DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS
November 2008

1) CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on 18 November 2008 and at 0730 on 19 November 2008 at the DoD Pharmacoeconomic Center (PEC), Fort Sam Houston, Texas.

2) ATTENDANCE

The attendance roster is found in Appendix A.

3) REVIEW MINUTES OF LAST TWO MEETINGS

A. Updates to the minutes — Updates to the June 2008 DoD P&T Committee meeting minutes for the reviewed drug classes' implementation dates were discussed. Implementation dates from the June 2008 meeting for the designated non-formulary drugs delayed to 26 November 2008.

B. Approval of August minutes — S. Ward Casscells, III, MD, approved the minutes of the August 2008 DoD P&T Committee meeting on 24 October 2008.

C. Interim October meeting — An interim teleconference meeting was held on 27 October 2008 to re-analyze the cost effectiveness of the triptan drug class for Uniform Formulary (UF) placement. The recommendations from the interim meeting were reviewed by CDR James Ellzy. The Committee agreed to maintain the original medical necessity (MN) criteria and implementation date (90 days; 26 November 2008). The minutes are under review by TMA.

4) REVIEW OF RECENTLY FDA APPROVED AGENTS

A. Re-review of Antidepressant-1 (AD-1) - Desvenlafaxine (Pristiq)

The committee re-reviewed the cost-effectiveness and Uniform Formulary (UF) status of desvenlafaxine (Pristiq) that was originally conducted at the August 2008 meeting. Manufacturers were offered the opportunity to re-submit Uniform Formulary Voluntary Agreement for Retail Refunds (UF VARR) submissions that exceeded the Federal Ceiling Price. A revised UF VARR was submitted for desvenlafaxine. The August 2008 DoD P&T Committee meeting minutes were originally signed by the Director, TMA on 24 October 2008.

Relative Clinical Effectiveness — The committee agree that there was no reason to repeat the review since there was no significant new information in the intervening three months. The relative clinical effectiveness of desvenlafaxine (Pristiq) was reviewed at the August 2008 meeting. Desvenlafaxine (Pristiq) is a Serotonin Norepinephrine Reuptake Inhibitor (SNRI) that is included in the Antidepressant-1 (AD-1) drug class. The AD-1 drug class was originally reviewed for UF placement in November 2005. Desvenlafaxine is an extended release (ER) formulation of the major active metabolite of venlafaxine ER (Effexor XR), and is approved solely for treating major depressive disorder in adults. Generic formulations of venlafaxine ER are

expected in 2010.

Relative Clinical Effectiveness Conclusion — At the November 2008 meeting the committee agreed to accept the conclusion from the August 2008 meeting. August 2008 P&T Committee meeting members concluded (15 for, 0 opposed, 0 abstained, 0 absent) that desvenlafaxine does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcomes over other AD-1 agents currently included on the UF. A review of the literature from August 2008 to the present found no new data to alter the previous clinical conclusion.

Cost Effectiveness — A cost minimization analysis (CMA) was used to evaluate the cost effectiveness of desvenlafaxine relative to the UF AD-1s: citalopram (Celexa, generics), sertraline (Zoloft, generics), venlafaxine immediate release (Effexor, generics), venlafaxine ER (Effexor XR), and the nonformulary (NF) AD-1s bupropion ER (Wellbutrin XL, generics), and duloxetine (Cymbalta). The analysis included pricing to reflect the offered UF VARR. Results of the CMA showed that the projected weighted average daily cost of desvenlafaxine was significantly higher than the current market drug mix of AD-1 class comparators, when future market conditions were considered.

Relative Cost Effectiveness Conclusion — The P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) that desvenlafaxine (Pristiq) is not cost effective relative to the other AD-1s included on the UF when future market conditions were considered.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** — Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations, and other relevant factors, the P&T Committee, based upon its collective professional judgment, recommended (13 for, 2 opposed, 1 abstained, 0 absent) that desvenlafaxine (Pristiq) remain designated as nonformulary on the UF. This recommendation was based on the clinical effectiveness conclusion and the cost determination when future market conditions were considered. Citalopram, sertraline, venlafaxine, and venlafaxine ER (Effexor XR) remain the most cost effective AD-1 agents on the UF compared to desvenlafaxine.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

2) ***COMMITTEE ACTION: MEDICAL NECESSITY (MN) CRITERIA*** —At the November 2008 meeting the Committee agreed to maintain the original MN criteria from the August 2008 meeting. Based on the clinical evaluation of desvenlafaxine and the conditions for establishing MN of a nonformulary medication provided for in the UF rule, the P&T Committee recommended in June 2008 (June vote:14 for, 0 opposed, 1 abstained, 0 absent) MN criteria for desvenlafaxine (Pristiq). (See Appendix B for full MN criteria.)

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** —At the November 2008 meeting the committee agreed not to change the original 60-day implementation period from the August 2008 meeting (August vote: of 14 for, 0 opposed, 1 abstained, 0 absent). The implementation date will be effective 07 January 2009. TMA will send a letter to beneficiaries affected by this UF decision.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

5) DRUG CLASS REVIEW — SHORT-ACTING BETA AGONISTS (SABAs)

Relative Clinical Effectiveness — The P&T Committee evaluated the clinical effectiveness of the inhaled Short-Acting Beta Agonists (SABAs). There are four SABA products marketed in the US that are formulated as pressurized metered dose inhalers (MDIs) or solutions for inhalation: albuterol (a racemic mixture), levalbuterol (the (R)-enantiomer form of albuterol), metaproterenol, and pirbuterol. The SABA inhaled solutions include albuterol (Accuneb, generics; various concentrations), levalbuterol (Xopenex), and metaproterenol (Alupent, generics).

As of 31 December 2008, hydrofluoroalkane (HFA) will replace chlorofluorocarbon (CFC) as the propellant in albuterol MDIs. The SABA MDI formulations include albuterol HFA (Ventolin HFA, Proventil HFA, ProAir), levalbuterol HFA (Xopenex), and pirbuterol (Maxair). Generic formulations of albuterol MDI and metaproterenol CFC (Alupent) using the CFC propellant are no longer manufactured, but supplies have not yet been exhausted. The three albuterol HFA products are not considered therapeutically interchangeable by the FDA.

In the past fiscal year, over $43M was spent on the SABAs at all three points of service in the Military Health System (MHS), with $30M spent in TRICARE Pharmacy Retail Network (TRRx), $10M in the Military Treatment Facilities (MTFs), and $3M in the TRICARE Mail Order Pharmacy (TMOP). In terms of numbers of prescriptions dispensed in the MTFs, Proventil HFA is the highest utilized SABA, followed by Xopenex HFA, Ventolin HFA, and Proair HFA. In the TRRx, the top three drugs in terms of numbers of prescriptions dispensed are generic albuterol CFC MDI (but has declining usage due to dwindling stock), ProAir HFA MDI, and Xopenex HFA MDI.

Information regarding the safety, effectiveness, and clinical outcomes of the SABAs was considered by the Committee. The clinical review included, but was not limited to, the requirements stated in the UF Rule, 32 CFR 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 outcomes over the pharmaceutical agents included on the UF in that therapeutic class. The clinical effectiveness review for the SABAs was limited to the outpatient setting; emergency department (ED) use was evaluated only when pertinent.

Relative Clinical Effectiveness Conclusion — The P&T Committee voted (16 for, 0 opposed, 0 abstained, 0 absent) to accept the following clinical effectiveness conclusion:

a) In terms of efficacy/clinical effectiveness, there is little evidence to suggest there are clinically significant differences between agents for their FDA approved indications. Other conclusions regarding efficacy include the following:

- Clinical Practice Guidelines – Evidence based guidelines from the VA/DoD Clinical Practice Group, Global Initiative for Asthma, National Heart, Lung and Blood Institute/National Asthma Education & Prevention Program, and Global Initiative for Chronic Obstructive Lung Disease do not list a preference for one SABA over another for treating asthma, exercise-induced bronchospasm (EIB) or chronic obstructive pulmonary disease (COPD).
- Asthma
  - *MDI and inhalation solution administration – placebo-controlled studies*: For asthma, all the SABA agents were more efficacious than placebo at improving the change in forced expiratory volume in one second (FEV1) $\geq$ 12% from baseline, whether administered via MDI or inhalational solution.
  - *MDI administration – albuterol vs. levalbuterol*: There are no studies in adults or children assessing efficacy of albuterol vs. levalbuterol when administered by metered-dose inhaler in the outpatient setting.
  - *Inhalation administration – albuterol vs. levalbuterol in adults:* For adults with asthma, there is little evidence to suggest there are clinically relevant differences between albuterol and levalbuterol when administered via inhaled solutions (e.g., nebulized route) in either the outpatient or emergency department (ED) settings in terms of number of puffs of rescue medication used daily or hospitalization admission rates from the ED.
  - *Inhalation administration – albuterol vs. levalbuterol in children*: There are conflicting and inconclusive results as to whether there are efficacy differences between albuterol and levalbuterol inhalation solution when administered in the outpatient or ED settings to children with asthma. Some studies reported no clinically significant differences in outcomes such as changes in asthma symptom score, symptom-free days, rescue medication use, and hospitalization rates between albuterol and levalbuterol. However, levalbuterol treatment resulted in statistically significant results in terms of more asthma-controlled days, higher quality of life scores, and lower hospitalization admission rates from the

ED compared to albuterol. Interpretation of the results of these studies is complicated by the low patient enrollment, varying definitions of criteria for hospitalization, and enrollment of patients as old as 18-21 years.

- EIB – Placebo controlled trials with albuterol administered via MDI 15 to 30 minutes before exercise reported statistically significant results in terms of preventing exercise-related symptoms compared to placebo. Although levalbuterol MDI (Xopenex) is not currently approved by the FDA for EIB, the results of placebo-controlled phase III trials do not suggest that the effect of levalbuterol at preventing EIB symptoms would differ from albuterol.
- COPD - There is insufficient evidence to compare the SABAs when used in COPD.
- CFC vs. HFA efficacy - HFA products were as effective as CFC products when evaluated in head-to-head studies. Placebo-controlled trials assessing efficacy of HFA albuterol with CFC albuterol have reported similar effects on percentage change in FEV1.

b) With regards to safety/tolerability, the following conclusions were made:

- *Discontinuation rates due to adverse events (AEs)* - SABAs are associated with similar systemic adverse effects. A systematic review found no clinically relevant differences in discontinuation rates due to changes in heart rate, blood pressure, palpitations, nervousness, anxiety, tremor, hyperglycemia or hypokalemia between albuterol and levalbuterol inhalation solution.
- *Rare but serious AEs* – There do not appear to be clinically relevant differences between the SABAs in terms of serious adverse effects (e.g., paradoxical bronchospasm, cardiac effects).
- *Inhalation solution administration – albuterol vs. levalbuterol* - In the outpatient setting, in both adults and children, the incidence of the withdrawal rates due to AEs and overall AE rates were similar between albuterol and levalbuterol inhaled solutions. However, in children there is insufficient evidence from the outpatient studies to determine whether there are clinically relevant differences in the incidence of tachycardia, as conflicting results were reported. One study reported a lower incidence of tachycardia with albuterol compared to levalbuterol, while another reported that both drugs resulted in a change of heart rate of 4 beats per minute.
- *MDI administration – albuterol vs. levalbuterol* - There is insufficient data with the SABA MDI formulations to assess safety differences between albuterol and levalbuterol.
- *Drug-Drug interactions*- Drug-drug interactions between the SABAs are well-known and considered a class effect.
- *FDA Adverse Event Reporting System (AERS)* – FDA AERS data shows higher signals than expected with device malfunction/failure for Proair HFA MDI and Proventil HFA MDI. However, this is observational data only and these safety signals have not been validated.

c) With regards to differences between the SABAs in terms of other factors, the following conclusions were made:

- Special populations – The Committee recognized that the pediatric FDA-approved age ranges differ between the products. All four SABAs are labeled as category C drugs for pregnancy and breast feeding, and infant risk cannot be ruled out.
- CFC Phase out – By 31 December 2008, all albuterol CFC metered-dose inhalers will no longer be available. Metaproterenol CFC MDIs (Alupent) will also cease manufacturing by the end of 2008. It is likely that pirbuterol CFC MDIs (Maxair) will also be removed from the market.
- HFA formulations - There are only minor differences between the HFA formulations of albuterol and levalbuterol, including presence of a dose counter (Ventolin HFA is the only product with a dose counter), requirements for priming, storage conditions, and excipients (Ventolin HFA is the only SABA that does not contain alcohol). However, per FDA ruling, the HFA albuterol agents are not interchangeable.
- Delivery devices - There are no clinically relevant difference among the SABAs in terms of alternative delivery devices (MDI with a spacer/holding chamber, nebulizer, dry powder inhalers) compared with a standard MDI in stable asthma or COPD.
- Provider Survey – A survey of MTF providers found that albuterol HFA MDI was preferred over levalbuterol HFA MDI (Xopenex) in the outpatient setting for relief of bronchospasm.

COMMITTEE ACTION: The P&T Committee voted (16 for, 0 opposed, 0 abstained, 0 absent) to accept the clinical effectiveness conclusions stated above.

Relative Cost Effectiveness — In considering the relative cost-effectiveness of pharmaceutical agents in the SABA drug class, the P&T Committee evaluated the costs of the agents in relation to the efficacy, safety, tolerability, 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 CFR 199.21(e)(2). Cost minimization analysis (CMA) and budget impact analysis (BIA) were used to evaluate the cost effectiveness of the SABA agents.

