16 February 2005

DECISION PAPER:

FEBRUARY 2005 DoD PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS

1. CONVENING

2. ATTENDANCE

3. REVIEW MINUTES OF LAST MEETING

4. INTERIM DECISIONS/ADMINISTRATIVE ISSUES

5. ITEMS FOR INFORMATION

6. DRUG REVIEW PROCESS

Implementation of the Uniform Formulary (UF) entails a wide variety of actions, with various levels of involvement of the DoD Pharmacy and Therapeutics (P&T) Committee, the Beneficiary Advisory Panel (BAP), and the Director, TRICARE Management Activity (TMA). However, not all of these actions require comment by the BAP, or recommendations or action by the P&T Committee or final decision by the Director, TMA, before they can be implemented. The P&T Committee developed a comprehensive list of the functions associated with formulary management and categorized each into one of three decision process categories, depending on the level of involvement for the P&T Committee, BAP, and/or Director, TMA.

COMMITTEE ACTION: Functions/actions of the Committee were reviewed and categorized according to the following processes: administrative functions (day-to-day maintenance not requiring DoD P&T Committee review), formulary recommendations requiring DoD P&T Committee review and approval by the Director, TMA, and formulary changes requiring DoD P&T Committee review and approval of the Committee's recommendations by the Director, TMA, after considering comments from the BAP. (See paragraph 6 and Table 1 on pages 13-14 of P&T Committee minutes.)

Recommendation: The Committee recommended approval of functions and decision categories as described.

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved

☐ Approved, but modified as follows

7. PRIOR AUTHORIZATIONS

The P&T Committee reviewed existing prior authorizations (PAs) and recommended rules for agents that are approved by the Food and Drug Administration (FDA) between Committee meetings that are in therapeutic classes for which PAs already exist.

COMMITTEE ACTION: The Committee discussed how to apply existing drug class PAs to newly FDA-approved drugs in within the class. (See paragraph 7 on pages 14-15 of P&T Committee minutes.)

The Committee recommended the following:

- Phosphodiesterase-5 (PDE-5) inhibitors – Any new PDE-5 inhibitor that may become available for the treatment of erectile dysfunction will be subject to the same PA as the existing agents.

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Injectable gonadotropins – Any new injectable gonadotropin that may become available for infertility treatment will be subject to the same PA as the existing agents.

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Antifungals for onychomycosis – Any new oral or topical antifungal that may become available for the treatment of onychomycosis will be subject to the same PA as the exiting agents, with course of therapy limits set based on recommended dosing.

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Growth hormone agents – Any new growth hormone agent that may become available will be subject to the same PA as the existing agents.

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

8. QUANTITY LIMITS

The P&T Committee reviewed all current quantity limits (QLs) with the intention to recommend any necessary additions, deletions, or changes, and to formulate and recommend rules for those QLs that apply to groups of medications, including new medications or formulations as soon as they become available. The P&T Committee's goal is to ensure a consistent benefit and avoid circumstances under which a newly approved medication, very similar to another medication for which a QL exists, is on the UF for several months of unrestricted use before a QL can be applied. The PEC would report changes to QLs following these general rules at the next scheduled DoD P&T Committee meeting.

A. COMMITTEE ACTION: The P&T Committee recommended the establishment of general QL rules for the following groups of medications (see paragraph 8 on page 15-16 of P&T Committee minutes and Appendix A for the rationale):

- Medications for the treatment of erectile dysfunction (PDE-5 inhibitors and injectable/intraurethral prostaglandins)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- 5-HT3 receptor antagonists (antiemetic medications)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- 5HT-1 receptor agonists ("triptans") for the treatment of migraine

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Dihydroergotamine products for the treatment of migraine

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Fertility agents (injectable gonadotropins)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Nasal inhalers for the treatment of allergic and nonallergic rhinitis

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Oral inhalers and inhalant solutions for the treatment of asthma, chronic obstructive lung disease, or allergies

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Tramadol-containing products

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows

B. COMMITTEE ACTION: The P&T Committee recommended the following specific changes to QLs (see paragraph 8 on page 16 of P&T Committee minutes and Appendix A for the rationale):

- Dihydroergotamine nasal spray (Migranal) – change to 16 amps per 30 days; 48 amps per 90 days)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

C. COMMITTEE ACTION: The Committee recommended the establishment of QLs for newly-approved agents: (See paragraph 8 on page 16 of P&T Committee minutes and Appendix A for the rationale):

- Azelastine nasal spray (Astelin) – 1 bottle per 30 days or 3 bottles per 90 days

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Tazarotene (Tazorac) cream – 60 gm (1 large tube) per 30 days; 180 gm per 90 days

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows

D. COMMITTEE ACTION: The P&T Committee recommended the deletion of QLs: (See paragraph 8 on pages 16-17 of P&T Committee minutes and Appendix A for the rationale):

- Azithromycin (Zithromax) 250- and 600-mg tablets

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Dornase alpha inhalation solution (Pulmozyme)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows

- Fluconazole (Diflucan, generics) 150 mg tablets

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Imiquimod cream (Aldara)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows

- Testosterone buccal system (Striant)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows

9. REVIEW OF RECENTLY-APPROVED DRUGS

The P&T Committee was briefed on agents who had been approved by the FDA and introduced into the U.S. market since the July 2004 meeting. None of the new medications fall into drug classes already reviewed by the P&T Committee; therefore, the P&T Committee deferred UF consideration until the applicable drug class reviews are completed.

COMMITTEE ACTION: The Committee recommended quantity limits for the following products (see paragraph 9 on page 17 of P&T Committee minutes and Appendix B for the rationale):

- Erlotinib tabs (Tarceva) – limit of 30 day supply in retail, 45 day supply in TRICARE Mail Order Pharmacy (TMOP) Program, up to 45 day supply in MTFs. No multiple fills for multiple co-pays in retail and TMOP

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

- Gemifloxacin tablets (Factive) – limit of 7 days supply per 30 days in retail, TMOP and MTFs

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

10. BASIC CORE FORMULARY (BCF) ISSUES

The DoD P&T Committee reviewed the relative clinical and cost effectiveness of timolol maleate ophthalmic solutions and gels, which had previously been placed on the BCF. MTFs are advised that the BCF listing for timolol maleate products relates to the product for which DoD has a sole source contract, and does not include the Istalol brand of timolol maleate ophthalmic solution.

11. ANGIOTENSIN RECEPTOR BLOCKER (ARB) DRUG CLASS REVIEW

The P&T Committee evaluated the relative clinical effectiveness of the seven angiotensin receptor blockers (ARBs): losartan (Cozaar), irbesartan (Avapro), valsartan (Diovan), candesartan (Atacand), telmisartan (Micardis), eprosartan (Teveten), olmesartan (Benicar), and included their respective combinations with hydrochlorothiazide. There has been an increase in the use of ARBs over the past five years, and the class is now in the top 10 of Military Health System (MHS) drug class expenditures.

A. COMMITTEE ACTION: The Committee concluded that (1) all seven ARBs have similar relative clinical effectiveness for treating hypertension; (2) that candesartan and valsartan have similar relative clinical effectiveness for treating chronic heart failure; (3) that losartan and irbesartan have similar relative clinical effectiveness for treating Type 2 diabetics with nephropathy; and (4) that all seven ARBs have similar safety and tolerability profiles. Valsartan, candesartan, losartan and irbesartan have higher clinical utility (overall clinical usefulness) relative to the three ARBs that are indicated solely for treating hypertension (telmisartan, eprosartan, and olmesartan). (See paragraph 11 A. on pages 18-19 of P&T Committee minutes.) The P&T Committee concluded that eprosartan was not cost-effective relative to the other ARBs for treating hypertension. Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the ARBs, and other relevant factors, the P&T Committee voted to recommend formulary status for candesartan, irbesartan, losartan, olmesartan, telmisartan, and valsartan, and non-formulary status for eprosartan under the UF. (See paragraph 11 B. on page 20 of P&T Committee minutes.) Under 32 C.F.R. 199.21(g)(3), no pharmaceutical agent may be designated as non-formulary on the UF unless preceded by such recommendation by the P&T Committee.

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved

☐ Approved, but modified as follows:

B. COMMITTEE ACTION: Based on the clinical evaluation of eprosartan, and the conditions for establishing medical necessity for a non-formulary medication provided for in the Uniform Formulary rule, the P&T Committee recommended medical necessity criteria for eprosartan. (See paragraph 11 C. on pages 20-21 of P&T Committee minutes for criteria.)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved

☐ Approved, but modified as follows:

C. COMMITTEE ACTION: Because relatively few patients are receiving eprosartan at any MHS pharmacy point of service (less than 1% of all patients receiving ARBs), the P&T Committee recommended an effective date of 30 days from the final decision date (the date that DoD P&T Committee minutes are signed by the Director, TMA, approving the Committee's recommendation). (See paragraph 11 D. on page 21 of P&T Committee minutes for rationale.)

