Department of Defense
Pharmacoeconomic Center

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MCCS-GPE **6 June 2001**

MEMORANDUM FOR: Executive Director, TRICARE Management Activity (TMA)

SUBJECT: Minutes of the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Executive Council Meeting

1. The DoD P&T Executive Council met from 0800 to 1215 hours on 6 June 2001 and from 0800 to 0900 hours on 7 Jun 2001, at the Uniformed Services University of the Health Sciences, Bethesda, MD. The DoD P&T Executive Council is responsible for performing certain inherently governmental functions relevant to the DoD pharmacy benefits program. The Council focuses primarily on issues related to the Basic Core Formulary (BCF), national pharmaceutical contracts, and blanket purchase agreements. The DoD P&T Executive Council is comprised of federal employees who are members of the DoD P&T Committee.

2. MEMBERS PRESENT

CDR Terrance Egland, MC	DoD P& T Committee Co-chair
COL Daniel D. Remund, MS	DoD P& T Committee Co-chair
COL John R. Downs, MC	Air Force
LtCol (select) George Jones, BSC	Air Force
CAPT (select) Matt Nutaitis, MC	Navy
CDR Kevin Cook, MSC	Navy
LTC (P) Joel Schmidt, MC	Army
MAJ Brett Kelly, MS	Army
CAPT Chuck Bruner	Coast Guard
Dick Rooney	Department of Veterans Affairs
MAJ Mickey Bellemin, BSC	Defense Supply Center Philadelphia
LtCol Greg Russie, BSC	Joint Readiness Clinical Advisory Board representative

MEMBERS ABSENT

COL Bill Sykora, MC	Air Force
COL Rosa Stith, MC	Army

OTHERS PRESENT

COL William Davies, MS	DoD Pharmacy Program Director, TRICARE Management Activity
COL Mike Heath, MS	Army Pharmacy Consultant; Chair, DoD Pharmacy Board of Directors
COL Ardis Meier, BSC	Air Force Pharmacy Consultant
CAPT Joe Torkildson, MC	DoD Pharmacoeconomic Center
CAPT Pat Welter, MSC	Navy Bureau of Medicine & Surgery
LTC Don De Groff, MS	DoD Pharmacoeconomic Center
MAJ Cheryl Filby, MS	Defense Supply Center Philadelphia
MAJ Barbara Roach, MC (by teleconference)	DoD Pharmacoeconomic Center
LT David Hardy, MSC	TRICARE Management Activity
Angela Allerman (by teleconference)	DoD Pharmacoeconomic Center
Howard Altschwager	Deputy General Counsel, TRICARE Management Activity
Jonathan Blaker	TRICARE Management Activity
Bill Chamberlain	Defense Supply Center Philadelphia
Shana Trice	DoD Pharmacoeconomic Center
Vincent Valinotti	Defense Supply Center Philadelphia
Paul Vasquez	Defense Supply Center Philadelphia

3. REVIEW MINUTES OF LAST MEETING

The minutes were approved as written.

4. ADVANCES IN MEDICAL PRACTICE (AMP) PROGRAM

All AMP funds remain "on hold" at TMA due to funding shortfalls in the Defense Health Program. If AMP funds are released, the PEC is prepared to provide usage and cost data to facilitate reimbursement of MTFs for expenditures on AMP drugs. Based on prime vendor data, MTFs spent $25,831,626 on AMP drugs during the first six months of FY 01 (see Appendix A).

5. REVIEW OF COX-2 INHIBITORS

The committee reviewed usage and cost data for COX-2 selective nonsteroidal anti-inflammatory drugs ("COX-2 inhibitors") and other nonsteroidal anti-inflammatory drugs (NSAIDs):

- Data from the Pharmacy Data Transaction Service from 1 Apr 01 to 25 May 01 indicated that market share for COX-2 inhibitors in MTFs has increased to 14% of all prescriptions for NSAIDs. Market shares for COX-2 inhibitors in the retail networks and the NMOP were 58% and 74% respectively (see table following).

	MTFs	MCSC retail network	NMOP
Number of prescriptions and percent of prescriptions for NSAIDs			
COX-2 inhibitors	56,822 (14%)	72,654 (58%)	25,525 (74%)
Traditional NSAIDs	345,621 (86%)	53,245 (42%)	8,853 (26%)
Total number of prescriptions for NSAIDs	402,443	125,899	34,378
Number of patients and percent of patients using NSAIDs			
COX-2 inhibitors	44,963 (13%)	54,151 (58%)	23,454 (75%)
Traditional NSAIDs	289,313 (87%)	39,946 (42%)	7,907 (25%)
Total number of patients using NSAIDs	334,276	94,097	31,361

Note: time period is 4/1/01 through 5/25/01; data from the Pharmacy Data Transaction Service Customer Service Support Center

- The PDTS data are consistent with data from the Uniformed Services Prescription Database (USPD), which indicated a 14% market share (by prescription volume) for COX-2 inhibitors at MTFs as of March 2001. TRICARE region market shares for COX-2 inhibitors ranged from less than 5% to more than 20%.
- According to prime vendor data, MTFs spent $19.1 million on NSAIDs during the first 6 months of FY 01, which is 84% more than the $10.4 million spent during the first 6 months of FY 00. The average unit cost of NSAIDs purchased by MTFs rose from $0.06 in October 98 to $0.22 in March 01.

The Council agreed that management of the COX-2 inhibitors should ideally focus on two issues:

- COX-2 inhibitor therapy should be targeted accurately and efficiently to those patients at greatest risk for GI adverse events
- DoD should reduce the unit cost of COX-2 inhibitors

DoD faces difficulty in trying to address these two issues simultaneously. A closed class contract that offers BCF status for a COX-2 inhibitor could possibly achieve a significant price reduction, but many MTFs do not want COX-2 inhibitors to be added to the BCF. These MTFs do not have a COX-2 inhibitor on their formularies because they do not have sufficient funding and/or they want to target therapy by using the non-formulary special order process to provide COX-2 inhibitors only to patients who are at greatest risk for GI adverse events. The Council agreed that:

- The PEC should continue data analysis and provide feedback to MTFs to assist them in targeting therapy
- MTFs should analyze utilization and cost of COX-2s at the local level
- The PEC should obtain feedback from MTFs concerning methods they use to target COX-2 therapy and the accuracy and efficiency of those methods.
- A contract for COX-2 inhibitors should be pursued only if there is a mechanism to target therapy to patients who are at greatest risk for GI adverse events.

