actually getting this not under the supervision of a doctor, but because it is such a popular drug and there is such an incentive to sell this drug and market it among kids the data doesn't cover them. No doctor is overseeing those.

My point once again to come back and politely say that I'm not saying never use it, I'm saying if you say you must always use it and exhaust it first you're making an error and I think yes there are going to be side effects or problems with any type of medication. But saying there's an exclusive policy that starts simply with that that doesn't consider the use of other drugs at that first stage level, if appropriate, is an error.

Vyn Reese: This is Dr. Reese.

Christopher Hurst: Yes sir.

Vyn Reese: They are the most efficacious as Patti Varley just said. They're the drugs that work best for this disease. So to say that you don't start with them first doesn't make a lot of sense to me. I understand the law enforcement issue and diversion is a big problem with these drugs…

Christopher Hurst: It's a huge problem.

Vyn Reese: It's a huge problem and diversion is a major problem and I agree. But if you get into medicine…if you bring law enforcement too far into medicine then you get a big problem too.

Christopher Hurst: I agree absolutely.

Vyn Reese: I would be very cautious about that.

Christopher Hurst: And herein lies where we should probably defer to a treating physician rather than broad blanket policy that's instituted. And I think if a physician has an opportunity to deal with that, they also can measure something else that can't be measured by these other statistics. A doctor in a doctor's office can look at a person, look at the parents and say, "Is this a family that's likely to properly manage the use of this medication?" And I know a lot of doctors that I've talked with that have said, "We can tell when somebody comes in. We know when people are trying to get scripts for pain meds for instance or other types of medications." But they also can make moral judgments as to, "Is this a family that's going to be likely to monitor carefully how this drug is used? Is this a family that's not likely to monitor that and is this likely to get out into this secondary diversion market, which is a huge problem?" So yes we have the treatment issue, but we also have the secondary market, a law enforcement, but more than just a law enforcement problem it's a social problem because we bear an enormous cost in our society for the diversion and use of prescription drugs. All I'm saying is that I think that you need to look at it in a case-by-case basis. A blanket policy is neither good one direction or another.

Barak Gaster: This is Barak Gaster. I would just like to say this is neither the time nor the place for us to be debating the pros and cons of the generics first law. Our motion says nothing about generics first. We are not here to sort of judge the generics first program. Many of your statements are better served in a drug utilization discussion. But we thank you for your comments.

Christopher Hurst: I thank you very much for hearing me today. I appreciate your attention.

Duane Thurman: Excuse me. This is Duane Thurman. I think what we have is a disconnect here and I'd like to talk to you outside when we get done here. In the capacity of the P&T Committee we're really not discussing the generics

first initiative, but the committee had previously asked the Department to come back and do a specific presentation on this drug class and we'll be setting that up and I think that's when we will want to have this discussion. But your remarks are well taken.

Christopher Hurst: That would be great. And my apologies if I'm in the wrong context and the wrong place. I was about an hour late. I had hoped to sit in on a little bit more. Coming in blind a little bit. Thank you for hearing me and for your kindness and your attention.

Patti Varley: Thank you.

Vyn Reese: Thank you. We know it's a problem.

Patti Varley: This is Patti Varley and what I will say is what you're pointing out is something we unfortunately don't have control over and if you had been here earlier, which is once these policies are in place how individuals out there in the real world have their practice. And unfortunately that is not our ability to control and we talk about that often. In an ideal world many of us would like to be able to do that. But you are pointing out, I think which is a practice problem not necessarily a policy problem amongst the P&T.

Christopher Hurst: And I thank you once again for your indulgence and your kindness today.

Vyn Reese: Thank you. This is Dr. Reese and I'd like to move on to the next item on the agenda. Is Susan Carson on?

Susan Carson: I am.

Vyn Reese: Okay. We'll start the statin discussion. The slides are up.

Susan Carson: Okay. Thank you. So this is the fifth update of the statins report and the authors of the report are shown on the slide. The new evidence that was added this update is highlighted with underlining on the slides.

If you go to slide 2 our inclusion criteria are shown. The major change to our included populations this update was to add children. So I'll be presenting the evidence for each question for adults first and then for children and that's the way the report is organized. Next slide.

Study designs – we had no changes to the included study designs this update. Just to remind you for assessment of efficacy or lipid levels only head-to-head trials were included because there was a large body of those type of studies. And other study designs such as placebo-controlled trials were included for other outcomes. Next slide.

The included drugs are shown on this slide. The major change to this update was the addition of the fixed dose combination products Advicor, Vytorin and Simcor. So Advicor is lovastatin plus niacin; Vytorin is Simvastatin plus ezetimibe and Simcor is Simvastatin plus niacin. Next slide.

We're on slide 5. So the included outcomes remain the same this update. Effectiveness outcomes were health outcomes such as reduction in mortality and MI and the efficacy outcomes were changes in lipid levels including the percent of patients in a study reaching their lipid goals. And then we also addressed harms as usual. Next slide.

We searched the literature through June 2009. In addition to bibliographic databases we used other sources including dossiers from pharmaceutical companies, reference lists and the FDA website. Next slide.

We're on slide 7. This shows the results of our literature searches. We ultimately added 135 new studies this update. So it was a large report. Next slide.

So we'll start the results for key questions 1 and 2 comparative efficacy for LDL cholesterol lowering and HDL cholesterol raising. Next slide.

So key question 1A addressed comparative efficacy for LDL cholesterol lowering.

Slide 10 shows the previous conclusions for this key question, which were that all of the statins can reduce LDL cholesterol up to 35%. Atorvastatin 20 mg or higher, lovastatin 80 mg, rosuvastatin 10 mg or higher, and simvastatin 20 mg all will meet the goal of up to 50% LDLC lowering. And atorvastatin 80 mg and rosuvastatin 20 mg are considered high potency statins and they can reduce LDLC by 50% or more. Next slide.

So for this update we added we added 20 new head-to-head trials that reported LDLC lowering. It brings the total of head-to-head trials for this outcome to over 90 studies. And the new…all the new trials assessed either atorvastatin or rosuvastatin compared to either each other or to another statin. Next slide.

So the percent LDL cholesterol lowering in the new head-to-head studies was consistent with existing evidence. So it didn't change the conclusions. There were 14 new head-to-head trials of atorvastatin versus rosuvastatin bringing the total number of studies with this comparison to 29 plus three meta-analyses. So overall the evidence shows that rosuvastatin at the highest dose of 40 mg had a greater lipid lowering effect than atorvastatin at the highest dose, which is 80 mg. Next slide.

So for the new agents included this update the fixed dose combination products we identified 13 active control trials of LDLC lowering. 10 of the trials included the combination of ezetimibe and simvastatin; that's Vytorin. And most compared by Vytorin to monotherapy with another statin. Two trials compared the combination product of simvastatin and niacin extended release to simvastatin alone. And one trial compared the combination of lovastatin and niacin as extended release to atorvastatin or simvastatin. So there were three arms in the trial. And we found no trials that compared one of the fixed dose combination products to another. Next slide.

We're on slide 14. So results show that the combination of ezetimibe and simvastatin lowered LDL cholesterol by 58 to 61%. So this was a greater effect than found with the statin alone. So Vytorin lowered LDLC more than statin monotherapy.

Vyn Reese: This is Dr. Reese. I have a question Susan. In this review I don't see the study that looked at intermediate outcomes – the carotid intimal thickness. Was that not…with ezetimibe and simvastatin and where the statin versus the…

Susan Carson: That was not an outcome that we included. We considered it an intermediate outcome and it's not a health outcome. We would have included it if the…just for the LDL outcomes, but not just the carotid…that outcome is not…was not considered a health outcome so the study would be excluded.

Vyn Reese: Okay. Thank you.

Susan Carson: So only one trial found greater LDLC lowering with the fixed dose combination products containing niacin compared with a statin alone. And this was a trial of lovastatin plus niacin extended release compared to simvastatin 20 mg and the LDLC lowering in this study was 42% for the combination product versus 34% for the simvastatin alone. Other than that the effect of the fixed dose combination product with niacin was similar to the effect of the statin alone. So in other words the addition of niacin didn't have an effect on LDL C. Next slide.

Key question 1B we assessed the ability of statins in fixed dose combination products to achieve LDLC goals according to the NCEP or equivalent goals based on the location of the study. Next slide.

Slide 16. So in a new fair quality head-to-head trial patients taking rosuvastatin 40 mg were more likely to meet their LDLC goal of less than 100 mg per deciliter than those taking atorvastatin 80 mg. Those are at the two highest doses of those statins. Higher doses of the fixed dose combination product ezetimibe-simvastatin were likely to meet NCEP goals when greater than 55% lipid lowering was needed. And fixed-dose combination products containing extended release niacin were not more likely to achieve LDLC goals than statin monotherapy. Next slide.

Moving on to key question 2, which addressed HDLC raising.

Next slide shows the previous conclusions. The evidence previously showed that when the doses that reduce LDLC by a similar amount are compared we also find similar increases in HDL C. We found conflicting evidence about whether simvastatin was superior to atorvastatin and whether rosuvastatin was superior to atorvastatin for HDLC increases.

Next slide shows the new evidence for this update, for this key question. We found that rosuvastatin 40 mg was superior to atorvastatin 80 mg in two open label fair quality trials. In trials comparing low to moderate doses of rosuvastatin to low to moderate doses of atorvastatin or simvastatin there was a greater increase in HDLC with rosuvastatin over atorvastatin, but there were mixed results in the comparison of rosuvastatin to simvastatin. Next slide.

This slide shows the new evidence on HDL cholesterol for the fixed-dose combination products. There is no difference between simvastatin monotherapy and the ezetimibe-simvastatin combination for increasing HDL C. However, there were greater increases in HDLC with fixed-dose combination products containing niacin. But patients taking the combination products had increased adverse events, mainly flushing and they had more discontinuations due to adverse events with the combination products than with monotherapy. Next slide.

We're on slide 21. And moving on to key question 2B comparative efficacy for reaching HDLC lipid goals. Next slide.

The evidence showed that the ezetimibe-simvastatin combination was equivalent to simvastatin alone and for HDLC and one 24-week double blind trial comparing the niacin extended release simvastatin product to simvastatin 20 mg monotherapy showed a greater ability to meet HDL goals, but at the cost of greater discontinuations due to adverse events. So with the combination product 70% of patients met their goal versus 45% with the monotherapy, but almost 16% discontinued versus 5% with the monotherapy. And again mostly because of flushing. Next slide.

We're on slide 23. This is key question 3 which addressed health outcomes. Next slide.

First primary prevention. For primary prevention we still have no direct evidence comparing one statin to another. And then we also identified no studies of a fixed dose combination product with health outcomes. So all the evidence as the committee member mentioned before the evidence…the fixed-dose combination product is just for the intermediate outcomes of the lipid levels. Next slide.

Slide 25. So new evidence in primary prevention comes from two trials. One is the Jupiter trial which you are probably aware of. It compared rosuvastatin 20 mg to placebo. Included patients had normal lipid levels, but elevated C reactive protein. Jupiter had a scheduled five-year follow up but it was stopped early at a median of 9.1 years due to benefit for cardiovascular events. There was a 44% decrease in risk of first major cardiovascular event. The absolute risk was 1.6% in the rosuvastatin group versus 2.8% in the placebo group. This translates to a number

needed to treat of 83 and the number needed to treat for all cause mortality was 167. In the report we cautioned that because the trial was stopped early we should be cautious in extrapolating these results beyond that length of follow up of 9.1 years. And then the second new trial in primary prevention was the Mega Trial, which compared lower dose pravastatin plus diet to diet alone in adults in Japan. There was a 33% reduction in the incidence of coronary events at five-year follow up. All cause mortality was lower in the pravastatin group but it wasn't significantly different from the diet alone group. Next slide.

This is slide 26 focusing on the new evidence in patients with diabetes. Two new trials of this update included patients with type 2 diabetes to make a total of eight trials conducted in this population. Results of the Aspen study conflicted with three other studies that showed a reduction in the risk of cardiovascular events with atorvastatin. In Aspen there was no reduction in the primary outcome with atorvastatin 10 mg. Possible explanations are that the Aspen trial enrolled patients at very low risk and they…it differed from the other trials in the primary outcome, which was a composite of cardiovascular death or events. And then the second new study in patients with diabetes compared fluvastatin 80 mg to placebo in patients following a PCI and in this study there was a reduction in the risk of cardiovascular events, which was the primary outcome, but they found no reduction in all-cause mortality. Next slide.

Slide 27. So new evidence in secondary prevention in this update. The SPARCL trial compared atorvastatin 80 mg to placebo in patients who had a recent stroke or transient ischemic attack. A five years of follow up the study found a reduction in stroke and major coronary events, but no decrease in cardiovascular disease death or all-cause mortality. Next slide.

Key question 4 addressed comparative effectiveness of statins in fixed-dose combination products in subgroup based on demographics or comorbid condition. Next slide.

Slide 29. Two new meta-analyses. This update confirmed results of other meta-analyses that showed that statins do not differ in efficacy based on gender or age. Three new studies this update confirmed existing evidence that harms do not differ among men, women and elderly patients at maximum doses of simvastatin and lovastatin. A new short-term head-to-head trials reductions in LDLC and frequency of adverse events with

rosuvastatin 10 to 20 mg and atorvastatin 10 to 20 mg in Hispanic, South Asian and African American patients were similar to those observed in studies conducted in primarily white, non-Hispanic populations. So overall this evidence shows that in the subgroup set are reported the statins performed similarly in the general population. Next slide.

Key question 5 addressed harms in the general population. Next slide.

Slide 31. This shows the previous evidence and the new evidence for this update. The new evidence for statin monotherapy is consistent with the previous conclusion—that there's insufficient evidence to determine if any statin is safer with regard to muscle toxicity or elevated liver enzymes. The new evidence in the six-dose combination products found the greater adverse events mainly flushing and more discontinuations due to adverse events in products containing niacin than for statin monotherapy. Next slide.

Key question 6 addressed harms in special populations including patients at high risk for myotoxicity or hepatotoxicity. Next slide.

We found…the evidence showed no changes or led to no changes in the previous conclusions this update. The new evidence for statin monotherapy is consistent with existing evidence. Next slide.

Slide 34 and slide 35, the two slides summarize the conclusions for update number 5 in adults. So regarding lipids rosuvastatin 40 mg had a greater LDLC lowering and HDLC raising ability than atorvastatin 80 mg. And the ezetimibe-simvastatin fixed-dose combination product had greater LDLC lowering ability than statin monotherapy. Fixed-dose combination products containing niacin have a greater LDLC lowering ability than…I'm sorry HDLC raising ability than statin monotherapy. And no studies of fixed-dose combination products with health outcomes and still no head-to-head evidence of equipotent doses of statins with health outcomes. Next slide.

Slide 35 continues the conclusions in adults. Regarding harms fixed-dose combination products containing niacin had more adverse events and discontinuations due to adverse events. Other than that their conclusions did not change for harms for this update.

So moving on to slide 36 we'll move to the evidence in children, which was a new population we added this update.

Next slide shows the first key question – how do statins and fixed-dose combination products containing a statin and another lipid lowering drug compare in their ability to reduce LDLC among children? Next slide.

Eight placebo-controlled trials of statins in children were included for LDLC reductions. This included one trial of atorvastatin, two of lovastatin, two of pravastatin, and three of simvastatin. All these trials were conducted in children with familial hypercholesterolemia or other familial dyslipidemias. Most of the trials were fair quality. One was good and one was poor and in all of the eight trials LDLC was reduced with a statin compared to placebo. And the reductions from baseline range from 17% to 32%. One head-to-head trial compared atorvastatin to rosuvastatin both at 80 mg and that study found no difference between the groups after six weeks. So the 19% reduction for rosuvastatin and 18% reduction for atorvastatin.

Christine Klingel: Could I interrupt? This is Christine Klingel. Did you say 80 mg of rosuvastatin?

Susan Carson: Yes.

Christine Klingel: Okay.

Susan Carson: And these are…the studies in child were in children with very high lipid levels. I'm not sure what the year was on that study either. So I know that that dose is not used now. Next slide.

Slide 39. So we conducted a meta-analysis of the placebo-controlled trials. Seven trials provided sufficient information to be included in the meta-analysis. Most were fair quality. Overall the statins reduced LDLC by 32%. The confidence interval ranging from 37% to 26%. The mean percent change was greater for atorvastatin 10 mg and simvastatin 40 mg than for lovastatin 40 mg and pravastatin 20 to 40 mg. So these results are similar to the percent LDLC reductions that are seen in adults at the same doses. And one trial included the fixed dose combination product of ezetimibe and simvastatin and it found a greater reduction in LDLC for the combination product compared with simvastatin alone—54% for the

combination product versus 38% for simvastatin monotherapy. Next slide.

Key question 2 looked at HDLC raising in children.

Slide 41, the next slide. So atorvastatin increased HDLC more than placebo in one study and there was no significant difference from placebo in trials including rosuvastatin, simvastatin, lovastatin and pravastatin. So no difference with the drug compared to placebo in the individual trials. In our meta-analysis pooling the placebo-controlled trials the pooled result indicated the statins as a class and increased HDLC by 3% with a 95% confidence interval of 0.6% to 5.6%. In the one head-to-head trial of atorvastatin versus rosuvastatin there was no difference between groups in the change from baseline in HDLC. So neither of the drugs improved the HDLC. And in the one trial that compared the fixed-dose combination products ezetimibe plus simvastatin to simvastatin alone. Again, there was no change from baseline in HDLC.

Moving on to slide 42 key question 3 addressed health outcomes in children whether there's evidence of reducing risk of major coronary heart disease outcomes and mortality among children.

