



Washington State Health Care Authority
Prescription Drug Program

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UNOFFICIAL TRANSCRIPT*
WASHINGTON STATE PHARMACY AND THERAPEUTICS COMMITTEE MEETING

June 18, 2008
Marriott Hotel Seatac WA
9:00am – 4:00pm

Committee in Attendance:
Angelo Ballasiotes, Pharm D
Carol Cordy, MD (Vice Chair)
Barak Gaster, MD
Alvin Goo, Pharm D
Jason Iltz, Pharm D
Janet Kelly, Pharm D
T. Vyn Reese, M.D.
Patti Varley, ARNP

Committee members absent
Kenneth Wiscomb, PA-C
Robert Bray, MD

Woman: ... plans.

Lisa Bloudek: Lisa Bloudek. I'm a pharmacy student working at Public Employees Health Plans.

Duane Thurman: I'm Duane Thurman with the Health Care Authority. And I'll take the chance to tell you all to speak into the mics because we're recording the meeting.

Ray Hanley: I'm Ray Hanley, the manager of the prescription drug program.

Steve Hill: Steve Hill and I'm the director of the Health Care Authority.

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

Patti Varley: Patti Varley, child and adolescent psych nurse practitioner, P&T committee member.

Janet Kelly: Janet Kelly, P&T member.

Carol Cordy: I'm Carol Cordy, P&T member, vice chair.

Vyn Reese: Vyn Reese, chair, internal medicine and geriatrics.

Angelo Ballasiotes: Angelo Ballasiotes, comprehensive mental health in Yakima, P&T member.

Jason Iltz: Jason Iltz, pharmacist, P&T committee member.

Jeff Graham: Jeff Graham, consultant for the Health Care Authority.

Siri Childs: Siri Childs, pharmacy administrator with HRSA.

Soraya Kanakis: Hi, I'm Soraya Kanakis, clinical pharmacist for Washington Medicaid.

Jeff Thompson: Jeff Thompson, chief medical officer Medicaid.

Jaymie Mai: Jaymie Mai with labor and industry.

Cathy Williams: Cathy Williams, pharmacist consultant, board of pharmacy.

Vyn Reese: And I believe Jeff Graham has some announcements for us today.

Jeff Graham: Well, Regina asked me to ask all of the people here at the table and also our guests to try to cut down the chit chat as we're recording today and sometimes gets in to the recording background and we can't hear much. So that was my main announcement.

Vyn Reese: Okay, let's go ahead and launch into the...

Jeff Graham: We have one more, Duane.

Vyn Reese: I'm sorry. You have another announcement?

Duane Thurman: We do have a brand new member of the P&T committee, Dr. Barak Gaster.

Barak Gaster: Good morning, my name is Barak Gaster, I'm a general internist at the University of Washington medical center and very happy to join you today.

Vyn Reese: Welcome.

Duane Thurman: And then I'd like to introduce the administrator of the State Health Care Authority, Steve Hill. And he'd like to say a few words on behalf of the governor.

Steve Hill: Thank you. Is that working? Yea, okay. I am Steve Hill and as Duane said, I am the administrator of the Washington State Health Care Authority. And my duty today is to thank you all for your hard work on this committee. We are closing in on five years of experience with the P&T committee and we, the governor has personally addressed a letter to each of you, thanking you for your service on this board. So Regina is going to distribute those while I am making just a couple of comments.

And I thought maybe the best way to make my comments was just to read what the governor had to say, which is that she wanted to extend her sincere thanks for your service as a member to the Washington State pharmacy and therapeutics committee. Your help to develop an evidence based prescription drug purchasing program for state agencies is truly appreciated. The committee's work is an important cornerstone in the state's efforts to use evidence based medicine to make sure that all Washingtonians receive health care that works.

Thanks to you the state has developed a nationally recognized program to ensure the state agencies purchase prescription drugs based on evidence of their safety and effectiveness. This program is key to creating a sustainable, affordable, and quality health care system for Washington. Once again thanks for your role in helping Washington citizens with access to more affordable prescription drugs. I appreciate your willingness to take time from your busy schedule and your commitment to this important work. Sincerely, Christine Gregoire, governor.

I just wanted to add to that that we really do appreciate your hard work, but I also just want to add to that that we do as a society have a serious issue with health care and it certainly manifests itself in access issues, but it's also the reason we have access issues is that there are serious quality and variability and effectiveness and efficiency issues in the way health care is delivered. And I think to get to a solution and to make something different we're going to have to do a lot more work around comparable effectiveness of drugs and treatments and technologies, and the work you're doing is really pioneering that and we have already, from your pioneering work moved on as you know to an evidence based program around treatments and procedures.

So I think this is really critical work and really cornerstone work and really pioneering work, and I think you also are demonstrating just about

how difficult it is to do this work. So with that I wanted on behalf of the governor and all of us that work with the governor and all of us that are really committed to this program, thank you. And I hope that you appreciate the letter from the governor. Thank you.

Vyn Reese: Thank you very much. Now without further ado let's launch into the first drug class review and scan and it's a couple muscle relaxants. Are we set?

Man: Kim are you on the line?

Kim Peterson: Yes I am.

Man: Good. We have the first slide up, so...

Kim Peterson: Okay, great. Well I'm KIM PETERSON and I'm going to go over the findings from our March, 2008 Horizon scan for new research on skeletal muscle relaxants. So on to slide number two.

A little history. The last time the skeletal muscle relaxant review was fully updated was back in May of 2005, and since then we conducted one Horizon scan for new research back in February of 2007, and then in March, 2008 conducted a second Horizon scan for new research in consideration of whether or not there is a need for a third full update of this drug class. Next slide.

So in terms of the methods we used to conduct this second Horizon scan to identify new potentially relevant RCTs we searched MEDLINE back to the time of our first Horizon scan, which was January of 2007 and then to find information about new drugs, indications, and safety alerts, we also searched the FDA and Health Canada websites using the names of all of the included drugs. Next slide.

Slide four, so as for what we found in our MEDLINE searches, we found 18 new citations and among those there were actually no new clinical trials that met our eligibility criteria. So as of January, 2008, we were only aware of one new trial of Tizanidine versus Thiocolchicoside that is available to be added if this review is selected for a full update. So that was a study that was identified in the first Horizon scan. We weren't expecting this trial to add much, since we already have a sizable body of head to head trial evidence available, from which we've already been able to draw conclusions about how Tizanidine directly compares to other skeletal muscle relaxants. And then as for the results of our searches of the FDA and Health Canada websites, first we did find out that there have been two new drug products released in the last year and those are listed on the slide so an extended release form of Cyclobenzaprine and an oral tablet form of Soma.

Next slide, which is the last slide. As for other results of our FDA and Health Canada website searches we did not find any new information about any relevant new indications for any skeletal muscle relaxants, nor did we find any information about any new serious or life threatening side effects that warranted the FDA to require any new black box warnings or any other special urgent actions to communicate new safety findings, so we only found a few more minor label changes, which are on this slide.

So in conclusion, based on the collective limited information from previous and more recent Horizon scans, the DERP participating organizations elected not to pursue a full update of this review at this time, but we do plan to do another Horizon scan in January of 2009 and we will reconsider the need for an update at that point. So I'll turn it back to you to ask any questions that you have about this skeletal muscle relaxant Horizon scan.

Vyn Reese: Thank you and I'll take a motion to accept the scan as an adequate review of this class.

Jason Iltz: This is Jason. I so move to accept the scan as an adequate review of the skeletal muscle relaxants.

Vyn Reese: And a second?

Angelo Ballasiotes: Angelo Ballasiotes, I'll second that.

Vyn Reese: All those in favor say I.

Group: I.

Vyn Reese: Opposed, same sign. Okay, the scan is accepted. Can you stay on the line a bit for the discussion period of the stakeholder input?

Kim Peterson: Sure.

Vyn Reese: Any other comments or discussion by the committee? There is stakeholder input, Dr. Nancy Lewis of King Pharmaceuticals. I want to remind you you have three minutes to comment and please hold your comments to that period of time.

Nancy Lewis: Just a few summary points regarding Skelaxin, metaxalone. With decades of clinical experience, Skelaxin continues to provide safe and efficacious therapy for those individuals diagnosed with acute, painful, musculoskeletal conditions along with providing minimal sedation, no adverse cardiovascular, effects, no dry mouth, urinary retention, or blurred vision. It's indicated for use as a skeletal muscle relaxant that has been

utilized safely and effectively for decades as an adjunct to rest, physical therapy, and other measures in the management of discomfort associated with acute, painful musculoskeletal conditions. For safety and sedation, potential [inaudible] to should factor into clinical utility of a skeletal muscle relaxant. In review of clinical experience with metaxalone, there were no reports of sedative like side effects in 100 patients who received metaxalone in two double blind studies. These findings were confirmed in another study, which reported drowsiness or sleepiness in only four of the 115 patients who were in the metaxalone group and one in the placebo group.

Its mechanism of action has not precisely been determined. It may be due to general nervous system depression. However, it is believed that Skelaxin suppresses the polysynaptic spinal cord reflexes, but leaves the monosynaptic, or sensory motor ones pathways intact. By acting mainly at the spinal level, Skelaxin has been associated with fewer sedative effects when administered at the recommended doses. A key advantage of metaxalone is its ability to reduce spasm in affected muscles without decreasing normal muscle tone or interfering with the motor activity involved in maintaining normal posture and balance. Two separate double blind placebo controlled studies confirmed the effectiveness and safety of Skelaxin. These studies illustrate the ability of Skelaxin to provide prompt relief of acute painful spasms and the improvement in mobility often within 48 hours. Range of motion improved in nearly 9/10 outpatients, essentially 88% compared with 43% in the patients treated with placebo. Muscle spasms, as determined by palpation, improved in 87% compared to only 37% in the placebo group. There was no significant sensory motor depression, no significant interference with motor activity involved in maintaining posture and balance and Skelaxin does not directly relax tense skeletal muscles in men. 800 mg of Skelaxin either three or four times a day can bring prompt relief to affected muscle regions. It has a rapid onset of action. Peak plasma levels are achieved in approximately two hours and the plasma half life is approximately two to three hours.

In summary, Skelaxin is a non-narcotic, non-addicting with no risk of dependence, no withdrawal symptoms, and no adverse cardiovascular effects. It can provide prompt relief of acute, painful musculoskeletal conditions with minimal sedation. Most common side effects are nausea, vomiting, gastrointestinal upset, drowsiness, dizziness, headache, and nervousness or irritability. Metaxalone does not directly relax tense skeletal muscles in men. It is contraindicated in patients with known hypersensitivity to any of the components of the product, known tendency to drug induced hemolytic or other anemias, significantly impaired renal or hepatic function, and liver function tests should be performed in patients with preexisting liver damage. Thank you. Any questions?

Thank you.

Vyn Reese: The next stakeholder is Mr. Robert Host regarding Cephalon.

Robert Host: Good morning, I'm going to share briefly with you some information on the new product Amrix that was presented by DERP. Amrix is an extended release formulation of Cyclobenzaprine and is the first and only once a day skeletal muscle relaxant in the class. A formulation has been developed to provide early systemic exposure of Cyclobenzaprine with release over a 24 hour period to reduce fluctuations in plasma levels. Amrix is indicated for the relief of musculoskeletal spasm and is adjunct to acute rest and physical therapy. Efficacy and safety were assessed in two identical, 14 day, double blind, parallel group, placebo controlled studies with over 500 patients. Patient were randomly assigned to one of four treatment groups, an Amrix 15 mg, 30 mg arm, a placebo arm, and a Cyclobenzaprine immediate release arm. The two primary efficacy assessments were patient's rating of medication helpfulness and the physician's clinical global assessment at day four. The pooled results from those two studies were the following: there was a statistically significant difference between Amrix 15 and 30 mg compared to placebo in the distribution of response to patient's rating in medication helpfulness. The distribution response was similar between the Amrix treatment groups and the Cyclobenzaprine immediate release group. An evaluation of physician's global assessment at day four showed no statistical significance between any groups versus placebo. A secondary end point was daytime drowsiness, somnolence. Daytime drowsiness results at day four were the following: greater percentage of patients in the Amrix treatment groups experienced daytime drowsiness compared to placebo. A greater percent of patients in the Cyclobenzaprine immediate release group 68% reported that they experienced some to extreme daytime drowsiness, compared with the Amrix group at 45% and 56% respectively. The safety profile of most commonly reported adverse events were fatigue, dry mouth, dizziness, nausea, constipation. Less than or equal to 2% of patients taking Amrix reported somnolence as an adverse event. Somnolence known to occur with Cyclobenzaprine was reported as an adverse reaction in 1% of the patients taking Amrix 15 mg and 2% of the patients taking Amrix 30 mg, compared to 7% of the patients taking Cyclobenzaprine immediate release arm.

Amrix is contraindicated with concomitant use of MAOIs or within the 14 day discontinuation of the therapy. Amrix is contraindicated during the acute recovery phase of myocardial infarction, in patients with arrhythmia, heart block, congestive heart failure, or patients with hyperthyroidism. Amrix should be used in caution with patients with a history of urinary retention, angle closure glaucoma, increased intraocular pressure, and patients on anti-cholinergic medications. The recommended adult daily

dose is 15 mg with the availability to go up to 30 mg once a day. It should be taken approximately at the same time. In clinical trials that was between 6 and 7 PM. Amrix should only be used for short periods of time, up to two to three weeks. In conclusion, Amrix 15 and 30 mg were superior to placebo on patients rating the medication helpfulness in the treatment of muscle spasms associated with acute painful musculoskeletal conditions. Although greater than placebo, fewer patients taking Amrix 15 and 30 mg reported some to extreme daytime drowsiness compared with Cyclobenzaprine immediate release at day four. Once daily Amrix 15 and 30 mg were generally safe and well tolerated with the majority of side effects mild in severity. Thank you very much.

Vyn Reese: Alright, thank you. Any questions from the committee? Any discussion on this class? Let's turn to the motions then. Carol you made the previous motion on skeletal muscle relaxants in 2007.

Jeff Graham: This is Jeff Graham. Kim are you able to stay on for the next presentation or do you want to come back?

Kim Peterson: No, I'm doing all of the scans, so I'm just going to be staying on the line.

Jeff Graham: Okay, thanks a lot.

Kim Peterson: The whole time.

Carol Cordy: Should I just reread that? This is Carol Cordy. After reviewing the updated information on skeletal muscle relaxants we accept the previous recommendation to the class of skeletal muscle relaxants.

Vyn Reese: Any other comment? Is there a second?

Patti Varley: Patti Varley, I'll second.

Vyn Reese: All those in favor say "I."

Group: I.

Vyn Reese: Those opposed, same sign. The motion is passed. Let's move on to the second drug class, anti-emetics.

Kim Peterson: Are you ready?

Vyn Reese: We're still trying to get the slides up, just a sec.

Kim Peterson: Okay.

Woman: Okay, we're ready now.

Kim Peterson: Okay. Now I'm going to go over the findings from our December, 2007 Horizon scan for new research on newer antiemetic drugs.

Next slide. So we completed our first review of this group of drugs back in January of 2006 and since then we conducted one Horizon scan for new research back in November of 2006 at which time DERP participating organizations elected against pursuing a full update. So then we conducted a second Horizon scan in December of 2007, again in consideration of whether or not a full update of this drug class was needed.

Next slide. And just like for all of these scans, our methods were to search MEDLINE to identify new, potentially relevant trials and to find information about new drug indications and safety alerts we also searched the FDA and Health Canada websites. So for this Horizon scan for our MEDLINE search we went back to the time of our first Horizon scan, which was in October of 2006.

Next slide. So here are the results of our MEDLINE searches. We found 64 new citations overall, and of those we identified ten new potentially relevant trials, the majority of which did involve head to head comparisons of one antiemetic directly to another. And taken together with the 19 new potentially relevant trials identified in our first Horizon scan, at that point there was a total of at least 29 new studies that could be added in a full update of this group of drugs.

Next slide. So this slide lists the details of the ten new trials that we found in the most recent scan and in the comparison column for this to the right you can see which antiemetic comparisons were included in the new trial. I'm not going to read through these one by one, I'll just point out that at the time of our original review, the only trials we had that involved Aprepitant were focused only on using it as an add on to Ondansetron. So a major gap in the evidence at that time was that we didn't have any head to head trials directly comparing Aprepitant in monotherapy to any other antiemetics. But in this scan, we identified two new head to head trials comparing Aprepitant monotherapy directly to Ondansetron monotherapy that could possibly fill this gap. I think that was the highlight of the findings in the most recent scan.