6. **NATIONAL PHARMACEUTICAL CONTRACTS AND BLANKET PURCHASE AGREEMENTS (BPAs)**

A. *Contract awards and renewals*

- The first joint DoD/VA closed class contract was awarded to Aventis Pharmaceuticals for the non-sedating antihistamine fexofenadine (Allegra) 60- and 180-mg tablets. The PEC previously issued implementation guidance for the non-sedating antihistamine contract (see Appendix B).
- DoD/VA single source contracts were awarded for the following drugs.
  - Ethinyl estradiol 35-mcg/norethindrone 1-mg tablets (Norinyl 1/35), 21s and 28s, to Watson Pharma
  - Norethindrone 35-mcg tablets (Nor-Q-D), 28s, to Watson Pharma
  - Ethinyl estradiol 35-mcg/1-mg ethynodiol diacetate (Demulen 1/35), 28s, to Pharmacia Corp.
  - Etodolac 200-, 300-mg capsules and 400-mg tablets, to Taro Pharmaceuticals
  - Hydrochlorothiazide 25-mg/50-mg tablets, to IVAX Pharmaceuticals (formerly Zenith-Goldline)
  - Prednisone 2.5-, 5-, 10-, 20-, and 50-mg tablets, to Pharmacia Corp.
  - Isosorbide mononitrate SA 30-, 60-, and 120-mg tablets, to Schwarz Pharma
  - Valproic Acid 250-mg capsules, to Sidmak Labs
  - Capsaicin 0.025% and 0.075% cream, to Qualitest Pharmaceuticals
  - Ticlopidine 250-mg tablets, to Par Pharmaceuticals
- As of 1 Jun 01, 44 joint VA/DoD national contracts have been awarded. Information on national pharmaceutical contracts, including NDC numbers and prices, is available on the DSCP website (www.dmmonline.com).

B. *Financial impact of contracts* – The estimated MTF cost avoidance due to national pharmaceutical contracts was $43.3 million for the first six months of FY 01. The $43.3 million in cost avoidance equals 7.9% of the $547.2 million that MTFs spent on pharmaceuticals through prime vendors during the first six months of FY 01. A summary of cost avoidance from national pharmaceutical contracts for FY 01 is provided in Appendix C.

C. *Report on Returned Goods Contract* – MAJ Cheryl Filby (DSCP) reported that, as of 5 June 01, 89 DoD facilities have signed up for the joint VA/DoD returned goods contract, which was awarded to Guaranteed Returns in Jan 01. More information on the Pharmaceutical Returns Management Program is available on the DSCP website at: http://dscp305.dscp.dla.mil/ dmmonline/pharm/return_program.asp

D. *Proton pump inhibitor contract* – Significant price reductions recently occurred in the proton pump inhibitor (PPI) market. Janssen lowered the FSS price of rabeprazole (Aciphex) to $0.22 per dose. In response to the market changes, the VA and TAP Pharmaceuticals have mutually agreed to cancel the VA's national contract for

lansoprazole (Prevacid) in favor of a BPA that sets the price for both strengths of lansoprazole at $0.55. Lansoprazole will remain on the VA National formulary, but the PPI class is now "open," so VA facilities may use other PPIs.

The DoD national contract price for omeprazole (Prilosec) is $1.09 per dose. The current option year expires on 30 Sep 01. The DoD P&T Executive Council strongly urges DSCP to negotiate a termination of the DoD national contract for omeprazole in a manner similar to what the VA negotiated.

E. *Potential contract for nasal corticosteroid inhalers* – The Council reiterated its support for establishing a joint VA/DoD closed class contract for a high potency aqueous nasal corticosteroid inhaler. Usage of nasal corticosteroid inhalers by pediatric patients should be taken into account in the contracting initiative.

F. *Potential contract for low molecular weight heparins/heparinoids (LMWHs)* — A closed class contract for a single LMWH for the outpatient treatment and prophylaxis of deep venous thrombosis (DVT) has been proposed. The Council assessed the therapeutic interchangeability of enoxaparin (Lovenox) and dalteparin (Fragmin) for outpatient treatment of DVT and prophylaxis of DVT and/or pulmonary embolism (PE) following hip or knee replacement surgery.

1) *Safety/Tolerability*

- Potential tolerability differences between the products are typically related to issues of administration (e.g., available syringe sizes) and are expected to be of relatively minor importance.
- The most important complication of anticoagulant therapy is bleeding. In a single head-to-head trial for prophylaxis of DVT following surgical repair of hip fracture, the incidence of major bleeding was 1/66 (1.5%) for dalteparin and 2/66 (3.0%) for enoxaparin. This was a small pilot study and may not represent the true incidence of major bleeding with either drug.
- Meta-analyses have found no significant difference between major bleeding rates with LMWHs and UFH, although differences have been reported in individual trials. In large clinical trials, major bleeding rates with UFH ranged from 0 to 7%, compared to 0 to 3% for LMWHs. It is difficult to draw any conclusion about the relative propensities of enoxaparin versus dalteparin to cause bleeding because of the lack of head-to-head data, differences in patient populations, dosing and regimen differences, and differences in how bleeding was defined across clinical trials.
- Enoxaparin and dalteparin are Pregnancy Category B and, unlike warfarin, are generally considered to be safe in pregnant patients requiring anticoagulation. According to case reports, patients with contraindications to warfarin have tolerated long-term use of dalteparin (2 months to 10 years) and enoxaparin (3 to 6 months).

2) *Efficacy for Outpatient Treatment of DVT*

- Enoxaparin is approved by the FDA for outpatient and inpatient treatment of DVT. Dalteparin is not approved by the FDA for treatment of either outpatient or inpatient treatment of DVT.
- There are no head-to-head trials comparing enoxaparin with dalteparin for treatment of DVT in either the inpatient or outpatient setting.
- *Enoxaparin vs. UFH* – Three large, well-conducted trials (two in the inpatient and one in the outpatient setting) compared enoxaparin with UFH for the treatment of DVT in a total of 917 patients. One trial also included patients with PE. No significant difference was noted in recurrent DVT/PE in the outpatient trial: enoxaparin 13/247 (5.3%); UFH, 17/254 (6.7%). However, only 33% of screened patients were considered eligible for study enrollment, and the studied population was generally at low risk for bleeding and did not have co-morbidities.
- *Dalteparin vs. UFH* – There are 11 published trials with dalteparin (seven in the inpatient and four in the outpatient setting) in a total of 1538 patients. However, while inpatient trials compared dalteparin with UFH, outpatient trials with dalteparin have not included an UFH comparison group. In a large (n=434), nonrandomized trial of dalteparin for the outpatient treatment of DVT, there were 7 cases of recurrent DVT (1.6%). These patients were considered to be at relatively low risk for bleeding and recurrent DVT/PE.
- Although most trials compared either dalteparin or enoxaparin to UFH, dalteparin trials were generally smaller and sometimes included patients with distal (calf vein) as well as proximal DVT (proximal DVT has a higher complication rate). Trials with enoxaparin primarily enrolled patients with proximal DVT. In addition, some of the dalteparin trials used surrogate efficacy measures (such as changes in thrombus size pre- and post-treatment) instead of clinical endpoints (such as incidence of recurrent DVT/PE). Comparison of the efficacy of the two drugs for outpatient treatment is further complicated by differences in patient populations (e.g., inclusion of patients with co-morbidities such as cancer, who are at increased risk for DVT/PE) resulting from differences in how patients were considered eligible for outpatient treatment.

3) *Efficacy for Prophylaxis of DVT Following Hip Replacement Surgery*

- Both enoxaparin and dalteparin are FDA-approved for DVT prophylaxis following hip replacement surgery.
- There are no head-to-head trials comparing enoxaparin with dalteparin in hip replacement surgery. Two trials compared dalteparin with warfarin and one trial compared enoxaparin with warfarin following hip replacement surgery. The incidence of symptomatic DVT/PE was lower with the LMWH than with warfarin in all three trials. There is insufficient evidence to conclude that enoxaparin and dalteparin differ significantly in efficacy for DVT prophylaxis following hip replacement surgery.