Director, TMA, Decision:

☐ Approved ☐ Disapproved

BW ☑ Approved, but modified as follows:
within 90 days

D. COMMITTEE ACTION: Within the MTFs, the majority of ARB usage is for treating hypertension, and not for treating chronic heart failure or Type 2 diabetic nephropathy. Although valsartan, candesartan, irbesartan, and losartan have additional indications, which are of importance in the UF at the MTF setting, selecting one BCF ARB with a sole indication for hypertension is sufficient to meet the needs of the majority of patients. Based on the relative clinical and cost effectiveness analyses, the P&T Committee recommended placing telmisartan on the BCF. MTFs can add additional ARBs to their local formularies if needed to meet the needs of their specific patient populations. (See paragraph 11 E. on pages 21-22 of P&T Committee minutes for rationale.)

Director, TMA, Decision:

BW ☑ Approved ☐ Disapproved

☐ Approved, but modified as follows:

12. PROTON PUMP INHIBITOR (PPI) DRUG CLASS REVIEW

The P&T Committee evaluated the relative clinical effectiveness of all the FDA-approved proton pump inhibitors (PPIs) available in the US: omeprazole (Prilosec, Zegerid & generics), lansoprazole (Prevacid), rabeprazole (Aciphex), pantoprazole (Protonix) and esomeprazole (Nexium). PPIs are among the top 10 MHS drug class expenditures.

A. COMMITTEE ACTION: The P&T Committee concluded that all PPIs have similar relative clinical effectiveness for treating gastroesophageal reflux disease (GERD) and peptic ulcer disease (PUD). All five PPIs have similar safety and tolerability profiles. (See paragraph 12 A. on paged 22-23 of P&T Committee minutes for the rationale). The P&T Committee concluded that esomeprazole was not cost effective relative to the other PPIs. Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the PPIs and other relevant factors, the P&T Committee voted to recommend non-formulary status for esomeprazole, with rabeprazole, lansoprazole, and pantoprazole maintaining formulary status with a formulary cost share, and omeprazole maintaining formulary status with a generic cost share. (See paragraph 12 B. on page 23 of P&T Committee minutes for the rationale.) Under 32 C.F.R. 199.21(g)(3), no pharmaceutical

agent may be designated as non-formulary on the UF unless preceded by such recommendation by the P&T Committee.

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

B. COMMITTEE ACTION: Based on the clinical evaluation of esomeprazole, and the conditions for establishing medical necessity for a non-formulary medication provided for in the Uniform Formulary rule, the P&T Committee recommended medical necessity criteria for esomeprazole. (See paragraph 12 C. on pages 23-24 of P&T Committee minutes for the criteria.)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

C. COMMITTEE ACTION: Based on the substantial number of patients currently receiving esomeprazole from one of the three MHS pharmacy points of service (138,739 patients, or 13.4 % of all patients receiving PPIs), the P&T Committee recommended an implementation date of 90 days from the final decision date (the date that DoD P&T Committee minutes are signed by the Director, TMA, approving the Committee's recommendation). (See paragraph 12 D. on page 24 of P&T Committee minutes for the rationale.)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

D. COMMITTEE ACTION: Based on the relative clinical and cost-effectiveness, the P&T Committee recommended placing omeprazole (generic) and rabeprazole (Aciphex) on the BCF. However, omeprazole suspension (Zegerid) and Prilosec 40 mg were excluded from the BCF, because they were less cost-effective than the generic omeprazole. (See paragraph 12 E. on pages 24-25 of P&T Committee minutes for rationale.)

Director, TMA, Decision: BW ☑ Approved ☐ Disapproved
☐ Approved, but modified as follows:

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.

William Winkenwerder, Jr., M.D.
Date: 18 April, 2005

Department of Defense
Pharmacy and Therapeutics Committee Minutes

16 February 2005

1. CONVENING

The DoD P&T Committee convened at 0800 hours on 15 and 16 February 2005 at the DoD Pharmacoeconomic Center, Fort Sam Houston, Texas.

2. ATTENDANCE

A. Voting Members Present

CAPT Patricia Buss, MC	DoD P& T Committee Chair
CDR Mark Richerson, MSC	DoD P& T Committee Recorder
Col James Young, BSC	Director, DoD Pharmacy Programs, TMA
Capt Michael Proffitt, MC (present Feb 15th only)	Air Force, OB/GYN Physician
Maj Nick Conger, MC	Air Force, Internal Medicine Physician
Maj Charlene Reith, BSC (for Col Phil Samples, BSC)	Air Force, Pharmacy Officer
CDR William Hall, MC	Navy, Internal Medicine Physician
LCDR Suzanne Haney, MC	Navy, Pediatrics Physician
CDR Brian Alexander, MC	Navy, Physician at Large
CDR Ted Briski, MSC (for LT Joseph Lawrence, MSC)	Navy, Pharmacy Officer
COL Doreen Lounsbery, MC	Army, Internal Medicine Physician
MAJ Roger Brockbank, MC	Army, Family Practice Physician
COL Joel Schmidt, MC	Army, Physician at Large
COL Isiah Harper, MS	Army, Pharmacy Officer
CDR Mary Fong (for CDR Patrick Marshall)	Coast Guard, Pharmacy Officer
LTC Donald DeGroff, MS	Contracting Officer Representative, TMOP
CDR Jill Pettit, MSC	Contracting Officer Representative, TRRx
Joe Canzolino	Department of Veterans Affairs

B. Voting Members Absent

Maj Brian Crownover, MC	Air Force, Physician at Large

C. Non-Voting Members Present

Howard Altschwager	Deputy General Counsel, TMA
Martha Taft	Resource Management Directorate, TMA
Capt Peter Trang, BSC	Defense Supply Center Philadelphia

D. Non-Voting Members Absent

COL Kent Maneval, MS	Joint Readiness Clinical Advisory Board

E. Others Present

CAPT Betsy Nolan, MSC	Navy Pharmacy Specialty Leader
CDR Bill Blanche, MSC	Future Navy Pharmacy Specialty Leader
CDR Denise Graham, MSC	DoD Pharmacoeconomic Center
CAPT Don Nichols, MC	DoD Pharmacoeconomic Center
Lt Col Dave Bennett, BSC	DoD Pharmacoeconomic Center
Lt Col Barb Roach, MC	DoD Pharmacoeconomic Center
Maj Wade Tiller, BSC	DoD Pharmacoeconomic Center
CPT Jill Dacus, MC	DoD Pharmacoeconomic Center
Shana Trice	DoD Pharmacoeconomic Center
Dave Bretzke	DoD Pharmacoeconomic Center
Angela Allerman	DoD Pharmacoeconomic Center
Eugene Moore	DoD Pharmacoeconomic Center
Julie Liss	DoD Pharmacoeconomic Center
Elizabeth Hearin	DoD Pharmacoeconomic Center
Dave Flowers	DoD Pharmacoeconomic Center
Col Nancy Misel, BSC	IMA, DoD Pharmacoeconomic Center
Todd Semla	Department of Veterans Affairs

3. REVIEW MINUTES OF LAST MEETING

Dr. William Winkenwerder, Jr., M.D. approved the minutes of the first meeting of the restructured DoD Pharmacy and Therapeutics (P&T) Committee held July 2004 on October 5, 2004.

4. INTERIM DECISIONS/ADMINISTRATIVE ISSUES

None.

5. ITEMS FOR INFORMATION

TRICARE Management Activity (TMA) and DoD Pharmacoeconomic Center (PEC) staff members briefed the P&T Committee on the following:

A. The TRICARE Pharmacy Benefit Program Formulary Management Policy (HA Policy 04-032) was signed by Dr. Winkenwerder on December 22, 2004. This new HA Policy addresses how formulary management in the Military Health System (MHS) is accomplished by the DoD P&T Committee through the Uniform Formulary (UF), the Basic Core Formulary (BCF), and the Extended Core Formulary (ECF). Formulary

management by the Services and individual Military Treatment Facilities (MTFs) is limited to the circumstances described in this policy.

B. Quantity Limits, Prior Authorizations, and Medical Necessity Criteria – 10 U.S.C. § 1074g requires the establishment of an effective, efficient, integrated pharmacy benefit program under chapter 55 of title 10, United States Code, which applies to MTFs as well as to the purchased care system. The DoD P&T Committee makes recommendations to the Director, TMA, not only on formulary/non-formulary status for pharmaceutical agents in a class, but also on prior authorizations, quantity limits, and medical necessity criteria. Therefore, prior authorizations, quantity limits, and medical necessity criteria established by the DoD P&T Committee will apply to all three points of service.

C. Review of Medications for the Uniform Formulary – The Director, TMA, directed the implementation of the UF as a phased-in approach, one class at a time. Operating rules of the UF will only be applicable for those drug classes already evaluated by the DoD P&T Committee. The P&T Committee will meet quarterly to review new and existing drugs and/or drug classes and recommend pharmaceutical agents for inclusion or exclusion on the UF based on their relative clinical and cost effectiveness.

D. Formulary Resources for Beneficiaries – The TRICARE Pharmacy website (www.tricare.osd.mil/pharmacy) was recently restructured to provide additional information to DoD beneficiaries regarding the pharmacy benefit. The site now provides general formulary information, information about eligibility and claims, MTF and retail pharmacy locators, and a Formulary Search Tool.

The Formulary Search Tool enables beneficiaries to determine cost share, availability, prior authorization status, and quantity limits for specific medications at retail network pharmacies and the mail order pharmacy. A particular strength is the fact that the database searched by the tool is not limited to medications available through the pharmacy benefit, allowing a beneficiary to determine, for example, that a particular medication is over-the-counter, not covered by TRICARE, or covered by TRICARE but not considered to be part of the pharmacy benefit. The Formulary Search Tool also designates whether medications are listed on the BCF and provides information on whether generic equivalents are available for specific medications.