Relative Cost Effectiveness Conclusion - Based on the results of the cost analyses and other clinical and cost considerations, the P&T Committee concluded the following:

a) Results from the CMA of SABA MDIs revealed that Ventolin HFA was the most cost effective SABA MDI agent overall.

b) Results from the CMA of SABA inhalant solutions revealed that albuterol inhalation solution (generic; 2.5 mg/3mLconcentration) was the most cost effective agent overall.

c) The potential impact of scenarios with selected SABA agents designated formulary or nonformulary on the UF was evaluated with the BIA. Albuterol CFC

inhaler and metaproterenol inhaler were not included in the BIA as they are no longer being manufactured. BIA results designated pirbuterol (Maxair) CFC MDI and metaproterenol inhalant solution (generic) nonformulary on the UF as the most favorable scenario for the MHS.

COMMITTEE ACTION: The P&T Committee voted (16 for, 0 opposed, 0 abstained, 0 absent) to accept the cost effectiveness conclusions stated above.

A. ***COMMITTEE ACTION: UF RECOMMENDATION*** — In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the SABA agents, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (14 for, 1 opposed, 1 abstained, and 0 absent) to recommend that:

1. Albuterol HFA inhaler (Ventolin HFA, Proventil HFA, Proair HFA), levalbuterol inhaler (Xopenex HFA), albuterol inhalation solution (Accuneb, generics), and levalbuterol inhalant solution (Xopenex unit dose nebulizer solution) be classified as formulary on the UF; and
2. Pirbuterol CFC inhaler (Maxair) and metaproterenol inhalation solution (Alupent, generics) be designated as nonformulary on the UF, based on cost effectiveness.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. ***COMMITTEE ACTION: MN CRITERIA*** — Based on the clinical evaluation for pirbuterol inhaler (Maxair)and metaproterenol inhalation solution (Alupent, generics), and the conditions for establishing medical necessity for a nonformulary medication provided for in the UF rule, the P&T Committee recommended (14 for, 0 opposed, 1 abstained, 1 absent) MN criteria for pirbuterol inhaler (Maxair) and metaproterenol inhalation solution (Alupent, generics). Albuterol CFC inhaler and metaproterenol CFC inhaler (Alupent) will not be included on the MN criteria as they will not be available after 31 Dec 08. (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

C. ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** — The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 1 absent) 1) an effective date of the first Wednesday one week following a 60-day implementation period in the TMOP and TRRx, and at the MTFs no later than a 60-day implementation period; and 2) TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin the first Wednesday one week following approval by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

D. COMMITTEE ACTION: BCF RECOMMENDATION — The P&T Committee considered the BCF status of the SABA agents. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (15 for, 0 opposed, 1 abstained, and 0 absent) to recommend that albuterol inhalant solution (generics, excludes Accuneb and the 0.5% [2.5 mg/0.5ml] unit dose vial) and the Ventolin HFA brand of albuterol HFA MDI be designated as BCF immediately on signing of the November 2008 P&T Committee minutes by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

E. COMMITTEE ACTION: QUANTITY LIMITS - The P&T Committee updated the quantity limits (QLs) for the SABAs. The P&T Committee voted (15 for, 0 opposed, 1 abstained, and 0 absent) to recommend the QLs outlined in Appendix E.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

6) DRUG CLASS REVIEW — NASAL ALLERGY DRUGS (NADs)

Relative Clinical Effectiveness — The P&T Committee evaluated the clinical effectiveness of the Nasal Allergy Drugs (NADs). The class is comprised of three subclasses as listed below. The nasal corticosteroids were previously reviewed for UF placement in November 2005 and August 2007.

- *Nasal corticosteroids*: beclomethasone (Beconase AQ), budesonide (Rhinocort AQ), ciclesonide (Omnaris), flunisolide (Nasarel, generics), fluticasone furoate (Veramyst), fluticasone propionate (Flonase, generics), mometasone furoate (Nasonex), and triamcinolone (Nasacort AQ)
- *Nasal Antihistamines*: azelastine (Astelin) and olopatadine (Patanase)
- *Nasal Anticholinergics*: ipratropium (Atrovent, generics)

Information regarding the safety, effectiveness, and clinical outcomes of these drugs was considered. The clinical review included, but was not limited to, the requirements stated in the UF Rule, 32 CFR 199.21(e)(1).

MHS expenditures for the NAD class exceeded $63M in FY 2008 (MTF: $18.6M, TRRx $37.5M, TMOP $7M). In terms of numbers of prescriptions dispensed, generic fluticasone propionate (Flonase) is the highest utilized nasal allergy drug in the MTFs,

followed by mometasone furoate (Nasonex), and azelastine (Astelin). This utilization pattern is also seen in the TRRx.

Relative Clinical Effectiveness Conclusion — The P&T Committee voted (16 for, 0 opposed, 0 abstained, 0 absent) to accept the following clinical effectiveness conclusion:

Nasal corticosteroids

a) With regards to efficacy/clinical effectiveness of the nasal corticosteroids, the following conclusions were made:

- FDA-approved indications – The Committee recognized that there were minor differences among the drugs with regard to FDA-approved uses for seasonal allergic rhinitis (SAR), perennial allergic rhinitis (PAR), prophylaxis of allergic rhinitis (AR) symptoms, nonallergic rhinitis, and nasal polyps. Additionally, the pediatric FDA-approved age ranges differ between the products.
- Clinical Practice Guidelines – Evidence-based guidelines from the American Academy of Allergy, Asthma and Immunology (AAAAI) consider the nasal corticosteroids as the most effective drug class at reducing allergic rhinitis symptoms of sneezing, rhinorrhea, nasal congestion, and itching.
- Pharmacodynamic/pharmacokinetic properties – The AAAAI guidelines concluded that despite differences in topical potency, lipid solubility, receptor binding affinity, and systemic bioavailability, the overall clinical response does not appear to vary significantly between drugs.
- Efficacy for SAR/PAR – The Committee concluded there was no new data to change the previous conclusion from the 2005 meeting that there was no evidence of clinically relevant differences between beclomethasone, budesonide, flunisolide, fluticasone propionate, mometasone, and triamcinolone at relieving AR symptoms.
- Efficacy of newer agents – Fluticasone furoate (Veramyst) was non-inferior to fluticasone propionate (Flonase, generics) at relieving symptoms of SAR; there was no new data to change this conclusion. The newest nasal corticosteroid, ciclesonide (Omnaris) does not have published data comparing efficacy to other nasal corticosteroids. Placebo-controlled trials with ciclesonide report statistically significant improvements in patients with SAR and PAR.
- Relief of ocular symptoms - None of the nasal corticosteroids are FDA-approved for use in reducing ocular symptoms of itching, tearing or erythema. However, all of the agents, with the exception of ciclesonide, have shown efficacy at reducing ocular symptoms in placebo-controlled trials.
- Nasal polyps – Data from clinical trials conducted with beclomethasone, budesonide, and fluticasone propionate report reductions in the size of nasal polyps. Both mometasone furoate and beclomethasone are FDA-approved for nasal polyps.

b) With regards to regards to safety and tolerability, the following conclusions were made:

- Local effects - Nasal irritation, epistaxis, and rhinorrhea are the most common local AEs and are equally likely to occur with any of the nasal corticosteroids.
- Pharmacodynamic/pharmacokinetic properties – Minor differences in binding affinity, lipophilicity, and bioavailability between the products have not correlated to clinically relevant differences in safety. Pharmacokinetic studies report that the newer agents would be expected to pose fewer risks than the older agents (flunisolide, beclomethasone, budesonide, and triamcinolone).
- Systemic effects- For systemic effects of hypothalamic pituitary adrenal-axis suppression, growth suppression, and cataract formation, there is insufficient evidence to determine whether one nasal corticosteroid is more likely to cause these effects than another. When given in recommended doses, the nasal corticosteroids are not generally associated with clinically significant systemic adverse effects. Providers and patients must assess the risks to benefits, if higher than recommended doses are required.
- Tolerability and patient preferences - Patient preferences may play a role in differentiating between the nasal corticosteroids. However, the available clinical data is poor, and no nasal corticosteroid has proven superior to the others in patient preference trials. More well-designed head-to-head trials are needed to support superiority of a nasal corticosteroid based on tolerability and compliance.

c) With regards to differences in other factors, the following conclusions were made:

- Special populations – Budesonide (Rhinocort AQ) is the only nasal corticosteroid with a pregnancy category B rating by the FDA (low evidence of risk to humans), which was based on a retrospective review of data from three Swedish registries and one prospective study. All the nasal corticosteroids have a class labeling that these drugs should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Provider survey – A survey of MTF providers found that the majority of prescribers (49%) preferred fluticasone propionate (Flonase, generics) as their first choice of nasal corticosteroid, followed by no preference (17%), and mometasone (15%). Providers showed no preference for differences in formulations between the products (e.g., hypotonic formulation, ergonomic design, prodrug active ingredient, scent-free product, or preservative-free product).

Nasal antihistamines

a) With regards to efficacy/clinical effectiveness of the nasal antihistamines, the following conclusions were made:

- FDA-approved indications – The Committee recognized that there were minor differences between olopatadine (Patanase) and azelastine (Astelin) with

regard to FDA-approved uses for SAR and nonallergic rhinitis (e.g., vasomotor rhinitis [VMR]), and pediatric approval.

- Clinical Practice Guidelines – AAAAI guidelines state that nasal antihistamines are generally less effective than nasal corticosteroids for treating AR, but may be considered for use as first-line treatment for AR and nonallergic rhinitis. Nasal antihistamines are associated with a clinically significant effect on nasal congestion.
- Efficacy for SAR – Both nasal antihistamines are superior to placebo in relieving symptoms of SAR. Determining whether there are relevant clinical differences in efficacy between olopatadine and azelastine is difficult because different rating scores were used in the individual placebo-controlled trials.
- Efficacy for VMR: Only azelastine is FDA-approved for treating the symptoms of VMR, which consist of postnasal drip, sneezing, rhinorrhea, and nasal congestion. FDA-approval was based on the results of two placebo-controlled studies in 200 patients that used a rating scale not previously seen in the literature.
- Head to head study- The one head-to-head trial comparing the use of olopatadine with azelastine was conducted in an allergan exposure unit, making applicability to the clinical setting difficult.

b) With regards to safety and tolerability of the nasal antihistamines, the following conclusions were made:

- Local adverse effects: package insert data- For safety data, package insert data report a higher incidence of bitter taste and somnolence with azelastine, while olopatadine has a higher incidence of epistaxis.
- Local adverse effects: AAAAI guidelines – the AAAAI guidelines recognize that the two nasal antihistamines can cause sedation and can inhibit skin test reactions, due to systemic absorption.
- Patient preferences and tolerability – There is insufficient evidence to determine whether clinically relevant differences exist between the nasal antihistamines with respect to patient preferences and tolerability. The available clinical data is sparse, and is limited to manufacturer-sponsored studies that are not yet available in peer-reviewed publications.

c) With regards to other factors,

- Provider survey - A survey of MTF providers found that 37% of responders preferred a nasal corticosteroid over a nasal antihistamine for managing AR and nonallergic rhinitis.
- Onset and duration of action – The Committee recognized that the onset of action to relieve AR symptoms was slightly faster with olopatadine compared to the package insert data for azelastine (0.5 - 1 hour vs. 2-3 hours). However, the onset of action with both nasal antihistamines is faster than that reported overall with nasal corticosteroids (2-3 days).

Nasal anticholinergic agents

a) With regards to efficacy/clinical effectiveness, safety, tolerability and other factors of the ipratropium nasal spray (Atrovent, generics), the following conclusions were made:

- FDA-approved indications – Ipratropium is solely indicated for the relief of SAR in adults and children 12 years of age and older.
- Clinical Practice Guidelines – AAAAI guidelines state that nasal anticholinergics may effectively reduce rhinorrhea, but have no effect on other nasal symptoms. Although AEs are minimal, dryness of the nasal membranes may occur.
- Efficacy - Further head-to-head trials are needed to prove the superiority of a nasal anticholinergic over a nasal antihistamine or nasal corticosteroid in the treatment of rhinorrhea.

COMMITTEE ACTION: The P&T Committee voted (16 for, 0 opposed, 0 abstained, 0 absent) to accept the clinical effectiveness conclusions stated above.

Relative Cost Effectiveness – In considering the relative cost-effectiveness of pharmaceutical agents in the NAD drug class, the P&T Committee evaluated the costs of the agents in relation to the efficacy, safety, tolerability, 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 CFR 199.21(e)(2). CMA and BIA were used to evaluate the cost effectiveness of the NAD agents.

Relative Cost Effectiveness Conclusion — Based on the results of the cost analyses and other clinical and cost considerations, the P&T Committee concluded (16 for, 0 opposed, 0 abstained, 0 absent) the following:

a) Results from the CMA of nasal corticosteroid agents revealed that flunisolide was the most cost effective nasal corticosteroid agent overall.

b) Results from the CMA of nasal antihistamines agents revealed that azelastine was the most cost effective nasal antihistamine agent overall.

COMMITTEE ACTION: The P&T Committee voted (16 for, 0 opposed, 0 abstained, 0 absent) to accept the cost effectiveness conclusions stated above.

A. ***COMMITTEE ACTION: UF RECOMMENDATION*** — In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the NADs, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (14 for, 1 opposed, 1 abstained, and 0 absent) to recommend that:

1) Fluticasone propionate (Flonase, generics), flunisolide (Nasarel generics), mometasone (Nasonex), azelastine (Astelin), and ipratropium nasal spray (Atrovent, generics) be classified as formulary on the UF.