Next slide unfortunately we found no evidence for this key question. The studies have not been conducted with a long enough follow up to assess cardiovascular morbidity and mortality. So only intermediate outcomes in children. Next slide.

Key question 4 comparative evidence in subgroups. Again, there was very little evidence. Next slide.

No trial included children with diabetes or with obesity. One trial of simvastatin found a 21% reduction in LDLC in children with neurofibromatosis 1. Otherwise there was no evidence in subgroups based on comorbidities or demographics. Next slide.

Slide 46. Key question 5 comparative harms there was also very little evidence. Next slide.

The reporting of adverse events was minimal in the short-term placebo-controlled trials. Multiple studies reported no significant elevations in

liver enzymes. When elevations did occur they were lower than three times the upper limit of normal and they resolved with interruption or discontinuation of therapy. But no long-term studies of harm in children.

And then finally key question 6 addressed the harms related to special populations or drug interactions in children. Next slide.

Slide 49 the only evidence came from one study of fluvastatin and this is in children with minimal change disease and there was a decrease in total cholesterol and no side effects were reported in this population. And that concludes the summary of the new evidence for key question 5. If you have any questions I'd be happy to address them.

Vyn Reese: Thank you. Are there questions from the committee? This is Dr. Reese again. I wanted to go back to the Vytorin. I know intermediate outcomes are not looked at by your group. In that study, though it was really a concerning outcome and I don't know how much longer we'll have to wait for health outcomes for that particular product. Do you have any idea when those studies will be completed or are there any studies in progress?

Susan Carson: Yeah, I'm not aware of that. Maybe there's someone from the company there who could tell us about that. But we didn't identify any studies in progress.

Vyn Reese: Any other questions? Can you stay on the line while the stakeholders speak, please?

Susan Carson: Sure.

Vyn Reese: The first stakeholder is Ms. Jennifer Dudman from Merck and on deck is Jamie Hurst from AstraZeneca.

Jennifer Dudman: Thank you. Again, I'm Jennifer Dudman with Merck and I do thank you for allowing this time for me to speak to the combination product of simvastatin and ezetimibe. And I would like to compliment your very thorough clinical data review and then also thank you for asking some of the pertinent questions around the ability of these products to help patients achieve their NCEP goals.

The only comment I would like to add is to speak to the complimentary mechanisms of action of simvastatin and ezetimibe as described in the prescribing information. So we know that statins decrease cholesterol synthesis which affects liver stores of cholesterol. Ezetimibe also affects hepatic cholesterol stores. It's primary site of action is to block cholesterol absorption in the small intestine. This leads to a decreased delivery of intestinal cholesterol to the liver causing a reduction of cholesterol hepatic stores which then increases the clearance of cholesterol from the blood. So again a complimentary and additive mechanism between the two and as you found in answering your questions 1 and 2 that ezetimibe…simvastatin fixed dose combination product does have greater LDL cholesterol lowering than statin monotherapy. So that's all the prepared comments I had to add. I'm happy to answer any questions though I am…can only speak to the prescribing information.

Vyn Reese: This is Dr. Reese. You don't have any idea when the health outcomes data is going to be available for that product? Or is there a study in progress?

Jennifer Dudman: That information is in the public domain but I am happy to send an information request from our medical department. I can get that sent by email, but that it out in the public domain. You could find that information very quickly.

Barak Gaster: But you don't know?

Jennifer Dudman: I can't speak to it. I can't bring that to your attention.

Duane Thurman: This is Duane Thurman. If you could submit that to the people at Oregon that would be appropriate.

Jennifer Dudman: Okay. We'll do that.

Vyn Reese: Any other questions? Thank you.

Jennifer Dudman: Okay.

Vyn Reese: Up next is Jamie Hurst, AstraZeneca.

Jamie Hurst: Good morning. Dr. Jamie Hurst, a Regional Scientific Manager with AstraZeneca and thank you for the opportunity to present on behalf of Crestor today. The data I'll present is in response to the request by the Washington State Medicaid for new clinical information. So in October of last year the FDA approved the use of Crestor in pediatric patients between the ages of 10 and 17 with heterozygous familial hypercholesterolemia. On February 8th of this year the FDA approved Crestor for the reduction of myocardial infarction, stroke and arterial revascularization in patients without clinically evident coronary heart disease but an increase in cardiovascular risk due to age, greater than or equal to 50 in men, greater than or equal to 60 in women, elevated HSCRP greater than 2 and the presence of at least one additional cardiovascular risk factor such as hypertension, low HDL, family history of premature coronary heart disease and smoking.

The indication was based on the Jupiter trial. In this study 17,802 patients were randomly assigned to receive either a placebo or rosuvastatin 20 mg daily and were followed up for a mean duration of two years. In compared to placebo rosuvastatin significantly reduced the relative risk of myocardial infarction by 54%, stroke by 48% and arterial revascularization by 46%. At one year Crestor significantly lowered LDL cholesterol, total cholesterol, serum triglycerides, HSCRP and significantly elevated HDL cholesterol. A higher percentage of rosuvastatin treated patients with true study medication due to adverse reaction versus placebo irrespective of treatment causality. The most common form of adverse event leading to study discontinuation was myalgia. The most common reported adverse event for rosuvastatin versus placebo were myalgia 7.6% versus 6.6%, arthralgia 3.8 versus 3.2%, constipation 3.3 versus 3.0% and headache 2.4 versus 2.3%. In the Jupiter trial there was a significant increase in the frequency of diabetes mellitus reported for rosuvastatin patients versus placebo 2.8% versus 2.3%. Mean HBA1C was significantly increased by 0.1% in the rosuvastatin treated patients versus placebo. Increases in HBA1C in serum fasting glucose have been reported for [inaudible] uptake inhibitors including Crestor.

So in addition to the aforementioned indications Crestor's been demonstrated to be highly efficacious at lowering LDL, raising HDL and slowing the progression of arthrosclerosis. Thank you. I'd be happy to answer any questions.

Vyn Reese: Thank you. Questions from the committee? Thanks. Let's bring up the…let's open it up for committee discussion and bring up the last review.

Barak Gaster: This is Barak Gaster and I have a question just about the mechanics of the therapeutic interchange program and I'm wondering whether…sorry that I don't remember this after years of doing this so far is whether the rules for the therapeutic interchange program even allow for therapeutic interchange for products that are fixed-dose combination products.

Chuck Agte: This is Chuck Agte with HRSA and currently since we don't have any combination products within the statin class there are…we don't have that kind of interchange currently because the P&T Committee has not given us a ruling on any of those.

Barak Gaster: Right. So I guess the question was whether the general sort of guidelines, approaches even allows something like that?

Duane Thurman: This is Duane Thurman. The way that it works…there are no external rules. It's up to the committee to decide whether it's appropriate from the evidence in the clinical usage of the drugs to allow therapeutic interchange or not. I'm trying to think of examples where…I mean as the current motion stands interchange is allowed between the selected drugs unless somebody needs one of the high potency statins which, you know, would not be interchangeable. At this point the combination drugs are not on. If you determine that they should be on it would be your decision as to whether those are interchangeable generally or against specific other alternative drugs. So it's really the committee's call.

Barak Gaster: So in terms of the way the therapeutic interchange program is written it doesn't say that it must be within a single class of medications?

Duane Thurman: That would be a direction we would ask from the committee. In many classes you've said that these drugs cannot be interchanged. Other classes you're comfortable with full interchange. Some classes you say that one drug is not subject to interchange but the others are.

Deborah Wiser: This is Deb Wiser. I guess my thoughts on that would be because there are different side effect profiles with different classes of medications I

think this would apply here as well then direct interchange without it actually being prescribed wouldn't make sense to me; especially given that some of the combination products can increase the risk of liver toxicity.

Barak Gaster: Right. This is Barak Gaster. I definitely would feel uncomfortable with a therapeutic interchange from a monostatin to a combination product, but I think the combination…interchange from a combination product to a monostatin would not have that difficulty.

Donna Sullivan: This is Donna Sullivan. The other option that you have is you've made decisions before in other drug classes like the diabetes medications to just not include the combination products within the drug class itself and then they would be handled based on each agencies own PDL decision.

Vyn Reese: This is Dr. Reese. I think that's the way to handle this. I think the combination products are just not…they're not easily interchanged and I think we should just do what we've done in other drug classes, which is leave them out.

Barak Gaster: Yeah. This is Barak Gaster again. It's a somewhat awkward use of the therapeutic interchange to go say from simvastatin/ezetimibe combo to simvastatin alone, but I guess I would say that the evidence that we have been presented in terms of hard clinical outcomes would say that that would be a rational and reasonable clinical exchange to make.

Patti Varley: This is Patti Varley. That being said but along with what was also said, which is that the combination drugs are newer drugs and that there's still data being collected that we don't have. To me it should stay separate for now where we leave the individual statins as is stated and not include the combination products because they aren't equivalent and aren't easily exchanged. They would still be available under DAW if somebody needed it or failed the single statins…or might be. But I'm not sure that combining it into the individual statins makes any sense for therapeutic interchange or otherwise at this point with the data we have of higher side effects potentially and lack of appropriate data.

Duane Thurman: This is Duane Thurman. This gets to the complicated part as to whether you're in the program or not in the program. In other examples I think we…there was one class where you said it was a secondary treatment and you decided not to put it on the preferred drug list program. The threshold

question here is whether you want to put the combination products on the PDL drug program, which would bring up the issue of therapeutic interchange. If you decided that the evidence is not sufficient to include then those drugs would not be part of the preferred drug list program, but would be subject to availability, however all the individual…programs make all other drugs available. The other issue is you could consider them second line therapy. You've done that in other classes so that's really within your discretion.

Barak Gaster: This is Barak Gaster and sorry it's just so funny how we have to recreate this sort of mental thought process wheel every time and so I would say that I would agree with keeping this combination product list off of the PDL at this time.

Vyn Reese: This is Dr. Reese and I concur. We don't have to vote on that. We can just vote on the statins that we discussed it. You don't have to vote not to put, you know, something on the PDL.

Susan Rowe: This is Susan Rowe and I…I think I would advocate having it as a combination products as second line. In the absence of outcome data I would be very uncomfortable looking at a reduction in LDL and possibly using this combination drug over a high potency statin which has outcome data and yet if someone were not able to tolerate a high dose statin this could be an alternative. So I guess I would advocate not a therapeutic interchange, but maybe as a second line drug where it could be available with prior authorization.

Vyn Reese: This is Dr. Reese. I think you probably could prescribe ezetimibe by itself and simvastatin by itself if you had that need. Is ezetimibe on? We really haven't looked at it by itself. So…niacin is on the formulary. That's on the PDL?

Donna Sullivan: No.

Vyn Reese: It's not there?

Donna Sullivan: This is Donna Sullivan. At this point in time…I mean niacin is a covered drug for the Health Care Authority. We cover the product Niaspan, but it's not included in this particular drug class. To address your comments the three combination products, I'm sorry Susan, the three combination

products would still be available for providers to prescribe for patients that were not able to take a single statin alone. But they would not be subject to therapeutic interchange and if they're not included on the preferred drug list as part of this drug class then if the doctor writes "dispensed as written" it doesn't mean it's automatically covered. So by putting it…by not including these drugs in the preferred drug list program each of the agencies can individually determine if the drug's going to be preferred or not preferred and whether or not they should require prior authorization. So they're still available for use but they're not…they just don't then follow the rules of therapeutic interchange and the DAW process.

Duane Thurman: An example…this is Duane Thurman. An example of where you've done something similar in the past was we are reviewing the…I believe the ACE inhibitors. I'm not a pharmacist. We brought to you the data…other ones, the Diovan drugs and you said that was not a first line therapy and declined to put it on the preferred drug list. What we need from you for this decision is a clear delineation of what drugs you want to include in the statin drug class for the purposes of the motion and if you want to exclude the combination products at this time then you still have access to it. The result of this motion is that there is therapeutic interchange with the exception of the need for a high dosage product.

Charles Agte: This is Charles Agte with HRSA and if it helps to clarify these combination products because they are not previously included in the PDL each agency already has rules governing those three combination products. So there are existing controls, existing decisions on how those are being allowed within the population already.

Jason Iltz: This is Jason. Chuck, can you kind of go into a little more detail as to what guides those decisions?

Nicole Nguyen: This is Nicole and those are just…anything that's not part of the PDL, the drug classes it goes through our own process where we have a group that reviews these drugs and decides based on the safety and if there's any potential for misuse, abuse and decide whether it's going to be covered without PA or any expedited authorization. They only allow it for certain diagnosis or any limits that need to be undosed or…

Alvin Goo: Hi. It's Alvin. So currently if you were…if one was to prescribe one of these combination products would it be denied if they have not tried a monotherapy statin or what criteria is it that it's allowed?

Nicole Nguyen: Right now I don't know if there are…I don't think there are any stops on the Vytorin and I don't think…I don't believe…a lot of it would depend on the…sometimes it depends on the FDA label and if the FDA label particularly says that something could only be used one they fail another but I don't believe we've had any limits on these.

Alvin Goo: Okay. I guess I would feel comfortable if we do not put these combination products on the PDL, but if they're being used as first line agents then I would have a concern and I would like to somehow remedy that and I don't know by putting it on the PDL and making that or leaving it off the PDL and having you do that, which would be the best?

Donna Sullivan: This is Donna Sullivan. I just want to mention for the Health Care Authority we have all three of those drugs…they're non-preferred but they are also subject to step therapy. They have to try and fail simvastatin prior to being prescribed one of these products. If the patient hasn't had simvastatin in their record, you know, then they can go through the prior authorization process as well. And actually we require that for all of the statins whether they are preferred or not preferred unless the patient requires greater than a 45% reduction in LDL.

Nicole Nguyen: This is Nicole. We don't have…the one thing we've done in the past is with the ARBs where you guys said you want it second line we have them on expedite authorization where they have to fail an ACE inhibitor first. So that's one way we have of handling it.

Donna Sullivan: And this is Donna Sullivan. A way to do that would be to…if you excluded them from the PDL program then as part of the DUR board you could instruct Medicaid to put certain coverage criteria on those products if you wanted them. That would not then impact the other agencies and how they're currently controlling those products.

Christine Klingel: This is Christine Klingel. So for my clarification then you have a product like ezetimibe solely by itself is on your…a patient could have that drug but they would have to…if they wanted the combination product would

have to have failed simvastatin by itself or would it be possible for them to take the two drugs separately and have them be covered?

Donna Sullivan: I would have to look. Thad, do you know if Zetia on step therapy as well?

Thad Mick: I don't know the answer to that.

Donna Sullivan: Yeah.

Thad Mick: Whether or not Zetia requires a step therapy at this point.

Nicole Nguyen: I'm thinking for simplicity in a patient's regimen and for decrease in costs if they're taking the two products separately a combination product isn't covered?

Donna Sullivan: I'd have to go back and look at our coverage criteria, but I'm thinking that they can take Zetia alone and then if they want to add the simvastatin they can. And then we would allow the combination product to go through. Whether or not that's an automatic coverage or if they would have to get a prior authorization I don't recall.

Jason Iltz: This is Jason. Just to remind everybody we're making some assumptions that maybe a combination product is cheaper than individual agents and realize that what we see at the pharmacy level in terms of costs is not what we are dealing with here. I mean it's much different and things are negotiated much differently at this level. So, you know, I think the agencies are doing a good job at looking at that and I think they would certainly make the decision to say, "Hey, let's take this one. Compliance may be better, it's cheaper for us anyway," rather than prescribe something that, you know, maybe compliance goes down and we're paying more. So we gotta be careful in realizing that the cost to the pharmacies that we may work at aren't necessarily the costs that we're going to be associated with state coverage.

Duane Thurman: No. This is Duane Thurman. I feel compelled to say that you should really not be considering cost at all at this point with the clinical evidence that's before you. There are a lot of drug classes that are not on the PDL program and the agencies are well established in how we deal with those and they're dealt with on a clinical basis also.

Vyn Reese: Any other discussion? If we just pass the motion below then it would essentially mean that the combination products wouldn't be on the PDL. Is that correct?

Duane Thurman: We would prefer a positive statement to that effect.

Vyn Reese: Yeah.

Barak Gaster: This is Barak Gaster. So I'd like to make a motion that we not include the fixed-dose combination products containing a station in the PDL.

Vyn Reese: You don't have to do that though. Does he have to do it?

Duane Thurman: It would be clearest, yes.

Vyn Reese: Okay.

Jason Iltz: I second. This is Jason.

Vyn Reese: Any discussion? All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed, same sign. Does anyone want to tackle the statin proposal?

Alvin Goo: Hi. This is Alvin. I make a motion that we accept the reiteration of the prior motion dated February 18, 2009.

Vyn Reese: Is there a second?

Jason Iltz: Second. This is Jason.

Vyn Reese: Any discussion? All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed, same sign. Passed. Okay. The next item on the agenda is the scan on drugs to treat insomnia. Susan Carson. I believe you're up for that too.

Susan Carson: I'm sorry. I didn't hear what you said.

Vyn Reese: It's the scan of the drugs to treat insomnia.

Susan Carson: Yeah. Right. You have those slides up?

Vyn Reese: We're just in the process of getting them up.

Susan Carson: Okay. Thanks.

Vyn Reese: Okay. The first slide's up.

Susan Carson: Okay. Thank you. This is the first update scan for update number 3 of the newer insomnia drugs. Go to slide number 2.

It shows the history of this report. The last full update was conducted in October 2008 with searches through January 2008. Next slide.