E. High Dollar Drugs – The introduction of clinically effective but costly new therapies can have a large, unexpected, negative impact on MTF pharmacy budgets. To complicate the issue, many of these new agents are biotech agents administered in inpatient or office/clinic settings, and therefore covered under the TRICARE medical benefit rather than the pharmacy benefit. Unfortunately, there is no uniform mechanism or policy in place across the services, or even across MTFs within a service, for dealing with this type of budget impact. Shifting use of the product to the network to be covered under the medical benefit will minimize pharmacy budget impact but increase the cost to the facility, since it will be billed for the network care. The P&T Committee concluded that attention needs to be given to formulating a uniform policy for handling high cost medications within the direct care system.

Col Nancy Misel, BSC, USAF, Director of the Air Force High Dollar Drug Program, briefed the P&T Committee on the program used by the Air Force to address this issue. Initiated at Wright-Patterson AFB in 1995, the High Dollar program is a centrally funded air staff program that provides high cost medications, on an individual patient basis, to

Air Force MTFs at no cost to the MTF. The criteria for drugs to be included in the program are predominantly based on cost. Other factors that would place a drug within the scope of the program include drugs with restricted distribution requirements that require administrative actions to procure or dispense (e.g., thalidomide) and drugs with low use and/or narrow therapeutic ranges. The program permits facilities to appropriately manage patient care without cost shifting to another venue or adversely impacting the local budget. It also ensures that funds for these medications do not need to be distributed to multiple locations and that access to medications is not interrupted when patients relocate or deploy.

Approximately 100 medications are being supplied under the current program guidelines, with approximately 75% of those drugs being new to the market since program implementation. The estimated expenditure for FY 05 is $25M. Advantages of the centralized program include 100% inventory control, minimization of MTF inventory requirements, the ability for a MTF to return unused drugs for future use at another MTF, expenditures which are easily attributable to user facilities, and a source for clinical oversight and support, as MTF expertise with these drugs may be limited. In addition, the program utilizes TRICARE quantity limits and prior authorization criteria to ensure an even playing field with the retail network and TRICARE Mail Order Pharmacy (TMOP) Program.

Col Misel noted that the Air Force program could be either the core for an expanded centrally-funded program, or easily exported to the other services, and is one option for dealing with the impact of costly therapies in the direct care system.

6. DRUG REVIEW PROCESS

Under 10 U.S.C. § 1074g and 32 C.F.R. 199.21, the DoD P&T Committee is responsible for developing the UF. Recommendations to the Director, TMA, on formulary status, preauthorizations, and the effective date for a drug's change from formulary to non-formulary status must be reviewed by the Beneficiary Advisory Panel (BAP) before the Director may make a final decision. Additionally, the P&T Committee may make recommendations on quantity limits, medical necessity criteria for non-formulary pharmaceutical agents, and additions, deletions, or clarifications to drugs that are on the BCF and ECF. These recommendations do not require review and comment by the BAP prior to decision by the Director. Finally, there are certain administrative processes required for the day-to-day operation of the UF that do not require recommendations or action by the P&T Committee or final decision by the Director, TMA, before they can be implemented. The P&T Committee developed a comprehensive list of functions associated with formulary management and categorized each in one of these three decision process categories which are outlined in Table 1.

Table 1: Processes and Recommendation/Approval Authorities

Process	Function
Administrative (not part of DoD P&T Committee process, Beneficiary Advisory Panel (BAP) comments not required, Director, TMA, approval not required) Responsible parties include: TRICARE Mail Order Pharmacy and TRICARE Retail Pharmacy Contracting Officer Representatives (TMOP and TRRx CORs), TMA Pharmacy Program, TMA Office of General Counsel, and Pharmacoeconomic Center (PEC) staff	▪ Identification of new FDA-approved medications, formulations, strengths, package sizes, etc. ▪ If situation unclear, determination as to whether a new FDA-approved medication is covered by TRICARE ▪ If situation unclear, determination as to whether a new FDA-approved medication is part of the pharmacy benefit ▪ If situation unclear, determination as to whether a new FDA-approved medication is suitable for dispensing through the TRICARE Mail Order Pharmacy (TMOP) ▪ Calculating and implementing quantity limits if already established through the DoD P&T Committee process for a given medication or class of medications ▪ Making changes to quantity limits as needed based on non-clinical factors such as changes to packaging (e.g., medication previously available in boxes of 5 now only available packaged in boxes of 8) ▪ Establishing adjudication edits (PDTS limitations which are set well above the clinical maximum and are intended to prevent entry errors [e.g., entering a quantity of 17 for a 17-gram inhaler for which the actual unit of measure is 1 inhaler] or are intended to limit diversion) ▪ Implementing prior authorization requirements if already established through the DoD P&T Committee process for a given medication or class of medications ▪ Making minor changes to prior authorization forms NOT involving changes to underlying criteria, such as correcting contact information or rewording clinical questions ▪ Making changes to PA criteria, medical necessity criteria, quantity limits and any associated documents to accommodate new FDA-approved indications or respond to changes in FDA-recommended safety limitations (changes will be reviewed by DoD P&T Committee at next meeting) ▪ Removing medications withdrawn from the U.S. market from Basic Core Formulary (BCF) or Extended Core Formulary (ECF) listings and other documents ▪ Providing clarifications to existing listings on the BCF or ECF to specify specific brands/manufacturers when a joint DoD/VA mandatory source generic contract is awarded for a given product (i.e., clarifying an existing listing for “atenolol” to include the contractual requirement to use a specific manufacturer’s products) ▪ As necessary to accomplish functions above: for example, making changes to PDTS coding for TMOP & TRRx, communicating status of medications as part of the pharmacy or medical benefit to Managed Care Support Contractors (MCSCs), making changes to the TMA Pharmacy website and the TRICARE Formulary Search Tool, and making changes to BCF and ECF listings on the PEC website.
Approval by Director, TMA, required based on DoD P&T Committee recommendations and BAP comments	▪ Classification of a medication as non-formulary on the Uniform Formulary (UF), and implementation plan (including effective date) ▪ Establishment of prior authorization requirement for a medication or class of medications, summary/outline of prior authorization criteria, and implementation plan (including effective date) ▪ Changes to existing prior authorization and medical necessity criteria (e.g., due to the availability of new efficacy or safety data) ▪ Discontinuation of prior authorization requirements
Approval by Director, TMA, required based on DoD P&T Committee recommendations (not required to be submitted to BAP for comments)	▪ Establishment of quantity limits for a medication or class of medications; deletion of existing quantity limits; changes to existing quantity limits based on clinical factors (e.g., new clinical data or dosing regimens) ▪ Establishment of medical necessity criteria for non-formulary agents ▪ Addition, deletion of medications listed on the Basic Core Formulary (BCF) or Extended Core Formulary (ECF)

7. PRIOR AUTHORIZATIONS

The P&T Committee reviewed existing prior authorizations and recommended rules that can be applied immediately to drugs approved by the Food and Drug Administration (FDA) between Committee meetings, when the drug belongs to a drug class for which prior

authorizations already exist. The recommended rules would provide a consistent benefit and avoid circumstances under which a newly approved medication, very similar to another medication for which a prior authorization exists, is on the UF for several months of unrestricted use before a prior authorization can be applied. The PEC would report changes to prior authorizations following these general rules at the next scheduled DoD P&T Committee meeting.

COMMITTEE ACTION: The P&T Committee made the following recommendations regarding rules that can be applied immediately to drugs approved by the FDA between P&T Committee meetings:

- *Phosphodiesterase-5* (*PDE-5) inhibitors* – Any new PDE-5 inhibitor that may become available for the treatment of erectile dysfunction will be subject to the same prior authorization as the existing agents – 14 for, 0 opposed, 1 abstention, 3 absent.
- *Injectable gonadotropins* – Any new injectable gonadotropin that may become available for infertility treatment will be subject to the same prior authorization as the existing agents – 15 for, 0 opposed, 1 abstention, 2 absent.
- *Antifungals for onychomycosis* - Any new oral or topical antifungal that may become available for the treatment of onychomycosis will be subject to the same prior authorization as the existing agents, with course of therapy limits set based on recommended dosing – 15 for, 0 opposed, 1 abstain, 2 absent.
- *Growth hormone agents* - Any new growth hormone agent that may become available will be subject to the same prior authorization as the existing agents – 15 for, 0 opposed, 1 abstention, 2 absent.

8. REVIEW OF QUANTITY LIMITS

The P&T Committee reviewed all current quantity limits with two goals: 1) to recommend any necessary additions, deletions, or changes; and 2) to formulate and recommend rules for those quantity limits that apply to groups of medications (e.g., oral inhalers, "triptans," PDE-5 inhibitors), including new medications or formulations as soon as they become available.

The quantity limits rules formulated by the P&T Committee for groups of medications include a number of factors which must be considered: the maximum quantity typically required by patients (usually based on product labeling); FDA-recommended safety recommendations in product labeling or other safety concerns; commercial package sizes available, and whether a given package size is typically dispensed to patients as a unit; and the operational requirement that 90-day limits should be three times the 30-day limits whenever possible. It should be noted that quantity limits have several operational safeguards in place to accommodate individual patient needs, including an exception process for patients with a valid clinical need for greater quantities than provided for by the quantity limits, and provisions to allow for dose changes, vacation supplies, and deployment supplies.

