



Washington State Health Care Authority
Prescription Drug Program

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UNOFFICIAL TRANSCRIPT*
WASHINGTON STATE
PHARMACY AND THERAPEUTICS COMMITTEE MEETING
October 21, 2009
Sea Tac Marriott Hotel
9:00am – 4:00pm

Jeff Graham: Is that Kim?

Kim Peterson: Yes.

Jeff Graham: Okay. We're not quite ready but we should be soon.

Kim Peterson: Okay.

Jeff Graham: In the next two minutes.

Vyn Reese: This is Dr. Reese and I want to welcome everyone to the Washington State Pharmacy and Therapeutics Committee Meeting. We'll start now with introductions. We'll begin on my left.

Kathy Williams: Kathy Williams, Pharmacist Consultant with the Board of Pharmacy.

Chuck Agte: Chuck Agte, Pharmacy Program Manager with Medicaid.

Siri Childs: Siri Childs, Pharmacy Administrator with Washington Medicaid.

Doug Tuman: Doug Tuman, Pharmacy Consultant, Labor and Industries.

Jaymie Mai: Jaymie Mai, Pharmacist with Labor and Industries.

Jeff Thompson: Jeff Thompson, Chief Medical Officer, Medicaid.

Jeff Graham: Jeff Graham, Health Care Authority.

Angelo Ballasiotes: Angelo Ballasiotes, P&T Committee Member, Yakima.

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

Carol Cordy: Carol Cordy, P&T Committee Vice Chair.

Vyn Reese: Vyn Reese, Chair.

Bob Bray: Bob Bray, P&T Committee.

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

Alvin Goo: Alvin Goo, P&T Committee Member.

Barak Gaster: Barak Gaster, P&T Committee Member.

Leta Evaskus: Leta Evaskus, Health Care Authority.

Regina Chacon: Regina Chacon, Prescription Drug Program.

Donna Sullivan: Donna Sullivan with the Health Care Authority.

Duane Thurman: Duane Thurman with the Health Care Authority and just to remind everybody to speak into the mic. We're transcribing the meeting. And I'd also like to introduce Leta Evaskus as our new Program Analyst for the Health Care Authority's Prescription Drug Program.

Ray Hanley: Ray Hanley, Health Care Authority.

Vyn Reese: The first drug class review today is the triptan drug classes. Is the presenter ready?

Kim Peterson: Yes. Shall I begin?

Vyn Reese: Yes. Our first slide is up.

Kim Peterson: Okay. I'm going to be presenting a summary of the new evidence that resulted from the fourth update of the drug effectiveness review project review on the triptans. Next slide.

I'll start by going over the changes to the inclusion criteria implemented in update number four. There were no changes to the population criteria, which remains focused on adults with migraines. As for interventions for update four we added the new six-dose combination product that contains sumatriptan plus naproxen. Next slide.

And here's the inclusion criteria for effectiveness and efficacy outcomes. For update four there were no new effectiveness or efficacy outcomes added. The only reason that phonophobia and patient satisfaction are

underlined is that although they've always been included in the review they had previously been inadvertently omitted from the eligibility criteria. So their addition to the criteria for update four was more of a correction intended to more accurately reflect what's already included in the review. Next slide.

Here's the criteria for harms outcomes and study designs. There were no changes to these criteria for update four. Next slide.

Here's the details of our searches. For update four we updated our searches of the Cochrane Library and Medline, which now extend through February of 2009. Also we received dossiers from the manufacturers of Almotriptan, Flovatriptan, Rizatriptan, Sumatriptan, and the new Sumatriptan/Naproxen six-dose combination product. Next slide.

Here's the details of our usual DERP data collection and analysis methods and there were no changes to these processes for update four. Next slide.

Now for results. And here are the details of our selection process with the numbers of new citations for update number four reflected in brackets. We found a total of 267 new citations in update four. We excluded 217 at the title and abstract level, another 23 at the full text level and ended up adding 27 new studies consisting of five head-to-head trials, 19 placebo-controlled trials and a few systematic reviews. Next slide.

So now for results for key question 1: effectiveness in efficacy and for update four we added sub questions 1B and 1C for evaluation of the new Sumatriptan and Naproxen six-dose combination product. As compared to triptan monotherapy and [inaudible] administration of its individual components. Next slide.

We'll start with the evidence on Eletriptan. This slide provides an overview of the numbers of included trials and there was very little new for this update. And we only added one placebo controlled trial of Eletriptan used as early treatment of mild pain. One placebo controlled trial that reported work productivity outcomes and a new meta-analysis that compared the time course of effectiveness response between encapsulated Sumatriptan and conventional Sumatriptan. Next slide.

Here's a summary of the results from the three head-to-head trials of Eletriptan compared encapsulated Sumatriptan that showed superiority for Eletriptan. And there's nothing new here for update number four. Next slide.

Here's the results for the head-to-head trials of Eletriptan compared with encapsulated Almotriptan and Zolmitriptan and nothing new here either.

So again Eletriptan was shown to be superior to both encapsulated Naratriptan and encapsulated Zolmitriptan. Next slide.

So here's a summary of the results from the studies that focused on evaluating the effects of encapsulation. For this update we added a meta-analysis conducted by Mandema and colleagues in 2005 that compared the time course of response for Sumatriptan with and without encapsulation using data from 19 head-to-head and placebo-controlled trials. It did not find that two-hour response rates for Sumatriptan were significantly decreased in trials where it was encapsulated compared to trials in which it was not encapsulated. In fact, it found just the opposite. It found that there was a non-significant increase in two-hour response rates in trials in which Sumatriptan was encapsulated. So how does this fit into the debate? Our previous interpretation of the debate over the findings from the five head-to-head trials that compared Eletriptan to encapsulated Sumatriptan, Almotriptan and Zolmitriptan was that evidence from in vitro and in vivo dissolution studies and meta-analyses still had not conclusively explained all of the anomalies that we observed in those trials. Our perspective has always been that the debate has focused primarily on the question of whether or not encapsulation suppressed the effects of Sumatriptan such as what was done in the new meta-analyses by Mandema and colleagues, which we added for this update. But we feel that this is only one piece of the puzzle. The other anomalies we've always thought are important are the pattern of higher pain relief and pain free rates for Eletriptan in the five head-to-head trials as compared to the rates in the placebo-controlled trials. And then secondly the pattern of lower pain relief and pain free rates for placebo in the head-to-head trials of Eletriptan as compared to the rates in other placebo-controlled trials. And since no new evidence from update four addressed these additional anomalies we still have uncertain confidence about the findings from the head-to-head trials of Eletriptan as compared with Sumatriptan, Almotriptan and Zolmitriptan. So no changes to our previous conclusions about those studies. Next slide.

And here's a summary from placebo-controlled trials of Eletriptan that we used to fill gaps in the head-to-head evidence. And for this update we added findings from one placebo-controlled trial that found Eletriptan superior in improving work productivity. The previous [inaudible] only shown in one placebo controlled trial but for this update we found another placebo controlled trial that confirmed those previous findings. Also for this update we added one placebo-controlled trial that is the first to confirm Eletriptan's efficacy in the early [tape cut out] of migraine when pain is mild. So that was the main focus of the new trials added for this update is the use of triptans to treat...for early treatment of migraine when pain is still mild. Next slide.

So now we're on to slide 14. Evidence for Rizatriptan standard oral tablets and here's an overview of the evidence. There were no new head-to-head trials for this update but we did add to placebo-controlled trials of Rizatriptan for early treatment of mild pain. Next slide.

So here's a summary of findings from the four head-to-head trials of Rizatriptan 10 mg compared with Sumatriptan 50 mg and 100 mg and there was no new evidence for update four so our previous conclusions still stand that based on pulled analyses using data from two trials, Rizatriptan 10 mg only had superior pain free rates only at two hours and only compared with Sumatriptan 100 mg. But Rizatriptan 10 mg did not have superior pain free rates at 24 hours compared with Sumatriptan 100 mg nor did Rizatriptan 10 mg have superior pain free rates at either two hours or 24 hours compared with Sumatriptan 50 mg. Next slide.

And here's the evidence from the head-to-head trials of Rizatriptan 10 mg compared with Naratriptan 2.5 mg and Zolmitriptan 2.5 mg. And again nothing new here. So our previous conclusion still stands that Rizatriptan is superior to Naratriptan and Zolmitriptan on most outcomes. Next slide.

Here's the evidence from placebo-controlled trials of Rizatriptan that we used to fill gaps in the head-to-head trials of Rizatriptan. For this update we found two new placebo-controlled trials of Rizatriptan 10 mg that are the first to confirm Rizatriptan's efficacy in the early treatment of migraine when pain is still mild. So both at two hour...on the two-hour pain free and 24-hour sustained pain free outcomes of the relative risks were significant. And we also have the numbers needed to treat there on the slide. Next slide.

So now onto evidence for the orally disintegrating form of Rizatriptan and for this update we added one new head-to-head trial of Rizatriptan orally disintegrating tablet 10 mg compared with Eletriptan 40 mg. And in the dossier provided by the manufacturer we also found some unpublished quality of life data for one published placebo-controlled trial and we added that. But we still don't have any evidence on Rizatriptan orally disintegrating tablets for the early treatment of mild pain or on work productivity outcomes or for evaluation of consistency of efficacy across multiple attacks. Next slide.

So here's the results from the head-to-head trials that compared Rizatriptan orally disintegrating tablets 10 mg to other standard oral triptans and we added one trial for this update. This was an open head-to-head trial that was primarily designed to evaluate patient preference in adults who had no prior experience with either triptan. And what they found was that Rizatriptan orally disintegrating tablet 10 mg and Eletriptan 40 mg were comparable in terms of the pain free outcomes,

patient satisfaction outcomes and functional disability outcomes, but that significantly greater number of patients expressed a preference for treatment with the Rizatriptan orally disintegrating tablets over Eletriptan with the most common reason being that the Rizatriptan orally disintegrating tablet “relieved my headache pain faster”. So our new conclusion for Rizatriptan orally disintegrating tablet is that it appears to have similar or higher efficacy for pain outcomes than other standard oral triptans. But there’s consistent evidence from two trials that patient preference is significantly higher for the orally disintegrating tablet form of Rizatriptan. Next slide.

Here’s the evidence from placebo controlled trials of the orally disintegrating tablet form of Rizatriptan that we use to fill gaps in head-to-head trial evidence and for this update we added unpublished data submitted by the manufacturer as a supplement to a published trial, which showed that Rizatriptan orally disintegrating tablet was superior to placebo in improving scores on all five subscales of the migraine specific quality of life questionnaire. Next slide.

Here’s an overview of the included studies for Zolmitriptan and for this update we added an unpublished trial that compared a 2.5 mg dosage of Zolmitriptan standard oral tablet to Naratriptan 2.5 mg that we identified from the reference list of a new meta-analyses of Zolmitriptan and for which we then accessed full information from the manufacturer’s website. And then we also added one new placebo-controlled trial of Zolmitriptan standard oral tablet for the early treatment of mild pain. Next slide.

And here’s the results of the head-to-head trials of oral Zolmitriptan compared with other oral triptans and for this update we added one unpublished trial of Zolmitriptan 2.5 mg compared with Naratriptan 2.5 mg. And the main issue for this trial, which is likely why it is unpublished, is that it appears that there was a flaw in the randomization or allocation processes, which resulted in more patients with severe pain at baseline getting into the Zolmitriptan 2.5 mg group. The statistical analysis for the primary outcome of two-hour pain relief did include adjustment for this baseline difference and showed no significant differences in the rates in the Zolmitriptan 2.5 and Naratriptan 2.5 mg treatment groups. But they didn’t make any adjustments for baseline differences to the other outcomes, which limits our interpretation of their findings. So we didn’t present any other data from this trial in our report. So the findings from this trial did not change our previous conclusion that there is no evidence that Zolmitriptan is consistently superior in efficacy to any other oral triptans. Next slide.

This slide summarizes the evidence from head-to-head trials involving a comparison to Zolmitriptan nasal spray. And we found no new trials for

this update. So this evidence should not be underlined in this slide and I apologize for this error. So our conclusion still stands that the only evidence showing a significant advantage for Zolmitriptan nasal spray was when a relatively higher dose of the nasal spray was compared to a lower dose of the Zolmitriptan oral tablet. Next slide.

So here's a summary of the evidence from placebo controlled trials of Zolmitriptan that we used to fill gaps in the head-to-head trial evidence. For this update we added one new placebo-controlled trial of Zolmitriptan that was the first to confirm Zolmitriptan's efficacy in the early treatment of migraine when the pain is still mild. But only for the outcome of two-hour pain free. The 24-hour sustained freedom from pain outcome was not reported in this trial. Next slide.

Provides an overview of the included studies for Almotriptan and for this update we added head-to-head trials that involved comparisons of Almotriptan to Rizatriptan 10 mg and Zolmitriptan 2.5 mg. As for placebo-controlled trials for this update we added studies that evaluated the consistency of Almotriptan across multiple attacks and also those that evaluated the efficacy of Almotriptan in early treatment of mild pain. Next slide.

Here's a summary of results from the head-to-head trials of Almotriptan and previously the only head-to-head trials we had involving Almotriptan only evaluated its comparison to Sumatriptan and found comparable effects on pain outcomes. For this update the new trials found that while pain outcomes were also similar for Almotriptan 12.5 mg and Zolmitriptan 2.5 mg pain outcomes were inferior for Almotriptan 12.5 mg as compared with Rizatriptan 10 mg. Next slide.

Here's a summary of evidence from placebo-controlled trials of Almotriptan that we used to fill gaps in the head-to-head trial evidence and for this update we added one new placebo-controlled trial that was the first...to confirm the consistency of its superiority over placebo for two-hour pain free outcomes across three attacks. And we also added two placebo-controlled trials that are the first to confirm Almotriptan's efficacy in the early treatment of migraine when pain is still mild. For two-hour pain free outcomes, 24-hour sustained pain free outcomes, and also for normal [tape cuts out] at two-hour time point and also for quality of life outcomes. Next slide.

Here's the overview of the included studies involved Naratriptan. We didn't add any new studies to Naratriptan for this update. Next slide.

So we still only have two head-to-head trials involving Naratriptan both evaluating its comparison to Sumatriptan and they were consistent in

finding no significant differences between the drugs in pain relief outcomes but we still don't know how they compare on pain free outcomes, which may be more important to patients. Next slide.

Here's a summary of the included trials involving reformulated oral Sumatriptan. We still have not found any head-to-head trials involving reformulated oral Sumatriptan. But for this update we added one placebo-controlled trial of reformulated oral Sumatriptan that evaluated its use in the early treatment of mild pain. We added findings from our own supplemental analyses in which we pooled data from placebo-controlled trials to indirectly compare two-hour pain free rates between conventional and reformulated Sumatriptan. Next slide.

So here's a summary of results from placebo-controlled trials of reformulated Sumatriptan, which are all new to this update. So in the placebo-controlled trial that examined the efficacy of reformulated Sumatriptan for early treatment of migraine low pain is still mild. It found reformulated Sumatriptan was superior to placebo both on rates of two-hour pain free and 24-hour sustained pain free outcomes. And then on the bottom of this slide we also have pooled relative risks and numbers needed to treat for two-hour pain free outcomes from placebo-controlled trials of reformulated Sumatriptan and placebo-controlled trials of conventional Sumatriptan respectively so you can get a sense of how they compare indirectly at the most common time point. As you can see the relative risk estimates were similar for conventional Sumatriptan and reformulated Sumatriptan and there's a large degree of overlap of the 95% confidence intervals, which doesn't suggest a clear advantage for the new formulation at least at two hours. But considering the new formulation has been described as being faster acting it would be even more relevant to compare the pain rates at the earlier time point such as 30 minutes. But these data were not available from those early placebo-controlled trials of conventional Sumatriptan so we couldn't explore that comparison. And the best thing still would be for this to be directly evaluated in a head-to-head trial. So these findings from this unadjusted, indirect comparison should be considered as very preliminary until they are confirmed in a head-to-head trial. Next slide.

This summary of the included studies for the nasal spray and injection forms of Sumatriptan and we added no new evidence for these products for this update. So the head-to-head trial evidence base is still limited to two poor quality trials that compared injectable Sumatriptan to oral Sumatriptan. And because these are poor quality we don't describe their results in detail in the report, but the findings from those trials can be found in the evidence tables. Next slide.

But based on a previously included meta-analyses we do mention that pooled data from placebo-controlled trials found the greatest benefit for freedom from pain at the early time point of one hour for injectable Sumatriptan compared with other oral triptans. And also evidence from previously included placebo-controlled trials found that injectable Sumatriptan has been proven superior to placebo in other important outcomes such as functional capacity, work productivity and quality of life all of which have not been proven for all oral triptans. Next slide.

Here's a summary of the included studies for Frovatriptan and their results. And we added no new studies for update four. So the best evidence we have for Frovatriptan is still limited to five placebo-controlled trials, which suggest that Frovatriptan is probably inferior to Sumatriptan 100 mg. Next slide.

Here's a summary of the included trials for the six-dose combination product containing Sumatriptan and Naproxen, all of which are new to this update. We found two head-to-head trials of the combination product compared with Sumatriptan monotherapy 85 mg and also some placebo controlled trials of the combination product as used for early treatment of mild pain. But we didn't find any trials that compared the combination product to co-administration of its individual components. Nor did we find any evidence on the combination product's affects on quality of life. Next slide.

So here's the results from the two head-to-head trials of the combination product compared with Sumatriptan monotherapy at 85 mg, which both found the combination product to be superior in 24-hour pain-free return to normal function overall productivity and patient satisfaction outcome. Next slide.

For early treatment of migraine in all six trials compared with placebo the combination product was superior both in rates of two-hour pain free and in rates of sustained 24-hour pain free. And also we included two placebo-controlled trials that examined the consistency of efficacy of the combination product over four attacks and the results of this trial demonstrated that only 21% to 28% of patients achieved two-hour pain free outcomes in all four attacks. Next slide.

So now we're moving on to key question 2, harms. And again this slide just points out that we added sub questions 2B and 2C for evaluation of the comparisons of harms between the new fixed dose combination product containing Sumatriptan and Naproxen to Triptan monotherapy and to co-administration of its individual components. Next slide.

And here's a summary of the results on the harms outcome. So for the comparison of monotherapy versus monotherapy findings from the new trials were consistent with our previous conclusions that the triptans are all pretty comparable in terms of their profiles of harms. So we made no changes there. And for the studies that compared the combination product to monotherapy with reformulated Sumatriptan at the 85 mg dose there were also no consistent significant differences in harms found. Next slide.

So on to the evidence for key question 3, comparative effectiveness in harms and subgroups. Next slide.

For this update we did add some unpublished data on subgroups based on gender, age and race and prophylactic treatment use. And on association with menstruation that were all provided by the manufacturer of Rizatriptan in their dossier. But they hadn't performed any statistical analyses on these data due to small subgroup sample sizes. So the new data from the dossier did not change our previous conclusion that the available evidence has not demonstrated any consistent differences between triptans in any patient subgroups.

Now on to the next slide which is the last slide and that concludes my presentation summarizing the new evidence from update four of the triptans review. Now I'll turn it over to you.

Vyn Reese: Okay. Thank you very much. Can you stay on the line for questions from the committee and then stakeholder input?

Kim Peterson: Okay.

Vyn Reese: Any questions from the committee? This is Dr. Reese. I had one question on comparative harms. Of the fixed combination versus the...just the plain triptan dosing. It didn't look like in the studies that...they were just sort of listing triptan side effects. It didn't talk about possible NSAID side effects like epigastric pain or nausea from NSAIDs that can frequently be found with that drug class. So I'm wondering was that looked at too? Or were those questions asked in the studies?

Kim Peterson: Oh boy, you know, we focused on...and you're right that there are different side effects associated with the NSAIDs and we didn't consider those. We focused on the main outcomes...the main side effects that are associated with the triptans. So I'd have to look back at those studies to...I mean we did look at the rates of overall adverse events, which would incorporate of those adverse events associated with the NSAIDs and there were no consistent significant differences there. So that might partially address your question.

Vyn Reese:

Okay. Thank you. Any further questions from the committee? I want to open it up now to stakeholder input and Jeff is going to be our timer. You have three minutes to speak. So please...and please introduce yourself and the committee that you're representing or the company you're representing. The first person on the stakeholder group is Jennifer Brizonoff(?) from GlaxoSmithKline. Second person will be Jonathan Stabin(?) from GSK. Her mic isn't on.

Jennifer Brizonoff:

Good morning. My name is Jennifer Brizonoff, Regional Medical Scientist with GlaxoSmithKline. Thank you for the opportunity to talk about Treximet this morning. I have three main points to address today. Treximet treats the multiple mechanisms of migraine, which sets it apart from all the other drugs in the triptan class. Point two, Treximet is proven superiority to Imitrex, the gold standard in treating migraine. And point three, I hope to address the question of why not give this as two separate tablets?

Current understanding of migraines suggests that there are multiple mechanisms involved including neurochemical release, vessel dilation, inflammation and also prostaglandin production. Single entity triptans addressed some but not all of the multiple components of migraine. Treximet, a single tablet containing 85 mg of Sumatriptan with RT technology and 500 mg of Naproxen addresses these multiple mechanisms of migraine.

Treximet provided superior results across a variety of efficacy outcomes versus Sumatriptan 85 mg in two pivotal trials treating patients with moderate to severe migraine pain. Treximet provided superior pain relief and pain free results at two and four hours as well as superior sustained pain freedom two to 24 hours versus Sumatriptan, Naproxen or placebo. In addition, the use of rescue medication was significantly reduced in patients that took Treximet. In addition, two studies evaluated Treximet's utility in patients who had reported poor response to previous treatment with short-acting triptans. Patients enrolled had failed an average of 3.3 triptans in the previous year. In this population Treximet provided superior efficacy results versus placebo across a variety of short- and long-term efficacy endpoints.

Now why not give this as two separate tablets? Data from managed care databases studies which are outlined in the Treximet dossier suggests that patients with access to multiple acute migraine therapies practice step care—taking first a non-specific medication like an NSAID and delaying taking their triptan. A survey of 425 migrainors showed that 71% used multiple medications to treat their migraine and that over half of them used step care with [inaudible]. Results from the disk study showed that stratified care taking the appropriate specific migraine therapy early in an

attack provides a significantly greater response and less disability time across attacks compared to step care.

Treximet does contain a box warning for cardiovascular and GI risk. In clinical trials it was generally well tolerated with the most common adverse events being dizziness at 4%, somnolence, nausea and chest and neck discomfort each at 3%, paresthesias and dyspepsia at 2%. Due to Treximet's ability to address the multiple mechanisms of migraine, its superior efficacy over Imitrex and the decreased need for rescue medication it is recommended that Treximet be available to patients enrolled in the Washington State Medicaid program. I'll address any questions.

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

Patti Varley: Yeah. This is Patti Varley. I have a question, which is, was this...did the study include looking at triptan with Naproxen given at the same time as opposed to step in comparison?

Jennifer Brizonoff: The study I spoke of was a survey but do...I think the question you're asking is, "Do we have clinical evidence looking at efficacy comparing the two?" No. We did a pharmacokinetic study comparing giving the two simultaneously separate tablets versus Treximet as a single table, but not an efficacy study.

Patti Varley: Okay.

Vyn Reese: Thank you. Next presenter up is Dr. Jonathan Stabin from GSK. On deck is Deborah Crawford, Endo.

Jonathan Stabin: Hi. Jonathan Stabin. I practice for Rockwood Clinic in Spokane. I studied under Dr. Bray on your P&T Committee. I also serve on the P&T Committee for Group Health so I understand the decisions you're about to make. I'm here to talk about Treximet. I do both urgent care and family medicine. I see a lot of acute migraines and chronic migraine patient management. The four real life goals I have for my migraine patients are first of all getting them down to only needing a triptan four or five times a month, getting them on an appropriate preventative medicine if needed. Second is lowering ER utilization. If the patient's aren't using their medication appropriately they are going to be more likely to get in that refractory migraine state and end up in the emergency room after hours, in my office in the urgent care the next day with a refractory migraine requesting things like more demurrals, you know, those things that drive up health care costs. We're going to be more and more graded as primary care physicians on ER utilization as part of our quality control measures and this is an important goal for me. Third is lowering their use of

narcotics. I've got way too many patients that love their hydrocodone and oxycodone for their migraine therapy. Both as using them inappropriately for initial migraine attack and using them as inappropriate rescue medicine. So if you don't get the migraine treated as effectively as possibly initially they're going to be more and more likely to use those types of medicines later on. Third is to...excuse me, fourth is to lower calls of refills for me and getting samples. Patient's are burning through these triptans quicker than they are...usually they have like an allotted 9 or 12 a month that they get and a lot of times they're using second doses. They are using them very frequently throughout the month so they're calling my office asking for more and more.

Treximet has got good head-to-head data against Sumatriptan. It's also got an impressive study where they looked at for a yearlong almost 25,000 attacks. This was an open label study where they could use second doses rescue medicines. 70% only needed one dose of the medication and 30% needed two and only 3% of that group used any kind of rescue medicines at all. And this is mimicked my personal clinical experience, which is why I'm talking today. I've had patients utilizing less rescue medications with their Treximet needing less times that they are needing the second dose and then also they're less likely to call my office asking for more refills, more samples because they have used all their allotted amount. So I've had experience with all the triptans over the last six years since I've been at Rockwood Clinic and I found that Treximet definitely, in my antidotal experience at least, has some superiority in that.

I also found that patients generally don't follow your recommendations. If they do, because I have a number of patients like on Group Health for instance that they only take Sumatriptan and Naproxen together. They will not follow those directions. They hoard their triptans; they take their hydrocodone or their naproxen first.

Jeff Graham: Would you conclude your remarks, please?

Jonathan Stabin: Yeah. That's pretty much all I have to say. Any questions?

Vyn Reese: Thank you. The next person up is Dr. Deborah Crawford from Endo and on deck is Dr. Sweena(?) Aurora.

Deborah Crawford: Good morning. Thank you for your time today. I'm Dr. Deborah Crawford, a member of the Health Outcomes and Pharmacoeconomic Team with Endo Pharmaceuticals. I would like to take this opportunity to make the case that individual patient response can and does vary significantly within the triptan class. While the OHSU report illustrates that there is little in the literature to distinguish these seven drugs it is not uncommon in the clinical setting for a patient to be switched from one

triptan to another for reasons of efficacy and/or tolerability. It is therefore important that multiple choices of triptans be available to patients and physicians.

A post-op comparison of the incidents of adverse events following the use of Sumatriptan 100 mg with Frovatriptan 2.5 mg during the first migraine treated in a double blind placebo-controlled parallel-group comparison study published in 2002 showed that for safety and tolerability Frovatriptan 2.5 mg was better tolerated than Sumatriptan 100 mg when the two were compared in a single study. The total number of adverse events reported was approximately 50% higher in the patients that took Sumatriptan at .91 events per patient than those that took Frovatriptan at .62 events per patient. When the adverse events were grouped together according to the body system the incidents was lower in the Frovatriptan treated group in all body systems except for the vascular extra cardiac system. Flushing, primarily in the face and neck resulted in a higher observed incidence of vascular adverse events in the Frovatriptan treated group at 3% versus 1%. The incidents of 14 commonly reported individual adverse events reported in at least 2% of the patients was lower in the Frovatriptan group with the exception of the flushing as previously described. Significantly fewer patients taking Frovatriptan than Sumatriptan experienced paresthesias, nausea, vomiting, asthenia and skeletal pain.

Migraine headache recurrence is also an important and common reason for patient dissatisfaction with 71% of patients citing recurrence as a reason for their dissatisfaction in a study with Lipton et al. A meta-analysis by Dero(?) showed that headache recurrence rates across the triptan class were variable and ranged from 7% in a study for Frovatriptan 2.5 mg to 47% in a study with Rizatriptan 10 mg. The mean incidence of 24-hour headache recurrence ranged from 17% for Frovatriptan 2.5 to 40% for Rizatriptan.

There is a high degree of [inaudible] correlation between elimination half life and mean headache occurrence. The elimination half life ranged from approximately two hours for Rizatriptan 10 mg to approximately 25 hours for Frovatriptan 2.5 mg. The triptans with longer terminal elimination half lives had a lower incident of headache recurrence. Based on its proven efficacy as well as its unique pharmacokinetic properties in established tolerability and safety profile...

Jeff Graham: Would you conclude your remarks, please?

Deborah Crawford: ...Frovatriptan is a sound and viable option for health care providers. Thank you very much.

Vyn Reese: Thank you. Any questions from the committee? Okay. Next up will be Sheena Aurora and on deck is Debbie Almquist.