We included adults and children with insomnia including primary insomnia, breathing related sleep disorder. For example sleep apnea, insomnia related to another disorder such as anxiety, substance abuse sleep disorder or a sleep disorder due to a general medical condition.

The next slide shows the six included sleep drugs. Nothing…there's the zaleplon, zolpidem, zolpidem extended release, eszopiclone, ramelteon and zopiclone which is available only in Canada, not in the United States.

Next slide shows the included effectiveness and harms outcomes. Next slide.

So for this update scan we searched Medline from January 2008 to September 2009 limiting our search to humans and clinical trials, English language and we found 131 new citations. Next slide, please.

After review of those citations we found 5 new potentially relevant trials. They compared efficacy compared to either placebo or to cognitive behavioral therapy. There was a study of zolpidem in children with ADHD, ramelteon with a six-month follow up, zolpidem with a six-month follow up, and zolpidem extended release in adults with comorbid anxiety

and a study of daytime functioning from a trial of zopiclone, the Canadian drug that was previously included.

Slide 8 shows the results of our searches of the FDA and Health Canada website searches for new drugs and safety information. We found Edluar was approved in March 2009. It's the sublingual form of zolpidem. And then Zolpimist is an oral spray form of zolpidem and that was approved in December 2008 by the FDA. And then an update on the drug Silenor or doxepin 3 and 6 mg. This drug was denied FDA approval for treatment of insomnia in February 2009. The company resubmitted in June 2009 and last we heard the anticipated action date was December 2009. I don't have a more recent update on that. And we found no new indications for drugs already included and we found no new safety alerts on drugs already included.

Vyn Reese: Thank you.

Susan Carson: So that's the new update.

Vyn Reese: Great. Any questions from the committee? I'll take a motion to accept the scan.

Ken Wiscomb: This is Ken Wiscomb. I move we accept the updated scan as adequate.

Vyn Reese: Second?

Barak Gaster: This is Barak Gaster. I second.

Vyn Reese: All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed, same sign. The scan is accepted. It doesn't look like there's a lot of new data. You can look at our previous motion. If we can just get a motion to reiterate the motion of April 15, 2009 unless there's further discussion.

Barak Gaster: This is Barak Gaster. I would move that we would reiterate the motion dated April 15, 2009 regarding insomnia drugs, sedative hypnotics, and repeat as was previously worded.

Vyn Reese: Is there a second?

Deborah Wiser: Deb Wiser, I second.

Vyn Reese: All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed, same sign. It's passed. The next scan is on ACE inhibitors and again it's Susan Carson.

Susan Carson: Okay. So this is the fourth preliminary scan for what would be update number 3 for ACE inhibitors. So this report has not been updated for a while.

Slide 2 shows the history of the report. The last full update was completed in June 2005 with searches through February 2005 and we've had a scan…three previous scans since then.

Next slide is the included populations for this report – adults with essential hypertension, heart failure, high cardiovascular risk, diabetic nephropathy and nondiabetic nephropathy, and a recent MI.

Next slide shows the…I think there's 10 or 12 included ACE inhibitors.

Next slide shows our included outcome and the effectiveness measures differed according to the clinical…the population…the clinical condition, but we looked at all cause and cardiovascular mortality, quality of life, cardiovascular events, end-stage renal disease, symptomatic improvement and hospitalization in heart failure and for patients with nephropathy we looked at deterioration of renal function. Next slide.

For this scan we searched Medline from November 2009 to early February 2010 and we found 198 new citations. Next slide.

After review of those 198 we only found 2 potentially relevant trials. One was a subgroup analysis of the EUROPA Trial, which was perindopril versus placebo. The EUROPA Trial is already in the report. This is a subgroup analysis in patients with prior MI or revascularization. The

second new trial we identified was one new trial of trandolapril versus placebo for sudden cardiac deaths in patients with stable coronary artery disease and preserved left ventricular systolic function.

And then the last slide shows results of our searches of the FDA and Health Canada website searches which identified no new ACE inhibitors, no new indications for the included ACE inhibitors and no new safety alerts. So really not a lot of new information for this class…this scan.

Vyn Reese: Thank you. Are there questions from the committee? If not I'll take a motion to accept the scan.

Susan Rowe: This is Susan Rowe. I move that we accept the scan.

Vyn Reese: Is there a second?

Alvin Goo: This is Alvin. I accept…I second.

Vyn Reese: All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed, same sign. It's passed. So let's look at the motion from before. This is from our last…the last time we reviewed this group. That was from June 2008.

Ken Wiscomb: This is Ken Wiscomb. I move that we reiterate the motion that was passed on June 18, 2008 with regard to ACE inhibitors.

Vyn Reese: Is there a second?

Christine Klingel: This is Christine Klingel. I second.

Vyn Reese: All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed, same sign. That motion is passed. That brings us to adjournment. We'll reconvene at 1:00 p.m. unless you have any additional business. We finished early. Amazing. We probably should

come at 1:00 because everybody is going to get here at 1:00. Is that correct?

Jeff Graham: It's been announced to the public.

Vyn Reese: We'll have public comment for the next part of the agenda. So we have to come back at 1:00. So we have a little longer break than normal. Right, so we're adjourned.

Vyn Reese: This is Dr. Reese. I'd like to have everyone take their seats. We'll now reconvene as the Washington State Drug Utilization Review Board. I'd like to start with introductions. I'll start on my left. Why don't you introduce yourself and we're go around the room.

Sharon Farmer: I'm Sharon Farmer and I'm here representing King Regional Support Network and I'm a member of the Mental Health Advisory Committee.

Amy Irwin: Amy Irwin, HRSA.

Chuck Agte: Chuck Agte, HRSA.

Nicole Nguyen: Nicole Nguyen, Pharmacist with HRSA.

Jaymie Mai: Jaymie Mai, Labor and Industries.

Doug Tuman: Doug Tuman, Labor and Industries.

Jeff Graham: Jeff Graham, Health Care Authority.

Susan Rowe: Susan Rowe, Pharmacy and Therapeutics Committee.

Ken Wiscomb: Member, DUR.

Christine Klingel: Christine Klingel, Member.

Patti Varley: Patti Varley, Member.

Deborah Wiser: Deb Wiser, Member.

Vyn Reese: Vyn Reese, Chair.

Jason Iltz: Jason Iltz, P&T Committee Member.

Barak Gaster: Barak Gaster, Member.

Alvin Goo: Alvin Goo, Committee Member.

Regina Chacon: Regina Chacon, Committee Coordinator.

Leta Evaskus: Leta Evaskus, Health Care Authority.

Jeff Thompson: Jeff Thompson, Washington State Medicaid.

Ray Hanley: Ray Hanley, Health Care Authority.

Vyn Reese: First item on the agenda is the minutes from the February 17th meeting. I'd like you to review the minutes. Hopefully you had a chance to do this before the meeting. If there any additions or corrections now is the time to speak.

Susan Rowe: Susan Rowe. I have two corrections. On page 18 at the bottom credited to Carol Cordy. It says talk screen and what it needs to say is tox screen, T-O-X.

Vyn Reese: This is Dr. Reese. I've got a correction on page 28. It's under my comments on the page. It's the third line up from the bottom and it should read, bringing them in for a tutorial and an educational session at the Pain Clinic instead of a sessioning clinic.

Susan Rowe: One more correction. On page 21 the fourth line down from the top it says to or for and it should be two or four, T-W-O, F-O-U-R.

Barak Gaster: This is Barak Gaster and I was absent on the first page where it says board members absent and my name is pronounced exactly like the president but it's spelled a little different. It's B-A-R-A-K, no C.

Christine Klingel: This is Christine Klingel. My last name is spelled K-L-I-N-G-E-L.

Deborah Wiser: This is Deb Wiser. My last name is spelled W-I-S-E-R.

Barak Gaster: This is Barak Gaster. On page 5 the middle paragraph Dr. Alex Kahana, his name is spelled with a C and not a K.

Vyn Reese: Any other additions or corrections? I'll take a motion to accept the minutes as corrected.

Ken Wiscomb: Ken Wiscomb, so moved.

Vyn Reese: Do I have a second?

Susan Rowe: Susan Rowe, I second the motion.

Vyn Reese: All those in favor say, "Aye."

Group: Aye.

Vyn Reese: Opposed, same sign. The minutes are corrected and the first item on the agenda is Jeff Thompson talking about Senate Bill 5892.

Jeff Thompson: So this is Jeff Thompson. I'll just give you a little [inaudible] here. Dr. Sharon Farmer will actually present some of the work that we've been doing in the Mental Health Work Group and then I'll follow up with not only 5892 but at your request coming back and looking at generics first or antipsychotics in our work with the mental health group with the recommendation for you to vote on. And then before you vote I know there are a number of people that would like to sort of weigh in here and take public testimony [inaudible] them three minutes like we do in the P&T and then have you vote if that's acceptable.

Vyn Reese: That's fine. That's what we usually do so we'll go ahead and do that.

Sharon Farmer: Okay. Is this mike okay? All right. I'm Sharon Farmer and I'm here presenting some work done by a few members of the Mental Health Advisory Group – Mark Avery and Rick Ries are psychiatrists as am I and Marla Hoffmann is the biostatistician at King County Regional Support Network. We also got a lot of help from Jeff both in conceptualizing the project and assisting us in getting the state data.

The questions to be answered by this project are on slide 2. We wanted to look at highly costly patients and try to figure out why they were so costly.

Can these high costs be prevented? And is there opportunities for improving quality of care? The secondary questions, and by the way you do have a copy of my slides. I believe it's in the last tab of your book. The secondary questions, which to some degree I think might be the primary questions for your committee is are the high costs related to some of the medication issues of concern to the Mental Health Advisory Work Group Committee and perhaps to this committee as well? Medication adherence, multiple prescribers involved in a patient's care and excessive use of atypical antipsychotics. The other secondary question, which to some degree was the one that I was most interested in are we drawing the correct conclusions from the state pharmacy data?

Slide 4. So here's what we did. We got HRSA to identify 200 people who were the most costly people in calendar year 2006 who met the following criteria: they had a diagnosis of schizophrenia, they were King County residents for at least one month in 2006 and they were the most costly totaling up the claims for community psychiatric inpatient stays, psychiatric medications and emergency room visits for all diagnosis.

When I got the list of 200 names I randomly selected 40 people from this list and the goal was to do an analysis using electronic data of the 200 people, but then for the 40 people in the subset to actually go to their treatment providers and study the medical records that were at the outpatient clinics. I also had the advantage of being able to look at the records by our staff that do involuntary treatment and in fact they were…offered a wealth of additional information.

When we got the list of 200 people, we're on slide 6 now, one of the first things that became obvious was that there was a lot of children in this. We weren't expecting any children at all because of the schizophrenia diagnosis. We decided to not study the children. We felt that those were probably just inaccurate diagnoses. We also noticed that there was a fair number of missing pharmacy claims. We were able to get back to HRSA and get that additional information.

So that left us down to, on slide 7, 161 people for the electronic data analysis and 29 people for the chart review subset. I was interested to notice that at King RSN(?) we had large amounts of information on almost all of these 161 people. They were not flying under the radar.

On slide 8 I've just broken down the claims information in the state data and you can see that by far the highest cost was the psychiatric hospitalization followed next by the cost of the psychiatric medications and the ER visits was the smallest contributor.

On slide 9 I was able to make some estimates of the additional costs that were being paid for by King RSN. We get capitated payments for treating people at the RSN level and we have to distribute it according to need and as you can see we to a large degree have identified these people as being high need and we're providing lots of additional resources for their care. The first box here is outpatient and residential care. The second box is Navos E&T, which is similar to a psychiatric hospital. It is for involuntary patients. It does not show up in state claims data. The third box here is specialized services. For example, we have a program in King County for people getting out of the Department of Corrections and some of them get a fair amount of additional support for their treatment in the community.

Moving on to slide 10. This is just a little pie chart which adds together what the state is paying for and what the RSN is paying for. I put it here mainly to make the point that RSN dollars pay for 81% of the costs of these people and the state costs, which are exclusively…the state claims that they…the state ends up paying for is primarily the medications and the emergency room. The average total cost at the state level was $38,000 for the year.

So slide 11 – who are these 161 people? I was very interested to see that many of them were people that I actually remembered from my residency, which was in the 1980s. They were very memorable people at that point and they continue to be very high profile people. So many of these people had very long histories of outpatient and inpatient mental health services. But there were a couple who actually had not been known at all in King County until the year of this study, 2006, and when I was doing my follow up to find out where the people were now a couple of those people haven't been seen since either.

On slide 12 I tried to do some matching between the diagnosis of schizophrenia that came from the state and the diagnostic information that we have in the RSN database and I think this is an important point for this particular committee. At the RSN level we get diagnosis reported from

our outpatient providers, residential providers, inpatient providers, and also emergency room visits if they happen to be at Harborview. And as you might suspect not everybody gives us the same diagnosis for an individual. I decided that the best diagnosis would probably be what the outpatient or residential provider told us at the end of 2006. So out of all of those diagnosis I put together this particular list and so do keep in mind that compare these diagnosis to the state pulling these people as having schizophrenia.

On slide 13 I think I've already made the point that these people got a fair amount of services by the RSN. Pretty intensive outpatient services. Keep in mind when you look at this slide, I'm not going to go through the details, that you can't really annualize these visits because some of these people were in the community and receiving community-based care really for very brief periods of time—sometimes just a couple of weeks.

On slide 14 a lot of these people were incarcerated during the course of 2006. 24% of the people spent some time in jail and our jail data primarily comes from King County jails. So other jails, prisons, we don't have it, but 24% is high in and amongst itself.

Okay. Slide 15. What did we learn? And now I'm moving to talking about the subset of people, the 29 people that had the most intensive review of their records. These people had a lot of physical health problems. I didn't even count the expected problems, which would be, as I'm sure you're aware, obesity, hypertension, diabetes, elevated lipids. But very notable histories of serious trauma, four of these people had histories of traumatic brain injuries. I think there was one person who…two people actually who had had gunshot wounds to their brains, one person suffered many complications, abscesses, partial lobotomy. A couple of the people were recovering from serious suicide attempts during that year and keep in mind that the costs of these things were not factored into their being high cost. Two of the 13 women in the chart review subset had had abortions that year, which I found interesting because one thinks of pregnancies as being a destabilizing factor in terms of mental illness. Many people had nutritional problems. This was often because of not eating because of being paranoid about food. Three or four people had tardive dyskinesia. One person was on dialysis, one person was blind, one person was deaf. So it was a very sick group of people in ways that we didn't think we were selecting for.

Slide 17. My main goal in this study was to look at the characteristics of the patients themselves. But I also had a lot of information about the prescribing practices. What I found was that the average person had 2.3 psychiatric prescribers during that year. The average person had .8 of a primary care physician that year, which basically means 80% of people had a primary care physician medication prescribed that year and a tenth of the people had had a prescription from an emergency room. So it was perhaps less chaotic in terms of multiple prescribers than one might think for such a high cost group of people.

I was pretty pleased with the quality of the prescribing that I saw for this group. There was a lot of attention being paid to medication adherence even though you'll see later that adherence was a major problem. And a lot of people who weren't responding well to antipsychotics were being moved on to clozapine and another person actually also ended the year with electroconvulsive therapy.

On the downside of the prescribing on slide 19 there were 20% of courses of treatment. There was at least one prescription over the FDA maximum. I think the highest I saw was a single prescription that was more than double the FDA maximum. In fact that was so surprising I kind of wonder if it was a mistake. The simultaneous use of two antipsychotics was very common in this group of people.

So slide 20 is kind of the heart of the study. Why were these people high cost? The largest group of people were those that were refusing to take psychiatric medications and obviously that would save in terms of the pharmacy claims, but it really contributed to the hospitalizations. Why was that happening? Just to give you a couple of examples one person was hearing the voice that she thought was God instructing her not to take her psychiatric medications. Another person who was suspicious and had no insight was not only refusing his psychiatric medications, he was refusing all medical treatment, and since he needed dialysis that was a significant problem. He actually ended up dying the following year. The second biggest category was the 31% of people who were abusing alcohol and drugs and refusing chemical dependency treatment. A group that surprised me was the 17% of people who simply didn't seem to benefit much from the antipsychotic medications. I think I already mentioned the one person who ended up the year getting electroconvulsive therapy after

several medications tried during the course of that year. Another person, and this was actually someone that I remembered from the 80s, was sent to Western State Hospital on a competency restoration and so a very structured setting where his taking the medications was absolutely ensured, very likely he was abusing drugs in the state hospital, and he simply wasn't able to improve enough to be discharged. He's actually still at the state hospital now in 2010.

The assaults in the nursing home group were also a bit of a surprise to me. If one assaulted someone in a nursing home that almost always led to at least four months in a psychiatric hospital and the issue there is placement. Nursing homes can refuse to take people and this is a group of people that for the safety of their staff and their residences they often don't want to take, if there's any chance it's going to happen again.

We had two people who got in this group almost entirely because of the high price of their medications. Only one or two that were serious emergency room abusers.

Slide 21 is primarily to make the point that we…most of these people were in very highly structured and highly supervised settings over the course of the year. In fact, I could tell in my data pretty much where they were supposed to be on any given day of the year and despite all of that supervision and all of that activity they were just not doing very well. In fact, on slide 22 in addition to just having supervision many of them are actually court ordered to get psychiatric treatment. The average person over a third of the year they were either court-ordered to be in inpatient or court-ordered to outpatient care.