4) *Efficacy for Prophylaxis of DVT Following Knee Replacement Surgery*

- Of the two drugs, only enoxaparin is FDA-approved for DVT prophylaxis following knee replacement surgery.
- There are no head-to-head trials of enoxaparin and dalteparin for DVT prophylaxis. One double-blinded trial comparing enoxaparin and warfarin for DVT/PE prophylaxis following total knee replacement showed significantly fewer recurrent DVTs with enoxaparin compared to warfarin. There are no published trials that assess the efficacy of dalteparin for this indication.

5) *Other Factors*

- Enoxaparin is available as prefilled syringes in a wide range of dosages, which is an advantage for outpatient use. Dalteparin has only been available in pre-filled syringes in two dosages (2500- and 5000-U per 0.2 mL) and in a 10,000 U/mL multidose vial. Neither the prefilled syringes nor the multidose vial are optimal for the higher doses used for DVT treatment, which may require multiple injections. The manufacturer of dalteparin anticipates introduction of a higher concentration multidose vial and 7500- and 10,000-U prefilled syringes.
- Articles in the pharmacy literature report on at least two health systems that have changed from enoxaparin to dalteparin using a therapeutic interchange program. The program at one institution includes only DVT treatment and prophylaxis. Patients receiving enoxaparin for knee replacement surgery and cardiology indications are excluded. A preliminary drug usage evaluation comparing rates of recurrent DVT/PE and major bleeding between dalteparin and enoxaparin supported the feasibility of the therapeutic interchange program, but no outcome data are available. Another institution replaced enoxaparin with dalteparin in 1996 as the sole LMWH on the formulary for prophylaxis of DVT/PE following orthopedic and abdominal surgery. Rates of recurrent DVT/PE and major bleeding seen with dalteparin were comparable to those that would have been expected with enoxaparin.
- A total of 8298 LMWH prescriptions were filled at MTFs in FY 2000. Approximately 96% of these were for enoxaparin.
- *Input from MTF providers* – Because of the morbidity and mortality associated with DVT and PE, the PEC sent its clinical review of LMWHs and a survey requesting input regarding the therapeutic interchangeability of the LMWHs to 30 providers in Internal Medicine, Cardiology, Hematology/Oncology, Ob/Gyn, Emergency Medicine, Orthopedics, and Family Practice. A total of 12 surveys (40%) were returned. Three other physicians also provided comments. Survey results are summarized in the following table:

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
There are at least 2 LMWH products they would feel comfortable prescribing for DVT prevention/ treatment.	0	8	0	3	1
Providers would accept a contract for dalteparin for DVT prevention/treatment.	1	4	2	3	2
Providers would accept a contract for tinzaparin for DVT prevention/treatment.	0	4	1	5	2
Enoxaparin is used more because of familiarity than superiority.	1	4	0	5	0
Dalteparin is equal to enoxaparin for VTE treatment despite the lack of FDA approval.	0	6	0	3	2
Respondents would be more likely to be sued if a bad outcome occurred after prescribing dalteparin.	3	4	2	2	0

Given the morbidity and mortality associated with DVT/PE, the Council requires a high degree of certainty about the interchangeability of the drugs for these indications. The Council found insufficient data to confidently conclude that enoxaparin and dalteparin are equally efficacious for the outpatient treatment and prophylaxis of DVT. Although the survey of MTF providers revealed some support for a closed class contract, the responses showed insufficient support to pursue such a contract. The Council concluded that enoxaparin and dalteparin are not sufficiently interchangeable for a closed class contract for the outpatient treatment and prophylaxis of DVT.

G. *Role of the DoD P&T Executive Council in BPA development* –MAJ Cheryl Filby reported the recommendations of the subcommittee regarding the role of the DoD P&T Executive Council in the BPA development process. The Council voted to accept the subcommittee's recommendations:

- DSCP will coordinate all proposed DoD and DoD/VA blanket purchase agreements with the DoD P&T Executive Council (or the PEC acting on behalf of the Council) to ascertain whether the terms and conditions are in accord with the Council's strategy for managing the pertinent drug class. The DoD P&T Executive Council will accept or reject the terms of the agreement.
- If the P&T Executive Council accepts the agreement, DSCP will then be responsible for the content of the agreement in regard to legal and contractual sufficiency.
- Individual MTFs and TRICARE regions may continue to negotiate facility-specific incentive agreements. However, MTFs and TRICARE regions are encouraged to forward any agreements to DSCP for a review of legal sufficiency.

H. *Levofloxacin BPA* – At the Feb 01 meeting the Council asked DSCP to eliminate unacceptable provisions from the levofloxacin (Levaquin) BPA. The Council reviewed a revised BPA for levofloxacin and found that the unacceptable provisions had been eliminated. The BPA offers levofloxacin 250 mg and 500 mg to all MTFs for $2.00 per tablet. Continuation of the $2.00 price is contingent upon levofloxacin achieving either (1) an 80% aggregate DoD market share by 1 Aug 01, or (2) a 50% market share at individual MTFs. Market share will be based on patient days of therapy calculated from

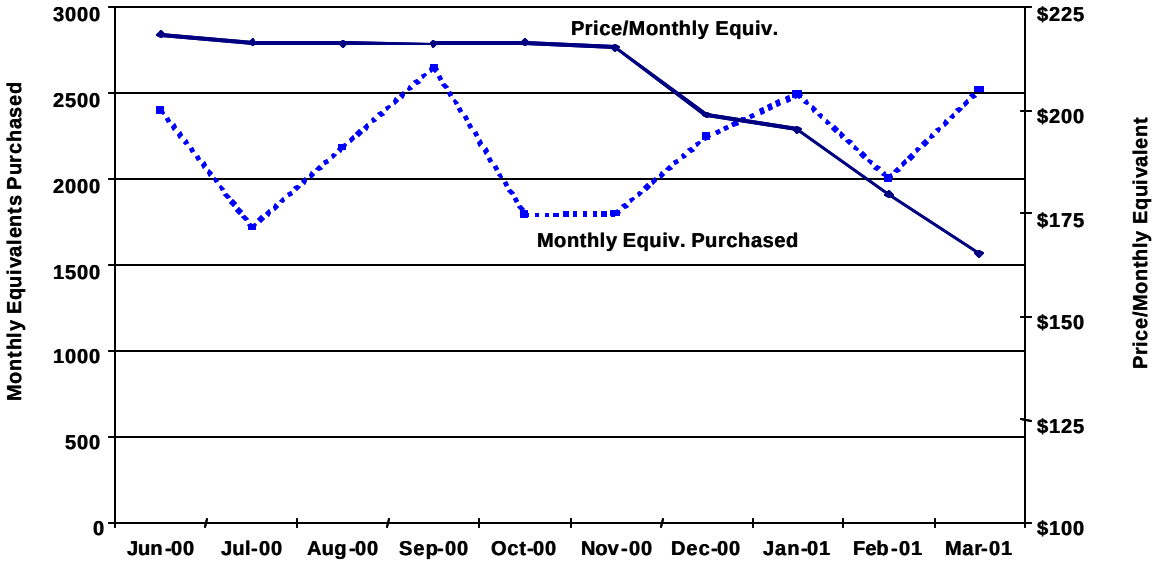
Uniformed Services Prescription Database (USPD) data. Levofloxacin is the only fluoroquinolone on the BCF, but the drug class remains "open," so MTFs may have additional fluoroquinolones on their formularies. As of April 2001, the aggregate market share for levofloxacin was approximately 77%.