Sheena Aurora: Thank you very much. I'm Sheena Aurora and I'm a neurologist at Swedish Hospital. I've been practicing headache medicine for nine years at Swedish. Prior to that I directed the Headache Clinic at Henry Ford Hospital. I've committed myself to headache medicine for the last 15 years. I'm here on behalf of my patients. I'm one of the only providers as a neurologist who sees Medicaid patients. So what I'd like to urge you to do is consider that patients have available options and a treatment choice. I have the fortunate...my patient here is also here to tell you that one size does not fit all. I don't want to repeat anything that's been said before but I think it's very important particularly for these patients they're on this insurance for a reason and sometimes have lost their jobs because they haven't been able to control their migraines. I think that most triptans are similar, that is true, but the fixed dose Sumatriptan/Naproxen combination has provided good benefit in our clinical practice. There seems to be less refills on that and one tablet seems to work for a longer period of time without need for rescue. Debbie's not going to give you a poster presentation of Treximet. In fact, I will let you know her clinical story.

Debbie Almquist: Hello. I'm Debbie Almquist and I'm not a scientist. I'm just an everyday patient who suffers from migraines. When I was first diagnosed I didn't know what was happening. It literally felt like my brain was boiling and then it would progress to nausea and vomiting for 24 to 48 hours. So initially prescribed to me was 25 mg of Imitrex. It took some of the pain away but not everything. I eventually found 100 mg of Imitrex stopped the headache in 20 minutes. It was life saving. I have great insurance and actually look forward to Imitrex turning generic. I was very excited to go to the pharmacy and get my first little box of pills that were going to be cheaper and still save my life. However, it was like not taking anything and it turned me right back into going to the ERs. I just couldn't function. I went back to the nausea and vomiting and the pain.

So I went to Dr. Aurora and said, "You have to do something. Our insurance makes us take generic and it's literally not the same drug." They say it is and maybe for some people it is, but not for certain individuals. So she prescribed to me Treximet which quite honestly did not take away the same effect as a straight 100 mg. I'll be very honest about that, but it does give me relief and I don't progress to the 24 or 48 hours of vomiting. So I cannot imagine life without Treximet. That's my viable option. Thank you all for doing what you do.

Vyn Reese: Thank you. Any questions from the committee? The last presenter or stakeholder is Alan Woo from Jansen. Okay. I'd like to open it now for discussion in the committee.

Jeff Graham: Dr. Reese, this is Jeff Graham. I wonder if we should ask Kim if she wants to stay on or call back in because she is doing the next presentation.

Vyn Reese: Kim, do you want to stay on for the discussion? Are you still there?

Kim Peterson: I am, sorry. I had you on mute. Um, how long do you think...I mean I could take a break and call back. How long do you think you're going to be discussing?

Vyn Reese: Probably a short time. It's hard to know. Maybe 10 minutes, 15.

Kim Peterson: Okay. Well, maybe I'll sign off and take a quick break and call right back in 10 minutes or so. If you're not done yet that's okay.

Vyn Reese: Okay. That's fine.

Kim Peterson: Okay. Thanks.

Vyn Reese: Again, let's discuss the triptans. Any thoughts or comments?

Patti Varley: This is Patti Varley again and I guess I'll ask the committee a similar question to what I was asking the presenter which is my understanding is that the addition of an NSAID whether it's naproxen or ibuprofen with the triptans had evidence for quite a while of being helpful to a lot of people and I'm still unclear as to whether the tablet with the combo is actually proven to be more efficacious than taking naproxen with a triptan together. Does anybody know?

Vyn Reese: According to the review that wasn't studied and that was a big gap in the data. They didn't study Sumatriptan plus a separate dose of Naproxen. You can get Naproxen at a big box store for 3 or 4 cents a pill and it's very inexpensive. Also, as the...as one of the presenters mentioned the generic formulation of Sumatriptan may not be as rapid release as the former rapid release Sumatriptan because that drug maybe bio available in a shorter timeframe. That's not known, but that was one of the things that was pointed out in the study. The release mechanism of Sumatriptan may be different in different products. I have real concerns about a combination product. I have a lot of patients with NSAID problems and GI bleeds and major dyspepsia and coming into me because they are taking too much naproxen and naproxen is not a benign drug. In a study group where nobody has a history of peptic ulcer disease, everybody is young and healthy, those drugs look pretty good. But when you get out into the general population like the people I see, you add naproxen to something and that ends up...you end up adding a whole other list of side effects. Plus to me it doesn't make sense to take...when you can go down and get

an inexpensive dose of naproxen, take that with your sumatriptan at the same time, you should expect to see the same result. I can't see that it's any different than putting the two in the same pill. Plus you have some dosing variability. You don't have to take the naproxen every time if you have dyspepsia from naproxen you may not want to repeat it again. Whereas you might want to repeat your combination...your Sumatriptan again, you know, later in the day. So to me it seems like it's an awkward combination because you have no dosing flexibility and I think that, you know, I don't see the advantage of it over the individual components other than one person says, "Well, patients don't take those together." If their migraines are bad they're going to take them together. I mean I can't imagine...I tell my patients to take an NSAID with a triptan when they have a bad migraine attack and if they're having problems with the NSAID they don't take it or they...it's true that it's cheaper to take an NSAID and they may try that first and a lot of times that's all they need. So they don't need the triptan for lots of milder migraines. So it's a very complex area. I don't see...to me it seems like a needless combination that takes away flexibility, but the results...and they're also differences in the Sumatriptans that are available.

Patti Varley: And this is Patti again. I thought the data was not just with Sumatriptan but that the addition of an NSAID with any triptan was beneficial to some people who could tolerate NSAIDs. So that was my other question. So is it specific to that particular triptan or is it that...my understanding, from what I read, was that it helped to compliment any triptan in people who could tolerate the NSAIDs. Does anybody else know?

Alvin Goo: This is Alvin. Patti, you're correct. The studies do show that combination therapy is typically better and should be used with any triptan, any NSAID, aspirin, even regulin or even compazine. So any combination typically is better than a single agent.

Barak Gaster: This is Barak Gaster. I share Vyn Reese's concern about an NSAID combination pill. I think just in terms of if you really are going to talk about global safety that until we're all using sort of smart electronic medical records that are going to flag that sort of brand name as an NSAID I think there are a lot of physicians who will scan a medication list and not realize that a patient is on an NSAID, which definitely causes risk to the patient that that medication wouldn't be discontinued if a patient develops a contraindication of an NSAID. That said I would sort of bring us back to the motion that we're asked to make, which is that these agents are safe, which I think we've been sort of mainly interpreting as sort of the FDA has made that determination that these agents are safe and that's why they're approved and that they're efficacious and again I think the FDA has made that determination. So I think in terms of saying, "Are all these medications safe and efficacious?" I think we're still left sort of saying

that for this group of medications. I don't think we've seen any data that calls out in a clear way that one is any better than the other. So I think we're still left saying that they should all be subject to therapeutic interchange and similarly with the fewer adverse effects in special populations. I think it's a little bit complicated because I think Vyn asked a good question of the presenter as to the side effect profile of adding the NSAID to the...to the triptan as a single pill that we don't know for sure that that adds the expected NSAID risks or adverse events. So I think we're probably left with repeating the same motion that we made previously.

Patti Varley: This is Patti Varley again. I can't see for sure but we also, yes, I would include also that we have the different routes available.

Bob Bray: This is Bob Bray. Is this on? I agree with what's been said. In the way that we've commented that we need to have all the different preparations available on the PDL the other thing that I would just like some reassurance from is the combination product would not be identified as the only oral agent because of the contraindication issues with the naproxen for those people who are allergic or sensitive. So if we were to leave that as it stands would that be an understanding that it could not be the only oral product, the combination? Or would we have to specifically state that?

Siri Childs: This is Siri. You would have to specifically state that because as it's written right now we'll consider that among all the rest of them.

Carol Cordy: This is Carol Cordy. A couple questions. I didn't really hear that we are including that or...

Patti Varley: This is Patti Varley. It was in the list of reviewed agents. So it has to be included in the reviewed agents

Carol Cordy: Has that generally been true for other combination drugs?

Patti Varley: Yeah, but those were reviewed. Drugs reviewed.

Jeff Graham: This is Jeff Graham. No, it has not been common in other combination drugs. We've not always placed them into that category. I do think we did that with the combination statin drug but I can't remember for sure.

Barak Gaster: This is Barak Gaster. That actually brings up a good issue with the therapeutic interchange, which is that the users of that combination drug may be better off not having this on...as part of this list in that if they leave the doctor's office thinking that they have a prescription for a combination drug and then they get therapeutically interchanged to a

triptan monotherapy would the pharmacist necessarily sort of flag that for the patient and say, "Gee, you've been switched to a monotherapy triptan. You're doctor thinks that you're taking a tablet that also has an NSAID. When you take this therapeutically interchanged monotherapy make sure you take an NSAID with it." So I mean...overall patient care may be better off leaving that not as a therapeutically interchanged product, which is probably the reason that we have sort of shied away from including combination pills in the past.

- Vyn Reese: This is Dr. Reese. I agree with Dr. Gaster. I'm concerned about...also about allergy too. NSAID allergies can be fatal and if the doctor is not aware that that is a combination...if he just says it's...if he just looks at the data and says it is more efficacious you open patients up to anaphylaxis from the naproxen. It's hard to interchange that drug with the others since they are different. One is two drugs and the rest are one. It gives us a very awkward, you know, preferred drug list if we have that drug combination on it.
- Barak Gaster: This is Barak Gaster again. It also brings up the issue of whether we should make a recommendation to the therapeutic interchange program that combination tablets can be therapeutically interchanged but carefully such that each individual component that's in the combination is actually directly...sort of interchanged.
- Janet Kelly: This is Janet Kelly. I think that's maybe a bit too prescriptive. I think that pharmacists would know to deal with that and I don't know that that's going to help us anywhere here. That's just kind of adding extra wording and doesn't really address what the preferred drug list is.
- Barak Gaster: This is Barak Gaster. So Patti do you feel confident that as incredibly close to 100% of the time a pharmacist would make that recommendation to the patient that they're sure to take an NSAID along with their triptan monotherapy?
- Janet Kelly: Well, since Patti's not a pharmacist maybe Alvin can address that as another pharmacist.
- Alvin Goo: I think most pharmacists would be able to recognize that and...but I can't guarantee 100% that that's going to...that information's going to get relayed to the patient or that because, you know, pharmacies are extremely busy. I don't know if that's going to be always the case.
- Patti Varley: And this is Patti and I'm not a pharmacist. However, I do believe that when I'm thinking in my head as I'm listening to this same for same that one isn't same for same. If you did therapeutic interchange you can't just therapeutically interchange same for same. That you would...that puts it

in a whole different ball game regarding the co prescribing of a second drug with the interchange, which I don't know we've ever run into before. At least I don't recall and I do think that that is a huge assumption and danger for our patients in regard to their understanding and again you would hope the prescribing clinician would understand it. But again I would fear that even if I knew prescribing the combination drug had an NSAID that I would assume that's what the patient got filled and if they were told it was interchanged and they weren't told to take naproxen with it I would be assuming as a prescriber they were on that. There's just so many possible confusions, errors that I don't think it should be seen as the same because of its combination. But that's my opinion.

Carol Cordy: This is Carol Cordy and I agree 100%. I think we shouldn't have this combination drug on this list.

Barak Gaster: This is Barak Gaster. Can anybody speak to whether the language, which is in the therapeutic interchange program even mentions the word combination product?

Donna Sullivan: This is Donna Sullivan. It doesn't specifically mention combination products. But if you were to try to substitute this for a single product my concern would be as the pharmacist I don't think has the prescriptive authority to prescribe the naproxen in addition to it if it's the prescription strength and not the over-the-counter strength. And they would not be able to fill the second prescription and it may or not be...so the patient may not get it. They would have to purchase it on their own. That may or may not be a problem for Medicaid as well.

Barak Gaster: So this is Barak Gaster. So I think that we're identifying a significant problem with the therapeutic interchange program language that should be addressed. There should be sort of a paragraph in there of how to handle combination products. I think this is a great example where we've got a top line therapy that's going generic that we'd all like to be able to always therapeutically interchange to and then we've got a new brand name combination product that could be sort of a clever way for pharmaceutical companies to try to circumvent that generic interchange and that we would be well served to have language in the therapeutic interchange program that would address how to handle combination products.

Patti Varley: This is Patti Varley again and I don't know if this is overly simplifying it and if it meets all of our needs but my thought was that you could list all but that combo as safe and efficacious and allowed to...subject to therapeutic interchange and at the end from our review if people felt comfortable you could say that that combo drug was also safe and efficacious but not subject to therapeutic interchange. I don't know if that meets all of our agendas here about that. I don't know if that meets it, but

to me separating it out by the discussion I've heard and having it be in and of itself its own entity makes more sense.

Vyn Reese: This is Dr. Reese. The question is should it be on the list at all since it is two drugs instead of one? I have a real problem with it being two drugs instead of one and you can sort of leave it out on the edge there but it still poses lots of other safety and...issues...and I'm just wondering if we would be safer just to leave it off the PDL entirely.

Donna Sullivan: Again, this is Donna Sullivan. You have made that decision in the past where there is a list of drugs and you felt one of them didn't fit within that class and you said this drug should not be part of the class. So you have made that motion before. So if you feel like you should do that then you can make that a motion.

Ken Wiscomb: This is Ken Wiscomb. My concern was if it's not part of the classes then does it not then have its own class automatically on the preferred drug list?

Siri Childs: No. This is Siri speaking for Medicaid and I wanted to clarify a couple of things. The pharmacist would not be able to interchange a combination drug without two separate prescriptions from Medicaid. We can't cover an over-the-counter product unless there's a prescription written for it. So it really complicates the whole tip program. Again, as Donna says there are several examples in the PDL program where drugs that are studied in the OHSU report really don't fit with the other drugs. And you have excluded them from the preferred drug list and we handle them individually as our individual benefit programs.

Duane Thurman: This is Duane Thurman and I want the pharmacists to listen to me carefully in case I mess this up. But I think that the options you have are to say that this is not part of the drug class and what that effect has is that some...an endorsing practitioner writing "dispense as written" would not be able to override the PA on that. If you were to say it is part of the drug class but it's not...you would say it should not be a preferred drug then an endorsing practitioner writing "dispense as written" would be able to get access to the drug and override the PA. And then I think the main issue is you clearly can say that that drug is not subject to therapeutic interchange. So not subject to interchange is definite. The other two options are not part of the class or not preferred in the class.

Siri Childs: Duane, I would like to add something to that because Treximet in Washington Medicaid is a drug that requires prior authorization because of the Naproxen component. We treat it like we would treat any other NSAID and we ask if they've had a history of a GI bleed or an ulcer. So, you know, we are actually screening them very carefully.

Barak Gaster: This is Barak Gaster. So I mean...I apologize that it feels like this committee is sort of reinventing the wheel every time we deal with a combination product. And that I would now say that of those options it makes sense for this combination tablet to not be included in this class and that perhaps for the sake of clarity we should change the name of this class to be Triptan Monotherapies and that...it still raises the question about whether we should make a recommendation that the therapeutic interchange program figures out a clearer way to handle combination products.

Vyn Reese: Barak, do you want to make that a motion?

Barak Gaster: For the...for this class you mean?

Vyn Reese: Yes.

Barak Gaster: Sure. So after considering the updated evidence of efficacy, safety and special populations for the treatment of migraine I move that Almotriptan, Eletriptan, Flovatriptan, Naratriptan, Rizatriptan, Sumatriptan and Zolmitriptan are safe and efficacious. The Washington Preferred Drug List must contain an oral, an oral dissolving, a nasal and a subcutaneous product. No single triptan monotherapy is associated with fewer adverse effects in special populations. The above-named triptans can be subject to therapeutic interchange in the Washington Preferred Drug List for the treatment of migraine. Sumatriptan/Naproxen should not be included in the triptan monotherapy class.

Vyn Reese: Any discussion?

Duane Thurman: I'll second.

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

Group: Aye.

Vyn Reese: Opposed, same sign? Motion's passed. Okay. Is our presenter still on the line?

Kim Peterson: Yes.

Vyn Reese: Okay. You came back in time. So the next item on the agenda is a scan of the oral hypoglycemics.

Kim Peterson: You ready to begin?

Vyn Reese: Just a second. We're needing to get our slides changed here. Wait just a second. Okay. Go ahead.

Kim Peterson: Okay. So this is the third preliminary update scan of the drug class review on oral hypoglycemics. It was conducted in May of this year and it was for consideration of a third full update of this review. Next slide.

So this review was last fully updated in May of 2005 and it has been scanned for consideration of a third update on two prior occasions in January of 2007 and in February of 2008. Next slide.

The next two slides provide an overview of the inclusion criteria from the last update, which is what we used for our search and study selection for the scan. For population this review has focused on adults with Type 2 diabetes and for interventions this review is focused on the sulfonylureas and the short-acting secretagogues listed in this slide. Next slide.

The effectiveness outcomes have included the important...long-term health outcomes such as mortality and disease progression as well as HbA1c lowering. And we included the usual safety outcomes as listed here. Next slide.

Here's the details of the search. We searched from February 2008, which is the end date of the last scan up to May of 2009 and we found a total of 42 new citations. Next slide.

And among those 42 new citations only 2 met the inclusion criteria. The details of those are shown in the table on this slide. Both evaluated the comparison of Nateglinide to Glyburide. Remember that glibenclamide is another name for Glyburide in that Derosa 2009 study. And both studies were both long-term. The Derosa study was one year and the Schwartz study had one part that was 104 weeks long. But neither reported mortality or disease progression outcomes such as were reported in the UK PDS study. So the UK PDS study is still the best evidence available for this drug class. So taken together with the 11 potentially relevant trials found during the prior two preliminary update scans now there's a total of 13 new trials that would likely be added in a full update of this review. Next slide.

So we also searched the FDA and Health Canada websites for identification of new drugs, new indications and new safety alerts. But for this preliminary update scan we didn't find any such new information. Next slide.

And that concludes the presentation of the findings from the third preliminary update scan for the review of oral hypoglycemics. And based

on the findings I just presented the DERP participating organizations again voted against a full update of this review. So the next time it will be considered for an update is estimated for May of 2010. So I'll turn it back over to you for questions and discussion.

Vyn Reese: Thank you Kim. We'll take a motion from the committee to accept the scan?

Man: So moved.

Vyn Reese: And a second?

Man: Second.

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

Group: Aye.

Vyn Reese: Scan's accepted. Any questions of Kim? Thank you. Any discussion? This is nothing new here. We have a new format for our motions for scans. It's...there's no stakeholders either. Nobody wants to talk about this. Okay. So I'll take...does everyone...could everyone turn to the P&T motion history and what we can do now is just basically have a motion to repeat the motion of October 15, 2008, which is the one we passed before.

Ken Wiscomb: This is Ken Wiscomb. I move we reiterate the prior motion from October of 2008.

Vyn Reese: Is there a second?

Bob Bray: Bob Bray, second.

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

Group: Aye.

Vyn Reese: Opposed, same sign. Motion is passed. The next item on the agenda is the scan of the antiplatelet drugs. Are you ready Kim?

Kim Peterson: Yep.

Vyn Reese: Okay. Wait just a second. We gotta get our slides up.

Kim Peterson: Okay.

Vyn Reese: We're not ready. Okay. We're ready to go I think.

Kim Peterson:

Okay. So this is the second preliminary update scan of the drug class review on newer antiplatelet agents. It was also conducted in May of this year and it was for consideration of a second full update. Next slide.

So far this review has only been fully updated once back in April of 2007. And the last time this review has been scanned for consideration of a second full update was in March of 2008. Next slide.

The next few slides provide an outline of the scope of the review. As a reminder the included populations are adults with acute coronary syndrome, recent or ongoing coronary revascularization by stenting or bypass grafting, prior ischemic stroke or transient ischemic stroke, and symptomatic peripheral vascular disease. The included interventions are Clopidogrel and Ticlopidine both taken either alone or in combination with aspirin. Dipyridamole taken in combination with aspirin and the fixed dose combination product that contains Dipyridamole ER plus aspirin. Next slide.

And this slide outlines the included effectiveness and safety outcomes. For effectiveness outcomes we've included all cause mortality, cardiovascular mortality, myocardial infarction, stroke and failure of an invasive vascular procedure. And then we have the usual safety outcomes. Next slide.

So to find relevant trials published since the last scan we searched Medline from March 2008 to May 2009 and we found a total of 160 new citations. Next slide.

Among the 160 new citations we found three that met inclusion criteria and we provided the details in this slide as well as five publications of secondary analyses of previously included trials which are presented in the next slide. So for the new trials in this slide the most interesting ones are outlined in the first two rows. First we found two new publications of results. So final results from the PROfESS trial, which was a trial of Dipyridamole extended release plus aspirin compared with Clopidogrel in patients with ischemic stroke. So this is a trial that is cited in the report as ongoing. So it was only ongoing at the time of the last full update but now there's final results available. And then next was a trial that compared Clopidogrel to Ticlopidine in Japanese patients with noncardioembolic cerebral infarction. And the thing we noted about this trial was that it would fill a gap in that it would be the first head-to-head trial in the stroke population. And then the third trial was a trial that compared taking Clopidogrel plus aspirin with taking aspirin alone following revascularization by bypass grafting. Next slide.

So at the top of this slide we have the details of the five new publications of secondary analyses of previously included trials that we found in the scan. We found two secondary analyses from the CREDO trial, one that evaluated bleeding in patients who received dual antiplatelet therapy for one year compared with receiving dual antiplatelet therapy for four weeks. So looking at optimal treatment duration. And then one that evaluated effects in a subgroup of patients with comorbid chronic kidney disease. And then we also found three secondary analyses from the CHARISMA trial, two of which evaluated effects in subgroups of patients who either had a history of atrial fibrillation or who were asymptomatic at baseline; so the primary prevention population in CHARISMA. And then we found a third secondary analyses which evaluated whether their ethnicity is an independent predictor for cardiovascular events in bleeding complications. And then at the bottom of the slide we've got the numbers of new publications found in the prior preliminary update scan. So taken together with the four new trials and six new secondary analyses found in the prior scan now there's a total of seven new trials and 11 secondary analyses that would likely be added in a full update of this review. Next slide.

We also searched the FDA and Health Canada websites for identification of new drugs, new indications and new safety alerts. For this preliminary update scan we didn't find any new information. Next slide.

But we did find information about a couple potential new drugs that at the time we were considering them as potential for receiving FDA approval in the near future. So Prasugrel and Ticagrelor and since our May 2009 preliminary update scan the first drug listed on the slide, Prasugrel in fact did receive FDA approval on July 10th of this year and is now being marketed under the trade name of Effient. Next slide.

And although not eligible for inclusion under the current scope of the review, as part of this preliminary update scan the Oregon EPC also identified a few scope expansion ideas for the next full update, which are outlined in this slide. The first was the idea of adding key questions to evaluate the issues of whether a high dose antiplatelet...whether high dose antiplatelet regimens are superior to standard dosing. And also whether shorter term treatment durations are not inferior as compared with longer term treatment durations. So these ideas were triggered by we were seeing a lot of new studies that were looking at these questions. So we just wanted to raise those ideas to the participating organizations of DERP that if they wanted to update this review they might consider adding those types of key questions. And then the second was the idea of adding the ST elevation myocardial infarction population as a new population in the next update. Again, the reason for this is because in the past, and then also for this scan, we've been seeing studies of new antiplatelets being done in this population. Next slide.

So that concludes the presentation of the findings from the scan. Based on those findings the DERP participating organizations again voted against a full update of this review. So the next time this review will be considered for a full update is estimated for May of 2010. And so I'll turn it back to you for questions and discussion.

Vyn Reese: Thank you Kim. First I'll take a motion to accept the scan.

Barak Gaster: This is Barak Gaster. I move that we accept the scan.

Vyn Reese: A second?

Carol Cordy: This is Carol Cordy. I second.

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

Group: Aye.

Vyn Reese: Opposed, same sign. The scan is accepted. I have a question Kim. What is the indication for Prasugrel? Is it an inpatient only drug now?

Kim Peterson: Repeat your question. What is the FDA approved indication for that drug?

Vyn Reese: Yes, exactly.

Kim Peterson: Oh boy. I could look that up real quick. I don't have that information on the slide.

Vyn Reese: Isn't it just post procedure? Is it a post procedure drug? So you don't have that?

Kim Peterson: No. But I could look it up on the FDA website real quick if you want to hold on.

Man: [inaudible]

Vyn Reese: So it's basically an inpatient drug, right?

Janet Kelly: Vyn, this is Janet Kelly. That's not correct. It is a medication that may be started initially after the procedure but it is continued. It is an oral medication.

Vyn Reese: So it can go to outpatient? It's not just before the procedure. There can be a tail on it?

Janet Kelly: Yes.

Vyn Reese: Okay.

Jeff Graham: Vyn, can we...are there stakeholders?

Vyn Reese: Well, no, she was just looking something up.

Jeff Graham: We might get them ready to go.

Kim Peterson: Yes, I'm still looking it up on the FDA website. Just a second.

Vyn Reese: Okay. Maybe you can be looking that up while we get our stakeholder input here.

Kim Peterson: Okay.

Vyn Reese: The first stakeholder is Dr. John Beety of Boehringer Ingelheim. On deck is Steve Chang from Lilly.

John Beety: Good morning. I'm John Beety. I'm with the Medical Affairs Department at Boehringer Ingelheim and I'm grateful for the opportunity to talk to you today. I'm offering information in support of retaining Aggrenox on the PDL for Washington Medicaid. Aggrenox 1 capsule b.i.d. is indicated for the prevention of recurrent stroke in patients who have had a previous ischemic stroke or a TIA. It's not interchangeable with the individual components of aspirin and persantine tablets. The Dipyridamole component is extended release. Aggrenox has been shown to be twice as effective for stroke prevention as aspirin alone. In the ESPS2 trial Aggrenox showed a statistically significant 22% relative risk reduction for stroke compared with aspirin. There's 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 ESPS2. A new label inclusion is this following point that in the event of intolerable headache during initial treatment patients may switch to one capsule of Aggrenox at bedtime and low dose aspirin in the morning. Patients should return to the usual regimen as soon as possible, usually within one week. Aggrenox should be avoided in the third trimester of pregnancy because of the aspirin component. Patient's who consume three or more alcoholic drinks each day may be counseled about the bleeding risk involved with chronic, heavy alcohol use while taking aspirin. Most of the potential drug/drug interactions noted in the Aggrenox product insert concern aspirin. Dipyridamole has been reported to increase the plasma levels and cardiovascular effects of adenosine. An adjustment of adenosine dosage may be necessary. Dipyridamole also may counteract the

pseudocholinesterase effect of cholinesterase inhibitors thereby potentially aggravating Myasthenia Gravis. In ESPS2 Aggrenox had similar bleeding rates to low dose aspirin.

The incidents of intracranial hemorrhage was .6% in the Aggrenox group, .5% in the extended release Dipyridamole group, .4% in the aspirin group and .4% in the placebo group. Extended release Dipyridamole and aspirin is recommended as first line therapy option for prevention of non-cardio embolic cerebral ischemic events in the ASA 2008 guideline update. That concludes the comments I have to make and I'd be grateful to answer any questions you have.

Vyn Reese: Thank you. Any questions from the committee? Okay. Thanks. The next speaker is Steve Chang from Lilly and on deck is Dan James from Bristol-Myers Squib.

Steven Chang: Good morning. My name is Steven Chang and I'm a health outcomes liaison with Eli Lilly and Company. Today I'd like to share a few points regarding Lilly's recently FDA approved cardiovascular drug Effient or Prasugrel. Effient is a new thienopyridine and is FDA indicated for the reduction of thrombotic cardiovascular events in patients with acute coronary syndrome who are to be managed with PCI or percutaneous coronary intervention as follows: patients with unstable angina or non ST-elevated myocardial infarction or UA NSTEMI and patients with ST-elevation MI when managed with primary or delayed PCI or NSTEMI patients. Effient acts as an inhibitor of platelet activation and aggregation through the irreversible binding of its active metabolite to the P2Y12 class of ADP receptors on platelets. Effient is started as a single 60 mg loading dose and then continued at 10 mg once daily. Efficacy for Effient has been demonstrated in a large randomized head-to-head trial versus Clopidogrel or Plavix. This trial was called the Triten trial. Effient in comparison to Clopidogrel proved to have a statistically significant difference in reduction of the primary composite endpoint of CB death, non fatal MI, non fatal stroke in both the UA NSTEMI patients at 9.3% versus 11.2% and in STEMI patients 9.8% versus 12.2%. This efficacy was primarily driven by reduction in non-fatal MIs. There were also 50% fewer stent thrombosis reported in patients randomized Effient than in patients randomized to Clopidogrel.