On slide 23 trying to figure out ways to show what goes on graphically and I think it's mainly Jeff and his crew that have come up with this particular way of graphing what happens over the course of a year. On the slide there running from 0 to 100 those are days' supply of medication. So in January for example that indicates a single prescription for a 60-day supply of medication. I guess that would be Geodon. And then using some of the RSN…so these scraps were generated by HRSA staff based on claims data and then I went back in and tried to put an H if the person was in the hospital part of the days of that month or I also have some Js in for…I guess I didn't bring any Js, but J for when people are in jail. And so this particular person, for example, was kind of in one of the other

categories in terms of why he was so high cost. He was someone who was in very intensive treatment because he was out of prison and had committed felonies in the past and despite all that supervision the staff did not realize that he was becoming more psychotic. He simply did not indicate that that was the case until things were so bad that he planned suicide by cop and sort of purposely held a knife up to the staff person with cops in the wings hoping that someone would intervene with a gun. The staff did a really good job of kind of finessing the situation. Instead he ended up hospitalized and a couple of times got his depression and his psychosis treated and he's an example of a person who actually hasn't been hospitalized since even though he's still in intensive outpatient care.

Slide 24 is a person with untreated drug abuse. You can see she had a whole series of hospitalizations and actually did not show up for outpatient care until she hit October. So many hospitalizations, many court orders to outpatient care, but she actually didn't show up for outpatient care until…towards the end of the year.

The next slide, slide 25, is also a situation that I think might be of particular interest to this committee. This was a young man who was actually employed at the start of the year and he was having side effects from his Clozaril. And even though you can't tell it from this particular information provided, he was being very gradually transitioned off the Clozaril and onto a different antipsychotic for the first six months of the year and then when the Clozaril was stopped you can see that all hell broke loose and he had several series of hospitalizations. He was someone who ended up, I believe you can tell this, going back on Clozaril by the end of the year.

Slide 26 – where are these people now? 15 of them are still receiving treatment here in King County. Seven people who know for a fact are no longer living. Two of these people were only age 21 at the start of 2006. So some particularly sad stories here. Three or four of these people are currently at Western State Hospital. Three we're pretty sure are no longer in the area. One person is in an intensive residential program for people with high medical needs.

At this point I'd like to leap ahead to slide 34. I'm going to skip over the whole quality improvement part of this presentation even though it was the main thing for the study. Please read that at your leisure.

In summary, we did feel that there were opportunities to decrease costs and improve quality for the care of these people. We're already working on some of these solutions and we would like to work with the state on several additional possibilities. So I think it was a positive study in that regard. On slide 35 I've attempted to put together some important points for the members of this committee and I think the most important at least for this group of high cost people I think you need to think of the state claims data as being kind of the tip of the iceberg. There's a lot going on with these people. Sometimes there can be very legitimate reasons that there appear to be gaps in their getting medications, or very legitimate reasons for them to have a change in prescribers. So please keep that in mind. We've already suggested to HRSA that perhaps more could be done to improve the quality of the diagnosis data that they get – perhaps just making…figuring out who's likely to provide you with the most accurate diagnosis. It might be a solution.

I think those are the main points. I guess the final point would be, and I think this would be a good thing for this committee to keep in mind as well, is that you can tell from a lot of these problems that the people who are prescribing the medication really can only do so much. Many of these problems are actually out of the hands of the prescribers and to a large degree are out of the hands of just about anybody.

We do have some time for questions and answers. I would like to point out that I am not the medical director at Compass Health. I work part-time for the King County Regional Support Network and my other part-time job is as a consultant to primary care at the Neighbor Care health clinics in Seattle.

Vyn Reese: Thank you Dr. Carson. Are there questions?

Patti Varley: This is Patti Varley. I know it wasn't your primary goal but because I'm a pediatric person I'm curious about any…I mean if you didn't look beyond what you just said that's fine, but if you had any insights into the children in regard to age, diagnoses, dosages and how many there were?

Sharon Farmer: Um, in the top 200 there were I think about 20 to 25% of those were kids. In general the kids were more expensive than the adults. If you looked at the top 10 people in terms of cost 9 of them were kids, 1 was an adult. I

happened to review a couple of the kids' charts before we decided not to include them. I think in both of these cases they were either in their way into or on their way out of the CLIP programs, the intensive inpatient programs for children. I will say that we're hoping to do a similar project on children in the future.

Patti Varley: Great. Thank you.

Sharon Farmer: Uh huh.

Vyn Reese: Any other questions? Thank you very much Dr. Carson, I appreciate your interest.

Jeff Thompson: This is Jeff Thompson. I think before I get up Senator Hobbs is here and would like to make a few comments about 5892 and the legislation and hopefully he can stay through the rest of the meeting.

Vyn Reese: Why don't you step up to the microphone up at the podium there.

Steve Hobbs: Sure. Okay. Well, thank you so much for allowing me to speak. I'm here on behalf of the Senate and the position that many of us took. There was a letter that we had about 16 signatures and we could have had more added to it. We were promised that we wouldn't have this generics first or fail first for atypical antipsychotics and then we voted for the bill and apparently this rule is happening. My background, you know, I'm not a doctor. I'm a state senator. My background is 20 years in the military. Ma'am, you spoke about the soldier that had some issues. I know a lot about that. I've been to Iraq, I've been to Kosovo, my best friend was also my campaign manager has TBI and traumatic PTSD. Many of my friends are in that situation. And so that was my concern when this bill came about, and the reason why I voted for it is we weren't going to go down this road. And regardless of what the issue in terms of generics or your feelings about it, the point is is that we were told one thing and something else happened. And we voted for the bill. So we are very concerned. So that's my message I'm giving to you on behalf of the 16 senators that signed onto the letter and voted for the bill.

[applause]

Vyn Reese: Can we ask what you're concerned about?

Steve Hobbs: Yeah. Well, I'm concerned about the fact that when we were told that you…it wouldn't happen and then it happens. That's the concern.

Vyn Reese: So you're concerned that…what exactly are you concerned about that…?

Steve Hobbs: Let me make this very clear.

Vyn Reese: Yeah.

Steve Hobbs: The legislature sets policy. When this bill came about we were told one thing. [inaudible] said, "Well, don't worry, we're not going to do this fail first or generic first." We said, "Okay, great." So we voted on the bill. So that's just the issue. That's pretty simple.

Vyn Reese: That's simple. We don't know what you were told. We're just taking the issues that were brought. So we have no control over what you were or weren't told.

Steve Hobbs: That's fine.

Vyn Reese: Thank you.

Jeff Thompson: Okay. So this is Jeff Thompson. So what I want to do is just a couple of things—refresh your memory on 5892 and then what we're doing both in the feedback reports and then what the Mental Health Work Group has done per your recommendations to come back with a process for generics first with antipsychotics in adults. A couple prefacing things. We've been doing generics first with antipsychotics for children since November. I can't give you the actual numbers to date. It's somewhere in the 250 to 300. I don't know how many of those are age under 5, or high dose, or generics first. But it's been up and running and we have a commitment to you, to the community, to the drug companies, to the senators that we're going to make sure that we have no unintended consequences and to that effect we're asking Harborview and the University of Washington to look at all of our data to make sure that things are going the way we want them to go. We're trying to be as transparent as possible in how we're going to implement 5892.

Just a couple of things – I want to say something about Sharon. I think she short-cutted all of the really good work that she did and I'd really like you to look at those recommendations. We spend a lot of time talking about generalities, evidence-based, but when it really gets down to the client and how we can best serve the client and do the best I think the claims data isn't enough. Even the evidence that you see sometimes isn't enough. And so what Sharon and Mark and Rick did is they went in and looked at charts and actually tracked in some cases, you know, a decade or more of utilization. Because what we really need to do, I think within Medicaid is to work with the providers out there to do the best job we can for our clients. We spend a lot of time talking about, you know, don't bother me, you know, push this legislation through and stuff, but this is really all about the clients and so what we're trying to do within the Mental Health Work Group, with the advocates at the table, with the drug companies at the table, with clinicians at the table, with the bureaucrats at the table, is try and do the best job for the clients. I'd really highly recommend you to look at those recommendations. I think they're extremely thoughtful. I think they generate a path that we're going to talk about in DSHS. The secretary has asked that we bring the county and the city to the state down in Olympia. We're going to talk about crisis intervention. Sharon will do her talk again and see how we can do a better job working state, county and city for our advocates here.

So let me just start…next slide. So let me refresh your memory on 5892. There's a lot of moving parts to this but basically it talks about some transparency and looking at where we're going forward with a number of the aspects of generic utilization, the use of DAW. So I'll talk to you a little bit about the feedback reports that we're doing. I always say if you can't remember what you ate last Wednesday for lunch you probably don't remember your last quarters' generic or DAW utilization for your 1,000 clients. And so it's been pretty remarkable in some of the feedback we've got. I know I sign generic every single time, but when they see a stack of paper with their quarter then they say, "Mmm, my perception wasn't really the reality." So we're going to…I'll give you some of the particulars here in a minute.

The law also talks about generics first. It gives us the opportunity for new clients starting on medication. So I'm going to be very, very clear about this. This is not about taking people off their stable medication. This is an opportunity to be better stewards of the program where the least costly,

equally effective drug can be considered as the first start, which is a generic, but in no way, shape or form do we want to take people off a stable therapy. And that was really the agreement with the legislature in this law as we move forward. It also talks about putting over-the-counter drugs and generics on the preferred drug list without having to wait for a committee because they're AB rated. And so that's one of the other portions and then finally, and we'll start talking about this over the next year or two, to do something about off-label drugs. You made considerations for the P&T on on-label indications, but we really don't spend enough time on the off-label. So this talks about how we need to work together in those. Next slide.

So within 5892 I think, you know, to Senator Hobbs' concerns there are a lot of safeguards that are built in. I think the one thing I want to speak to is we don't want unattended consequences, we don't want to take people off stable medications. But if you look at some of Sharon's slides and some of the graphics, what is stable medication use? We know that in this state in children and adults 40% of the people have more than 20 or more days of gap in therapy—40%. Is that stable dosing? You can see from some of those graphs that we have many clients that have antipsychotic free days that can't be explained by jail or hospitalization. Is that stable? Now I'm not pointing fingers, but I'm saying we can do a better job. We can do a better job as the state, we certainly need to do a better job as a state working with our contracted providers, the clinicians out there. We need to do a better job talking with our clients and going to NME(?) and other organizations so that you actually know what we're doing. And we need to do a better job working with the drug companies, and I think they need to do a better job working with us to basically say that we need to do a better job of the right drug at the right dose, at the right time, for the right reason. Because the perception is all is working and it's not. And I think we're putting both the state and our clients at danger with that. So we also have a commitment to dispense as written. So within 6892, and you are an endorsing provider, what we don't want to do is interrupt is that doctor/patient relationship, that doctor/client relationship to write DAW. But if it is abused or if you're using DAW and not having full knowledge that your client is not taking the med, or that somebody else is prescribing another med we need to engage in a dialogue to make sure that DAW, generics and brands are all used to the best possible extent that it can because the reality is it's almost $500 million in expenditure in Medicaid and antipsychotics are almost a quarter of that. So if we're not talking

about this, if we're not dialoging about this, if we're not ensuring that we have the best stewardship and the best trends possible, and the best ability to get the clients the drugs that they need then unfortunately what happens is cuts are made in other programs. So this dialogue is really very important and that's why we have everybody sitting at the table with the Mental Health Work Group, which includes the drug companies, which includes the advocates, which includes very smart clinicians, as well as the people from the state and the table is very broad. Anybody can come to the monthly meetings and I would encourage people to come because we want to be transparent as we go through that and share information and show you a different side of what it is – not just looking at claims data but getting down to now only the chart data, but hearing from the advocates about how to, you know, do things with the least amount of unattended consequences as possible. Next slide.

So to that extent within the first provision of looking at what is going on with DAW and generic utilization, we know that our generic utilization in Medicaid is not up to where other community activities are; specifically within the health plans or other Medicaid states. And to that extent the first thing I always think is always to communicate. So we're sending out communication called Generic News and it's basically informing providers about what is the reality of brand and generic? What does the science say trying to bring it down to a bite size level. You're 900 pages I've tried to get them down to a paragraph or two, which is sometimes not easy. So the next addition has gone out with the second set of feedback reports and I'll talk to you a little bit about it. I heard loud and clear from the P&T DUR Committee, "Make it simple, make it stupid, make it…try and bring it down." So this is a lot more white space, a lot more just here's how to read the reports. So next slide.

And then to talk about what's going on out there. I mean there's an $18 billion industry of samples. A $16 billion industry of drug companies going out and giving some very good information about their drugs, but I think the state need to also, with probably a couple thousand dollars worth, send information about what are the realities as to evidence about samples as it is about what are the costs, what are the trends, what does the evidence say? And so in this addition we talked about who pays for the pizza and what does the science say about the reality of the utilization of samples? And I'll talk a little bit more about how that works within the processes. Next slide.

What are we seeing? Again, if you can't remember what you ate last Wednesday for lunch you probably need to have some information about what your generic and DAW utilization is. So I'm proud to say that with the opportunity to give some feedback, and I'll talk about where we're trying to go with some carrots, 112 providers have actually improved their generic performance about the 80% that we're trying to achieve with the instruction, the legislature to meet our savings goal. We're also seeing a lot of improvement in DAW, DAW and generics, and only 18% of the providers that we saw were the highest prescribers of band, the most utilizers of dispense as written did we see no change. Now I also want to say that there's a lot of really good activity from the clinical staff at DSHS that is changing some things around the PPIs, the proton pump inhibitors, some other things around statins and things that we're doing. So this isn't all just about feedback reports and we're in the process of trying to attribute what is feedback report versus what are some of the clinical programs? But I think what's even more important is we're seeing change in the top quartile. It's not only the persons that are getting the feedback reports and their peers, but even the top quartile we're seeing improvement in generic and DAW utilization and I think that's a testament to the prescribing community stepping up and say, "Can we improve the cost trends without reducing the quality trends in the state of Washington?" And so I think this is evidence and we'll see…we'll go through three rounds and I'll probably be coming back to you this summer in talking about what is the process for the 18% where we don't see any change and what happens to DAW? Because I want to be very transparent about if we are going to ignore the DAW that needs to be known to the advocates, to the clients, to the prescribers, to you and so you'll help me sign off on that process. Next slide.

So within that not only are they getting nice little graphs, but they're also seeing some trend charts about how they compare…about how your prescribing compares between quarter one and quarter four, how you're improving in generic and DAW utilization and we're also showing the savings. So this is an aggregate report of all prescribers comparing quarter one to quarter four, looking at what the differential cost was between those two quarters as well as the average prescription cost per client. And so the good news is the trends are getting better and what is incumbent on us is to make sure that there's no unintended consequences along that direction. I just want to say that if a provider wants to dig in even further we're

giving them 12-month prescription histories on all their clients so they can go in and look and so this is the kind of data that I think is incumbent on us to give to our prescribers so that we know that we're being best stewards of the program. Next slide.

Any questions on the provider feedback before I launch into generic firsts for antipsychotics? Yes sir.

Vyn Reese: This is Dr. Reese. On the quarter one versus quarter four there's a lot fewer Medicaid clients too. There's 7,000 fewer clients. Is that right?

Jeff Thompson: Yes.

Vyn Reese: So that's a substantial amount of the savings.

Jeff Thompson: It is, but you can also see the per client utilization. So we're seeing…we need to look at that and see. Sometimes there are seasonal affects, we didn't think there would be a season affect with these six drug classes, so we'll be looking at all of these things and finding out what's happening to these clients, seeing if they lost eligibility, seeing if something else happened, and that's our commitment to actually looking at this data and being very transparent.

Okay. So now we're going to talk about antipsychotics and generics first. So back a few quarters ago when we first started to implement 5892 we started to implement a number of classes and you said, "Let's stop and take a big deep breath when we get to adult antipsychotics." And you asked us to work with the Mental Health Work Group to come up with some criteria, some processes and we've done so. So I'm going to go over what those principles and standards and how we're going to communicate those and do some next steps. What I'm going to do a little bit different is I'm going to show you the cost trends and this is very different than I think what you've seen in the past or heard from the past, but I think because we are in dire straits in the state you need to take some cost into comparisons about what goes on with generics and brands as it relates to our most expensive drug class. Because I think to be really good stewards of this program, you know, we have to basically say it can't be about everything without any controls, without any transparency because in fact if we do that what happens is we lose programs. So this is not about actually saying you can't have something, it's about being good stewards

and saying, "Let's understand this and if there's an opportunity for a least costly alternative, which is equally effective this is the process that we're suggesting we follow." Next slide.

So a few principles that we came up with the Mental Health Group and I want to say that this mental health group included advocates who were at the table for the last four year, and I want to encourage the advocates that are here that if you want to come it's the second Friday. We need to hear your voice. It may not be as well representative and the table is big. So please attend if you can. We also have the drug companies at the table. We also have very expert people not only from the University of Washington and Harborview, but people that are active in prescribing and treating not only with kids and adults, but also across even some of our institutional care Eastern and Western State. I might add that in the generic first program that we're going to talk about this has now been instituted at Eastern State and Western State Hospital. Now they don't get many naïve clients, but what they are saying is that if you have to start a second, a third, a fourth or a fifth antipsychotic could the next antipsychotic be risperidone? At least have a consideration because it's much less expensive. So we're going to talk about provisions about how to ensure that emergency care can happen because we're not always there 24/7. So what happens on weekends and Friday night at 8:00? I want to get your input on what is appropriate communication out to the advocate community as well as the prescribing and the pharmacies. I want to talk about flexibility with the program. One of the things that we're looking at, because it can't all be about sticks and process, maybe there has to be some carrots. So we're actively looking at gold carding. If the prescriber has very good prescribing habits let's leave them alone, trust but verify. We're talking about how to reduce provider burden. We heard very loud and clear. So I think it's good news that we're going to do this as an expedited prior authorization. That means that you don't have to call us, it can be done between the pharmacist and the client, or between the pharmacist, the client and the provider, no need to call us. So that's how we're going to reduce the burden. I think we heard from Mr. Miles, you know, that we need to have cultural competence taken into account. I'm looking forward to working with Lilly and getting their expertise on how we can build that cultural competence in there. Not only for the race and ethnicity with the clients, but perhaps even the race and ethnicity with the prescribers. So I'm looking forward to working with Mr. Miles on that.