Next slide. This slide lists some other main gaps, potentially addressed by evidence from the 19 trials identified in our first Horizon scan. So here again we see that the importance of new evidence is that it fills gaps where we didn't have any head to head trial evidence before, including for Ondansetron orally disintegrating tablets, also in the area of treating established nausea and vomiting in general and then also for the

comparison of Dolasetron versus Granisetron for prevention of postoperative nausea and vomiting in adults.

Next slide. So as for other results of our FDA and Health Canada website searches, we didn't find any information about the release of any new antiemetic drugs, nor did we find any new indications for any of the newer antiemetics.

Next slide. Finally, we also didn't find any information about any new serious or life threatening side effects that warranted the FDA requiring any new black box warnings or any other special urgent actions to communicate new safety findings. Just a bit of information about some standard additions to the precaution in adverse reactions section of the Dolasetron product label.

So in conclusion, based on the collective information from the previous and most recent Horizon scans, the DERP participating organizations voted in favor of pursuing a full update for this review, which is in progress as we speak. So we expect the final report for this update to be available in early January of next year. So now I'll turn it over to you for questions.

Vyn Reese: Thank you. Any questions from the committee? I'll take a motion to accept the scan as an adequate review of this class.

Jason Iltz: This is Jason. I move to accept the 5HT3 antagonist scan as an adequate update.

Vyn Reese: Second?

Carol Cordy: This is Carol Cordy. I'll second it.

Vyn Reese: All those in favor say "I."

Group: I.

Vyn Reese: Opposed same sign. It's accepted. Any other questions or discussions? There is no stakeholder input on this class. Let's turn our attention to the motion section. Bob Bray did the motion last time. So we'd like to tackle this, looks like it's pretty much the same.

Jason Iltz: This is Jason. So a question right now with Emend, Aprepitant. Where does that fit? I know we said it wasn't part of this class. Is it just at this point not part of the PDL and are we getting requests for it? Is it getting covered under certain criteria? Can we walk through that process just real quickly?

Siri Childs: This is Siri Childs, pharmacy administrator for Washington Medicaid. All of the antiemetics, even those preferred on the Preferred Drug List require EPA for their FDA labeling. And Emend is not part of the drug class because at the time we reviewed it, its indication was for the nausea and vomiting of chemotherapy and it had to be given with one of the other drugs. Now I believe that it's indicated as monotherapy in postoperative nausea and vomiting, but not the chemotherapy.

Vyn Reese: It's not a 5HT3 drug too, it works in a different mechanism, that's why we didn't put it in with this class. So it's a separate drug in a sub class too. That was the thinking on that. And it does apparently have new indications, so it's still... it's not really an 5HT3. You're not denying that though, right? You're not denying Aprepitant for anything?

Siri Childs: No, it has the criteria is its FDA indications.

Vyn Reese: Right. Is anyone going to make a motion in this class or is there further discussion?

Barak Gaster: This is Barak Gaster. I would move to reinstate the previous recommendation for the new antiemetics class.

Vyn Reese: Is there a second?

Janet Kelly: Janet Kelly, I'll second it.

Vyn Reese: All those in favor say "I."

Group: I.

Vyn Reese: Those opposed same sign. Motion is passed. Let's move on to the next class, and that's Triptans.

Carol Cordy: This is Carol Cordy. Can I just ask for a point of clarification? When a new medication is added, and I don't know if Siri, you can answer this. When a new medication is added, is that automatically put on the Preferred Drug List?

Siri Childs: Okay, if it has not been studied by the Oregon Health Sciences or if it has not been reviewed by you at the P&T committee, it is part of the drug class, but it automatically assumes a non-preferred status and it is not subject to tip or DAW. So they must try and fail a preferred drug or... in some cases in two of our drug classes we have refill protection and so if they have been tried on a sample for antidepressant or an atypical, we will allow it as a continuation of therapy in two of the...

[side A ends]

Vyn Reese: Are we ready with the triptan scan?

Kim Peterson: Just let me know when you have the slides up.

Vyn Reese: We're getting there. Here we are.

Kim Peterson: Okay.

Woman: We're ready to go now.

Kim Peterson: Ready? Okay. So now we're on to the most recent Horizon scan for new research on triptans, and that scan was completed earlier this year in March.

Next slide. A little history again. We completed our third update of triptans back in November of 2005 and since then we conducted one Horizon scan for new research back in March of 2007, at which time the participating organizations elected against pursuing a full update, so we then conducted a second Horizon scan again this March.

Next slide. So for our MEDLINE search we went back to January of 2007, which was near the time of our first Horizon scan, and then we also searched FDA and Health Canada websites for identification of new drugs, indications, and safety alerts.

Next slide. So in this scan we identified 38 potentially relevant citations and then of those we identified seven that appeared to meet all of our eligibility criteria for population intervention, outcome, and study design. And then taken together with the 18 new trials identified in the first scan, there is now a total of 25 new trials that have emerged since our last full update that could be added in a subsequent full update. In terms of the nature of the new evidence, we still haven't found any new trials of eletriptan compared with unencapsulated sumatriptan, which is one of the main controversies from the previous research if you recall, but I would point out that two, and this is detailed in the scan report, two of the new head to head trials identified in this most recent search involved comparisons with almotriptan, which has historically been one of the two triptans with the lowest strength of evidence on how it compares directly to any other triptans. So that's a gap that this new evidence could potentially fill.

Next slide. As for the results of our FDA and Health Canada website searches, we found information about the release of some new forms of

sumatriptan, both as an injectable and then as a component included in a new six dose combination product with Naproxen.

Next slide. However, we didn't find any information about new indications or new serious or life threatening side effects for any triptans. So in conclusion, based on the collective information from the previous and more recent Horizon scans, the DERP participating organizations voted in favor of a full update of this review and we will be looking at the first draft of the key questions in a couple of weeks, and if all goes according to the schedule, the final report for this fourth update will be completed in May of 2009. So I'll turn it back to you for questions.

Vyn Reese: Any questions from the committee?

Patti Varley: This is Patti Varley. In your review was there any data collected about the association of increased risk for serotonin syndrome with people taking these along with SSRIs?

Kim Peterson: Well at this point we haven't started reviewing the details of the new evidence. So I'm not sure yet whether we'll have new evidence in that area for this fourth update.

Vyn Reese: Any other questions? Is there a motion to accept the scan as an adequate review of the triptan class?

Alvin Goo: This is Alvin. I move to accept the scan as an adequate review of the triptan class.

Vyn Reese: Is there a second?

Barak Gaster: I second that motion, Barak Gaster.

Vyn Reese: All those in favor say "I."

Group: I.

Vyn Reese: Those opposed same sign. The motion is passed.

Jeff Graham: Vyn I have a question, this is Jeff Graham, I have a question of Kim. I believe that the participating organizations have asked that the combination drug be included in this update. Is that correct Kim?

Kim Peterson: That is correct, yes.

Jeff Graham: Because in a lot of the classes we haven't done combinations, but this one will include it.

Vyn Reese: It's in the appendix...

Kim Peterson: Yea, that's correct, but I think they, the feedback was that this is going to be an interchangeable product, that it would be relevant to have evidenced reviewed for this product in this class. I think we are going to include it this time around.

Vyn Reese: There is stakeholder input in this class. First it's Dr. William Schmidt from Glaxo Smith Kline. And remember, comments are three minutes.

William Schmidt: Good morning everyone. My name is Dr. Bill Schmidt. I am a medical scientist with Glaxo Smith Kline and I want to take the next couple of minutes to talk to you briefly about Imitrex, which is the most studied migraine medication world wide and it has been used to treat over 800 million migraine attacks since it was introduced back in the 1990s. It is widely used in the Medicaid market. Imitrex is the only triptan improved for use as an injection and also for the acute treatment of cluster headaches. It's acknowledge that Imitrex offers unsurpassed pain free efficacy, the fastest onset tablet commercially available, and it's the only triptan available in three formulations: injection, nasal spray, as well as tablets.

I'd actually like to make two points regarding the OHSU triptan report from back in 2005. Firstly, the report provided an excellent comparison of triptan studies using internal and external [inaudible] criteria. However, on page 28 of that report table 13 concluded that rizatriptan 10 mg was superior to sumatriptan 100 mg for various outcome measures. The conclusion actually was based upon only one study that included non-responders to Imitrex, while excluding patients with prior exposure to rizatriptan, thereby introducing study bias in favor of rizatriptan.

Four other head to head studies excluded from the report have failed to confirm the superiority of rizatriptan over Imitrex, and since other important outcomes such as 24 hour sustained relief were not examined in the one study reviewed, the report did conclude that evidence was insufficient to judge the advantages and disadvantages of rizatriptan over Imitrex and secondly, in that report... I'm sorry, in the OHSU scan report from 2007 last year, on page eight data from the Asset trial was included, which found Excedrin superior to Imitrex 50 mg. However, it's important to note that the patients who vomited more than 20% of their attacks or required bed rest for greater than 50% of the time were excluded from this study, introducing potential bias. With the exception of patients with severe head pain at the time of treatment, most had no migraine associated symptoms with their attack, and may well have been treating tension type headaches, which would help explain the lack of response to Imitrex.

In addition, it's important to remember that acetaminophen containing compounds are the second highest cause of medication overuse headache, according to the report by Begal, et. al in 2004. Now the most recent OHSU triptan scan report, which was just mentioned in the slide review for March of this year offers no new comparative data on Imitrex. However, the report does mention Trexima, the new sumatriptan Naproxen sodium combination with FDA approval expected late this year. Trexima however, has been approved as Treximet with approval on April 15th.

So, in consideration of the history and the efficacy and safety data presented in the OHSU report, we request that all formulations of Imitrex be maintained on the Washington State Medicaid formulary. Thank you, are there any questions?

Vyn Reese: Thank you. Any questions from the committee?

William Schmidt: Thank you.

Vyn Reese: Thank you. Next speaker is Scott Johnson, from Merck.

Scott Johnson: Good morning. I'm Scott Johnson, neuroscience health science advisor with Merck. I'm here to ask you to consider adding Maxalt and Maxalt MLT to your PDL. I have five points that I'll touch on. First, proven efficacy. In pivotal clinical trials, a single dose of Maxalt provided 67-77% of patients with pain relief at two hours. In early treatment trials, when migraine pain is still mild, 57-59% of patients were pain free with only a single dose of Maxalt. In the acute treatment of menstrual migraine, 70-73% of patients taking Maxalt achieved pain relief at two hours, and 82-90% achieved pain relief at four hours.

Second formulation. Maxalt is available in two formulations, the MLT or tablet in either five or ten mg dose. The MLT dissolves on your tongue within seconds and can be taken without water, which does allow flexibility for the 90+% of patients who experience nausea with migraine. Third, patient preference. In a randomized cross-over study, significantly more patients preferred Maxalt MLT to Relpax tablets. The major reason given was faster pain relief. Cost effectiveness. In the 2002 study, 85% of patients who took Maxalt only needed one tablet per attack. This was based on information on 149 migraine attacks. Finally, proven relief. Since 1998 more than 14 million prescriptions for Maxalt have been written in the United States.

In summary, I ask that you do consider adding Maxalt and Maxalt MLT to the PDL. Thank you for your attention. Are there any questions?

Vyn Reese: Questions? Thank you.

Scott Johnson: Thank you.

Vyn Reese: The next stakeholder is Anne Speiser from Endo Pharmaceuticals.

Anne Speiser: Thank you. I'm Dr. Anne Speiser, I'm a clinical affairs manager with Endo. I wanted to say how pleased I am that we will be reviewing this drug class as we move forward. I want to take the opportunity to tell you about a piece of data that hasn't actually shown up in this review yet, it was just presented late last year as poster form and will be hopefully published in time to get included in this review, but we will be providing the data. It's a head to head trial with sumatriptan, hence the interest. Additionally, I want to make the case that individual patient response does vary significantly within the triptan class, and while the OHSU does very strongly illustrate that there is little in the literature to distinguish the seven drugs, it's not uncommon in a clinical setting for patients to be switched from one triptan for another for either reasons of efficacy or tolerability.

It's therefore important that multiple choices be available to patients and physicians. So in this head to head study, Frova was studied in a randomized, placebo controlled parallel group phase three B study, using the usual doses of both Frova and sumatriptan and compared to placebo. In this study, both of course Frova and sumatriptan were better than placebo. Interestingly, at the two and four hour time points, sumatriptan actually had demonstrated superiority in terms of responder rate to Frovatriptan, although interestingly, patients were no more likely to take rescue medications in the Frova group, so regardless of the difference in efficacy, the rescue medications did not differ. However, at all the other time points, six through 24 hours there was no difference between the drugs. Although at 24 hours, Frova was numerically superior to sumatriptan and placebo, which were equivalent to one another.

On the tolerability side however, frovatriptan was superior to sumatriptan in all cases. There was a 50-80% increase in the number of adverse events per patient in the sumatriptan group compared to the frovatriptan group, and when looking at incidents of symptoms associated with migraine pain such as nausea, vomiting, allodynia, these were all superior in the Frova group. As the triptan class matures, it's going to be important for providers to have an option to switch, especially as we move toward generics within the class. It's reasonable to conclude that patients who switch from sumatriptan do so for reasons of tolerability and efficacy. Head to head trials such as this with Frova demonstrate that Frova is effective and it has a favorable safety and efficacy... I'm sorry, safety and efficacy profile in

our post-marketing experience, and it's a sound option as an inclusion in this class. Any questions? Thank you.

Vyn Reese: Thank you. Discussion? I just had a comment, one is that I'm not a big fan of combination drugs, combining a triptan with another drug, like Naproxen. I think it takes away from dosing flexibility. They're both effective drugs, as the study that was presented show, but you get Naproxen for a penny a piece at Costco, you can add it on if you need to. But it doesn't make sense to me to combine it so you can get a really big dose of Naproxen if they have to repeat the triptan. And it takes away dosing flexibility. I don't know what others think about that. That's one concern I had for that combination product. It looks like the data is pretty much the same for the triptans, we have a little bit of [inaudible], but not much.

Woman: Dr. Reese could you please speak in to your microphone for the recording purposes?

Vyn Reese: Okay, I'll get closer. Did you catch anything I said? Do you want me to repeat that? I'm not a big fan of combination drugs in general, and in this case it's a combination of a triptan and Naproxen. And if you have to repeat the dose of the triptan then you've got to take extra Naproxen, which is not... that would be a very large dose of Naproxen. It takes away dosing flexibility and Naproxen is very cheap and easily accessible and people can take it as an add on if they need to. They see fit to do that and then repeat the triptan too. So that's my concern about that combination product. That's about the only new drug that was presented.

Barak Gaster: This is Barak Gaster. I would also second a lot of caution about use of combination drugs like this. I think it's going to create a lot of confusion among providers and among patients as to... they're going to have a single brand name for a combination and I think both providers and patients will be confused as to sort of what's in that drug, non-steroidals have serious adverse effects and potential for allergic reactions. So I think we're definitely never going to be in a place of being able to do therapeutic interchange for an agent like this. So I think we should just be cautious about adding a combination drug to this class because of both potential for provider confusion, patient confusion, and danger in therapeutic interchange.

Jeff Graham: This is Jeff Graham. I want to say too that we probably wouldn't even consider that until we look at the update next year, so we'll have to remember this discussion at that time too.

Vyn Reese: Any other comments on the drug class? So can I get a motion on the triptan class?

Jason Iltz: This is Jason. I'll go ahead and, if there's no more discussion, put a motion forward. I think based on the comments and what we see at least printed in front of us today there's really not a lot of new evidence so I think our original motion really from August 16th of '06 that we then brought forward again on June 20th of 2007 would make sense, so I move to put forward the motion that was previously moved on August 16th of 2006 and then reinstated on June 20th, 2007.

Vyn Reese: Is there a second?

Patti Varley: Patti Varley, I'll second.

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

Group: I.

Vyn Reese: Opposed same sign. Motion is approved. We now move to the calcium channel blockers. Okay we're ready, we have the slides up on the calcium channel blockers.

Kim Peterson: Okay. So now the findings from our December, 2007 Horizon scan for new research on calcium channel blockers. Let's go on to the next slide. So for a little history, we completed the second full update of this review back in March of 2005 and since then we've conducted two Horizon scans for new research, the first was in March of 2006, at which time the DERP participating organizations did not elect to pursue a full update of this class, so we conducted a second Horizon scan more recently in December of 2007.

Next slide. So for the methods of the December 2007 scan. We used the same searching methods as described in the previous scans. And for MEDLINE we went back to December of 2006. That's close to the time of the first Horizon scan.

Next slide. For the results of the December 2007 scan, our MEDLINE search resulted in the identification of 84 new citations in total. Of those however, we identified only three that appeared to meet all of our eligibility criteria for population intervention, outcome, and study design. And actually among those, two were only secondary analyses of previously included trials, those being Vest(?) and Action. Which was also the case, so going back to the findings from the first Horizon scan, it was also the case where the majority of the 24 potentially relevant citations found then were just, appeared to be companion publications to studies that we had already included. So taken together with the 24 publications identified in the first preliminary update scan, as of December 2007, there

were a total of at least 27 new publications that could be added in a full update, but again most of them seemed to pertain to previously included studies.