Regarding safety the primary safety end point of non [inaudible] major bleeding was significantly higher in the Effient arm than in Clopidogrel. A 2.2% versus 1.7%. Effient carries a boxed warning regarding bleeding risk. It is contraindicated in patients with a history of TIAs or stroke. It is contraindicated in patients with active pathological bleeding, in patients greater than 75 Effient is generally not recommended because of increased risk of fatal and intracranial bleeding except in high risk patients such as

diabetes or prior MI where its effect appear to be greater and its use may be considered.

Additional risk factors for bleeding include body weight less than 60 kg or propensity to bleed and [inaudible] committed use of medications that increase the risk of bleeding. Clinicians should always weigh the risks and benefits of therapy when considering their choice of antiplatelet regimens. We hope you consider Effient for inclusion in the PDL. Thank you for your time. Full prescribing information for Effient can be brought on at your request.

Vyn Reese: Thank you. Questions from the committee? Thanks. Next presenter is Dan James, Bristol-Myers Squib.

Dan James: Hi. Good morning. I'm Dan. I'm from the medical department at Bristol-Myers and representing Sanofi Aventis also. I just have a very brief comment that Plavix is the only agent in this class that is indicated for the reduction of atherothrombotic events in acute coronary syndromes in patients with recent stroke and with established peripheral arterial disease. With that I'd be happy to answer any questions that any committee members would have.

Vyn Reese: Any questions? Thank you.

Dan James: Thank you.

Vyn Reese: So Kim, did you finish your research?

Kim Peterson: I did but I will say that the second to the last speaker read to you word-for-word from the product label in terms of what are the FDA approved indications for that drug. So he answered the question for you.

Vyn Reese: He was talking Plavix. Are you talking about the one before?

Kim Peterson: The second to the last speaker. I'd be happy to read that again to you.

Vyn Reese: Okay. And you really didn't have a chance to review this completely because it wasn't FDA approved by the time you finished this scan, right?

Kim Peterson: Right. So at the time of the scan we were simply identifying it as one that was pending approval. And so I was simply mentioning that we are aware that since the scan it has been approved. But we didn't search for evidence in the scan and we certainly haven't reviewed any. So this would be something that would be considered to be added to the report next year at the time of the next scan.

Vyn Reese: Okay. Thank you. So discussion on the committee? Janet, is this drug being used a lot in cardiology?

Janet Kelly: This is Janet Kelly. I think it is in PCI and where we're starting to see it used is in people who have had a clot following PCI when they go back and do it again they want to use...because of this it's theoretical, potentially more potent. They're willing to take the risk of additional bleeding in some patients. There's quite a discussion about it at our P&T as to, you know, what niche it is. I suspect that we'll start seeing it used. That's it. I mean it hasn't been reviewed yet. I don't know what we're supposed to do about it. It's not something we can address until it's been reviewed.

Vyn Reese: Right. We're sort of stuck on it. Any other thoughts?

Janet Kelly: I think it was just kind of an unfortunate timing that we didn't get it in to this.

Vyn Reese: I have a question. If a doctor tried to order this for a Medicaid patient and it hasn't been reviewed, it's not on the PDL could they actually get it for the patient? It sounds like there may be a few patients this drug will be prescribed in.

Siri Childs: This is Siri for Medicaid. Is this on? What we would do is we...and what we've already done is we have included it in the drug class as a non-preferred drug not studied, not subject to TF or DAW.

Vyn Reese: So could they prescribe it?

Siri Childs: Yeah.

Vyn Reese: That's my only question.

Siri Childs: What we would ask for is why they need that drug instead of Aggrenox or Clopidogrel.

Vyn Reese: Okay.

Siri Childs: Yeah.

Vyn Reese: All right. So we've accepted the scan and let's look at the prior motion that was from June 18, 2008.

Carol Cordy: This is Carol Cordy. I just have a question on the last...where we said I move that Ticlopidine not be put on the PDL due to safety concerns.

What does that mean because it is on the PDL according to this list? Is that right? Or do we mean to say...

Donna Sullivan: This is Donna Sullivan. What it means to me and Siri you can jump in if you think otherwise. It means it should be not preferred on the PDL and then it also allows the agencies to either prior authorize it and it's not subject to the DAW override if the endorsing prescriber writes DAW for Ticlopidine.

Carol Cordy: So I guess I feel like we need to restate that.

Vyn Reese: Just restate the whole motion? It looks like to me it's part of the motion.

Carol Cordy: Yeah. But I think we need to re-write that last part if we can.

Man: So are you thinking it shouldn't be available at all?

Carol Cordy: Well, no, but I mean...what it's interpreted as is that it is not a preferred drug on the Preferred Drug List.

Siri Childs: This is Siri and for Medicaid we do not include it on the PDL. We handle it by prior authorization because of the safety concern.

Vyn Reese: As I remember it caused agranulocytosis and a big drop in platelets. It was a drug that we had safety concerns about so we didn't want to put it on with these two drugs that there weren't as many safety concerns. So that's why we left it off.

Barak Gaster: This is Barak Gaster. So right it does sound like we're going to restate this motion with the only change being the last sentence that instead of it not be on the preferred drug list that it not be a preferred agent on the preferred drug list.

Man: Siri...right. If the agencies haven't had problems with this wording I would leave it be.

Vyn Reese: Just leave it be.

Siri Childs: Medicaid has not had a problem with this wording.

Vyn Reese: Okay. I'm not sure we need to reinvent the wheel on this motion. But if others differ that's fine.

Barak Gaster: This is Barak Gaster. I mean my only thinking is that we do reinvent the wheel just being confused about what is a preferred drug list and what is a preferred agent on the preferred drug list. So if we can try to have our

language be clearer on our motions then we'll be a little clearer every time we review.

Duane Thurman: This is Duane Thurman. Maybe this will clarify it. If you want it to be part of this program but non-preferred you say, "We want it to be non-preferred." If you say we do not want it to be part of the PDL then it is not part of this program and the agencies will handle the drug as they would handle anything that's not on this preferred drug list.

Donna Sullivan: This is Donna Sullivan...

Vyn Reese: It's a tighter restriction. Is that right? I mean this is...saying it's not on the PDL at all is a much tighter restriction than saying it's PDL but not preferred.

Donna Sullivan: Correct. This is Donna Sullivan and I guess to make it clearer for not up to interpretation if you don't want it to be part of the class you might want to say, "Not make it part of the class." It won't change how we handle the medication as far as the agencies but then it would just not be a part of the PDL, which I think is what you're trying to say here.

Siri Childs: This is Siri and the wording is exactly right, right now. It's not part of the preferred drug list but it is part of the drug class. So I would hate to have you say that it's not part of the drug class.

Carol Cordy: This is Carol Cordy. I'm sorry I opened up a can of worms here. I was just looking at the Washington Preferred Drug List at the front of our notebook here and since this drug is on that list...that's where I was confused because we said don't put it on the list but it's on the list. If we don't want it on the list it shouldn't be on there.

Donna Sullivan: It's listed there because it is part of the class and then there's notes that show that it is not preferred and I believe, Siri, I don't have it in front of me. Does it have an indication that it's restricted?

Man: No.

Donna Sullivan: I can make a note that it's restricted.

Siri Childs: This is Siri. To be consistent, Donna, it really should not appear on the preferred drug list if the committee has said it's not part of the preferred drug list.

Duane Thurman: This is Duane Thurman. I mean I think...I agree with Siri it's part of the drug class and if you want it to be non-preferred that should be reflected on the list that you have. If it's not it's a typographical error.

Carol Cordy: But I think the other step is should it be on the list at all?

Vyn Reese: It shouldn't be on the list at all according to what we said before and I agree that it should not be listed as on the PDL. It's a drug that's been reviewed but it shouldn't be on the PDL.

Duane Thurman: Okay.

Vyn Reese: That's what we said before. So Carol's right, it shouldn't appear there.

Duane Thurman: It's a type-o. But I assume the programming underlying the preferred drug list does not treat it that way.

Vyn Reese: Okay. After all this discussion do we want to change this motion in any way or can we just have a motion to accept the previous motion?

Bob Bray: This is Bob Bray. I move that we accept the prior motion.

Vyn Reese: Second?

Barak Gaster: This is Barak Gaster. I second it.

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

Group: Aye.

Vyn Reese: Opposed, same sign. Motion is passed. Now we'll adjourn for a brief...

Jeff Graham: Vyn, we're running about 15 minutes...well, a little bit more than 15 minutes behind right now. So if we could cut this to 10 minutes it would be better.

Vyn Reese: Okay. So we'll get back here in 10 minutes exactly and resume the meeting.

Jeff Graham: So Kim, did you hear that?

Kim Peterson: Yes, so 10 minutes and then we'll do atypical antipsychotics.

Jeff Graham: Yep.

Kim Peterson: Okay.

Jeff Graham: Thanks. Bye.

Vyn Reese: Please take your seats. Kim, are you on the line?

Kim Peterson: Yes.

Vyn Reese: I'd like to call the meeting to order again. Kim Peterson, are you ready?

Kim Peterson: Yes, I am.

Vyn Reese: Why don't you go ahead? We have our first slide up for atypical antipsychotics.

Kim Peterson: Okay.

Vyn Reese: Please take your seats. I'm calling the meeting to order. Please take your seats and stop talking. Thank you. Okay, Kim, I think we can begin.

Kim Peterson: Okay. Great. So now I'm going to be presenting findings from the first preliminary update scan of our drug class review on atypical antipsychotics. This scan was conducted in June of this year and it was for consideration of a third full update of this review. Next slide.

So history on the report. The last full update of this review, which was update two was completed in May of 2008. Next slide.

The next three slides outline the final inclusion criteria used in the last update. The included populations were adults with schizophrenia, related psychoses or bipolar disorder; children and adolescents with pervasive developmental disorders or disruptive behavior disorders and older adults with behavioral and psychological symptoms of dementia. Next slide.

Here are the seven atypical antipsychotic drugs that were included in the last review. They are aripiprazole, clozapine, olanzapine, paliperidone, quetiapine, risperidone and ziprasidone. Next slide.

Is the list of effectiveness, efficacy and harms outcomes included in the last update. Effectiveness and efficacy outcomes included mortality, quality of life, functional capacity, hospitalization, emergency department visits, etc., caregiver burden, symptom improvement, adherence and persistence and then the usual harms outcomes. Next slide.

So to identify the relevant new controlled clinical trials published since our last update we searched Medline back to November of 2007 using terms for the included populations and drugs that I outlined in the inclusion criteria I just went over and overall we found a total of 303 new citations. Next slide.

And among those we identified 75 publications of trials that appeared to meet all of our population drug and outcome criteria. 50 appeared to be publications of head-to-head trials that in all but two involved adults with schizophrenia. However, we did note that among the 48 head-to-head trials publications in adults with schizophrenia at least nine involved secondary analysis of the CATIE trial and three involved secondary analysis from the SOHO trial. So only around 36 look like completely new trials but that's still a lot of new trials...a lot of new head-to-head trials. Next slide.

So we also searched the FDA and Health Canada websites for identification of new drugs, indications and safety alerts. And on this slide we're showing information on the new drug that was identified at the time of the scan, which was iloperidone. It was FDA approved on May of 2008. When we looked through the results of our search for relevant trials we did find one head-to-head trial of iloperidone compared with ziprasidone and placebo. Next slide.

Here we're showing the new information on new indications we found in our FDA website searches. Aripiprazole, quetiapine, quetiapine XR and risperidone all got new indications for various aspects of treatment of bipolar disorder in adults and as well in May of 2008 aripiprazole was approved for treatment of adolescent schizophrenia and pediatric bipolar mania. Next slide.

So on the next couple slides we're summarizing the new information on the new safety alerts we found in our searches of the FDA websites. The main one is the one listed in the first row of the table, which is regarding the FDA's decision in August of last year that a black box warning should be added to all atypical and conventional antipsychotics regarding increased risk of mortality in elderly patients treated for dementia-related psychosis. And then in the second row there we've listed some information about additional material added to the warning section of the product label for clozapine standard oral tablet as well as the product label for the orally disintegrating tablet form in June of 2008 noting that they may be different from other antipsychotic drugs and their potential for inducing tardive dyskinesia. For two reasons: one noted that there is a pre-clinical finding that they have relatively weak dopamine blocking effects and then secondly there's a clinical finding of a low incidence of certain acute extrapyramidal symptoms. Next slide.

In here's details on more new safety alerts that we found in our searches of the FDA website. In the first row of the table we have information on the new material added to the drug interaction section of the product label of paliperidone added in September of 2008 about its potential to affect other drugs due to it being a weak inhibitor of P-glycoprotein at high

concentrations and its potential to likewise be affected by other drugs that are P-glycoprotein substrate such as carbamazepine. And then finally in the second row of the table we have some information about more new material added to the clozapine product label. One, that the precaution section was revised to include details about how cytochrome P450 isozyme inhibitors may increase the plasma levels of clozapine and then secondly that hypercholesterolemia and hypertriglyceridemia were added as potential adverse reactions. Next slide.

So that was all from our searches of the FDA website whereas this time we didn't find any additional information on new drug indications or safety alerts from our searches of the Health Canada website. Next slide.

So in addition to searching for information on the drug populations and outcomes that were already included in the last update the DERP participating organizations also requested we look for evidence on a few investigational drugs that may be approved in the near future. This was at the time of the scan. So the time of the scan paliperidone palmitate the once monthly intramuscular injection and asenapine were both still investigational whereas...since that time they've now been both FDA approved. So paliperidone palmitate received FDA approval in July of this year and then asenapine in August of this year. In terms of evidence we didn't find anything...we didn't find any clinical trials on paliperidone palmitate but we did find a few publications for asenapine. One was a head-to-head trial of asenapine compared to risperidone and placebo in adults with schizophrenia and the other was a review publication describing protocols of additional trials that we anticipate may become fully published in the future. Next slide.

Also in consideration of expanding the scope of this review to include children and adolescents with bipolar disorder the DERPs participating organizations also asked us to conduct a preliminary scan for identification of potentially eligible trials in those populations and this slide outlines the finding of those searches. Most of the evidence we found was from uncontrolled open label studies whereas we only found a total of five controlled trials involving atypical antipsychotics in children and adolescents with bipolar disorder and only two of those were head-to-head trials involving comparisons between olanzapine, risperidone and quetiapine. Next slide.

So that concludes the presentation of the findings from the first preliminary update scan for consideration of the third update of this review on atypical antipsychotics and based on those findings the DERP participating organizations voted in favor of a full update of this review, which is already in progress. I'll also mention that they voted in favor of expanding the scope to include all three of the new drugs I talked about—

iloperidone, paliperidone palmitate and asenapine. We also expanded the scope to include three new populations. So pediatric bipolar disorder, major depressive disorder in adults and also adolescent schizophrenia. And so this report is in progress and the final report for this update is anticipated for July of 2010. So we're looking at adding all of that evidence that I went over, and then some, into this update. So I will now turn it back over to you for discussion and questions.

Vyn Reese: Thank you Kim. I'll take a motion to accept the scan.

Man: So moved.

Vyn Reese: And a second?

Patti Varley: Patti will second.

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

Group: Aye.

Vyn Reese: Opposed, same sign. The scan is approved. I'd like you to stay on the line, Kim for the stakeholder comments.

Kim Peterson: Okay.

Vyn Reese: We have 15 stakeholders so I'd like you to be really cognizant of the fact that you need to only spend three minutes in your discussion. The first stakeholder is Kimberly Lovemeyer of Bristol-Myers Squib. The next person is Lyle Laird of Schering-Plough.

Kimberly Lovemeyer: Good morning. My name is Dr. Kim Lovemeyer. I'm the Senior Medical Science Liaison for Bristol-Myers Squib and I'd like to thank you for this opportunity to provide testimony on Abilify or aripiprazole. In the spirit of evidence-based practice I'm going to focus my comments today on three key areas. One – indications; two – recent pediatric trials and three – unique mechanism of action. In addition I'll touch on some important safety information. Aripiprazole currently has 13 FDA approved indications, which can be summarized as follows: In schizophrenia aripiprazole is indicated for the acute maintenance treatment in adults and adolescents age 13 to 17. In bipolar one disorder aripiprazole is indicated for acute maintenance treatment of manic or mixed episodes as well as acute adjunctive therapy to the lithium or valproate in adults and pediatric patients 10 to 17. In major depressive disorder aripiprazole is the first and only agent indicated as adjunct therapy to antidepressants for the treatment of MDD in adults. Finally, the IM formulation is also available. Given the recent scrutiny around the use of atypicals in youth I will also provide

a more detailed review of the aripiprazole efficacy and safety data in the pediatric populations. And please note that these studies were conducted using full adult doses and all the dosing started with 2 mg.

In adolescent schizophrenia a six-week trial was conducted to evaluate aripiprazole 10 or 30 mg in patients 13 to 17 and both doses showed significant improvement versus placebo on the primary endpoint which was a mean change in PANSS total score. In pediatric bipolar one disorder a four-week trial was conducted using those same doses of aripiprazole in patients that were 10 to 17 years and again both doses were superior to placebo on the primary endpoint, which was the mean change in the YMRS total score. An SNVA has also been filed for the treatment of irritability associated with autistic disorder in pediatric patients 6 to 17 and is currently under review with the FDA. Here two eight-week registrational trials were conducted using 2 to 15 mg and aripiprazole showed significant improvement versus placebo on the primary endpoint, which was the mean change in the caregiver rated ABC irritability scale.

Overall aripiprazole was safe and well tolerated in these pediatric registrational trials and importantly there were no clinically significant differences observed on metabolic parameters. When looking at mechanism reaction I remind you that aripiprazole is the first and only dopamine partial agonist in this category and a fair balance I will call your attention to the two boxed warnings. The first is increased mortality in elder patients with dementia-related psychosis and the second is suicidality and antidepressant. And I can provide a full copy of the package insert upon your request.

So in closing mental health disorders, when not controlled, can have large impact on cost. There is inter-patient variability in response and tolerability and there's differential metabolic risk across atypical antipsychotics. Relative to the other agents in this class aripiprazole has a broad of indications across adult and pediatric populations and importantly is only one of two atypical with FDA approvals in youth less than 19 years of age. As such I respectfully ask that aripiprazole remain available as a first line agent and that open access to atypicals be preserved in the State of Washington. Upon request I can provide any additional information or take any questions.

Vyn Reese: Thank you. Any questions from the committee? Okay. The next speaker is Lyle Laird. On deck is Jim Adams from NAMI Washington.

Lyle Laird: Good morning and thank you for allowing me to present today. I'm Dr. Lyle Laird and I'm NSL for Schering-Plough. I'm going to speak on behalf of asenapine or Saphris. Saphris is a novel atypical sublingual antipsychotic that was approved recently in August of '09 for two

indications right off the bat, which is quite unusual. These two indications are for the acute treatment of schizophrenia in adults and secondly for the acute treatment of bipolar one adults with manic or mixed features, psychotic or non psychotic features. Each of these indications is supported by two positive randomized double-blind, double-dummy, placebo-controlled studies. And the clinical study population includes over 3,000 patients. The safety program includes over 4,500 patients with around 700 patients being on Saphris for over a year.

In the bipolar studies the doses 10 mg b.i.d. with the option to go to 5 b.i.d. showed that on the primary outcome measure the young [inaudible] rating scale that there was significant separation from placebo as early as day two and it separated in the three-week studies at 21 days or three weeks. For the schizophrenia studies, again, there were two studies, 5 mg b.i.d. is the starting dose, it's the target dose. The PANSS or the positive/negative syndrome scale was a primary outcome measure and this separated at day 14 for these studies.

Moving on to safety and tolerability if you look at the most common adverse events and that is at 5%...at least 5% and twice the rate of placebo. For bipolar there were four— somnolence, extrapyramidal symptoms other than acathexis, dizziness and increased weight. For schizophrenia there were only three—acathexis, somnolence and oral hypoesthesia.

This was a well tolerated medication as evidenced by the discontinuation rate that was approximately equal to placebo. If you look at the current adverse events that are considered highly important in this day and age, and I'll talk about those right now, they are weight changes and there was a modest weight change/weight increase in bipolar disorder 1.3 kg and schizophrenia 1.1 kg. In the long-term study going out 52 weeks the weight change was an increase of about 1 kg (.9 kg), which is two pounds.

Metabolic parameters, total cholesterol, triglycerides, glucose there were no clinically relevant changes or differences between placebo in both long-term and short-term studies. Prolactin the same—no clinically relevant changes versus placebo also in the long-term study.

Jeff Graham: Could you conclude your remarks?

Lyle Laird: Okay. Extrapyramidal QTC likewise. I would like to say, in total, that Saphris is a novel antipsychotic and it should be considered as a first line treatment that is well tolerated and the unmet needs and the fact that there are no red flags in this area of adverse events I'd like you to consider this medication to be available to your patients who might need it. Thank you very much.

Vyn Reese: Any questions? Okay. The next person on the agenda is Jim Adams and on deck is Lisa Trigg(?).

Jim Adams: My name is Jim Adams. I'm with NAMI Washington and I'm the Outreach Partner for the National Institute of Mental Health for the State of Washington. Our research at the National Institute of Mental Health is we generally recognize, as a universal truth, that for all of these primary diseases we're talking about no one person will respond to any one of the available medications with any degree of certainty. So that way the key thing is getting the right medication for the patient as soon as possible. Now that part is what brings me here today because I represent the family members and I have three family members who are mentally ill and I've had that experience with most family members for over 50 years. So the stage of getting them the diagnosis and medication has been probably the most painful first steps that are available to anybody because they don't want to go.

Secondly, if we turn them off by getting them on the wrong medication, which happened in the early years with about 90% certainty, then they are harmed physically, they are harmed psychologically so cooperation is lessened, and sometimes they never recover so that they can in fact go into a recovery program. It's important then that this first step be evaluated. We have so many options now compared to when I first got involved in this business. It wasn't a matter of fail first, second, third or fourth, it was failing for 5 years, 10 years, 15 years, 20 years and there's pain and costs associated with that.

NAMI and the National Institute of Mental Health believes in open access. Now we know the practical world out there. We sometimes have to do some compromise with that because of realities of costs and availability and some other issues. However, we should always strive to get as close to open access. And what that really comes down to in a practical sense is getting the right medication to the person in need as soon as possible and not making him suffer any longer than necessary.

In line with this there were two medications mentioned specifically in the report that were introduced this year, but of course are not available to have a study and to be accepted in the PDL. However, we have to find a way of once they're introduced of speeding that process up because I had almost a fatality in my family because a drug that was promised would be on the market 18 months ago made it in the last couple of weeks. In the meantime she had some serious effects and, you know, that's the thing that family members suffer on. Had it come out the time when it was supposed to...

Jeff Graham: Jim, please conclude your remarks.

Jim Adams: Yeah. It might have worked. And so my plea is urgency here is to consider that the open access part of this is getting the right medication to the patient's needs as fast as possible. Thank you.

Vyn Reese: Thank you. Any questions from the committee? Next on the agenda is Lisa Trigg. On deck is Meredith Fine(?). If Lisa Trigg is not present can Meredith Fine step to the podium? Next is David Gross of Pfizer. And next is Steven Chang of Lilly after David Gross.

David Gross: Good morning. My name is Dave Gross and I'm with the Medical Affairs Division with Pfizer Pharmaceuticals and I'm here to testify on behalf of Geodon. Geodon provides proven efficacy in treating both the positive and negative symptoms of schizophrenia, the acute exacerbation of symptoms in both schizophrenia and schizoaffective disorders, and the prevention of relapse with long-term use. Geodon is also indicated for patients with acute manic or mixed episodes with or without psychotic features associated with bipolar disorder. Geodon has a well established safety and favorable tolerability profile with neutral affects and in some cases improvement relative to other atypical antipsychotics on weight and metabolic parameters.

Geodon has both oral and intermuscular formulations and common to both schizophrenia and bipolar disorders there's a significant rate of comorbid medical conditions such as cardiovascular disease, diabetes and obesity. And in many reports this leads to a reduction in lifespan on average of 25 years in people suffering from these diseases.

In both the olanzapine and risperidone head-to-head trials with Geodon equivalent efficacy was seen but Geodon excelled in superior metabolic and tolerability profiles. This superiority and metabolic profiles was also acknowledged by a consensus statement from the APA, the ADA, the American Association of Clinical Endocrinologists and the North American Association for the Study of Obesity. And this consensus statement was turned into a dual publication in both the Journal of Clinical Psychiatry and Diabetes Care.

As stated previously unlike several other atypical antipsychotic drugs Geodon is not associated with weight gain, hyperlipidemia or elevated plasma glucose levels. And this was borne out in the landmark CATIE trial, which has been discussed.

After treatment in phase one of the CATIE study validated risk equations indicated increases in 10-year diabetes and cardiovascular risk for olanzapine, quetiapine and risperidone, but no increase in medication

attributable risk were found for Geodon treated patients relative to their baseline risk.

In a study where patients were switched to Geodon from conventional antipsychotics or risperidone or olanzapine due to suboptimal symptoms control or poor tolerability results showed improved symptoms and normalization of metabolic parameters.

It is well recognized by researchers and physicians who treat these patients that there exist many differences amongst atypical antipsychotics and how they work in individual patients. We firmly believe it is very important to have open access to atypical antipsychotics so clinicians can provide the best care for their patients and match appropriate medicine to the individual patient.

In summary, Geodon...

Jeff Graham: Please conclude your remarks.

David Gross: In summary, Geodon has several therapeutic benefits and proven advantages and I thank you for your attention and considering Geodon as one of the necessary tools in treatment patients in the State of Washington.

Vyn Reese: Thank you. Questions from the committee? Next is Steven Chang from Lilly and on deck is Ellen Tebarse of AstraZeneca.

Steve Chang: Thanks again. My name is Steven Chang. I'm Health Outcomes Liaison with Eli Lilly and Company. Today I would like to share some new information regarding Zyprexa or olanzapine. First, Zyprexa has a new FDA indication as of March 2009. This wasn't mentioned in the report. This indication is for Zyprexa and fluoxetine in combination for the acute treatment of treatment resistant depression in adults. Second, there have been two recent meta-analyses studies published in the Lancet Journal earlier this year comparing antipsychotics in the treatment of persons with schizophrenia. Both of these meta-analyses provide valuable comparative information that also helps to highlight the benefits and risks of Zyprexa when compared to first generation antipsychotics and other second generation antipsychotics. The first meta-analyses was funded by the NIMH. It compared first and second generation antipsychotics in the treatment of schizophrenia. This study evaluated the efficacy and safety of nine second generation antipsychotics compared to first generation psychotics and it focused on overall efficacy as a primary outcome measure. The study found that only four of the nine second generation antipsychotics were more efficacious in the first generation antipsychotics. These included Clozaril, Zyprexa and Risperdal. The other five, which

included Seroquel, Abilify and Geodon were found to be as efficacious as first generation antipsychotics in this analysis.

On relapse prevention Zyprexa and Risperdal were better than first generation antipsychotics and on quality of life all second generation antipsychotics, except for Clozaril, did not significantly differ from first generation antipsychotics. Patients treated with Clozaril and Zyprexa experienced the greatest weight gain in this analysis.

The second meta-analyses compared nine second generation antipsychotics head-to-head. This study found that on overall efficacy Zyprexa proved superior to Abilify, Seroquel, Risperdal and Geodon, but was not significantly different from Clozaril. The authors note that most of these differences between drugs were due to changes in positive symptoms rather than negative symptoms. Zyprexa also proved superior to Seroquel, Risperdal and Geodon on dropout rates due to lack of medication efficacy.

Safety assessments were not included in this clinical trial meta-analysis. Thank you for your time and full prescribed and safety information for Zyprexa can be provided at your request.

Vyn Reese: Thank you. Questions? The next speaker is Ellen Tebarse of AstraZeneca and on deck is Michael McCain from Hero House.

Ellen Tebarse: Good morning. I'm Dr. Ellen Tebarse a Regional Scientific Manager for AstraZeneca Neuro Sciences. Thank you for the opportunity to speak to you about Seroquel XR and Seroquel. On behalf of AstraZeneca we express our support for open access to atypical antipsychotic agents. Today I'll highlight key points with respect to Seroquel XR and Seroquel. Seroquel XR and Seroquel are approved for the treatment of acute bipolar depression, acute bipolar one manic episodes as adjunctive therapy [inaudible] for maintenance treatment of bipolar one disorder and for acute schizophrenia. Seroquel XR is also approved for acute bipolar one mixed episodes and schizophrenia maintenance. Seroquel XR and Seroquel are the only atypical antipsychotic agents with proven efficacy in bipolar depression as monotherapy. Seroquel XR is the only oral atypical FDA-approved agent for acute depressive, manic and mixed episodes of bipolar disorder as monotherapy.