2) Beclomethasone dipropionate (Beconase AQ), budesonide (Rhinocort Aqua), ciclesonide (Omnaris), fluticasone furoate (Veramyst), olopatadine HCl (Patanase), and triamcinolone acetonide (Nasacort AQ) be designated as nonformulary under the UF, based on cost effectiveness.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. COMMITTEE ACTION: MN CRITERIA — Based on the clinical evaluation for Beclomethasone dipropionate (Beconase AQ), budesonide (Rhinocort Aqua), ciclesonide (Omnaris), fluticasone furoate (Veramyst), olopatadine HCl (Patanase), triamcinolone acetonide (Nasacort AQ), and the conditions for establishing medical necessity for a nonformulary medication provided for in the UF rule, the P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) MN criteria for beclomethasone dipropionate (Beconase AQ), budesonide (Rhinocort Aqua), ciclesonide (Omnaris), fluticasone furoate (Veramyst), olopatadine HCl (Patanase), and triamcinolone acetonide (Nasacort AQ). (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

C. COMMITTEE ACTION: IMPLEMENTATION PERIOD — The P&T Committee recommended (15 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday one week following a 60-day implementation period in the TMOP and TRRx, and in the MTFs, no later than a 60-day implementation period; and 2) TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin the first Wednesday one week following the approval by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

D. COMMITTEE ACTION: BCF RECOMMENDATION — The P&T Committee considered the BCF status of the NADs. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (9 for, 5 opposed, 1 abstained, and 1 absent) to recommend that fluticasone propionate (Flonase, generics) and azelastine (Astelin) be designated as BCF immediately on signing of the November 2008 P&T Committee minutes by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

7) UTILIZATION MANAGEMENT — PRIOR AUTHORIZATIONS (PA)/ Quantity Limits (QL) / MEDICAL NECESSITY (MN)

A. Serotonin subtype 3 receptor-blocking agents – QLs

Palonosetron capsules (Aloxi) – The serotonin subtype 3 receptor-blocking agent (5-HT3 antagonist) palonosetron was previously available only in an intravenous solution. The antiemetic is now approved as a 0.5 mg capsule for the prevention of chemotherapy induced nausea and vomiting (CINV) associated with initial and repeat courses of chemotherapy. It is administered as one capsule one hour prior to moderately emetogenic chemotherapy. There is no published data to support the chronic continuous use of palonosetron for prevention of nausea and vomiting. Palonosetron has the longest half-life of the 5-HT3 antagonists (37 - 48 hours), vs. 4-5 hours with ondansetron, 8 hours with oral granisetron, and 9-11 hours with dolasetron. Quantity limits apply to the other 5-HT3 receptor antagonists. The Committee recommended a QL of 1 capsule per fill in both the TRRx and TMOP, due to the long half-life and limited FDA-approved indication for palonosetron (solely for prevention of CINV). A new prescription would be required for each course of chemotherapy.

Granisetron transdermal (Sancuso) – Granisetron is now available in a new transdermal formulation, in addition to tablets (Kytril, generics) and an oral solution. The transdermal system is approved for the prevention of CINV for patients receiving moderately to highly emetogenic chemotherapy regimens. Granisetron is available as a 34.3 mg patch that delivers 3.1 mg per 24 hours for up to 7 days. It is applied as a single patch to the arm 24 hours prior to receiving chemotherapy, and removed 24 hours after completion of chemotherapy; it can be worn for up to 7 days, depending on the duration of chemotherapy. The Committee recommended a QL of 1 patch per fill in both the TRRx and TMOP, due to the long duration of action and limited FDA-approved indication for granisetron transdermal system (solely for prevention of CINV). A new prescription would be required for each course of chemotherapy.

COMMITTEE ACTION: The Committee voted (15 for, 0 opposed, 1 abstained, 0 absent) to recommend quantity limits for palonosetron of 1 capsule per prescription fill in the TMOP and TRRx, and for granisetron transdermal system of 1 patch per prescription fill in the TMOP and TRRx.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Ciclesonide oral inhaler (Alvesco) – QL: Ciclesonide is an oral inhaled corticosteroid approved for the treatment of asthma in patients 12 year of age and older. It is dosed twice daily. There are existing QLs for the other oral inhaled corticosteroids. The Committee recommended QLs for ciclesonide, consistent with the limits imposed on other inhaled corticosteroids in the class.

COMMITTEE ACTION: The P&T Committee voted (15 for, 0 opposed, 1 abstained, 0 absent) to recommend QLs for ciclesonide oral inhaler of 2 inhalers per 30 days in the TRRx, and 6 inhalers per 90 days in the TMOP.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

8) STATUS OF RAMIPRIL ON THE UF

On an ongoing basis, the DoD PEC monitors changes in the clinical information, current costs and utilization trends to determine whether the UF status of agents designated as non-formulary needs to be readdressed. The P&T Committee reevaluated the UF status of ramipril (Altace, generics) in light of recent price reductions in the generic formulations across all three points of service.

Clinical Effectiveness Conclusion — The angiotensin converting enzyme (ACE) inhibitors were evaluated for UF status at the August 2005 meeting. At that meeting, the Committee concluded, in general, that ramipril had similar clinical effectiveness relative to other ACE inhibitors in regards to efficacy for treating hypertension, safety, and tolerability. The P&T Committee recognized that there were differences in clinical outcomes for myocardial infarction, heart failure, diabetic nephropathy, and patients at high cardiovascular risk.

Cost Effectiveness Conclusion — The P&T Committee voted (16 for, 0 opposed, 0 abstained, 0 absent) that ramipril has similar cost effectiveness relative to the other UF ACE inhibitors.

COMMITTEE ACTION: UF DECISION — Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations, and other relevant factors, the P&T Committee, based upon its collective professional

judgment, voted (15 for, 0 opposed, 1 abstained, and 0 absent) that ramipril be immediately reclassified as generic on the UF. Ramipril was included on the "list of non-formulary drugs for re-evaluation of UF status" presented to the BAP in January 2008 and approved by the Director, TMA on 13 February 2008. As such, no further approval is needed.

9) BASIC CORE FORMULARY / EXTENDED CORE FORMULARIES (ECF) ISSUES

The Committee was briefed at the August 2008 meeting on the efforts to implement electronic prescribing in the MHS. As part of the ongoing plan to systematically review drugs represented on the BCF/ECF, the Committee periodically reviews recommendations for changes to the BCF/ECF. At this meeting, the BCF was reviewed, as greater specificity in the drug listings is required to assist with e-prescribing efforts. Several BCF deletions were recommended by the Committee, due to such factors as low MHS utilization, therapeutic duplication, change in prescribing patterns (e.g., newer therapies causing existing drugs to be outdated), availability of generic formulations, and VA/DoD joint contracts. Appendix F outlines those drugs recommended for deletion from the BCF.

COMMITTEE ACTION: The P&T Committee voted (14 for, 1 opposed, 1 abstained, 0 absent) to recommend the BCF deletions as outlined in Appendix F.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

10) ITEMS FOR INFORMATION

A. Outcomes Research Reports — The Pharmacy Outcomes Research Team (PORT) reported on the status of two large outcomes studies that focused on the effects of UF changes to DoD beneficiaries and are currently underway in conjunction with the MHS Scientific Advisory Panel (SAP).

1) *Hypertension/Diabetes* — The study focuses on hypertension management among DoD beneficiaries with diabetes. One arm is designed to assess the effect of the February 2006 formulary changes in the ACE inhibitor class (i.e., classification of moexipril, moexipril/hydrochlorothiazide (HCTZ), perindopril, quinapril, quinapril/HCTZ, and ramipril as Tier 3 [nonformulary] under the UF) on blood pressure control among DoD beneficiaries receiving care at MTFs. In late October 2008, medical record abstraction for this arm was approximately 81% complete. The study will also assess cardiovascular event and procedure rates among beneficiaries who were receiving Tier 3 (nonformulary) ACE inhibitors before February 2006 and were affected by changes in the formulary status of these agents in comparison to those who were receiving formulary ACE inhibitors. Results of the study will be reported to the DoD P&T Committee in FY09.

2) *Proton Pump Inhibitor (PPI)* — The study assesses the effect of the step therapy/prior authorization program instituted in the PPI class on 24 October 2007. The UF changes placed lansoprazole (Prevacid), omeprazole/sodium bicarbonate (Zegerid) pantoprazole (Protonix), and rabeprazole (Aciphex) in Tier 3 of the UF, with generic omeprazole and branded esomeprazole (Nexium) both available at a $3 copay in TRRx and TMOP. Beneficiaries presenting prescriptions at the retail and mail order points of service for nonformulary (Tier 3) PPIs who had not received a PPI prescription in the last 180 days (new users) were required to first try omeprazole or Nexium or meet MN criteria.

   The study will assess effects of the step therapy/prior authorization program on clinical outcomes (e.g., occurrence of serious gastrointestinal (GI) events) among TRICARE for Life (TFL) beneficiaries (age 65 and older) who were new users of omeprazole or Nexium (and would not have encountered a step therapy rejection) vs. those who were new users of PPIs subject to the step therapy/prior authorization program. The analysis plan for the study is currently under development; final results are expected in FY10.

B. Joint Forces Pharmacy Seminar – LTC Spridgen gave an abridged version of the PEC plenary presentation given at the 2008 Joint Forces Pharmacy Seminar. She highlighted the trends in MHS spending and utilization of the pharmacy benefit. Also identified were trends in MTF formulary management that resulted in significant cost avoidance at the individual points of service (MTF, TMOP, TRRX).

C. National Defense Authorization Act (NDAA) Section 703 Inclusion of TRICARE Retail Pharmacy Program In Federal Procurement Of Pharmaceuticals Update - CAPT Blanche updated the committee on the litigation and status of the final rule that will implement Section 703 of the 2008 NDAA. With regards to the current litigation, the judge had not rendered a decision. The final rule is at the Office of Management and Budget (OMB). Key members from the TMA Pharmacy Operations Department and Office of General Council have met with OMB personnel. The time table for approval and the impact on the DoD P&T process are not known.

11) UF DRUG CLASS OVERVIEWS

The drug class overviews for the Pulmonary I drug class (comprised of the long-acting beta agonists, inhaled corticosteroids, and combination long-acting beta agonists/inhaled corticosteroids), Antilipidemic-Is (statins, ezetimibe, niacin, and combination products) and Fluoroquinolones were presented to the P&T Committee. The Committee provided the PEC with expert opinion regarding those clinical outcomes considered most important to use in completing the clinical effectiveness review and developing appropriate cost effectiveness models. The clinical and economic analyses of this drug class will be completed at upcoming DoD P&T Committee meetings.

12) ADJOURNMENT

The second day of the meeting adjourned at 1100 hours on 19 November 2008. The next meeting will be 18-19 February 2009.

Appendix A – Attendance
Appendix B – Table of Medical Necessity Criteria
Appendix C – Implementation Status of UF Recommendations/Decisions
Appendix D – Table of Abbreviations
Appendix E – Quantity Limit Criteria - SABAs
Appendix F – Basic Core Formulary Deletions

SUBMITTED BY:

Col John Kugler, MC
DoD P&T Committee Chair

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.

2 Feb-09

S. Ward Casscells, III, M.D.

Appendix A – Attendance

Voting Members Present	
COL John Kugler, MC	DoD P&T Committee Chair
LTC Stacia Spridgen, MSC	Director DoD Pharmacoeconomic Center (Recorder)
COL Ted Cieslak, MC	Army, Physician at Large
COL Peter Bulatao *for Col Isiah Harper, MSC*	Army, Pharmacy Officer, Alternate
CAPT Bill Blanche, MSC	Chief, Pharmaceutical Operations Directorate
CAPT Stephanie Simon, MSC	Navy, Pharmacy Officer
CAPT Vernon Lew	Coast Guard, Pharmacy Officer
Col Mark Butler, BSC	Consultant to the AF/SG
LTC Michael Wynn *for LTC Bruce Lovins*	Army, Family Practice Physician, Alternate
LTC Jack Lewi *for COL Doreen Lounsbery*	Army, Internal Medicine Physician, Alternate
CDR Walter Downs, MC *for LCDR Scott Akins*	Navy, Internal Medicine Physician, Alternate
CDR David Tanen, MC	Navy, Physician at Large
Lt Col Brian Crownover, MC	Air Force, Physician at Large
LCDR Ron Garcia	Navy, Internal Medicine Physician
Major Jeremy King, MC	Air Force, OB/GYN Physician
Mr. Joe Canzolino	Department of Veterans Affairs
Voting Members Absent	
LCDR Michelle Perrello, MC	Navy, Internal Medicine Physician
COL Isiah Harper, MS	Army, Pharmacy Officer
Major William Hannah, MC	Air Force, Internal Medicine Physician
LTC Bruce Lovins, MC	Army, Family Practice Physician
LCDR Scott Akins, MC	Navy, Pediatrics Physician Alternate
COL Doreen Lounsbery, MC	Army, Internal Medicine Physician
Nonvoting Members Present	
CDR James Ellzy	DoD P&T Vice Chairman
Lt Col Paul Hoerner	Deputy Director, DoD Patient Safety Center
Ms. Carol Cooper	Deputy General Counsel, TMA
Nonvoting Members Absent	
COL Kent Maneval, MS	Defense Medical Standardization Board
LCDR Thomas Jenkins	TMA Aurora
Maj Peter Trang	Defense Supply Center Philadelphia

Appendix A – Attendance – (continued)

Guests	
LT Joe Bryant	Indian Health Service
Mr. Tom Emmendorfer	Department of Veterans Affairs PBM
Ms. Brenna Mann	University of Texas Pharmacy Student
Others Present	
CDR Matthew Carlberg	DoD Pharmacoeconomic Center
Lt Col James McCrary, MC	DoD Pharmacoeconomic Center
MAJ Misty Carlson, MC	DoD Pharmacoeconomic Center
Maj Joshua Devine, BSC	DoD Pharmacoeconomic Center
LCDR Joe Lawrence	DoD Pharmacoeconomic Center
Dr. Shana Trice	DoD Pharmacoeconomic Center
Dr. Eugene Moore	DoD Pharmacoeconomic Center
Dr. Angela Allerman	DoD Pharmacoeconomic Center
Dr. David Meade	DoD Pharmacoeconomic Center
Dr. Harsha Mistry	DoD Pharmacoeconomic Center
Dr. Jeremy Briggs	DoD Pharmacy Operations Center contractor
Dr. Stephen Yarger	DoD Pharmacy Outcomes Research Team contractor
Dr. Esmond Nwokeji	DoD Pharmacy Outcomes Research Team contractor
Ms. Deborah Garcia	DoD Pharmacy Outcomes Research Team contractor

Appendix B – Medical Necessity Criteria

Drug / Drug Class	Medical Necessity Criteria
Olopatadine (Patanase) Beclomethasone (Beconase AQ) Budesonide (Rhinocort Aqua) Ciclesonide (Omnaris) Fluticasone furoate (Veramyst) Triamcinolone (Nasacort AQ) **Nasal Allergy Drugs**	• Use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from formulary alternatives. • Formulary agents have resulted or are likely to result in therapeutic failure.
Pirbuterol CFC* MDI (Maxair) Metaproterenol inhalation solution **Short-Acting Beta Agonists**	• Use of formulary alternatives is contraindicated • The patient has experienced or is likely to experience significant adverse effects from formulary alternatives. • The patient previously responded to nonformulary agent and changing to a formulary agent would incur unacceptable risk.
Desvenlafaxine (Pristiq) **(Antidepressant-1s)**	• The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.