And then the transparency. So here we start with the transparency. Next slide.

So this is the reality – we cannot under federal law tell you what our net costs are. That is foreboden. I'd lose my job if I did that. But one of the things that we've done over the past five years if we used the average daily cost ratio, which basically means that if we look at the amount of prescribing that happens on a typical basis on average with a client, multiply that times the net costs to the state, which means Labor and Industry, Uniform Medical Plan and Medicaid we can then take a ratio of the least costly to the most expensive medication and we've done so with all the other drug classes and you've seen that in the first edition of Generic News. So in the next edition we're actually going to disclose that at the least costly right now the average daily cost ratio if you make risperidone one then the next costly clozapine at over three and a half times, Geodon six times the cost, Seroquel XR at eight times the cost all the way to 24 times the cost. Now I think what you need to do is mix this in with a little bit of the evidence. We don't see evidence that there are 24 four times, five times the efficaciousness of these drugs. What we do however see is that there are differentials in the side effect profiles, but not to the extent that we're seeing in the cost differentials and I leave it to you to weigh the differential in this. But I think really what's important to understand is that with these cost differentials people come on and off Medicaid. We're not going to have health care reform until 2014. We are trying to purchase for you the least cost, most effective drug in Medicaid, but if you leave Medicaid you are not going to get these prices and we've seen some prices from even Harborview where it could be instead of $30 a month for the generic, it could be several thousand dollars a month. So one needs to ask themselves as if we're starting somebody on a sample that's very expensive and you lose coverage, because remember health care reform doesn't come on until 2014, will you be able to afford this drug? And so this is the disclosure of what the cost differential for the state is net cost. So that's rebate, taking into consideration rebates and discounts. It's very uncomfortable to talk about costs. But in this economic environment I think we have to be good stewards and if there is an opportunity, is an opportunity to do less cost equally effective we need to take that opportunity. Next slide.

So these are some cost trends because you need to know what happens when a generic hits the market. So this is looking at going back to 2007

all the way up to 2009. I believe it's September. What happens when a generic actually enters the market? So the cost trends with both utilization and cost with antipsychotics are some of our steepest climbs. Not only are we increasing the number of clients that are utilizing it in double digits, but we see an escalation in the cost per milligram going up by double digits every single year. But in March of 2008 the generic came on and you can see what happened to not only the cost but something else. We've also done low dose Seroquel. We said that it's probably not good to give an antipsychotic as a hypnotic or a sleeper agent. So we put that on. And I think one thing that we've done a phenomenal program in the kids is we started the PAL Program, the Provider Access Line where you can call a pediatric and adolescent psychiatrist five days a week, eight hours a day and get a consultation. At $1.3 million a year…now one of the things that I think is helping us is we achieve some savings with generic programs. We can sustain these type of programs like the PAL Program, which is also written guidelines, which is also making sure that the 155 clients that we have under the age of 5 that are getting an antipsychotic that is off label they have been reviewed by a peer-to-peer interaction. So I'm very comfortable that we even have down to age 3 clients on antipsychotics. I'm very comfortable about that because the prescriber has talked with a pediatric and adolescent psychiatrist at the University of Washington and they've agreed that this is the most effective care. But every year now that we've had that peer-to-peer interaction we've seen a smaller and smaller number of clients under the age of 5, and clients that are children that are on very high doses, doses that exceed the adult maximum dose in adolescents and children. But I am comfortable that now that…because there's been a peer-to-peer interaction that this is now safe and reliable therapy.

Now look at that with the next slide of what is happening with the adults. We see the same trend in cost and utilization. We see a blip when the first antipsychotic generic came on, risperidone, but the only thing that we've been able to do with the community to improve the safety and the efficacy is really around low dose Seroquel being used for sleep because we haven't been able to dialogue enough about how do we control too many, too young, and perhaps even too old? So I'm hopeful that with generics first, if we can come to an agreement about where you can do less expensive equally effective, that perhaps the savings could be shown to the legislature and maybe we could do a PAL Program for adults where a prescriber could call in five days a week, eight hours a day and get a

consultation and achieve the same thing that we've been doing with kids. Maybe we can spend some time to do generic…or to do guidelines and some other things with these type of savings and communicate. But I have to quote, you know, my old Catholic background, "No margin, no mission," so I'm just going to be very frank. Hopefully with this generic savings we can improve the safety of prescribing antipsychotics in the adults. Next slide.

So we went through about three or four months of discussions, very active discussions. I will tell you that there was some dissent in there in those discussions and I believe you have a letter from some physicians that are dissented in these but these are the criteria that we came up with that we are suggesting that they be on the expedited prior authorization program to promote generics first in antipsychotics in the state of Washington for Medicaid clients. The first was that we don't want to disrupt care. So if there's any indication that they've been on this medication in the past or any medication we are not going to insist that they start a generic first. If there's been any indication that they've tried risperidone or generic in the past as more generics come on we obviously don't want them to foisted on a generic that didn't work. So this is, no, we want you to get what you need so if there's an indication that hasn't worked with even the patient's recollection take the brand that's prescribed. If there's been a past trial but it's been discontinued because of lack of benefit, hopefully noted in the clinical record, get whatever brand is prescribed. If there's been a history of hyper-prolatinemia, which is one of the side effects that can happen with risperidone or a movement disorder, fine. Get whatever brand is prescribed. And then where there's an FDA indication where risperidone doesn't have that indication, whatever brand is prescribed, we're fine with that. And then if a person refuses or indicates that they want to take another drug and that's indicated on a script then that's fine with us. So these indications will be part of an expedited prior authorization. What does that mean? It means you don't have to call the agency. What you have to do is indicate this on a script or between the prescriber and the pharmacist and if any of these follow then the dispense gets done and the brand gets dispensed whatever is written. But if none of these apply and it's a new start what we'd like to do is engage in a conversation of why the least costly equally effective generic might not be an opportunity. It might not be an opportunity – that means that we're not going to insist unless the provider can give a rationale. There will be exceptions here. And so we're willing to take those exceptions. Next slide.

So can you get an emergency fill? The answer is yes. We've had for, Chuck, how long? A decade? More?

Chuck Agte: Since the implementation of over 90 there has been an emergency fill policy.

Jeff Thompson: So over 1990. So under federal law we are required to assist the pharmacies in ensuring that an emergency supply is dispensed. If you read the federal law it says you can dispense a 72-hour supply. We've gone above that. We have said that if you, the pharmacist, want to dispense a 30-day supply and you notify us within 72 hours we'll pay for it. So Friday night, Saturday nights, whatever, we're going to ensure…and we've done that for diabetes and asthma and it's worked very effectively that an emergency supply will be available. If a prescriber writes "adult in crisis" or any of the criteria that I went over in the script and we'll communicate how to make that happen, the brand gets dispensed.

Samples is a tough one. You can read in Generic News what we said about samples. I think samples is an unsafe activity because when you are given a sample and then you have to get a second drug at the pharmacy, the pharmacist doesn't know what you're taking. There's no record. All you're doing is given a pack of pills. And so we are not in theory going to honor samples as a continuation therapy, but we'll make exceptions. We obviously don't want to take somebody off their samples if their psychosis is being improved. But I want to stipulate to you is my impression and it is backed up by the Mental Health Work Group that samples is not a very safe activity when we're talking about psychosis where you're taking a drug that is unknown to any prescriber out there, emergency room or second prescriber. But we will make exceptions. And then can I continue on my existing medications? The answer is yes, yes, yes, yes. And we'll have a very low threshold about what constitutes the continuation of therapy all the way down to an attestation by the client. Next slide.

So one of the other questions was if there's an emergency start, Friday afternoon, Friday night, Saturday afternoon and I get an emergency supply will we fill protections? Very clear from the legislature that we don't want to disrupt people's continuation of therapy. So if you get an emergency supply you're going to continue on that medication.

What defines a naïve client or new start? And we're only talking probably in the neighborhood of 50 to 100 clients per month, probably even less than that. So we're talking about less than, you know, half a percent of the total of…or I'm sorry 21,000 clients that are on antipsychotics. We'll look back 180 days and if we can see an antipsychotic there you continue on that antipsychotic. We'll have a very low threshold and what constitutes continuation of care, which includes the attestation by the client to the pharmacist, you continue on that brand name. And then we'll consider…we're actually not in consider…we will probably implement this with your approval sometime late summer, early fall. It will be an expedited prior authorization. Again, what that means is you don't have to call us. The interaction between the pharmacist and the client or the interaction between the prescriber, the pharmacist and the client they can put in a code and you get the brand or you get the generic. But we have to be better stewards. This is $100 million in expenditure and you can see from Sharon's, and I'm not pointing fingers, I just think we need to work together to make sure that we get the right drug for the right reason, right dose, right time and if we aren't we're not being very good stewards. So the next step will be to over communicate all of this out. We've got several months before we implement and that's the end of my presentation.

Vyn Reese: Thank you Jeff. Are there questions from the committee?

Patti Varley: This is Patti Varley.

Jeff Thompson: How come you're always first?

Patti Varley: Ladies first, Jeff. I'm not a sample person because I'm not allowed where I work to have samples, but I am just thinking globally outside the box with access and cost and all of that. Is there a way that if and when a sample is used that there's a way to document that? Because I agree that the concern would be safety in regard to that record keeping. I know on my system I can document a patient on a med by history without giving a prescription and it's in their record. The problem I see though is that it's still not filed anywhere in a pharmacy.

Jeff Thompson: And that is the problem. So you are given, you know, let's say olanzapine and you were given samples only and you present to your primary care

provider and you now have elevations in your triglycerides, cholesterol in your glucose, you know, and most people can't really tell you what they're taking. "I'm taking some pill from something." You now get started on a diabetic medication, on a statin, without any indication. I'm not even talking about all the drug/drug utilization review that happens at the pharmacy level where that pharmacist has no ability to know what you're taking when samples are used. So I would say in this class where there's a low therapeutic index with a high, you know, need to really have all the providers interacting why would we use samples? We have no co-pays, and quite frankly if samples are being used, you know, I'm waiting to hear from the advocacy community that if you have to pay for a sample risperidone over-the-counter is $30 and several hundred to several thousand dollars on a month's supply where, you know, which would you start first if it is the most effective? So we'll hear from the advocacies.

Vyn Reese: This is Dr. Reese. Jeff, I want you to walk me through how this works. Okay? I have a patient who I diagnosed as psychosis and it's a new start. I don't know about the state law and I write down a brand name neuroleptic and the patient takes it to the pharmacy. So what exactly happens then?

Jeff Thompson: And you haven't said "in crisis" for any of these?

Vyn Reese: No. I haven't said in crisis. I'm not aware of the statute. So what happens when this patient takes that to a pharmacy?

Jeff Thompson: I'm going to let Chuck go through a bit, but basically what we're going to do is communicate all these processes so that doesn't happen. But if it does happen, Chuck, why don't you…

Chuck Agte: In the process as laid out by Dr. Thompson this afternoon what would happen is the claim would be submitted for that patient to the first time Medicaid system and the system the first thing it would do is look in the client's history to see if it can see that there have been any antipsychotics used for the client in the past because although you're writing this as a new start for the patient you might not know that the client really has had something from another prescriber. So if the system sees any history it's going to let that prescription go through. If there is genuinely no history there and the client is a new start on the medication or within the class the system will reject the claim indicating to the pharmacy that a generic

atypical antipsychotic would be required for a new start. At that point the pharmacy who would be familiar with the criteria because we regularly update the pharmacies with our expedited authorization criteria, they all use the codes regularly, they're printed in a single, you know, I think 16-page document that they can look up the drug and see what codes are associated with it. They would look at that and determine are any of the conditions present that would allow me to automatically override this? If the pharmacy did not know that, did not know it was an emergency, did not know there was some other condition for the client then usually their next step would be to contact you as the prescriber and say, "The state is saying that this needs to be generic risperidone. Is there a reason that it can't be?" And you would be able to make your own informed decision at that time whether the client should in fact be changed to generic risperidone. If you decided that the client should not be change to generic risperidone and you wanted that prescription filled as originally indicated there would be several options there at that point based on the criteria that Dr. Thompson indicated. If it's a situation where you possibly addressed with the client that you wanted to start them on risperidone and they specifically said, "No, I don't want that drug for this reason and so you've selected another drug," that would be a reason in order to promote patient adherence that would be a reason for an override to be able to be used and the claim would pay. If there was an indication at that point from you and the communication with the pharmacy that this was a crisis situation, that the client was, you know, in danger of a psychiatric break of some kind if they didn't start on a medication right away that would be an overrideable situation. There would be any number of conditions where we have established criteria that would say this is a reason that we're not going to stop this prescription at all. And if none of those were true then the pharmacy would be able to request a prior authorization from the state and your specific reasoning for the need for that medication would be looked at. That would be…it would be in absence of all possible other reasons. And as I said, including…if you indicated that it was a crisis in any way, that you felt it was urgent and that the client receive something now that would be another reason that we would go ahead and let that claim go through using override codes that the pharmacy had available without having to contact the state.

Jeff Thompson: I just want to…this was a request by one of the pharmacists from high school pharmacy as well as the drug companies to do this as an expedited prior auth and so we're going to honor that request. Chuck, how many

drugs do we have generally on EPA? Several hundred if I remember correct?

Chuck Agte: Off hand I would say it's in the range of 100, couple hundred, somewhere in there. It depends on if you're measuring by drug or by drug inform or if you're just looking at the straight generic ingredient we've got probably right around 100 or so.

Jeff Thompson: So it is a program that we've had for a long period. It does work and we will over-communicate the criteria to the pharmacies and to the prescribers.

Vyn Reese: A couple more follow up questions. If on the prescription I wrote, "Patient has tried risperidone in the past" just on the prescription and "has had a side effect" then it would automatically go through without me getting a call back as long as it was written on the prescription. Is that correct?

Chuck Agte: Correct. In your original scenario that you outlined you've indicated that there was no additional information on the prescription.

Vyn Reese: So if I wrote that simple line that would automatically get that drug in?

Chuck Agte: Correct. You could write anything from "client in crisis" to…you wouldn't even have to be as specific as "the client tried risperidone with a negative side effect". All you would need is to provide the information that the client had in fact been on any atypical in the past.

Vyn Reese: And that wouldn't require a callback to me or anything if I wrote it that way?

Chuck Agte: No. If the information was provided on the prescription and the pharmacist had it available at the time they were attempting to fill it they could perform the override without any further contact.

Vyn Reese: In the first case would the pharmacy call me right back at that time when they figured out that it wasn't a prescription that they could fill, would they call me back immediately and let me know that that was one that they couldn't fill and they suggested the risperidone. Is that right?

Jeff Thompson: So I have a question for you Vyn on that scenario.

Vyn Reese: What?

Jeff Thompson: Did you know that they had tried another antipsychotic in the past?

Vyn Reese: Well, let's say I'm really, you know, out in left field and I didn't read my latest update on what the generic drugs are…

Jeff Thompson: No. I'm asking you…

Vyn Reese: Pretend like I didn't hear that. Okay?

Jeff Thompson: I think one of the…if you didn't know that somebody was on an antipsychotic in the past and you wrote for another antipsychotic, you know, I think what this offers up is a dialogue to inform because you can look at some of Sharon's graphs here that we've seen…

Vyn Reese: I know. But let's say I was detailed last week by my drug rep who told me this is the drug I should use for everyone and I wasn't informed about what the plan was. And so this is what…all my pins say this name of this drug and all my mugs say the name of it and I've got lunch with the rep last week and he took me…I went to Victoria on a conference that he paid for and all of those things. So if I didn't know and I wrote that, they would call me back right away. Is that correct?

Chuck Agte: That would be our hope; however we cannot guarantee what actually happens at the pharmacy level. The pharmacy's compliance with attempting to get our clients the right medications at the right time is at the hands of the pharmacist.

Christine Klingel: This is Christine Klingel speaking as a pharmacist and seeing some potential problems that may occur and maybe you can help clarify. So usually these patients tend to present at 8:00 on a Friday night when DSHS is closed and when the prescribing physician is also not available and we would say, "Get a prescription for a number atypical antipsychotic" there is no indication that the patient is in crisis or the patient has tried anything else. The patient probably, maybe it's not even them, it's their agent. So we're not getting any information from the patient, we're not getting any information from the prescriber, we're not

able to do anything. Would this be where the emergency issue would come into play and could the pharmacy use the 72-hour emergency fill for the atypical antipsychotic because there's a lack of information and then get reimbursed?

Chuck Agte: Yes. That's exactly where our emergency fill policy kicks in. Again, this is Chuck Agte. I keep forgetting to introduce myself each time for the record. That's exactly where the emergency fill policy kicks in. It is at the discretion of the pharmacist in their own professional judgment whether or not it is an urgent or emergent situation at that point. We do not restrict to a 72-hour fill. The 72-hour clause as the state implements it is that's how long you have to call us and tell us you did an emergency supply, but you can choose to fill up to our standard 34-day maximum if you feel that that's what's needed for the client at that time. So at that point in time we always honor anything that a pharmacist indicates was an emergency call on their part. That's not questioned, it's not second guessed, it is not subject to audit. If a pharmacist using their professional judgment has decided that this is what is needed right now we will reimburse for that.