Next slide. Now for results from our FDA and Health Canada website searches. In those searches we found no new information about any new calcium channel blockers or any new indications for any included calcium channel blockers.

Next slide. However, we did find some new safety information on some calcium channel blockers, which is all detailed in the next four slides and all of which only pertains to new information added to the precautions section for the product labels of the different calcium channel blockers, so no new serious or life threatening adverse effect information that warranted a black box warning or other urgent action by the FDA.

On to the next slide. So for the long acting form of diltiazam there was some new information added to the product label about potential for interaction with buspirone and quinidine.

Next slide. That same information about drug interactions was also added to the product label for the extended release form of diltiazam, so there's a long acting form and then an extended release form and both labels received the addition of this new information about drug interactions.

Next slide. There was also some information about side effects of hypotension, bradiarrhythmias, and lactic acidosis added to the label for extended release Verapamil.

Next slide. And then finally, there was some new information added to the nicardopine product label about how there is still some uncertainty about any differences in responsiveness between the elderly and younger patients. So still a gap in evidence about how elderly patients respond to nicardopine, but again none of the safety information was deemed to be serious enough by the FDA to warrant a black box warning or any other special urgent handling.

So in conclusion, based on the information about new research found across both Horizon scans as well as this new safety information, the DERP participating organizations did not elect to pursue a full update of this review as of December, 2007. But we will revisit this decision in January of 2009, at the time of the next Horizon scan for this drug class. So I'll turn it back to you for questions.

Vyn Reese:

Any questions from the committee? Take a motion to accept the scan as an adequate review of the calcium channel blocker class.

Barak Gaster: Barak Gaster. I second that.

Vyn Reese: Now we need a second.

Barak Gaster: Barak Gaster. I motion that this should be accepted.

Carol Cordy: This is Carol Cordy. I'll second it.

Vyn Reese: Alright, now we've got a motion. All those in favor say "I."

Group: I.

Vyn Reese: Those opposed, same sign. The motion is passed. Any other discussion about calcium channel blockers? Doesn't look like we have a lot of new evidence.

Jeff Graham: Vyn, are there any stakeholders?

Vyn Reese: There is no stakeholders.

Jeff Graham: Okay.

Vyn Reese: Alvin, I think you made the motion last time.

Alvin Goo: Well, this is Alvin. I move that we again put forward the motion from the previous scan of June 20th, 2007.

Vyn Reese: Is there a second?

Jason Iltz: This is Jason, I'll second.

Vyn Reese: All those in favor say "I."

Group: I.

Vyn Reese: Those opposed same sign. The motion is passed.

Jeff Graham: Dr. Reese, this is Jeff Graham again. I think we could probably take a 15 minute break now in that we're moving right along and should be able to handle all of the three remainder in the time we have left.

Vyn Reese: Okay, so we'll be back here about 10:15.

Jeff Graham: And Kim, you're free to go during that time if you'd like and call back in.

Kim Peterson: Call back at what time?

Jeff Graham: 10:15.

Kim Peterson: 15, okay, thanks.

Jeff Graham: Thank you.

Kim Peterson: Bye bye.

Jeff Graham: Kim are you on the line?

KIM PETERSON: Yes I am.

Jeff Graham: Great. Our slide is up.

Kim Peterson: Okay, great. On to the results of our November, 2007 preliminary update scan for new research on newer drugs for insomnia.

Next slide. Here's the history slide. We completed our first update of this, our first full update of this review in July of 2006 and since that time we've conducted two preliminary update scans for new research. The first was in November of 2006, and the second one which we're going over today was conducted in November of 2007.

Next slide. So we used the standard scanning methods that I described previously and for this scan our MEDLINE searches spanned the time since our last scan in October 2006 and then went through October of 2007.

Next slide, results. Now the MEDLINE searches resulted in 18 new citations and after reviewing all eight citations based on the eligibility criteria from update number one, the number of potentially relevant new trials was narrowed down to just five. One was a head to head comparison of Zolpidem and Zaleplon in patients with sleep maintenance insomnia conducted in a sleep lab. One was a placebo controlled trial of ramelteon in older adults with insomnia that we had previously known about from an available abstract. So now it appears to have been full published. And then the other three were placebo controlled trials of Eszopiclone. One involved only women, another examined the effect of discontinuing Eszopiclone after co administration with Fluoxetine in patients with depression and insomnia, and then the third evaluated the effects of six months of treatment with Eszopiclone on quality of life and work limitations.

Next slide. From our searches of the FDA and Health Canada websites we did not identify any new indications for any of the newer insomnia drugs, but we did learn that in April of 2007, the FDA approved the first generic version of the immediate release form of Zolpidem.

Next slide. As for new safety information, the main focus was on the new warnings for all newer insomnia drugs about severe allergic reactions and complex sleep related behaviors in patients using these drugs. Apparently the FDA notified health care professionals of its request that all manufacturers of the newer insomnia drugs one strengthen the product labeling to include stronger language concerning these potential risks, two that they send letters about the risks to health care providers, and then three that they develop patient medication guides to caution consumers about these risks.

Next slide. And then this slide just lists out all of the drugs that the new warnings pertain to and you can see that all the drugs included in the DERP review are involved in this.

Next slide. Otherwise, the only other new information, new safety information pertains only to the product label of Zolpidem, in which they added information about uncertainties around its use in the pediatric population.

So in summary, based on the new studies and safety information identified in this scan, the DERP participating organizations voted in favor of a full update of this review, which is in progress now, and the due date for the final report for this full update is only a few months away. It will be completed this October of 2008. So now I'll turn it back to you for questions.

Vyn Reese: Thank you. Are there any questions from the committee? Take a motion to move that the scan is an adequate update on the newer sedative hypnotics.

Janet Kelly: Janet Kelly. I move that we accept the scan as an adequate update.

Vyn Reese: And a second.

Patti Varley: This is Patti Varley. I just wanted to clarify on the new data about the hallucinations in kids, is there any evidence of it being associated with the use of any of the other agents or was it just reported in that one?

Siri Childs: I would ask you to, well, this question will be addressed in the report, the update of this report that is currently in progress, which is being lead by Susan Carson and I will bring this question back to her as being of interest

for her to address in her report. But at this time, I really can't comment on that because the report is not yet complete.

Patti Varley: And part of the reason is that, am I looking at it correctly that right now that is the only one on the PDL? So, as a pediatric person has concerns that if that one has safety issues directly related to pediatrics.

Siri Childs: So your question is in related to the new safety information about on [inaudible]?

Patti Varley: Correct. It is unique to that agent or is there evidence that any agent in this class would also have the same risk or not because then it makes it an issue that if somebody is going to use a medication in the class and that's the only one approved on the PDL and it has that safety risk, that's a concern within the pediatric population. Not that I think they should use that often in the pediatric population.

Siri Childs: You know that one of the main points that warning though is just the uncertainty more about the uncertainty of the effects of that drug in this population. So it has just been less well studied in pediatrics. So that was my interpretation of another point that was made by the additional of that information to the product label.

Vyn Reese: Is there any evidence that any of the other drugs are any safer than Zolpidem or not?

Siri Childs: Well, I will go ahead and go to the report. You know, I do want to clarify that for the purpose of the DERP reviews, we don't necessarily consider this information of product labels to be evidence. We focus on fully published studies and so not being totally familiar with the report, I don't know off the top of my head without looking at the report whether the study that is referred to in this information is fully published but I can have a look at the report real quick to see if I can find that.

Jason Iltz: While that is being looked at a have one quick question for Siri related to this so this particular petty concern is pretty narrow as you mentioned so my question to Siri, and maybe you might not know off the top of your head but how many six to seventeen year olds are we filling this type of prescription for and since it is already part of an EPA process, could we add that as an edit in terms of the age and would that take care of this issue?

Siri Childs: This is Siri Childs. Actually when we brought to this Board our ADHD recommendations for age dose and combinations, we actually brought to you a proposed policy for sedative use in children and at that point in time, you approved the policy that we would not approve sleepers in children

unless there was a specific, you know, extenuating circumstance and then we would approve 5 doses is like a lifetime, until they got to age 18. So, we don't have use in our children now that we have adopted that policy.

Vyn Reese: So, it is not a problem?

Siri Childs: Uh uh.

Vyn Reese: I think the fear was that children were going to get sleepers because their ADHD drugs were keeping them awake...

Siri Childs: Exactly.

Vyn Reese: ...and then they will hallucinate from the sleepers. So it's like, you are treating a problem from another drug with another drug it causes its own set of problems.

Siri Childs: Exactly. That's why we brought that to you with the ADHD, you know, limitations and that's what you all told us to do so, thank you very much.

Patti Varley: So, this is Patti Varley again and as I said it would not be a practice I would use but my concern was that if someone had a different opinion clinically would that put patients more at risk? So if they are not doing that at all, that makes me a happy camper.

Vyn Reese: So it doesn't any evidence. I guess she is still looking and the others are really safer than Zolpidem so I...

Siri Childs: ...of the most recent full report. It actually confirms that at the time of that full report, we actually had no evidence in using any of these drugs in the pediatric population. So, I was looking through the abstracts from this preliminary update scan from November 2007 and I am also not seeing any studies in pediatric patients there either. So, as for this new information added to the product label, it seem that we don't have, that that study, perhaps, hasn't been fully published but in answer to your original question, it does appear that it is specific to Zolpidem but that that doesn't preclude it being, you know, I would say the same issue is there for the other drugs is that without evidence there is uncertainty about using it in children.

Vyn Reese: It sounds like our current policy is what we should keep doing.

Siri Childs: Thank you.

Patti Varley: Yeah.

Vyn Reese: And I made this motion previously and I will move that we put forward the previous motion of June 20th 2007 in regard to the newer sedative hypnotics.

Carol Cordy: This is Carol Cordy. I will second that.

Vyn Reese: All in favor say "I".

Group: I

Vyn Reese: Those opposed same sign. Motion is approved. Now move on to the ACE inhibitors. Kay, the slides are up and ready to go.

Kim Peterson: Okay, so now I will go over the results of our February 2008 preliminary update scan for new research for ACE inhibitors.

Next slide. So, the final report for the last full update of this review was completed in June of 2005 and since that time, we have completed two preliminary update scans for new research on ACE inhibitors. The first was in February of 2007, at which time the DURT participating organizations did not elect to pursue a full update and so we conducted a second preliminary update scan in February of this year.

Next slide. For our February 2008 scan for new research on ACE inhibitors, we used the standard search methods with our med line searches in this case extending back to the time of the first scan which was February of 2007.

Next slide. The results of our med line searches are listed in the slide. Overall, we found 149 new citations but among those over 13 appeared to meet all of our eligibility criteria based on information in the abstract about the population intervention, outcomes and designs. And then additionally, as I said, since the DURT participating organizations didn't elect to fully update this review following the first horizon scan, there is still the 23 new potentially relevant citations from that scan pending full review as well. So today there is a total of at least 36 new potentially relevant publications of ACE inhibitors available to be reviewed in the next full update of this drug class.

Next slide. So, in addition to the med line searches, we also searched the FDA and Health Canada websites and a portion of those results are listed in this slide. We did not find any information about any new ACE inhibitors or any new indications for the ACE inhibitors. But we did learn

that there is a new tablet form of Ramipril available so that's in addition to the previously available capsule form.

Next slide. As for new safety alerts for lisinopril, we found new information about changes to the precautions section of the product label regarding the risks of exposure to it during pregnancy.

Next slide. More importantly though was that in February of 2007, the FDA required that the manufacturer of benazepril would need to actually add a boxed warning to the product label for the drug to especially highlight, in this case, the several dozen cases of fetal and neonatal morbidity and death that have been reported internationally in women using this ACE inhibitor during pregnancy.

Next Slide. And finally, we also found new information that in October of 2007, some new information was also added to the product label of Enalapril regarding the risk of intestinal angioedema in some patients and then about a small number of cases of birth defects in infants whose mothers had taken Enalapril during the first trimester of pregnancy. So, in conclusion, considering all the new potentially relevant studies that have emerged since the last full update, as well as the new safety information. The DUR participating organization still did not elect to pursue a full update of this class of drugs at this time. But again, we will revisit this need to update this review at the time of the next preliminary update scan which is scheduled for March of 2009. So I will turn it back to you for questions.

Vyn Reese: Any questions from the committee?

Jason Iltz: Kim, this is Jason, committee member. Do you have any, I am trying to remember back to incidents of angioedema, in general, for these particular medications. My thought is that this is really a class affect and that one didn't stand out but with the other new warning of specific to intestinal angioedema, I guess it brings the question so do you have sort of relative incidents of angioedema, in general with this class.

Kim Peterson: Well, I am going to pull the report up real quick to just confirm this but it's my recollection that we don't have any head to head trials in this class so that we don't have that information from direct comparisons. It would just be in placebo controlled studies or actually more likely in studies that are comparing ACE inhibitors to other types of medications in these populations.

Vyn Reese: As I recall, it is a class affect. I mean, it is not safe to give them another ACE inhibitor if they have already had angioedema, which is potentially a fatal complication with another one. Any other questions? I will take a motion to approve the scan.

Janet Kelly: I move that we approve the scan.

Barak Gaster: I second that.

Vyn Reese: All those in favor say "I".

Group: I

Vyn Reese: Those opposed same sign. Motion is approved. There are no stake holders who wish to comment on ACE inhibitors so let's discuss the motion.

Kim Peterson: Yeah, just to come back to this looking at the report and it is true that we felt there wasn't enough data to make conclusions about whether they differ from one another in adverse affects because there is no head to head trial so, just to close the loop on that question.

Vyn Reese: Thank you, Kim. Actually, I made the previous motion to so I move to make the previous motion of June 20th, 2007 regarding ACE inhibitors.

Jason: I'll second.

Vyn Reese: All those in favor say "I"

Group: I

Vyn Reese: Those opposed same sign. Motion's approved. We now move to the anti platelet drugs. Okay, the slides are up.

Kim Peterson: Okay, for the newer anti platelet agents. So now we have come to the last scan. The preliminary update scan we completed in March of 2008 for the newer anti platelet agents.

Next slide. So our review, the DUR review of the newer anti platelet agents has only been fully updated once and we completed the final report for that update back in April of 2007. So actually in March of 2008 was the first time we've done any preliminary update scan for new research for this group of drugs.

Next slide. So for this preliminary update scan, we use the same methods as in all the others. In this case, with our med line search going from May

Of 2006, which was the cutoff date from the last full update, through March of 2008, it is kind of a larger time period.

Next slide. And here is the results of the med line search. Overall, we found 94 new citations related to the newer anti platelet agents. Among those though, only 10 appeared to be trials that would meet all of our eligibility criteria for intervention, population, outcome and study design. And those are listed in the slide there. Of those 10 though, I want to mention that 6 of them actually appear to be secondary publications to trials that have already been included previously such as charisma, credo, esprit and so on. So that really just leaves 4 new trials of a newer anti platelet agent compared to placebo as monotherapy or a newer anti platelet agent added to either aspirin or acetaclyic acid compared to using those drugs alone.

Next slide. So, now for the results of our FDA and Health Canada website searches. We found no information about the release of any new anti platelet agents since May of 2006, but we did find some new information about a new indication for Clopidogrel in August of 2006. The FDA granted approval for use of Clopidogrel in patients with ST (inaudible) elevation acute myocardial infarction and that was based on evidence they had that Clopidogrel has been shown to reduce the rate of death from any cause and the rate of a combined in point of death reinfarction or stroke in these patients. So, a new indication for Clopidogrel.

Next slide. As for new safety alerts, we found information about several product label changes since the last review and these are detailed in the remainder of the slides but none were apparently deemed severe enough to warrant any request by the FDA for addition of a box warning or other special urgent actions. So I will just quickly go over the label changes that occurred. First in August of 2006, there was new information added to the warnings, precautions and adverse reaction section of the product label for Clopidogrel about some rare reports of thrombotic thrombocytopenic purpura TTP.

Next slide. Also in August of 2006, there was information added to Clopidogrel's product label in the precaution section about the potential for drug interaction risks thrombolytic and oral anticoagulants and then also some additional potential adverse reactions were added to the adverse reactions section. Those are listed there.

Next slide. Next are the details on some new adverse reactions added to the product label for Aggrenox. So, information about headache and skin reactions were added to the list of potential side affects for the product label of Aggrenox.