I. *Status of BPAs for leutinizing hormone releasing hormone (LHRH) agonists* – A BPA makes goserelin (Zoladex) available to MTFs at the VA national contract price in exchange for attainment of an 80% overall share of the MTF prescriptions for LHRH agonists for prostate cancer by 1 Sep 2001.

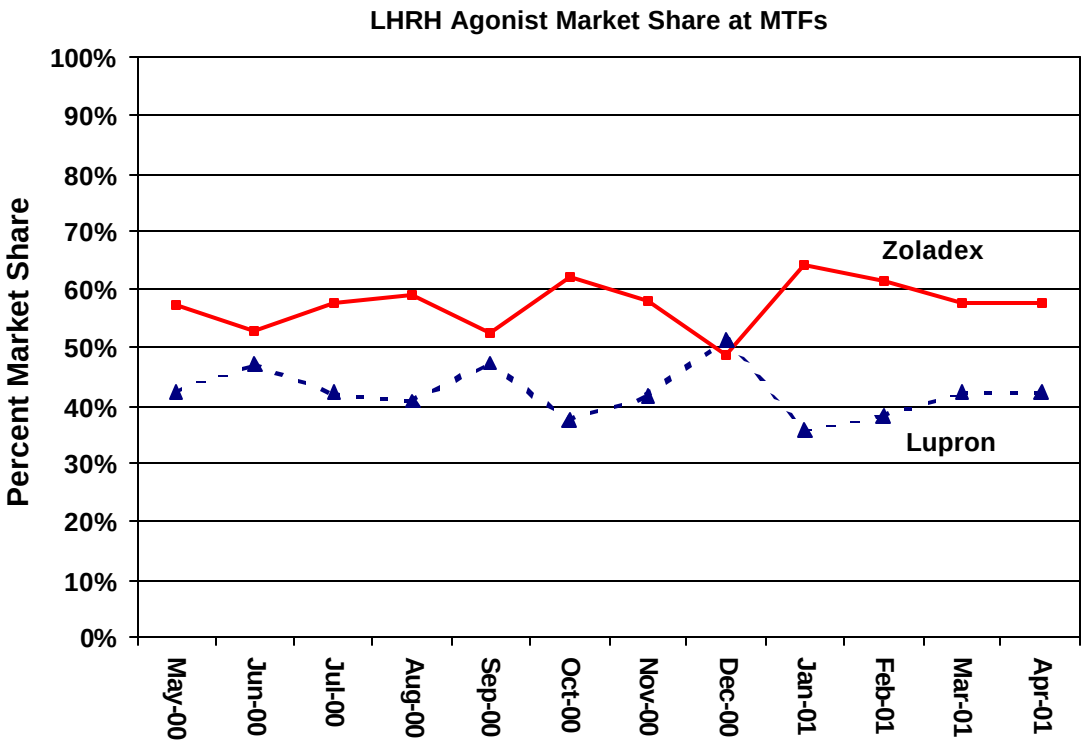
A BPA from TAP Pharmaceuticals makes leuprolide (Lupron) 1, 3, and 4-month depots available at a cost per dose just slightly higher than Zoladex. TAP modified the BPA in May 2001 so that the BPA price is available without any market share requirements (the original BPA required that Lupron attain an 80% market share within 6 months).

The Zoladex and Lupron BPAs have reduced the weighted average cost per monthly equivalent of LHRH agonist therapy for prostate cancer by 23% from $215 in Nov 00 to $165 in Mar 01. The BPAs yielded $294,000 in cost avoidance for MTFs from Nov 00 to Mar 01.

LHRH Agonist Price per Monthly Equivalent and Purchases at MTFs



Market share trends suggest that the 80% market share goal for Zoladex will probably not be achieved (see graph below). The Council asked DSCP and the PEC to talk with Astra Zeneca about the potential extension of the BPA price beyond August 2001 even if the 80% market share goal is not achieved.



The VA contract for Zoladex expires in February 2002. The Council asked the PEC to assess the potential for a contracting action for LHRH agonists for prostate cancer and present a recommendation at the August 2001 P&T Executive Council meeting.

J. *Proposed BPA for metformin/glyburide (Glucovance; BMS) and glyburide extended release (Glucophage XR; BMS)* – Bristol Myers Squibb (BMS) proposed a BPA that would reduce the price of Glucovance and Glucophage XR if they were added to the Basic Core Formulary. BMS also promised to further reduce the price of Glucovance and Glucophage XR to meet or beat any price offered on generic metformin until which point the generic metformin price falls below a price at which BMS can no longer compete. The proposed BPA did not specify the price at which BMS can no longer compete.

The Council concluded that there is insufficient evidence to prove conclusively that the extended release and combination dosage forms offer a clinically significant advantage regarding safety, tolerability, or efficacy over immediate release metformin or immediate release metformin plus generically available glyburide. While the proposed BPA would provide an economic benefit to DoD in the short run, it might be costly in the long run. DoD would benefit economically from the BPA until generic versions of metformin become available at a price below the BMS price protection point. If and when the price of generic metformin falls below the BMS price protection point, DoD would forgo the savings that could have been accrued through the use of the lower priced generic metformin because patients taking Glucovance or Glucophage XR would not likely switch back to generic metformin.

The current market share for various metformin products in MTF pharmacies, retail network pharmacies, and the NMOP are shown in the following table:

Number and percent of patient obtaining Rxs for various metformin products	MTFs	MCSC retail network	NMOP
Metformin (Glucophage)	42,756 (94%)	9,917 (72%)	4,912 (78%)
Extended release metformin (Glucophage XR)	2,401 (5%)	1872 (14%)	673 (11%)
Metformin/glyburide (Glucovance)	389 (1%)	1925 (14%)	722 (11%)
Totals	45,546	13,714	6,307

Note: time period is 4/1/01 through 5/25/01; data from the Pharmacy Data Transaction Service Customer Service Support Center

Since 94% of MTF patients using metformin products are currently using immediate release metformin (Glucophage), DoD has the potential to realize significant cost savings if these patients are treated with inexpensive generic versions of metformin in the future. The Council advised DSCP to reject the proposed BPA. The Council's rejection of the proposed BPA does not preclude an MTF from adding Glucovance or Glucophage XR to its formulary. MTFs should consider the local usage patterns and the degree to which their patients are getting prescriptions for Glucovance or Glucophage XR filled in retail pharmacies where the cost to DoD is much higher.

7. BCF ISSUES

A. *Proposal to add lancets to the BCF* – The Council decided not to add lancets to the BCF.

- Some MTFs provide lancets through central supply or other places in the MTF besides the pharmacy. There is no compelling reason to require all MTFs to provide lancets through the pharmacy.
- Standardization of medical and surgical supplies is being worked on a regional basis. Lancets and other items related to diabetic care might be more appropriately handled on a regional basis.