Christine Klingel: Could this be…I know…I don't know how well this is communicated. I know we get expedited prior authorization codes on a regular basis, but maybe with this particular sensitive class can this be reiterated with that? Because I wasn't aware that this could actually be done and, you know, I would hate to have someone be turned away at 8:00 on a Friday because pharmacies and pharmacists were not aware, maybe I'm the only one in the state that doesn't know that this exists, but I'm sure I'm not and there's gotta be other pharmacies out here who may not know that this exists and that we, you know, can override without DSHS's permission and without the prescribing physicians expedited code to get the patient's their medications when they need it.

Jeff Thompson: So our agreement to you is we will over communicate on this one.

Christine Klingel: Please.

Jeff Thompson: We have the ability to do a fax, a broadcast fax to all pharmacies, but I'll work with Jeff Roshon(?) to make sure it gets out to all the pharmacists because sometimes it gets…I mean we'll show you what we're going to

do. I mean we will over communicate on this both with Generic News and everything else.

Christine Klingel: Thank you.

Jeff Thompson: And I might just add that I mean it has been working for years with diabetes, with asthma, you know, with other mental health medications and including antipsychotics, you know, emergency supplies. Sometimes they show up without a coupon and they get an emergency supply recognizing that, you know, in 72 hours they can bring the coupon back. So it is working now, but what we don't want is unattended consequences.

Jason Iltz: This is Jason. Chuck, a question for you kind of going back to Vyn's original scenario of, you know, he prescribes something without any prior knowledge of utilization in the same class. And you had indicated that when that claim is processed the system will look back 180 days for prior use within the class. If it finds something then you indicated the claim would go through. My question is will it return some information back as often times it does for other things telling that pharmacy that there have been prior fills? And I ask the question because kind of to Jeff's comment not only do we not know sometimes with samples, we also don't know if they filled the last prescription across the street. And so from that standpoint sometimes we will get that message back on other drug classes to say, "Hey, sorry, this won't go through. This was filled seven days ago at another pharmacy. It doesn't tell us where or exactly what was filled, but obviously it's bumping against something in the same type of medication or class. Will it give us that information so that we can then look at our profile and say, "Wow, we haven't filled anything, I wonder what it was or I wonder what they're on or I wonder if this Dr. Reese knows about this?"

Chuck Agte: Chuck Agte. There's a simple and a complicated answer to that. I was over-simplifying earlier when I said that that claim would go through because standard DUR edits would still be in place. So if they were filling olanzapine today and seven days ago they had a fill of risperdal across the street, the system would still give you that return message indicating that it has detected that there is a duplication of some kind so you would still receive that standard messaging and as you know a pharmacist has the ability to override that sort of thing as well. And that's an even more standard part of the practice than say our expedited codes are. And so you

would still get that kind of return information if there was some kind of duplicative fill in the recent past with a direct overlap in days supply and we could, in response to your question, we could also look at similar to, as you may or may not be familiar with our duration limit on proton pump inhibitors. We currently have our system set so that whenever a fill of a proton pump inhibitor does pay it's accompanied by a message about the fact that the client is only going to receive a total of 90 days over time. We could incorporate into the process messaging so that when a fill is detected to not be a naïve start…so if it was in that 180 days range you could in fact get a response indicating that the client has been on an atypical. We could return verification of that. I can't say without more research if we could tell you exactly which one, but we would be able to at the very least indicate that this fill went through because we know they've had something before.

Jason Iltz: This is Jason again. That's just very helpful. I'm not asking that we have to know exactly what it was, but having the knowledge of a prior fill it's a starting point with the patient or their agent to ask the question. And so that's very, very helpful.

Jeff Thompson: And I think this is going to help us at least start with this adherence issue that we have in the state. We have one of the highest non-adherence rates that I've seen in the country. But we have actually some of the best rates of high dose, low age polypharmacy. So I don't know how to explain this. And I'm looking across to other states comparing equal data. So I think this will help start the dialogue between the agency, the pharmacy, the client and the prescriber because at least in my experience as I look at the data, you know, when there's not adherence you don't know that. So you just start another drug or go up on the dose because you're not seeing the clinical manifestations of the good effects that these antipsychotics can have. So I think this is the start of the dialogue. Next month we'll continue where we left off. We have all the data looking at polypharmacy, polyprescribing, adherence, high dose across all ages, all different drugs, and so we'll continue the dialogue about how we improve. I do want to say that Washington State, as I look at it with the exception of adherence we look very good. I'm hopeful we can go to great. And that's why we need the dialogue and work with everybody.

Alvin Goo: Hi Jeff, it's Alvin. Another question – what was the largest gap you saw as far as refills?

Jeff Thompson: Oh it could go months. So what's interesting is if you look at monopharmacy they take their drug from January through December without fail. You throw a second drug in there and you'll see gaps. You'll see gaps because of hospitalizations, you'll see gaps because of jail and you'll see gaps because they didn't pick it up. So I think this is why we need to work really closely with Sharon and everybody, including the clients, why are people not taking their meds? And see the issue is I think we confuse things with generics first. When we look at the KATY(?) study we know that 75% of the people who start on a med will not end up on that same med. So that's not even odds. So let's be more rigorous, you know, and say that if there is an opportunity for a least costly, equally effective with all of the protections here and then let's march and see if we can't improve adherence and lower polypharmacy because we know when we do polypharmacy, polyprescribing, adherence, our clients are going into the hospital more often, they're going into the emergency more often, and quite frankly they are having more mortality, more morbidity more often. So this is the dialogue. This starts the dialogue and I'm very sorry sometimes that it has to be with generics first, but I think it's an opportunity that if we do have some savings that hopefully then can be turned into more resources for our clients like the PAL program.

Alvin Goo: So I'm also wondering…right now you have 180-day review back and I'm just wondering if maybe that should be extended a little bit longer.

Jeff Thompson: Well, when we did all the other mental health drugs we started out with like 30 days, 60 days, and we ended up with 180 days. I will have to say that 180 days, but if they've got gaps in care I think this generics first can then start to inform Vyn, you know, that knows somebody prescribes something else and did you know that?

Alvin Goo: Right. That's why I'm wondering if that 180 days might not be long enough and that that additional information would have been helpful to Dr. Reese.

Jeff Thompson: Six months, two years, four years? I think…in the agreement when we did this for the…which just came up with the antidepressants we agreed to six months. I think it's a good start. We can't go more than a couple of years because our data systems aren't loaded like that.

Vyn Reese: Any other questions for Dr. Thompson?

Jeff Thompson: Thank you.

Barak Gaster: Good work, Jeff, thank you.

Vyn Reese: Yeah, thank you very much. Okay. I'd now like to move into the stakeholder input part of the meeting. And I want to make sure all stakeholders let me know who they are representing especially if it's a pharmaceutical company and whether they were paid to show up here or who asked them to come. And remember too we have several people who like to talk and we need to limit the time to three minutes per person so everyone has a chance. The first person on the agenda is Stephen Cheng from Eli Lilly. On deck is Jim Adams from NAMI Washington.

Stephen Cheng: Again, my name is Stephen Cheng. I'm a Health Outcomes Liaison for Eli Lilly and Company. Regarding the generic first policy that is being proposed I would like to inform the P&T Committee of two recent Medicaid public policy articles that were published recently. One was in 2008 by Dr. Sumari(?) published in Health Affairs entitled *Use of Atypical Antipsychotic Drugs for Schizophrenia in Maine Medicaid Following a Policy Change*. The second is published in Medical Care authored by Lou in 2010 entitled *Unintended Impacts of a Medicaid Prior Authorization Policy on Access to Medications for Bipolar Illness*.

In the first publication Sumari investigated the impact of a PA policy in Maine on atypical antipsychotic use, spending and treatment discontinuities among non-elderly Medicaid patients with schizophrenia. Using claims data analysis the authors results showed that patients initiating atypicals during Maine's PA policy experienced a 29% greater risk of treatment discontinuity than patients initiating atypicals before the policy took effect. This adverse clinical outcome of treatment discontinuation may be a strong predictor of acute psychotic episodes, hospitalization and other negative clinical and economic outcomes. T heir findings also suggest that step therapy and PAs of atypicals for patients with schizophrenia may result in suboptimal use of essential medications, observed increases in treatment discontinuities without cost savings suggest that atypicals should be exempt from PAs for patients with severe mental illnesses.

In the second publication Lou examined the impact of the Maine Medicaid PA policy on initiation and switching of anticonvulsant in atypical antipsychotic treatments among patients with bipolar disorder. The Maine PA policy was associated with marked decrease in rates of initiation of bipolar treatments, a relative reduction of 32.3% compared with expected rates at four months after policy implementation. This decrease was driven primary by reductions in initiation of non-preferred agents. The findings of this study provide evidence that PA implementation can be a barrier to initiation of non-preferred agents without offsetting increases in initiation of preferred agents. Barriers to medication access may exacerbate the problem of poor adherence like Dr. Thompson had mentioned and may lead to declines in the health of these vulnerable patients including higher risks of relapse, hospitalizations and suicide.

In both of these articles the authors stated the Maine Medicaid suspended the PA requirement for second generation antipsychotics and implemented provider education programs after numerous case reports of adverse effects associated with the policy. In light of this growing body of evidence we ask that you recognize the potential unanticipated and unintended impacts of treatment of a PA policy when applied to antipsychotic agents and consider preserving the current access for your patients in Washington. I can provide copies of these articles at your request.

Vyn Reese: Thank you. Are there questions from the committee?

Ken Wiscomb: Yeah. This is Ken Wiscomb. Are you aware of either of these articles prior authorizations that were used as comparison if they had any fail safes in them or if the fail safes that are comparable to the program we're talking about here?

Stephen Cheng: I could get that detailed. They didn't provide that in the article.

Vyn Reese: This is Dr. Reese. There are a lot of different PA authorizations and depending on how strict they are it's all in the details. So if you have one that's very strict and doesn't acknowledge all the safeguards that are in this PA policy it's comparing apples to oranges.

Stephen Cheng: I just want to make sure you're aware of this evidence.

Barak Gaster: We're just not sure how it applies to us without a comparison of how the Maine program compares to the Washington state program.

Stephen Cheng: Okay. I'll provide that to the P&T Committee.

Vyn Reese: Thank you. Any other questions from the committee? Next speaker is Jim Adams, NAMI Washington. On deck is Stephanie Lane, NAMI Washington.

Jim Adams: Thank you sir. I'm Jim Adams from NAMI Washington. I also have been a member of the Adult Mental Health Work Group since its inception and I want to express NAMIs enthusiastic support for proceeding with the plan that Dr. Thompson outlined. This is probably the most difficult kind of task to be given to somebody when you have a relatively controversial and unpopular law passed and we have to make it work and all of the discontent hasn't gone from the public arena yet. And there's a lot of confusion and a lot of concerns because of problems from the past. I have to tell you though this work group, after working together for four years, we have learned each other, we don't necessarily have to even speak our reservations about certain issues and everybody understands and tries to do what's best for the client at the end of the road. We are not unmindful of the problems of the state, but we have to recognize that the patient comes first. It does no good to save $1 million if we lose 100 patients. So there are some limits onto what we can do.

However, in this case we have learned from the past experiences with other medications and psychiatric drug medications how to go about this and how to make it work and the record speaks for itself and it's the kind of thing so that if we make a mistake or if something doesn't work as planned we can change it very quickly. And we have done that. And so I think this is a very effective process and with your knowledge and your questions and your support we're able to do a very effective job together. On this I think this begs urgent resolution and so we plan to proceed at all full speed and due diligence and we need your support and would like to have that in advance so that we can get this job done and erase the confusion and introduce the clarity and get medication into the hands of those that need it. Thank you very much.

Vyn Reese: Thank you. Are there questions from the committee? Thanks. Next on the agenda is Stephanie Lane, NAMI Washington and on deck is Helen Nilon, Community Treatment Partnerships.

Stephanie Lane: Hi. My name is Stephanie Lane. Hi everybody. I just want to thank the advocates and Jeff and the Committee I do know that you guys have worked really hard for this. And I know that the Adult Mental Health Subcommittee has worked really hard. I'm actually the former Director of the Office of Consumer Affairs for the Mental Health Division and I worked at the office of the Governor at the Transformation Grant for three years before I took that position. I resigned in January and I'm currently on the board of directors of NAMI and I have in front of me…it's just some people who don't believe that this process has been as transparent as Jeff thinks it is, some people who think that it hasn't been as fair and there is still some confusion and we don't believe…I actually have a letter from NAMI national and the NAMI state saying that they oppose the process. So I'm a little confused at the last testimony. I have the letter and I have a packet for everybody on this committee and I'd like for you guys to look at it.

On the back of this letter just for the sake of time it says, "While NAMI opposes the proposed policy requiring new starts to fail a trial of generic risperidone before requesting authorization for the trial of a different atypical antipsychotic, NAMI Washington supports the following revisions to the clinical exception policy for the atypical antipsychotics as important to mitigate the unintended consequences that Jeff was talking about. So if you could please read this letter and in its entirety you'll see that NAMI Washington actually does not support this process. It supports recovery first, not fail first and very quickly I just want to let you know that in here is an atypical antipsychotic consideration for Medicaid coverage American Journal article, a letter from the Sheriff…is the Sheriff from King County here? She's going to come and she's going to read this letter to you opposing this process. Several letters from physicians, Kendra from High [inaudible] Pharmacy opposing this process. And it's not...opposing is a strong word. It's just wanting more consideration and less of kind of a ram through of this and more looking at recovery because what you guys are doing is you're dealing with the patient…you're dealing with self direction and recovery and self-directed care, which the key component of that is the patient/doctor relationship and there isn't a pharmacist out there that's going to be able to look at a DAW and know

what kind of relationship that doctor has with that patient. And we don't want a lot, maybe a presentation on recovery to this committee, maybe having more representation on the adult mental health subcommittee. We do have a letter from the Community Transformation Partnership that's going to be read a little bit later by Tamara Johnson and this is a lifespan coalition and it represents over 200,000 people in the state of Washington from NAMI, DRW, family, youth advocates and adult consumers and there's also serious concerns about risperidone and the fail first policy.

But the crisis, Washington state is way ahead of the curve…

Woman: Please conclude your remarks.

Stephanie Lane: Oh thank you. I'm done. I'm an easy one. Thanks.

Vyn Reese: Any questions from the committee? Next up is Helen Nilon. On deck is Mark Avery, MD.

Helen Nilon: Hello. My name is Helen Nilon and I'm here today for two different groups: the first is the Mental Health Planning and Advisory Council of which I am Chair, the planning council directed me last week to let you know that they recently became aware of the state through your committee reviewing medications for adults with mental illnesses. We're quite concerned that there has been virtually no or poor public input into the implementation process for senate bill 5892 enacted in 2009. In our review the minutes for the adult mental health work group, which consumer advocates across the strait have not been aware of, we have not found that public input has been provided for.

This far reaching proposal could have serious implication for both current and future clients in Washington's Medicaid system and we urge you to slow down this process to allow the public to participate in its implementation.

I'm also here as the President for Mental Health Action, which is the largest grassroots consumer-only membership organization. We have approximately 175 members and every RSN in the state. They also had recently become aware of this. This far reaching and potentially dangerous proposal could have serious implementation problems for both the current and future clients. We ask that you slow down this process.

In addition to human consequences we feel a real and significant increase in costs for other health care systems when individual or naïve clients as you say are globally provided a drug without consideration of individual preferences or past history. During the last Adult Mental Health Work Group meeting held on April 9, 2010 the drug most often referred to was risperidone. Somebody during that meeting indicated that 70% of the time people fail on their first drug attempt so why not use risperidone? It's going to…if they're going to fail anyway? Mental Health Action believes that this is an unacceptable approach and policy to the treatment of individuals. Studies have shown that individuals, when given the proper medication during their first break, will recover almost 70 to 80% of the time. Why would the state knowingly prescribe medication when it's expected to fail? We believe in the right to have an informed choice about medications and that this decision, without coercion, should be determined by the medical team involved and with direct knowledge of the individual's needs along with the input of the individual where possible.

We do not believe that a sheet of paper with a diagnosis is a ground for prescribing medication X. It is well known that barriers to proper medication increase the number of psychiatric hospitalizations, emergency room visits, incarceration and homelessness. The shifts of costs to these other systems will be more than the cost you're saving in medications. Nor does this take into account the loss of productivity from the months or years due to poor policy such as this.

Woman: Please conclude your remarks.

Helen Nilon: Yes, please. Mental Health Action requests that you, the Drug Utilization Board and Pharmacy and Therapeutics Committee and the Adult Mental Health Work Group slow down this process and allow for full public discussion. We look forward to working collaboratively with you in the future.

Vyn Reese: Thank you. Any questions? Next speaker is Dr. Mark Avery. On deck is Bill Struyk, Johnson & Johnson.

Mark Avery: Good afternoon everyone. My name is Mark Avery. I'm a psychiatrist. I'm Chief Medical Officer of a community mental health center in South King County called Valley City. I also sit on the Medical Director's

Committee of King County that Sharon Farmer chairs. I also sit on the Mental Health Work Group that has developed a lot of the recommendations that you heard earlier. I want to say that I appreciate Jeff's presentation. I feel that what was presented today was in fact an accurate presentation of the Mental Health Work Group's discussion and recommendations. I want to offer both my qualified support for the recommendations and also to pass on that I have been perhaps a bit surprised, but I definitely notice that the psychiatrists that I've talked to both at my agency and on the Medical Director's Committee have generally been in support of a decision tree like process like this for choosing an atypical antipsychotic. I personally believe we are in era of evidence-based practices and that's a very good thing and I've been surprised how the psychiatrists that I've talked to and other prescribers by the way have been supportive and interested in such a process.