Next slide. So then on this slide are the details about another change the product label for Clopidogrel regarding the risk of TTP that was brought up in August of 2006 and from what I could find, the change at this time was that they actually removed a sentence from the previous wording in the product label that TTP was not seen during Clopidogrel's clinical trials but only in world wide post marketing experience. So that wording was removed from the product label.

Next slide. And then on this last slide are details about some more language added to the precaution section of the product label. Also in May of 2007 recommending that patients be sure to inform their doctors that they are taking Clopidogrel before they undergo any surgeries or start any medications. Some of the new safety information changes that occurred to the product labels since our last full update of this review. So then the DUR participating organizations took all that new information about new trials and new indications and safety alerts and considered whether the new information warranted a full update of this topic and ultimately they decided it did not and elected not to pursue a full update at this time. So the next steps on this review that DUR will conduct another preliminary update scan in April of 2009 a ways away and at that time, the participating organizations will reconsider the need for a full update. So I will turn it back to you for questions.

Vyn Reese: Any questions from committee members? I will take a motion to approve the scan.

Carol Cordy: This is Carol Cordy. I move to approve the scan.

Vyn Reese: A second?

Patti Varley: Patti Varley, I'll second it.

Vyn Reese: All those in favor say "I"

Group: I

Vyn Reese: Those opposed same sign. Motion's approved. There are two stakeholders who want to talk about the antiplatelet drugs. The first is Laura Zanyoni of Bristol Myers Squibb.

Laura Zanyoni: Hello, my name is Laura Zanyoni with Bristol Myers Squibb field medical and I thank you for the opportunity to comment today. And I think you are all aware that Plavix does have approved indication for reduction of ischemic events in patients with recent ischemic stroke. It's sort of always

been thought of a little bit less because it comes from a sub group analysis from the Capri trial since our original approval and any comparisons were always in direct comparisons made to Aggrenox, the other agent that is approved for reduction of secondary stroke because the trials were never head to head and it was always indirect and the comparator dose of aspirin was different and the inclusion criteria were different and we were lucky, very lucky that there was a trial presented, a very large stroke trial presented at the European Stroke Conference last month called the Profess Trial and it was a head to head trial comparing the fixed dose formulation of extended release Dipyridamole plus aspirin known as Aggrenox given twice a day compared to Plavix 75 mg. given once a day in patients with a history of recent ischemic stroke. They qualified within 90 days of their ischemic stroke or 90 to 120 days if they also had additional risk factors conferring an additional risk. They were followed for an average of 2 ½ years and the patients, there was more than 20,300 patients, so this was the largest stroke trial to date and also one of the largest antiplatelet trials to date. The primary efficacy end point was recurrent stroke of any type, hemorrhagic, ischemic or undetermined origin. Secondary efficacy end point was stroke, and myovascular death and then there were additional safety end points and tolerability end points that were evaluated as well. The primary efficacy end point of recurrent stroke of any type occurred in relatively similar numbers in the two treatment groups: 9.0% in the Aggrenox group and 8.8% in the Plavix group. Note: very similar. And the secondary end point of stroke and myovascular death also occurred in almost the same percentage of patients in both the Plavix group and the Aggrenox group. However, there were differences when looking at the safety end points of major hemorrhagic events and intracranial hemorrhage. There was a trend towards a significant increase that did not reach statistical significance in major hemorrhagic events. These occurred in 4.1% of the Aggrenox group versus 3.6% in the group receiving Plavix. This was a p-value of .057, so again just barely did not reach statistical significance. However, there was a statistically higher incidence of intracranial hemorrhage reported in the group of patients receiving Aggrenox compared to those receiving Plavix 1.4% versus 1.0% in the group receiving Plavix. Additional adverse events that were reported higher incidents in the group receiving Aggrenox included permanent discontinuation of study medication due to headache as well as migraines. Although the primary efficacy end point of recurrent stroke occurred in a relatively similar number of patients in each group the trial failed to reach its primary statistical end point which was to establish non-inferiority of Aggrenox compared to Plavix because the confidence interval (inaudible) stand beyond the margin of non-inferiority that was established prior to entering the trial.

Vyn Reese:

We need to wrap it up pretty quickly here.

Laura Zanyoni: That's it.

Vyn Reese: Thank you very much. Good timing. Any questions?

Laura Zanyoni: Any questions? Thank you for your attention.

Vyn Reese: Thank you. The next person is John Beady from Boehringer Ingelheim.

John Beady: I can say that, Boehringer Ingelheim. I am John Beady, I'm from the medical affairs office there. Thanks very much this morning to allow me to speak. A stroke is the 30 leading cause of death in the United States and the leading cause of disability. Aggrenox, one capsule, b.i.d., is indicated for the reduction of risk of recurrent strokes in patients who had a non-cardio embolic stroke or TIA. Aggrenox is a novel formulation, contains 25 mg. of aspirin and 200 mg. of Dipyridamole pellets. Each Dipyridamole pellet has an extended release coating and a core of tartaric acid for increased absorption. In individuals with low gastric acid the extended release Dipyridamole in Aggrenox provides 50% higher bio availability than immediate release Dipyridamole also called Persantine. For that reason, Aggrenox is not interchangeable with the individual components of aspirin and Persantine. It inhibits thrombosis through the combined actions of two components of its two components which are aspirin and Dipyridamole. Aggrenox has been shown to be twice as effective for secondary stroke reduction as low dose aspirin alone. In the SPS 2 trial, Aggrenox showed a significant 22% relative risk reduction for stroke p-value of .008 compared to low dose aspirin. There is an increased risk of headache with Dipyridamole compared to placebo. Studies with extended release Dipyridamole show that headache is generally mild and transient. Headache was the most common side effect of Aggrenox in ESPS 2 study. Aggrenox should be avoided in the third trimester of pregnancy owing to its aspirin content. It contains aspirin, as I mentioned. Patients who consumed three or more alcoholic drinks every day should be counseled about the bleeding risks involved with chronic heavy alcohol use while taking aspirin. In the SPS 2, Aggrenox had similar bleeding rates to low dose aspirin in ESPS 2 the incidence of intracranial hemorrhage was 0.6%. That's 9 patients out of 6,602 total subjects in the Aggrenox group. 0.5% six patients in the extended release Dipyridamole group, 0.4% or 6 patients in the aspirin group and 0.4%, seven patients in the placebo group. Extended release Dipyridamole and aspirin is recommended as a first line therapy option for prevention of non-cardio embolic cerebral ischemic events in the ASA 2008 stroke guidelines update. I'll take any questions you have. Thanks very much.

Vyn Reese: Thank you. Any comments from Kim about that recent study issue, you probably haven't reviewed it yet. The big...

Kim Peterson: I am searching Medline right now to find information about the (inaudible) trial.

Vyn Reese: Is that published?

Kim Peterson: We didn't seem to find it in our....

Vyn Reese: It is not published so you can't review it. So that's something we can't just I mean that if you haven't had a chance to review it, we can't use that as evidence at this meeting, we will have to...

Vyn Reese: Any other questions regarding these drugs? Let's turn our attention to the anti-platelet motion from June 20th, 2007. That was the last time it was made. There's a new indication for Clopidogrel and so we have to include that in the motion. Since I made the motion I'll just go ahead and read it and add the new indication. After considering the evidence of safety, efficacy, and special populations for the treatment of acute coronary syndrome (ACS), will add ST segment elevation acute myocardial infarction, and percutaneous coronary intervention (PCI) I move that Clopidogrel is safe and efficacious. No single anti-platelet medication is associated with fewer adverse events in special populations. Clopidogrel cannot be subject to therapeutic interchange in the Washington Preferred Drug List for the treatments of ACS, ST segment elevation acute myocardial infarction, and PCI. That's the new motion. Take a second.

Barak Gaster: Barak Gaster, I'll second that.

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

Group: I.

Vyn Reese: Those opposed same sign. And Alvin I think you were the one who made the prior motion regarding Aggrenox.

Alvin Goo: Hi, this is Alvin. After reviewing the updated information on anti-platelets for the treatment of stroke and TIA or transient ischemic attack, our previous June, 2007 recommendations remains [inaudible].

Vyn Reese: Is there a second?

Jason Iltz: This is Jason, I'll second.

Vyn Reese: All those in favor say "I."

Group: I.

Vyn Reese: Those opposed same sign. The motion is passed. In the past we did not have Ticlopidine on the PDL because of safety concerns. I don't know if we need to make that motion again?

Siri Childs: It's the same... it would be the same as a non-preferred drug.

Vyn Reese: Right, so do we need to even...

Siri Childs: I don't think you need to do anything.

Vyn Reese: Okay, so that concludes our business this morning. Unless any other agenda items that you want to add Jeff.

Jeff Graham: Duane do we have any others? So we can adjourn until 12:30 for our presentation on long acting opioids. And Dr. Childs and I are available until then.

Vyn Reese: We're adjourned.

Vyn Reese: Class review on opioids for chronic, non-cancer pain.

Dr. Chou: Are we ready to go?

Vyn Reese: Yea, we're ready to go.

Dr. Chou: Okay, so I'll be presenting our drug class review on opioids for chronic non-cancer pain. This is, I think this is the very first DERP report actually, so we're up to update number five. I think that's the most updates on any of these reports as well. And then we have some of the folks who worked with me on this project. Susan, Carson, Mark, and Marion.

Next slide. So the key questions are unchanged. We have kind of our typical comparative effectiveness key question for evidence from head to head trials. We did look at indirect evidence from placebo controlled and active controlled trials. The one difference I think with this drug class review is we also looked at the class of long acting opioids versus short acting opioids, so that's a little different from other reviews. The comparative safety questions basically parallel the effectiveness questions. And then we looked at subgroups as in other reports.

Next slide. So the populations are also the same. We looked at adults, which we defined as over 18 years old. Chronic non-cancer pain we defined chronic as six months or longer in duration. We excluded cancer pain and HIV associated pain. None of these are changes.

Next slide. We didn't add any new drugs for this update. What we included were oral and transdermal, long acting opioids. We defined long acting as drugs taken three times per day or less frequently. So this is either drugs with a long half life like methadone and levorphenol or drugs with a short half life, but formulated for sustained release. So those are all the other drugs on that list. Hydromorphone, as you guys probably recall was briefly on the market, and then taken off of the market because it was found to change from a sustained release to an immediate release formulation, even if it was exposed to just a little bit of alcohol like the amount in cough syrup and whatnot. So that was taken off the market and as far as I'm aware is not on the market again. And then Oxymorphone is the newest drug that was approved in June, 2006.

Next slide. The outcomes are also the same. For effectiveness we looked at pain control and functional status. For harms or safety we looked at nausea, cognitive changes, constipation, and when possible we looked at things like addiction and abuse and death.

Next slide. So this shows the literature search results for update number five. We identified 1,500 citations, 1,400 were excluded on the abstract and citation level. Most of these are excluded because they are post-op pain and cancer pain and whatnot. There is no good way to filter those out. They're in your search without just going through the citations. We retrieved 37 articles, 25 more were excluded after we reviewed the full text and we ended up with ten new studies, three were head to head trials, six were placebo controlled, and there was one observational study.

Next slide. So this shows all the head to head trials. The new ones are the highlighted ones. So they're the first, the third, and the fourth rows there. And as you can see, two of those were rated fair quality, one was rated poor. The longest one was 24 weeks, the other two were pretty short studies, four and eight weeks in duration. We have two comparisons of Oxymorphone versus Oxycodone now, two of long acting morphine versus Oxycodone and then three of long acting morphine versus transdermal Fentanyl and then one that compared different, you know types of long acting morphine a once a day preparation versus a two times a day preparation.

Next slide. So the results of these trials were that essentially there is not enough evidence to identify one long acting opioid as being more effective than another. Six of the eight head to head trials found no differences. The two studies that did find differences were poor quality and open label studies. One of them compared transdermal Fentanyl, which it found to be superior to long acting morphine. Another one found long acting morphine superior to sustained release Oxycodone. The problem is that in addition to being poor quality open label studies, there's also better quality studies

that found no differences in these comparisons. So we don't put a lot of weight on these findings.

Next slide. There were six placebo controlled trials added for update number five. This summarizes the studies, the duration, and the sample sizes. Most of these were rated fair quality. There was one good quality study of Oxymorphone for osteoarthritis, but it was only two weeks. The bottom, below the table there shows the total number of placebo controlled trials for each drug. We now have three trials of Oxymorphone, they're all from this update. There are six trials of Oxycodone and then one of transdermal Fentanyl.

Next slide. We found that the placebo controlled and active controlled trials were too diverse to allow reliable and direct comparison. So indirect comparisons are basically you're comparing results to drugs that are looked at versus a common comparator, usually placebo. The problem is to do that, you have to have similarity of treatment effects across all of those studies. And we found that in addition to methodological shortcomings, there were different study designs, patient populations, the doses differed, the duration of the studies differed, and the outcomes also differed. One of the things that we tried to look at was withdrawal either due to lack of efficacy or overall withdrawal rates and again, this was more kind of consistently reported than other outcomes. But these rates also varied quite a bit and there was no clear patterns suggesting that one long acting opioid was any better than others. These conclusions are similar to previous reports on this class.

Next slide. So again, we also again looked at long acting drugs as a class versus short acting opioids. There were no new trials that we identified for this update, so from previous reports we're just repeating conclusions there. There were seven fair quality trials, insufficient evidence to identify either short acting or long acting drugs as superior. There were three relatively homogeneous trials comparing long and short acting Oxycodone and they looked to be similarly effective. Again, one of the issues is that all of the trials varied in study design, patient populations, etc. so there are some questions about heterogeneity.

Next slide. For comparative safety new evidence for this update. Transdermal Fentanyl there was a study showing a slight trend towards less constipation but more withdrawals due to adverse events compared to oral long acting morphine. This was a randomized trial. So I think that finding is kind of mixed. So even though there seems to be less constipation, something is making people withdraw more. So it's either a wash or you can even interpret that as being in favor of long acting morphine. There is an observational study of Oregon Medicaid patients. For disclosure I was one of the authors on this study. We found no

difference between Methadone, long acting Oxycodone, long acting morphine, and transdermal Fentanyl in rates of hospitalization, mortality, overdose symptoms, or constipation. There were more ED encounters with transdermal Fentanyl compared to sustained release morphine. The relative risk was 2.37. Now there are some issues with this study. Actually I think that's supposed to be 1.37, I'm sorry. I'll look and check on that. But if you look at the confidence intervals the 2.37 is not correct. So I'll check on that and make sure on that, but I'm pretty sure that's 1.37. So there are some issues with those observational study and that is that there are pretty big baseline differences between groups. So people that got for example transdermal Fentanyl tended to be quite a bit older than people that got like long acting Oxycodone or some of these other drugs. They also tended to have more comorbidities and those kinds of things. Even though you try to control for all of those issues, you're kind of limited in how much you can control for in these administrative database studies. So I think is largely hypothesis generating. The other issue is that all those outcomes are kind of surrogates for opioid adverse events. So for example hospitalizations can occur for a ton of reasons, not necessarily for opioid associated problems. So again, I think this is all kind of hypothesis generating. But it at least gives us some direct comparative data.

Next slide. In summary, for comparative safety, most of these trials were not designed to assess harms. They were really designed to measure efficacy, so there are some methodological issues in terms of how good, how they assess harms. The head to head trials didn't identify any clear differences among the long acting opioids for adverse events. And the placebo controlled trials were too clinically diverse and of insufficient quality to provide reliable indirect evidence. Again, these are similar to previous updates that were versions of this report.

Next slide. So the safety of long acting compared to short acting opioids there was no new evidence identified for update number five. Again, summarizing from the previous reports. There was no evidence of lower adverse event rates with long acting opioids compared to short acting opioids. No data comparing rates of addiction or abuse. The two kind of caveats to all of this stuff is that the trials compare round the clock long acting opioids versus round the clock short acting opioids, which may not be the real comparison that people are interested within in clinical practice where a lot of people on short acting opioids kind of take them on a p.r.n. basis. So that's one issue with the trials in terms of interpretability. The other issue is that these trials were not designed to look at rates of addiction or abuse and in fact they tried to get rid of patients who, or they excluded patients who they felt would be a higher risk for these adverse events. So we really have no good data on addiction or abuse.

Next slide. So this is our overall summary of the evidence for this update. We have poor to fair overall evidence for comparative efficacy and then poor evidence for the other key questions. There is no differences in the efficacy or adverse events that we could find from this body of evidence. We did add some new data for the comparisons of long acting morphine versus Oxycodone, Oxymorphone versus placebo, and transdermal Fentanyl versus placebo. I'd like to remind people that we still only have one trial of Methadone placebo controlled trial of Methadone for chronic non-cancer pain and it's not a very good trial. So we really have very little data on Methadone's use in this population. And we found overall that the new evidence really doesn't change our overall conclusions. So I think that's it.

Vyn Reese: Thank you. Are there any questions of Dr. Chou?