Seroquel XR extended release formulation offers once-a-day dosing across all approved indications in an easier, more rapid, titration schedule. [inaudible] recommended ranges are achieved as early as day two of treatment for schizophrenia and acute bipolar one manic and mixed episodes and day four of treatment for acute bipolar depression. Schizophrenia and bipolar disorder have a significant impact on patients,

caregivers, families, clinicians and the health care system. An opportunity to reach a recommended dose within four days across this varying disorders is invaluable to patient care. The immediate release formulation is rapidly absorbed and reaches peak plasma levels in approximately one and one-half hours. Seroquel XR formulation continuously delivers drug over the course of a day with peak plasma levels in approximately six hours.

Seroquel and Seroquel XR have the following box warning: elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Antidepressants increase the risk of suicidal thinking and behavior in short-term studies in children, adolescents, and young adults in major depressive disorder and other psychiatric disorders.

Seroquel and Seroquel XR are not improved for the treatment of patients with dementia related psychosis or for use in patients under the age of 18. Prescribing information for Seroquel and Seroquel XR including warnings and precautions for hyperglycemia and diabetes, hyperlipidemia, weight gain, neuroleptic malignant syndrome, leucopenia and neutropenia, [inaudible], and the risk of [inaudible], hypertension, cataracts, seizures, hyperprolactinemia and dysphasia. The most commonly observed adverse events associated the use of Seroquel XR and Seroquel [inaudible] dry mouth, constipation, [inaudible], dizziness or [inaudible] hypertension, weight gain, increased appetite, fatigue, [inaudible], nasal congestion, [inaudible], abdominal pain, pharyngitis, lethargy, and SGPT increases. Thank you very much for your time and I'll be happy to entertain any questions you might have.

Vyn Reese: Thank you. Questions from the committee? Next speaker is Michael McCain from Hero House and on deck is Mary Watson from Hero House.

Michael McCann: Thanks. It's Michael McCann incidentally and I'm representing, along with five other people, Hero House in Bellevue. I presented last year the very same statistics I'm going to provide this year because frankly they haven't changed. World health organizations still declares mental health the world's greatest financial burden. One in four people in the United States is affected with mental illness and in this state we spend \$900 million on social services inclusive of mental health concerns while spending \$24 billion on the prison systems. In the prison there's 50% of the people that are diagnosed mentally ill. 75% of which are actively psychotic. So the point is if you restrict access, what happens? Well, you pay now or you pay later. You can pay now pennies or you can pay later in dollars.

If you restrict access homeless goes up, the educational dropout rate goes up, the institutional rate goes up, the hospitalization rate goes up, and the prison rate goes up. Now I've gone from making \$100,000 a year to being homeless three times in the last three years because I haven't been able to get access to specific antipsychotics that now work for me. And I don't think that's fair that you expect from anyone that they go back and try everything to the point of failure only to resolve right back where they started. I spent 30 years trying to find a proper medication. I found one that works. Medicaid is now refusing to pay for it and I've endured an episode of 65 hours without sleep, literally, no sleep at all, and I can assure you the effects of which I was seriously considering grievous bodily harm. That is not a period anyone should endure without sleep because the antipsychotic that I was forced to use doesn't work.

So basically it amounts to dollars and cents. You can pay for it now or you can pay for it later.

Vyn Reese: Thank you. Any questions? Next speaker is Mary Watson.

Michael McCann: Oh, and I'd like to provide this to the committee. I provided it last year.

Vyn Reese: The next stakeholder is Mary Watson. On deck is Stanley Donohue.

Mary Watson: Hi. My name is Mary Watson. I've been taking pharmaceutical meds regularly since 1986. I first started out medications that I don't remember what they were. I was in New Mexico and I had a nervous breakdown and went into a student health center and they gave me medication because I wasn't sleeping. So they gave me medication and I had a nervous breakdown. I got afraid of the person I was with. I thought he was in the mafia and all this stuff. And then I went back to Idaho and they got me on shots. I'm not sure what they were but right now I'm Seroquel 15 mg...about 300 mg and Haldol by pill 15 mg and I like the combination of drugs I'm on. It works for me. I want to thank you for listening to me today. Thank you.

Vyn Reese: Thank you. The next person to speak is Stanley Donohue and on deck is Karen Smith.

Stan Donohue: Hi. My name is Stan Donohue. I live in Lynnwood, Washington. I'm here because I'm bipolar II with chronic depression. I take the drugs Abilify, Effexor, Neurontin and Trazodone and it works for me. My life has changed a lot. I've always had a stroke in 2006, a heart attack in 1997 and I live with blood clots. This is my 30th anniversary of being a bipolar person. I started out on MAO inhibitors, which didn't work. I hope you don't give those to anybody. Now on these...this combination to drugs I'm married. I bought a new house. I bought a Porsche. I live a normal

life. I think that if these drugs were taken away from me I would go back to the life that I had before laying in bed and not being able to accomplish anything. Unfortunately, I'm not on Medicare, I'm on Medicaid...excuse me. I'm not on Medicaid, I'm on Medicare and parts A, B and D. Now what I'm worried about is what you're doing here could trickle down to Medicare and Part D and we would be in the same situation for those of us on SSDI. That's what you're talking about doing here and I don't want to see that happen. Thank you very much. Any questions?

Vyn Reese: Thank you. Next is Karen May Smith. On deck is Jesse Levine.

Karen May Smith: Hello. I'm Karen May Smith and I'm an active citizen of the community. I have a volunteer job on Wednesday afternoons at Marionwood Providence Nursing Home helping the home and garden club there. And I teach a class at Hero House called Putting Your Best Step Forward. It's a very popular class there and people who come are blossoming and changing and growing and it's exciting and I've done tons of different volunteer work since I was 19, when I had my first breakdown and first got on SSDI. And I had struggled through all kinds of medication diagnosis [inaudible] schizophrenia, paranoid and had thorazine, [inaudible], stelazine, and then risperidone and then lithium and lithium was the worst drug. I was on it for years and in fact...they finally...they took me off of it because it was interfering with my kidneys, liver, but they...I...I was told recently that I should have never been on lithium. I have hyperthyroidism and it increases that condition and also it was responsible for me having hyperparathyroidism, which I recently got fixed. I had hyperparathyroidism surgery and they removed three and one-half parathyroid glands. I'm a new person. I don't have to walk with a cane and my osteoarthritis is gone. But the lithium was also responsible for me having CPOS, which is a...a...I can't remember, but anyway it has to do with your ovaries. That's responsible for a whole lot of things that...conditions that I had during my marriage. I was married 38 years. My husband just passed away a year ago. This last month is his one-year anniversary and being a member of Hero House has helped me be in recovery and have a stability in my life. The relationships there are supportive and a true sense of recovery of a person being a member of a community that is moving forward and having leadership skills there and gain there and the medicines I take now are Seroquel, Topamax and gabapentin and a thyroid...they increased my thyroid and after I got the Topamax, the Topamax was the drug in 2006 I got when it was just on a trial at Fairfax Hospital. The psychiatrist that retired from Group Health was doing research there and I got the drug as part of the, you know, a test. And that made all the other drugs work best. All the other drugs made you gain weight, but the Topamax makes you lose weight. So I was able to...

Jeff Graham: Karen, could you conclude your remarks?

Karen May Smith: Yes. Please don't limit people to just a certain drug and make one drug a catch all for one disease like manic depressive...they graduated me. I'm schizoid effective disorder, which means you're half and half schizophrenic and manic depressant. So please give people access and choice. It's very important. This is a very important hearing and you are very important and I thank you for your time.

Vyn Reese: Thank you. Next speaker is Jesse Levine from Hero House and on deck is Lisa Coleman.

Jesse Levine: Good morning. My name is Jesse Levine and I suffer from bipolar one. I'm here today to say that I've been on over 20 different medications over the past 11 years. I've been hospitalized twice due to poor medications. Open access is crucial. I myself have failed on several meds. Plus I just want to add that my colleagues here if you...along with other people if you restrict the medications they're going to end up in jails, hospitalized and stuff like that. I know I will end up there myself. So I just want to leave you with this remark. Taking away people's meds to save a few dollars or human life? You just tell me. Thank you.

Vyn Reese: Thank you. Next is Lisa Coleman. On deck is Alan Wu(?).

Man: She passes.

Vyn Reese: Okay. Alan Wu from Jansen.

Man: No comment.

Vyn Reese: Okay. That ends our stakeholder presentation. Any discussion from the committee?

Patti Varley: This is Patti Varley and I guess I feel the need to make a comment versus having a particular question. And that is the intent has always been to have patients have access to the appropriate medications and to do it safely and to understand the idiosyncrasies of individual responses. But I think there are some concerns in regard to the dramatic increase volumes of medications that have pretty significant side effects; many of which were new drugs you all did a wonderful job of describing. That they came out, you tried them, you used them, and then we only, after the fact, found out about side effects that we were unaware of because the subjects that are study cases are not you. They are not the real people out in the real world with a lot of comorbidities. My concern is the safe practice of making sure medications in the hierarchy of safety, efficacy, evidence based are used appropriately before going to the level of either mixing, adding or

trying meds that have a higher side effect profile and can cause untoward side effects and dangers. I can say that I empathize with the stories that were shared because I'm on the other side of the fence sharing those stories and that I clearly understand the issue that not one size fits all and not every med works for every person.

I am though concerned as a clinician about the jump to what I believe is a cannon when that shoots at everything when we really need more of a laser approach—really understanding the symptoms people have, really understanding their metabolic system, side effects, efficacy, and evidence based. And I think that that's what this committee is trying to do is not limit access, but have people given the right meds for the right symptoms at the right amounts for the right amount of times before jumping to something that is the newest thing on the block that isn't necessarily tested to the level of which many of you have been part of testing, which is to find out those effects. So that's just my comment.

Vyn Reese: Any other discussion? Can we have the motion slide back up?

Man: [inaudible]

Vyn Reese: I can't read Russian, sorry.

Kim Peterson: Can we let Kim go?

Vyn Reese: Yeah. Kim, are you still there?

Kim Peterson: Yes.

Vyn Reese: Okay. Do you have any comments or thoughts? You did...we did in the scan review iloperidone. Is that right?

Kim Peterson: Yes.

Vyn Reese: But the other drugs that were mentioned we haven't reviewed yet—you haven't reviewed yet.

Kim Peterson: Well, we did actually look for the evidence on them and so we hadn't found any studies on paliperidone palmitate but we did find some studies on Asenapine and all three of those new drugs have been added and they are being reviewed for this update. So although I can't comment on the evidence yet that it will be thoroughly reviewed in the final report of the update, which is due July 2010.

Vyn Reese: Okay. Thank you.

Jeff Graham: Clarification, Kim. This is Jeff Graham. Iloperidone though it looks to me that...did you do a full review of that one trial?

Kim Peterson: Well, no, we haven't. Just for the scan all we do is just identify whether or not trials...we just identify trials and then for the full update we'll fully assess their quality and describe their results. So for the scan that's beyond the scan. That information will be available in the final report for the third update in July.

Vyn Reese: So iloperidone hasn't been completely reviewed yet and won't be until the next full update?

Kim Peterson: That's correct.

Vyn Reese: Okay. Any other discussion?

Carol Cordy: Just to clean it up, you've got risperidone and risperdal both on the list. Just take the risperdal off. And the iloperidone I guess we're taking off. Right?

Kim Peterson: I'm sorry. Was that a question to me?

Carol Cordy: Oh, no. I was just looking at the list.

Vyn Reese: No, don't worry. It's our list.

Jeff Graham: I think Kim could probably go at this time, Vyn. Are we okay with that?

Vyn Reese: Go ahead. I think you can be adjourned for a while.

Kim Peterson: Okay. Thank you.

Vyn Reese: Thank you.

Bob Bray: This is Bob Bray. Just as a point of clarification did we not craft this proposal...the past proposal based on the recommendations of the mental health subcommittee after input from the mental health subcommittee?

Vyn Reese: I believe we did and I also note on the prior motion that atypical antipsychotics cannot be subject to therapeutic interchange in the Washington Preferred Drug List. So we've never planned on interchanging drugs that somebody is stable on for another drug. So it's never been our practice. Since this is a scan we will probably reaffirm that today. We are not taking people's atypical antipsychotics away if they are stable in those drugs. And these other drugs can't be substituted for them. So that's not part of our practice and it won't be changed at this meeting.

Can I get a motion to move that the prior motion is acceptable and needs to be renewed?

Barak Gaster: This is Barak Gaster. I would make a motion that we repeat the motion that we made on October 20, 2008 as written.

Vyn Reese: Is there a second?

Jeff Graham: Second.

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

Group: Aye.

Vyn Reese: Those opposed same sign? Motion's approved.

Jeff Graham: Susan should be on the line just as soon as our slides come up.

Vyn Reese: All right. Now we're running very late. So I think we'll probably go until 12:30 and get as far as we can and then just adjourn for a half hour lunch and then come back at 1:00. Okay? We'll go as far as we can and then we'll have to resume after lunch on P&T business since we haven't completed our agenda. It doesn't look like we will until after lunch. Any discussion about that? Is that acceptable to people? I don't know if we have a choice.

Next item on the agenda is antihistamines. Is Susan Carson on the line yet?

Jeff Graham: No, we'll hear her come on. I gave her about four or five minutes.

Vyn Reese: Okay.

Woman: Ready when you are.

Vyn Reese: Ready? Susan, are you there?

Jeff Graham: Just a minute. I'll get her.

Vyn Reese: Is she there?

Jeff Graham: No, she's not here yet.

Vyn Reese: Okay. You're ready but she's not. Okay.

Jeff Graham: I think she must be dialing.

Vyn Reese: Hello?

Susan Carson: Hello?

Vyn Reese: Is this Susan?

Susan Carson: Yes. Hi.

Vyn Reese: Hi. Great. Our first slide is up on the drug class review for newer antihistamines. It's a scan.

Susan Carson: Okay. Great. I'm going to put you on speaker phone. Can everyone hear me okay?

Vyn Reese: Yeah. You're a little distant so you have to speak up.

Susan Carson: Is this better?

Vyn Reese: Yep.

Susan Carson: Okay. I'll take you off speaker. This is our preliminary update scan number three for the newer antihistamine drugs. If you go to the next slide it shows that the date of our last full update of this report was completed in April 2006 with searches through August 2005. And then we conducted two previous preliminary update scans in 2008 and 2007. If we go to the next slide.

It shows the inclusion criteria just briefly—adults or children with seasonal or perennial allergic rhinitis or urticaria.

And the four interventions are shown on the next slide. We're on slide 4 now. And the new drug levocetirizine isn't in our last report because it hadn't been approved at the time it was completed. Next slide.

Shows our included outcomes and they're mainly symptom related and functional capacity. Next slide, slide 6.

Our usual harms outcomes overall adverse events, withdrawals due to adverse events and the specific adverse events shown on the slide.

The next slide shows the Medline search for this preliminary update scan. It was conducted through June 2009 and we found a total of 76 citations. After reviewing them, the next slide, slide 8 shows that there were 19 potentially relevant new trials and all of those trials included levocetirizine as one of the study arms. That's the newest drug recently approved in

2007 and your table 1 in your scan document summarizes the populations and the comparisons in those studies. And then from the previous scan of May 2008 we also found 15 potentially relevant new trials and those are shown in table 2 of your document...your scan document.

If we go on to slide nine as I mentioned the new drug levocetirizine was approved in May 2007 for the indications that are part of our inclusion criteria. For the other drugs we found no new indications and no new safety alerts. And that is the new information on antihistamines. Oh, and we...the participating organizations of DERP did vote to update this report. So we're working on that right now and the...it will be led by Nancy Lee and the final report is scheduled to be released in May 2010.

Vyn Reese: Okay. Thank you. I'll take a motion to accept the scan.

Bob Bray: This is Bob Bray. So moved.

Vyn Reese: And a second?

Barak Gaster: Barak Gaster, I second.

Vyn Reese: All of those approved say aye.

Group: Aye.

Vyn Reese: Opposed, same sign. Scan's approved. Any discussion? So I'd turn your attention to the prior motion from October 15, 2008. It doesn't look like there's anyone that's going to be speaking today as a stakeholder so we can go ahead and proceed with this. It was last reviewed October 2008 and that's the motion before us. Can I get somebody to reiterate the prior motion?

Ken Wiscomb: This is Ken Wiscomb. I move to reiterate the prior motion from October 15, 2008.

Vyn Reese: And a second?

Bob Bray: This is Bob Bray. I'll second that.

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

Group: Aye.

Vyn Reese: Opposed, same sign. It's passed. Next item on the agenda is a scan of the skeletal muscle relaxants. Susan, are you still there?

Susan Carson: I'm here, yes.

Vyn Reese: Okay. Great. We just need...

Susan Carson: Are you ready for the skeletal muscle relaxant scan?

Vyn Reese: We need a couple of minutes to get our slides up. We're almost there.

Susan Carson: Okay. Thanks.

Vyn Reese: Yeah, here we go.

Susan Carson: Okay.

Vyn Reese: So go ahead.

Susan Carson: Okay. Thank you. So this is the third preliminary update scan and it would be the third update of this report. It was conducted in June 2009.

If we go to the second slide it shows our last update was back in May of 2005 and previous preliminary update scans were done in February 2007 and March 2008.

The next slide shows the inclusion criteria—adults or children with spasticity or a musculoskeletal condition. We did include patients with nocturnal leg cramps but not restless leg syndrome or nocturnal myoclonus. And we also excluded obstetric and dialysis patients.

On slide four the included drugs are shown. And just to clarify we did not include...well, we included benzodiazepines or other medications if they were a comparator arm in a study of one of the included drugs, but we didn't include those drugs themselves. For example compared to placebo or to another drug. Next slide.

Effectiveness outcomes are shown on this slide. So we looked at the health outcomes of pain, functional status, quality of life, but not non-clinical outcomes.

And on slide seven are shown the harms outcomes.

And slide eight shows our Medline search dates. They were conducted through May 2009 and the searches identified only nine citations. After review of those citations, we're on slide nine now. We found no potentially relevant citations, none met inclusion criteria. And then in the last scan, number two, we also found no relevant citations and then for the first scan we looked back on the four studies that were identified but on

further review they did not meet inclusion criteria. So there's really no information in this drug class even though we've done three new...three scans.

If we go to slide 10 it shows that we found no new drugs in this class and no new indications. There is one new safety alert, a precaution, which talks about sedative effects of Skelaxin and other CNS depressants. They caution that the...taking these simultaneously is...may be additive...their effects may be additive. And that's...there's really just not any new studies for that scan.

Vyn Reese: Thank you very much. I'll take a motion from the committee to accept the scan.

Patti Varley: Patti Varley, I accept the scan.

Vyn Reese: And a second?

Ken Wiscomb: Second.

Vyn Reese: All those in favor say...that was Ken Wiscomb. All those in favor say, "Aye".

Group: Aye.

Vyn Reese: Those Opposed, same sign. Scan's approved. Any discussion? I want to turn your attention now to the motion. The primary motion was made on June 18, 2008. Can I get a reiteration of the prior motion?

Carol Cordy: This is Carol Cordy. It seems like this is a...similar to the first most part. The committee finds that Carisoprodol is subject to abuse and is recommended not to be covered. I think the intent there was also not to have that on the Preferred Drug List. But it seems like again it is. I don't know how that's handled. It's listed on the...

Donna Sullivan: This is Donna Sullivan. Dr. Cordy we'll take that off to the side, I think, and work with that as the work group and get the PDL corrected or updated with an explanation of what we did for the next meeting.

Jason Iltz: And this is Jason. It does have a little comment there that says it is excluded from the class. I think our intent was for it to never be covered, but my understanding is now that you can't limit a medication like that if there's an FDA approved indication. So if it is written for it is considered for coverage only under those various...or only the single indication that it's approved for.

Angelo Ballasiotes: This is Angelo Ballasiotes. Are you having much problem with that medication?

Siri Childs: This is Siri and I can tell you that absolutely no way are we having trouble with Carisoprodol.

Jason Iltz: Are we still waiting for a motion?

Vyn Reese: Yeah. We're still waiting for reiteration of the prior motion.

Jason Iltz: Okay. This is Jason and I move that we reiterate the prior motion on June 18, 2008. Do we have to break it down into those three or can I just say that?

Vyn Reese: That's fine. That's the prior motion. Can we have a second?

Bob Bray: This is Bob Bray. I'll second that.

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

Group: Aye.

Vyn Reese: Opposed, same sign. Okay. Thank you. Now we'll move on to the last scan. It's on Alzheimer disease drugs. And it's Megan Van Noord. Is she on?

Jeff Graham: She should be on. I told her to call right at 12:00.

Vyn Reese: You what?

Jeff Graham: I asked her to call right at Noon time. I didn't think we would be this quick.

Vyn Reese: We're quick.

Jeff Graham: Well, I know sometimes we are.

Vyn Reese: We're catching up. We're hungry, yeah, that's right. It makes you move faster.

Man: Do we have stakeholders for the last topic?

Vyn Reese: No. We didn't have stakeholders for the skeletal muscle relaxants. And I don't know about Alzheimer's yet. We do have for Alzheimer's.

Man: How many are there?

Vyn Reese: There's only three.

Megan Van Noord: Hello?

Vyn Reese: Yes. Is this Megan Van Noord?

Megan Van Noord: Yes. This is Megan.

Vyn Reese: We're ready for you.

Megan Van Noord: Okay. Great. Can you hear me all right?

Vyn Reese: Yes.

Megan Van Noord: Okay. So my name is Megan Van Noord and I'll be presenting the preliminary scan report for Alzheimer's disease. A little background information – the original report was completed in June of 2006 and included searches through December of 2005. There have been two previous preliminary scans. The first was completed in June of 2007 and the second completed in May of 2008.

Included populations for study participants with Alzheimer's disease.

Included interventions were donepezil, galantamine, rivastigmine, tacrine and memantine, which are all currently available in the U.S. And a quick note on study design N was greater than or equal to 100. The study duration was greater than or equal to 12 weeks and only RCTs were included.

The next two slides go over effectiveness outcomes, which are stabilizing or slowing the rate of decline in health outcomes measures, activities of daily living, instrumental activities of daily living, level of care changes, quality of life and behavioral symptoms, stabilizing or slowing the rate of decline in intermediate outcome measures including cognition and global assessment, discontinuation effects, reducing caregiver burden, hospitalizations or nursing home placement and mortality.

Harms outcomes include overall adverse effect reports, withdrawals because of adverse effects, serious adverse event reports, adverse events due to discontinuation and specific adverse events. Okay?

To identify relevant citations we searched Medline from March 2005 through June 17, 2009. This search resulted in 152 citations. Of those there were 20 new potentially relevant randomized controlled trials, which are listed in Appendix A.

For the study selection one reviewer assessed abstracts of citations identified from literature searches for inclusion using the criteria previously described. Okay?

We also searched FDA and Health Canada websites for identification of new drugs, indications and safety alerts. However, there were no new drugs and no new safety alerts. So that concludes the presentation. Are there any questions?

Vyn Reese: From the committee? Thank you. I'll take a motion to approve the scan.

Barak Gaster: I move that we approve the scan. This is Barak Gaster.

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

Vyn Reese: A motion has been made and seconded to approve this scan. All those in favor say, "Aye".

Group: Aye.

Vyn Reese: Opposed, same sign. Motion has passed. We have three stakeholders who would like to speak. Mr. Jake Knee(?) from Forrest Labs and on deck is Jill Carik-Walker(?) of Pfizer.

Jake Knee: Good morning. It's almost not morning. I'll try to get us out of here for lunch. Today I'm just here to ask the committee to continue with what the committee has done in the past, which is allow access to Alzheimer's medications specifically memantine. Since launch has been categorized as an NMDA receptor antagonist and it's in a class of its own categorized by USP. Whether it be federal, state or commercial the general accepted practice is dual access for Alzheimer's medication when there's a situation like memantine has where there's one of a kind. I'd like to draw your attention to two pieces of clinical data that have recently come out. There's an NIH funded trial...the lead author was Dr. Aughtry that was recently released. It's the largest clinical collection of data that's ever been done on Alzheimer's. It was roughly a 17-year trial from start to finish. There's a four-year period in which memantine was included post its launch and availability in the United States in which the clinical trial found that combination therapy is clearly the standard of care. It was not funded by any pharmaceutical companies. This is an NIH trial. What was interesting in the trial was not only combination therapies statistically significant over the control groups, which were placebo or [inaudible] cholinesterase inhibitor. Regardless, when adding memantine the duration...the duration of loss of cognition was extended as well as the separation got greater as the disease progressed. So later on in the clinical

trials the average duration per patient was roughly 2.5 years. As the trial went on the separation between the control group got greater. One of the things to consider as well is that when Alzheimer's patients are not receiving optimal therapy, which is combination therapy typically two things happen—one is institutionalization or other medications are thrown at the disease state as kind of a last ditch effort. One of the things speaking specifically about is off label use of atypical antipsychotics. With the black box warning for increased morbidity and mortality...specific mortality in geriatrics it's obviously something we don't want to do. This is a relatively small number of patients taken care of by fee-for-service. Medicare Part D now has 99.4% unrestricted access to memantine nationwide. It is now the most widely unrestricted Alzheimer's medication on the market today. Again, in the grand scope of things \$3,000 to \$8,000 a month for institutionalization, if you can postpone that for one month it not only pays for their Alzheimer's medications, it theoretically pays for all their medications for the rest of their life.

So being able to delay behavioral onsets as well as mitigate current behavioral problems...

Jeff Graham: Please conclude your remarks.

Jake Knee: You got it. Is one of the unique attributes of memantine. Dr. Cummings showed that behavioral outbursts were mitigated by memantine and there's no other data like that of its kind. So I would just ask the committee to continue to allow unrestricted access to memantine considering it's unique.

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

Bob Bray: I have a comment. This is Bob Bray. It's not a question, but it's a comment. I just want to say that I have to stop and object to the use of the term standard of care when you're talking about a very complex problem with issues that are very patient specific and so notwithstanding the evidence that talks about dual therapy I think we should not use the term standard of care.

Jake Knee: I completely understand.

Vyn Reese: Thank you. Next up is Dr. Jill Carik-Walker from Pfizer and on deck is Nick Polosage from Novartis.

Jill Carik-Walker: Good afternoon. I'm Dr. Jill Carik-Walker. I'm a Director with Pfizer Neuroscience and U.S. Medical Affairs. And I thank the committee for the opportunity to speak on behalf of Aricept or donepezil. Aricept, the

most widely used first line treatment for the symptoms of mild to moderate Alzheimer's disease maintains cognition, preserves function, improves behavior. Clinical efficacy has been demonstrated in 18 double-blind randomized placebo-controlled trials. Some of which have been more than one year in duration and with patient follow up of greater than five years. Aricept has efficacy in patients with severe Alzheimer's disease and thus is the only monotherapy agent FDA approved for all stages of Alzheimer's disease—mild, moderate and severe. It's clinical efficacy translates into important benefits to the state of Washington, specifically delay in time to nursing home placement of nearly two years and the associated reduction in cost.

The second point that I want to make is the excellent safety and tolerability profile of Aricept. Patients and caregivers report significantly higher satisfaction due to lower rates of adverse events and lower incidents of drug interactions. Aricept allows the physician to initiate treatment at an effective 5 mg dose without titration, without food and maintain them on a once-a-day regime. Discontinuation would lead to a rapid loss of benefit that cannot be regained. Switching would also necessitate a washout and retitration to the effective dose of another medication. In fact, current guidelines from the Alzheimer's Disease Management Council Consensus Panel and Scientific Roundtable recommend that those who have successfully titrated and are tolerating a therapeutically effective dose of a cholinesterase inhibitor should be maintained on that therapy and not switched.

Lastly, Alzheimer's disease patient incur higher medical costs due to their concurrent conditions. Aricept offsets these costs with a savings of \$3,900 per patient per year by reducing inpatient hospitalizations, skilled nursing facility costs and emergency room visits. Aricept also decreases utilization of expensive psychotropic agents resulting in polypharmacy and its associated costs.

In summary, it's imperative to maintain patients on the same therapy, to slow the progression of symptoms. Interruption of treatment may produce irreversible decline. Persistent treatment with Aricept provides positive clinical outcomes and cost savings. Thus Aricept benefits vulnerable and a fragile population, its caregivers and medical payers. Continued access will allow the State of Washington to continue to provide quality care while reducing medical costs with Aricept for mild, moderate as well as severe Alzheimer's disease. Thank you very much for your attention.

Vyn Reese:

Thank you. Questions from the committee? Thank you. Next speaker is Nick Polosage from Novartis.

Nick Polosage: Good afternoon and thank you very much for allowing me to speak at least three minutes. I promise it's going to be three minutes or less. I'm one of the doctors of internal medicine who practices in Federal Way, Auburn and Des Moines area. I've been in practice for 13 years and I am a Medical Director of some of the few long-term care facilities in this area and I've been a full-time, long-term care practitioner for the past three years.