The P&T Committee noted that quantity limits apply to MTFs, as well as to the TMOP, and the retail pharmacy network. Network retail pharmacies typically dispense up to a 30-day supply of medications, although patients may obtain up to a 90-day supply of most medications by paying the appropriate multiple cost shares. The TMOP dispenses up to a 90-day supply. MTFs make local decisions as to days supply dispensed, but typically dispense a 90-day supply of chronic medications. Accordingly, quantity limits are listed in these

minutes as amounts per 30 or 90 days whenever possible. It is anticipated that MTFs will most often utilize the quantity limits that apply to the TMOP.

A. Quantity Limit Rules: The P&T Committee recommended the establishment of quantity limit rules that apply to groups of medications, including new medications or formulations as soon as they become available. This will provide a consistent benefit and avoid circumstances under which quantity limits exist for very similar medications, but which are applied to newly-approved medications of the same type only after several months of unrestricted use. The PEC would report changes in quantity limits following these general rules at the next scheduled DoD P&T Committee meeting.

COMMITTEE ACTION: The P&T Committee recommended the establishment of quantity limit rules for the following groups of medications. Details may be found in Appendix A.

- Medications for the treatment of erectile dysfunction (PDE-5 inhibitors and injectable/intraurethral prostaglandins) – 16 for, 1 opposed, 1 abstention
- 5-hydroxytryptamine (serotonin) receptor 3 (5-HT3) antagonists (antiemetic medications) – 17 for, 0 opposed, 1 abstention
- 5-hydroxytryptamine-1 (5HT-1) receptor agonists ("triptans") for the treatment of migraine- 17 for, 0 opposed, 1 abstention
- Dihydroergotamine products for the treatment of migraine – 17 for, 0 opposed, 1 abstention
- Fertility agents (injectable gonadotropins) – 17 for, 0 opposed, 1 abstention
- Nasal inhalers for the treatment of allergic and nonallergic rhinitis – 17 for, 0 opposed, 1 abstention
- Oral inhalers and inhalant solutions for the treatment of asthma, chronic obstructive lung disease, or allergies – 17 for, 0 opposed, 1 abstention
- Tramadol-containing products – 17 for, 0 opposed, 1 abstention

B. Quantity Limit Changes: The P&T Committee recommended specific changes to QLs for one product.

COMMITTEE ACTION: The P&T Committee recommended a reduction in QLs for this product. Details may be found in Appendix A.

- Dihydroergotamine nasal spray (Migranal) – change to 16 amps per 30 days; 48 amps per 90 days – 17 for, 0 opposed, 1 abstention

C. Quantity Limit Establishment: The P&T Committee recommended establishment of QLs for several drugs.

COMMITTEE ACTION: The P&T Committee recommended establishment of QLs for two drugs, both of which are very similar to medications which already have QLs. Details may be found in Appendix A.

- Azelastine nasal spray (Astelin) – 1 bottle per 30 days or 3 bottles per 90 days – 17 for, 0 opposed, 1 abstention
- Tazarotene (Tazorac) cream – 60 gm (1 large tube) per 30 days; 180 gm per 90 days – 17 for, 0 opposed, 1 abstention

D. Quantity Limit Deletion: The P&T Committee recommended deletion of QLs for several drugs.

COMMITTEE ACTION: The P&T Committee recommended deletion of QLs for five drugs. Details may be found in Appendix A.

- Azithromycin (Zithromax) 250- and 600-mg tablets – 17 for, 0 opposed, 1 abstention
- Dornase alpha inhalation solution (Pulmozyme) – 17 for, 0 opposed, 1 abstention
- Fluconazole (Diflucan, generics) 150 mg tablets – 17 for, 0 opposed, 1 abstention
- Imiquimod cream (Aldara) – 13 for, 4 opposed, 1 abstention
- Testosterone buccal system (Striant) – 17 for, 0 opposed, 1 abstention

9. REVIEW OF RECENTLY-APPROVED AGENTS

The PEC presented clinical information on 13 new medications approved by the FDA and introduced to the U.S. market since the July 2004 meeting (see Appendix A). Since none of the new medications fall into drug classes already reviewed by the P&T Committee, UF consideration was deferred until drug class reviews are completed. The P&T Committee did not recommend prior authorization requirements for any of the new drugs.

The PEC also informed the P&T Committee of two newly approved medications that do not fall under the outpatient pharmacy benefit, but may substantially impact MTF pharmacy budgets. These medications are natalizumab (Tysabri), an intravenous infusion for the treatment of multiple sclerosis, and pegaptanib (Macugen), an intravitreous injection for the treatment of neovascular (wet) age-related macular degeneration. [Note: as of February 28, 2005, distribution of natalizumab was suspended by the manufacturer due to two serious adverse events, including one fatal case and one possible case of progressive multifocal leukoencephalopathy.]

COMMITTEE ACTION

The P&T Committee recommended quantity limits for the following recently approved products:

- Erlotinib tabs (Tarceva) – limit of 30 day supply in retail, 45 day supply in TMOP, up to 45 day supply in MTFs. No multiple fills for multiple cost shares in retail and TMOP – 16 for, 0 opposed, 1 abstention, 1 absent at time of vote.
- Gemifloxacin tablets (Factive) – limit of 7 days supply per 30 days in retail, TMOP, and MTFs - 16 for, 0 opposed, 1 abstention, 1 absent at time of vote.

10. BASIC CORE FORMULARY (BCF) ISSUES

The BCF is a subset of the UF and is a mandatory component of all MTF pharmacy formularies. The DoD P&T Committee previously placed timolol maleate ophthalmic solution and gel on the BCF. Timolol maleate ophthalmic solution 0.25% and 0.5%, administered twice daily, are available with a contract price of $1.52 per 5 ml. Timolol maleate ophthalmic gel 0.25% and 0.5%, administered once daily, are available at the contract price of $10.57 and $12.81 per 5 ml for the 0.25% and 0.5%, respectively.

Timolol maleate 0.5% ophthalmic solution (Istalol) was approved by the FDA in June 2004, and became available on the market in January 2005. Istalol contains potassium sorbate, which is stated to enhance the bioavailability of the drug in solution, allowing for once daily administration. Istalol has similar efficacy, safety, and tolerability compared to timolol maleate products currently on the BCF, but costs much more, with a FSS price of $24.33 per 5 ml. The FDA has given Istalol a Therapeutic Equivalent Code of BT, meaning that it is a topical product that has acceptable clinical performance, but is not bioequivalent to other pharmaceutically equivalent products or lacks sufficient evidence of bioequivalence.

MTFs are advised that the BCF listing for timolol maleate products relates to the product for which DoD has a sole source contract, and does not include the Istalol brand of timolol maleate ophthalmic solution.

11. ANGIOTENSIN RECEPTOR BLOCKERS (ARBs) DRUG CLASS REVIEW

A. ARB Uniform Formulary Relative Clinical Effectiveness: The P&T Committee evaluated the relative clinical effectiveness of the seven ARBs marketed in the U.S. by considering information regarding their safety, effectiveness, and clinical outcome. The ARB therapeutic class was defined as losartan (Cozaar), irbesartan (Avapro), valsartan (Diovan), candesartan (Atacand), telmisartan (Micardis), eprosartan (Teveten), olmesartan (Benicar) and their respective combinations with hydrochlorothiazide. The clinical review included consideration of pertinent information from a variety of sources determined by the P&T Committee to be relevant and reliable, including but not limited to sources of information listed in 32 C.F.R. 199.21(e)(1). The P&T Committee was advised that there is a statutory presumption that pharmaceutical agents in a therapeutic class are clinically effective and should be included on the Uniform Formulary unless the P&T Committee finds by a majority vote that a pharmaceutical agent does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome over the other pharmaceutical agents included on the UF in that therapeutic class.

There has been an increase in the use of ARBs over the past five years, and the class is now in the top 10 of MHS drug class expenditures. The P&T Committee agreed that in the MHS, ARBs are not recommended as first-line agents for treating hypertension due to their higher cost and fewer trials supporting a mortality reduction, compared to diuretics or angiotensin converting enzyme (ACE) inhibitors. The ACE inhibitors and ARBs have similar safety concerns regarding hyperkalemia, elevations of serum creatinine, angioedema, and pregnancy category labeling. The ARBs have an incidence of cough similar to placebo. An ARB is an appropriate agent for hypertension if a patient cannot tolerate an ACE inhibitor.

1.) Efficacy for Hypertension: All seven ARBs are approved by the FDA for treating hypertension. In clinical trials, ARBs lowered systolic blood pressure by 7.5-10 mm Hg and diastolic blood pressure by 4.5 to 6.5 mm Hg, compared to placebo. The P&T Committee agreed that there is no evidence that any one ARB is more efficacious than the others for lowering blood pressure.

2). Efficacy for Chronic Heart Failure: When evaluating the ARBs for treatment of chronic heart failure, the P&T Committee agreed that evidence of a favorable effect on clinical outcomes (i.e., irreversible outcomes such as hospitalization for heart failure or death) is more important than evidence of favorable effects on physiologic outcomes (i.e., reversible outcomes that are surrogate markers of disease, such as changes in pulmonary capillary wedge pressure).