Alvin Goo: Hi, this is Alvin. In your view of the studies on the efficacy, the outcomes that were measured, were those mainly pain type survey scales or did anything look at return to work or return to functional goal or functionability?

Dr. Chou: Yea, so I think the question was did most of those studies look at pain or did they look at functional outcomes including return to work. And most of the studies do focus on pain. In the placebo controlled trials at least, in general you get about... if you transform things to a 1:10 scale you get maybe a one to two point, maybe a three point improvement in pain versus placebo with most of these drugs. The function stuff is a little bit less well defined and not as well studied. So some studies do look at functional outcomes. Some of them, like for the low back pain trials will look at something like the Oswestry's(?) index or the Roland index. Some will look at generic functional scales like the SF36 and I say that in general the functional results are not as impressive as the pain... I mean the pain results aren't all that impressive and the functional results are less impressive even though they tend to still have trends or mild results in favor of the opioid, at least versus placebo. Return to work has not been looked at very well. I can only think of a handful or maybe less of studies that actually looked at return to work, and in general it was hard to show that... it would be hard if you took this body of evidence to show that the opioids facilitate return to work. Part of that is this population is pretty disabled from other psychiatric comorbidities and things like that. Not all of them are employed to begin with and whatnot. Again, if you can't show real big improvements in function on some of these scales, you would expect not to find a big return to work thing either. But it hasn't been real well looked at. Unfortunately, most of the studies still seem to focus mostly on pain scales.

Alvin Goo: Thank you.

Vyn Reese: Any other questions?

Barak Gaster: This is Barak Gaster. I'm struck again by the very longest trial being 24 weeks for treatment of a chronic condition like this. I mean there's definitely stuff in review articles about potential adverse effects of long term chronic opiates. Do you know where that data comes from?

Dr. Chou: Yea, so there is one trial. So if you go back to that table that shows the head to head trials, there is one trial that's 13 months long. But you're right, almost everything else is very short. We do have one that's 24 weeks, but almost everything is six months or less or more like four weeks or less. The stuff on long term side effects of opioids, some of that comes from epidemiologic studies or kind of uncontrolled observational studies. And it can be pretty hard to interpret. I'll give you an example. So there's a lot of studies or a lot of people that talk about endocrinologic side effects associated with opioids. Most of that is based on cross sectional studies, so this is you just take a bunch of people who are on opioids and then you measure some endocrine level some tests and then you compare it to people with chronic pain or without chronic pain and see what their hormone levels are. And from those studies, the problem is you can't really tell causality really well. So it's quite possible that pain itself is causing the endocrine levels to change and it's not actually the opioid per se. Or there's other kind of confounders there. And there's no real good prospective studies that actually look at that. So people are talking now about adrenal suppression, and osteoporosis and sex hormone deficiencies. I think that requires a lot more study number one, and number two I'm not aware of any good data suggesting that one opioid is associated with more or less than the others. People have said that Levorphanol and Methadone might be a little bit different because they... they're partial I think an MDA antagonist also and so there's some... they may have different effects compared to the other opioids in terms of some of these effects, but people don't really know for sure and nobody has really done a rigorous study to look at that. The other stuff people are looking at nowadays are hyperalgesia, so this is kind of a paradoxical increased pain as you kind of go up to really high doses of opioids and again, if you restrict your focus to comparative data, we have none. So we don't know if one may be associated with more hyperalgesia than another. The other issue is that it's really unclear, it's very difficult to define hyperalgesia. I mean you can see it in rats and things like that. It's very hard to define what it exactly is in people, or if it's really a clinical issue. So I think that's another one that requires a lot more study. So I think those are the main things. The addiction abuse thing is always a concern and we know that from observational studies, but the numbers are all over the place and it's because the populations are different and people define abuse and addiction in different ways. There needs to be a lot more standardization. We just have no good way right now of telling whether one drug is better

than another for those kinds of outcomes. We've mentioned before, I didn't go in to depth on this, but the Methadone associated deaths of course have been a concern. But again, all that data is epidemiologic data. They don't always separate people who receive Methadone for chronic pain versus people who are getting Methadone for Methadone maintenance programs and they don't compare Methadone death rates with other drugs, or they don't control for kind of rates of Methadone prescription use. In Oregon, we found that the rate of Methadone deaths went up like five fold over a ten year period or something like that, but it was exactly proportional to how much Methadone was being prescribed. And so those kinds of things make it hard to interpret the epidemiologic data and we really don't have good comparative data on those kinds of adverse events.

Vyn Reese: Thank you. Any other questions? I'll take a motion to accept the update. Or the full review. We don't need to, okay. It's confusing, because it's a review and update. That's a good review. Any discussion on the committee? There are two stakeholders. The first is Dr. Nancy Lewis from King Pharmaceuticals.

Nancy Lewis: Hello, my name is Nancy Lewis, I'm a medical science liaison with King and I'm here today to talk about Avinza, which is morphine sulfate extended release. And in patients with chronic, moderate to severe pain, it's important for us to treat with a pain medication that not only relieves the patient's pain, but also improves overall functioning and helps the patient get back to active living. Avinza capsules are a modified release formulation of morphine sulfate intended for once daily administration indicated for the relief of moderate to severe pain requiring continuous, around the clock opioid therapy for an extended period of time.

The pharmacokinetic profile of Avinza allows for convenient, once daily dosing. The unique [inaudible] technology, which is steroidal oral drug absorption system allows for steady morphine plasma concentration throughout a 24 hour period. Avinza capsules contain both an immediate release beads, it's about 10% and extended release beads, that are 90% that then provide for unique balanced delivery resulting in consistent steady state plasma concentrations.

Avinza can be administered without regard to food and also can be conveniently sprinkled on applesauce for patients who have trouble swallowing. Clinical studies have demonstrated that Avinza is effective for the treatment of chronic pain of various etiologies ranging from osteoarthritis to chronic lower back pain to malignant and non-malignant pain as well. In a pivotal efficacy study comparing Avinza in the morning or in the evening to MS-Contin and placebo statistically significant decreases in pain were observed in all of the treatment groups compared with placebo. Clinical benefits began as early as one week and continued

through the four week study endpoint. Sleep parameters were also assessed in this trial. The data demonstrated that Avinza improved sleep parameters to a greater degree than MS-Contin. In a second analysis of this study, there was a trend toward reduced use of a rescue medication as well during the active daytime period compared with MS-Contin.

Avinza is not intended for use as a p.r.n. analgesic. Avinza capsules must be swallowed whole or sprinkled on applesauce. The risk for a potentially fatal dose of morphine exists if the capsule beads are chewed, crushed, dissolved, or taken with alcohol or medications containing alcohol. The most common serious adverse events reported with the administration of Avinza were constipation, somnolence, headache, vomiting, nausea, death, dehydration, dyspnea, and sepsis. Serious adverse events caused by morphine include respiratory depression, apnea, and to a lesser degree circulatory depression, respiratory arrest, shock, and cardiac arrest. Through its unique sustained release technology, Avinza has been shown to provide consistent once daily around the clock pain relief as evidenced by significantly reduced pain scores, improved sleep and physical functioning, probable efficacy when compared to other, oral sustained release opioids, and stabilized dosing over an extended period of time. Once daily Avinza is a true sustained release opioid offering a convenient and consistent dosing regimen, reduction in rescue medications and a similar adverse event profile to the other oral sustained release opioids. Thank you.

Vyn Reese: Thank you. Any questions? The next stakeholder is Dr. Anne Speiser of Endo Pharmaceuticals.

Anne Speiser: Thank you for the opportunity to present some information regarding Oxymorphone extended release, Opana ER. Very briefly I'd like to mention the science behind the clinical experience that suggests that multiple unique opioid molecules are necessary to treat pain in a genetically diverse patient population and I'd like to draw your attention to the variety, quality, and [inaudible] results of trials conducted with Opana ER, some of which have been included in the OHSU report.

The Oxymorphone molecule is chemically and pharmacologically distinct from all other opioids. Taking advantage of this distinction is important to providing the best possible analgesic care for patients in pain. Conventional wisdom is held that all new opioids act through a single class of opioid receptor, but we're now learning that the effectiveness and potency of different new opioids can vary unexpectedly and unpredictably among patients, as can the side effects that go along with it. This is due to the variety of receptor subtypes that are produced by splice variants on the gene that codes for the new receptor. So in patients who are given an opioid, its ability to activate any particular receptor subtype will vary, and

this accounts for the efficacy of opioid switching and rotation that is observed clinically. When patients are changed from one opioid to another, a different complement of receptor subtypes becomes activated, so patients who are either not responding adequately or are experiencing significant side effects may well experience much more satisfactory pain relief from a different opioid. Effective pain relief requires treatment to be tailored to the individual and opioid activity is dependent upon the genetic polymorphism of that patient. Since it's not yet possible to predict which patients will be sensitive to which opioids, there must be a full range of opioid molecules available to the patients and physicians in order to optimize treatment. Opana ER, Oxymorphone is an important member of the range of opioid molecules. The clinical program includes 15 phase two and three clinical trials that represent more than 2,000 patients across a range of chronically painful conditions including lower back pain, osteoarthritis, and cancer pain. The Opana ER clinical program is the first to demonstrate durability of analgesic effect in both opioid naive as well as opioid experienced patients. In these studies, patients were able to reduce their visual analog scale scores from approximately 70 mm down to 20 mm and this significant drop was actually maintained in 80-90% of the patients over the duration of the three month study.

So in conclusion, there are a number of genetic as well as clinical variables that determine how well each individual patient will respond to a particular opioid both in terms of efficacy and side effect profile. Including Oxymorphone within the full range of choices within the long acting opioid medication class will allow health care providers to effectively tailor the choice of medication and of molecule to the individual and this is essential in pain management and leads directly to more positive outcomes. Any questions?

Vyn Reese: Thank you. Any further discussion on long acting opioids?

Barak Gaster: I have a question that is mainly just my newness to this process. This is Barak Gaster. So now that we have generic Fentanyl, that's not currently listed on the Preferred Drug List as even a non-preferred. Will that sort of automatically appear there and when it does will that affect sort of what is preferred or not preferred? Has that been discussed here before?

Siri Childs: Yes, that's been discussed here before and we have had the generic in our models that we've done and we have consistently selected morphine generic long acting and Methadone as our preferred drugs.

Barak Gaster: So then, I'm just wondering why isn't the generic Fentanyl listed in the non-preferred list?

Siri Childs: Oh, it's not listed?

Vyn Reese: It's down at the bottom.

Barak Gaster: Okay. It's not on the Preferred Drug List document that's on the website I guess.

Vyn Reese: It's non-preferred.

Jeff Thompson: The way it works is that if you consider all the drugs...

Jeff Thompson: Whether it be long acting or dermal deliverable, it's whatever.

Vyn Reese: Now, is it, this is Dr. Reese, is it still the case where an endorsing provider can order a non preferred drug or not, because recently in this class, I had a patient who had been on a non-preferred drug for awhile, so what's new to me and I tried to order it and I was told that even though I was an endorsing provider, I couldn't order it because it was non-preferred. So is that a new regulation?

Siri: No, that was not accurate. That is when you need to call me if it is Medicaid.

Vyn Reese: It was Medicaid. And I was confused. I said, "Is this a new regulation that I am not aware of?"

Siri: No, it's not and you know things like that do happen and just keep my number handy and give me a call and I'll help you.

Vyn Reese: Okay, well. Give me your number after the meeting.

Siri: I will give it to all of you right now. My telephone number is (360) 725-1564. And, you know, I am happy to give my number out because we really don't get a lot of calls. But if you do have a problem, give me a call.

Woman 2: Or you can email her.

Siri: Or you can email me.

Jeff Thompson: ...we'll find pharmacists, new pharmacists, this is a unique state that has, you know, the dispenses written, brand/brand interchange, blah, blah, blah and so sometimes there is an opportunity to educate so if you call Siri or Donna or Jamie, that is an opportunity to educate so nobody else gets in that but, if you are an endorsing provider like DAW for a non-preferred drug, we haven't agreed to put safety limits on it you get the drug.

Barak Gaster: This is Barak Gaster, I run into this because it is just so not my usual course to write DAW and so it happens to me all the time when I forget to order something as a DAW. Going back, Barak Gaster again. So, is this the only situation on the preferred drug list where there is a generic, which is not preferred?

Donna Sullivan: This is Donna Sullivan. No, there's actually many drug classes where generics are not preferred. One of them is with the sulfonylureas, the older ones were not chosen as being preferred. Going back to your question about the generic fentanyl, the transdermal patch generic, it is on the PDL but it is not preferred and you would be able to get it with a DAW when you write the prescription. I don't know if you are referring to the lozenges or the bucal tab...okay, those are not included in the drug class at all because they are not long acting.

Dwayne Thurman: I guess, why don't you give me a call and I can walk you through some of this because the ultimate, what ends up on the preferred drug list is not the total result of what you're making a decision on today. It is the result of you're saying whether they are equally effective, safe and how they appear in special populations and then we do a cost analysis then to say that if there are no differences then we will make that decision on cost. So, what you are doing here is outlining specific issues you have with particular needs the patients would have or therapeutic equivalency and it is a convoluted system but I can walk you through that. It is not, we are trying to balance the obvious State policy to use generic drugs against our ability to do a cost analysis to figure out what... Sometimes the results are different than you would expect.

Barak Gaster: Barak Gaster again. Because the odd situation I have been in then as a prescriber is finding myself writing duragesic DAW as opposed to being able order the generic fentanyl patch for somebody.

Donna Sullivan: This is Donna Sullivan. What you would need to do in that regard is to write your prescription for fentanyl patches and sign that DAW and then you would get the generic product?

Barak Gaster: Okay

Vyn Reese: Barak, you are not alone. I think a lot of us have been in the habit of doing, you know, therapeutic substitutions and in this case, if you really want it, you have to sign on the other line and I did last week and I didn't get anyway then either. So sometimes that doesn't work. Now I know how to get around it.

Jeff Graham: This is Jeff Graham and actually, I have a website up now and we do not have fentanyl transdermal on there, on the non-preferred list so it would

make it clear if we did put it there. We have duragesic but we don't have the generic on there.

Vyn Reese: I think it was new since the last meeting, so it might have been for that reason, so maybe we should add fentanyl patches on the non-preferred list then.

Jeff Graham: We just need to put it down specifically. We have it listed as duragesic.

Vyn Reese: Yeah, that's what I mean, a generic fentanyl patch needs to be listed...

Jeff Graham: We can do that.

Barak Gaster: Thanks.

Donna Sullivan: When I am looking at this long acting opioid's motion, there are a whole lot of narcotics listed there, some of which are not long acting and some of the long acting ones aren't on the preferred drug list. The non preferred drugs on the preferred drug list. So, my question really is, there is not consistency across here. It might be (inaudible)...

Vyn Reese: And the other thing that I wanted to mention, I don't think we need to keep Roger Chou on the line for this do we? Are you still there, Roger?

Roger Chou: I'm still here.

Jeff Thompson: I don't think we do either and there is really not much in the way of new data in this class either. Thank you very much Roger for helping us with this group.

Roger Chou: All right, thank you, goodbye.

Jeff Thompson: There was a long acting hydromorphone and that was withdrawn from the market. And might have been part of the problem. It was long acting and then it was taken off the market.

Vyn Reese: But this doesn't, yeah, so we might want to delete that drug since it was taken off the market. I don't know if there is a long acting...hydro.. A hydro codeine. 2006, yeah, that was our previous motion. So maybe we want to clean that up and take the ones that aren't long acting out of there. It would be the transdermal fentanyl, oral oxycodone, morphine, methadone are all long acting and levorphenol is not long acting, is that right? Codeine and dihydrocodeine and oxymorphone is long acting. But the ones the ones that need to be taken off are levorphenol, codeine, dihydrocodeine and hydromorphone. Those 4 need to be stricken.

Donna Sullivan: And maybe the others that have short and long acting forms, we should designate the long acting ones by the ones we are talking about.

Vyn Reese: This is the long acting opioid motion so it's; we are just talking about long acting opioids here.

Janet Kelly: This is Janet Kelly. I always thought of levorphenol as being a long acting. I think that needs to be included on the list.

Vyn Reese: It's a half life right? Because if it is 3 times a day then it is okay. It can be dosed either 2-6H or q.a.h., so if it is q.a.h., it would fit in the category, so let's leave it on. Any other changes we want to make to the long acting opioid motion? Sort of change by, motion by committee.

Janet Kelly: And then when we look at the list that is on the website, would we not want to include all of those on that list? Or are they...