I'm here to speak on behalf of Novartis, specifically Exelon Patch, which is one of the medications we use for Alzheimer's, [inaudible] inhibitors, family and there are three things I would like just to get feedback from in my experience using an Exelon Patch in the population that we serve—geriatrics in the nursing homes. As you can imagine most of the patients that we take care of are elderly who are polypharmacy. I could tell you I raised probably more than pills today. This, of course, most of them are already taken. It's very hard for them, especially the caretakers, to give all this medications. One of the advantages of Exelon Patches of course is it's a patch. It takes a lot of burden from the caregivers, you know, giving all these pills. It takes time. So it's really a good cutoff on their passing time for medications.

Secondly, the patch has a better compliance because of course you know it's easier to administer and the compliance is better because you just have to put the patch instead of giving them the pills and sometimes it's difficult to give the pills to these people. And third, you know, Exelon Patch, in my experience because of the better compliance and the absorption is more steady first during the 24-hour period. We noticed that the side effects in terms of GI tolerabilities is much better than the oral that we give.

So I think with those advantages cutting the medication time for the nurses to give the medications orally. It's easier for them to give this medication. They have lesser side effects and a better compliance. I'm just hoping that your committee will consider having the Exelon Patch more access to the formulary in the State of Washington. Thank you.

Vyn Reese: Thank you. Any questions from the committee? Okay. That concludes the stakeholder input. I'd like to turn your attention now to the prior motion of December 17th, 2008.

Jeff Graham: Excuse me, Vyn. Do you think Megan could leave the phone now?

Vyn Reese: Yeah. Megan, are you still there?

Megan Van Noord: Yes. I'll sign off now.

Vyn Reese: Okay. Great. Thank you.

Megan Van Noord: Thank you. Bye.

Vyn Reese: I'd like to have a motion to reiterate the prior motion of December 17th, 2008.

Bob Bray: This is Bob Bray. Can I ask for some clarification first?

Vyn Reese: Sure.

Bob Bray: We've...our motion in the drug class addresses Alzheimer's disease, but there are related disorders and...that these have been used for and one of the drugs has an indication for Parkinson's related dementia, which I think has also been interpreted by others to include Lewy body dementia. So for those folks who wish to use that drug, if it's not on the PDL, what happens in that regard?

Vyn Reese: They're also used for multi-infarct dementia as well. So it's not...and there are some positive studies for multi-infarct dementias for some of the drugs. So we did not deal with either of those disorders. They're less common but they are certainly used for those other indications.

Jeff Thompson: I can tell you...this is Jeff Thompson. I can tell you we are seeing an increasing amount of use of these drugs in children for the treatment of Autism as another indication.

Vyn Reese: What? That's amazing.

Donna Sullivan: This is Donna Sullivan. For Uniform Medical Plan and the Aetna Public Employee's Plan right now if they prescribed...if it was a non-preferred drug that was being prescribed for one of these indications that's not listed here, if it's an endorsing provider, it would go right through and not be subject to interchange. So it would be the DAW process.

Siri Childs: For Washington Medicaid this is Siri Childs the endorsing prescriber could write DAW and it would go right through. But for a non-endorser right now currently we do have it as a non-preferred drug for the Alzheimer's indication. Since you've brought it up we've discussed it and we should probably have an EPA code for the off...for the...not off label, but the off PDL indication for Parkinson's disease and we'll take care of that.

Bob Bray: Thank you.

Vyn Reese: So we can pass this motion and that won't interfere with your workings?

Siri Childs: Yeah.

Vyn Reese: Okay.

Bob Bray: This is Bob Bray. I move that we reiterate the prior motion.

Vyn Reese: Second?

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

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

Group: Aye.

Vyn Reese: Opposed, same sign. Motion is approved and we're adjourned until 1:00.

I'd like to reconvene the committee. We have one more bit of P&T work to do before we launch into the DUR. It's a clarification of the P&T motion and hopefully you all have this in front of you. It's the P&T motion history on ADHD. And there's confusion about...as I understand it, maybe you can clarify that, Jeff about this particular motion.

Jeff Thompson: Sure. So this is Jeff Thompson. So the issue has been raised and a concern that as we venture forward and trying to do a generics first in the drug class called stimulants for treating ADHD there is an issue that you have indicated that the three subclasses are on the preferred drug list and should be made available. Those being dextroamphetamine and methylphenidate in a non-stimulant and then how does that comport with, as we move forward with 5892, a generics first for naïve and new starts in this class when you've indicated that all three subclasses should be available? So there needs to be some kind of discussion about how to reconcile that.

Duane Thurman: And just before we go on...this is Duane Thurman. The reason that we want to clarify this is that we're getting lots of questions with regard to the generic first initiative and the questions are, "Well, is that going to overrule what the P&T Committee has decided in its separate role?" And my answer has been, "No." That the P&T Committee is responsible for looking at the evidence and safety and making a decision as to what we should do in terms of formulating the ultimate preferred drug list and then looking at that drug list you'll turn into the DUR Committee and look at reasonable ways of utilizing that drug list in light of the generic first initiative that the governor proposed. The issue will come up once in a while and this is one of those issues where it's unclear what...how they would implement the generic first proposal in light of a distinction you

made in the subcategories of the drug class in terms of whether they're interchangeable and whether that...we want to make sure we're consistent with what the P&T Committee did before we go on and present anything to you that would change it in terms of generic first. And there may be situations where you say, "No. Our earlier clinical decision precludes you from making that kind of a substitution." So that's where we come today.

Vyn Reese: The thing is our previous motion was based on patient's who may have already been taking a certain medication where you are going to substitute another medication instead. If they've never been on any medication at all before and this is a new start then we can...with our DUR hat on you can say you have to start one of these drugs.

Duane Thurman: That's what we're asking you.

Vyn Reese: So it's...

Patti Varley: Isn't that obvious? No?

Duane Thurman: We're making it really obvious. Anyway, Jeff, so...

Vyn Reese: The only special circumstances I can see is Strattera in a patient who has a history of amphetamine abuse. That would be the only...if somebody wrote for Strattera and if the patient had a history of amphetamine abuse they didn't want to write for a stimulant that would be a sensible thing.

Duane Thurman: Right. I'm just talking in general to make clear the different duties of your various roles and then Jeff, why don't you focus on specifically on what you want?

Jeff Thompson: I'll focus on the specifics, but I think the issue is in 6088 you have things like the preferred drug list, preferred and non-preferred status therapeutic substitution. Now we have a new law, new statute, 5892 that entertains a generic first in new starts. So there's an issue that needs to be clarified with your hats on the P&T of what you meant with your decision for the preferred drug list as it relates to stimulants and then we'll discuss all the issues around how we would do a generics first in the stimulant class in the DUR.

Vyn Reese: As I understand it there's a generic methylphenidate and there's generic amphetamines both.

Patti Varley: Yes.

Vyn Reese: So you can't...so if you said generic first you have to try one of those before you can go to a brand name. That doesn't seem that difficult.

Patti Varley: I guess...this is Patti and that was my understanding is that you would start with the PDL approved and I would assume generic first and then you could DAW but you couldn't interchange between atomoxetine and a methylphenidate agent. You couldn't change from a methylphenidate to a dextroamphetamine based agent. But within each of those you could do generic first. Am I wrong?

Vyn Reese: That seems obviously what we intended.

Jeff Thompson: Here is the other nuance. There is only one now generic that is "long acting". There are in both subclasses the amphetamines and the methylphenidates short, medium and long acting. We now have the first only generic long acting in this class. So therein lies the rub of...and is it only dextroamphetamine? There is no long acting methylphenidate in the class generic as yet.

Vyn Reese: There's an intermediate acting, the SR...methylphenidate SR.

Jeff Thompson: Right. And if you look at the generic news that I put out you would see the vast majority of prescribing in both classes, subclasses is with the long acting; very little in the short and a moderate amount in the intermediate. But the primarily...the prescribing is in the long acting agents.

Patti Varley: And I would say that the evidence regarding the efficacy and the safety in that has been...I mean the longer acting agents is clinically the appropriate thing to use the majority of the time.

Jeff Thompson: So the issue is, is that, you know, can you clarify that you will perhaps make a statement with your P&T hat on that will then be clarified in the DUR Committee? And then you have a connection. That's all we're looking for is just to connect somehow your P&T discussion with your DUR discussion for the purposes of the people who are not at this meeting. It could be as simple as, you know, we will reconvene in the DUR to discuss how generics first 5892 will comport with our 6088 discussion for the preferred drug list and stimulants.

Vyn Reese: That might be the easiest thing. Otherwise it's going to be blurred the two. I think we need to look at it from a DUR point of view. So I don't think this is...I think we should adjourn as a P&T Committee and then when we go to your review of the generics first we'll talk about this again. Okay? Does anybody on the committee think differently or should we...otherwise we're going to get too much blurring of our different functions.

- Patti Varley: I would agree with you because I think that based on our P&T review this is what we agreed upon and what we thought was appropriate.
- Duane Thurman: All I would ask is that if at any time during the...this is Duane Thurman...anytime during the DUR thing if there becomes an issue where you believe there is a conflict with what you did as the P&T Committee that we revisit that. We just need to be absolutely clear that we're getting direction from you. That's all we're asking for.
- Vyn Reese: Okay. So now we're going to officially adjourn as a P&T and open the meeting in our DUR capacity and Jeff Thompson is going to start. But we'll first review the minutes from the prior meeting. They are printed up for you in the handout. Are there any additions or corrections to the minutes?
- Carol Cordy: This is Carol Cordy. I was left. I was left off the board members attending.
- Chuck Agte: This is Chuck Agte and I can submit my identifications later but there's a variety of places where there is an unknown man who is me.
- Vyn Reese: I have a correction. This is Vyn Reese. It's the last...it's page 16, the sixth paragraph up from the bottom and it should read...it's the last sentence in that paragraph when I was speaking. Um, we would be downgraded if we prescribed a generic instead of a person-to-person generic. I don't know what I was rambling on about, but that doesn't make any sense. So that should be we would be downgraded if we prescribed a generic. That's that last sentence.
- Barak Gaster: This is Barak Gaster. I noticed that I am listed as being attending and being absent and I believe that I was absent. I wanted to be here. I really, really did. I was unable to attend. So I should be taken off of the attending list.
- Vyn Reese: Any other additions or corrections? Actually I have one more addition or correction. On page 26 the second paragraph from the bottom I would just strike "I don't believe in this". I don't believe I said that, period. Okay? I don't know how I got misquoted. I don't know what I actually did say, but I don't think that's what I said. I didn't say "I don't believe I said that." So just strike that and put a period. Any other additions or corrections? Okay. Then I'll take a motion to accept the minutes as corrected.
- Bob Bray: Bob Bray. So moved.
- Vyn Reese: A second? I'll second that. All those in favor say, "Aye".

Group: Aye.

Vyn Reese: Opposed, same sign. Okay. Now we can turn the meeting over to Jeff Thompson who is going to present the material on generics first.

Jeff Thompson: Okay. So I'm just going to go really quickly through the provider feedback reports just so you and this is Jeff Thompson. Next slide. Next slide.

So in 5892 there are five components. Section A...2A of 5892 allows the state to give feedback reports back to prescribers and within those feedback reports to actually try and improve generic performance and we have started to do that and I just want to give you an example of what we're doing and some stats. Ray and I have been working on some numbers. So there's roughly 824 providers that have any one of these three criteria. Their DAW is over 25%, their generic performance is under 80% or they are differential from their peer. And the peers are either primary care, pediatrics, mental health or other. And we are using a company HWT out of Maine to look at this. So the reports have gone out. We've mirrored the same reports that have gone out by clinics from uniform medical plan so they will see both their counts in the number of clients. They will see their cost in the six drug classes that we are doing. They will see their brand, their generic and their DAW performance both in a table that will have all the numbers as well as what is on the slide looking at how they compare to the peers and a Z test will be done to statistically look at the difference between their prescribing and their peers and then we'll also show them what a best in class is or a best in practice. And again those will be for the six drug classes, PPIs, long-acting narcotics, the stimulants, the second generation antidepressants, the non-steroidal anti-inflammatory agents and the PPIs.

So we've narrowed the classes to just the ones that have the biggest opportunity. I think within these classes because there's a lot of generic opportunity and you've opined on many of these classes that there is not a clear winner in the brand versus generic so there should be less of a patient selection issue. Albeit there might be providers that, you know, get the person that failed everything or that's allergic to every one of the pink pills. And so there's a safety valve within this that after we've gone through three-quarters their statistical analysis will be discussed with me before any kind of action is taken on their DAW. And just so you know that the numbers...this represents about 6.6 million, 37,000 clients. The lucky news is, the good news only six doctors in the state had 100% brand performance in those. But the rest of them, the vast majority of them, are sitting in the 50 to 80%, you know, generic performance largely primary care, which was kind of a surprise. So we'll be working with the

community and I'll probably even be out working with Siri and doing some academic detailing because just the top 50 providers represents 22% of that overall 6.6 million. So it's the Pareto effect. You know, it's a small cadre that, you know, effect a large part. So I think we have opportunity not only to inform the provider community, to work with them, to better educate them on your decisions in the preferred drug list, as well as maybe even academically detailing a small minority of providers that may benefit from detailing and some education. Questions or comments?

Vyn Reese:

I think it's past due that the State did this. I think generics in general are safer from all the TZD, you know, all the controversy about TZDs and the hazards there. The COX2 inhibitors. They were the newest kid on the block and they had serious problems. And the generic drugs that have been out a while at least their side effects are well understood and their adverse reactions are well documented. With the newer drugs we don't have that and they haven't been...some of them haven't been out in the general population for long. And generics in general in my view from all that I've learned in serving on these committees are safer for the most part than the newer brand name drugs. It's a no brainer that we do this.

I also think that the big group practices in Seattle and the big insurance companies are already doing this. We have our own pharmacist in our group practice that counter details us on prescribing generically. So it's like it's old hat that this is...we've been doing that for several years. So it's not like the State is sort of late to get on the band wagon here in a very sensible approach. So I think that...I'm glad this is finally getting off the ground and it seems like it will be better for quality and for cost effectiveness.

Man:

So Jeff I think it's cool that even if I'm behind the curve I get a star above my name. I thought that was a nice touch. How do you determine best practice?

Jeff Thompson:

Basically it's the top quartile. In that class of drugs, in that type of provider, what does the top quartile look like? Easy.

Man:

I think that would be helpful to make sure everybody knows that when they get it. Because when we see best practice sometimes we kind of...the defensive thing is by whose definition? So I think by that definition that's real clear that that's where the mark is.

Jeff Thompson:

It's on the letters. If you haven't got a letter you're not getting the feedback report.

Vyn Reese:

The other thing I would caution...

Jeff Thompson: I would hope that the P&T Committee doesn't get a feedback report.

Vyn Reese: We probably need one sometimes.

Patti Varley: Although some of us might want one.

Vyn Reese: Right. Another concern I have is to...I think that we can make a big impact here whether we can get the whole...all the doctors in the state to do 83% generic I think might be a stretch. I know myself. I was 76% generic last quarter. The quarter before I was 82%. But I've never reached 83%. The closest I've gotten is 82 personally. It's tough to hit 83.

Jeff Thompson: That's a personal best?

Vyn Reese: That's a personal best, yeah.

Jeff Thompson: We're going to make every shot we can at this and again just...next slide. I think this is a good introduction on generics first. This is not about taking people off their meds. This is about opportunities for when there is a new client who presents for three drug classes, the PPIs, the stimulants and the antipsychotics in children. Is there an opportunity to present them with the generic first as the first opportunity and I might hearken back to what the NAMI representative said. No one person will respond in any predictable or certain way to any one antipsychotic. The question is, is that if we knew you were able to predict a winner and loser for a naïve new start in generics or brand we wouldn't be having this conversation. But if there is no way of knowing then would it not be the best stewardship as a prescriber to state-funded pharmacy programs to start them on the lowest cost, most efficacious drug? So I just want to be very clear and we'll go through the rules. This is not about taking new people off. This is about an opportunity to start new people on a generic drug not taking old starts off their medications. But I am going to show you some other indications that all is not well in the adult antipsychotic prescribing. Next slide.

Some of the first principles starting out with, you know, if there is a rational reason that somebody can come up with why they would want to start the brand...let's say that the coding on the generic caused them to have an allergic reaction in the past. Fine. We're fine with that. I don't...I haven't heard that yet but maybe there is a rational reason and we will entertain that either at the agency level or with our second opinions because at least for the children with antipsychotics any discussion will be peer-to-peer with the consultants at Children's Hospital in Seattle. We will also, and I will talk about this, we do not want to interrupt emergent

issues. So if there are issues where they need something Friday night when we're not open or Saturday morning or some other thing we have got some safety valves in place we think are going to make this work. And obviously we always give emergency supplies. I'll talk about those here in just a minute. Next slide.

So these were some Q&As that everybody wanted to know. Can I get an emergency fill of whatever I am prescribing? The answer is yes. We've always had emergency fills where the pharmacist can dispense any number, any duration of medications that they want and we will pay them within 72 hours. That's been the rule in the administrative code since I've started, you know, for the last seven years. So the same is true for antipsychotics, diabetics, blah, blah, blah. Once they're on it likely then they will be on a refill. So we'll talk about some of that here as we get through. If they're in crisis we'll be communicating that if you put on the script "child in crisis" we will honor that. The pharmacy will dispense that drug because obviously if there is a behavioral or psychosis issue we want them to get the medication and not have to wait, you know, the weekend or several days to get records.

Can I use samples as refill protections? We have changed the administrative code now so that samples will not be automatically thought of as a refill protection. We feel that this is an unsafe activity in the state of Washington to give samples out where it's not indicated at the pharmacy, the ER or the hospital what the client is taking. We pay for all the meds. We have no co-insurance, no co-payments. Why would we give samples to a clientele where we pay for everything? And I've actually in the Mental Health Workgroup given for discussion next time some of the literature coming out that it is perhaps a myth that the social indigents are getting the majority of the samples. That is, at least, not what the literature would portray.

Can I continue on my existing medication? The answer is yes. Anytime that we can find out from our drug files looking back 180 days if you've been on any med in that class then it's not a new start. Or if there is any indication by the provider of the client or the prescriber or the pharmacy then we'll work with that as an indication that this is not a new start.

And then finally, you know, what drug classes will start this adventure? It will be PPIs, antipsychotics in children and then stimulants in the adult and the child.

Carol Cordy: Can I add a question?

Jeff Thompson: Sure.

Carol Cordy: If someone is on a medication and it's not working and you're trying something else wouldn't it make sense for that to count as a new start and go generic or not?

Jeff Thompson: Well, all we're looking at is naïve clients. They're never had this medication. Now if you're on a brand and it's not working, you know, then we'll start educating the community, "Would not you try the generic next?"

Carol Cordy: Right. But that's not part of this.

Jeff Thompson: But that's not part of this. If they've been on a drug in the class they're not a naïve client, they're not a new start. And I'll show you some...we just run the adult data. So I'll show you what it looks like out in the community and what's happening with one drug, two drug, etc. Yes?

Alvin Goo: Hi. Alvin here. On the child in crisis is there going to be a more clear definition? Is that to be written by the pharmacist or is it written on the prescription and who can write that on the prescription I guess?

Siri Childs: This is Siri speaking on behalf of Medicaid and if we are told and we meaning our prior authorization line by the pharmacist, by the physician, by the caregiver, by the patient that this is a child in crisis and they need the medication right now we will approve it on the spot.

Alvin Goo: Then my second question is for the 180 days I think for children that's pretty adequate but for adults they're going on and off coverage. Would it be reasonable to extend it out for a year or is there any flexibility on that?

Jeff Thompson: Well, I think with the 180 days that's what we agreed with the Mental Health Workgroup on refill protections and so we got our system primed for that. If they go into the prison system, the jail system, they come out from Premera, lose their job and come on it. We'll be very flexible in basically what is a refill. Now I do have some aberrance that if they haven't been taking it for 180 days, you know, then I would hope that somebody did an analysis that they weren't taking it because it wasn't working versus it worked and then they got better and then they went off. Yes?

Barak Gaster: This is Barak Gaster. And I don't know if this is the right time then for us to begin our discussion about ADHD drugs that we started out looking at the motions that we passed.

Jeff Thompson: Could I just make a point? Could we do the next slide, go through the Risperdal first and then just go through each one individually so we're not bouncing around?

Barak Gaster: Okay.

Jeff Thompson: So next slide. So actually what we'll be asking for though in addition to the seven drugs is as we go through and operationalize 5892 only where we have opportunity for generic performance, I will come back to this slide at the end asking you to read in these drug classes in this way so it's very clear, you know, what your direction is. And then we'll finish up with this last...we'll go back to this slide. Next slide.

So this is our first opportunity for...because there is now a generic in the antipsychotic class, risperidone, for children only and we'll be working with the Children's Hospital for second opinions. Would it not be appropriate to start the...in a naïve client a risperidone first generic with these caveats? It would be reasonable to start out another agent or another brand if they were actually a continuation of therapy, if there was a past trial of risperidone that resulted in discontinuation due to side effects, if there was a past trial of risperidone that resulted in a lack of benefit – positive or negative symptoms, if there was a history of hyperprolactinemia or the prescriber writes DAW, child in crisis. I realize several of these really actually mean that the person is not naïve, but I just wanted to have them up there that we discussed this at the Mental Health Workgroup that these would be, you know, because we kind of go down these rabbit holes. This is truly for no evidence of brand superiority in a naïve client. We worked with a group and we could not come up with anything where obviously the brand was a clear winner. Even when it came to weight, because this is a weight at least either neutral or moderate. The prolactin, you know, I mean it's going to be a rare event that somebody presents naïve with a prolactin producing tumor, etc., etc.

Man: Sexual dysfunction is an issue with risperidone.

Jeff Thompson: In a child?

Man: Not in a child. Maybe in a child.

Jeff Thompson: I think always these discussions go off to the rare exception. We think that this is an opportunity because the vast majority, the belly here is in naïve clients. There is no clear winner between brand and generic and an opportunity to start the generic first and then move forward with an adequate trial and duration, which is according to the provider's arts and science.

This would be for all provider types. There would be no distinction between primary care pediatrics or psychiatry and again it would be using the services of Children's Hospital to have a discussion about why there

was. I feel that's an educational opportunity, you know, an opportunity to start the brand over the generic and maybe there's something we're missing. We'll see. So the next slide.

Again, the issue in the stimulant class is this is the first long acting generic stimulant in the class with Adderall XL. It is a dextroamphetamine. There is no generic methylphenidate nor is there a generic non stimulant in the class. So again would it not be advantageous because there's no difference in these classes, no brand superiority in a naïve client unless there was another brand that was actually a continuation of therapy or that they had had a past trial of Adderall XL or dextroamphetamine that resulted in a discontinuation due to side effects or there was a past trial of Adderall XL or dextroamphetamine that resulted in discontinuation because of lack of benefits or the last one is where there was a history of substance abuse where you might want a non-stimulant. So again the discussion in the Mental Health Workgroup was, looking at these, is there an ability to pick out a clear winner brand versus generic in a naïve client? We could come up with nothing. So is this an opportunity to do better stewardship in our prescribing if you can't choose?

Vyn Reese: This is the time to clarify the issue that Barak was talking about. Let's say if they prescribed a long-acting methylphenidate would they get Adderall XL?

Jeff Thompson: There would be a discussion with either the Children's Hospital or us, the adults, about why they want the methylphenidate over the Adderall XL. It would be a prior authorization to explain why in a naïve client you want the brand over the generic either with Children's or with the agency.

Barak Gaster: This is Barak Gaster. And so if the provider wrote a prescription for Strattera in a naïve patient that would be switched to generic Adderall XL?

Jeff Thompson: Only after...this is not therapeutic interchange. This would only be after a conversation and the only reason we could come up with for Strattera in a naïve clinic if there was a history of substance abuse.

Barak Gaster: This is Barak Gaster again. I am outside of my expertise in practice and so I would sort of look to Patti and I really mean Patti and not Janet.

Jeff Thompson: Because Patti's not an MD.

Patti Varley: No, no, I'm not a pharmacist.

Jeff Thompson: Sorry. Janet's not an MD.

Barak Gaster: That's right. So Patti, because I guess in my mind I have always wondered about the concern about...you're not sure someone has a history of substance abuse but you kind of wonder about it or are suspicious for it or are aware of that possibility and wondering, in that situation, would there be a rational for using Strattera ahead of the long-acting generic? Patti, could you comment on that?

Patti Varley: Okay. Barak, this is Patti. I think a couple of things. One is it's Adderall XR, I believe, not XO. Am I correct? Just for point of editorial correction and I guess...the question really, and I'll get to yours Barak in a minute, is for instance if somebody wrote a prescription for Vyvanse would that be substituted with the generic Adderall XR?

Barak Gaster: What's Vyvanse?

Patti Varley: Vyvanse is the newer replacement pro drug for Adderall XR.

Jeff Thompson: Right. So I just want to be very clear the substitution does not happen at the pharmacy. This is not therapeutic interchange. This is a conversation between either the agency or Children's with the prescriber about their rationale of why a brand is superior to a generic. Now what the nuance here...just to make this a little bit...there are generic methylphenidates. They are intermediate. There is a controversy in the community about whether you start a child out with a long-acting or whether you start a child out with an intermediate because of the issues of dosing them during school or extracurricular activities. And there are pros and cons either way, you know, all I would do is say that the American Academy of Pediatrics sees no difference between the subclasses. But this issue around do you start all new starts on a long acting one would just have to look at the utilization and see that's where most of the utilization is.

Patti Varley: And I would comment...this is Patti again that the data does show, for instance in pre-school age children, that they're more susceptible to side effects unless while treated efficacy wise and I would be personally hesitant to put a three-year-old or a four-year-old on a generic XR Adderall with that in mind. So I think that, you know, those are the kind of things that these nuances are going to be challenging and I do think...I agree with you there are different clinical opinions regarding starting everybody on a 12-hour med versus on an 8-hour med or a 6-hour med. Also, you know, the issue of if you sign DAW what happens when you put different stimulants in? I mean I think that's the bottom line question. If I'm writing DAW for a methylphenidate based agent or a dextroamphetamine based agent what gets put there? What do they get given and how is that communicated? I think those are the questions.

Jeff Thompson: Right. So just so we're very clear under 5892 the agency is allowed to ignore the DAW-endorsing status for a naïve clinic where you are prescribing a brand. That was the deal with the legislature in 5892. So DAW will not apply when you write for a naïve client in a brand in the stimulant class and that will trigger a prior authorization in a conversation with Children's or the agency—adult or child respectively.

Patti Varley: Maybe I was unclear. That still doesn't answer the clinician out there who writes "may substitute" and puts a name in like Ritalin. What happens to that prescription if it gets to a pharmacy?

Jeff Thompson: Do you want to go over the edits Siri?

Siri Childs: This is Siri. Again, speaking for Medicaid and Patti I'm going to try to answer your question. Remember these are all C2 drugs.

Patti Varley: Right.

Siri Childs: And so when a brand name is written by an endorsing prescriber and he writes DAW it is going to trigger prior authorization and a trip to our second opinion specialist. Does that answer your question?

Patti Varley: Yeah, but what about if you write "may substitute" but you wrote Ritalin on there?

Jason Iltz: This is Jason. So at the pharmacy level a controlled substance, a C2, you are only able to substitute to the generic. So for example if you write Ritalin the only two...and "may substitute" the only thing you can prescribe is Ritalin or generic methylphenidate.

Patti Varley: Right.

Jason Iltz: And that's it.

Patti Varley: And I'm kind of being devil's advocate here because I can see somebody writing Ritalin LA, may substitute and...

Siri Childs: Was not a generic.

Patti Varley: Right. So what would be substituted?

Siri Childs: Nothing.

Jason Iltz: Nothing can be substituted.

Siri Childs: Nothing can be substituted. It will hit an edit if they are an endorsing prescriber they will...I mean this is really a bad thing to say I'm sure, but they will receive the privilege of getting a prior authorization. And that privilege means that that's not the end of it for them. It will go to a second opinion and they'll have the opportunity to convince our second opinion doctors that that brand is what's medically necessary.

Patti Varley: And I guess in my mind I was thinking, just to sort of think about people, that that just wouldn't automatically get changed to Metadate CD or...

Siri Childs: Absolutely not.

Patti Varley: ...or something like that?

Siri Childs: No.

Patti Varley: Okay. That's the clarification.

Jeff Thompson: This is Jeff Thompson. If they did write "for an opportunity with an intermediate acting" where there was a generic that would automatically be substituted anyway at the pharmacy level.

Patti Varley: But no. I just said that. That's the question I just asked.

Jeff Thompson: Right. An intermediate that has a brand generic AB rated they would be substituted at the pharmacy level. Correct me if I'm wrong here.

Siri Childs: Not for Ritalin LA.