Two ARBs have clinical evidence from large, well-conducted, randomized controlled trials showing a reduction in the risk of hospitalization due to chronic heart failure, a clinically relevant outcome. Based on the results of the Val-HeFT trial, the FDA approved valsartan for use in patients with heart failure who are intolerant of ACE inhibitors. The CHARM trials with candesartan support its use in chronic heart failure, although at the time of the meeting the FDA had not yet approved candesartan for this indication. (Note: Candesartan was approved for heart failure on February

22, 2005, following the DoD P&T committee meeting). The P&T Committee agreed that there was no evidence that either valsartan or candesartan were preferable relative to the other for the treatment of chronic heart failure. Since none of the other ARBs have outcome studies showing a reduction in clinically relevant outcomes related to chronic heart failure, the P&T Committee agreed that valsartan and candesartan were preferable to the other five ARBs for the treatment of heart failure.

3.) *Efficacy for Type 2 Diabetic Nephropathy*: When evaluating the ARBs for treatment of type 2 diabetics with nephropathy, the P&T Committee agreed that evidence of a favorable effect on clinical outcomes (i.e., irreversible outcomes such as development of end stage renal disease, the need for dialysis or renal transplantation, or death) is more important than evidence of favorable effects on physiologic outcomes (i.e., reversible outcomes that are surrogate markers of disease, such as changes in the urinary albumin to creatinine ratio, urinary albumin excretion rate, or glomerular filtration rate).

   Based on the results of the RENAAL and IDNT trials, the FDA has approved two ARBs, losartan and irbesartan, respectively, for treatment of diabetics who have an elevated serum creatinine and proteinuria. The P&T Committee agreed that there was no evidence that either losartan or irbesartan were preferable relative to the other for the treatment of renal nephropathy in type 2 diabetics. Since none of the other ARBs have outcome studies showing a reduction in clinically relevant outcomes related to Type 2 diabetic nephropathy, the P&T Committee agreed that losartan and irbesartan were preferable to the other five ARBs for the treatment of Type 2 diabetic nephropathy.

4.) *Safety/Tolerability:* The P&T Committee agreed that there is no evidence that any one ARB is preferable to the others with respect to safety or tolerability. These medications are generally well-tolerated, with adverse event rates for all the ARBs similar to placebo in controlled trials. The likelihood of potentially serious adverse events, including hyperkalemia, elevations of serum creatinine, and angioedema, do not appear to differ among agents. Drug interaction profiles are similar. All ARBs are pregnancy category C during the first trimester, and pregnancy category D during the second and third trimesters, based on the occurrence of fetal abnormalities with ACE inhibitors.

Conclusion: The P&T Committee concluded that (1) all seven ARBs have similar relative clinical effectiveness for treating hypertension; (2) that candesartan and valsartan have similar relative clinical effectiveness for treating chronic heart failure; (3) that losartan and irbesartan have similar relative clinical effectiveness for treating Type 2 diabetics with nephropathy; and (4) that all seven ARBs have similar safety and tolerability profiles. Valsartan, candesartan, losartan, and irbesartan have higher clinical utility (overall clinical usefulness) relative to the three ARBs that are indicated solely for treating hypertension (telmisartan, eprosartan, and olmesartan).

COMMITTEE ACTION: The P&T Committee, based upon its collective professional judgment, voted (17 for, 0 opposed, 1 abstention) to accept the conclusion that valsartan, candesartan, losartan, and irbesartan have increased clinical utility (due to their evidence for uses in addition to hypertension) relative to the three ARBs that are only indicated for treating hypertension (telmisartan, olmesartan, and eprosartan), and concluded that there is no evidence that any one ARB is more efficacious than the others for lowering blood pressure.

B. ARB Uniform Formulary Relative Cost Effectiveness: In considering the relative cost effectiveness of pharmaceutical agents in this class, the P&T Committee evaluated the costs of the agents in relation to the safety, effectiveness, and clinical outcomes of the other agents in the class. Information considered by the P&T Committee included but was not limited to sources of information listed in 32 C.F.R. 199.21(e)(2). To determine the relative cost-effectiveness of the agents within the ARB therapeutic class, two separate economic analyses were performed, a pharmacoeconomic analysis and budget impact analysis (BIA). The preceding conclusion from the P&T Committee that all seven ARBs showed similar relative clinical effectiveness for treating hypertension; that candesartan and valsartan showed similar relative clinical effectiveness for treating chronic heart failure, and that losartan and irbesartan showed similar relative clinical effectiveness for treating Type 2 diabetic nephropathy was incorporated into the models. Given the results of the clinical analysis, a series of cost-minimization analyses (CMA) were conducted which revealed: that: candesartan was more cost-effective relative to valsartan for the treatment of heart failure; irbesartan was more cost-effective relative to losartan for treatment of Type 2 diabetic nephropathy; and irbesartan was more cost-effective relative to the other ARBs for the treatment of hypertension. Moreover, it was determined that eprosartan was not cost-effective relative to the other hypertension-only ARBs (telmisartan and olmesartan).

The results of the CMA were subsequently incorporated into a BIA, which accounts for other factors and costs associated with a potential decision to recommend one or more ARBs status be changed from formulary to non-formulary such as: market share migration, cost reduction associated with non-formulary cost shares, medical necessity processing fees, and costs incurred while switching patients from non-formulary agents to formulary agents. The results of the budget impact analyses further confirmed the results from the cost minimization analyses. Eprosartan was found not to be cost-effective relative to the other hypertension ARBs.

Conclusion: The P&T Committee concluded that eprosartan was not cost-effective relative to the other ARBs for treating hypertension. Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the ARBs, and other relevant factors, the P&T Committee recommended that eprosartan's status be changed from formulary to non-formulary, with candesartan, irbesartan, losartan, olmesartan, telmisartan, and valsartan maintaining formulary status with the formulary cost share.

COMMITTEE ACTION: The P&T Committee, based upon its collective professional judgment, voted (9 for, 7 opposed, 1 abstention, 1 absent) to recommend formulary status for candesartan, irbesartan, losartan, olmesartan, telmisartan, and valsartan, and non-formulary status for eprosartan under the UF.

C. ARB Uniform Formulary Medical Necessity Criteria: Based on the clinical evaluation of eprosartan and the conditions for establishing medical necessity for a non-formulary medication provided for in the Uniform Formulary rule, the following medical necessity criteria were proposed for eprosartan.

1.) Use of all the formulary ARBs (losartan, irbesartan, valsartan, candesartan, telmisartan, and olmesartan), is contraindicated, and the use of eprosartan is not contraindicated.

2.) The patient has experienced or is likely to experience significant adverse effects from all the formulary ARBs (losartan, irbesartan, valsartan, candesartan, telmisartan, and olmesartan) and the patient is reasonably expected to tolerate eprosartan.

3.) Use of the formulary ARBs (losartan, irbesartan, valsartan, candesartan, telmisartan, and olmesartan) resulted in therapeutic failure, and the patient is reasonably expected to respond to eprosartan.

4.) The patient has previously responded to eprosartan, and changing to a formulary ARB would incur unacceptable risk.

COMMITTEE ACTION: The P&T Committee voted (15 for, 0 opposed, 1 abstention, 2 absent) to recommend the medical necessity criteria for eprosartan listed above.

D. ARB Uniform Formulary Implementation Plan: Because relatively few patients are receiving eprosartan at any MHS pharmacy point of service (less than 1% of all patients receiving ARBs), the P&T Committee proposed a 30-day transition period for implementation of a decision by the Director, TMA, to classify eprosartan as non-formulary on the UF. Prior to the P&T Committee meeting, the Government had solicited a request for blanket purchase agreement (BPA) price quotes from manufacturers. One manufacturer subsequently filed a protest concerning this class with the Government Accountability Office (GAO). Any decision by the Director, TMA, concerning this class, including an implementation plan, may proceed; however, no award of a BPA, based on these quotes will occur until after the GAO has issued a ruling on the protest. The TMA and PEC web sites will notify all interested parties when GAO has ruled on the protest, and what subsequent decisions have been made.

MTFs are not allowed to have non-formulary pharmaceutical agents on their local formularies. MTFs will be able to fill non-formulary requests for non-formulary agents only if both of the following conditions are met: 1) the prescription is written by a MTF provider, and 2) the beneficiary and/or his or her provider has established medical necessity for the agent. MTFs may (but are not required to) fill a non-formulary prescription written by a non-MTF provider to whom the patient was referred as long as medical necessity has been established.

COMMITTEE ACTION: The P&T Committee voted (14 for, 1 opposed, 1 abstention, 2 absent) to recommend an effective date of 30 days from the final decision date if the Director, TMA, approves the P&T Committee's recommendation.

E. ARB Basic Core Formulary (BCF) Review and Recommendations: The P&T Committee reviewed the ARBs recommended for inclusion on the UF to select a BCF ARB. It had previously been decided that at least one, but no more than three ARBs, could be added to the BCF, based on the outcome of relative clinical effectiveness and relative cost effectiveness determinations.