B. *Status of digoxin on the BCF* – The BCF listing for digoxin oral currently specifies Lanoxin brand (Glaxo Wellcome) only. The Council removed the specific brand designation from the listing because there is now an "A-rated" generic equivalent (Digitek; Bertek).

C. *Clarification of BCF listing for doxycycline oral* – Periostat (CollaGenex Pharmaceuticals) is a 20-mg capsule formulation of doxycycline hyclate with FDA approval as an adjunct to scaling and root planning to promote attachment level gain and pocket depth in patients with adult periodontitis. The mechanism of action is not antimicrobial, but is related to doxycycline's ability to inhibit collagenase.

The Council excluded Periostat from the BCF listing for doxycycline oral due to its low usage across the system (503 bottles of 100 purchased in the last 12 months, 65% of these by two large medical centers), its high cost relative to generic doxycycline, and the absence of a compelling reason to require all MTFs to have it on their formularies.

D. *Clarification of methylphenidate listing on the BCF* – The Council excluded Metadate CD from the BCF listing for methylphenidate oral.

- Metadate CD offers no safety or tolerability advantage compared to other dosage forms of methylphenidate already on the BCF.

- Metadate CD has an 8-hour duration of action. Concerta has a 12-hour duration of action and is on the BCF. With a shorter duration of action, Metadate CD is less likely than Concerta to eliminate the need for repetitive dosing.
- An FSS price is not yet available for Metadate CD and actual dose distributions for Metadate CD and Concerta are unknown, so a precise cost comparison is impossible. Assuming "standard" FSS pricing and a dosage distribution similar to that seen in clinical trials, the estimated weighted average daily cost of Metadate CD is $1.27. Concerta would be only slightly more expensive. The estimated weighted average daily cost for Concerta (based on manufacturer-supplied daily consumption data) is $1.42, $1.52 and $1.70 for the 54 mg, 36 mg and 18 mg strengths respectively.
- Metadate CD is a controlled substance, so all MTFs would experience the administrative burden associated with accounting for an additional controlled drug if Metadate CD were added to the BCF.
- The Council does not want to add another dosage form of methylphenidate to the BCF until it assesses how well Concerta reduces the frequency of midday dosing.

E. *Status of nifedipine extended release on the BCF* – The BCF listing for nifedipine extended release currently specifies Adalat CC as the BCF selection. At the last meeting, the DoD P&T committee requested that the PEC report back on whether the availability and pricing of generic nifedipine extended release products necessitated a change in the BCF listing. After reviewing the current availability and prices for generic versions of both Procardia XL and Adalat CC, the Council concluded that it is not necessary to make changes in the Basic Core Formulary until a generic manufacturer offers prices that are competitive with Adalat CC. The PEC will continue to monitor pricing for nifedipine extended release products.

8. MTF REQUESTS FOR BCF CHANGES

A. *Request to remove micronized glyburide from the BCF* – Glyburide oral and micronized glyburide are both listed on the BCF. An Air Force pharmacist requested that micronized glyburide be removed from the BCF because it is seldom used and more costly than other glyburide formulations. Alternately, he requested that a DoD or VA/DoD contracting initiative be considered to reduce the unit cost of the drug.

The safety, tolerability, and efficacy of glyburide and micronized glyburide appear to be similar. The primary difference between the formulations is improved and more consistent bioavailability with the micronized product, resulting in a less variable half-life and a lower propensity for food to interfere with absorption. The duration of action is similar with both drugs (16-24 hours), due to intracellular accumulation of glyburide. It is unclear whether the pharmacokinetic differences result in any improvement in glycemic control.

Generic micronized glyburide is at least 2 to 3 times more costly than generic glyburide. Of the 15.2 million sulfonylurea tablets or capsules purchased by MTFs through the Prime Vendor program during the first quarter of FY 01, 44% were glyburide; 43% glipizide, 10% micronized glyburide, 2% glimepiride, and essentially 0% tolazamide, tolbutamide, or chlorpropamide. A joint VA/DoD contracting initiative that includes micronized glyburide is already in progress.

The Council did not make any changes to the BCF pending results of the contracting initiative for micronized glyburide.

B. *Request to add gatifloxacin (Tequin) and remove levofloxacin (Levaquin) from the BCF* – A Director of Pharmacy Services at an Air Force MTF cited a price advantage for gatifloxacin in a request to replace levofloxacin with gatifloxacin on the BCF. Gatifloxacin is available to MTFs through an incentive price agreement at a price of $1.90 for the 200 mg and 400 mg tablets. The incentive price is contingent on gatifloxacin having a preferred or co-preferred formulary position at an individual MTF, but there are no market share requirements.

   The Council voted to keep levofloxacin on the BCF. Removal of levofloxacin from the BCF would nullify the BPA that makes levofloxacin available to all MTFs at a price of $2.00 per dose. MTFs are reminded that the fluoroquinolone class is open on the BCF, so MTFs may add gatifloxacin to their formularies if they wish to take advantage of the lower price for gatifloxacin.

C. *Requests to add tolterodine extended release capsules (Detrol LA) to the BCF* – MAJ Roach reported that the PEC received 10 requests for addition of Detrol LA to the BCF in a single week. With the exception of one request from an obstetrician-gynecologist, the requests came from specialty providers (urogynecology or urology). Four requestors noted that tolterodine extended release should be considered a second line agent after the patient has failed oxybutynin; two of the four specifically mentioned tolerability and compliance benefits in elderly patients who could not tolerate oxybutynin. Three requestors cited comparable costs for the tolterodine immediate release and extended release preparations. One requestor felt that tolterodine had become standard of care in community and academic practice for treatment of Overactive Bladder (OAB). The Council considered these requests as part of the overall review of OAB drugs (see Paragraph 9C).

D. *Review of form for requesting BCF changes on PEC website* – MAJ Roach reported that requestors provided little information about how the requested drug compared to other drugs regarding safety, tolerability, efficacy and price. The Council agreed with the PEC recommendation to change the wording on the form to more clearly ask MTF providers to compare the requested agents to other drugs on the BCF or in the same drug class.

9. BASIC CORE FORMULARY REVIEW

A. *Ongoing review* – The PEC is reviewing topical medications for acne and benzodiazepines for anxiety disorders. Information on these drugs will be presented at the next meeting of the P&T Executive Council.

B. *Review of topical corticosteroids for the BCF* – MAJ Barbara Roach reported on the PEC review of topical corticosteroids (see Appendix D for a table of topical corticosteroid agents). Topical corticosteroids were grouped by potency category, ranging from Class I (Very High Potency Agents) to Class IV (Low Potency Agents). According to input from dermatologists, primary care providers, and others, there is little or no difference within potency categories except for the difference between fluorinated and nonfluorinated agents and availability in the desired vehicle (e.g., ointment, cream). The Council considered each potency category for potential changes to the BCF:

Class I Agents (Very High Potency) – There is currently no Class I agent on the BCF. These agents are not generally considered to be primary care drugs. No agent from this class was added to the BCF.

Class II Agents (High Potency) – There are currently no Class II agents on the BCF. After considering the opinions of dermatologists and primary care providers and the relative usage and cost per gram for specific agents within this category, the Council decided to add fluocinonide 0.05% cream to the BCF.