Jeff Thompson: No. But for...

Siri Childs: Ritalin SR, yes.

Patti Varley: But again what you're gonna...I mean that's the...

Man: [inaudible] for Ritalin SR.

Jeff Thompson: Exactly.

Patti Varley: I'm just...because that's going to be a very true clinical issue is that that's going to be what you're going to see as people write for that and yet they may want to be compliant but they, you know, that's the discrepancy thing. I think that will get confusing for people.

Vyn Reese: This is Dr. Reese. So you can't substitute Adderall XR for a methylphenidate. I mean it's a cross class. That would not work. So that

clearly we can't...you couldn't do that. And there's really no generic long acting methylphenidate so that sort of leaves that option out.

Jeff Thompson: So...and this is where this gets confusing with Medicaid because we do not have co-payments, we do not have a formulary. The evidence would say that there's no difference and you can't predict in a naïve client, would this be the best stewardship for prescribing? And the state to enter into how to prescribe for new clients. And again back to the P&T because in the P&T discussion you said all three subclasses have to be available—methylphenidate, dextroamphetamine and non-stimulant. This would tend to sort of call into question where the P&T direction is and where your DUR direction will be.

Vyn Reese: This is Dr. Reese. It sounds like we've got generics in two of those classes.

Jeff Thompson: Right.

Vyn Reese: Okay. We don't have a long-acting generic in both of the stimulants and the Strattera is in a class by itself. I mean it's...they should be substituted within their classes if there's an available product that's a generic. That's the key statement. If there's not an available product then they're going to be getting a call from Siri or one of her cohorts.

Siri Childs: This is Siri. Again, speaking for Medicaid what...the practicality of it is that if they write for a long acting methylphenidate brand it's going to hit the edit and we are going to ask our second opinion folks at Seattle Children's to discuss that with the prescriber and ask the prescriber why the child couldn't be started on the generic. On a generic for the stimulant class. Or if Strattera hits and the endorsing prescriber writes "DAW" it's going to trigger a review with Seattle Children's and it's going to be, "Is there a reason why you need to have brand Strattera or can you use one of the other generics?" They're going to have a full discussion with the prescriber. So between them and the prescriber there should be a resolution and DSHS will do what's recommended by the experts at Children's.

Jeff Thompson: If there are no other questions I want to just real briefly...I'm just going to go over just a picture of what's happening in the antipsychotic class and then we can go through all the...any other questions about the stimulants?

Alvin Goo: Um, I had one question on the history of substance abuse. I wasn't here at the last P&T meeting. I apologize for that. But as far as I know the evidence does not support not being able to prescribe a stimulant for someone with substance abuse. So that doesn't preclude...I mean it makes common sense, but actually the studies demonstrate that if you

have a patient with ADHD and they have substance abuse, giving them a stimulant actually will reduce their use. So I'm a little confused on this history of substance abuse.

Bob Bray: This is Bob Bray. I guess from my perspective, and I have not done a lot of prescribing of this, but from my perspective I'm much more likely to be concerned about the history of another person with substance abuse in the home that has access to the drug as opposed to the patient itself. So that's...

Jeff Thompson: And that would be another indication where we would allow the non-stimulant. All we want is a discussion about what the rationale is and we'll live and die by what the evidence and the rationale is.

Angelo Ballasiotes: This is Angelo Ballasiotes. I think the literature shows that with kids growing up in a family with stimulants are not...they don't lean towards substance abuse. I don't know if that's kind of what you're getting at. That does not seem to be the problem. The problem is usually that if they haven't been treated or they've had head injuries and things of this nature, or they have been using the drugs is where the problem really arises.

Alvin Goo: I guess I just don't want to see people being pushed towards Strattera just because of this substance abuse history. I'm not aware of much evidence as far as Strattera in the substance abuse population either. So I didn't even know there was any evidence to support the use of Strattera in that population although it makes kind of common sense. It seems like we're pushing people towards Strattera without a lot of evidence.

Jeff Thompson: Again, that would be a conversation about why and if the rationale were correct, either a history of substance abuse that you were concerned that they were taking, you know, amphetamines in the past or a history of abuse where they were sharing medications in a family totally acceptable to...but if it's sort of, you know, not known, but that's kind of what I'm thinking. Well, that will be part of the discussion.

Barak Gaster: This is Barak Gaster again and I was wondering if I could get back to my question to Patti, which is...so you've got a naïve patient with ADHD and you're sort of weighing whether to start as a first line stimulant or Strattera and in the back of your mind you're wondering if there's substance abuse in the family. How do you sort of make the clinical determination as to whether Strattera should be your first choice or the long-acting stimulant or the medium-acting stimulant should be your first choice?

Patti Varley: This is Patti answering Barak's question. The evidence shows that stimulants by enlarge and all hands down is the better treatment of choice for true ADHD symptomatology control. So I would do that. If I

suspected abuse then what I would do is do what I do, which is either have the school administer that med Monday through Friday to the kid or I would make sure I have pill counts of 30 days at a time, document in the chart, but I would not, not give that child an opportunity to be on what's proven to be the best and safe medication just because there is substance in the family. I would address it head on and I would monitor it but it would not deter me from using that.

Barak Gaster: Great. Thanks. This is Barak again. And so...so now I'm sort of putting my general internist hat back on and the kind of case that I'm more likely to see is somebody who does not necessarily have clear cut, 100% easily identifiable ADHD but has ADHD like symptoms, which have gone undiagnosed into his or her early 20s and is now presenting to a primary care doctor having failed antidepressants because it doesn't look like these symptoms are actually depression and perhaps there are symptoms of ADHD. And so I'm faced with what should I then be sort of trying as a first line for that patient.

Patti Varley: And again this is Patti and if you look at the data the data would say if it is ADHD symptomatology the likelihood is stimulants would be the best approach.

Barak Gaster: Okay.

Jeff Thompson: This is Jeff Thompson. Could I ask just for...I've invited some of the clinicians that we've been working with on these. They have to get back to clinic and I see that Senator Pflug is here. So I wondered if we might...before I go in and do the data on the adult antipsychotics I wonder if they might be able to have time to comment on this or anybody else because this is really the operative issue.

Vyn Reese: These are stakeholders that want to speak?

Jeff Thompson: Yes. I'm not sure. Do we call a senator a stakeholder?

Vyn Reese: Well, she probably is.

Jeff Thompson: So senator if you would like to talk and then we have other people signed up. If that's all right with the chair.

Vyn Reese: Sure.

Jeff Thompson: Okay.

Senator Pflug: Well thank you. I'm mostly common to listen but I have a couple of questions. One is there's not an "or" after your first bullet up there. Is

there intended to be an or, or is there an and between the first and the subsequent bullets?

Jeff Thompson: The first three bullets were put there as place holders because we typically talked about these. These are not naïve clients. So I put those up there only as to hone the discussion around that if they were continuation, discontinuation, [inaudible] they would not be naïve clients. They would get what they were started on.

Senator Pflug: Which brings up another question and these are broader questions not necessarily relating to just Adderall in children. But what happens with...we have some significant at risk populations where physicians who are specialists with that population will start them on a trial and that would probably be sample. So when that patient presents for the prescription after they've done well on the sample are they a naïve client or not?

Jeff Thompson: I apologize you missed the first part. The agency has changed its WAC(?) that samples will not be considered a continuation of care. However, we will take everything on a case-by-case basis. The agency feels that it is an unsafe practice to give samples where the pharmacist, other prescribers and ER or hospital do not know of what the client is taking and because we in Medicaid have no copayments, no coinsurance and make all drugs available that have a federal rebate, we can't figure out a rational reason why you would give samples to a client and make it non transparent to all other treating providers what that client is taking. So we'll take it on an individual...but obviously if somebody were on samples for several weeks, were stabilized, no psychosis, far be it from us to take them off a medication like an antipsychotic or in the case where their behaviors had quieted down and were fine. We're not going to be taking people off. But we also want to make the statement that...at least the agency would like to make the statement that samples are not a way around refill protections on the preferred drug list.

Senator Pflug: And I agree with you. I'm actually thinking of a fairly narrow...maybe we can talk about that later but there are some situations where I can see where they would want to do a sample. A couple more. When the physician in the case where there's no generic and has written "dispense as written" is referred to prior authorization and has a privilege of a trip to the second opinion doctor, my questions are around timeframe. Is there a response timeframe that the physician can count on? And also is that trip...is that blinded in some way or are we collecting data on physicians that, you know, for the number of times that they are referred?

Jeff Thompson: So Senator we do have obligations under both the federal and the state laws that we hold ourselves accountable to a 10-day response time. We typically do these in 24 to 48 hours. When there's a second opinion on

this it could go up to four or five days while we chase around records to have a conversation with Children's. But in the first drug class where antipsychotics are involved we will honor "child in crisis". We're going to make sure they get the drug on Friday night, the drug they need. We will communicate to all pharmacies that they can use our emergency fill criteria because we obviously don't want to interrupt a script. But in conversations with all the community experts there would be no reason, no rational reason, scientific or otherwise clinical why a generic first start in a naïve client in these two classes would not be the best stewardship.

Senator Pflug: Okay. So my...the timeframe you've addresses. My next question though was about the physician. Are we collecting data? If they have a certain number of trips are they frequent flyers?

Jeff Thompson: You missed the first part. We actually are under 5892 Part A we are doing feedback reports to 824 physicians who have high DAW, high brand utilization or look different from their peers. So those feedbacks will be going out on a quarterly basis and we have an opportunity to also detail about 50 docs that represent 22% of the overall cost of this issue with brand generics.

Senator Pflug: So what I would like to see personally is that there would be some kind of blinding there so that although you may do the counter detailing or the education it might be done the intermediary at Children's and not necessarily...and not fed back to the agency as something that would be a black mark against that particular provider.

Jeff Thompson: Right. So in the case of the Adderall for children and the risperidone for children the conversation will be peer-to-peer with Children's Hospital. Not with the bureaucrats. And so...

Senator Pflug: Your word.

Jeff Thompson: My word. I am a bureaucrat. And proud of it too I might say. But they do track customer service. We don't know physicians or prescriber names from that conversation. So I think we've taken care of any concern about black balling anybody.

Senator Pflug: Okay. That sounds good. And my final question so far is after this conversation I wasn't quite sure and Siri said DSHS will do what Children's has...recommends. And you said all we want is a discussion. So I'm...is this discussion one which must come to a resolution or if the provider still doesn't agree does Children's doc overrule?

Jeff Thompson: And we have Dr. Brian King and Dr. Chris Varley here who have run our second opinion process now for three years. They can talk about that.

There is a rare event where there is an issue. But to my knowledge we've always been able to work through those issues.

Senator Pflug: Okay.

Jeff Thompson: And they've graciously come and they would like to also talk and they can inform the committee about what we had in mind here and how we think this could work towards better quality safety and customer service.

Senator Pflug: Okay. So you're going to address that in a minute then?

Jeff Thompson: I think they are best to address it because they are the ones that actually talk on a daily basis with the providers. We do track their customer service and contracts so we do get feedback on customer satisfaction with the prescribers. Does that answer your question?

Senator Pflug: In that rare event where the second opinion doc and the prescribing doc do not agree what happens?

Jeff Thompson: It could come to my office or Siri's office where we would be the tie splitter and we would make that decision. But we give deference to, you know, the experts at Children's who have reviewed all the records. We obviously know that the child has been touched by the prescriber. Many of those, the way we do the tie breakers is we have a face-to-face appointment at Children's Hospital. We've actually even hospitalized clients where the provider's really not sure what's going on in the prescription. And so we've actually hospitalized clients to figure out what's going on. So those have been some of the tie breakers. I'd have to, you know, nothing comes to mind where I've had to get involved and be the tie breaker. But I imagine it's probably happened once or twice.

Senator Pflug: Okay. Thank you for the opportunity for questions.

Jeff Thompson: Thank you, Senator, for coming.

Vyn Reese: Thank you. And the next stakeholder is Christopher Varley, Dr. Christopher Varley from Children's.

Chris Varley: Good afternoon. My name is Chris Varley. I'm a child psychiatrist and I have been a participant in this process since the inception of the review process and maybe I can answer your question as well. I was involved in the workgroup that laid out the criteria for the second opinion network as to ADHD and also as it rolled out with other psychotropic medication and then our division at the University School of Medicine at Seattle Children's were agents in terms of the stuff that's in front of you today as to the generics first. Perhaps just to answer the Senator's question first,

um our opinion actually trumps. So the provider could take exception to that and in those instances, and I actually don't recall one that's happened, but in those instances it would defer back to Dr. Thompson and he would have to somehow take action on it himself. If there were...obviously by definition it is not a disagreement, but it's come to a review. But if the outcome of the review that we said no to what the provider was recommending they would have an opportunity for appeal, which would revert to Dr. Thompson. There are other intermediary steps if the picture is unclear, which could include for example making alternative suggestions for that child and then having another discussion with the provider, having a direct examination of that child by one of our review group, or in very rare instances and I think this has happened less than a handful of times, the child could be hospitalized. But it's happened with such infrequency as to be something that I frankly don't recall. Apart from a handful of kids who we've directly interviewed and then come up with a judgment about it. I would say that 99% of the time plus the provider has perhaps not agreed with the decision, but hasn't taken particular exception to the decision. They may not like it but they don't move forward to some secondary appeal process at all.

Jeff Thompson: So Senator, in 1,000 reviews with ADHD drugs we've had 30 fair hearing requests, 28 of them did not show up to the fair hearing. So we continued the drug and in 2 the agency basically prevailed with the second opinion. So in the administrative appeals rules and rights of an entitlement population 1,000, you know, 30 out of 1,000 and the agency has prevailed in all of those. And I think the client has been best served in my opinion.

Chris Varley: So as to the generics first to mention about it we were asked as a division, the academic faculty, who are pediatric psychopharmacologists in our division at Child and Adolescent Psychiatry at the University School of Medicine to entertain the question with regard both to generics first as to ADHD and also to the antipsychotic medications. As to the slide that is up there now the evidence in terms of meta-analyses that have been done with regard to all of the various classes of medications that are used to treat ADHD shows the following: that stimulant medications are far superior to any other class of drugs. That the effect size for example of atomoxetine, of tricyclic antidepressants, of Alpha 2 agonists, of bupropion, another noradrenergic reuptake inhibiting antidepressant as to ADHD and the aggregate have an effect size of about .3 with regards to the stimulants as a class the effect size on average in treatment naïve patients is about 1.0. That effect size is statistically meaningful at a .00001 level. So there's no question that stimulants, really throughout the lifespan whether it's a 25-year-old or a 3-year-old supports the use of stimulant medication. Within the stimulant class in meta-analyses that have been done and in essentially all the studies that have been done there is no differentiation between studies that have looked at amphetamine

preparations as compared to methylphenidate preparations. There are no published head-to-head control trials looking at amphetamine versus methylphenidate or any other methylphenidate derivative such as dexamethylphenidate to date. Essentially what has been demonstrated is parity in those studies, the effect sizes, the response rates are essentially identical. There are some modest questions about side effect differences by age and also between amphetamine classes compared to methylphenidate, but they statistically don't differentiate when you compare one study to the other.

As mentioned, the only agent out there in terms of what we think as truly the long acting group of medications within the stimulant class to treat ADHD is Adderall XR, which is a mixed salts of amphetamine, a combination of levo and dextroamphetamine. The other agents, methylphenidate products or dexamethylphenidate to date do not have a generic out there.

So our perspective was that in the long-acting group of stimulant medications there was no evidence that an agent at the face in anticipation in a drug-naïve patient would show a superiority to a product other than Adderall XR. That you cannot, I think, in a scientific basis at least make an argument that a methylphenidate product would be preferable. The one exception in terms of a choice that actually is real is the last one on the slide up there in terms of the history of substance abuse. I don't know that there is a metric about that that is the gold standard that will say, "This is true or it isn't true," but we know that there is a substantial likeability factor, which anticipates substance abuse with all of the stimulant medications—methylphenidate or amphetamine in basis. And if that one case alone, in a drug naïve patient, I think that the presence of substance abuse in that child or an approximate first degree relative would trump the generic first use in our view with regard to Adderall XR and be permissive with regard to the use of either atomoxetine, which in studies have showed no abuse potential whatsoever in any fashion and a number of investigations with tens of thousands of subjects involved with them or the use of Daytrana, which is a transdermal preparation of methylphenidate which cannot be abused because of the inherent nature of the median in which the drug is transmitted through the skin. But with that exception I think there's no evidence as to long-acting stimulants that you would predictably get a better response with substance, with a medication formulation other than Adderall XR. An interesting question is, which is unanswered I think and it's really come out in this conversation today is the issue as to the kids who you start on generic forms of immediate release methylphenidate and then the provider says, "Hey, this works. I like what happens with 5 mg of immediate release methylphenidate three times a day. I want to prescribe Concerta or Ritalin LA or one of the truly long acting agents." And I don't think we have a definition and maybe it's

up to you guys to make a judgment about that as to whether that child constitutes a treatment naïve patient. I would say not at that juncture but I don't think the issue is clear and it really begs an answer in terms of what happens at that point if a child is identified as a clear responder to immediate release methylphenidate and the provider wants to switch to a longer acting agent.

So those are my comments with regard to the stimulant medications. I think no question of anything other than parity across classes and only one agent in this class in the stimulant group, Adderall XR, that is now available in a stimulant form.

Maybe I could briefly move on to the atypical antipsychotics. Right now, as has been mentioned by Dr. Thompson, the only atypical antipsychotic that's out there is risperidone. It received the first FDA indication. There right now are two in class—aripiprazole and risperidone, which have FDA indications as safe and effective in children down to the age of seven. In the case of risperidone for autistic spectrum conditions and psychosis in the case of aripiprazole for bipolar disorder and schizophrenia, within the class of the five agents that are typically prescribed there is no evidence of any individual drug superiority. There have been very few small end comparator studies, which to date do not offer predictive, positive value for one agent or the other. And there have been approximately 10 times as many studies done for risperidone as there have been for the other atypical antipsychotics. And on that basis and in the absence of meaningful distinctions as to side effects I think you could not make an argument that with anticipation in a drug naïve child that you would have anything other than the predictable level of response with risperidone than with any of the other atypicals. And hence our position was about this that risperidone was a clear first choice in terms of the advocacy in a generics first bill as compared to other atypicals.

Frankly, the evidence that a child in crisis would be a foundation to use an alternative medication with the rare exceptions of some of the medications that have injectable preparations is frankly without substance in terms of scientific support as well. So those are my comments about it. If there are any questions I'm happy to take them. But that's what I wanted to convey.

Jeff Thompson: This is Jeff Thompson. Just as a point if they were on a methylphenidate intermediate they would not be naïve and therefore could move on to Ritalin or Concerta. We're truly looking at somebody that's a first time start.

Bob Bray: So just a process question. This is Bob Bray. I'm from Spokane. There's two of us from Spokane and one from Yakima. So in the process that you

described where a prescriber would contact you and maybe there's not consensus after the phone call and you mentioned possibly seeing the client and maybe this is going to need some help from you all too. What happens for those folks who are remote from the Puget Sound area?

Chris Varley: Several things can happen. We've had, in the past, a provider as part of the review team who was in fact situated in Spokane. She's no longer part of the team. But there is a telemedicine capacity that we have at our institution, which essentially goes throughout the state. There are portals in Spokane, in Wenatchee, in Longview, in Vancouver, Olympia, as well as the child coming to our facility. I'd say that the frequency with which there were a direct face-to-face second opinion, direct examination of the child is something of the order and one in every 200 reviews. It's really substantially unusual. So in those instances we have those alternatives. If it somehow didn't work out we'd have to figure it out, but so far it has not been a prohibitive barrier, but that's what we've tried to offer would be telemedicine portal access if transportation were prohibitive.

Bob Bray: So just to remind the committee that we have done 1,000 edits for too young, too many, too much in ADHD over the past three years. 50% change rate working with the Children's and a high satisfaction rate with this opportunity. Not without sometimes a little bit of mashing the teeth, but as far as I know we could find only one ER visit that was from medication disruption when we published that paper.

Jason Iltz: Dr. Varley, this is Jason Iltz. One of the questions that I wanted to ask you is if when you guys got together this child in crisis definition is...I need a little more clarity from a pharmacy standpoint. Is it, you know, what is the objective component to defining a child in crisis or did you guys even have that discussion?

Chris Varley: I've been an agent in that conversation. I have to say that I share your confusion about it. As I said I think that with the exception of those instances particularly as to the atypical antipsychotics in which a provider deemed the necessity of an injectable form of medication for one reason or another and they only had access to that I could imagine that one might be drawn to perhaps a variety of atypical antipsychotics. Absent that there is not a scientific reason that would anticipate that one atypical antipsychotic would trump another. And hence our conclusion that risperidone would be the agent of first choice. Having said that I think that there was a sense that there would be left to the provider discretion in those circumstances that they defined as emergent. And it could be left principally to the provider but also being informed by the parent or pharmacist to be an agent in that process. But frankly I think that from the standpoint of some scenario that I could imagine in a clinical context it seems improbable to me to be likely to occur. So I'm with you on that. But having said that the

determination was that the child in crisis denomination would stand as it was defined by Siri earlier.

Jason Iltz: Thank you.

Siri Childs: This is Siri and again representing Medicaid. We implemented the child in crisis rule, if you would, when we started the age and dose of atypicals in children in March. I can tell you that maybe there's been two requests for a child in crisis. Other than that they are new starts and they wait until the second opinion folks have had the consultation with the prescriber and, you know, there's an agreement and a recommendation from the second opinion folks and we follow the recommendation of the second opinion folks.

Jeff Thompson: So again I think there were a couple of other clinicians that wanted to speak.

Chris Varley: Thank you.

Vyn Reese: Thank you Dr. Varley. The next person on the list is Dr. John Childs from Western State.

John Childs: Which mic?

Vyn Reese: Whichever one you want, John. Chris warmed that one up.

John Childs: I'll do what Chris did. My name is John Childs. I'm the medical director at Western State Hospital. Like Dr. Varley I'm on the faculty at the UW Department of Psychiatry and I'm actually on a contract to Western State for my services there. I've had fairly extensive background in evidence based treatment of schizophrenia and have been on a variety of publications in that area.

About six months ago we undertook a project to try to deliver a good clinical product at a better price with the use of antipsychotic medications at Western State Hospital. I've talked to Jeff about this on several occasions and he thought it might be informative to you for me to tell you what we've done and kind of what we have in mind for the future. Let me first say something about the mechanism. Everything I'm going to describe to you we developed first through our P&T Committee at Western. That is a committee of the medical staff. Therein we did the legwork and ran the numbers. It was then taken to the medical staff and only after the medical staff had voted positively to proceed did we do that. And this comes from my past experience in that if you can get prescriber buy in to changes you will avoid a lot of difficulties down the road.

The first three things we did and I want to tell you this quickly because the percentage is helpful in terms of what we do next. Is we really looked at a better outcome at a better price. And what we took on was therapeutic duplication using two or more antipsychotics for more than six weeks. Over max dosing, that is prescribing an antipsychotic at over the maximum dose allowed by the FDA for more than six weeks and prescribing a medication on a multi-dose per day basis when once-a-day might suffice. We sent a letter, actually an email, to every physician who had a patient in one of those categories saying that, “Here’s your patient, here’s the situation. Please make a change or explain your clinical reasoning.” Now Western States Hospital as you might imagine does not have treatment naïve patients. They are as rare as hen’s teeth and in an algorithmic sense we are stage three or four or five or six down the line. I sent out 297 letters and got a lot of explanations back. My sense was I really wasn’t so concerned about what the reasons was but that the physician thought it through and gave me a reason. And I can tell you the categories of that if you’re interested. Anyway, the net result was 97 patients had a significant change [coughing] and we saved \$150,000 on an annualized basis. We have continued that program so every time we come to that parameter an email is generated and goes out and so that will continue. It’s been interesting that initial one-third response. Now that we have continued it for the next three months it’s up at about 50%. So we’re getting more kind of physician buy in to taking a second look at this.

Just for your interest our one non-psychiatric area is we’ve looked at proton pump inhibitors. Some of you may know this. There was recent literature to suggest that these really should be viewed as short-term medications and yet most people who get put on Nexium never got off it. When we looked at this we had 167 people on that drug. We did a similar kind of procedure and three months later we had 65 people on these proton pump inhibitors. That saved about \$85,000 a year.

Our next big project is different and speaks to what you’re considering today. We get a number of patients who are being treated with an antipsychotic medication and the clinician makes a decision to change to another antipsychotic medication. The literature does not support using one drug over another in that situation. It is the flip of a coin and so we are now vetting this through P&T. I will soon be going to the medical staff with this and the idea is that when you make that change, unless you have a clinical reason to do otherwise the second medication needs to be a generic medication. As Chris said right now we have one risperidone. I think probably in a year we might have two if Seroquel comes on line. If we get the same one-third response to that as we got to the initial programs, and there can be lots of good reasons to pick another—a relative responded, past response, I feel like it’s good, something like that. But anyway, just tell me what you think. If we got that same one-third

response that would equate to a savings of probably about \$750,000 a year for Western State Hospital pharmacy.

All that comes together we are saving 10, 15, 20% of our pharmacy costs based on the preceding year with no detriment to treatment and in some cases the first three I gave actually gave an improvement in treatment. You shouldn't be on two drugs if they're not helping. That's more side effect possibilities. Over max dose is the same with an increasing risk of an adverse cardiac event and certainly taking a medication more than once a day when you get better and leave Western as we hope all people do your adherence goes down—multiple day dosing versus once-a-day dosing. So there's a good clinical rationale for all of that.

So those are the programs we are embarking on. We're asking our clinicians to think hard about what else we might do. We're getting a lot of clinician-generated ideas in this area.

Vyn Reese: Thank you Dr. Childs. Are there questions for Dr. Childs?

John Childs: Gee.

Vyn Reese: Quiet group.

John Childs: Okay.

Vyn Reese: Thank you so much.

John Childs: Thank you.

Vyn Reese: Any other stakeholders that wish to speak?

Tracy Davies: Thank you. I didn't sign up. I'm sorry. I didn't realize there was a sign up. My name is Tracy Davies and I'm from Eli Lilly and Company. I wasn't going to speak directly to a particular class of medications except to say that sitting here I was thinking back to earlier in the day when several people came from Hope House to testify and they talked about their particular experiences with medications whether as a naïve patient or as somebody who had lots of experience in several medications over many, many years. And what really occurred to me was that all of those people walked out today really thinking that they had participated in the process because they walked out thinking today that their medications, at least their atypical antipsychotics would be unrestricted and then they didn't stay because I don't think they necessarily understood. I can't speak for them, certainly, but they didn't stay to participate in this piece of it. And I think it's unfortunate because the way we're defining therapeutic interchange wouldn't necessarily make sense to a lot of people outside this

room. To them it's about, "Is there access or is there not access?" Whether you're naïve or a person who's been very experienced in this system I think it's unfortunate that a lot of people walked out of the room earlier thinking there would be open and unrestricted access and I think their opinions and their experiences still need to be considered this afternoon.

Vyn Reese: This is Dr. Reese. I don't know if you listened to what we just said as far as what therapeutic interchange meant. It meant if a patient was on a medication and was stable that patient would remain on the medication. It would be naïve starts on medication. We just heard there is no difference in any of the atypicals in that regard and it's reasonable they started the generic first, which has been out, has a long track record and is less expensive. That seems like a totally reasonable thing. We're not taking these people's medications away. If they're on a stable medication we're giving it to them. And that's part of the program. I'm not sure if you heard that.

Tracy Davies: No. I did hear it and I appreciate you making that point specifically because I do understand the difference between naïve patient and switching a patient and certainly I understand that patients won't be switched and I think that the people who were here earlier would certainly appreciate that specific fact. But I also believe that the people who were here earlier wouldn't necessarily differentiate between a naïve patient a person who's on a medication. Because of that relationship that a person has with their prescriber and the information that they exchange and quite frankly what goes on between a person and their physician is very private. And making sure that that person gets the right medication at the right time I think is every prescriber's best interest. And having to go back to a peer panel, as good as it might be, and filled with people who are very talented and experienced does create a barrier and that's quite frankly why we're doing this here today. So I think that they're not necessarily aware of what's happening this afternoon.

Jeff Thompson: So this is Jeff Thompson. We also give the advocates and any clients that want to come to our monthly meeting with the Mental Health Workgroup. I'll double my efforts to make sure that they're here. They have not attended very often other than NAMI at the table and I'd be more than happy to get out and talk with some of the...the Hope House or right across the street from Medicaid is another peer counseling group. So I'll double my efforts to make sure the community knows what's going on.

Tracy Davies: Thank you.

Vyn Reese: Go ahead.