Vyn Reese: Let me tell you what is on the website, I have it right here: Avinza, which is morphine sulfate ER, duragesic transdermal fentanyl, Dolophine (?) which is a methadone, Kadian morphine SR, Levorphanol which is levorphenol, Methadose which is methadone, MS Contin Morphine SR, Oramorph SR which is morphine, Sulfate SR and Oxycontin, Oxycodone ER. That is what it says on our website now.

Barak Gaster: So the only one that is not there is codeine?

Janet Kelly: And the generic methadone.

Donna Sullivan: And also that dihydrocodeine is not on there. It's not long acting.

Duane Thurman: This is Dwayne Thurman again. I really would be reluctant to work your way back looking at what is on the preferred drug list itself and look at what drugs were included in the review that you just heard and make your decisions based purely on what drugs were included in the review and how you want to treat those drugs because the output of the PDL is not going to be determined by your decision today. Our next steps is to do our cost analysis, taking into account the supplemental rebate bids that the manufacturers have made and then to use that in the universe of what you have instructed us to do in terms of what, you are telling of the parameters of what must be on the list or what should not be on the list or what are equivalent on the list and then the next step is for us to do the cost analysis that turns out to be the result of the PDL that you are looking at. So I don't think we want to reverse engineer it.

Vyn Reese: That is not what we are doing. We are just trying to make sure that the motion is correct...

Duane Thurman: Let's also make sure that these are the ones that are included in the review itself.

Vyn Reese: Right. And, I think they are.

Woman: Yeah.

Vyn Reese: They are included in the review. So they are all there.

Barak Gaster: I have actually got the, this is Barak Gaster, I've got the full final report update that was emailed to us that I think is too long to be in our folders, so I have got that list here and it does look like it matches up pretty well with the list that's on the screen now. It does have codeine in it. It does have dihydrocodeine in it. It does have oxymorphone in it.

Vyn Reese: Oxymorphone does have a long acting preparation so it should be there. I am not aware of a long acting one for codeine and hydrocodeine.

Barak Gaster: It says there is a brand name of codeine contin. That's a list of included drugs.

Vyn Reese: Some may be Canadian drugs too. They do review Canadian drugs, so the only drugs that are available in the U.S., we have had to change our motions in the past because of that. Does anybody actually want to tackle this motion and make it...hopefully; we have cleaned it up...if there are any other errors in it.

Carol Cordy: This is Carol Cordy. I'll do it except I thought we were going to take the codeine off and the dihydrocodeine. Yeah, since this is long acting. Who's doing the typing? Okay. After considering the updated evidence of safety efficacy in special populations for the treatment of non-cancer pain, I move that transdermal fentanyl; oral oxycodone ER, morphine ER, methadone, levorphenol and oxymorphone are safe and efficacious when used appropriately and have similar adverse effects. There should be more than one preferred drug in the long acting opioid class. No long acting opioid is associated with fewer adverse effects in special populations, adverse events in special populations.

Vyn Reese: Any comments or is there a second to that motion?

Janet Kelly: Janet Kelly, I will second it.

Vyn Reese: Any discussion? All of those in favor say "I".

Group: I.

Vyn Reese: Those opposed say sign. Motion's passed. We will have a brief adjournment before we go into the DUR mode or do you have any other things on the agenda? I think we are a little ahead of schedule.

Man: Obama is going to try to be here but....

Vyn Reese: Do we meet here back at 1:45 or what? Are we ready to go? What is your preference? Are we ready to go? Okay so maybe we should adjourn and have a little break. So we will meet back here again at 1:45.

Vyn Reese: Approve the minutes from the last meeting.

Man: That's awesome.

Vyn Reese: Hopefully everyone's had a chance to look at the minutes. These are tapes of the last DUR board meeting and sometimes some of the words aren't quite right but roughly it is pretty much what we said verbatim, even the hems and haws.

Woman: Dr. Reese, the last two pages were inserted there inadvertently, those are notes from a different meeting, a consortium advisory meeting. Don't read those.

Vyn Reese: Delete those.

Siri: Regina, didn't you say that the tape ran out?

Regina Chacon: Yes it did at the last meeting.

Vyn Reese: And the tape did run out. Given those...any other additions or corrections to the minutes.

Duane Thurman: I do have a correction. On page 24, I made a statement with regard to "if you treat both of those together you're not going to have good results." I meant to say or it should have been interrupted that "we will have good results or you are going to have good results," not, not, should be removed. The word "not" should be removed.

Vyn Reese: Any other additions or corrections?

Carol Cordy: This is Carol Cordy. My name is still spelled wrong.

Vyn Reese: That's important. Find anything else?

Carol Cordy: Well, there was an interesting, I can't find it right now, where it said port noise, p-o-r-t-n-o-i-s-e and I think it was supposed to be court noise.

Vyn Reese: Yeah, that sound like a spelling that was sort of by sound instead of by knowledge. Anything else?

Siri Childs: Do we know where that is?

Carol Cordy: I will try to find it.

Woman: Okay.

Vyn Reese: If every body could look at their own statements and correct those that would be best.

Jeff Graham: This is Jeff Graham, who is the "Man" in this discussion?

Donna Sullivan: "Man" is when someone does not identify themselves ahead of time.

Vyn Reese: Do we know who that might be?

Jeff Graham: Well, he is asking himself questions, I guess. No, I am just pointing out that we should remember to identify ourselves. I mean, I do the same thing.

Jeff Thompson: Actually, I am trying to remember, this is the Department of Health Director at the Port Gamble clinic. I will get you the name.

Vyn Reese: Right. He made several long statements in here. He wasn't identified and he didn't know. He was the Indian health guy.

Jeff Thompson: Falsely accused to be the name.

Vyn Reese: All right, okay, any other additions or corrections? Take a motion to approve the minutes. As amended. A second?

Jason Iltz: This is Jason Iltz.

Vyn Reese: A second?

Angelo Ballasiotes: Angelo second

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

Group: "I"

Vyn Reese: Opposed, same sign. Minutes are approved. Okay, go for it.

Jeff Thompson: I am going to try, (inaudible) will be here and so he will give you what is going on with (inaudible) but let me just go back a couple legislative sessions ago. Senator Hargrove and Senator Dick and Representative Nickerson basically put legislation forward House Bill 1088, which is an extension that will help benefits for children. And I can go over, Bob's not here on all the expansions. One of the elements is trying to look at safety as relates to antipsychotic use. And there is special legislation to look at actually children less than 5 getting antipsychotics. So, what I am going to talk to you about what we have done is we have built a program looking at overall mental health drugs and safety. We have actually, I will tell you about the community of we've.... You have a remote turning? So we will talk about the work we have been doing, Siri and I for about the last 9 months with the pediatric and adolescent psychiatrists here. So, today's agenda, this is going to go through some national and local trends about what is going on when you are looking at mental health prescriptions. We heard from the drug companies (inaudible) over and over and over again that we have got to go beyond this (inaudible) that the drug utilization and I think that you will find out we are doing that and we are going to do it bigger and better than we have ever done before, which is really the immeasurable, but we are going to get there because the bill actually asked us to measure things like graduation rates or foster care placement disruptions, etc.,etc., and I will go over those. We are going to look beyond the claims data. You know, I mean in your function as DUR, you were just asking, I mean ask Siri or I what you would like to look at. I think the utilization data is a treasure chest of where could we do a better job and psychopharmacology or pharmacology in general in the state of Washington. We are loading depth data on there now with reason for depth. So, if there is something that you want to look at, you know, let us know and we can start looking at it and I will give you some examples about how you can even look at regional variation. I want to show you a picture about what happens in the intersection now. I think that as I travel nationally now, many of my colleagues in Medicaid says, "Your P&T and DUR Committee will let me do that?" So, and I think it is because we work well together and work well with the community together where you can actually mix administrative codes with patients or provider autonomy. And so maybe to just step back from what Steve says, thank you very much because from my perspective, I think we are running one of the best pharmacy programs in the country and I can say that now because I am actually am interacting with almost 42 states now as the Medicaid Medical Director (inaudible) network, which I will talk a little bit about so, I really want to extend my thank you for all the work that you've done with us because I am proud to be from the State of Washington and do what we do here. And then lastly, we are going to talk about what I am going to propose which is Part of 1088, which is some thresholds for antipsychotics

in children and what we are going to do those thresholds. So this is your antipsychotic growth and (inaudible) trends for the State of Washington. We are now at about 78 million, 76 million dollars in the antipsychotic class alone growing at about 21% per year. If you want, later on we can bring by drug, and it is interesting how as new drugs come on, for instance, in Seroquel 47% trend increase, whereas Olanzapine is more of a negative to a flat trend. And so, these are things that we can share with you. So both you see the total in red, the green is the adult and the blue, you can see a rising trend of the use in children. I think it is not just in children, but it's either at very young age or a high dose at multiple times FDA adult dose in children, as well as, and I will show you the data, multiple antipsychotics in one child. And so this is where I think that the utilization and claims data is offered up to the community and you as a snapshot in what we are doing in psychopharmacology.

This is an example of what you can do with the data, and I think really gets the providers enterprised this, we need to understand what is going on here. So what you see here is basically the variation in dosing in the State of Washington using a benchmark. There is the foster care program in Texas, I think, is a national program where they set and work with the community to set some standards about what are large doses in children by age. So, we use this benchmarking and it really looks a lot like this in your folders, it set a threshold by which now we can look at. What are the dosing parameters around the State? So, in under age 18, 2007 data, this is the rate of, let's see, this is the antipsychotic, this is the rate of large dosing of antipsychotics in children. And it really looks like the dosing schedule that you see in your handouts there. So, the question is, what's going on in Spokane and what's going on down in Southwest Washington? I can tell you down in Columbia and Walla Walla, the numbers are really small so the denominators and numerators are a little bit...but, it is interesting that those two areas which have large numbers both numerators and denominator have higher ratings. And this is one of the reasons why we are putting in with Dr. (inaudible) to talk to you about our phone based consultation programs where 8 hours a day 5 days a week you can call a pediatric and adolescent psychiatrist in the Spokane area and the Region 6 area from Clark to Clallam and get a consultation as a primary care because this is where our rates are higher. And the question is, "Why is that?" Interesting. And people start leaning into this. I can tell you, this doesn't look any different when you look at polypharmacy and it doesn't look any different when you look at age. The lower age ranges, the more medications are all pretty consistent with this pattern. So, something is different about these regions. My sort of hypothesis, biased as it may be is that this represents new leadership. This is where community leaders basically have to find what is the community practice, it surprises them. That is the only explanation that I can find out. But what we are going to go is to engage the community and talk about it and

not sort of put our thumbs down on it and say, “What’s going on here?” And so there will be academic detailing. There’ll be programs in place, which we will talk about to actually understand this and it is not about “the know” but is this variation acceptable when it comes to children in the State of Washington?

Angelo Ballasiotes: This is Angelo. Do you have an idea with regards to leadership?

Jeff Thompson: This population of pediatric analysts is psychiatrists is small enough, I know names. But I am not going to tell you names in an open meeting.

Angelo Ballasiotes: That’s fine.

Woman.: Are they psychiatrists? Or are they other practitioners?

Jeff Thompson: They are all psychiatrists that were PCP’s that actually do primarily mental health care.

Woman: That was my (inaudible). So our sample...

Jeff Thompson: There is only one of those.

Barak Gaster: This is Barak Gaster. So, are the white counties all ones that have tiny numbers or are there any sort of no data.

Jeff Thompson: It’s really tiny numbers and so the new range for denominators are just really, really small. But these are rates so it is new range denominator and so what is going on here, and so when I use this data is to get the primary care docs that do mental health care and the pediatric and adolescent psychiatrist to now lean into the discussion because; A. I am not a psychiatrist; and B. I don’t have enough gray hair and I don’t shout well enough to change their behavior and they need to change my behavior so this is where we engage now.

So, a couple things that are happening. This is a big national thing so one of the things that Siri and I are doing nationally is we have now have 20 states that are doing a benchmark in exercise. And I will show you some data and I’ll compare it to the other states. What we are looking at cost utilization across Medicaid programs in states like Texas, New York and California, Ohio, Washington, Idaho, Oklahoma, and so we are going to start comparing this data with real time data and find out what is going on because when you look at across the Nation in the Medicaid total population, you get a low in Arizona and Texas, 4% of the Medicaid population are on an anti-psychotic and then you move to Massachusetts, 13 % of the Medicaid population are on an antipsychotic and so you need to start asking yourself, what is going on here? And the same variation 2

to 3-fold difference is in children across the United States. And so we need to not only look locally and statewide but we even need to look nationally and so we will be looking at establishing some safety thresholds, some polypharmacy ways of looking at it, trying to define what polypharmacy is of, prescribing, looking at adherence just because you write this script doesn't mean they take it. Especially when we are talking about mental health drugs. And so we are going to be looking at gaps and (inaudible) and actually comparing what is going on. If somebody figured out how to improve adherence, we will look at eligibility points and I foster care children, not untypically difficult two mood stabilizers, two antipsychotics, lithium, a sedative, etc., etc. in one client. Very common in our foster care and because they are our responsibility. Is that the right thing to do? And so we will be looking at that along with diagnosis and providers. It will be very interesting because some states only have psychiatrists can write this. In other states, the primary care doctor can write this. We used to have a rule, which said; only a mental health professional or a neurologist should look at this and to be able to prescribe these. So, it is going to be a real interesting look across the country. Next.

So, this is what your State looks like for pediatric care with mental health. We have approximately 360,000 children on Fee for Service Medicaid. 122,000 of them or 34% are on (end tape) So, what is going on? Why isn't there that much variation?

Jeff Graham: I was just wondering and guess the correct update you, this is Jeff Graham, you have 360,000 children, are those just the Fee for Service, they don't include the...

Man: Just Fee for Service not Healthy Options.

Jeff Graham: And so that might change your, well, you don't know...

Jeff Thompson: Well, it is know that healthy kids are more on Healthy Options then on Fee for Service we have the SSI children. We have an ED (?) population, etc., etc. And we will try and correct for that but this is the first time that we have ever really looked at the data and started asking ourselves just as we require our banking accounts to be looked at and adjusted, when is the last time they have lost a check or Visa receipt? You know, quality is job 1 and 4 but that is not how we really work in healthcare. Quality is really an individual thing, not a community thing and so we need to start looking at this data and asking ourselves questions and we will feed that back and forth and come up with some solutions. Yes.

Jeff Graham: When I was working with Medicaid and so forth, the mental health drugs were carved out so are you including their expenses in there but not the number of them?

Jeff Thompson: This is by number utilization and we pay for the mental health drugs that are written by a Fee for Service provider or an RSN provider.

Jeff Graham: All right.

Jeff Thompson: They are not carved out. Well, they are carved out of the RSN concept but they aren't carved out of Medicare.

Jeff Graham: I am talking about the Healthy Options case.

Jeff Thompson: It is only Fee for Service, not Healthy Options?

Jeff Graham: So you don't have their numbers. The total dollars that you are giving do not include any kids that are in Healthy Options?

Jeff Thompson: No. Only Fee for Service

Jeff Graham: Okay.

Jeff Thompson: But you bring up a good point is when I send complications now with Columbia Med Providers and Group Health and I have talked with Kaiser and they are seeding things end. They are very worried about the escalation and use of antipsychotics in kids regardless of whether it is in the commercial or the public insurance companies. And that's where we have actually had some discussions with some of the Healthy Options Plan and they'll be producing some of this data with us, hopefully, so we can look and understand and make sure that it's not just a risk selection issue. Next light.

So, 2 years ago Siri and I (inaudible) and we put in a second opinion program based on some (inaudible) threshold that we all agreed upon and that was Methylphenidate over 120 milligrams or Serterol over 120 milligrams. The Dextroamphetamine over 60 milligrams. Combination use of the three because those are all preferred or Dosilethin H 5. So, now after a thousand reviews with second opinions that were done by community psychiatrists, what happens, it's actually 1,048, 58% change rates. So, we have decreased the number of less than 5 year olds by 24% and there is a lot of discussion of whether we should lower it from 5 to 4, because there are very few children under 4 that are on now. Most of the controversy that we had between the second opinions and the community where it is in that 4 to 5 age range. Because a 4 year old 11 month, it that truly a 5 year old? But when we went through a second opinion, 24%

reduction there. Polypharmacy, a common issue, should be as Strattera on a Methylphenidate, 48% reduction. Okay, high doses of stimulants, 63% reduction and then most stimulant reduced all but Focalin. Focalin went up by 150% in our population. Every other stimulant went down.

Patti Varley: Jeff is that also like if you did the map? Is it in certain areas that the Focalin went up?

Jeff Thompson: I didn't look at Focalin but I can tell you that polypharmacy issue is very...I will look at that.

Patti Varley: Yeah, I mean I am just curious.

Jeff Thompson: And then so, I can tell you after now 2 years and a thousand reviews, there are no children under 5 that are on any of those high doses there were before, zero.