Fluocinonide represents 58% of all MTF purchases of Class II agents (by number of tubes) and is available under a VA/DoD national contract at approximately $0.10 per gram. (Costs per gram in this category range as high as $1.17 per gram). Fluocinonide 0.05% cream represents the great majority of all purchases of fluocinonide products. MTFs may decide whether or not to add fluocinonide 0.05% ointment or solution to their formularies according to local usage patterns.

Class III Agents (Medium Potency) – Triamcinolone 0.1% is currently listed on the BCF as "triamcinolone acetonide 0.1% topical." The Council did not add another Class III agent to the BCF.

The Council agreed that listings for topical agents on the BCF should specify formulation (e.g., cream, ointment) and concentration. After considering the relative usage of the various formulations, the Council clarified the listing to "triamcinolone acetonide 0.1% cream." To avoid confusion, the Council instructed the PEC to clarify the definitions section on the BCF page of the PEC website to note that formulary requirements for topical agents include only the specified formulation(s) and strength(s). The PEC will review the BCF to see if further clarifications are necessary for individual topical agents.

Class IV Agents (Low Potency) – The only low potency topical corticosteroid on the BCF is hydrocortisone 2.5% rectal cream. The Council discussed addition of a Class IV nonfluorinated topical corticosteroid agent for general use. Nonfluorinated agents cause less skin atrophy than fluorinated agents, which is particularly important for pediatric patients and for administration to the face.

The majority of MTFs already have hydrocortisone cream on their individual formularies and many also have desonide (both are nonfluorinated). Hydrocortisone cream and ointment are available in both OTC and prescription formulations. The BCF generally does not include OTC medications, so the Council did not add hydrocortisone cream or ointment to the BCF. The Council also did not add desonide to the BCF because it costs approximately eight times more per gram than hydrocortisone, and the Council did not wish to mandate that facilities using hydrocortisone cream must also add desonide to their formularies.

C. *Review of medications for overactive bladder (OAB) for the BCF* – Oxybutynin immediate release is the only medication for overactive bladder currently on the BCF. Tolterodine (Detrol, Detrol LA) and oxybutynin extended release (Ditropan XL) have a lower incidence of anticholinergic side effects (e.g. dry mouth) than oxybutynin immediate release. The clinical significance of the lower incidence of side effects is uncertain because the percentage of patients who discontinued these drugs due to side effects in clinical trials is small and not clinically or statistically different between the

drugs. Ditropan XL, Detrol, and Detrol LA all cost more than 10 times as much as oxybutynin immediate release. The Council concluded that Ditropan XL, Detrol, and Detrol LA should not be added to the BCF because they do not offer sufficient clinical benefit to justify their significantly higher cost compared to oxybutynin immediate release.

D. *Review of sedative/hypnotic medications for the BCF* – Temazepam and zolpidem currently account for over 90% of sedative/hypnotic medications dispensed from MTF pharmacies. One or more of these drugs are present on 90% of MTF formularies, and 55% of MTFs have both drugs on formulary. The Council considered only these two sedative/hypnotic medications for addition to the BCF.

   Eighty percent of MTFs have temazepam on formulary, but prime vendor data show that usage is declining. Council members speculated that usage is shifting toward newer agents that might have a lower propensity to cause tolerance and dependence in long term use). The Council concluded that temazepam should not be added to the BCF because there is no clinical reason to require 20% of the MTFs to add it to their formularies.

   Sixty-five percent of MTFs have zolpidem on formulary. Anecdotal reports suggest continued efficacy of zolpidem in long-term use without the development of tolerance or dependence; however, clinical trial evidence is limited to trials of 35 days or less. Zolpidem costs more than 40 times as much as temazepam. The Council concluded that zolpidem should not be added to the BCF because the magnitude of the incremental clinical benefit is uncertain and the incremental cost is too large to require every MTF to have it on their formularies.

   No changes were made to the BCF. The sedative/hypnotic class will not be represented on the BCF at this time.

10. The meeting adjourned at 0900 hours on 7 June 2001. The next meeting will be held at Ft Sam Houston, TX and is scheduled for 15 Aug 01 at 0800. All agenda items should be submitted to the co-chairs no later than 20 Jul 01.

<signed>	<signed>
DANIEL D. REMUND	TERRANCE EGLAND
COL, MS, USA	CDR, MC, USN
Co-chair	Co-chair

LIST OF APPENDICES

Appendix A: MTF Expenditures for Drugs Included in the Advances in Medical Practice (AMP) Program

MTF Expenditures on AMP Drugs, First Six Months of FY 01

Drug Name*	Air Force	Army	Navy	Grand Total
Abciximab	$153,356	$135,960	$61,384	$350,699
Alpha-1-Proteinase Inhibitor			$5,676	$5,676
Becaplermin	$42,589	$55,966	$28,194	$126,749
Cyclosporine	$229,898	$157,445	$119,904	$507,247
Cyclosporine Microemulsion	$465,749	$425,208	$436,010	$1,326,967
Dornase Alfa	$160,855	$92,255	$112,092	$365,203
Epoetin Alfa	$2,083,361	$2,444,833	$1,197,215	$5,725,408
Eptifibatide	$38,665	$198,383	$124,977	$362,025
Etanercept	$804,539	$529,045	$300,484	$1,634,069
Factor VIIa,Recomb				
Filgrastim	$713,677	$880,520	$499,944	$2,094,141
Gemcitabine Hcl	$107,075	$205,731	$123,202	$436,008
Glatiramer Acetate	$258,059	$116,704	$64,836	$439,600
Infliximab	$153,880	$153,784	$187,743	$495,407
Interferon Beta-1a	$851,257	$632,273	$322,213	$1,805,742
Interferon Beta-1b	$280,715	$361,135	$237,275	$879,125
Interferon Gamma-1b,Recomb.	$30,794	$25,793	$20,854	$77,441
Irinotecan Hcl	$114,396	$303,743	$126,862	$545,001
Leflunomide	$105,700	$189,325	$103,047	$398,072
Mycophenolate Mofetil	$282,012	$333,083	$151,995	$767,090
Mycophenolate Mofetil HCl	$460	$1,681		$2,141
Palivizumab	$1,261,189	$1,294,001	$851,639	$3,406,830
Ribavirin/Interferon A-2b	$398,410	$899,484	$297,228	$1,595,122
Rituximab	$143,969	$660,609	$203,242	$1,007,820
Sargramostim	$14,918	$75,739	$7,850	$98,507
Sirolimus	$20,452	$43,216	$22,488	$86,155
Tacrolimus Anhydrous	$293,731	$241,897	$167,910	$703,538
Temozolomide	$83,072	$72,879	$51,571	$207,522
Tirofib Hc M-Hyd/Na Chlor 0.9%	$2,023	$21,087		$23,109
Tirofiban HCl M-Hydrate	$62,628	$47,964	$15,166	$125,759
Trastuzumab	$69,227	$153,578	$10,647	$233,452
Grand Total	**$9,226,657**	**$10,753,321**	**$5,851,648**	**$25,831,626**

* Celecoxib and rofecoxib were removed from the AMP list for FY 01

Appendix B: Implementation Guidance for the Non-Sedating Antihistamine Contract

Note: The following implementation plan was distributed to the field via e-mail the last week of April 2001.