My support is qualified with a couple of caveats, though. First off I think there's been discussion and I really support the idea of keeping this process absolutely as simple and transparent as possible. We know that even very simple obstacles of making prescribers right even more than a few words on a prescription can ultimately result in access barriers. So we want to keep that very simple and we want to get information out to everybody. I think we should consider your situation of the prescriber not knowing how to do this thing should be a rare exception. We need to get the information out so people know how to do it. They are smart people and they can learn this stuff.

The second thing is the other occurrence that was described of a client potentially showing up a pharmacy and walking away empty handed should be reduced to zero in this process. That…somebody presenting to a pharmacy with a psychosis wanting treatment is such a precious and wonderful situation that we don't want to impede that process at all. So I would suggest that one possibility is we might want to ask the state to measure any of those such incidents and critically review them to reduce that incidence down to…as much as possible. Thank you.

Vyn Reese: Thank you. Are there questions from the committee? Thanks. Next speaker is Bill Struyk from Johnson & Johnson. On deck is Eleanor Owen from NAMI Greater Seattle.

Bill Struyk: Hi. Good afternoon. I just have a few clarifications and Dr. Thompson most of these questions are going to be directed at you. But when I looked at the Mental Health Drug Work Group minutes from April 9th I saw some things that were somewhat inconsistent with your presentation and I just want to clarify that if I could, please.

On page 2 under emergency fills and this would affect you too Chuck, the last line of the minutes says, "Medical necessity requirements will be applied to any future refills of the same medication, i.e. one filled under emergency situation, but will be waived to ensure payment of emergency fills. Does medical necessity…let me ask it this way. Does refill protection pertaining to emergency fills trump the need for medical necessity?

Jeff Thompson: So this is Jeff Thompson. So I need to ask you some clarifying questions. Does that mean that antipsychotics for off label use for…as a hypnotic or are you talking about on label use because you weren't clear?

Bill Struyk: It would be on label use.

Jeff Thompson: For on label use the answer is we will honor the refill protection if there is an emergency supply given for on label use.

Bill Struyk: Without medical necessity?

Jeff Thompson: Without medical necessity.

Bill Struyk: Okay. Thank you.

Jeff Thompson: [inaudible] qualification [inaudible] use medical necessity you're kind of getting into off label and on label. So I'm not clear…

Bill Struyk: No. I'm being very specific here, Jeff.

Jeff Thompson: So when you say medical necessity you absolutely mean for on label indications?

Bill Struyk: Right.

Chuck Agte: Jeff, I would like to address part of that as well. This is Chuck Agte and the excerpt that you're reading is from our stated emergency fill policy and that clause is meant to…because the emergency fill policy applies to all forms of drugs; some of which do not have a refill protection involved. So that clause in regard to our emergency fill policy is intended to reiterate that all policies apply to future fills of that medication. In the case of a refill protection class, refill protection is one of those policies that applies.

Bill Struyk: Okay. Thank you. Jeff, could we get a copy of your presentation made available to the public, please?

Jeff Thompson: Yes.

Bill Struyk: Thank you. [inaudible] by a patient is grounds for meeting the criteria, the exception criteria?

Jeff Thompson: Yes.

Bill Struyk: Stable patients…and this has to do with your comment earlier that stable patients will not be switched regardless of how the therapy was initiated. I'm aware of patients that are started in criminal justice settings, typically county jails, city jails, on samples. They come out on samples. They're as stable as they can get coming out of the criminal justice setting. Will they be allowed continuity of care?

Jeff Thompson: So as I said in the presentation and with the Mental Health Drug Work Group we will take these on a case-by-case basis, but I will not commit to the state for the overall use of antipsychotic samples as standard of care and I think we heard that in the Mental Health Work Group for a new start giving a sample may not be the best thing. So on a case-by-case basis…

Bill Struyk: But if they're stable…if they're stable they won't be switched?

Jeff Thompson: Again, on label or off label?

Bill Struyk: On label.

Jeff Thompson: And stable meaning…yes, we will honor that. We don't want to take somebody off of medications and produce a psychosis.

Bill Struyk: Thank you. Now I want to clarify something. There's iron clad commitment from HRSA to construct expedited prior authorization criteria for the exception listed or for the exceptions that the Mental Health Drug Work Group agreed to. That could be satisfied by EPA code or notation on the prescription. Is that correct?

Jeff Thompson: That is correct.

Bill Struyk: Okay.

Jeff Thompson: Per our discussion in the Mental Health Work Group.

Bill Struyk: Just two final things, three final things, gold carding for high utilization of generics. I would suggest gold carding for outcomes is a more appropriate measure. Patient assistance, Dr. Reese, you mentioned something about patient assistance or high cost when people lose coverage. I'll make available…I'm a board member of the Prescription Drug Assistance Foundation, which has pilots in eight counties currently and is designed to help people access more efficiently the prescription drug assistance programs that the industry offers and most of these clients, if they lose coverage from some dilemma, would qualify for those patient assistance programs and we would want to make those available.

And Dr. Reese this is just an editorial comment. You'll be glad to know that pharma guidelines would not allow you to go to Vancouver or Victoria and so…you can take your…unpack your suitcase and…

Vyn Reese: This is Dr. Reese. I have been offered that trip before from a pharmaceutical rep.

Bill Struyk: Not in the last two years.

Vyn Reese: But not recently, exactly. It was a couple of years ago. It's not a falsehood that I spoke of.

Bill Struyk: No.

Vyn Reese: It was a great trip, too.

Bill Struyk: We're all reformed. Well, it takes two to tango. I'm glad you enjoyed the trip.

Vyn Reese: I didn't go, but it was a great trip that was advertised.

Jeff Thompson: Bill, is Johnson & Johnson with their membership on the Mental Health Work Group in support of this EPA criteria?

Bill Struyk: How did you phrase it Dr. Avery?

Dr. Avery: Qualified.

Bill Struyk: Qualified support. Thank you.

Jeff Thompson: Thank you.

Eleanor Owen: My name is Eleanor Owen.

Vyn Reese: Next on the agenda is Eleanor Owen. I was just going to introduce you.

Eleanor Owen: Eleanor Owen and I am currently the Interim Executive Director of NAMI Greater Seattle. By way of introducing you to my real self I am a founder of the local state and national alliance for mental illness. I've been involved for over 30 years. Prior to that I was an educator—preschool through graduate level and I want to preface my statements by saying that I have never seen the kind of scrupulous attention to detail to come up with a list of criteria that would provide the best possible outcome for the greatest number of people, the greatest safety measures for access, and I commend Dr. Thompson without reservation for the process by which we have come to. I served on the committee for almost four years and listened with a very cynical eye because as an advocate I'm always questioning everything. So that is my summary statement for the process that we have gone through and without reservation I personally endorse the conclusion that we have come to.

I also want to respond to what appears to be some confusion. I think that a great deal of information was…misinformation that a lot of decisions that have been arrived at are decisions that were made maybe a year or two ago prior to the thorough and careful evidence that has been accumulated by both Dr. Farmer and Dr. Thompson so that I can say that one of the things

that NAMI Greater Seattle has been doing, and I represent the two largest…NAMI Greater Seattle and Citizens Guild of Western State Hospital have been thoroughly educated on this process for several years and therefore we come to this conclusion. I think that in an effort to educate the entire advocacy movement we are holding a conference on April 30th to invite as many people as possible to come and get some of the hard data to help them accept the conclusions that we've come to. Thank you very much.

Vyn Reese: Thank you. Questions from the group? Next on the speakers list is Judie Ebberton-Rich.

Judie Ebberton-Rich: Good afternoon. My name is Judie Ebberton-Rich. I'm the Executive Director of Village Project II. Village Project II is a non-profit organization located in King County and we provide youth and parent partner services to families that are raising sons and daughters who are challenged with a variety of mental health disorders. The partner group came together recently and we met as a group and we were informed at our monthly group meeting that the issue of…discussions arose concerning branded versus preferred drug list for psychotherapy, prescriptions and treatments of serious mental health disorders. And the conclusion was that the group feels that the guidelines which the state is considering, which is a [inaudible] drug, a typical antipsychotic drug for mental health treatment appears to focus on initial acquisitions cost, ignores both the optimum treatment and actual total net cost, is short sided, and this is a quote that they stated, "and will actually result in greater expenses to the state". We know from our own experience as family members that often there are spontaneous fractures in children and adolescent treatment with preferred mental health drugs and that's a concern they have is the issue of fail first is a real concern to the families that we work with because often times the youth and children go through a whole series of trying to be diagnosed given their mental health challenges and the group pretty seriously feels that let's not guess, let's not put a [inaudible] population in a situation where it may in fact…the prescriptions may in fact inhibit their ability [inaudible] people. Thank you.

Vyn Reese: Thank you. Next on the speakers list is King County Sheriff Sue Rahr.

Sue Rahr: Good afternoon. I'm coming in here cold. I apologize. I haven't been able to be here all day. The reason I'm here today is I simply wanted to read a letter that I sent in last fall expressing my concerns about the impacts on public safety of the fail first policy. So I'll just read my letter out loud to you. I think that's probably the most simple and efficient way to get my point across.

I understand the agency is currently considering rules to implement Senate Bill 5892, which would overrule physician-selected brand name drug prescriptions substituting generic medications for many on state assistance. The King County Sheriff's office asks that when writing those rules you protect the doctor/patient relationship especially with regard to mental illness medicines to ensure that such rules do not have serious and costly public safety consequences.

I can leave you a copy of the entire letter, but the essence of what I want to convey is there is greater considerations out there that I hope people will consider. I'm not a pharmacist, I'm not a chemist, I'm a pragmatist and I don't think that when we're dealing with mental health issues where the potential impact of somebody failing is…could endanger their safety or could endanger the safety of others. The other consequence that occurs is if somebody goes into a failure mode. That could propel them to go into a system, the criminal justice system, that is ill equipped to deal with their problems. And so I'm just asking that you consider medications to treat mental illness in a very different way. It's not like the side effect of dry mouth or something like that. These have profound consequences not only for the individual, but for the people that are around them. In my opinion it would be a penny wise, pound foolish solution to this problem.

I'd be happy to answer questions if people have those. I'm sorry I'm not familiar with the format this afternoon.

Vyn Reese: This is Dr. Reese. We just have gone through all the safeguards involved with the state program. This is basically…I'm very…I'm a prescribing physician. I'm an internist in geriatrician, I've been in Seattle in practice for 31 years. Okay? I've seen a lot…I'm prescribed a lot of drugs for a lot of different indications. We've reviewed this class of drugs very carefully. We've had a lot of input from the mental health community. This is the issue in a nutshell. You've got one drug that costs a unit of 1 and you've got other drugs that are 25 times as expensive. The one that

has the unit of 1 has been shown to be equally efficacious and the side effects are basically very similar to the other drugs that it costs 25 times as much. The chances of success are equal in both drug groups. So why not ask people to prescribe the cheaper drug first, which is a drug that's been out for a long time. Generic first doesn't mean a bad drug. Generics are often…have been out longer, we understand the side effects better, we know that their efficacy is better, so a better understanding of what's going to happen with those drugs than we do with drugs that have been recently introduced.

Recently introduced drugs are pushed, you know, by the pharmaceutical industry on doctors and if they don't stay up with the literature they may not be aware that these drugs aren't any efficacious…more efficacious and in some cases may be more dangerous than drugs that have been out for quite a while. I'm very concerned about the prescribing thing and making sure it's safe and patients get their medication right away and if the doctor doesn't understand [inaudible] for the wrong one I want to make sure that there are emergency, you know, steps in the process so the patient can get medication. That's the key.

But if there's no difference between the chances of success of a drug that costs 25 times more than another one why not try the less expensive one first? That's all that this is saying. That's in a nutshell. And you've got to remember doctors have a lot of pressure on them to prescribe the latest, greatest drugs and these drugs often aren't the most safe or efficacious. So you understand that that's…the doctor may write that because that was the last thing he heard from the rep that just left his office and it may not be the best drug for the patient, it may be a drug that turns out to have a dangerous side effect that we haven't even seen yet. So you have to understand this is a very complex issue. There have to be safeguards involved and I'm very much in favor of that because I don't want to have my patient…I don't want to write for a drug and have them not get it and have me find out next week they didn't get it and they're in a psychiatric hospital. That's the worst outcome, but there's a lot of safeguards involved in this and it looks to me like a pretty sound program based on the medical side of it.

Sue Rahr: All I can…I can only base this on my personal experience with personal family members and I've seen the different…the behavioral differences between a generic and a name brand drug that were supposedly the same

thing. I don't know the chemistry behind it. I guess I would rather put my faith in the physician to be ethical and make the appropriate call about what to prescribe. So I understand what you're saying about the pressure. I think the converse argument can be made for, you know, the pressure to be on a generic drug when a doctor who may be up on the literature and very experienced doesn't have the opportunity to prescribe the medication that that doctor feels is most appropriate.

Patti Varley: Thank you. I would like to reiterate some of what Vyn said but in a little different angle. I'm a psychiatric nurse practitioner and have been prescribing psychotropic meds mainly to children and adolescents for almost 30 years now. I'm very uncomfortable with the fail first because that's not a term in this committee that I have heard. What I have heard is generic first and what I'm going to share with you is my understanding both in training here and the university system, as well as at NIH the National Institute of Health.

As a society what we have done is we have handed over manufacturing of medications to for-profit agencies. So there is, unfortunately, no longer an unbiased development of literature, research data, etc. What happens is when a drug is developed for a particular disorder the first drug that comes out has to be proven to be better than placebo. And what happens is that drug if it's first release becomes generic because there's a paten limitation and there's all this business that happens around patents. When the second and third drug within a class gets developed it does not have to prove for FDA approval that it is better than the first one released. It only has to prove that it is better than placebo and in many cases we know that the reason we don't have, you don't have, I don't have, none of us have the data we need, which is head-to-head studies done is because there is not a financial gain to any company to do that kind of work and we don't have money in the government to do that work that we all need, which is that. So the dilemma is that quite often the first drug in a class was more efficacious than any of the rest but…as far as comparison to placebo, but we don't have a good way of comparing A to B.

Secondly, the side effects are quite often better known 10 years later than they are with something that's been out a year. And so when we are looking at the generic first we actually were looking at the old brand names, the old brand names now generic in comparison for safety and efficacy.

The other is that I hope I live long enough that there is a scan that says, "You can't take generic, you can only take this one, you can only take that one," and the reason that this is discussed is financial is only one part and you weren't here earlier when I'm very passionate about the fact we have more and more people who we need to serve. So we have to think about how to save the resources, the money tree isn't there. So when I have a drug that I know by the data interpreting has safety and efficacy and has been off pattern, nobody is marketing anymore that drug. I teach at the University and my students will say to me, "How come I don't hear about that drug?" And I say, "Well, because no one markets it anymore." And they say, "But I read and it's safer. It has less side effects than…" But there's this whole access of information in how we get it that's influenced by our economy.

So I get upset when I hear that we're fail first or that we're trying to be cheap and not give people the best thing because quite often what we're proposing is the best thing and has the best evidence, and yes, happens to be cheaper, which means I can serve more patients that way. So for me that misnomer or confusion is upsetting. On the other hand I work in tertiary care and Jeff will tell you I fail the generic comparison of my prescribing practice to the general public of my colleagues. I am the bad guy. I write for the more expensive meds more often, but only if I can't have them on what is more cost-effective because of their particular ability to metabolize it or to be benefited by it isn't there. But to not start with something that has a better track record and is cheaper wouldn't be right. And I have to defend and should be able to defend why I have to have my patients on things that are more costly for that patient's good.

I'm hoping this is clarifying some of the rationale where the dollar sign isn't it and fail first isn't it. And then I also want to say that in the realm of medical practice there are things like the Texas algorithms and they'll say things like, "If you're psychotic you start with an antipsychotic," and they don't specifically say which one to start with, but there is a decision-making tree and that's kind of what we're suggesting is a clinically evidence-based decision making tree of where do you start for safety and efficacy outcomes? And where are you allowed to go if those fail? It's a decision making tree just like any model would be.

I think I covered all my points. I hope it clarifies at least some of the differences because if you hear from here everybody wants the same thing. We want our patients to have access to the best treatment possible and we have a society that sometimes misunderstands that the most expensive isn't always the best and isn't always the safest and we've learned that if look at it that some of the newer things, when we find out, they have side effects we didn't think they could have because the test subjects and the research that's done are done on non-real people. They're not our patients who have multiple problems, live in multiple crises, all of those things. So I know I'm longwinded but it's a very passionate area for me and someone again who believes strongly in generic first and fails miserably with the patient load I have.

Sue Rahr: Well I want clarify my position too. I'm not saying we should automatically go to the most expensive, I'm saying that, and maybe this is naïve, I would rather trust the physicians judgment than a rule that was imposed with the purpose of saving money. I understand we have a lot of people that need treatment and we need to share that money amongst a lot of people. But again I am very cautious about second guessing the physician that hopefully has some experience with that patient. I am most interested that when you're looking at your criteria for approval that safety is way at the top of that list and that it isn't trumped by the least expensive…and I get that some of the older medications are still the best ones. It's not that. It should be the physician's decision and please consider the downstream impacts if it's the wrong decision.

Vyn Reese: This is Dr. Reese. I think you have too high of an opinion for every physician. We're not all created equal, okay? And…

Patti Varley: Or nurse practitioners.

Sue Rahr: Or police officers.