Within the MTFs, the majority of ARB usage is for treating hypertension, and not for treating chronic heart failure or Type 2 diabetic nephropathy. Although valsartan, candesartan, irbesartan, and losartan have additional indications, which are of importance in the UF at the MTF setting, selecting one BCF ARB with a sole indication for hypertension is sufficient to meet the needs of the majority of patients. The relative clinical effectiveness review demonstrated that all seven ARBs have similar efficacy, safety, and tolerability for treating hypertension. The six remaining UF ARBs were reviewed for placement on the BCF for the treatment of hypertension. The same process used for the UF relative cost-effectiveness decision, i.e., a cost-minimization analysis

(CMA) followed by a budget impact analysis (BIA), was employed for the BCF decision. The CMA revealed, and the BIA confirmed, that telmisartan was the most cost-effective ARB for the MTF point of service. Based on the relative clinical and cost effectiveness analyses, the P&T Committee recommended placing telmisartan on the BCF. MTFs can add additional ARBs to their local formularies if needed to meet the needs of their specific patient populations.

Conclusion: The P&T Committee concurred with the recommendation to place telmisartan as the sole ARB on the BCF.

COMMITTEE ACTION: The P&T Committee voted (15 for, none opposed, 2 abstentions, 1 absent) to recommend telmisartan as the BCF agent.

12. PROTON PUMP INHIBITORS (PPIs) DRUG CLASS REVIEW

A. ***PPI Relative Clinical Effectiveness:*** The P&T Committee evaluated the relative clinical effectiveness of all the FDA-approved proton pump inhibitors available in the U.S. The PPI therapeutic class was defined as omeprazole (Prilosec, Zegerid & generics), lansoprazole (Prevacid), rabeprazole (Aciphex), pantoprazole (Protonix) and esomeprazole (Nexium). The clinical review included consideration of pertinent information from a variety of sources determined by the P&T Committee to be relevant and reliable, including but not limited to sources of information listed in 32 C.F.R. 199.21(e)(1). The P&T Committee was advised that there is a statutory presumption that pharmaceutical agents in a therapeutic class are clinically effective and should be included on the UF unless the P&T Committee finds by a majority vote that a pharmaceutical agent does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome over the other pharmaceutical agents included on the UF in that therapeutic class.

PPIs are among the top 10 MHS drug class expenditures. The P&T Committee agreed that in the MHS, PPIs are not recommended as first-line agents for treating gastroesophageal reflux disease (GERD), and they are not intended for the immediate relief of infrequent GERD symptoms. For GERD symptom relief, PPIs are best used after lifestyle modification, antacid, and histamine-2 (H2) blocker therapies have failed. PPIs are first-line therapy for peptic ulcer disease (PUD), whether non-steroidal anti-inflammatory drug (NSAID)-induced, associated with *Helicobacter pylori* infection, or due to a hypersecretory condition.

1.) *Efficacy:* Although FDA indications differ slightly amongst the PPIs, the vast majority of studies found no significant difference in efficacy in treating GERD and PUD. Minor differences in clinical utility, such as pediatric indication, possible need for dosage adjustment in hepatic failure, and availability of alternative dosage forms were noted. After a review of head-to-head trials and meta-analyses, the P&T Committee concluded that all of the PPIs show similar efficacy when equivalent doses are used.

2.) *Safety/Tolerability:* The P&T Committee found that PPIs were not significantly different with respect to major contraindications, drug interactions, and adverse drug events. The dropout rates in clinical trials due to adverse events were comparable amongst the five PPIs. All PPIs are pregnancy category B, except omeprazole, which is category C.

Conclusion: The P&T Committee concluded that all PPIs have similar relative clinical effectiveness for treating GERD and PUD. All five PPIs have similar safety and tolerability profiles.

COMMITTEE ACTION*:* The P&T Committee, based upon its collective professional judgment, concluded that all five PPIs demonstrate similar relative clinical effectiveness. (16 for, 0 opposed, 1 abstained, 1 absent).

B. PPI Uniform Formulary Relative Cost Effectiveness: In considering the relative cost effectiveness of pharmaceutical agents in this class, the P&T Committee evaluated the costs of the agents in relation to the safety, effectiveness, and clinical outcomes of the other agents in the class. Information considered by the P&T Committee included but was not limited to sources of information listed in 32 C.F.R. 199.21(e)(2). Two analyses were used to determine the relative cost-effectiveness of agents within the PPI therapeutic class; a pharmacoeconomic analysis using cost-minimization techniques, and a budget impact analysis (BIA). Cost-minimization (CMA) was chosen for the pharmacoeconomic analysis because the clinical analysis, determined the outcomes of interest (effectiveness, safety, and tolerability) to be similar among all the PPIs.

Results of the CMA showed omeprazole to be the most cost-effective PPI across all points of service (MTF, Retail, Mail), followed by rabeprazole, lansoprazole, and pantoprazole. It was determined that esomeprazole was not cost effective relative to the other PPIs

The results of the CMA were then incorporated into a BIA, which accounts for other factors and costs associated with a potential decision regarding formulary status of PPIs within the UF. These factors included: market share migration, cost reduction associated with non-formulary cost shares, medical necessity processing fees, and switch costs. The results of the budget impact analysis further confirmed the results of the CMA. Esomeprazole was found not to be cost effective relative to the other PPIs.

Conclusion: The P&T Committee concluded that esomeprazole was not cost effective relative to the other PPIs. Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the PPIs and other relevant factors, the P&T Committee recommended that esomeprazole's status be changed from formulary to non-formulary, with rabeprazole, lansoprazole, and pantoprazole maintaining formulary status with the formulary cost share, and omeprazole maintaining formulary status with a generic cost share.

COMMITTEE ACTION: The P&T Committee, based upon its collective professional judgment, voted (14 for, 2 opposed, 1 abstained, 1 absent) to recommend non-formulary status for esomeprazole, with rabeprazole, lansoprazole, and pantoprazole maintaining formulary status at the formulary cost share, and omeprazole maintaining formulary status at the generic cost share.

C. PPI Uniform Formulary Medical Necessity Criteria: Based on the clinical evaluation of esomeprazole, and the conditions for establishing medical necessity for a non-formulary medication provided for in the Uniform Formulary rule, the P&T Committee recommended the following medical necessity criteria for esomeprazole.

1.) Use of all formulary PPIs (omeprazole, rabeprazole, lansoprazole, and pantoprazole) is contraindicated, and the use of esomeprazole is not contraindicated.

2.) The patient has experienced or is likely to experience significant adverse effects from all the formulary PPIs (omeprazole, rabeprazole, lansoprazole, and pantoprazole), and the patient is reasonably expected to tolerate esomeprazole.

3.) Use of the formulary PPIs (omeprazole, rabeprazole, lansoprazole, and pantoprazole) resulted in therapeutic failure, and the patient is reasonably expected to respond to esomeprazole.

4.) The patient has previously responded to the non-formulary esomeprazole, and changing to a formulary PPIs (omeprazole, rabeprazole, lansoprazole, and pantoprazole) would incur unacceptable risk.

COMMITTEE ACTION: The P&T Committee voted (16 for, 0 opposed, 1 abstention, 1 absent) to approve the medical necessity criteria.

D. PPI Uniform Formulary Implementation Plan: Because a substantial number of patients are currently receiving esomeprazole from one of the three MHS pharmacy points of service (138,739 patients, 13.4 % of all patients receiving PPIs) the P&T Committee proposed a 90-day transition period for implementation of the decision to change esomeprazole to a non-formulary drug on the UF. Patients wishing to fill prescriptions for esomeprazole at retail network pharmacies or the TMOP would then have to pay the non-formulary cost share unless medical necessity for esomeprazole is established by the beneficiary and/or his or her provider.

Prior to the implementation of the UF, the former DoD P&T Committee had made a decision that prescriptions for esomeprazole could not be filled through the TMOP, unless medical necessity was validated. If the Director, TMA, concurs in the P&T Committee's recommendation, prescriptions for esomeprazole may be filled through the TMOP, but will require payment of the non-formulary cost share of $22. Beneficiaries who already have a medical necessity validation on file at the TMOP are required to re-establish medical necessity for esomeprazole under the medical necessity criteria approved by the Director, TMA, in order to receive esomeprazole at the formulary cost share.

MTFs will not be allowed to have esomeprazole on their local formularies. MTFs will be able to fill non-formulary requests for esomeprazole only if both of the following conditions are met: 1) the prescription must be written by a MTF provider, and 2) the beneficiary and/or his or her provider must establish medical necessity for esomeprazole. MTFs may (but are not required to) fill an esomeprazole prescription written by a non-MTF provider to whom the patient was referred, as long as medical necessity has been established.

COMMITTEE ACTION: The P&T Committee voted (16 for, 0 opposed, 1 abstention, 1 absent) to recommend an effective date of 90 days from the final decision date (the date that DoD P&T Committee minutes are signed by the Director, TMA, approving the P&T Committee's recommendation).

***E. PPI BCF Review and Recommendations*:** The P&T Committee reviewed the PPIs recommended for inclusion on the UF to select a BCF PPI. It had previously been decided that at least one but no more than two PPIs could be added to the BCF, based on the outcome of the relative clinical effectiveness and relative cost effectiveness determinations.