Implementation Plan for the Non-Sedating Antihistamine Contract

Department of Defense Pharmacoeconomic Center

Effective Date: 1 May 2001 (Contract will be in effect for one year with an option to extend the terms of the contract for 4 additional one-year periods).

Selected Product: Fexofenadine (Allegra®) 60 mg tablets and 180 mg tablets; Aventis Pharmaceuticals Inc.

Contract Prices

Table 1

Strength	Dosage Form	NDC	Price per tablet/capsule	QTY per Package
60 mg	Tablet	00088-1107-47	$0.37	100
60 mg	Capsule*	00088-1102-55	$0.37	500
180 mg	Tablet	00088-1109-47	$0.60	100

* Aventis Pharmaceuticals informed the Pharmacoeconomic Center that production of the Allegra® 60mg capsule product will be phased out over the next 12 months. The contract price of $0.37 for the 60mg capsule only applies to the 500-count package size. The contract price for the 60mg capsule will only apply until such time that the 500-count package size of the Allegra 60mg tablet is available. We suggest that MTFs **not** add the 60 mg capsule to their formularies, as it will necessitate switching patients to the tablet formulation in the near future.

Formulary guidance

- This contract closes the non-sedating antihistamine (NSA) class on the Basic Core Formulary (BCF) and therefore:
  1) Allegra® 60 mg tablets and Allegra® 180 mg tablets must be on all Military Treatment Facility (MTF) formularies.
  2) Claritin® 10 mg tablets and Claritin Reditabs® must not be on any MTF formularies.
- Table 2 delineates formulary status requirements for all Allegra® and Claritin® products. While MTFs are not precluded from having the products in column 3 on formulary, MTFs should only include these products on formulary if the needs of their specific patient population require their availability. This decision requires critical evaluation of the relative costs of all products that can meet the clinical needs of patients.

Table 2

MTFs must have on formulary:	MTFs cannot have on formulary:	MTFs may have on formulary:
Allegra 180 mg tablets	Claritin Reditabs	Allegra 60 mg capsules
Allegra 60 mg tablets	Claritin 10 mg tablets	Allegra 30 mg tablets
		Allegra D
		Claritin Syrup
		Claritin D 12 Hour
		Claritin D 24 Hour

- Other NSAs that may be approved by the FDA after the date of this announcement may not be added to MTF formularies during the term of this contract.
- Cetirizine (Zyrtec®) is classified as a second-generation antihistamine but is not classified as an NSA. Therefore, this contract does not affect the current or future BCF or MTF formulary status of Zyrtec® products.
- This contract does **not** affect the current or future status of any Allegra®, Claritin®, or Zyrtec® product on the National Mail Order Pharmacy (NMOP) formulary. All Allegra®, Claritin® and Zyrtec® products remain available through the NMOP. Please note that the contract price for the Allegra® products as presented in Table 1 *will* apply to the NMOP.
- This contract does **not** apply to Managed Care Support Contractor retail network pharmacies.

Prescribing guidance for prescriptions filled at MTFs

- **New patient starts (patients who have not previously been prescribed a Claritin â or Allegra â product):** The contract requires that all new patients who have a clinical need for an NSA be prescribed either Allegra® 60 mg tablets or Allegra®180 mg tablets. If the patient fails to achieve adequate symptom relief or experiences unacceptable side effects with Allegra®, it is permissible to prescribe Claritin® under the provisions of medical necessity. Other examples of medical necessity include:
  - documented allergy to Allegra® products
  - pregnant patients with a clinical need for an NSA (Claritin® is assigned a pregnancy risk category B. Allegra® is assigned a pregnancy risk category C)
- **Patient who were previously treated successfully with Claritin 10mg or Claritin Reditabs:** Unlike the contracts currently in place for the proton pump inhibitor and statin drug classes, this contract does not mandate the conversion of NSA patients currently receiving Claritin® 10 mg tablets or Claritin Reditabs® to Allegra® 60 mg tablets or Allegra® 180 mg tablets. It is therefore **permissible** for patients who were successfully treated with Claritin® 10 mg tablets or Claritin Reditabs® to continue to receive these products. However, it is important to note that while the contract does not mandate patients be switched, **MTFs may decide to encourage their providers to switch patients.** This decision will be made at the MTF level.
- This contract does not preclude providers from prescribing alternate agents to patients for whom the contracted dosage forms and strengths are clinically inappropriate (i.e., pediatric patients).
- Both Allegra® 180 mg tablets and Allegra® 60 mg tablets are included in the NSA contract. This gives providers greater flexibility by allowing them to prescribe either Allegra® 60 mg in the morning and a generic sedating antihistamine in the evening at a cost of approximately $0.40 per day, Allegra® 180 mg once daily at a cost of $0.60 per day, or Allegra® 60 mg twice daily at a cost of $0.74 per day.

Points of Contact:

Note: Points of contact changed from initial version due to personnel changes at the Pharmacoeconomic Center

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Appendix C: Cost Avoidance in DoD MTFs Due to National Pharmaceutical Contracts, First 6 months of FY01 (Oct 00 – Mar 01)

Estimated Cost Avoidance in DoD MTFs Due to National Pharmaceutical Contracts, First Six Months of Fiscal Year 2001						
Drug/Drug Class	**Contract Start Date**	**Weighted Average Price/Unit Before Contract**	**Theoretical 1st and 2nd Quarter FY 01 Cost If Not Contracted**	**1st and 2nd Quarter FY 01 Actual Cost**	**Cost Avoidance**	**Percent Reduction in Cost**
Statins	1-Oct-99	$0.961874	$40,684,953	$31,484,021	$14,510,274	35.66%
PPIs	1-Oct-99	$1.681407	$50,953,184	$34,252,261	$16,700,923	32.78%
Lisinopril	1-Aug-99	$0.284396	$11,378,013	$6,869,586	$4,508,426	39.62%
Diltiazem	15-Dec-98	$0.631469	$6,373,438	$3,493,867	$2,879,571	45.18%
Ranitidine	16-Nov-98	$0.066602	$1,841,140	$1,544,368	$296,772	16.12%
Hepatitis A	18-Sep-99	$16.981597	$4,452,914	$2,967,127	$1,485,788	33.37%
Albuterol	16-Nov-98	$3.297032	$1,437,275	$1,749,002	($311,727)	-21.69%
Timolol Gel	14-Jan-00	$14.598153	$625,487	$255,067	$370,420	59.22%
Verapamil	20-Aug-99	$0.125912	$1,188,225	$821,203	$367,022	30.89%
Cimetidine	16-Nov-98	$0.072763	$332,088	$187,941	$144,147	43.41%
Terazosin	5-Sep-00	$0.459093	$4,014,631	$1,991,315	$2,023,316	50.40%
Captopril	18-Oct-99	$0.036173	$97,191	$56,579	$40,612	41.79%
Nortriptyline	15-Oct-99	$0.049281	$151,200	$111,120	$40,079	26.51%
Gemfibrozil	1-Jan-00	$0.077935	$530,685	$536,119	($5,433)	-1.02%
Naproxen	3-Jul-00	$0.069829	$1,384,510	$1,363,885	$20,625	1.49%
Amoxicillin	7-Aug-99	$0.040549	$291,247	$286,829	$4,417	1.52%
Insulin Syringes	1-May-00	$0.098121	$577,609	$407,346	$170,263	29.48%
Timolol Drops	14-Jan-00	$2.795264	$115,908	$94,615	$21,294	18.37%
Nicotine Patches	1-Jun-00	$2.567746	$751,541	$638,886	$112,654	14.99%
Levobunolol	14-Jan-00	$4.641527	$30,356	$21,778	$8,578	28.26%
Fluocinonide	1-Sep-99	Cream $1.816402 Oint $6.210282 Sol $6.422653	$179,959	$178,805	$1,154	0.64%
Prazosin	1-Nov-99	$0.032916	$63,057	$55,562	$7,495	11.89%
Amantadine	28-Aug-99	$0.063871	$31,744	$28,649	$3,095	9.75%
Naproxen Sodium	3-Jul-00	$0.073176	$78,586	$74,645	$3,941	5.01%
Salsalate	15-Mar-00	$0.026462	$59,335	$74,599	($15,264)	-25.73%
Insulin	1-Nov-99	$5.292812	$2,593,605	$2,726,349	($132,744)	-5.12%
Acyclovir	1-Oct-00	$0.121623	$462,557	$414,140	$48,416	10.47%
Azathioprine	1-Oct-00	$0.477152	$389,785	$349,282	$40,503	10.39%
Hydroxyurea	1-Oct-00	$0.295324	$78,497	$79,258	($761)	-0.97%
Pentoxifylline	1-Oct-00	$0.182262	$385,192	$383,409	$1,782	0.46%
Rifampin	1-Oct-00	$0.566776	$93,201	$86,415	$6,786	7.28%
Sucralfate	1-Oct-00	$0.198476	$192,692	$192,541	$152	0.08%
Acetaminophen	1-Jan-01		NA	NA	NA	NA
TOTAL			**$131,819,804**	**$93,776,570**	**$43,352,575**	**32.89%**