Vyn Reese: Right, exactly. We aren't and some of us are really influenced by marketing from the drug companies.

Sue Rahr: But that sounds like a different problem to me.

Vyn Reese: No, no, no, it's the same problem because then you prescribe the drug that's been heavily marketed to you and you don't, as she said, think about

the drug that's been out longer that may be safer and more efficacious and less expensive. So marketing is very important in this first prescription and I guarantee…that's why they spend so much money marketing. Okay? That's common sense. So that's why physicians often prescribe right off the bat that 25 times as expensive drug. Okay? And that's why we're trying to make it just a common sense way. All these drugs have roughly an equal chance of success and so why not try a drug with a good track record that's safe and efficacious and that's been out a while? And also has a side effect of being a lot cheaper.

Sue Rahr: Right. I just…just don't forget those one tenths of one percent. That might be the person that commits suicide or ends up barricaded in a police standoff.

Vyn Reese: We have to worry about that. We have to worry about that too. So we're not…we're not worrying about that.

Jeff Thompson: This is Jeff Thompson. I just want to thank you. We include your medical directors from King County and Pierce from the jails. They're at the table occasionally and they get all the minutes. So we do rely on them so I want to thank you for their activity. And then the other was just Secretary Drafus(?) has indicated that we really need to work closely with you. We'll be planning a DSHS county and city sort of get together probably in the fall. We hope you can come, you know, along with some of the other people because she's really pounding us that it's not just about the drugs, it's about looking at criminal justice and home and getting people a job. So we really want to work with you on that. So thank you for your support.

Sue Rahr: Yeah. I would be happy any way I can and I will be reaching out to you again. We're getting some traction in Washington, D.C. on getting the government to reconsider the policy of suspending Medicaid benefits when people are booked into jail and I think if you talk about saving dollars at the local level, I think this will pale by comparison. So anybody who's interested in that issue I want to just let you know it's ramping up again and I'm going to need a lot of support on that. Thank you.

Vyn Reese: Thank you Sheriff Rahr. I appreciate you coming and that you care enough about this issue to come and give us input. Thank you very much.

[applause]

Vyn Reese: Anyone else? Any other stakeholder that would like to talk? I've gone through my list.

Man: Angelo Ballasiotes, one of our former members.

Vyn Reese: Dr. Farmer, did you want to say something or should Angelo go first?

Sharon Farmer: Angelo, you're on your feet, please go first.

Vyn Reese: Go ahead.

Angelo Ballasiotes: Thanks for the opportunity. I just got into town. I spent a little bit of time in traffic, etc. I just have a couple of concerns and I wasn't fully acquainted with everything that was going on. But I would just kind of like to give you an overview of what I do as a clinician and how things impact me. I'm a concerned clinician as you folks know and I treat a lot of people that are pretty ill. They are really pretty sick. And what I want to say is there is more involved in the process than just prescribing medications. Clinicians I know because I work with other clinicians, we're under a lot of tremendous pressure to keep people out of the hospital. That's really a mandate and you folks all know that there's capitations on communities with regards to the amount of money that can be spent in a community. And what happens if we go over the allotted amount, then the community needs to absorb that money. So with the pressure and everything else there's a balance. What I'm trying to, you know, treating the mental ill is not a one drug proposition. There's a lot of variables involved in treating people with mental illness. These antipsychotics, the atypical specifically, have different mechanisms of action. They all do, every one of them. And they also have problems with adverse events, no doubt. Also people that are treated by these medications have genetic factors that affect them. Okay? Now the majority of these people being treated have co-occurring disorders and that is a real, real problem. Co-occurring disorders are physical as well as mental. There's diabetes, there's obesity, there's depression, there's anxiety and also there is drug abuse and drug dependence. All those variables are intermixed and a lot of these patients have multiple variables and these people respond differently to medications.

I don't want to feel hamstrung in treating a patient. And I'll give you an idea of what happened to me last week. In my program at Pathways, which is an in-patient resident co-occurring program we had a young lady, 24 years old, that was in our program and she had been using chronically meth and marijuana. She was crazy. And it was very difficult to treat her because she didn't think she was ill. And this is a lot of times what happens to people who are mentally ill. We started her out on a antipsychotic and she took it for the first couple of doses and then on the third dose she started spitting it out or cheeking it. We monitored her very closely and the fourth time she started vomiting. Now she is really close to a hospitalization and what we did is we made a fast switch to a dissolvable tablet. She is stable now…well, not stable, she is getting stable. She's not delusional and she's not really psychotic, but she's got some delusions and she kind of knows that they are delusions now. I guess that's kind of one of the points that I want to bring to you folks is these are the type of people we do treat. It's very difficult sometimes if we have a bureaucracy that we have to go through and wait a couple of days to get an answer back. That's really one of my main, main concerns. I just gave you that example but it happens too often to me, you know, this particular issue and I really feel frustrated as a clinician in treating these people. Okay?

The other thing I would like to say – psychiatry is a science as well as an art. And the art is generated by experience and please don't take the art out of treating mentally ill because this is where we get some of our best results. Thank you for the time.

[applause]

Vyn Reese: Angelo, do you want to…are there any questions from the committee? I don't know if anyone wants to ask a question of you.

Angelo Ballasiotes: I'd be glad to answer any questions if I can.

Vyn Reese: Anyone have a question for him? I have one question.

Angelo Ballasiotes: Sure.

Vyn Reese: You know, doesn't it make sense to try a generic drug first in most cases? And then if you can't get it…if you can't…we're trying to make sure we

do expedited prior auths where you get it quick and we've been promised that's the case. Okay?

Angelo Ballasiotes: And that's the thing that I tried to point out here is it's a little bit different than treating high blood pressure and things of this nature. We have to react a little bit more rapidly and that's why I'm saying there's a little bit more involved in this process in treating patients than it is in probably general medicine. I think any clinician just kind of hopes to keep these people out of the hospital. Now I'm giving you kind of an overall broad picture of how I see it. I think medications are very important. I don't begrudge using generics and I got Dr. Thompson's letter and I got an A from him with regards to my drug utilization so I'm pretty proud of that.

Vyn Reese: Any other questions?

Jeff Graham: This is Jeff Graham. Angelo, were you able to see the whole outline of how to protect patients in such a matter that Jeff has put together with the mental health group?

Angelo Ballasiotes: No, I didn't. I got here late.

Jeff Graham: I think a lot of your issues would be answered if you got to see that.

Vyn Reese: You should see the handout, yeah.

Angelo Ballasiotes: Well, I just hope it's true, but I thought it was very imperative that I make this meeting and talk to you folks about what my opinions were and how I saw things.

Vyn Reese: Thanks for coming.

Angelo Ballasiotes: Okay. Thank you.

Vyn Reese: Dr. Farmer?

Sharon Farmer: Hi. I'm Sharon Farmer as you know. I wasn't sure if I could do a presentation and make comments in the same meeting so I didn't officially sign up.

Vyn Reese: You can. You're allowed.

Sharon Farmer: But I just wanted to say that the criteria and the processes will definitely meet my needs. To me the expedited prior authorization process and the emergency fills and the person in crisis I think it's really answered all the concerns that I've had about the person who's in an emergency or a unique situation. I also am really happy that there's been such an emphasis on communication to the prescribers and the pharmacists and I think getting more information out to persons with mental illness and the advocacy groups will be a real plus as well.

But I'm really up here because I wanted to repeat a comment that another participant in the Mental Health Advisory Committee had made. I thought it was worth sharing with this committee. Just to kind of refocus everybody we're talking about people who for the most part have never been on an antipsychotic before and when you think about it who are those people going to be? They may well be young people, young adults, older teenagers who are in the first episode of what will be a chronic mental illness. They may be geriatric people in nursing homes who have become psychotic or agitated as part of their dementia and they will be people of any age who have become psychotic because of drugs of abuse. That's who I'm thinking these new people are going to be. Where are they going to present for treatment? Some of them may go to emergency rooms or psychiatric crisis services, but I think a lot of them are going to show up in primary care. That's where I think these people are going to present and the comment that I wanted to convey to you was made by a primary care physician on this committee and she said that she feels that having an identified first choice is a plus for primary care providers. That that gives them a medication that they will learn about, focus all their learning on antipsychotics on that one medication, they will get a lot of experience with that medication, and she felt in the long run that that would actually enhance quality for people who are trying their first antipsychotic medication. I've been working for the last two plus years as a consultant to primary care physicians and I think that that really had the ring of truth for me. So I wanted to pass on that comment.

Vyn Reese: Thanks Dr. Farmer. Any additional questions of Dr. Farmer? Thanks again. Any other stakeholder comment? So this is an action item. Is that right?

Jeff Thompson: Yes. So we would ask that you bless the principles, the criteria and the FAQs as a first start and then you'll start to see the communication plan that will come out.

Susan Rowe: Susan Rowe. Dr. Thompson, I have a question. Because I was really disturbed by your comment that we have one of the highest non-adherence rates in the country and that's with the status quo. So I'm wondering what the…in terms of monitoring that I'm assuming you will and what kind of turnaround time would…when would we start seeing whether there's a difference in adherence for patients?

Jeff Thompson: This is Jeff Thompson. We'll be bringing this up. I mean the committee has seen this data for at least a year and so actually now that we've…hopefully we'll have this past us and we'll actually start having some continued efforts on how to look at polypharmacy, polyprescribing, dose, age adherence and then we have some benchmarking and we have some best practices from other states that we can consider. I will say that adherence is something that the agency, you know, even with all the activities we could do this really has to be at the prescriber and the pharmacy level as well at the client level. Because our data is too old to really action on this. So those will be the activities that we'll talk about.

Vyn Reese: Any other questions from the committee?

Man: [inaudible]

Jeff Thompson: So if you approve the generics first process we're looking at probably at late summer, early fall. So we'll have plenty of time to do communication and get out there. And I want to say to the advocacy group if you want me to come to any of your meetings, share this data, listen to you, I'm there. I just need an invitation. So I'm there for you.

Patti Varley: And I'm Patti Varley. If you start this in late summer, early fall what is the plan in regard to collecting data around some of the concerns that are expressed and hearing back about that in an outcome-based way?

Jeff Thompson: This is Jeff Thompson again. I've been working with the University of Washington. We have a data dictionary for adult. We're actually putting in for a national grant to look at this, which includes not only medication spends and trends, utilization, but to look at hospitalization, ER, narcotics.

Just want to let you know we're hearing a lot about the mental health issues. We've actually, as a state, led 11 new mental health codes into the AMA and so hopefully we'll have…be able to track not only the dose, duration and frequency of drugs, but the dose, duration and frequency of mental health care in the future. And that's also in the data dictionary as well as criminal justice activity. We're going to wire it as best we can but I think we're going to need a lot of support from you and the community to make sure that there's no unintended consequences.

Vyn Reese: This is Dr. Reese. My only concern about the program is the emergency dispense and that Friday night scenario that was outlined is a very frightening one for patients and for doctors too. It's very frightening that if the doctor isn't available whatever…it's 8:00 Friday night and you can leave that patient off medication for three days or until you can get a hold of the doctor. If the pharmacist understands that and every pharmacy in the state is going to have to understand that. Then that is a very important safeguard.

Jeff Thompson: Right. So Chuck and I have been talking along with Amy and so we'll be pushing out, you know, all I can say is we've had this for…since over 90. It's been working for diabetes, seizure, asthma, but loudly hear you. We will over communicate to both the prescribers as well as the pharmacist and the pharmacies, you know, what we allow is a very generous opportunity for emergency fill.

Jason Iltz: This is Jason. In regards to that emergency fill policy there was communication that just came out I believe it was last week via fax that reminded of the policy and I think it's a direct fax from HRSA. So I appreciate those things and I know that every pharmacist doesn't see them, but it has been out there. I guess maybe just kind of thinking outside of the box, is there a possibility when, you know, Friday night comes along and everybody leaves the office and somebody picks up the phone at the pharmacy level to call anyway and gets a, "Hey, there's nobody here." Is there an option maybe that that pharmacist could push on the phone? And I'm not familiar enough with it to know, you know, maybe option 5 is here are our policies and procedures about the emergency fill or something like that. Is that something that could be added?

Chuck Agte: This is Chuck Agte. We can definitely look into that. To be honest our phone system completely changes here in about two weeks with the

implementation of provider one. So we can attempt to get that in there. I can tell you that currently, unless they've changed it and I don't know it, there is in the long spiel of information that you're likely to not want to listen to when you call us, in there there is some information about our emergency fill policy currently but I know for a fact that 99% of all people star out or zero out from there to get somewhere else.

Vyn Reese: That should be one of the first choices. You know? If you get one of those electronic…

Patti Varley: Menus?

Vyn Reese: Exactly. You have to listen to 17 things before you find, "This is a doctor's office calling or a pharmacy calling," it should be up near the top of the list. When you get your new phone system in that needs to be right up there.

Chuck Agte: And we can definitely look into that. Currently part of the reason it's so buried and there is so much information is we do not have…it is a less advanced phone system than we will have. So you don't have as many options to put in there. But we can definitely work on getting our emergency fill policy onto the line itself for when people call. Also I haven't discussed with Dr. Thompson, but we were looking at, Amy and I, earlier this week and last week there are actually ways that we can possibly set up in the system to have essentially an expedited authorization code related to emergency fills that can actually be coded in the system to only work during the hours when you can't reach us by phone.

Jason Iltz: And I think that would be great. That's probably even a better idea. I just know that in most pharmacies now a days you don't have access to the outside world in terms of an internet. It's locked down and you have what's called an intranet and so you can't log onto the HRSA website and get the latest EPA code for this or that. So that's part of the issues. If I can't find it printed somewhere in a book I've gotta have another avenue that I can get it from. So that's per my comment.

Jeff Thompson: So this is Jeff. Just other things…I mean WSMA just put out in their recent edition of the WSMA News a handout on the feedback report. So if any of you have any sort of control over the pharmacy I'll work with Jeff

Roshan to get it out in the Pharmacy News. If you have other avenues we can give you a blurb and get it out and so we'll make every effort.

Vyn Reese: I don't want to find out Monday morning that my patient Friday didn't get their meds. I'll go through the roof about that.

Jeff Thompson: Well I can tell you…

Vyn Reese: Well, I have a call system so you should be able to get my…me 24 hours a day or one of my partners who would certainly…

Jeff Thompson: And I hear this loudly but I do…I want to go back to this. I can guarantee you that 40% of your clients aren't picking their meds up when they're…

Vyn Reese: Sure.

Jeff Thompson: So I think it's already happening.

Vyn Reese: I know. But if I don't know about it it doesn't bother me as much.

Jeff Thompson: Well I'm going to make sure you know about it. Okay?

Patti Varley: Jeff, there's two problems. One is…this is Patti. One is if we find out they didn't get it we're upset. The other is if they don't get it we get them upset with us. So it's a double whammy.

Duane Thurman: This is Duane. We have one clarification that I'd like Jeff to address.

Joe: Hi, Joe [inaudible] with AstraZeneca. And I thought I heard you say, Jeff, when you were going through your slides that if a patient had failed on a branded atypical, not just generic risperidone that another branded atypical would be approved. So can you clarify that point?

Jeff Thompson: So if they had failed on another atypical what would be the next reasonable step?

Joe: Or if it's documented they had failed on any atypical branded or generic risperidone that then a provider would be free to prescribe any branded…

Jeff Thompson: Right. Any other branded atypical.

Joe: Okay.

Jeff Thompson: So just a clarification from you. Does your company support this with this EPA criteria? And you've been at the workgroup from the beginning?

Joe: I would say as Dr. Avery did, a qualified approval, yes.

Jeff Thompson: Okay. Thank you.

Chuck Agte: This is Chuck Agte and I would like to take the opportunity to add to that clarification because this is in fact, and this is true for all of our generics first drug classes that have been implemented, this is true for new starts within the drug class. So it is a fact that if you have been on any drug in the class then you are in fact not a new start in the class and none of these policies apply. The key here is that we are attempting to reach those clients who have not been on any product within the drug class before. So it's not a matter of were you on generic risperdal before? It's a matter of have you been on any product in the class?

Vyn Reese: Okay. I'd like a motion for…unless there are other questions…have we exhausted our questions?

Ken Wiscomb: This is Ken Wiscomb. I think first I'd like to thank Dr. Thompson. You've presented us with a lot of data over the last year on this and have been very diligent in making sure that all the parties communicated and got on board and this has been a very difficult process I'm sure and I can't think how we could have come together with something that sort of pleased most of the people most of the time any better than what you've done and I would like to make the motion that board fully support the processes described by Dr. Thompson.

Vyn Reese: We'll go ahead and make a motion to do that.

Patti Varley: That's what he said.

Ken Wiscomb: That's what I said.

Vyn Reese: Okay.

Barak Gaster: This is Barak Gaster. I second that motion.

Vyn Reese: Okay. And all those in…okay, we gotta have a name for the motion. The way…

Ken Wiscomb: I would like to make a motion that the board support the generic first process for atypical antipsychotics as described by Dr. Thompson.

Vyn Reese: Okay. And you seconded it.

Barak Gaster: I second it.

Vyn Reese: Any further discussion? All those in favor say, "Aye".

Group: Aye.

Vyn Reese: Opposed, same sign. It's approved. Thank you very much. And that's the last agenda item. So we're…

Chuck Agte: Dr. Reese, before the board goes I would like to take the opportunity to let you all know that we are in a resource crunch at the moment and so if you have sent me your annual DUR materials but not received a response from me I have in fact received them, I've tried to reply to everybody. I know I've got two or three in my inbox that I haven't acknowledged. So if you've gotten it to me thank you and if you haven't, please get it to me soon.