Man: There is a type-o there in your last bullet. It says there are no less..

Jeff Thompson: No less.

Man: No children less.

Jeff Thompson: No children less.

Man: You left children out.

Jeff Thompson: Sorry about that. But what we are going to be doing is we are actually working with Dr. (inaudible) where we will actually be looking at this and looking at juvenile justice issues, on truancy issues, graduation ratings; but actually how we are capturing that data base at the University of Washington. And we will start looking at this and how do pharmacy changes actually influence some of these as well as our mental health expansion programs. And so the legislation actually allows the University of Washington to start measuring these things. So it is not just the prior authorization utilization control, this is actually to improve the mental health care to our children.

Barak Gaster: This is Barak Gaster. You had mentioned that one of your theories that there are community leaders. Another possibility is drug diversion, especially for the very high doses. Is that something that you have any sort of sense of?

Jeff Thompson: Well, we do. We do know that in a stimulant class and even in the antipsychotic class believe it or not, there is drug diversion and that is something that we need to look at. I am telling you it's my theory and just

because I know, I have been working on this for 5 years and I know pretty much everybody's prescription patterns. But that's not why we are here. But I think diversion is something we need to work on, on some tools and we actually did this in the adults and we've seen very similar reductions now in the adult side that Siri's programmed the medical consultant's forecast. And I think, on the adult side, I think there was more diversion than there was on the pediatric side but I think you have got a little bit of both.

Patti Varley: This is Patti Varley again. I was just going to comment but I think, unfortunately, there are situations where, I call it the "cat chasing it's tail", where with kids they are prescribed a medication, it causes a side affect, so then they give them another med, and so most kids who come in to the hospital for an evaluation are on an average of 7 or 8 meds at a time. So...

Jeff Thompson: And I didn't put that down in the slide is that we have actually hospitalized several children so that they could actually be sort in detoxed from this and figure out what the diagnosis is and we did that as part of the second opinion process. We did and look and see, did we have unattended consequences. We could only record one emergency room visit because of behavior because they couldn't get the drugs. Now we did learn a lot from this program, you know, on customer service. And so now instead of 3 locations which were, Mary Bridge, Spokane, and Children's Seattle, doing the consultation, we've actually written the contract with Seattle Children's to do this and now a second opinion about antipsychotics, where this is actually contractual obligations to answer a phone in a certain amount of time and respond back to the prescriber in a certain amount of time and do a phone consultation with them, not just a letter. And so we got a lot of learning there. I could guarantee it's going to be when we turn the switch on this program; we are going to talk about second opinions on antipsychotics, there is going to be some disruptions and, you know, call Siri, call me and we will figure it out. But I think that we have learned some lessons from that and we will get excellent service from Children's, I think to provide those second opinions out in the community.

Siri Childs: Jeff, when you mentioned that there is only (inaudible)

Jeff Thompson: Right. And so go to the next slide, I will go through. Actually, I just want to re-enter it.

Woman: That was Patti Varley's comment supposedly.

Jeff Thompson: These were the stops that we did and right now, the slide is out of order, I am talking with a family practice, Pediatric Association, and we have the pediatric (inaudible) psychiatrist and all these letters of support made sure

all of these people have actually been on our pediatric advisory committee as we have gone through the threshold and normed and stormed is where do you want to set the thresholds and so next slide.

Part of the polypharmacy one is to let you know is when we talk about polypharmacy this is the polypharmacy we are talking about. It is actually a fairly controversial term and we might have to reclass for the that because not it has become actually, how do I say, it psyches people a little bit. But the reality is, this is when we say polypharmacy or multiple drugs we'll be looking at these classes and setting some standards here with special attention on the antipsychotic focus typical of the ages above. And it is a big long list but you can see the highlights of this and we have kids on every single one of these drugs or more. So next slide.

So, based on the starting point of the Texas T-Map and the foster care study, we are going to now agree to these safety limits where there will be a second opinion, if we step over this and that second opinion will be a peer interaction or a psychiatrist primary care interaction where absent of a diagnoses and our claims and they're getting antipsychotics, that's probably not the best practice. We may not implement this first but that's not the best practice that they are getting an antipsychotic and there's no mental health information or claims, that's not good. If they are on (inaudible) or psychotropic medications, that go one beyond 60 days, which you saw the list, that will trigger a second opinion. If they are on two or more antipsychotics, which are both typical and atypical for more than 60 days, that will trigger a second opinion. If they are on 3 or more mood stabilizers, which a mood stabilizers will include both the anti-seizures and the lithium's and the group actually wanted to include antipsychotics in what we call mood stabilization. So that is what that means there, three or more. If the prescribed psychotropic medications without consistent or appropriate care and will figure out how to implement that. But these are actually what Texas came up with and so these will be sort of principles that we start with and then polypharmacy where we don't have a monopharmacy start. And again, these are principles. Some of these may not be implementable easily within our claims basis but these start with principles about, should you start somebody on two when you have not started model therapy first. That is the C-Map approach and just so you know, this is moving over into Western State where Dr. John Childs is looking at the type sound rhythm approach for the inpatient side on Western State. And the psychotropic medications prescribed up to 5 years of age. Any questions about these? These are very similar to what Texas came up working with the bearer and they have actually helped published and when the institute gets working with the community they didn't (inaudible), your actually see more production than use of too many, too young, too much. Hopefully we will see that and then the last slide is the actual dose by age.

Duane (?): Some of the problem might be that there are two providers involved with one patient and you get overlap or duplication of therapy.

Jeff Thompson Or the client didn't tell their prescribing provider that they were taking that, a very common issue that happens especially with the mental health drugs. And so what we will also be providing, the second opinion and the prescriber with a 12 month history, ER and outpatient along with...that way when 2 psychiatrists knock heads together, they will have more information than when they were just prescribing along without that information. And so, what Siri and I are asking you is your permission to institute this program following the Fall with due diligence and communication as well as working with all the associations, letters of support and then we will just keep coming back to you to let you know what goes on. I think that learning from the HE Program will help us with a much smoother start especially on the customer service side. And I think the big learning was the phone consultation happen in concurrent with a suggested medication change. I think that is going to be a big, big help. So, we have doses too young, too many, too much by age. This is the right thing to do.

Barak Gaster: This is Barak Gaster. I am also looking at dose numbers that you have up there and I mean a lot of times when I hear and when I read something in the newspaper about this, I am thinking about older teens thinking, "Oh, this is a 16 or 17 year olds who are almost adults," but then if you look at that data, almost half of the numbers you are talking about are people under 12, which is in that 6 to 12..

Jeff Thompson Well, I will tell you the numbers here if you look at all these thresholds, and again it is hard to look at the current use and things like that. Out of the numbers you've seen, roughly about 12,000 children, we are looking at about 3,500 children that will be in excess of these thresholds. So, the probably be turning it on in stages, not all at once. It will be a grandfather clause so that they've can on it, they can continue it on till the 2nd opinion with it's a new start, we will ask them to either go lower or to get a second opinion if they want to prescribe at a very young age. Yes.

Jeff Graham: A question, Jeff. This is Jeff Graham. Do you have the numbers of the children in each class there? How many are going to be affected?

Jeff Thompson I do and I was trying to bring that up and I couldn't but it's, Brett, would we go back one slide, 5 or more medications, we're talking roughly about 500 kids. Two or more antipsychotics, roughly around 150.

Siri Childs: We actually have it here, if you just turn the page.

Jeff Thompson

Okay, there are estimates. So, 155 age 5 or less, 355 dose threshold 6 with 5 or more, 700 with 2 or more. I haven't done the mood stabilizers yet. So, we are looking at half of a percent of the higher population or 8% of the mental health medications that are prescribed but 36% of the antipsychotics is in children. With the threshold. It depends on how you cut it so both transparencies there. That is a big jump. But I think it is necessary for us to agree that this is how we want to practice psychopharmacology in the State where we have an agreement and a working relationship between an administrative control that says, let's stop and take a deep breath and then you are in control with a peer to peer interaction, which I don't think you can do it any better. And I read the literature or in my session with my colleagues.

Siri Childs:

Jeff, I wanted to make sure that everyone understands that chart. Would you just go through that a little bit more in detail?

Jeff Thompson

Well again, the everyday a new medication with a new age of a new drug comes out and so what now what we are saying, these is the FDA dosing max. There is where the maxes are from the state hospital (inaudible) and then what we are going to say is that if you want to prescribe less than 3 years of age with Olanzapine or quetiapine or risperidone but we are going to allow for a age 3 to 5 up to 2 or 2 1/2 milligrams oral Olanzapine or Risperdal. You want to see that...just a second, please, and this goes on by HA. This was a discussion with Pediatric and Advisory Committee which had an ARNP representative on the committee for the community. Two PDD practicing pediatric psychiatrists, people from the University of Washington, as well as people from family practice and (inaudible) population and one pediatrician that is actually practicing a lot of mental health care. And this was agreed upon by the association with this comprise the group and we sort of normed and stormed about where is the literature because this is off label on some of these. But where is the literature that they need a teacher of this (inaudible) or in a teenager at a higher dose might be an effective way of looking at this and it's a lot like the sensitivity specificity. This is the way that we are going to allow some autonomy out there but with these bills we are going to reach higher levels and as you saw with the stimulus as many as 50% change. Because we have set the sensitivity and the specificity enough, and we will go through this as we go through. Mainly, we will set the threshold lower or higher as we get more information but this basically has got (inaudible) standard in the State of Washington. This is a big thing. These are our kids and this is a pretty contentious drug class and I don't know if you remember when we actually had to change the State law and then we even shared this information with you because back before Senate Bill 5773 the psychotropic medication was considered a mental health treatment record and you couldn't share that between the prescribers. So, we would have done this a year or two ago if we hadn't

changed State laws to a lean share restriction information across this prescriber. So, that is one of the reasons why times (inaudible).

Angelo Ballasiotes: Jeff, this is Angelo. Why even have typical antipsychotics for kids? Why allow them?

Jeff Thompson: Because this is your prescribing fact. This is what the expert panel agreed that there are occasions where you need a typical in psychotics by psychiatrists, pediatricians and family practice.

Angelo Ballasiotes: It is my understanding that the typicals will cause tarrive of dyskinesia a lot more readily in children. And that's the cumulative type affect. So to me that is kind of dangerous as the kids get older and things of this nature.

Patti Varley: This is Patti Varley and Jeff you can correct me if I wrong, I think that the idea here would be if you had tried the atypical and had failed just like with adults there are some children from Stinson CSTC that might require a trial with those things. You are correct that the side effects are higher but I would argue that the increase use of them just in general in the atypical department did not come without consequence as well. That the risk was less but we still have kids that develop side affects like tarrive dyskinesia and we certainly have the increase in weight gain and diabetes profiles in their blood work. And so I think that what they are saying is that I hope at least and I wasn't in those meetings personally but the idea was that severely impacted children who had not responded to atypicals there would at least be the option for them to go...

Jeff Thompson: A couple of other things, remember we are also talking about children that developmental disability so some of them are on some of these doses, especially at Rainer and other schools of which they take care. The other thing is I think we want to be smarter about this it can't start doing this drug class specific. We have got to start looking beyond because we did see in the stimulants where they went around stimulants, (inaudible) just prescribed in antipsychotics. So, what we don't want is the independent consequence putting restrictions on atypical antipsychotics and then people actually prescribing typical antipsychotics. And I have heard from all psychiatrists and I think in my practice, when I was practicing, you know, we all got probably some kids and adults that we don't want anybody to see our prescription pads. I mean that is the reality.

Patti Varley: Jeff, Patti Varley again, I would argue that what it is is that you would want an opportunity to describe and discuss why your prescribing practice is that way, which is, I think, the whole idea behind the second opinion is that, for instance, I work at Children's, mine have gotten second opinions just like everybody else out there. And I actually had a situation where one of the second opinion people said, "Well, where is the trial with the

alternative stimulant?” And it turns out that the kids record was so old that it was in the paper, it predated our computer access record and it was a resident who had done that trial prior to me. So digging that out, but I knew the child had been tried on the alternative. But that would have been a great question, that if it wasn’t. But I should be able to defend those outliers and have a discussion about why that family should have informed consent that we are functioning outside. But those should be exceptions to the rule not the commonplace.

Jeff Thompson: ...allowing the stimulant while we have a 56, 58% change, we also had, you know, a 44% continuance. So that allows for the autonomy and if functionally they are doing better and keeping document, why wouldn’t we pay for it? But, if sort of left to our own devices, you know, things just kind of migrate. So this establishes a community standard.

Angelo Ballasiotes: This is Angelo again. I think in prescribing with regards to in the mental health business, I think some people, clinicians prescribe the diagnoses and others prescribe the symptoms. That need to be reconciled. It depends probably their training, where they got their training and their habits and things of this nature.

Jeff Thompson: And that is interesting you mentioned that. A couple comments: 1. We decided because the cow is out of the barn now that primary care doc can diagnose and use these medications because we don’t want to go back to where we were where we were restricting medications by provider type. But we are also, and I am sorry Bob isn’t here, and we have also now guideline that’s (inaudible). It is out on the Web. It is actually being detailed now. We are doing C and D on this where we actually have what looks like the Washington version of the Texas T-Map or C-Map. Where these is a (inaudible) base which includes, I think, our version is number one, have you considered mental therapy beyond prescriptions first? So, and then we have got all the tools to get them into the services because I will show you why we did standard services. So that’s the first step and along with good diagnostic capabilities where there is validating tools to diagnose whether it’s the Vanderbilt’s or others. What is interesting about bipolar is there is no tool. But we have got a list of the symptoms where it is not just behavior, it is those 4 or 5 aspects of whether you’re looking at, you know, the mood swings, you are looking at hyperactivity, you know, blah, blah, blah before you get to, “Oh, it’s bipolar and now antipsychotic.” And have you thought about ADHD with conduit disorder first? And so we have got that guideline and we are out there doing C and D and we are out doing medication that is posted on the website and Siri and I will send it to you because I think that you are absolutely right.

Angelo Ballasiotes: Well, let me clarify it, I mean I hope that we are talking the same. I find that diagnosing, when you give a diagnosis, it is not as accurate as treating the symptoms.

Jeff Thompson: Right.

Angelo Ballasiotes: I think we all fall into a trap like that because people present differently over time and that is where you go get the real diagnoses is over time. If you look at somebody that is maybe a child that, or an adolescent that's been used substances and that person is going to get a diagnosis that's bipolar when in actuality there is no bipolar. You look at them a couple months later, there is no bipolar diagnosis.

Jeff Thompson: And I think that is what the guidelines will help and we will get education out there and we will just keep with it. Because, I mean, I have interacted with a number of families during this process and there are some kids that are pretty scary and they're (inaudible) that you need this medications. That perhaps even doses that are higher ones. Let's agree upon a process which you can accurately make sure that the diagnosis is correct and the treatment is correct. And this is the best we can come up with because (inaudible) but give up a little bit of control also. And I will be honest with you, it also saves money. And the ADHD program, we saved 1.2 million, we spent a quarter million. So it was about 3 to 1 ROR.

Patti Varley: And this is Patti Varley to address what you were talking about. I think the tools that where that people are promoting be done as measurements are going to measure symptoms. There are not just going to measure just the diagnosis. So, if this person's symptom is irritability, you know, what diagnosis will irritability in the DSM 4's and almost every.... Right? ...diagnosis. So, I think the idea is to have an ability to monitor and show evidence that the medicine you are using is actually helping that symptom regardless of what the diagnostic category is because many of these meds now are being used for multiple diagnoses. So, I think you are right and I think that the idea is that we want people practicing safely and thinking about their practice so that there is evidence that the symptom you are giving that medicine for is actually improving with that.

Jeff Thompson: So, asking your permission.

Man: So read a formal motion, right?

Jeff Thompson: So this would start only with communication a lot about (inaudible). We set the contracts up. We can check what you want. We have custom service standard and probably would be happening sometime in the early to late Fall because we have got to get to our systems change with our DOS.

Patti Varley: And this is Patti Varley again for point of clarification. The things that we have learned from the first time around is that: 1. There will not be a disruption in the patient getting that prescriptions if it is a refill but that the second review will take place while the patient is still receiving treatment because that was an issues, I think.

Jeff Thompson: Let me that one of the big issues why is happens, there was a, it was difficult for the pharmacist to differentiate a fee for service in Healthy Options client. So, I am now working with health plans to implement this within Healthy Options to there will be a one standard for both their formula and our preferred drug list as it relates to mental health drugs and children. That will help the pharmacy (inaudible) because that, I think, was a major disruption issue. And the last thing, that's actually going to get solved next year where Healthy Options will be responsible for all prescriptions coming out of the RSN's.