CFC: chlorofluorocarbon

MDI: metered dose inhaler

*: CFC-containing pressurized MDIs likely will cease marketing as of 31 Dec 2008

Appendix C – Implementation Status of UF Class Review Recommendations / Decisions

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	**Decision Date** (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	**Effective Date for Non-Formulary Medications** (Implementation period)
Nov 08	Short-Acting Beta Agonists	▪ albuterol chlorofluorocarbon (CFC) metered dose inhaler (MDI) (no longer manufactured) ▪ metaproterenol (Alupent) CFC MDI (no longer marketed) ▪ metaproterenol inhalation solution ▪ pirbuterol (Maxair) MDI	BCF	▪ Ventolin HFA (albuterol hydrofluoroalkane (HFA) MDI ▪ Albuterol inhalation solution; Note – does not include the following: Accuneb 0.021% [0.63 mg/mL] Accuneb 0.042% [1.25 mg/3mL] Albuterol 0.5% [2.5 mg/0.5 mL in 0.5 unit dose vial]	pending approval	pending approval
Nov 08 (update to include nasal antihistamines; nasal steroids reviewed Nov 05 & Aug 07 for Veramyst)	Nasal Allergy Drugs	▪ olopatadine (Patanase) ▪ ciclesonide (Omnaris) ▪ fluticasone furoate (Veramyst) ▪ beclomethasone (Beconase AQ) ▪ budesonide (Rhinocort Aqua) ▪ triamcinolone (Nasacort AQ)	BCF	▪ Fluticasone propionate (generic Flonase) ▪ Azelastine (Astelin)	pending approval	pending approval
Nov 08 & Aug 08 (update; reviewed Nov 05)	Antidepressants I	**Recommended for non-formulary status Aug 08; no change to non-formulary status in Nov 08** ▪ desvenlafaxine (Pristiq)	BCF	No changes to BCF recommended Aug 08	Nov 08: pending approval; original signing date 24 Oct 08	26 Nov 08 (60 days)
Aug 08 (update; reviewed Nov 05)	Antidepressants I	To remain NF ▪ paroxetine HCl CR (Paxil) ▪ fluoxetine 90 mg weekly admin. (Prozac Weekly) ▪ fluoxetine in special packaging for PMDD (Sarafem) ▪ escitalopram (Lexapro) ▪ duloxetine (Cymbalta) ▪ bupropion extended release (Wellbutrin XL)	BCF	Currently BCF ▪ citalopram ▪ fluoxetine (excluding weekly regimen & special packaging for PMDD) ▪ sertraline (Zoloft) ▪ trazodone ▪ bupropion sustained release	19 Jan 06	19 Jul 06 (180 days)
Nov 08	ACE inhibitors – Renin Angiotensin Antihypertensives	Previously non-formulary, recommended for UF status Nov 08 ▪ ramipril (Altace generic)	BCF	▪ No changes recommended to BCF at Nov 08 meeting; ramipril removed from Non-formulary status and designated as Uniform Formulary immediately upon signing of the minutes	pending approval	N/A

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Oct 08 (interim teleconference meeting) & Jun 08	Triptans	▪ almotriptan (Axert) ▪ frovatriptan (Frova) ▪ naratriptan (Amerge)	BCF	▪ rizatriptan (Maxalt), immediate upon signing of the minutes ▪ sumatriptan oral and one injectable formulation, when multi-source generics are available	Nov 08 meeting pending approval: ; original signing date: 27 Aug 08	26 Nov 08 (90 days)
Aug 08	Self-Monitoring Blood Glucose Systems (SMBGS) test strips	▪ One Touch Ultra 2 strips (for One Touch Ultra 2, Ultra Mini, and Ultra Smart meters) ▪ TrueTrack strips (for TrueTrack meter) ▪ Accu-chek Comfort Curve strips (for Accu-chek Advantage meter) ▪ Accu-chek Compact Plus drum (for Accu-check Compact Plus meter) ▪ Accu-chek Simplicity, Ascensia Autodisk, Ascensia Breeze 2, Ascensia Elite, Assure, Assure 3, Assure II, Assure Pro, Bd Test Strips, Chemstrip Bg, Control AST, Dextrostix Reagent, Easygluco, Easypro, Fast Take, Freestyle test strips (other than Freestyle Lite), Glucofilm, Glucolab, Glucometer Dex, Glucometer Elite, Glucose Test Strip, Glucostix, Optium, Precision Pcx, Precision Pcx Plus, Precision Q-I-D, Precision Sof-Tact, Prestige Smart System, Prodigy, Quicktek, Sidekick, Sof-Tact, Surestep, Surestep Pro, Test Strip, Relion Ultima, Uni-Check ▪ Plus all other store/private label brand strips not included on the UF (see BCF/ECF column)	BCF	**Basic Core Formulary SMBGS test strips** ▪ Precision Xtra strips (for Precision Xtra meter) **Uniform Formulary SMBGS test strips** ▪ Accu-chek Aviva (for Accu-chek Aviva meter) ▪ Ascensia Contour (for Ascensia Contour meter) ▪ Freestyle Lite (for Freestyle Freedom Lite and Freestyle Lite meters)	24 Oct 08	17 Mar 09 (120 days)
Aug 08 (re-review; Feb 06 original review)	Overactive Bladder (OAB) Agents	▪ tolterodine IR (Detrol) ▪ trospium IR (Sanctura)	BCF	▪ tolterodine ER (Detrol LA) ▪ oxybutynin ER (Ditropan XL, generics) (Note: oxybutynin IR [generic Ditropan] removed from BCF, but still UF)	24 Oct 08	4 Feb 09 (90 days)
Aug 08 (update; reviewed Aug 05; also updated Nov 07)	Calcium Channel Blockers	**Recommended for non-formulary status Aug 08** ▪ nisoldipine geomatrix (Sular geomatrix)	BCF	No changes to BCF recommended Aug 08	24 Oct 08	7 Jan 09 (60 days)
		Previously non-formulary, recommended for UF status Nov 07 ▪ amlodipine besylate (Norvasc generic)		Recommended for addition to BCF Nov 07 ▪ amlodipine besylate tablets	13 Feb 08	13 Feb 08