The same process for the UF decision was used for the BCF decision, which consisted of evaluating the relative cost-effectiveness with a cost-minimization analysis (CMA),

followed by a budget impact analysis (BIA). The CMA revealed, and the BIA confirmed, that omeprazole (generic) and rabeprazole (Aciphex) were the most cost-effective PPIs for the MTF point of service. Based on the relative clinical and cost-effectiveness, the P&T Committee recommended placing omeprazole (generic) and rabeprazole (Aciphex) on the BCF. However, omeprazole suspension (Zegerid) and Prilosec 40 mg were not included on the BCF, because they were less cost-effective than the generic omeprazole.

Conclusion: Omeprazole and rabeprazole were recommended for inclusion on the BCF. Omeprazole suspension (Zegerid) and Prilosec 40 mg were not included on the BCF, because they were less cost-effective than the generic omeprazole.

COMMITTEE ACTION: The P&T Committee voted (16 for, 0 opposed, 1 abstained, 1 absent) to recommend that omeprazole and rabeprazole be on the BCF.

14. ADJOURNMENT

The second day of the meeting adjourned at 1730 hours on February 16, 2005. The dates of the next meeting are May 16–19, 2005.

Patricia Buss

Patricia L. Buss
CAPT, MC, USN
Chairperson

List of Appendices

Appendix A: Recommended Changes to Quantity Limits

Medications	Committee Recommendation	Comments
General Quantity Limit Rules		
Medications for the treatment of erectile dysfunction (ED) Phosphodiesterase-5 (PDE-5) inhibitors [sildenafil (Viagra), tadalafil (Cialis), and vardenafil (Levitra)] Injectable / intraurethral prostaglandins [alprostadil] injection (Caverject, Edex); alprostadil intraurethral pellet (Muse)]	Quantity limits will apply to all injectable/intraurethral prostaglandins and PDE-5 inhibitors for the treatment of ED, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits will be based on the following: 6 tablets, injections, or intraurethral pellets per 30-day supply or 18 per 90-day supply, consistent with current quantity limits for PDE-5 inhibitors and injectable/intraurethral prostaglandins. This quantity limit will apply collectively to all strengths and formulations of all injectable/intraurethral prostaglandins and PDE-5 inhibitors for the treatment of ED.	The rule would represent a change from quantity limits currently in place for the PDE-5 inhibitors and the injectable / intraurethral prostaglandins (as listed on the TMA Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#ED) in that it provides for a collective quantity limit for this entire group of medications. Currently, collective quantity limits are in place for PDE-5 inhibitors and for injectable / intraurethral prostaglandins, but they do not apply across the entire group of medications.
5-HT3 receptor antagonists (antiemetic medications) Dolasetron (Anzemet) Granisetron (Kytril) Ondansetron (Zofran)].	Quantity limits will apply to all 5-HT3 receptor antagonists, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits for these medications will be set based on the following factors: quantities sufficient to allow for chemotherapy prophylaxis and post-operative use based on recommended dosing regimens, taking into account FDA safety recommendations in product labeling and other safety concerns; commercial package sizes; and operational requirements.	Quantity limits are currently in place for the three available 5-HT3 receptor antagonists, as listed on the TMA Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#Antiemetics.
5HT-1 receptor agonists ("triptans) for the treatment of migraine Almotriptan (Axert) Eletriptan (Relpax) Frovatriptan (Frova) Naratriptan (Amerge) Rizatriptan (Maxalt) Sumatriptan (Imitrex) Zolmitriptan (Zomig)	Quantity limits will apply to all 5HT1 receptor agonists ("triptans") for the treatment of migraine, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits for these medications will be set based on the following factors: sufficient quantities to allow for recommended dosing regimens for the treatment of migraine, not to exceed the treatment of an average of more than 4 migraine attacks in a 30-day period based on FDA safety recommendations in product labeling; other safety concerns; commercial package sizes; and operational requirements.	Quantity limits are currently in place for the seven available 5HT-1 receptor agonists ("triptans") for the treatment of migraine, as listed on the TMA Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#Antimigraine.

Medications	Committee Recommendation	Comments
Dihydroergotamine products for the treatment of migraine Dihydroergotamine nasal spray (Migranal) Dihydroergotamine injection (DHE-45, generics)	Quantity limits will apply to all dihydroergotamine products for the treatment of migraine, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits for these medications will be set based on the following factors: sufficient quantities to allow for recommended dosing regimens for the treatment of migraine, not to exceed more than 4 mg of the nasal spray or more than 6 mL of the injectable product per week, based on FDA safety recommendations in product labeling; other safety concerns; commercial package sizes; and operational requirements.	Quantity limits are currently in place for these medications, as listed on the TRICARE Management Activity Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#Antimigraine.
Fertility agents (injectable gonadotropins) Follitropin alpha Follitropin beta Menotropins Urofollitropin	Quantity limits will apply for all injectable gonadotropins for the treatment of infertility, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits will be based on the following: 3600 IU (or equivalent) per 30 day supply, no refills, in all pharmacy points of service, consistent with current quantity limits for injectable prostaglandins. This quantity limit will apply collectively to all injectable gonadotropins (no more than 3600 IU of any combination of products per 30 days in any pharmacy point of service, no refills).	This would represent a change from quantity limits currently in place for the injectable gonadotropins (as listed on the TMA Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#Fertility) in that it provides for a collective quantity limit for this group of medications. Currently, quantity limits are in place for injectable gonadotropins but they do not apply across the entire class of medications. A collective quantity limit is desirable to prevent patients from accumulating excessive quantities of injectable gonadotropins by submitting prescriptions for two or more different injectable gonadotropins during the same time period.
Nasal inhalers for the treatment of allergic and nonallergic rhinitis Multiple products, including nasal corticosteroids, ipratropium, and antihistamines	Quantity limits will apply to all nasal inhalers for the treatment of allergic and nonallergic rhinitis, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits for these medications will be set based on the following factors: sufficient quantities to allow for recommended dosing regimens for the treatment of allergic and nonallergic rhinitis, taking into account FDA safety recommendations in product labeling, and other safety concerns; commercial package sizes; and operational requirements.	Quantity limits are currently in place for the medications in this category, as listed on the TRICARE Management Activity Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#Nasal.

Medications	Committee Recommendation	Comments
Oral inhalers and inhalant solutions for the treatment of asthma, chronic obstructive lung disease, or allergies Multiple products, including oral inhaled corticosteroids, bronchodilators, mast cell stabilizers, and combination products	Quantity limits will apply to all oral inhalers and inhalant solutions for the treatment of asthma, chronic obstructive lung disease, or allergies, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits for these medications will be set based on the following factors: sufficient quantities to allow for recommended dosing regimens, taking into account FDA safety recommendations in product labeling and other safety concerns; sufficient quantities to allow for an extra inhaler at school or place of business for those inhalers (multi-dose inhalers or dry powder inhalers) commonly given as needed for acute treatment of bronchospasm; commercial package sizes; and operational requirements.	Quantity limits are currently in place for the medications in this category, as listed on the TRICARE Management Activity Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#Oral. The rule would represent a change from current quantity limits by allowing an extra inhaler for "rescue" medications for acute treatment of bronchospasm (e.g., albuterol).
Tramadol-containing products Tramadol (Ultram, generics) Tramadol/acetaminophen (Ultracet)	Quantity limits will apply to tramadol-containing products, including new FDA-approved medications and new formulations of existing medications as soon as they become available, and will be adjusted as necessary to accommodate changes in recommended dosing regimens and commercial package sizes available. Quantity limits for these medications will be set based on the following factors: sufficient quantities to allow for recommended dosing regimens, taking into account FDA safety recommendations in product labeling and other safety concerns; commercial package sizes; and operational requirements. These quantity limits would apply collectively to all tramadol-containing products, unless a newly approved product required a more stringent limitation for safety reasons.	A collective quantity limit is currently in place for tramadol (Ultram, generics) and tramadol / acetaminophen (Ultracet) (as listed on the TRICARE Management Activity Pharmacy website at www.tricare.osd.mil/pharmacy/quant_limits.cfm#Miscellaneous), based on FDA safety recommendations in product labeling (maximum of no more than 8 tablets per 24 hour period).
Specific Changes to Quantity Limits		
Dihydroergotamine nasal spray (Migranal)	Change in quantity limits to 16 amps per 30 days; 48 amps per 90 days	Dihydroergotamine nasal spray (Migranal) is used for the treatment of migraine. It comes in a kit with 4 ampules. Each 1 mL ampule contains 4 mg. A dose is 2 (0.5 mg per spray, 1 mg total). The weekly max per FDA safety recommendations is 4 mg; however, a patient may use up to 3 mg in a 24 hour period. A patient may potentially use as many as 4 ampules per week if he or she only uses one dose per ampule. The P&T Committee agreed that the current quantity limits for this medications (30 amps per 30 days; 90 amps per 90 days) are too high, and recommended changing them to 16 amps per 30 days; 48 amps per 90 days.