Joe Fellow: Joe Fellow with AstraZeneca. This is just a point of clarification. Slide number 7 states what drug classes are to be reviewed and recommended for inclusion in the generics first new starts initiative at today's meeting and the first bullet point says antipsychotics in children and adults. It's my understanding that for the purposes of today's meeting it's just antipsychotics in children. Is that correct?

Jeff Thompson: This is Jeff Thompson. What I wanted clarity from the committee is that we can move forward in the Mental Health Workgroup to work on a generics first program for adults and bring that back in 2010 so that I don't have to ask permission again sometime in 2010 and then to begin the discussion.

Vyn Reese: Any other questions? Go ahead.

Dick Miyoshi: I've heard a lot about the Mental Health Workgroup and I actually am on the Mental Health Workgroup.

Man: And who are you?

Dick Miyoshi: I'm Dick Miyoshi from Harborview and the Mental Health Workgroup. What we've done is we've gotten very good data from children on both ADHD drugs and antipsychotics. Unfortunately, when we get to adults it starts to get messy and so that information actually probably will come later because the...partially because of the comorbidities we run into and we have to kind of weed that out. We've been struggling with, you know, metabolic syndrome and things like that and substance abuse, which you know may stop people from taking their meds for two months much less 180 days. So we're kind of struggling with that and we will probably work that out. We're going through multiple different agencies. I talked to the folks at the University yesterday and we're trying to figure out an equitable way to do this without breaking the bank. Any questions from...thank you.

Vyn Reese: Thank you. Anyone else wish to speak?

Jeff Thompson: So Vyn before I ask you to sort of go through this and discuss do you want me to go through...I just wanted to present some of the adult data because we are...it does kind of inform what's going on and it looks a lot like the children's. I just want to spend five minutes going through this.

Vyn Reese: Sure.

Jeff Thompson: So can you just flip through the slides? Keep going. One more. Okay. So...

Vyn Reese: Jeff, stop right here. Make sure we understand all the abbreviations.

Jeff Thompson: Sure. Sure. I have to remember them all too. So basically one of the things that we're doing in the adult mental health group just like we did with kids is going through who's using these drugs? Where are they using them? Why are they using them? Trying to use the claims data to the largest extent possible and this slide basically looks at some of the demographics from a large county that we may or may not be sitting in who are touched by many services. So this is looking at any of the clients that are getting an antipsychotic and they are...and boy, they are being touched by the Division of Vocational Rehab, the Mental Health Division, the Economic Services Agency, the Division of Alcohol and Substance Abuse and help me Duane, I forgot what AAS is. I apologize. But basically the slide was...I'm sorry. Aging and Adult Services. There you go. I need some meds. And then also by our criminal justice system. So basically I think Dick's absolutely correct. We need to go carefully when we talk about adults in antipsychotics in any program. But I did want to say that they're getting touched by a lot of services. Next slide.

What I want to show you is where I don't think we're doing as good a job as they get touched as 21,000 clients or 5% of all our enrolled clients in Medicaid are getting an atypical antipsychotic. Of those, now that we don't have Part D, 412 are over the age of 65. There's a black box warning and quite frankly I have seen escalating doses and we need to probably do a better job with this group too because I have seen some deaths related to...now, true, true and unrelated I'm not really sure. The high user types obviously it's the age, blind and disabled or SSI as opposed to temporary assistance to needy families. The other group is largely GAU and GAX group. So it just gives you an idea of which clients are using antipsychotics. Next slide.

This is an area where we can talk about the use. It's going up and so we've gone for some reason from 2005 from 4.6 now up to 4.5% of our population and it just continues to grow with the indications. In all populations kids and adults and elderly. Next slide.

Barak Gaster: Jeff, can I ask a quick question?

Jeff Thompson: Sure.

Barak Gaster: This is Barak Gaster. On that last slide so is this atypical antipsychotics?

Jeff Thompson: This is atypical antipsychotics only. So one of the things that we're looking at and we've agreed across our benchmarking and across multiple states is we are looking at what is the use of multiple atypical antipsychotics? Now this is not concurrent use. In other words there may

be a rare person on file. This is any use during a year, any prescription, but you can see that 20% of our clients have had a prescription for two antipsychotics, you know, 4% for three, you know, and you heard from those people at Hope House how many times they've been on many medications. And I think what we need to do is pay more attention to this sort of wheel of motion as we're just trying to figure out what works and become a little bit more disciplined with this, you know, and then six people that are on five or more during a calendar year. If we were to look at concurrent use just multiply these numbers by about 30% less and that would be concurrent use. Next slide.

If you look at multiple mental health drugs now this is taking in account both the atypicals, the typicals, as well as the mood stimulators, the stimulants, the...all the medications that sort of compromise a mental health drug, you can see the number goes from 21,000 up to 70,000 clients and then you can just go through the math about one drug, two drug, three drug, four drug, five drug, six drug. Some people...and John would attest that we do see some people coming into Eastern and Western State that are on five mental drugs, six mental drugs, seven mental health drugs at one time. And one of the things I want you to sort of wrap your mind around, and it's very difficult, is this is not a one single entity. If we just took out, you know, multiple mental health drugs problem solved. The more drugs, the more prescribers, the more gap. That's what I want you to think about. The more prescribers, the more drugs, the more gap. And I'll show you what I mean by that. Next slide.

When a client...and we did a random sample of mono pharmacy and polypharmacy in antipsychotics. And so I took a random sample of about 120 clients that were in that multiple antipsychotic and I just said, "Are they taking them?" Without fail when they're on a single agent they take it from January through December and they never miss a dose. Next slide.

When you add a second agent this is what I see every single time. I see escalations in a dose. I see gap and the more drugs I see the more prescribers I see. So in this case they're taking Zyprexa and risperidone. You can see they have a 30-day gap in therapy, you know, between...so they are antipsychotic free during one more and I think that's month four or five, and then there's escalations and de-escalations and switching. Next slide. So here we have three antipsychotics in a single individual with four prescribers. The same thing—up and down, in and out and every single patient that I see that is on two or more has this pattern where they could have Seroquel, Geodon, risperidone and the more drugs you put on the more gap you get, the more prescribers you get. What's going on? So in King County right now Dr. Sharon Farmer, Rick Reese were actually doing chart reviews on 200 clients because we don't know. We do not know why this happens. Is it because of substance abuse,

homelessness, side effects, we don't know. And we need to find out because we have got to do a better job here because these are the people, and I'll show you the last slide, that cycle in and out of the ERs and in and out of the hospitals.

Vyn Reese: Jeff, one of the reasons is these people are the most severely disturbed. I mean I guarantee you that they are the ones that are in grave risk of being hospitalized again. And they'll see a different doctor, they'll move around, they won't be in a stable place. Each doctor will start their own favorite antipsychotic maybe not knowing about the other doctor and so the patients are moving around. They're very disturbed. They're not on any drug long. And so you really get this...

Jeff Thompson: So you are absolutely right, Vyn that that is one scenario. But that is a conjecture and so what we want to do is go through and do a discipline chart review and find out, "Is this the type of client that has a substance abuse history? Is the kind of client that has a homelessness history? Is this the type of client that was misdiagnosed and maybe is being thought was schizophrenic but maybe has an access two disorder or something else?" We simply don't know. But this is where we're chewing up resources.

Patti Varley: I have a question because this just happened to me. Out of those four prescribers are they all of the same discipline because if I'm in the psych world as a prescriber and my patient goes to a PCP it's happened where not even for a psychiatric reason but they're put on a psychotropic type medication, which interacts with their psychiatric meds that unless I ask I might not know about because it's not necessarily part of that same service. So when you're looking at these prescribers are they same discipline prescribers or are they from different disciplines?

Jeff Thompson: So in this case 80% of these are likely to be a mental health professional. The other scenario that plays out in this, especially when you see long gaps, is they might go into a community mental health hospital. They get on a different cocktail of drugs and trying to stabilize them they exit or they get discharged, the side effects happen and then the community prescriber is dealing with the side effects and then trying to change the medications. So that's another scenario that we see play out. I frankly don't know but I don't think anybody knows and until we know really what's going on here we're not doing the best job because these are the clients; these are what we call the 550. These are 5% of the clients that chew up 50% of Medicaid. 50,000 clients \$1.2 billion. We've gotta find out what's going on.

Angelo Ballasiotes: Well, I see this all the time with this multiple medications. It doesn't mean that they're taking them all but again somebody will be taking

Seroquel and be using for a long period of time and when they use they don't use the Seroquel. They wind up in the ER or they wind up in jail. So they are started on another medication and you go to their house and you can see the plethora of drugs that they have with them.

Jeff Thompson: You're absolutely right. So one of the reasons why we changed 5773 that you can now actually share the mental health drug history across providers until we change that law, you know, all of you prescribing an antipsychotic to me couldn't talk. And so now we have that ability and hopefully EMR will be up and going. Next slide.

If you look at where the trends are I think this is the good news that the trends for multiple use of antipsychotics seems to be trimming down a little bit and so mono pharmacy is becoming a little bit more likely. I think that's a good...that's frankly a good trend. Next slide.

But then when we look at the gaps in therapy...so this is looking at the different age groups and then looking at their average days of gap you can see that there are large percentages, 23% to 8% who have gaps of 40 or more days in antipsychotic use. Why is this? Now some of it might be they are going into jails. Some of it might be that they're going in community hospitals and we don't see the prescriptions, but that's less likely because they're usually on admitted for 14 days. So if we don't nail this we're not doing the best job for our clients and that's why, actually with our children's project across 16 states we're going to make this an emphasis across the nation to figure out why people aren't taking the meds. And quite frankly not to beat up on mental health meds this doesn't look any different than diabetes or asthma or any of the other drugs we talked about. But I think it is critical that we understand what's going on. Next slide.

Because when you actually start looking at the outcomes, which you know Nate Miles has really taught me that we need to look at outcomes. And so when you look at...as you increase the gap in therapy, you increase the amount of psychiatric hospitalizations, the amount of ER hospitalizations and the amount of...not only that, but medical inpatient hospitalizations. So what's going on here? Why when they don't take their meds they're more likely to go into the hospital or go into ER and then below there we're starting to look at possession ratios that actually...they have many medications they're actually in possession of but when we look at the claims we don't find that they're picking them up on time. So we're going to be looking at this and making this a special project because this may be one of the brass rings that we can do to help decrease the mortality and morbidity in mental health. But we start with being more disciplined about using the data and so I have to give real credit to RDA and Dave Mancuso(?) who we've been working with to try and collate these.

Vyn Reese: Jeff, are you looking at all the other variables you just talked about? Are you looking at homelessness, substance abuse, alcoholism, all the other things that impact this?

Jeff Thompson: We are. And the way we are doing that is we're actually doing chart reviews and it's really sad to actually read these charts. In some of the younger people they've actually been in foster care. We're looking back as much as 10 years. They go in the system, they go out of the system, they go in jail and then the end result is death in a 20-year-old. It's really sad. Many of them have substance abuse issues, etc., etc. But I think this has been the beauty of working with the community, working with you that we're starting to actually use the data, use the claims data, work with people to try and actually take a hit on this. It's complex and I don't have a lot of answers, a lot of questions. Last slide.

So the question we're asking you, and I...sort of a little bit of apples and oranges, but I think the data kind of informs why we're doing some of this generics to be much more disciplined with our stewardship of our money asking you, you know, number one is, "What do you want me to report back on the reports, the feedback reports?" Number two, I just want to list the generic first programs that we want to start on in addition to the ones that you...we started last time. And then ask for your permission to enact 5892 to do the generics first and the PPIs, the antipsychotics in children and then the stimulants in adults and children. And these are the other drug classes that we're considering. We may not do it. But we want to start looking at this. So we want to be transparent in addition to the six classes that you talked about last time and did not actually say in your report to look at antipsychotics. So that's really what we want you to opine on and read into the record about what are your instructions to the agency.

Vyn Reese: I have one observation. Looking at the other drug classes for consideration right now there's no generic Alzheimer's drugs. So it's going to be hard to find one unless there is one coming off patent pretty soon. So we're sort of stuck there. The other classes look like they are pretty reasonable and that there are generics in just about all the others.

Siri Childs: Dr. Reese, this is Siri Childs and galantamine is a generic in the Alzheimer's class.

Vyn Reese: Is it now?

Siri Childs: Uh huh.

Vyn Reese: How long has that been? Okay.

Jeff Thompson: Just so we're clear this does not mean that we are going to do a generics first program, but we want to be transparent that these are ones that we will look at because what we don't want to do is do a lot of prior authorizations or second opinions and not have an ROI or a decrement in quality. So we'll work on all of these in addition to the PPIs, the antipsychotics and stimulants.

Siri Childs: This is Siri again and I can tell you that these drug classes round out all of the drug classes that are on the PDL that have generics in them. It will take us probably a year or two years in the biennium to actually implement all of them. So by the time we get there, there will probably be more generics too in the classes.

Patti Varley: So this is Patti. My...I'm curious as to how this gets known about and the education to the practitioners outside of this room about the rollout, about what it means and about the information, I think, that they need to have buy in.

Jeff Thompson: So with all these programs we do the broadcast fax to all the pharmacies. And then we work with the Mental Health Workgroup and then we send out letters. It's...

Woman: And numbered memos.

Jeff Thompson: And numbered memos also. And to be really quite frank, you know, most of the time you guys, prescribers, are so busy they're not paying attention and when they hit the prior authorization then they get the education. We try but it is hard because we're only one insurance company. We are going to make every effort and that's why I'm talking tonight with the ARMP community and we'll be talking with WAYCAP(?) here pretty soon. The Pediatric Mental Health Workgroup meets on Friday. There's only so many of us to go around. So we're going to make every effort.

Siri Childs: This is Siri again and I do want to again introduce Chuck Agte who is our Pharmacy Program Manager and Chuck has designed the computer edits so that the pharmacists will be told step-by-step by return messages exactly what to do at every step in this process too.

Patti Varley: I am just encouraging whoever the powers that be can I think getting on the speaker list of presentations in large groups where people can ask questions and therefore be better informed for all prescribers is not a bad idea. I know we've invited people to some of ours but I think that is an opportunity for people to hear it firsthand and to have an opportunity to ask questions, which I think then you're buy in and your marketing is much better.

Jeff Thompson: And we're on those speakers lists. It gets a little [inaudible] but we're going to do it. So that's the pitch.

Vyn Reese: So you want us to pass a motion okaying you doing this approach?

Siri Childs: Yes, Dr. Reese that is correct and we actually need two motions. We need the motion to clarify the ADHD situation with the stimulant drugs and Strattera and we need to have the recommendation for these additional drug classes.

Vyn Reese: So we actually never formulated a motion for the ADHD drugs and so as...let me just restate what we talked about. We said that basically the ADHD drugs...there are three classes of them that you could only substitute in the class for a generic drug versus a brand name drug. That you couldn't substitute a shorter intermediary drug for a long-acting drug if that wasn't a generic in the class. And so these are all the things we talked about. The question is, "How do we put that into our...?" Let's go back to that motion. The problem with that motion is we don't have a long-acting and a short-acting formulation of each stimulant in every class that's generic. That's the main problem.

Patti Varley: This is Patti Varley and that's my, I guess...I'm confused because to me this still says what I think we said and I don't know how to create something that doesn't exist which is generics that aren't generics yet. So is there something I'm missing?

Siri Childs: This is Siri again. I think that the direction that we need is whether you all believe that it is...that there is evidence to support...and when I say substitution I don't mean by pharmacists, I mean by our second opinion folks—a substitution of a stimulant generic for both methylphenidate and dextroamphetamine. If we can use the generic amphetamine salts combination for the stimulants and if you can give us some direction for the Strattera too.

Jeff Thompson: In new starts.

Siri Childs: In new starts.

Jeff Thompson: Only.

Vyn Reese: Patti, this is Dr. Reese. I had a question to ask you. Do you always start someone who is a naïve patient on a long-acting preparation or do you start them on a short-acting titrate to dose and then switch them to a long-acting?

Patti Varley: This is Patti Varley answering that question as Patti Varley, which is not evidence-based. This is Patti Varley. And I have my, you know, 30 years into it. I tend not to start all my new starts with a 12-hour med. My belief is that if I have...especially I treat children so I'm treating young people who if they have a really bad side effect like not sleeping most families get pretty mad at me. And the kids aren't doing very well in school when they don't sleep at night. So I tend to start with a...whether it's a...depending on the age, depending on the circumstance, the kid, the family history, a shorter acting agent with the understanding that if I have evidence of efficacy and tolerability and I need to cover them longer, because of course we know they don't...eight hours isn't always eight hours and 12 hours isn't always 12 hours, that I would move within that class to a better coverage. I think what you're asking is that should we say within the stimulants that all stimulant naïve patients be started on a dextroamphetamine salt. Is that what you're asking?

Vyn Reese: No, no.

Patti Varley: Okay.

Siri Childs: No, no, no. I'm sorry.

Vyn Reese: What we're saying is if you want to start a naïve client on a non...on a long-acting agent then the first choice would be Adderall XR.

Siri Childs: This is Siri again. You know that we have generics in both methylamphetamine and...so there's not a problem except when you get to there's no generic for a long-acting methylphenidate. And so that would be the issue. How do you feel about substituting the mixed salt Adderall XR generic for a long-acting methylphenidate?

Patti Varley: In a treatment naïve though. You're talking about two different things.

Siri Childs: Right.

Vyn Reese: Right.

Patti Varley: Because when you say substitute I'm thinking of a kid on metadate CD who I want on a 12-hour med and then I have to go to Adderall XR and I'm going to go, "Wait."

Vyn Reese: That is not naïve.

Patti Varley: Okay. Thank you.

Vyn Reese: But I will stipulate that while Patti has 30 years of experience and will start low and slow that is not the typical prescribing pattern out in the community. The typical prescribing is to start with a long-acting in a naïve client.

Patti Varley: So I'm totally...if the question I'm being asked, which I think I'm now understanding, sorry it took a while. Is that if I had someone who has never been on a stimulant and someone comes in and we're going to start them on a med for ADHD and we want to pick a 12-hour med is it okay to do Adderall XR first?

Woman: Yeah. Why not?

Patti Varley: No evidence to say otherwise.

Bob Bray: This is Bob Bray. Just as a point of clarification though if that kind of thing was to happen, since it's a C2, you would need a prescription for that exact product by some provider that has the ability to write C2. So I guess I could have asked Dr. Varley about this. But if that's the case they have a discussion with the provider. They agree that it should be a substitution for another drug. Then the prescription, I would assume, would come from the provider if they agreed. If they disagreed and the provider won't do it, what happens then? Because I was assuming that Dr. Varley or your consultants would not be the prescribers.

Jeff Thompson: In that case then they basically would...the client could exercise their rights for a fair hearing. I would probably get involved in it and find out what's going on because we want to make sure that interruptions of meds is not what this program is about. But if there is a difference of opinion between a university expert and a prescriber that's seen the client I want to know about that and we'll look at that. But again I just wanted to...in the too young, too many, too much—1,000 reviews, 30 fair hearings.

Angelo Ballasiotes: You know, realistically somebody that is starting...somebody out that is naïve and what I do is I start them on a usually t.i.d. or b.i.d. to see where we hit it. That's common sense for me.

Siri Childs: And you know what? Those would go through without a stop because they are generics. So the reason we're focusing on the Adderall XR generic is because that's where the issue is going to be if they start them on a long-acting methylphenidate and we don't have a generic substitution. So that's why we have brought that to you.

Patti Varley: And this is Patti Varley because I think this is a marketing point, which is if you have someone who has never been on stimulants and you're picking a 12-hour med and you've got your option of Concerta because Focalin

XR really is not...it's an isomer difference. So in my mind you've got Concerta and you've got Adderall XR. Those are really your comparable methylphenidate and dextroamphetamine long acting. Concerta can't be opened and sprinkled. So you have more flexibility in administration of Adderall XR than you do with Concerta. So if you need another point of...if they'd never been on either and you have to use one, that one actually gratefully gives us more flexibility to treat more patients than does a capsule that I can't give to someone who can't swallow.

Vyn Reese: This is Dr. Reese. The only problem I have is if you right for Concerta and then you're going to therapeutically substitute Adderall XR. That's a across classes. So you can't do that. I don't see how we can do that any other way other than just call the provider and say there's not...we do not have a generic for Concerta so therefore you either need to pick a long-acting amphetamine generic or you need to pick a medium-acting methylphenidate.

Patti Varley: Now this is Patti Varley and now I am going to again play devil's advocate. So I have a kid who is the fourth kid in a family I've treated. No one in that family ever responded well to a dextroamphetamine based agent so do I...if I have that information and I share it in that discussion I'm assuming that gets overwritten just like a substance abuse problem. So it's not never, it's just you have to have a really good rationale. Is that correct?

Jeff Thompson: Yes, that is correct. This is Jeff Thompson.

Vyn Reese: And so you have to talk to someone about it.

Jeff Thompson: Right. So when she talks to Chris...so we did talk about first generation who have responded to either...not responded to risperidone or not responded to a dextroamphetamine but in the opinion of the experts who are here it's such a rare, rare issue as to not even come up that often. But that would be one. That might be an exception.

Vyn Reese: So why do we need to change this at all? There's nothing wrong with that. I mean basically we're just saying you prescribe a generic first as to new starts.

Donna Sullivan: This is Donna Sullivan. I think the motion that you're making is part of the DUR Committee, not part of the P&T Committee so you're right, it doesn't apply to this particular motion. You're not changing this one. You're making a new one on behalf of Medicaid for their DUR program.

Patti Varley: So if I understand it correctly the motion we're being asked to make for the DUR is that in the stimulant group if there...if in the ADHD meds if

they are going to do a new start using a long-acting formulation that the recommendation is they start with Adderall XR generic first before other options.

Siri Childs: That is correct.

Jeff Thompson: That is correct.

Alvin Goo: This is Alvin and I think in addition if you want to do that they should...if they're gonna start the Patti Varley way and start low with a short-acting then they need to start with short-acting Adderall mixed stimulant.

Patti Varley: Yeah. This is Patti Varley. I don't know. I think that's harder to...but...

Jeff Thompson: Again...this is where I want to be very clear.

Patti Varley: We're not doing that right now.

Jeff Thompson: That is not a naïve client. Once they've started on something then they're off the naïve client issue.

Patti Varley: Alvin, do I understand you're saying that a treatment naïve client because we have the 12-hour generic Adderall that we should think about saying, "If you have a new start and you're going to start with a shorter acting one you start in that group?"

Alvin Goo: Correct.

Patti Varley: It's an interesting question.

Alvin Goo: Because if you don't do that than your whole reason to try and move people towards XL Adderall generic it's lost.

Jeff Thompson: If you would like to have us include in the education that it is better to start low and go slow with intermediate or shorter acting you can certainly make that and we will make that part of the communication.

Patti Varley: I don't think you can...but...

Jeff Thompson: But again that's only part of the communication because if they start on a lower intermediate generic they don't touch this program. Once they've done that then they can go up to Concerta or Adderall XL and they'll never get touched.

Vyn Reese: Right.

Jeff Thompson: Again, it's...and that's why I put all those slides together. That would not be considered a naïve client.

Vyn Reese: I don't prescribe that much for this group but there are a lot more 25 year olds coming in now that realize they've ADHD from the time they were kids and they test positively for the test. And so...and I'm starting low and going slow just like Patti is. I've learned that's the best way to do it because I've had to. And I think that should be a guideline to providers that they should start with generic drugs that are lower or shorter intermediating until they figure out the dose the patient needs. And some patients will need, for compliance reasons and for school day reasons a longer acting drug. I mean that's what is going to happen.

Siri Childs: This is Siri, again, Medicaid. Then maybe that should be your motion.

Vyn Reese: Okay.

Bob Bray: Well, this is Bob Bray. I guess I wanted to say it seems to me there's this fairly simple solution, which is that we would say that we recognize that generics first for naïve patients should apply to this drug class just as every other drug class and that we're acknowledging that. Once we acknowledge that, for the specific problem of not having a generic in a certain class, the process takes care of that problem. It's not a prescription that can be...it's going to be stopped. There's going to be an edit. It will stop it and someone...and then...I guess the big question is somebody then needs to present to the provider in an efficient the information that allows them to know, "Well, what could we start?" And so that's an education process. So I think...it sounds like what we're all agreeing is we're all agreeing that generics first should apply to this class and that there is a specific education need, which is also part of the problem solving if somebody writes for the drug that does not have the generic.

Patti Varley: So this is Patti again. I think, and I apologize, I can't remember who made this point. I think this issue about do we then encourage everybody to start with the Adderall short-acting because it hasn't a long acting, I don't...I'm a little uncomfortable with that one. However, here's my question. If somebody started with a short or a mid-length methylphenidate product and then went to Concerta my understanding is there would be no hard stop. That prescription would get filled. But is there an opportunity for someone to contact that provider and say, "Did you know that the 12-hour Adderall is generic, but the Concerta isn't?" They could still stay with the Concerta but it would educate them that there was another 12-hour option in the stimulant group. That feels more comfortable to me than telling people they can't use generic methylphenidate because that's the standard of care.

Duane Thurman: This is Duane. Let me offer up an option here. I think that the simplest way and I think what you're talking about maybe goes a little bit beyond...I think it's something the department could look at and come back. I think for the purposes of today what the department is looking for is your acceptance of their recommendation with regard to these two drug classes and categories and in regard to the ADHD recommendation that you believe that's consistent with your decision that you made as the P&T Committee in light discussion here today. So I don't know that you need a formal motion. I think Patti summarized it pretty well in terms of what the department's recommendation is. If you're comfortable with that you may want to re-do it so you know exactly what the recommendation is, but I think the only motion you need is to accept it and with the ADHD drugs to mention that it is...you do believe or you vote that you agree it's consistent with your prior decision as the P&T Committee. It's just a suggestion.

Vyn Reese: And I also think there needs to be a teaching...part of this needs to be a teaching effort about the need to start low and titrate the drugs up. I mean that's...starting out on long-acting is not high standard of care.

Patti Varley: This is Patti Varley and I agree but I will tell you that is not what is always the recommendations out there in the literature.

Vyn Reese: Okay.

Siri Childs: This is Siri again. And you are the DUR board committee and I have to take my recommendations from you. So I really do need you to tell me how you would like me to handle this when we get the orders. So I am going to press you for a recommendation regarding this.

Vyn Reese: I think what Duane said is just fine—generics first.

Siri Childs: No, it is not.

Vyn Reese: Why isn't it?

Man: What Duane said was fine with what Patti just said.

Duane Thurman: I think it would be helpful...I think what Siri needs, Jeff, is for you to set forth what the recommendation is specifically and have the committee say, "Yes, we agree," and vote on it.

Jeff Thompson: So here's what I'm hearing from the committee. That generics first in the stimulate and the antipsychotic class and for...

Vyn Reese: We're just talking about stimulants.

Jeff Thompson: Okay. Okay. The generics first in the stimulant class for adults and kids is the best practice with new starts. If a long-acting stimulant drug is the first choice in a naïve client then Adderall XR is the appropriate choice.

Patti Varley: Is the preferred drug.

Jeff Thompson: I don't want to say preferred drug. Is the choice that we will go through and educate the providers with through second opinions and information. And a best practice is to go low and start slow.

Vyn Reese: Or start low and...

Jeff Thompson: Or start low and go...

Patti Varley: Start low.

Jeff Thompson: Start low and go slow.

Jason Iltz: I think you should probably use the generic name of that since there will be changes to that class that come.

Jeff Thompson: Right.

Jason Iltz: So instead of saying, "Adderall X..." This is Jason.

Patti Varley: I like that.

Carol Cordy: Can I just throw another scenario out? It sounds like...what Patti's saying is the long acting are often the first drug rather than starting low and going slow. So there could...the only place I could see this making an impact right now is if someone is making a choice to start a medium or long-acting methylphenidate versus the long-acting dexamphetamine.

Jeff Thompson: So again those are all generic. Those wouldn't even enter into this process.

Carol Cordy: Right. But what I'm saying is if the first drug that I prescribe is the long-acting methylphenidate and someone is going to say, "It would be better to do the long acting stimulant." So that's the education piece. Patti, is that a good idea?

Patti Varley: Sorry Carol, it's Patti. I'm confused by what you said. I think if you saw a new patient and you wrote a prescription for Concerta they would stop and say, "No. If it's a new start, never been on any stimulant, the long acting one that we provide is Adderall XR." To me that's a whole

separate issue than a clinician deciding to start with Focalin tablets or...or I'm sorry, Adderall tablets before Adderall XR or Ritalin or metadate CD before Concerta or whatever. That's a different issue. But I think for the purpose of this approval right now it's saying, "If a treatment naïve patient is going to be started on a long-acting agent in the stimulant class what will be approved at this time is Adderall XR generic."

Carol Cordy: Exactly. It's a different issue. But this is the issue we're talking about because this is when it's really going to happen. If you start it on the shorter acting methylphenidate it's not going to be a problem. If you start on the long acting then it is going to be a problem.