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
		To Remain Non-Formulary ▪ isradipine IR, ER (Dynacirc; Dynacirc CR) ▪ nicardipine IR (Cardene, generics) ▪ nicardipine SR (Cardene SR) ▪ verapamil ER (Verelan) ▪ verapamil ER HS dosing (Verelan PM, Covera HS) ▪ diltiazem ER for bedtime dosing (Cardizem LA)		Currently BCF ▪ amlodipine besylate (Norvasc, generics) (Recommended at Nov 07 meeting) ▪ nifedipine ER (Adalat CC, generics) ▪ verapamil SR ▪ diltiazem ER (Tiazac, generics)	13 Oct 05	15 Mar 06 (150 days)
Jun 08	Osteoporosis Agents	▪ calcitonin salmon nasal spray (Miacalcin)	BCF	▪ alendronate (Fosamax) ▪ ibandronate (Boniva) (Note: raloxifene (Evista) removed from BCF, but still UF)	27 Aug 08	26 Nov 08 (90 days)
Jun 08 (update; reviewed May 07)	Antilipidemic Agents II	No changes to NF recommended Jun 08	BCF	**Recommended for addition to BCF Jun 08** ▪ fenofibrate meltdose (Fenoglide), to replace fenofibrate IDD-P (Triglide) (Note: fenofibrate IDD-P (Triglide) removed from BCF but still UF)	27 Aug 08	Revised implementation da 26 Nov 08 original implementation da 29 Oct 08 (60 days)
		To remain NF ▪ fenofibrate nanocrystallized (Tricor) ▪ fenofibrate micronized (Antara) ▪ omega-3 fatty acids (Omacor) ▪ colesevelam (Welchol)		Currently BCF ▪ gemfibrozil	24 July 07	21 Nov 07 (120 days)
Jun 08 (update; reviewed Nov 07)	Adrenergic Blocking Agents	**Recommended for non-formulary status Jun 08** ▪ nebivolol (Bystolic)	BCF	No change to BCF recommended Jun 08	27 Aug 08	Revised implementation da 26 Nov 08 original implementation da 29 Oct 08 (60 days)
		(No ABAs selected for NF placement at Nov 07 meeting)		Currently BCF ▪ atenolol tablets ▪ metoprolol tartrate IR tablets ▪ carvedilol IR tablets ▪ metoprolol succinate ER tablets	13 Feb 08	-
Jun 08 (update; reviewed Aug 07	Newer Antihistamines	**Recommended for non-formulary status Jun 08** ▪ levocetirizine (Xyzal)	BCF	No change to BCF recommended Jun 08	27 Aug 08	Revised implementation da 26 Nov 08 original implementation da 29 Oct 08 (60 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
		To remain NF ▪ desloratadine (Clarinex) ▪ desloratadine/pseudoephedrine (Clarinex D)		▪ MTFs required to carry at least one single ingredient agent from the newer antihistamine class (loratadine, cetirizine, or fexofenadine) on their local formulary, including at least one dosage form suitable for pediatric use	17 Oct 07	16 Jan 08 (90 days)
Jun 08 (update; reviewed Aug 07)	Leukotriene Modifiers	**Recommended for non-formulary status Jun 08** ▪ Zileuton ER (Zyflo CR)	BCF	No changes to BCF rec Jun 08	27 Aug 08	Revised implementation da 26 Nov 08 original implementation da 29 Oct 08 (60 days)
		To remain NF ▪ zileuton (Zyflo)		Currently BCF ▪ montelukast (Singulair)	17 Oct 07	16 Jan 08 (90 days)
Jun 08 (update) Original reviews ▪ ACE inhibitors: Aug 05 ▪ Miscellaneous antihypertensives, including ACE/CCB combos. Feb 06 ▪ ARBs: May 07 ▪ Renin inhibitors. Aug 07 ▪ CCB/ARB combos Nov 07 update	Renin Angiotensin Antihypertensives	**Recommended for non-formulary status Jun 08** ▪ olmesartan/amlodipine (Azor)	BCF	No change to BCF recommended Jun 08	27 Aug 08	Revised implementation da 26 Nov 08 original implementation da 29 Oct 08 (60 days)
		To remain NF ▪ valsartan amlodipine (Exforge)		No change to BCF recommended Nov 07	13 Feb 08	16 Apr 08 (60 days)
		To remain NF ACE inhibitors ▪ Moexipril +/- HCTZ (Univasc; Uniretic) ▪ perindopril (Aceon) ▪ ramipril (Altace) ACE/CCB combos ▪ felodipine/enalapril (Lexxel) (D/C'd from market) ▪ verapamil/trandolapril (Tarka) ARBs ▪ eprosartan +/- HCTZ (Teveten; Teveten HCT) ▪ irbesartan+/- HCTZ (Avapro, Avalide) ▪ olmesartan +/- HCTZ (Benicar; Benicar HCT) ▪ valsartan +/- (Diovan; Diovan HCT)		Currently on the BCF ACE inhibitors ▪ captopril ▪ lisinopril ▪ lisinopril / HCTZ ACE/CCB combos ▪ amlodipine/benazepril (Lotrel, generics) ARBs ▪ telmisartan (Micardis) ▪ telmisartan HCTZ (Micardis HCT)	ACE inhibitors ▪ 13 Oct 05 ACE/CCB combos ▪ 26 Apr 06 ARBs ▪ 24 July 07	ACE inhibitors ▪ 15 Feb 06 ACE/CCB combos ▪ 26 Jul 06 ARBs ▪ 21 Nov 07
Nov 07	Targeted Immunomodulatory Biologics	▪ etanercept (Enbrel) ▪ anakinra (Kineret)	ECF	▪ adalimumab (Humira) injection	13 Feb 08	18 Jun 08 (120 days)
Nov 07 re-review (Aug 05 original)	BPH Alpha Blockers	▪ tamsulosin (Flomax) Automated PA requiring trial of alfuzosin (Uroxatral) applies to new users of tamsulosin (no use of uroselective alpha blockers in last 180 days)	BCF	▪ terazosin tablets or capsules ▪ alfuzosin tablets (Uroxatral)	13 Feb 08	16 Apr 08 (60 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (implementation period)
Nov 07 (update, original review Nov 06)	ADHD / Narcolepsy Agents	**Recommended for non-formulary status Nov 07** ▪ lisdexamfetamine (Vyvanse)	BCF	No change to BCF recommended Nov 07	13 Feb 08	16 Apr 08 (60 days)
		To remain NF ▪ dexmethylphenidate IR (Focalin) ▪ dexmethylphenidate SODAS (Focalin XR) ▪ methylphenidate transdermal system (Daytrana)		Currently on the BCF ▪ methylphenidate OROS (Concerta) ▪ mixed amphetamine salts ER (Adderall XR) ▪ methylphenidate IR (Ritalin)	17 Jan 07	18 Apr 07
Nov 07 (update, original review May 06)	Contraceptives	**Recommended for non-formulary status Nov 07** ▪ EE 20 mcg/levonorgestrel 0.09 mg in special packaging for continuous use (Lybrel)	BCF	No change to BCF recommended Nov 07	13 Feb 08	16 Apr 08 (60 days)
		To remain NF ▪ EE 30 mcg / levonorgestrel 0.15 mg in special packaging for extended use (Seasonale) ▪ EE 25 mcg / norethindrone 0.4 mg (Ovcon 35) ▪ EE 50 mcg / norethindrone 1 mg (Ovcon 50) ▪ EE 20/30/35 mcg / noreth. 1 mg (Estrostep Fe)		Currently on the BCF ▪ EE 20 mcg / 3 mg drospirenone (Yaz) ▪ EE 20 mcg / 0.1 mg levonorgestrel (Lutera, Sronyx, or equivalent) ▪ EE 30 mcg / 3 mg drospirenone (Yasmin) ▪ EE 30 mcg / 0.15 mg levonorgestrel (Nordette or equivalent / excludes Seasonale) ▪ EE 35 mcg / 1 mg norethindrone (Ortho-Novum 1/35 or equivalent) ▪ EE 35 mcg / 0.25 mg norgestimate (Ortho-Cyclen or equivalent) ▪ EE 25 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen Lo) ▪ EE 35 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen or equivalent) ▪ 0.35 mg norethindrone (Nor-QD, Ortho Micronor, or equivalent)	26 Jul 06	24 Jan 07
		▪ EE 30/10 mcg / 0.15 mg levonorgestrel in special packaging for extended use (Seasonique) ▪ EE 20 mcg / 1 mg norethindrone (Loestrin 24 Fe)			17 Jan 07	18 Mar 07
Aug 07	Growth Stimulating Agents	▪ somatropin (Genotropin, Genotropin Miniquick) ▪ somatropin (Humatrope) ▪ somatropin (Omnitrope) ▪ somatropin (Saizen)	ECF	▪ somatropin (Norditropin)	17 Oct 07	19 Dec 07 (60 days)
May 07 re-review (Feb 05 original)	PPIs	▪ lansoprazole (Prevacid) ▪ omeprazole/sodium bicarbonate (Zegerid) ▪ pantoprazole (Protonix) ▪ rabeprazole (Aciphex) Automated PA requiring trial of omeprazole OR esomeprazole (Nexium) applies to new users of non-formulary PPIs (no use of PPIs in last 180 days)	BCF	▪ generic omeprazole 10 mg and 20 mg (excludes Prilosec 40 mg) ▪ esomeprazole (Nexium)	24 July 07	24 Oct 07 (90 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
May 07 re-review (Feb 05 original)	ARBs	• eprosartan +/- HCTZ (Teveten; Teveten HCT) • irbesartan +/-HCTZ (Avapro; Avalide) • olmesartan +/- HCTZ (Benicar; Benicar HCT) • valsartan +/- HCTZ (Diovan; Diovan HCT)	BCF	• telmisartan (Micardis) • telmisartan HCTZ (Micardis HCT)	24 July 07	21 Nov 07 (120 days)
May 07	5-Alpha Reductase Inhibitors	• dutasteride (Avodart)	BCF	• finasteride	24 July 07	24 Oct 07 (90 days)
Feb 07	Newer Sedative Hypnotics	• zolpidem ER (Ambien CR) • zaleplon (Sonata) • ramelteon (Rozerem) Automated PA requiring trial of zolpidem IR applies to new users of eszopiclone (Lunesta), ramelteon (Rozerem), zaleplon (Sonata), or zolpidem ER (Ambien CR) (new users = no use of newer sedative hypnotics in last 180 days)	BCF	• zolpidem IR (Ambien)	02 May 07	01 Aug 07 (90 days)
Feb 07	Monoamine Oxidase Inhibitors	• selegiline transdermal patch (Emsam)	ECF	• phenelzine (Nardil)	02 May 07	01 Aug 07 (90 days)
Feb 07	Narcotic Analgesics	• tramadol ER (Ultram ER)	BCF	• morphine sulfate IR 15 mg, 30 mg • morphine sulfate 12-hour ER (MS Contin or equivalent) 15, 30, 60 mg • oxycodone/APAP 5/325 mg • hydrocodone/APAP 5/500 mg • codeine/APAP 30/300 mg • codeine/APAP elixir 12/120 mg/5 mL • tramadol IR	02 May 07	01 Aug 07 (90 days)
Feb 07	Ophthalmic Glaucoma Agents	• travoprost (Travatan, Travatan Z) • timolol maleate for once daily dosing (Istalol) • timolol hemihydrate (Betimol) • brinzolamide (Azopt)	BCF	• latanoprost (Xalatan) • brimonidine (Alphagan P); excludes 0.1% • timolol maleate • timolol maleate gel-forming solution • pilocarpine	02 May 07	01 Aug 07 (90 days)
Nov 06	Older Sedative Hypnotics	-	BCF	• temazepam 15 and 30 mg	17 Jan 07	-
Nov 06 (update; reviewed Nov 06)	Dermatologic Topical Antifungals*	**Recommended for non-formulary status Nov 06:** 0.25% miconazole / 15% zinc oxide / 81.35% white petrolatum ointment (Vusion)	BCF	No change to BCF recommended Nov 06	14 Jul 05	17 Aug 05 (30 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
		▪ econazole ▪ ciclopirox ▪ oxiconazole (Oxistat) ▪ sertaconazole (Ertaczo) ▪ sulconazole (Exelderm)		▪ nystatin ▪ clotrimazole	17 Jan 07	18 Mar 07 (60 days)
Aug 06	H2 Antagonists / GI protectants	-	BCF	▪ ranitidine (Zantac) – excludes gelcaps and effervescent tablets	23 Oct 06	-
Aug 06	Antilipidemic Agents I	▪ rosuvastatin (Crestor) ▪ atorvastatin / amlodipine (Caduet)	BCF	▪ simvastatin (Zocor) ▪ pravastatin ▪ simvastatin / ezetimibe (Vytorin) ▪ niacin extended release (Niaspan)	23 Oct 06	1 Feb 07 (90 days)
May 06	Antiemetics	▪ dolasetron (Anzemet)	BCF	▪ promethazine (oral and rectal)	26 Jul 06	27 Sep 06 (60 days)
Feb 06 (re-classified Aug 07; and updated Jun 08; see above)	Misc Antihypertensive Agents (ACE/CCB combos now part of RAAs class)	(ACE/CCB combos now part of RAAs class) ▪ felodipine/enalapril (Lexxel) ▪ verapamil/trandolapril (Tarka)	BCF	(ACE/CCB combos now part of RAAs class) ▪ amlodipine/benazepril (Lotrel) ▪ hydralazine ▪ clonidine tablets	26 Apr 06	26 Jul 06 (90 days)
Feb 06	GABA-analogs	▪ pregabalin (Lyrica)	BCF	▪ gabapentin	26 Apr 06	28 Jun 06 (60 days)
Nov 05	Alzheimer's Drugs	▪ tacrine (Cognex)	ECF	▪ donepezil (Aricept)	19 Jan 06	19 Apr 06 (90 days)
Nov 05	Macrolide/ Ketolide Antibiotics	▪ azithromycin 2 gm (Zmax) ▪ telithromycin (Ketek)	BCF	▪ azithromycin (Z-Pak) ▪ erythromycin salts and bases	19 Jan 06	22 Mar 06 (60 days)
May 05	PDE5 Inhibitors	▪ sildenafil (Viagra) ▪ tadalafil (Cialis)	ECF	▪ vardenafil (Levitra)	14 Jul 05	12 Oct 05 (90 days)
May 05	MS-DMDs	-	ECF	▪ interferon beta-1a intramuscular injection (Avonex)	14 Jul 05	-

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)

BCF = Basic Core Formulary; ECF = Extended Core Formulary; MN = Medical Necessity; TMOP = TRICARE Mail Order Pharmacy; TRRx = TRICARE Retail Pharmacy program; UF = Uniform Formulary
CFC = chlorofluorocarbon; ER = extended release; HFA = hydrofluoroalkane; IR = immediate release; SR = sustained release; IDD-P = insoluble drug delivery-microParticle;
AD-1s: Antidepressant-1 Drugs; ADHD = Attention Deficit Hyperactivity Disorder; ARBs = Angiotensin Receptor Blockers; ACE Inhibitors = Angiotensin Converting Enzyme Inhibitors; BPH = Benign Prostatic Hyperplasia; CCBs = Calcium Channel Blockers; EE = ethinyl estradiol; GI = gastrointestinal; GABA = gamma-aminobutyric acid; H2 = Histamine-2 receptor; HCTZ = hydrochlorothiazide; LIP-1 = Antihyperlipidemic-1 Drugs; LIP-2 = Antihyperlipidemic-2 Drugs; MDIs = metered dose inhalers; MOAIs = Monoamine Oxidase Inhibitor Drugs; MS-DMDs = Multiple Sclerosis Disease-Modifying Drugs; NADs = Nasal Allergy Drugs; OAB = Overactive Bladder Medications; PDE5 Inhibitors = Phosphodiesterase- type 5 inhibitors; PPIs = Proton Pump Inhibitors; RAAs = Renin Angiotensin Antihypertensives Drugs; SABAs = Short-Acting Beta Agonists; SMBGS: Self-Monitoring Blood Glucose Systems; TIBs = Targeted Immunomodulatory Biologics; TZDs= Thiazolidinediones
*The Dermatologic Topical Antifungal drug class excludes vaginal products and products for onychomycosis (e.g., ciclopirox topical solution [Penlac])

Appendix D – Table of Abbreviations

5-HT3	Serotonin subtype 3 receptor-blocking agents (5-HT3 antagonists)
ACE I / RAAs	Angiotensin Converting Enzyme Inhibitor / Renin Angiotensin Antihypertensive drug class
AD-1	Antidepressant-1 drug class
AE	adverse event
AERS	Adverse Event Reporting System
AAAAI	American Academy of Allergy, Asthma and Immunology
AR	allergic rhinitis
BAP	Beneficiary Advisory Panel
BCF	Basic Core Formulary
BIA	budget impact analysis
BID	twice daily
CEA	cost effectiveness analysis
CFC	chlorofluorocarbon
CFR	Code of Federal Regulations
CI	confidence interval
CINV	chemotherapy-induced nausea and vomiting
CMA	cost minimization analysis
COPD	chronic obstructive pulmonary disease
DoD	Department of Defense
ED	emergency department
EIB	exercise-induced bronchospasm
ER	Extended release
ESI	Express Scripts, Inc
FCP	Federal Ceiling Price
FDA	Food and Drug Administration
FEV1	forced expiratory volume in one second
FSS	Federal Supply Schedule Price
FY	fiscal year
HA	Health Affairs
HCTZ	hydrochlorothiazide
HFA	hydrofluoroalkane
IR	immediate release
LIP-1	Antilipidemic-1 drug class
MDI	metered dose inhaler (pressurized)
MHS	Military Health System
MN	medical necessity
MTF	military treatment facility
NAD	Nasal Allergy drug class
NDAA	National Defense Authorization Act
OMB	Office of Management and Budget
P&T	Pharmacy and Therapeutics
PA	prior authorization
PAR	Perennial allergic rhinitis
PEC	Pharmacoeconomic Center
PORT	Pharmaceutical Outcomes Research Team
PPI	Proton Pump Inhibitor
QD	once daily
QL	quantity limit
SABAs	Short-Acting Beta Agonist drug class
SAR	Seasonal allergic rhinitis
SNRI	Serotonin Norepinephrine Reuptake Inhibitor

Appendix D – Table of Abbreviations (continued)

TFL	TRICARE for life beneficiary
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TRRx	TRICARE Retail Pharmacy Network
UF VARR	Uniform Formulary Voluntary Agreement for Retail Refunds
VMR	vasomotor rhinitis

Appendix E – Table of Short-Acting Beta Agonists Quantity Limits

Drug	TMOP QL	TRRx QL
Current Quantity Limits		
Albuterol (AccuNeb; generic) soln 0.63mg/3mL & 1.25 mg/3mL	1650 mL per 90 days (550 unit-dose vials)	600 mL per 30 days (200 unit-dose vials)
Albuterol (generic) soln 0.083% 2.5 mg/3 mL	1650 mL per 90 days (550 unit-dose vials)	600 mL per 30 days (200 unit-dose vials)
Albuterol (generic) soln 0.5% 2.5 mg/0.5 mL (20 mL)	180 mL per 90 days (9 bottles)	60 mL per 30 days (3 bottles)
Levalbuterol (Xopenex) soln 0.63 mg/3 mL & 1.25 mg/3 mL	1080 mL per 90 days (360 unit-dose vials)	360 mL per 30 days (120 unit-dose vials)
Albuterol CFC (generic) 90 mcg MDI	102 gm per 90 days (17 gm MDI: 6 inhalers)	34 gm per 30 days (17 gm MDI: 2 inhalers)
Proposed Quantity Limits (in addition to current QLs)		
Levalbuterol (Xopenex) soln 0.31 mg/3 mL	1080 mL per 90 days (360 unit-dose vials)	360 mL per 30 days (120 unit-dose vials)
Levalbuterol HFA (Xopenex) 45 mcg MDI (8.4 gm MDI)	50.4 gm per 90 days (8.4 gm MDI: 6 inhalers)	16.8 gm per 30 days (8.4 gm MDI: 2 inhalers)
Levalbuterol HFA (Xopenex) 45 mcg MDI (15 gm MDI)	90 gm per 90 days (15 gm MDI: 6 inhalers)	30 gm per 30 days (15 gm MDI: 2 inhalers)
Albuterol HFA (Ventolin HFA) 90 mcg MDI	108 gm per 90 days (18 gm MDI: 6 inhalers)	36 gm per 30 days (18 gm MDI: 2 inhalers)
Albuterol HFA (Proventil HFA) 90 mcg MDI	40.2 gm per 90 days (6.7 gm MDI: 6 inhalers)	13.4 gm per 30 days (6.7 gm MDI: 2 inhalers)
Albuterol HFA (ProAir HFA) 90 mcg MDI	51 gm per 90 days (8.5 gm MDI: 6 inhalers)	17 gm per 30 days (8.5 gm MDI: 2 inhalers)