Explanation of Cost Avoidance Calculations: Cost avoidance equals the difference between (1) the theoretical cost that would have occurred in FY 00 if a contract had not existed, and (2) the actual cost that was incurred in FY 01 for the "market basket" of drugs that pertains to each contract. The theoretical cost that would have occurred in FY 01 if a contract had not existed was estimated by multiplying the weighted average price/unit that existed before the contract took effect by the quantity purchased in FY 01. The "market basket" of drugs includes both the contracted and the non-contracted drugs that pertain to a given contract. For example, the cost avoidance for statins takes into account the expenditures for all six statins, not just the two contracted statins.

Appendix D –Topical Corticosteroid Table

After receiving input from dermatology consultants, providers, and pharmacists, topical corticosteroids were divided into four categories depending on potency. The potency of a topical corticosteroid is standardized according to its ability to induce vasoconstriction. This is partially determined by the concentration of the drug and the vehicle used. The categories range from Class I (Very High Potency Agents) to Class IV (Low Potency Agents).

Ranking the topical corticosteroids in this manner may present some discordance among different classification schemes when attempting to categorize a specific drug into a particular level of potency; overall, however, disagreements are minor. Disease severity, age, body location and concomitant medical conditions usually determine the potency of topical corticosteroid treatment, while characteristics of the dermatologic condition usually determine the vehicle chosen. There appears to be little clinical reason to prefer one drug to another within a given category except for availability in the desired vehicle and a preference for nonfluorinated products for pediatric use or use on the face. Nonfluorinated products appear to cause less skin thinning (atrophy).

Topical Corticosteroids Categorized by Potency

Class I – Very High Potency			
Brand Name	**Generic Name**	**Vehicle**	**(%)***
Diprolene	Augmented betamethasone dipropionate	Ointment	0.05
Temovate, Cormax, Temovate E	Clobetasol propionate	Cream, Ointment, Gel, Solution	0.05
Psorcon	Diflorasone diacetate	Ointment	0.05
Ultravate	Halobetasol propionate	Cream, Ointment	0.05

Class II – High potency			
Brand Name	**Generic Name**	**Vehicle**	**(%)***
Cyclocort	Amcinonide	Cream, Ointment, Lotion	0.1
Diprolene AF	Augmented betamethasone dipropionate	Cream	0.05
Alphatrex, Del-Beta, Diprosone, Maxivate	Betamethasone dipropionate	Cream, Ointment, Lotion	0.05
Betatrex	Betamethasone valerate	Ointment	0.1
Topicort	Desoximetasone	Cream, Ointment Gel	0.25 0.05
Florone, Florene-E emollient, Maxiflor	Diflorasone diacetate	Cream, Ointment (emollient base)	0.05
Synalar-HP	Fluocinolone acetonide	Cream	0.2
Lidex, Lidex-E, Lidex soln.	Fluocinonide	Cream, Ointment, Solution, Gel	0.05
Halog (water soln cream), Halog solution, Halog-E	Halcinonide	Cream, Ointment, Solution	0.1
Aristocort, Aristocort A Kenalog, Trymex	Triamcinolone acetonide	Cream, Ointment	0.5

Topical Corticosteroids Categorized by Potency (continued)

Class III – Medium potency			
Brand Name	**Generic Name**	**Vehicle**	**(%)***
Benisone, Uticort	Betamethasone benzoate	Cream, Gel, Lotion	0.025
Alphatrex, Diprosone	Betamethasone dipropionate	Lotion	0.05
Valisone, Beta-Val, Betatrex	Betamethasone valerate	Cream, Lotion	0.1
Cloderm	Clocortolone pivalate	Cream	0.1
Topicort LP	Desoximetasone	Cream, Gel	0.05
Fluonide, Synalar, Synemol	Fluocinolone acetonide	Cream, Ointment	0.025
Cordran	Fluandrenolide	Cream, Ointment Lotion	0.025, 0.05 0.05
Cutivate	Fluticasone propionate	Cream Ointment	0.05 0.005
Locoid	Hydrocortisone butyrate	Cream, Ointment, Solution	0.1
Westcort	Hydrocortisone valerate	Cream, Ointment	0.2
Elocon	Mometasone furoate	Cream, Ointment Lotion	0.1
Aristocort A, Kenalog, Trymex,	Triamcinolone acetonide	Cream, Ointment Lotion	0.025 0.025, 0.1

Class IV – Low potency			
Brand Name	**Generic Name**	**Vehicle**	**(%)***
Aclovate	Alclometasone dipropionate	Cream, Ointment	0.05
Valisone, Celestone	Betamethasone valerate	Cream	0.01, 0.2
DesOwen, Tridesilon	Desonide	Cream, Ointment, Lotion	0.05
Decaderm	Dexamethasone	Gel	0.1
Synalar, Fluonid	Fluocinolone acetonide	Cream, Solution	0.01
Hytone, Lacticare, Synacort	Hydrocortisone	Lotion Cream, Oint, Lotion Cream, Oint, Lotion, Solution Cream, Oint, Lotion	0.25 0.5 1 2.5
Numerous	Hydrocortisone acetate	Cream, Ointment	0.5, 1
Medrol	Methylprednisolone	Cream	0.25
Oxylone	Fluoromethalone	Cream	0.025
Numerous OTCs			

fluorinated agent; nonfluorinated agent; disagreement among references concerning potency class

* Not all brands or concentrations are available in all vehicles or formulations; specialized formulations such as aerosols or tapes are not included in this table