Jeff Thompson: So again I'm hearing you say that generics first in the stimulant class is a best practice in new starts.

Vyn Reese: We don't say best practice.

Jeff Thompson: Okay. Is an acceptable policy for the agency.

Chuck Agte: Jeff, I'd like to ask for clarification there because are we talking...excuse me. This is Chuck Agte and I have a cold. Are we talking specifically about the stimulants within the ADHD class or are we talking about the entire ADHD class?

Patti Varley: I had a reaction. Sorry. This is Patti and I broke the microphone. No, you cannot include atomoxetine in this discussion about stimulants in my opinion.

Jeff Thompson: So you believe for a new naïve start atomoxetine is an appropriate new start in a naïve client?

Patti Varley: If you were a clinician choosing a non-stimulant there should be a rational as to why the non stimulant is being chosen and I would assume that that would be why since all the evidence points to the stimulants again as has been repeated by several clinicians and practitioners. That if it is ADHD and there are no other variables, so there's no a substance abuse issue, there's not, you know, I could argue a kid with comorbid anxiety. You might be able to argue you wanted atomoxetine. I might be able to argue a kid with ticks. You might want to start with atomoxetine. But if that was true I should be able to say why I'm choosing that.

Jeff Thompson: Okay. Could I...could I...what I'm hearing then is the generics first in the ADHD treatment class is an acceptable policy for new starts for the agency or recommended.

Vyn Reese: That's what I said a long ago.

Carol Cordy: So you're not distinguishing...Carol Cordy. You're not distinguishing short-acting versus long-acting?

Vyn Reese: Just the generics.

Jeff Thompson: The generics...

Barak Gaster: This is Barak Gaster. Could I read a proposed sort of motion?

Vyn Reese: Sure.

Barak Gaster: The DUR Committee has reviewed the procedures for the generics first program and we agree that this is a...that these procedures are appropriate for the class of all ADHD drugs.

Woman: Not enough?

Barak Gaster: Isn't it like a five-slide procedure?

Vyn Reese: Read the one you just read, Jeff. It says the same thing.

Jeff Thompson: The generics first in the ADHD treatment class is an acceptable policy in new starts...a recommended policy in new starts. There's another one. So that takes care of all the subclasses and it also takes care of all the short, intermediate and long.

Man: Yes, it does.

Jeff Thompson: Then the next one is if a long-acting stimulant is the drug of choice...or a long-acting stimulant is ordered the drug of choice is Adderall XL...

Vyn Reese: XR.

Jeff Thompson: XR in the policy.

Patti Varley: In treatment naïve patients.

Vyn Reese: Treatment naïve patients.

Jeff Thompson: Let's do one. So if a long-acting stimulant is the...

Patti Varley: Treatment of choice in treatment naïve patients.

Jeff Thompson: So we're going to be affirmative. In long-acting stimulants...I'm not good at this. I do affirmatives better. If a long-acting stimulant is the prescription...

Patti Varley: Is chosen to be used in a treatment naïve patient.

Jeff Thompson: In a treatment naïve patient Adderall would be the drug of choice.

Patti Varley: Adderall XR.

Jeff Thompson: Would be the drug of choice.

Patti Varley: Generic Adderall XR...

Vyn Reese: I think to clean that up I would do...

Patti Varley: Yeah because it isn't...it goes by the salt name doesn't it? I think you need to say that. And then maybe parenthesis so people know what it is because I'm not sure everybody knows that that's what it is.

Woman: I will know.

Patti Varley: I know.

Vyn Reese: The verbiage is awkward.

Chuck Agte: Just for the...this is Chuck Agte and just to make sure we don't get ourselves into a corner I'm worried about the language. So when a long acting generic methylphenidate does come out that is also an acceptable choice.

Jeff Thompson: Absolutely

Patti Varley: Good point. This doesn't work for that.

Chuck Agte: I don't want to come back in a year and a half and say, "Now there's a generic..."

Patti Varley: So maybe we just leave it generic.

Carol Cordy: I agree. Just don't put the name of the drug at all.

Patti Varley: Just don't put anything because change generics all the time. You know?

Vyn Reese: One thing I want to do is change the verbiage. It's very cumbersome. I'd just say if a long-acting stimulant is selected in the treatment of a naïve patient...just chop all that out.

Patti Varley: You know what though? But as we discuss this...the reality is it's generic in the stimulant class regardless. It's regardless if you use a short-acting, an intermediate or a long-acting. The fact of the matter is it is generic that we're after. So that leaves it open to whatever generic because I'm going to confess to the group now, bless me Father for I have sinned, because I have to continually stop myself from writing Ritalin LA because it's a drug I use a lot and that's not going to be on here. And so, you know, even though I cognitively know things we clinically have our things that we do. There are rationales for it but right now that's not a cost-effective medicine to use first. I just think if you leave it more open as these things become available it allows us to have a larger variety of options without having to change this every time.

Vyn Reese: Okay.

Carol Cordy: Why not leave...why not just say in the generics first program generic stimulants are the drugs of choice in the treatment of stimulant naïve patients and leave the whole long-acting thing out of there?

Vyn Reese: Yeah, that's what we're doing right now.

Carol Cordy: I mean leave the second sentence out.

Barak Gaster: Which is what I said 15 minutes ago.

Carol Cordy: Right.

Vyn Reese: Well, I said it an hour ago. I don't know.

Carol Cordy: Read yours again, Barak and we'll see...

Woman: That's it right there.

Jeff Thompson: Well, actually can I just say that not stimulants and just put ADHD drug class?

Carol Cordy: No.

Jeff Thompson: Because that means that what you said is atomoxetine is an appropriate first start in a naïve client.

Carol Cordy: Is it?

Duane Thurman: No.

Vyn Reese: No, it's not.

Patti Varley: Only under certain circumstances.

Jeff Thompson: Right. But that's what you said there.

Vyn Reese: It's not a stimulant anyway.

Patti Varley: It's not a stimulant.

Carol Cordy: No, but we're saying stimulants, not just ADHD.

Jeff Thompson: See, that's where we're getting wrapped up. For some people this is the stimulant class.

Patti Varley: No, it's ADHD.

Jeff Thompson: I'm just...I'm just...for some people when they talk about this class it's the stimulus class. Alan, correct me if I'm wrong, of which they will include Strattera.

Patti Varley: No, no, no.

Jeff Thompson: Even though it's a non stimulant.

Chuck Agte: This is Chuck Agte and for the purpose of implementing these rules what we're trying to get to is the fact that if you say stimulants here it means that we don't have the ability to stop Strattera for that same conversation.

Man: But it's not generic.

Chuck Agte: Right. But it's not a stimulant either. So if we say stimulants we don't get to stop Strattera. If you say within the ADHD class...

Jeff Thompson: So if you change that to stimulants to the ADHD drug class it allows that to happen.

Barak Gaster: This is Barak Gaster. I mean the clinical scenario that this is most...that is frequently going to apply to for adult primary care doctors and maybe sort of people who see kids as well, but people who are sort of just scared to prescribe a stimulant and they have had a detailer come to them and say, "Hey, I've got a non-addictive, non-stimulant treatment for ADHD. You can use it with impunity." And so a lot of those people are going to be

starting Strattera when they see their 25-year-old patient who says, “I’ve had these symptoms of ADHD my whole life and nobody has ever done anything about it.” And so in that case if a provider really is just too afraid to prescribe a stimulant then perhaps the option should be provided to them in that sort of follow up discussion phone call is bupropion. As a...probably not as effective...

Woman: No.

Barak Gaster: Wait. Probably not as effective as a stimulant but safer than a stimulant because non addictive.

Patti Varley: This is Patti Varley. That’s way beyond our scope on this thing and you’re really getting into discussions of lack of evidence and lots of clinical nuances and case studies. But I will say to support you I have parents who come in with their kids who will not let me give them stimulants because they have an Aunt Susie who was a stimulant abuser and they will say, “I only...” Now again I can have a talk with them that, you know, that’s not the appropriate thing to do blah, blah, blah, but if push comes to shove and that’s the only thing they’ll let me use to treat their child I’ll probably have to do that pre-authorization thing. But again I don’t have an issue with that because...but here’s a question. If I don’t have a medical reason, but I say to you, “This family is saying to me they will not give their kid a stimulant, but they will be willing to try atomoxetine. Would you approve it?”

Woman: Yes.

Patti Varley: Okay.

Vyn Reese: So let’s go back to this. I think it’s almost right now. ADHD generics first program...ADHD generics first program generics stimulants are the drugs of choice for the treatment of...

Man: Just remove the word stimulants.

Jeff Thompson: Can I just...so in the ADHD drug first program, generic ADHD drugs are the choice in a naïve client.

Carol Cordy: No. It would have to be naïve to something.

Jeff Thompson: When you specify stimulants then atomoxetine is not in the game.

Vyn Reese: It should be treatment naïve patients. Not treatment of naïve patients. It’s treatment naïve patients.

Man: We're all naïve. Everybody is naïve when it comes to health care.

Carol Cordy: This is Carol Cordy. What would happen if we don't put stimulants like we're doing now? What will happen when atomoxetine becomes generic? That's the worry.

Siri Childs: Actually, that's a good point.

Carol Cordy: So...

Vyn Reese: I think this is fine.

Siri Childs: This is fine just like this.

Carol Cordy: Well...but, like this though when Strattera becomes generic it will be preferred. Is that right?

Vyn Reese: This is generic ADHD. Yeah.

Patti Varley: Can I edit that? The choice for treatment...oh, I guess. Never mind.

Nate Miles: Mr. Chairman?

Vyn Reese: Yes.

Nate Miles: My name is Nate Miles with Eli Lilly and Company and one of the things that I wanted to do during this part of the testimony, if you don't mind, is make a statement to the board. This subject...we've been working at the Mental Health Taskforce with, as you know, the clients that we have...I'm going to take my hat off as a Lilly person and you can say fine or...but I really am speaking as also a member...I'm on the National Association of Colored People (NAACP) Executive Committee on the board of the African American Agenda. We have been here talking about issues that are very particular to our community. When we talk about ADHD it is a problem in the criminal justice system where African Americans in this state, though they only make up 3% of the population, are about 35% of the criminal justice population. We understand now, after looking at this, that there is a high percent of ADHD in the criminal justice system. One of the things that our community has been trying to get to the bottom of and we asked the department to look at is to find out what the impact drug restrictions are having on particular communities including the African American community. We were told four years ago that we were going to pull and do outcomes research and see if it was having any adverse effect because as Patti Varley just said a minute ago you have some of these drugs that are being used to self-medicate. You have them being used illegally on the street and it's turning around and our children are winding

up in the criminal justice system. And I stand here as a parent of those kids and as a relative of people that have seen their lives destroyed. This department was supposed to bring back and say, "Is there any evidence that shows that there has been a negative impact?" We found out about three weeks ago, four weeks ago now that none of that research has been done that was promised to the legislature and to our community. As you all remember that last time that we went through with 6088. None of that research was shown and yet we're getting ready to build another jail in King County and fill it with a lot of my young kids that live in my community. I just think that when you have alternatives like non-stimulant medications that this board before has said, and just two weeks ago at our Mental Health Taskforce, Jeff you'll tell them this was not even brought up that this would be a consideration that the non-stimulants it would be too much to cross those over and it became an interchange that they weren't going to do. The community was promised two weeks ago that that was not going to happen. And I just think that to change it today...that to change it today really...the legislature and our community...I won't speak for the legislature, but I'll speak for our community. I'd like our community to know because this community has been too drastically impacted by these...by these illnesses...by this illness and we've got too many of our young kids whose lives have been destroyed and two weeks ago when the church council asked me...when the Ministerial Alliance asked me, "How are we looking on those drugs?" We told them based on what came out of our Mental Health Taskforce that there would be an option for parents if they wanted stimulants or non-stimulants because the non-stimulants were taken off the table. I'll take any questions you might have.

Vyn Reese:

This is Dr. Reese and I think Patti Varley just asked that question. She said, "If a parent wanted Strattera for their kid," because they were worried about this, that they could ask for it and that would be passed. That's just what Siri Childs said. That that would be okay. The thing is that there's not...I don't think it's going to be that difficult to get the medication.

Nate Miles:

But the thing of it is...what I'm understanding this to say is, "If a parent doesn't know the difference between a stimulant and a non-stimulant and you don't have doctors who have some of the cultural competency that we've been asking about working with the department to make sure that these doctors are culturally competent in dealing with some of the kids of color in their deal then...and they give them the stimulant. A lot of times their parents don't know. A lot of times it's grandparents that take them with them and just think, "This is what the doctor gave them." And if it's changed they don't know that."

Vyn Reese: Let me answer one question of the two. We know just from listening to the testimony so far the stimulants are the best drugs for ADHD and they are better than Strattera. Strattera does not have as good a response rate so for most people, unless there's a problem with addiction in the family or something like that, Strattera is not the first choice.

Patti Varley: And this is Patti Varley. This has been a very confusing conversation but I want to assure you that what this is saying is that no matter what that the best treatment is stimulants and that there is no evidence right now that generic stimulants are any worse than regular stimulants. And that we would...so we could serve more kids to keep them out of prison. We would keep the cost to the most effective and the most cost-effective and the safest first. That this doesn't restrict our choosing within those classes other than if someone hasn't ever had a stimulant we're going to start with one we know works and with one that is the most cost-effective. This does not say that if I had a...

Man: [inaudible]

Patti Varley: Well, in any class. So in short, medium or long and that if a family, for whatever reason, needs the atomoxetine, the Strattera instead that we can still choose that at this point and that the way we've now made the language is that if that is...becomes generic we don't even have to say why. Right now if your son needed Strattera instead of a stimulant and had never been on meds I would just have to say, as the clinician, why that was. I got assurance that if I said, "The family really is anti-stimulant. The child really has ADHD. I really want to treat this kid. They don't want to do stimulants and I'd rather treat them than not treat them. Can I use Strattera first?" I've just gotten assurance that I can. So I think it's accomplishing what you're wanting.

Nate Miles: I think you raised a couple of good issues that there are two very key things. Number one, when you say that there...see, I don't want my hat on as a Lilly person right now because I'm not going to argue whether Strattera is as good as a...that's not for me. I'm not a clinician, I'm not a doctor. I'm just standing here as a life member of the NAACP. That's just all. I'm just saying that when one makes a statement that they work better...I want to know do they work better in African American children than stimulants?

Patti Varley: Yes.

Nate Miles: And the research that we have seen and what we were promised that we were going to get from the department was not done. It's not that it's not complete. It was never done.

Patti Varley: Well, I will tell you that, again, not within this state but within the evidence-based peer review there is no evidence that stimulants work less well for core symptoms of ADHD in any specific population.

Nate Miles: Because none have been—no studies have been done.

Patti Varley: That's what I'm saying. Within the studies that have been done that have included cross cultural, and there have been, in special populations that has not been evidenced yet as being an issue. I think that, if I can take a moment to say, that I think outside of ethnic differences there are individual differences of metabolism. That goes across ethnic and cultural differences, which is why I've been fighting so much for always having the short-acting, the intermediate and the long-acting. I have not seen that difference necessarily by race or culture. I've seen it by individuals and that is where I have been very specific about keeping those individual abilities.

Nate Miles: When this issue came up before, as you will recall, the issue here, Jeff and Dr. Graham and Dr. Thompson both know the issue was we, as African Americans and people of color, were never included in the stimulant...the generic studies and we wanted to know based on that...look at the old ones, look at the new ones, I don't care what they use. Dr. Varley, I just want our kids to stop going in with issues. We don't talk about mental health and that's our problem in the black community. We're working right now to try to get ministers and everything to talk about mental health, to be able to get parents and grandparents to understand mental health and be able to decide whether their kid...and to get them help. But right now because that hasn't happened like it should we need every safeguard that we can. And when we asked the department and the department, Jeff, you guys know you told us you would pull that research out and we found out three weeks ago that it was never pulled out because it was too hard. We were told after four years of thinking we had four years of research because to tell you the truth no pharmaceutical company, no one has done a study on the cultural differences in these medications and they know there's a cultural difference. That argument has been made and we asked to do that here in Washington State and it was not done.

Jeff Thompson: So Nate, this is Jeff Thompson. My promise to you is that as we pull the data, and as I look to the data in the addendum we started to pole different races. So I just want to distinguish this. We will use our claims data, not research, our claims data to help inform the clinical community if there are any issues that need to be taken into consideration on age, race or gender and I'm hopeful that the drug companies in their wisdom can do the studies that you're talking about in the future to inform the agency, the research, the actual randomized trials or research, but I will make a commitment to you as I did two weeks ago that we will use our claims

data to inform the clinical community around any issues around gender, ethnicity or age that the clinical community need to be advised within what we have.

Nate Miles: With all due respect I talked to the doctor you said. There is no money to do that first of all. Secondly, the pharmaceutical companies, Jeff, are doing studies like that but then the studies get thrown out because they say, "Well, the pharmaceutical industry paid for them." Of course they say that. So it's a catch 22 of just trying to get them to do this. But what I would say is, "Until that data gets ready what's the rush to move from where this committee has been, which is leaving the doctor...giving the doctor the opportunity to have an open access to the non stimulant versus where they're going with the stimulant until you have the data in your hand to say," if what Patti Varley said is right there is no difference. I don't have a problem with that. If there is no difference and you pull the data and you said, "Nate, none of these people that are going into...these kids didn't have any difference then that shouldn't be...it shouldn't take long."

Patti Varley: So for clarification this is Patti Varley again. I'm nurse practitioner, not Dr. Varley. He was that one over there. Because I'll lose my license if I let you call me doctor illegally.

Nate Miles: Oh, sorry.

Patti Varley: Is that what I did say and what actually Dr. Varley stated is that the research to date does show that for core ADHD symptoms stimulants are the best in the studies we have with all the specific population considerations. That atomoxetine or Strattera is a choice but the efficacy was less, but there are reasons why and this leaves that option open to those of us who prescribe. I think it's what you want it's just...it did get confusing.

Nate Miles: Well, if it was that the...in a different category in the non-stimulant category that there was not open access in non-stimulant that's not where I got to. Where I was trying to get to, and I believe the department will pull this stuff, but I believed four years ago that we would have this information there. So when it comes out...there shouldn't be a problem, at least in my humble opinion, to leave it open in the non-stimulant category until we get the data in.

Duane Thurman: I guess I would take a little bit of exception because we're not sure the data is not in. We've looked at the Oregon Health Sciences review. We've looked at that. There was no evidence in that review that they did not include special populations. They may not have been able to pull the data out of the special population group to tell us what ethnicity was

specific percentages of ethnicity that was included in those special populations, but we know as Patti said that special populations were included in that review. And that review told us what we passed...

Nate Miles:

Do we know how many...do we know what percentage of people were in it? No. I can tell you if it's like most reviews, and I look at them all the time, there's really only been one study that really went in and looked at...that was accepted by them and it was on a drug called BiDil where they went in and found a specific population of people where they said African American's this drug works. But there has been a lot of general studies that say Asian Americans have an incidence of their bones being...and so when it relates to osteoporosis there's a problem. Native American's have very high levels of diabetes. African American's have about one and one-half, almost two times the rate of diabetes. There's those kinds of general studies but there's nothing that has gone into these drugs to look at. And so it's easy to say there's no studies that say that. Well, there's no studies on the other side, but there is one clear piece of evidence—30% of all prisoners in jail in Washington State today are African American. In the juvenile justice system it's closer to 40% and we're only 3% of population.

Patti Varley:

I would agree with you that the data is lacking. I would have to defend the department, the state, our committee that we have mentioned many times over that the data provided to us by the studies that are done, drug sponsored or not, have not always had all the evidence we would like it to have. But I have to say in defense of everybody here it's not something we have control over other than to continue to mention that the data does not have in it what we want, which are head-to-head trials, which are looking at special populations in more detail. But it really is outside of our control to be able to do that.

Nate Miles:

I agree with that. You don't have to defend that. I've heard you say that and you're absolutely right. It's not there. It's our industry needs to put more African American, Asian, Hispanics in clinical trials. But to get people of color, especially African Americans, into clinical trials is much more than a notion. It is deeper than that. It is the Tuskegee experiments. It's the distrust of the system. It's a lot of those things that we're just now starting to get people into them. And to be able to take people who think their kids are being declared ADHD and being over stimulated and put on medications that don't necessarily work for them and their kids are winding up kicked out of school and in the juvenile justice system. That's what you have going on right now. We try to tell them they're not being looked at enough. We're not paying enough attention to their mental health. But in their mind their kids are being labeled, they're being stigmatized and they're being over medicated and by giving them a choice where their kid has a stimulant or non-stimulant this board here, this very

body here, has on three different occasions kept the non-stimulants available without restriction. You've done that three times. And if we got into a case now where it's a matter of...we're trying to raise money or it's an economic situation there's nothing in the medicine, there's nothing in the literature that has changed since the last time you looked at this that has changed because there's not one more study, especially not from the department, that was supposed to look at whether there's an impact on African American kids in the system. There's nothing that has changed. So I'm just trying to figure out why wouldn't we leave it the way it was until at least we got some new information in that said there's a reason to change?

Duane Thurman: This is Duane Thurman. I just want to point out that this is not a debate. This is a public hearing with input and I think that...I need to ask the chair how much more input we'd like in light of other speakers that have been somewhat limited.

Nate Miles: Thank you. I'm sorry.

Vyn Reese: We get your message. You're talking for Eli Lilly, right?

Nate Miles: No. I'm talking for me. This is for me as a life member of the NAACP and a member of the African American community. I'm the chair at African American Agenda. I'm saying that for me and Mr. Chairman I appreciate your indulgence.

Vyn Reese: We'd appreciate the next person to be able to speak.

Helen Nylon: Thank you very much for allowing me to speak. I thought you were having testimony this after...after your testimony from the committee. My name is Helen Nylon and I'm the president of Mental Health Action, which is the largest consumer organization in the state made up of individuals with mental health challenges. So we're particularly interested in this subject both for those of us who are adults and also for children because we were once children. Many of us had these problems before.

I want to clarify that when you talk about a naïve client you're talking about an individual who has never, in private practice or on Medicaid system, used a drug for that purpose. And I'd like that to be very clear because when the generics were allowed under the antipsychotics a few years ago people within the system who had been on those drugs for a long time many, many of them were changed to generics even though they had been successful on the non-generics. And I know people who have symptoms like within 48 hours on some things. I know you're focusing on ADHD kind of indications. Go ahead.

Patti Varley: Yeah. I can make a comment. What I think you're referring to is that when patients have been maintained on a particular medication when that particular medication comes generic then quite often they are switched from the brand name to the generic of the same medication.

Helen Nylon: Actually, I'm not talking about that. I'm talking about something that happened after that occurred.

Patti Varley: Oh. Because I was going to say that I have been able to go back to the state because I will admit occasionally I will have someone who was on the brand name of a drug when the generic came available. There was evidence that their status changed and then I've gone to the state and DAW'ed the brand name. I would say that's the exception to the rule but there are individuals where that is the case.

Helen Nylon: Right. And I'm sure that...

Patti Varley: And they do accept that.

Helen Nylon: I'm sure that most folks can go with the change but a lot of people can't and mental health is often, to me, an area that we shouldn't play with that.

Vyn Reese: Pardon me. To answer your question though, a treatment naïve patient is someone who's not been treated before for the condition.

Helen Nylon: Period.

Vyn Reese: It's somebody who is...according to all our claims data, private and public that's available within the state in the last 180 days, has not received any prescriptions for an antipsychotic or a drug that's...

Helen Nylon: So if you have someone who hasn't been able to be compliant for whatever reason that individual can be restarted on a generic?

Vyn Reese: If there's evidence the patient was on a drug before and was doing well on it that patient would be started on the same drug.

Helen Nylon: Great. Second, I wanted to know if an individual is on the generic and it fails how long do they have before they go onto a different medication before they're tried on a different generic and different generic? Basically I don't want someone ill prolonged.

Patti Varley: This is Patti Varley again. I would say, and I would like other people to comment, I would not treat that any differently than a brand name drug. I mean many meds within the mental health field I've never had generics. So I've had to try people on SSRIs of different kinds—all brand name. I

would hope people use the evidence base about efficacy time. That it takes a certain amount of time and you need to put them on an adequate dosage in order to judge efficacy. I don't think the rule of that clinically changes whether it's a generic or whether it's a brand name.

Helen Nylon: Okay. Thank you very much.

Vyn Reese: Thank you. Any other questions or people that would like to speak?

Dick Miyoshi: This is Dick Miyoshi.

Vyn Reese: We're recording you. Please come down and talk in the microphone.

Dick Miyoshi: This comes down to not race. It doesn't come down to even sex. It's down to genetics. And, you know, we have not worked out the genetics of the dopamine transporter. We have not worked out the genetics of ADHD. We have not worked out the genetics for, you know, a number of things. We're going in that direction. We probably will not get that data for probably five or 10 years is what we're looking at. And, you know, I applaud you guys for trying to do what you can with what you have. But that testing outside of Many Clinic is not going to be for at least probably five years because it's too expensive and it's not going to pull out the population you want. And so all the minorities probably are some [inaudible] plus psycho social things. And so, you know, you have to do what you can do now with what you have because it ain't coming soon.

Patti Varley: Yep.

Vyn Reese: Thank you. As I understood this is the motion before the committee and you'd like someone to make that motion and to pass it and say that that's what we'd like you to do as a DUR?

Jeff Thompson: Right. And then there would be a second motion as it relates to the antipsychotic class for kids.

Vyn Reese: The whole list on the previous slide?

Jeff Thompson: And then the whole list of drugs that we went...

Patti Varley: This is Patti Ledger...Patti Ledger. That was a brain fart. Oh my God. Thank God my husband's not here. Where did that come from? This is Patti Varley.

Man: It will be in the transcript.

Patti Varley: I need some stimulants. Yeah. In the ADHD generics first program generic ADHD drugs are the drugs of choice for treatment naïve patients.

Vyn Reese: I'd like to take a second.

Duane Thurman: Second.

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

Group: Aye.

Vyn Reese: Opposed, same sign. Okay.

Duane Thurman: And just to be a stickler, this is Duane Thurman, would you make a statement that you believe this is consistent with your P&T motion in the drug class?

Patti Varley: I will make an addendum that this motion is consistent with the motion made by the P&T Committee regarding this class of medications.

Vyn Reese: So we may have to read...since it's been modified we'll have to pass it again. Okay Patti read...so you've made your motion again. Can we have the second again?

Duane Thurman: I'll accept it again.

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

Group: Aye.

Vyn Reese: Opposed, same sign. It's passed.

Patti Varley: So I have a proposed motion for the antipsychotics. In the atypical antipsychotics generics first program, generic atypical antipsychotic drugs are the drugs of choice for treatment naïve children.

Vyn Reese: Just children...

Patti Varley: And adults?

Vyn Reese: It's just children now.

Patti Varley: I thought we were just doing children first?

Vyn Reese: We're going to study adults. Right?

Jeff Thompson: Right. This is Jeff Thompson and I would just like you to sanction that the Mental Health Workgroup can start to work on a program for adults.

Vyn Reese: That's in the preceding slide.

Patti Varley: Right. But I thought we were going to do that with all of those together. No?

Vyn Reese: No.

Duane Thurman: This should address children and then you should approve the whole list, which will include the adults for later consideration.

Vyn Reese: Right. That was the previous slide. So we'll pass this first. Okay. So Patti has made that motion. Do we have a second?

Barak Gaster: I second. Barak Gaster.

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

Group: Aye.

Vyn Reese: Opposed, same sign. Let's go back to the previous slide.

Siri Childs: Please go back to the one, two, three, four, about fifth slide in the deck.

Vyn Reese: Which one are you looking for?

Siri Childs: All the way back to the [inaudible] list.

Vyn Reese: Oh, okay.

Siri Childs: A little bit more. There. That was it.

Duane Thurman: Back one.

Siri Childs: One more.

Man: Forward.

Vyn Reese: Forward one? Two?

Man: The other way.

Vyn Reese: The other way?

Man: There.

Siri Childs: There you go. This takes us through all of the drug classes that have generics in them at this point in time for the whole biennium.

Barak Gaster: This is Barak Gaster. I move that the DUR Committee approves of a review of the generics first new starts initiative for the classes of drugs which include antipsychotics for adults, antiemetics, Alzheimer's drugs, calcium channel blockers, estrogens, oral hypoglycemics, overactive bladder drugs and triptans.

Vyn Reese: Is there a second?

Man: I'll second.

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

Group: Aye.

Vyn Reese: Opposed, same sign. Is there any...

Man: I think we're done.

Vyn Reese: ...to talk about? Okay.

Jeff Thompson: I think we're done on this one.

Vyn Reese: We're adjourned. Thank you.

Jeff Thompson: Thank you.