CFC: chlorofluorocarbon
HFA: hydrofluoroalkane
MDI: metered dose inhaler
Soln: solution

Appendix F – Basic Core Formulary Deletions

Therapeutic Category	Generic Name	Dosage	Dosage Form
ALDOSTERONE ANTAGONISTS	SPIRONOLACTONE	100MG	TABS
	SPIRONOLACTONE	50MG	
ANTIARTHRITICS	NAPROXEN	375MG	TABS
ANTICONVULSANTS	PHENYTOIN SODIUM	30MG	CAPS
	CARBAMAZEPINE	100MG	CP12
	CARBAMAZEPINE	200MG	
	CARBAMAZEPINE	300MG	
	GABAPENTIN	250MG/5ML	SOLN
	GABAPENTIN	100MG	TABS
	GABAPENTIN	400MG	
ANTIHISTAMINES	HYDROXYZINE PAMOATE	100MG	CAPS
	HYDROXYZINE PAMOATE	25MG	
	HYDROXYZINE PAMOATE	50MG	
	PROMETHAZINE HCl	12.5MG	TABS
	PROMETHAZINE HCl	50MG	
ANTINAUSEANTS	PROMETHAZINE HCl	50MG	SUPP
	METOCLOPRAMIDE HCl	5MG	TABS
ANTIPARASITICS	METRONIDAZOLE	375MG	CAPS
ANTIPARKINSON	AMANTADINE HCl	100MG	TABS
	TRIHEXYPHENIDYL HCl	5MG	
ANTI-ULCER PREPS/GASTROINTESTINAL PREPS	RANITIDINE HCl	300MG	TABS
ATARACTICS-TRANQUILIZERS	BUSPIRONE HCl	30MG	TABS
	BUSPIRONE HCl	7.5MG	
BRONCHIAL DILATORS	ALBUTEROL SULFATE	0.5% in unit dose (2.5 mg/0.5 mL)	NEBU
CEPHALOSPORINS	CEPHALEXIN MONOHYDRATE	250MG	TABS
	CEPHALEXIN MONOHYDRATE	500MG	
CNS STIMULANTS	METHYLPHENIDATE HCl	20MG	TABS
DIURETICS	HYDROCHLOROTHIAZIDE; TRIAMTERENE	25MG; 37.5MG	CAPS
	HYDROCHLOROTHIAZIDE; TRIAMTERENE	25MG; 50MG	
	CHLORTHALIDONE	100MG	TABS
	HYDROCHLOROTHIAZIDE	12.5MG	
	CHLORTHALIDONE	15MG	
	FUROSEMIDE	80MG	
ELECTROLYTES & MISCELLANEOUS NUTRIENTS	POTASSIUM CHLORIDE	8MEQ	CPCR
	POTASSIUM CHLORIDE	20%	LIQD
	POTASSIUM CHLORIDE	25MEQ	PACK
	POTASSIUM CHLORIDE	10MEQ	TBCR
	POTASSIUM CHLORIDE	8MEQ	
ERYTHROMYCINS	ERYTHROMYCIN	250MG	CPEP
	ERYTHROMYCIN ETHYLSUCCINATE	400MG/5ML	SUSP
	AZITHROMYCIN	200MG/5ML	SUSR
	ERYTHROMYCIN ETHYLSUCCINATE	400MG/5ML	
	ERYTHROMYCIN	250MG	TABS

Therapeutic Category	Generic Name	Dosage	Dosage Form
ERYTHROMYCINS	ERYTHROMYCIN ETHYLSUCCINATE	400MG	
	ERYTHROMYCIN ERYTHROMYCIN STEARATE	500MG	
	AZITHROMYCIN	600MG	
	ERYTHROMYCIN	333MG	TBEC
	ERYTHROMYCIN	500MG	
ESTROGENS	ESTROGENS, CONJUGATED	0.9MG	TABS
FUNGICIDES	NYSTATIN	500000UNIT	TABS
GLUCOCORTICOIDS	FLUTICASONE PROPIONATE	50MCG/BLIST	AEPB
	PREDNISONE	5MG/ML	CONC
	BUDESONIDE	180MCG/ACT	INHA
	BUDESONIDE	90MCG/ACT	
	PREDNISONE	2.5MG	TABS
	PREDNISONE	50MG	
MUSCLE RELAXANTS	CYCLOBENZAPRINE HCl	5MG	TABS
	METHOCARBAMOL	750MG	TABS
NON-NARCOTIC ANALGESICS	ACETAMINOPHEN; BUTALBITAL; CAFFEINE	325MG; 50MG; 40MG	CAPS
	SUMATRIPTAN SUCCINATE	4MG/0.5ML	KIT
OPHTHALMIC PREPARATIONS	PILOCARPINE HCl	3%	SOLN
	PILOCARPINE HCl	6%	
OTHER ANTIBIOTICS	ERYTHROMYCIN	2%	OINT
	CIPROFLOXACIN	500MG/5ML	SUSR
OTHER CARDIOVASCULAR PREPS	VERAPAMIL HCl	120MG	CP24
	VERAPAMIL HCl	180MG	
	VERAPAMIL HCl	240MG	
	VERAPAMIL HCl	360MG	
	AMIODARONE HCL	100MG	TABS
	AMIODARONE HCL	400MG	
OTHER HYPOTENSIVES	HYDRALAZINE HCl	100MG	TABS
PENICILLINS	AMOXICILLIN; CLAVULANIC ACID	200MG; 28.5MG	CHEW
	AMOXICILLIN; CLAVULANIC ACID	400MG; 57MG	
	AMOXICILLIN	875MG	TABS
PSYCHOSTIMULANTS-ANTIDEPRESSANTS	DOXEPIN HCl IMIPRAMINE PAMOATE	100MG	CAPS
	IMIPRAMINE PAMOATE	125MG	
	DOXEPIN HCl IMIPRAMINE PAMOATE	150MG	
	LITHIUM CARBONATE	600MG	
	NORTRIPTYLINE HCl	75MG	
	AMITRIPTYLINE HCl	100MG	TABS
	FLUOXETINE HCL	10MG	
	AMITRIPTYLINE HCl	150MG	
	FLUOXETINE HCL	20MG	
	BUPROPION HCL	200MG	TB12
TB PREPARATIONS	RIFAMPIN	150MG	CAPS
VASODILATORS CORONARY	NITROGLYCERIN	0.3MG	SUBL

Therapeutic Category	Generic Name	Dosage	Dosage Form
VASODILATORS CORONARY	NITROGLYCERIN	0.6MG	
	ISOSORBIDE DINITRATE	2.5MG	
	ISOSORBIDE DINITRATE	5MG	
XANTHINE DERIVATIVES	THEOPHYLLINE	100MG	CP24
	THEOPHYLLINE	200MG	
	THEOPHYLLINE	100MG	TB12
	THEOPHYLLINE	450MG	
	THEOPHYLLINE	600MG	TB24

DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE
RECOMMENDATIONS
INTERIM MEETING
Oct 2008

DRUG CLASS REVIEW – 5-HYDROXYTRYPTAMINE AGONISTS (TRIPTANS)

The P&T Committee held an interim teleconference meeting on 27 Oct 2008 during which it re-reviewed the cost-effectiveness of the triptan drug class that was originally conducted at the June 2008 meeting. Nine voting Committee members, who constituted a majority of the entire voting Committee members, participated. All triptan drugs originally recommended for inclusion on the UF were covered by Uniform Formulary Voluntary Agreement for Retail Refunds (UF VARR) submissions at or below the Federal Ceiling Price (FCP). (One of the triptan drugs recommended for non-formulary status was also covered by a UF-VARR at or below the FCP, but was not considered cost-effective.) However this meeting was held because manufacturers were offered the opportunity to re-submit Uniform Formulary Voluntary Agreement for Retail Refunds submissions to include offers that would exceed the Federal Ceiling Price and to re-evaluate the clinical and cost-effectiveness of the drugs after resubmissions were received. A revised UF VARR was submitted for one drug. The 12-13 June 2008 DoD P&T Committee meeting minutes were originally signed by the Director, TMA on 27 August 2008.

Relative Clinical Effectiveness: The relative clinical effectiveness of the triptan drugs was previously reviewed at the June 2008 meeting; there were no changes to the clinical effectiveness conclusion at the interim Oct 2008 teleconference meeting. The relative clinical effectiveness review presented at the June 2008 meeting is provided below.

The P&T Committee evaluated the relative clinical effectiveness of the eight marketed 5-hydroxytryptamine agonists (triptans) in the US, almotriptan (Axert), eletriptan (Relpax), frovatriptan (Frova), naratriptan (Amerge), sumatriptan (Imitrex), sumatriptan/naproxen (Treximet), rizatriptan (Maxalt), and zolmitriptan (Zomig). None of the triptans are available in generic formulations, although generic formulations of sumatriptan are expected in early 2009.

MHS expenditures for the triptans were approximately $70 million for the time period of May 2007 to April 2008. In terms of total quantity dispensed between May 2007 and April 2008, sumatriptan is the highest utilized triptan in the MHS (~150,000 tablets dispensed/month), followed by zolmitriptan (~60,000 tablets/month), and rizatriptan (~45,000 tablets/month). To review the full clinical effectiveness evaluation, see the Triptan DoD Drug Class Review found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion: The P&T Committee voted in June 2008 (15 for, 0 opposed, 0 abstained, 0 absent) to accept the following clinical effectiveness conclusion:

a) With regards to efficacy at providing pain relief at 2 hours,1) rizatriptan 10 mg (Maxalt) appears superior to the other triptans; 2) almotriptan (Axert), eletriptan (Relpax), sumatriptan (Imitrex) and zolmitriptan (Zomig) have comparable relative effectiveness; 3) frovatriptan (Frova) appears inferior to the other triptans, although these results are based on limited data; 4) naratriptan (Amerge) appears inferior to the other triptans; and 5) sumatriptan/naproxen (Treximet) appears superior to sumatriptan 85 mg, but there is insufficient evidence to suggest clinically relevant differences between Treximet and the other triptans.

b) With regards to other efficacy endpoints, 1) rizatriptan 10 mg (Maxalt) and almotriptan 12.5 mg (Axert) are superior to the other triptans for pain free response at 24 hours; and 2) rizatriptan 10 mg is superior to the other triptans for pain-free response at 2 hours.

c) With regards to safety and tolerability, almotriptan (Axert) and naratriptan (Amerge) had the most favorable adverse event profiles compared to the other triptans. There is only limited data for frovatriptan from the product labeling.

Relative Cost Effectiveness: The DoD P&T Committee evaluated the relative cost effectiveness of the triptans at the interim 28 October 2008 teleconference meeting. 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 efficacy, safety, tolerability, 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 CFR 199.21(e)(2).

Relative Cost Effectiveness Conclusion: The cost effectiveness of the triptan agents was evaluated by CMA, cost effectiveness analysis (CEA), and by budget impact analysis (BIA). Based on the results of the cost analyses and other clinical and cost considerations, the P&T Committee concluded (9 for, 0 opposed, 0 abstained, 0 absent) the following:

a) Results from the triptan CMA revealed that sumatriptan/naproxen (Treximet) was the most cost effective agent overall. However, sumatriptan (Imitrex) is expected to become the most cost-effective triptan when generic formulations reach the market in early 2009.

b) Results from the 2 hour pain response CEA revealed that 1) sumatriptan/naproxen (Treximet) and rizatriptan (Maxalt) are the most cost-effective agents; and 2) when the price for generic formulations of sumatriptan (Imitrex) drops below 70% of the current price, sumatriptan will become the most cost-effective agent.

c) Results from the 2 hour pain-free response CEA revealed that 1) sumatriptan/naproxen (Treximet), eletriptan (Relpax) and rizatriptan (Maxalt) are the most cost-effective agents; and 2) when the price for generic formulations of sumatriptan (Imitrex) drops below 70% of the current price, sumatriptan will become the most cost-effective agent.

d) The BIA evaluated the potential impact of scenarios with selected triptans designated formulary or non-formulary on the UF. Results from the BIA revealed that the scenario that designated almotriptan (Axert), frovatriptan (Frova), and naratriptan (Amerge) as non-formulary under the UF was more favorable to the MHS.

A. COMMITTEE ACTION: UF RECOMMENDATION – In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the triptans, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (8 for, 0 opposed, 1 abstained, and 0 absent) to recommend that:

1) Sumatriptan (Imitrex), sumatriptan/naproxen (Treximet), eletriptan (Relpax), rizatriptan (Maxalt), and zolmitriptan (Zomig) be classified as formulary on the UF.