Medications	Committee Recommendation	Comments
Azelastine nasal spray (Astelin)	Establishment of quantity limits: 1 bottle per 30 days or 3 bottles per 90 days	Azelastine (Astelin) is an antihistamine indicated for the treatment of seasonal allergic rhinitis and vasomotor rhinitis. It is packaged in bottles containing approximately 200 sprays (about 1 months supply). Based on the precedent for quantity limits for other nasal inhalers for the treatment of allergic and nonallergic rhinitis, the P&T Committee recommended a quantity limit of 1 bottle per 30 days; 3 bottles per 90 days.
Tazarotene 0.05% and 0.1% cream (Tazorac)	Establishment of quantity limits: 60 gm (1 large tube) per 30 days or 180 gm (3 large tubes) per 90 days	Currently, quantity limits exist for tazarotene (Tazorac) gel, but not for tazarotene (Tazorac) cream. Both formulations are used for the treatment of acne and psoriasis. The P&T Committee agreed that tazarotene (Tazorac) cream should have a quantity limit consistent with that currently in place for tazarotene gel, which equates to 1 large tube per 30 days, 3 large tubes per 90 days. The P&T Committee noted that tazarotene cream is also available by the brand name Avage, which is not a covered benefit under TRICARE, since the sole FDA-approved indication is for wrinkling, hypopigmentation, and lentigines (age spots).
Azithromycin (Zithromax) 250- and 600-mg tablets	Deletion of quantity limits	The P&T Committee agreed that while azithromycin 250 mg is a costly, widely used antibiotic that has a high potential for inappropriate use, most of that inappropriate use is for the treatment of viral infections. The existence of a quantity limit is unlikely to influence such use. The P&T Committee also did not see the need for a quantity limit for the 600-mg strength of azithromycin, which is less commonly used and unlikely to be inappropriately prescribed, particularly since the quantity limit currently in place is not adequate for the treatment of disseminated Mycobacterium avium complex (MAC) disease.
Dornase alpha inhalation solution (Pulmozyme)	Deletion of quantity limit	This product is given by nebulization once to twice daily for the treatment of cystic fibrosis. Based on previous DoD P&T Committee minutes, the current quantity limits were set to allow for an alternative dosing regimen (4 ampules twice daily, two weeks on, two weeks off). It is not clear that this regimen is currently in clinical use. Since the quantity limits are probably set too high to influence use and since the potential for inappropriate use is unclear for this specialized indication, the P&T Committee recommended deleting the quantity limit for dornase alpha.

Medications	Committee Recommendation	Comments
Fluconazole (Diflucan, generics) 150 mg tablets	Deletion of quantity limit	Historically, the 150 mg tablet of fluconazole was far more costly than other strengths since it was intended and specially packaged for single-dose use for the treatment of vaginal candidiasis. Since fluconazole is available as 50-, 100-, and 200-mg tablets, there was no justification for using the 150-mg tablets for other indications, which typically require daily dosing. Fluconazole 150 mg tablets are now generically available and available at a much lower cost ($6.63 per tablet in 2001 for brand name Diflucan vs. $0.18 in Feb 05 for the generic equivalent, based on FSS prices). Although there is still little reason to use the 150 mg strength of fluconazole for other indications, the P&T Committee agreed that the cost differential between the strengths no longer warrants the existence of a specific quantity limit.
Imiquimod cream (Aldara)	Deletion of quantity limit	Imiquimod has a long-standing FDA indication for genital/perianal warts (3 times per week for maximum of 16 weeks) and two new indications, for actinic keratoses (2 times per week for 16 weeks) and superficial basal cell carcinoma (5 times per week for 6 weeks). Labeling for superficial basal cell carcinoma recommends dispensing no more than 3 boxes (36 individual packets) per 6-week treatment period. The current quantity limit for imiquimod is for 12 packets per 30 days or 36 packets per 90 days, which is not adequate for superficial basal cell carcinoma based on approved dosing. Imiquimod is a costly medication and the potential for wastage appears relatively high. Given the new indication, however, the P&T Committee recommended deleting the quantity limit for imiquimod. They requested that the PEC monitor imiquimod utilization for excessive use.
Testosterone buccal system (Striant)	Deletion of quantity limit	This product is the only testosterone replacement product for which a specific quantity limit is listed. This dosage form does not appear to be any more likely to be used inappropriately than other testosterone replacement products.

Appendix B – Newly Approved Drugs

Medication & Mechanism of Action	FDA approval date; FDA-approved indications	Committee Recommendation
Acamprosate (Campral) tabs; Forest; glutamate receptor modulator (alcohol deterrent)	Jul 04: Maintenance of abstinence from alcohol in patients with alcohol dependence who are abstinent at treatment initiation. Treatment with Campral should be part of a comprehensive management program that includes psychosocial support.	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.
Apomorphine (Apokyn) SQ injection; Bertek ; dopamine agonist	April 04: Acute, intermittent treatment of hypomobility, "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) associated with advanced Parkinson's Disease. Has been studied as an adjunct to other medications. Note: Not available at TMOP due to controlled distribution requirements.	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.
Duloxetine (Cymbalta) capsules; Eli Lilly; serotonin norepinephrine reuptake inhibitor (SNRI)	Aug 04: Treatment of major depressive disorder (MDD). Also indicated for management of neuropathic pain associated with diabetic peripheral neuropathy.	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.
Erlotinib (Tarceva) tabs; Genentech / OSI; human epidermal growth factor receptor type 1 (HER1/EGFR1) tyrosine kinase inhibitor	Nov 04: Treatment of patients with locally advanced or metastatic non-small cell lung cancer after failure of at least one prior chemotherapy regimen.	Quantity limits recommended due to precedent set by the other HER1/EGFR1, gefitinib (Iressa); potential for wastage; and high cost: Limit of 30 day supply in retail, 45 day supply in TMOP, up to 45 day supply in MTFs. No multiple fills for multiple cost shares in retail and TMOP. Consideration of Uniform Formulary status deferred until drug class is reviewed.
Ezetimibe / simvastatin (Vytorin) tabs; Merck Schering Plough; cholesterol absorption inhibitor plus statin	Aug 04: Primary Hypercholesterolemia: Indicated as adjunctive therapy to diet for the reduction of elevated total-C. LDL-C, Apo B, TG and non-HDL-C, and to increase HDL-C in patients with primary (heterozygous familial and non-familial) hypercholesterolemia or mixed hyperlipidemia. Homozygous Familial Hypercholesterolemia: Indicated for the reduction in elevated total-C and LDL-C in patients with homozygous familial hypercholesterolemia, as an adjunct to other lipid-lowering treatments (e.g., LDL apheresis) or if such treatments are unavailable.	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.

Medication & Mechanism of Action	FDA approval date; FDA-approved indications	Committee Recommendation
Gemifloxacin (Factive) tabs; Oscient; fluoroquinolone antibiotic	April 03: Community-acquired pneumonia (includes multi-drug resistant strains of *Strep. pneumoniae);* and acute exacerbations of chronic bronchitis	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed. Quantity limits recommended based on the maximum 7-day course of therapy and FDA safety recommendations noting a much higher incidence of rash—which can be severe—if treated for more than 10 days. The product is packaged only in 5s and 7s. Recommendation: Limit of 7 days supply (one course of therapy) per 30 days in retail, TMOP, and MTFs.
Lanthanum carbonate (Fosrenol) chewable tabs; Shire Phosphate binder (rare earth metal; trivalent cation)	Oct 04: Indicated to reduce serum phosphate in patients with End Stage Renal Disease (ESRD)	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.
Overactive Bladder Medications		
Darifenacin (Enablex) sustained release tabs; Novartis; muscarinic antagonist	Dec 04: Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency and frequency	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.
Solifenacin (Vesicare) tabs; GSK/Yamanouchi; muscarinic antagonist	Nov 04: Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency and frequency	
Trospium (Sanctura) tabs; Indevus; muscarinic antagonist	May 04: Treatment of overactive bladder with symptoms of urge urinary incontinence, urgency and frequency	
Rifaximin (Xifaxan) tabs; Salix; rifampin derivative antibiotic (nonabsorbed)	May 04: Treatment of patients $\geq$12 years of age with traveler's diarrhea caused by non-invasive strains of *Escherichia coli.* Rifaximin should not be used in patients where *Campylobacter jejuni, Shigella* spp, or S*almonella* spp are suspected as causative pathogens. Rifaximin should not be used for diarrhea complicated by fever of bloody stools. (Orphan status for hepatic encephalopathy)	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.

Medication & Mechanism of Action	FDA approval date; FDA-approved indications	Committee Recommendation
Telithromycin (Ketek) tabs; Sanofi-Aventis; ketolide / macrolide antibiotic	April 04: Treatment of patients 18 years and older with the following conditions: community-acquired pneumonia due to *Streptococcus pneumoniae* (includes multi-drug resistant isolates [MDRSP]*), Haemophilus influenzae, Moraxella catarrhalis, Chlamydophila pneumoniae,* or *Mycoplasma pneumoniea***;** acute exacerbations of chronic bronchitis (AECB) due to *Streptococcus pneumoniae, Haemophilus influenzae*, or *Moraxella catarrhalis***;** sinusitis due to *Streptococcus pneumoniae, Haemophilus influenzae*, or *Moraxella catarrhalis* or *Staphylococcus aureus.*	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.
Tinidazole (Tindamax) tabs; Presutti Labs; anti-protozoal antibiotic	May 04: Treatment of trichomoniasis in post-pubertal female and male patients caused by *T. vaginalis*; giardiasis caused by *G. duodenalis* (also termed *G. lamblia*) in both adults and pediatric patients**;** intestinal amebiasis (amebic dysentery) and amebic liver abscess caused by *E. histolytica* in both adults and pediatric patients older than 3 years of age.	No Uniform Formulary recommendation at this meeting. Consideration of Uniform Formulary status deferred until drug class is reviewed.