Patti Varley: And then I think the other part, this is Patti Varley again, has to do with the fact that there will be communication and recommendations about what to do differently, not just told you can't, you can't do that, and an opportunity, I think, to supply information or evidence with good suggestions about how maybe to look at it differently or try something different.

Jeff Thompson: Any things for a phone call.

Barak Gaster: This is Barak Gaster. I think this has so many parallels to opiate prescribing and sort of maclum dose opiate prescribing in terms of, I mean the thing that really sort of struck me is when you mentioned that this means taking away some autonomy and I think that is why you are approaching the customer service thing so well and that is so important because most of these providers are probably overwhelmed by some of these outlying patients and as long as they are approached in sort of respectful way...

Vyn Reese: Now I don't have, I mean I have the number, but I'm not sure all the other pediatric providers are out there prescribing these drugs too. So I think the customer service is very important. I think this is very important work for quality and safety. I just think it's absolutely critical we have a... we've got to make sure that the kids don't have their prescriptions interrupted. They really need them, if they are an outlying kid that they don't... they can't get their meds and they do decompensate.

Man: And that bears the risk on our part. We don't want the disruption because if something bad happens and we are the cause of that, I mean that's basically our big risk. And so we're going to work hard on that. I will personally love academic details from the higher prescribers. That will

take care of hopefully 60 plus percent. And then we're working on a big communication plan that [inaudible] with this. The pharmacists are, and that's the one Alan that we've got to work on. Because this is different. This isn't your simple DUR yes no type thing. And that's... and so we'll work with the Pharmacy Association.

Vyn Reese: This is Dr. Reese. The pharmacy is very important. That is where a lot of this stuff gets totally confused that would pass drugs that we've looked at. We have the right idea, we know what we're doing, that we've implemented. And the pharmacists don't understand it and that gets totally botched.

Man: Say you're the nice gal working the Pharmacy Association, there's a thing called overrides that we spent how many months and how many meetings and...

Siri Childs: We started in September and we met monthly with the Pharmacy Association and they're billing folks through April. So we hope that we've really worked with them to try to help them understand exactly when it comes to us and when they're supposed to do what.

Patti Varley: So Siri, this is Patti Varley. This just came to my mind. So like if I were in this situation and the family said the pharmacy is refusing to fill this, if I call that pharmacy, do I give them your number to call?

Siri Childs: No.

Patti Varley: Oh hey, that's what I want to know.

Vyn Reese: How do we do that?

Patti Varley: Because they won't let, I mean I agree.

Siri Childs: I want you to call me.

Patti Varley: I call you?

Siri Childs: You call me, I'll call that pharmacy. What I actually do is I ask to speak to the responsible pharmacist. Because every pharmacy has a state board of pharmacy designated responsible pharmacist.

Patti Varley: Okay, so I would still call you, I wouldn't tell them to call you.

Siri Childs: You call me and then I call them, speaking from a DSHS.

Patti Varley: Yea, because when I pull my P&T committee hat on they don't care.

Siri Childs: Well I talk... sometimes I have to talk to them about following the rules of their core provider agreement. So call me, I'll take care of it.

Patti Varley: So, the other question, this is Patti Varley again for you Jeff is one thing that you alluded to with the ADHD meds or the kids on multi meds and things, which I think will become probably at times a bigger issue with this population is is there going to be some kind of coordination of care with the idea that if there is a kid who's a real outlier, they ability to inpatient them quickly for a reevaluation? Because I think there are some clinicians who would be happy and parents who have very disruptive kids, would feel much more comfortable having that look at meds and titration and adjustment done in the safety of an inpatient evaluation, and sometimes these might be clinicians who the family doesn't want to hospitalize the kid or where they haven't been able to access a bed.

Jeff Thompson: Let me talk about that when we go through 6088. Because we've gotten expansion services, more care, and if there is a unique patient who we have actually got people into hospitalizations. But we don't have enough pediatric psychiatric beds.

Patti Varley: That was my bet.

Jeff Thompson: But that's a whole other issue on clip status. Yes.

Jeff Graham: This is Jeff Graham. I would think though that a lot of the providers that you're going to be working with have already been contacted about the ADHD drugs once you have this have the same group.

Siri Childs: A lot of them already know my number.

Jeff Thompson: We sort of move on to the pain of wanting to stay by pilot, now we're going to go through... this is going to be a different provider group. I mean this is going to impact more the mental health [inaudible] and many more of the pediatric and adolescent psychiatrists. So whether it was 80% practice stuff in stimulants with PCPs, now we've go the other side.

Alvin Goo: Jeff, this is Alvin. What type of outcomes are you going to be tracking?

Jeff Thompson: Like on that one slide, the first, obviously we'll look at utilization and we'll look at the drugs, but then as part of this 1088 which I'm going to talk about during the next, it will be looking at foster care placements, it will be looking at if we can do some school based metrics, it will be looking at we're actually on the executive meetings with both Sheryl Stephanie at Children's and John Taylor at JRA. So I think the other opportunity is start to standardize across their agencies. So when you go in to the institutions

in JRA, we saw they actually prescribing very similar to what the community is. And so we are really linking up with a lot of the agencies. Absolutely right.

Siri Childs: Jeff, do you want to mention anything about the standardization of formularies that we did early on in January?

Jeff Thompson: Sure, so what we did, Siri and I met with all the health plans, and despite what your opinion is, or your perception is, actually the PDL and their formularies actually are very, very matched. It's on that one single drug, say Focalin, or and where we have a little bit of disparity is on the anti-psychotics. But pretty much on the anti-depressants and the stimulants and we looked at the anti... we looked at one other drug class.

Siri Childs: We did three.

Jeff Thompson: Three. On the two day ones, we're almost 100%

Siri Childs: ADHD and antidepressants.

Jeff Thompson: And we're almost 100% parallel between preferred and formulary. And where you have the [inaudible] is on that one single favorite. But one of the things I'm willing to do is go to the health plan and try and see if we can get consistency. But I'll be honest with you, I won't tell the provider community out there if we can't control our appetite for brand or there's no evidence that brand is effective within these programs, then I have to allow the healthy options plans to make a business case for their formularies. But I think we can now open dialog, can we have some consistency, which is what I think you really want. But it really just has to be a dialog with the provider community. Because you've heard that with stimulants about some of the brands. I like this new brand. I'm going to use it on everybody. So everybody's got an opinion about how they track this and sometimes it's not evidence based.

Vyn Reese: Thanks Jeff. Are we ready, any more questions?

Jeff Thompson: Do you want drug companies?

Siri Childs: Jeff did you have another presentation?

Jeff Thompson: I'm just [inaudible] up here so I'm just going to give you one slide. I'm not going to do the whole thing. So we get [inaudible] first. Or do you want to do it?

Vyn Reese: I think we had a vote first. I'd like a motion that we approve the atypical anti-psychotic drugs age dose and combination limits.

Siri Childs: And does that include all of your that in drug class.

Jeff Thompson: This would be basically more or less the safety thresholds for psychopharmacology in children, because it's beyond just...

Vyn Reese: In children. Do we approve the atypical anti-psychotic drugs, age, dose, combination limit in children.

Patti Varley: Patti Varley, I'll second.

Vyn Reese: I didn't make the motion, but I will. I wanted somebody to make the motion. But I'll make it, and so you second it.

Patti Varley: I thought that's what you were doing.

Vyn Reese: That's okay. I'm trying not to do that as much. That is the motion. I make it, you second it. Any discussion? I'll call for the question all those in favor of the motion say "I."

Group: I.

Vyn Reese: Opposed.

Jeff Thompson: Okay, so I'll just go through this real quick. As part of 1088 we have a number of other programs that are involved. It's about an eight million dollar bill for improvement of mental health care in children. So one is there will be revised access to care standards for entering in to the RSN that will be actuarially based. That will probably come out next year. We're just starting it. What does that mean? So when a child or an adult gets in to the RSN, it's really based on diagnosis and severity. And the question is should we relook at that. Are we basically risk selecting fee for service because some of the moderately severe people are coming out and trying to get their... for service and not the RSN. More on that later. It's trying to actuarially assess where we should set the standard on dose and severity where clients will get mental health care in the RSN. That's one of the provisions. There is a revised [inaudible] package. We will go from 12 hours of psychiatric care in children to 20 hours of master's level or more care in children starting July 1st. And we'll pay for that out of the new fee schedule. So we're currently enrolling master's level mental health professionals for care of our children and they can bill fee per service in addition to any RSN care for office based mental health services, which includes group visits and we will be sharing the actual code fee schedules. We will pay ARNPs and physicians on a 100% and master's levels at 90% of fees that range anywhere from \$80 down to \$24 depending upon the code and we'll pay the group therapies, both family and group therapies.

Improved medication management, which is the second opinion. They actually legislated almost a million dollars to do this with the goal of actually losing five million, but we're going beyond that. So it actually was legislated and funded. So that's good things. Convening where we've got primary care education going on not only in region one and region six, which is Clallam to Clark and Spokane, but will be doing state wide outreach to mental health professionals and primary care providers through Mary Troupin's (?) program and at University and Brian Haight's (?) program at Children's. And we produced a guideline with the number of step therapies, which include both mental health therapy and drug therapy, validated tools to diagnose and follow. And so that will be part of the education program going out. We're going to be looking at Medicaid eligibility, that's a whole other issue with [inaudible] and some other things which we have [inaudible] along with the federal government. Extended healthy options coverage, which includes that 12 to 20 hours. So it'll happen both in the fee per service and the healthy options clients and if we can, Siri and I will try and get these programs instituted in healthy options. They don't contractually have to do it, so I'm making the business argument with them so we have consistency in these processes. There's an evidence based practice instituted so Dr. Eric Troupin (?) has actual monies to look beyond pharmaceuticalization with a number of things that are available in data, school children's health, foster care, juvenile justice. Obviously those are long term, but I think we'll actually, if we can get this up and going in the early fall, we'll actually have some data to give the legislators in 2009 that we can do this together and not against each other. The one that's not in there, we also have wrap around services. So there are two pilot projects where we actually are having families engage in the treatment protocol, what we call wraparound programs so that the family are engaged in those pre-pilot projects going on in the State of Washington.

And then outside this program, we've integrated all of these things I've talked about in the new foster care centers returned to Spokane, Longview, and Seattle. We have six pediatricians that are on contract with Children's for foster care consultation, which we've integrated all of these in to and and and. So we're having discussions across the agency for the first time with JRA, mental health, Children's, and I'll be honest with you guys they're talking gossip because drug and alcohol is on the rise and we're starting to have that. And then there's a lot of stuff coming out of gossip alcoholism in children. And so we'll start [inaudible]. And then finally, with the change in statute where now we can share information, what I need to do that to help us out, Siri and I, is how can we format that information in a way that is accessible and easy to read just like a lab test. That's the next nirvana. How do we give you data and convert that into information so we know right away whether somebody is not an inherent,

somebody else is prescribing, or there's some red flag going on like an ER that we don't know about. And that we could actually use your help on in developing those.

So that's 1088. I can go through all of the particulars if you want. It's an interesting bill. It's a whole bunch of pieces and parts, but essentially it's not house bill 1088 in the center. It's family and child in the center and rather than parts of that child or family up by contract, let's put the resources where they need so that the child gets the right care at the right time for the right reasons.

Carol Cordy: Carol Cordy here. I have two questions. Does the 20 hours include the group or family therapy?

Jeff Thompson: It includes both family therapy with and without the client and group therapy where you can have multiple clients and bill for each one.

Carol Cordy: Okay, so it's not 20 hours with a psychiatrist plus more time.

Jeff Thompson: It's... whoever, it's the psychiatrist, a master level health professional can bill out for each hour of service and if they want to have... there are two codes one for family with client, family without client, they can bill that. Which is what they call a group therapy. But then there's another group therapy code where you can have multiple clients, hopefully not 50, maybe ten or five and you can bill individually for each one of those clients.

Carol Cordy: But it's a total of 20 hours.

Jeff Thompson: It's a total of 20 hours and as always, if you need extra hours we'll do a limitation extension, but my first question to providers will be if it's that severe, why aren't they being care of the RSNs?

Patti Varley: Jeff can I clarify? Because I think Carol wants to clarify this and I do too, is that's the therapy piece, is that separate from the medication...

Jeff Thompson: It's separate from [inaudible]. So if you do an hour of consultation, you can, and you do prescription management, you can bill them both. I'll have a little bit of a problem though if you bill 20 clients in group therapy and 20 medication regimens. On 20 clients. I might have a little problem with that.

Carol Cordy: The other question. Does the counseling or the master's level therapy does that have to occur in the community mental health centers? Or can that be anywhere?

Jeff Thompson: We're actually kind of turning a little bit of a blind eye on that. If you're wearing your RSN hat, and you are providing those services as an RSN provider, you can't bill fee per service because you've already [inaudible] for that. But if somehow, for instance, you are a community based provider and doing services for Malina, but you're sitting in an RSN, you can then bill for those services. So it depends on which hat you're wearing. And you've already contracted with the RSN to do mental health care, so you can't bill those.

Carol Cordy: So again if you're in the clinic.

Jeff Thompson: Right. Non-RSN. Non contracted RSN.

Carol Cordy: Then you can bill it.

Carol Cordy: Then you can bill it. When you say master's levels. We've had problems, there's a master's degree in counseling, but it's in family therapy.

Jeff Thompson: Family therapy, family counseling, marriage counseling, psychologist...

Patti Varley: It's true? Any certified counselor..

Jeff Thompson: Master's level or better. And we're asking for trained and testing for training with children. We're not getting our doors beaten down. Last time I saw 60 that signed up, so we've got to do some work, education communication. I think you probably really might ask can a primary care doc bill this and the answer is no.

Carol Cordy: Right and or can a master's level counselor of any sort who is in a community clinic rather than a mental health center.

Jeff Thompson: As long as they enrolled for our process, the answer is yes.

Carol Cordy: They can bill.

Jeff Thompson: Yes, so they have to enroll in fee per service.

Man: How are you going to determine if they need to be in the RSN program?

Jeff Thompson: Well, I mean that's part of the guidelines that we're doing is that part of the package we'll send to you. [inaudible] has done a very good job and Siri and I and many others are starting to put a one stop shopping package where you can actually show where people should go down these different paths, sort of like no wrong door, but many paths. If they need to get in to RSN services, we've got some information to the provider about what

could qualify them for RSN services so they don't have to get all their services from fee per service.

Man: Is it going to be kind of an algorithm type...

Jeff Thompson: In this case it's more of a let me show you what the benefit is and...

Man: You choose.

Jeff Thompson: We can tell you 100% time you should get an EPS(?) exam that will done by RSN. They are contractually obligated to do that for an assessment. Know the rules, [inaudible] if they don't do that. And there's time frames that they're held accountable. So we're trying to make transparency about what the benefit is, because it's been very difficult. We have carved up health care, carved up our clients is by contract. Not by wrapped around services. So this is our first attempt to really wrap around the services, but it will be difficult. So that's 1088 and we're also asking for funding where we could take this beyond into the '09-11 budget, because it's got some sunset clauses. So part of this is actually and maybe we'll ask you is if you're in Spokane or in region 6, Clark Clallam, help to sell this, make sure that Bob, you overwhelm the phone based services. That's the last thing. So Children's hospital will run 8-5 pediatric and adolescent consultation services in region 1 and region 6. It's insurance for them. So any client that's being treated by a primary care physician in region 1 or region 6 has a question about the mental health therapy, you call Children's and I think it's they respond within, I think it's within 24 hours. I can't remember if it's four or 24 hours, I'll have to look. Very similar with Massachusetts though. And if we can make the system run, we can maybe go save [inaudible] the next claim. So that's 1088.

Siri Childs: And the prescriber gets paid for that consultation.

Jeff Thompson: And the prescriber will get paid for that consultation. So we're paying on both sides and so I think the proof in the pudding is is there going to be better care and not just less meds, but actually better care. That's a very difficult thing to [inaudible], but we're going to try. So that's 1088 in a nutshell. Thank you very much.

Vyn Reese: Thank you Jeff. Any other items for discussion? Are there stakeholders who wish to comment? Nobody signed up, so I don't know. If you have an urge to speak, now's the time.

Siri Childs: This is Siri Childs, and I wanted to add my thank you to the board, because your work on the annual DUR report this year was just phenomenal, you did a really great job. So thank you, thank you very much.

Vyn Reese: Thank you for our pay raise too. I don't know who implemented that, but we all appreciate that. But thank you from the committee.

Man: It just comes out of your B&O.

Vyn Reese: Right, that's what I'm worried about.

Man: You laugh, but it's true.

Patti Varley: What is B&O?

Man: Business and operating tax.

Vyn Reese: Okay, I'll take a motion for adjournment.

Patti Varley: I'll move that... this is Patti Varley. I'll move that it's time to adjourn.

Vyn Reese: Let's go.