2) Almotriptan (Axert), frovatriptan (Frova), and naratriptan (Amerge) be designated as non-formulary under the UF, based on cost effectiveness.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. COMMITTEE ACTION: MN CRITERIA – The Committee agreed to maintain the original MN criteria from the June 2008 meeting. Based on the clinical evaluation for almotriptan (Axert), frovatriptan (Frova), and naratriptan (Amerge), and the conditions for establishing medical necessity for a non-formulary medication provided for in the UF rule, the P&T Committee recommended in June (13 for, 0 opposed, 1 abstained, 1 absent) MN criteria for almotriptan, frovatriptan, and naratriptan. (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

C. COMMITTEE ACTION: IMPLEMENTATION PERIOD – There was no change to the original 90-day implementation period from the June 2008 meeting (vote in June of 13 for, 0 opposed, 1 abstained, 1 absent). The implementation date will be effective 26 November 2008. TMA will send a letter to beneficiaries affected by this UF decision.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

D. COMMITTEE ACTION: BCF RECOMMENDATION – The P&T Committee considered the BCF status of the triptan agents at the October interim teleconference meeting. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (8 for, 0 opposed, 1 abstained, and 0 absent) to recommend that 1) rizatriptan (Maxalt) be designated as BCF immediately upon signing of the

interim October 2008 DoD P&T Committee minutes by the Director, TMA; 2) sumatriptan (Imitrex oral tablets and one injectable sumatriptan formulation be designated as BCF when multi-source generic formulations that are cost effective reach the marketplace. As a result of the above actions, zolmitriptan (Zomig) would no longer be designated as BCF, but maintained as formulary on the UF.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

E. COMMITTEE ACTION: QUANTITY LIMIT (QL) RECOMMENDATIONS – There was no change to the quantity limits from the June 2008 meeting. The P&T Committee voted (13 for, 0 opposed, 1 abstained, 1 absent) to 1) to recommend QLs for sumatriptan 85 mg/naproxen 500 mg (Treximet) of 9 tablets per 30 days and 27 tablets per 90 days; 2) to recommend QLs for sumatriptan (Imitrex) 4 mg injection of 9 syringes per 30 days and 24 syringes per 90 days; and 3) to maintain the existing QLs for the other triptans.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

SUBMITTED BY:

COL John Kugler, USA, MC
DoD P&T Committee Chair

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.

DEC - 2 2008

S. Ward Casscells, MD

DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS
August 2008

1) CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on 12-13 Aug 2008 at the DoD Pharmacoeconomic Center (PEC), Fort Sam Houston, Texas.

2) ATTENDANCE

The attendance roster is found in Appendix A.

3) REVIEW MINUTES OF LAST MEETING

A. Corrections to the minutes – Corrections to the June 2008 DoD P&T Committee meeting minutes were tabled until the next meeting.

B. Approval of June minutes – Dr. Samuel Ward Casscells, III., M.D., will review the minutes of the June 2008 DoD P&T Committee meeting on 27 Aug 2008.

4) REVIEW OF RECENTLY APPROVED AGENTS

A. Antidepressant -1 (AD-1) – Desvenlafaxine (Pristiq)

Relative Clinical Effectiveness –Desvenlafaxine (Pristiq) is a Serotonin Norepinephrine Re-Uptake Inhibitor (SNRI) that is classified as part of the Antidepressant-1 (AD-1) drug class. The AD-1s were reviewed for Uniform Formulary (UF) placement in November 2005. Other SNRIs included on the UF are venlafaxine immediate release (Effexor, generics) and venlafaxine extended release (ER) (Effexor XR). The desvenlafaxine clinical evaluation included, but was not limited to, the requirements stated in the UF rule, 32 CFR 199.21(e)(1).

Desvenlafaxine is FDA-approved for the treatment of major depressive disorder in adults. Desvenlafaxine is an extended release formulation of the major active metabolite of venlafaxine ER. Generic formulations of venlafaxine ER (Effexor XR) are expected in 2010. To review the full clinical effectiveness evaluation of desvenlafaxine, see the Desvenlafaxine New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder DoD P&T library. Note that rxnet is restricted to those with a ".mil" e-mail address.)

Relative Clinical Effectiveness Conclusion – The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) that desvenlafaxine does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcomes over other AD-1 agents currently included on the UF.

Relative Cost Effectiveness – The P&T Committee evaluated the relative cost effectiveness of desvenlafaxine (Pristiq) in relation to efficacy, safety, tolerability, and clinical outcomes of the other agents in the AD-1 class, particularly to the following medications: citalopram (Celexa, generics), sertraline (Zoloft, generics), venlafaxine (Effexor, generics), venlafaxine ER (Effexor XR), bupropion ER

(Wellbutrin XL), and duloxetine (Cymbalta). Information considered by the P&T Committee included, but was not limited to sources of information listed in 32 CFR 199.21 (e)(2).

A cost minimization analysis (CMA) was employed to evaluate the cost effectiveness of desvenlafaxine relative to the UF AD-1s citalopram, sertraline, venlafaxine, and venlafaxine ER, and the Non-formulary (NF) AD-1s bupropion ER, and duloxetine. Results of the CMA showed that the projected weighted average daily cost of desvenlafaxine was significantly higher than its AD-1 class comparators.

Relative Cost Effectiveness Conclusion – The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) that desvenlafaxine (Pristiq) is not cost effective relative to the other AD-1s included on the UF.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations, and other relevant factors, the P&T Committee, based upon its collective professional judgment, recommended (14 for, 0 opposed, 1 abstained, 0 absent) that desvenlafaxine (Pristiq) be designated as non-formulary on the UF. This recommendation was based on the clinical effectiveness conclusion, and the determination that citalopram (Celexa, generics), sertraline (Zoloft, generics), venlafaxine (Effexor, generics), and venlafaxine ER (Effexor XR) remain the most cost effective AD-1 agents on the UF compared to desvenlafaxine.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

2) ***COMMITTEE ACTION: MN CRITERIA*** – Based on the clinical evaluation of desvenlafaxine and the conditions for establishing medical necessity of a non-formulary medication provided for in the UF rule, the P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) MN criteria for desvenlafaxine (Pristiq). (See Appendix B for full MN criteria).

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** – The P&T Committee voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend: 1) an effective date of the first Wednesday one week after the minutes are signed, following a 60-day implementation period in the TRICARE Mail Order Pharmacy (TMOP) and TRICARE Retail Pharmacy Network (TRRx), and at MTFs no later than a 60-day implementation period; and 2) TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following approval by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Calcium Channel Blockers (CCBs) – Nisoldipine (Sular geomatrix)

Relative Clinical Effectiveness – Nisoldipine (Sular geomatrix) is a dihydropyridine calcium channel blocker (DHP CCB) approved for treating hypertension. The CCBs were reviewed for UF placement at the August 2005 P&T Committee meeting. Other anti-hypertensive DHP CCBs included on the UF are amlodipine (Norvasc, generics), felodipine (Plendil, generics), nisoldipine coat core (Sular, generics), and nifedipine ER (Adalat CC, generics). The nisoldipine geomatrix clinical evaluation included, but was not limited to, the requirements stated in the UF rule, 32 CFR 199.21(e)(1).

Nisoldipine geomatrix employs a different extended-release mechanism than the original nisoldipine product, nisoldipine coat core; both products are dosed once daily. Generic formulations of the original coat core product recently became commercially available. The geomatrix delivery system allows for a 15% lower dosage than the coat core product. To review the full clinical effectiveness evaluation of nisoldipine geomatrix, see the Nisoldipine geomatrix New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder DoD P&T library. Note that rxnet is restricted to those with a ".mil" e-mail address.)

Relative Clinical Effectiveness Conclusion – The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) that there is no evidence to suggest that there are clinically relevant differences in the efficacy, safety, and clinical outcomes of nisoldipine geomatrix (Sular geomatrix) compared to nisoldipine coat core, as both products contain the same active ingredient. Additionally, the Committee agreed that nisoldipine geomatrix does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcomes over other CCB agents currently included on the UF.

Relative Cost Effectiveness – The P&T Committee evaluated the relative cost effectiveness of nisoldipine (Sular Geomatrix) in relation to efficacy, safety, tolerability, and clinical outcomes of other DHP CCBs, particularly to amlodipine (Norvasc, generics), felodipine (Plendil, generics) and nisoldipine (Sular coat core, generics). Information considered by the P&T Committee included, but was not limited to sources of information listed in 32 CFR 199.21 (e)(2).

A CMA was employed to determine the relative cost effectiveness of nisoldipine geomatrix relative to other UF DHP CCBs (nisoldipine coat core, felodipine, amlodipine). The results from the CMA revealed that the projected weighted average cost per day for therapy for nisoldipine geomatrix (Sular Geomatrix) is significantly higher than other UF CCBs amlodipine, felodipine, and nisoldipine (Sular coat core, generics).

Relative Cost Effectiveness Conclusion – P&T Committee, based upon its collective professional judgment, voted (15 for, 0 opposed, 0 abstained, 0 absent) that

nisoldipine geomatrix (Sular Geomatrix) is not cost effective relative to other UF DHP CCB agents.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness of nisoldipine geomatrix, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend that nisoldipine geomatrix (Sular geomatrix) be designated as non-formulary on the UF. This recommendation was based on the clinical effectiveness conclusion, and the determination that amlodipine (Norvasc, generics), felodipine (Plendil, generics) and generic nisoldipine coat core remain the most cost effective CCB agents on the UF compared to Sular Geomatrix.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

2) ***COMMITTEE ACTION: MN CRITERIA*** – Based on the clinical evaluation of nisoldipine geomatrix and the conditions for establishing medical necessity of a non-formulary medication provided for in the UF rule, the P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) MN criteria for nisoldipine geomatrix (Sular geomatrix). (See Appendix B for full MN criteria).

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** – The P&T Committee voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend: 1) an effective date of the first Wednesday one week after the minutes are signed, following a 60-day implementation period in TMOP and TRRx, and at MTFs no later than a 60-day implementation period; and 2) TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following approval by the Director, TMA.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

5) DRUG CLASS REVIEW – OVERACTIVE BLADDER AGENTS (OABs)

Relative Clinical Effectiveness: The DoD P&T Committee evaluated the clinical effectiveness of the Overactive Bladder Agents (OABs); this class was first reviewed for UF placement in February 2006. There are nine marketed anticholinergic drugs for overactive bladder (OAB) in the US, darifenacin (Enablex), oxybutynin immediate release (IR) (Ditropan, generics), oxybutynin extended release (ER) (Ditropan XL; generics), oxybutynin transdermal (Oxytrol patch) solifenacin (Vesicare), tolterodine IR (Detrol), tolterodine ER (Detrol LA), trospium IR (Sanctura) and trospium ER (Sanctura XR).

Information regarding the safety, effectiveness, and clinical outcomes of these drugs was considered. The clinical review included, but was not limited to the requirements stated in the UF Rule, 32 CFR 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 outcomes over the pharmaceutical agents included on the UF in that therapeutic class.

All nine drugs are FDA approved for the treatment of OAB with symptoms of urge incontinence, urgency and urinary frequency. Oxybutynin ER is also approved for the treatment of patients aged 6-years and older with symptoms of detrusor overactivity associated with a neurological condition (e.g. spina bifida), but was not reviewed for this indication by the Committee. Only oxybutynin IR and ER are available in generic formulations.

Military Health System expenditures for the OAB class exceeded $74 million from July 07 to June 08. Tolterodine ER (Detrol LA) is the highest utilized OAB agent at the MTFs, followed by oxybutynin ER (Ditropan XL, generics). To review the full clinical effectiveness evaluation, see the OAB DoD Drug Class Review found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library. Note that rxnet is restricted to those with a ".mil" e-mail address.)

Relative Clinical Effectiveness Conclusion: The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent) to accept the following clinical effectiveness conclusion:

a) Evaluation of clinically relevant differences in efficacy of the OAB agents at relieving urinary symptoms is hampered by the high placebo response rate (30-50%), varying use of non-pharmacologic measures such as bladder training and behavioral modification, and differing outcome measures used in clinical trials.

b) With regards to efficacy at reducing the number of urge incontinent episodes, urgency episodes, and micturation frequency, the available evidence does not support clinically relevant differences between oxybutynin IR (Ditropan, generics), oxybutynin ER (Ditropan XL, generics), oxybutynin patch (Oxytrol), tolterodine IR (Detrol), tolterodine ER (Detrol LA), trospium IR (Sanctura), trospium ER (Sanctura XR), solifenacin (Vesicare), and darifenacin (Enablex).

c) With regards to safety and tolerability, the following conclusions were made:

- There are no differences between the OAB drugs in terms of black box warnings (e.g., acute urinary or gastric retention, acute angle-closure glaucoma, and myasthenia gravis), listed in the product labeling.
- Oxybutynin IR had higher rates of withdrawals of therapy due to adverse events and occurrence of dry mouth then the other OAB agents, but no single agent has shown a clearly superior profile.
- The incidence of adverse events including dry mouth, and constipation, overall was lower with extended release preparations compared with immediate release formulations of the agents. The oxybutynin patch has been associated with pruritis and rash.
- The newer agents (trospium IR and ER, solifenacin, and darifenacin) do not appear to have a significantly lower incidence of dry mouth or constipation compared to extended-release forms of the older agents (oxybutynin ER, and tolterodine ER).
- All the OAB agents may cross the blood brain barrier and result in significant central nervous system effects, although this may be less likely with trospium IR and ER.
- Drug-drug interactions are less likely with trospium than the other agents.

d) With regards to tolerability and persistence rates, the following conclusions were made:

- Persistence rates for OAB medications reported in the medical literature are in general low (<10%); and a 2005 PEC analysis reported that only about 11% of MHS patients continued to obtain prescriptions for OAB medications on a regular basis after 1 year.
- An updated analysis performed by the Pharmacy Outcomes Research Team (PORT) included 35,121 DoD beneficiaries who were new users of OAB medications at any DoD pharmacy point of service from 1 Dec 06 to 31 May 07. Trospium ER was not commercially available at the time of the review and was not included in the analysis. The reported 1-year persistence rate with OAB therapy was 14% overall, with generally higher persistence for patients receiving newer agents and extended release versions of older agents, compared to those receiving immediate release versions of tolterodine and oxybutynin. About 28% of patients who were considered to be non-persistent continued to occasionally obtain prescription refills, consistent with use on an "as needed" rather than routine basis.

e) With regard to special populations, only oxybutynin IR and oxybutynin ER are approved for use in children ages 6 years and older. For pregnancy, oxybutynin IR, oxybutynin ER, and the oxybutynin patch are labeled as category B drugs, while the other OAB drugs are labeled as category C drugs.

Relative Cost Effectiveness: In considering the relative cost-effectiveness of pharmaceutical agents in the OAB class, the P&T Committee evaluated the costs of the agents in relation to the efficacy, safety, tolerability, 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 CFR 199.21(e)(2).

Relative Cost Effectiveness Conclusion: The relative clinical effectiveness evaluation concluded that the newer OAB drugs darifenacin and solifenacin and the extended release formulations had higher persistence rates in the MHS than oxybutynin IR and tolterodine IR. Therefore, the cost effectiveness of the OAB agents was evaluated by CMA, cost effectiveness analysis (CEA), and by budget impact analysis (BIA). Based on the results of the cost analyses and other clinical and cost considerations, the P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) the following:

a) Results from the CMA for the immediate release OAB agents (oxybutynin IR [Ditropan, generics], tolterodine IR [Detrol], and trospium IR [Sanctura]) revealed that oxybutynin IR was the most cost effective immediate release OAB agent overall.

b) Results from the CMA of extended release OAB agents (oxybutynin ER [Ditropan XL, generics], tolterodine ER [Detrol LA], trospium ER [Sanctura XR], oxybutynin transdermal [Oxytrol patch], darifenacin [Enablex], and solifenacin [Vesicare]) revealed that 1) trospium ER (Sanctura XR) was the most cost effective extended release OAB agent overall; and 2) when the price for generic formulations of oxybutynin ER (Ditropan XR) drops by 21.3% from the current price, oxybutynin ER will become the most cost-effective agent.

c) The results from a CEA comparing immediate release vs. extended release agents revealed that patients are more persistent with therapy when taking extended release products than when taking immediate release products. This is done at a significantly higher incremental cost per day of persistence gained by taking extended release products. However, the incremental cost per day of persistence gained is ~ 18% lower than when compared to MHS costs in 2005 when the OAB drugs were previously reviewed for UF placement.

d) The BIA evaluated the potential impact of scenarios with selected OAB agents designated formulary or non-formulary on the UF. Results from the BIA revealed that the scenario that designated tolterodine IR (Detrol) and trospium IR (Sanctura) as non-formulary under the UF was more favorable to the MHS.

A. COMMITTEE ACTION: UF RECOMMENDATION – In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the OAB agents, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (14 for, 0 opposed, 1 abstained, and 0 absent) to recommend to recommend that:

1) Oxybutynin IR (Ditropan, generics), oxybutynin ER (Ditropan XL, generics), oxybutynin patch (Oxytrol), tolterodine ER (Detrol LA), solifenacin (Vesicare), trospium ER (Sanctura XR), and darifenacin (Enablex) be classified as formulary on the UF.

2) Tolterodine IR (Detrol) and trospium IR (Sanctura) be designated as non-formulary under the UF, based on cost effectiveness.

All OAB drugs recommended for inclusion on the UF were covered by Uniform Formulary Voluntary Agreement for Retail Refunds (UF VARR) submissions at or below the Federal Ceiling Price (FCP).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. COMMITTEE ACTION: MN CRITERIA – Based on the clinical evaluation for tolterodine IR (Detrol) and trospium IR (Sanctura) and the conditions for establishing medical necessity for a non-formulary medication provided for in the UF rule, the P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) MN criteria for tolterodine IR (Detrol) and trospium IR (Sanctura). (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

C. COMMITTEE ACTION: IMPLEMENTATION PERIOD –The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday one week after the minutes are signed following a 90-day implementation period in the TMOP and TRRx, and at the MTFs no later than a 90-day implementation period. 2) That TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following the approval by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

D. COMMITTEE ACTION: BCF RECOMMENDATION – The P&T Committee considered the BCF status of the OAB agents. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (13 for, 1 opposed, 1 abstained, and 0 absent) to recommend that 1) tolterodine ER (Detrol LA) continue to be designated as BCF; 2) that oxybutynin ER (Ditropan XL, generics) be designated as BCF; and that 3) oxybutynin IR (Ditropan, generics) be removed from the BCF, but maintained as formulary on the UF, starting the first Wednesday one week after the signing of the August 2008 DoD P&T Committee minutes by the Director, TMA. As a result of the above actions oxybutynin IR (Ditropan, generics) would no longer be designated as BCF, but maintained as formulary on the UF.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

6) DRUG CLASS REVIEW – SELF-MONITORING BLOOD GLUCOSE TEST SYSTEMS (SMBGS) TEST STRIPS

Relative Clinical Effectiveness: The P&T Committee evaluated the relative clinical effectiveness of the Self-Monitoring Blood Glucose Test Systems (SMBGS) test strips. The clinical evaluation included, but was not limited to, the requirements stated in the UF rule, 32 CFR 199.21(e)(1).The primary goal for the UF recommendation is to ensure uniform availability of quality SMBGS test strips across the MHS (MTF, TRRx, and TMOP points of service). SMBGS meters are not included as part of the TRICARE outpatient pharmacy benefit (they are included under the medical benefit) and are not the focus of the review; however provisions have been made to provide SMBGS meters at no cost to MHS beneficiaries.

The FDA classifies SMBGS test strips and meters as medical devices, rather than drugs, thus the focus of the clinical effectiveness review centered on differences in the technical aspects/attributes among the products. The P&T Committee had previously determined that all SMBGS test strips considered for inclusion on the UF must meet minimum technical standards relating to accuracy, blood sample size, availability of testing sites other than the fingertips, result time, memory capacity, ease of use (e.g., calibration and coding, large visual display), manufacturer customer support services, downloading capabilities, availability of data management software, and size.

The test strips included in the SMBGS class were those products approved by the FDA and available in the marketplace as of May 2008. Due to the complexity of evaluating the more than 40 commercially marketed SMBGS test strip brands, the number of test strips eligible of inclusion on the UF was determined by DoD P&T Committee minimum technical requirements, operational limitations of the existing TMOP and TRRx contract, and Federal Government contracting regulations.

Relative Clinical Effectiveness Conclusion: The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) that:

a) With regard to efficacy, all meters that are approved by the FDA for licensing in the USA must meet the FDA standard of accuracy, which is a total analytical error of <5%. The International Organization for Standardization (ISO) also has standards. All the SMBGS test strips meeting the minimum technical requirements for inclusion on the UF met both FDA and ISO standards. There was insufficient published clinical trial data to determine if there were clinically relevant differences between the SMBGS test strips with regard to accuracy. The most common cause of inaccurate SMBGS test results is operator error.

b) With regard to calibration and coding, the SMBGS test strips with the lowest risk of coding/calibration errors (as they do not require coding) are the Ascensia Contour and Freestyle Lite test strips. The Accu-chek Aviva, Precision Xtra, and TrueTrack test strips require insertion of a coding chip or strip. The One Touch Ultra test strip requires manual coding.

c) With regard to blood sample size, the Freestyle Lite test strip requires 0.3 microliter (µL) blood; the Accu-check Aviva, Ascensia Contour, and Precision

Xtra require 0.6 µL; and the One Touch Ultra and TrueTrack test strips require 1 µL blood.

d) With regard to alternate site testing, the Accu-chek Aviva and Freestyle Lite strips are FDA-approved for testing at 5 alternate sites other than the fingertips, the Ascensia Contour strip is approved for 4 alternate sites, the Precision Xtra and One Touch Ultra strips are approved for 3 alternate sites, and the TrueTrack strip is approved for one alternate testing site other than the fingertips.

e) With regard to test result time, the Accu-chek Aviva, Ascensia Contour, Freestyle Lite, Precision Xtra, and One Touch Ultra provide test results within 5 seconds, while the TrueTrack strips provide test results in 10 seconds.

f) With regard to SMBGS test strip degradation due to heat and humidity, the Precision Xtra test strips are individually foil-wrapped; however patients with dexterity problems may have difficulty opening the foil wrappers.

g) With regard to safety, the Accu-chek Aviva and Freestyle Lite SMBGS test strips employ technology using glucose dehydrogenase (GDH) pyrroloquinolinequinone, which may cause falsely elevated blood glucose readings in patients receiving concomitant therapy with icodextrin-containing substances (Extrarenal peritoneal dialysis solution and the IV immunoglobulin product Octagam). SMBGS strips using GDH nicotinamide adenine dinucleotide [Precision Xtra], GDH flavin adenine dinucleotide [Ascensia Contour] or glucose oxidase technology [One Touch Ultra and TrueTrack] do not interfere with Extrarenal or Octagam.

h) With regard to special populations, those patients requiring intensive blood glucose monitoring (e.g., women with gestational diabetes, Type 1 diabetics, children and adults using insulin pumps) may prefer SMBGS test strips used in certain meters that can communicate wirelessly with insulin pumps.

i) With regard to provider opinion, a survey of MTF providers reported that accuracy and small blood sample size were the two technical requirements considered most important when comparing SMBGS.

j) With regard to therapeutic interchangeability, there is a high degree of therapeutic interchangeability between the SMBGS test strips meeting the DoD P&T Committee minimum technical requirements.

Relative Cost Effectiveness: In considering the relative cost-effectiveness of pharmaceutical agents in the SMBGS test strip class, the P&T Committee evaluated the costs of the agents in relation to the efficacy, safety, tolerability, 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 CFR 199.21(e)(2).

The relative clinical effectiveness evaluation concluded that for those SMBGS test strips meeting the minimum technical criteria, there were no clinically relevant differences between the agents. As a result, a CMA and BIA were conducted.

Relative Cost Effectiveness Conclusion: The P&T Committee concluded (14 for, 0 opposed, 1 abstained, 0 absent) the following:

a) Results from the CMAs for the condition sets for both the 3 or less and 4 or more included on the UF revealed that Ascensia Contour was the most cost effective SMBG system while One Touch Ultra was the least cost effective. The ranking of most to least cost effective SMBGS test strips based on prices submitted for each condition set was: Ascensia Contour >TrueTrack > Freestyle Lite > Precision Xtra > Accu-chek Aviva > OneTouch Ultra.

b) The BIA evaluated the potential impact of scenarios with selected SMBGS products designated formulary or non-formulary on the UF. The BIA results showed that the scenario that designated the One Touch Ultra and TrueTrack self SMBGS as non-formulary on the UF was more favorable to the MHS.

A. COMMITTEE ACTION: UF RECOMMENDATION – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost-effectiveness determinations of the SMBGS test strips, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (12 for, 2 opposed, 0 abstained, 1 absent) to recommend that:

1) Accu-chek Aviva, Precision Xtra, Freestyle Lite, and the Ascensia Contour SMBGS test strips be designated as formulary on the Uniform Formulary.

2) One Touch Ultra, TrueTrack, Accu-chek Comfort Curve, Accu-chek Compact Plus, Accu-chek Simplicity, Ascensia Autodisc, Ascensia Breeze 2, Ascensia Elite, Assure, Assure 3, Assure II, Assure Pro, Bd Test Strips, Chemstrip Bg, Control AST, Dextrostix Reagent, Easygluco, Easypro, Fast Take, Freestyle Test Strips (other than Freestyle Lite), Glucofilm, Glucolab, Glucometer Dex, Glucometer Elite, Glucose Test Strip, Glucostix, Optium, Precision Pcx, Precision Pcx Plus, Precision Q-I-D, Precision Sof-Tact, Prestige Smart System, Prodigy, Quicktek, Sidekick, Sof-Tact, Surestep, Surestep Pro, Test Strip, Relion Ultima, Uni-Check, and all store/private label brands not specified as formulary in "1" above be designated as non-formulary on the UF.

The SMBGS test strips are a medical device and subject to wholesale acquisition cost, rather than FCP pricing.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. COMMITTEE ACTION: MN CRITERIA – Based on the clinical evaluation for he SMBGS and the conditions for establishing medical necessity for a non-formulary medication provided for in the UF rule, the P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) MN criteria for the non-formulary SMBG systems listed in section A 2 above. (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

C. COMMITTEE ACTION: IMPLEMENTATION PERIOD – The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday one week after the minutes are signed, following a 120-day implementation period in the TMOP and TRRx, and at the MTFs no later than a 120-day implementation period. 2) That TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following the approval by the Director, TMA

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

D. COMMITTEE ACTION: BCF RECOMMENDATION – The P&T Committee considered the BCF status of the SMBGS. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (13 for, 0 opposed, 1 abstained, and 1 absent) to recommend that Precision Xtra be designated as the BCF SMBGS the first Wednesday one week after the signing of the August 2008 DoD P&T Committee minutes by the Director, TMA

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

7) UTILIZATION MANAGEMENT – PRIOR AUTHORIZATIONS (PA)/ QUANTITY LIMITS (QL) / MEDICAL NECESSITY (MN)

Ondansetron (Zofran) – QL – Currently QLs are in place for the oral anti-emetics used for chemotherapy-induced and post-operative nausea and vomiting. Generic formulations of ondansetron tablets recently became available, with a corresponding reduction in cost. The current ondansetron QLs of 45 tabs per 90 days in the TMOP, and 15 tabs per 30 days in the TRRx are not sufficient to meet current FDA-approved dosage recommendations. The Committee recommended increasing the QLs for ondansetron 4 mg and 8 mg oral tablets and orally disintegrating tablets, to reflect the dosages recommended in the FDA-approved product labeling.

COMMITTEE ACTION: The P&T Committee voted (12 for, 2 opposed, 1 abstained, 0 absent) to approve ondansetron QLs of 60 tablets per 30 days at the retail point of service, and 180 tablets per 90 days at the mail order point of service.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

8) RE-EVALUATION OF NON-FORMULARY AGENTS

The P&T Committee's process for re-evaluation of non-formulary agents established at the May 2007 meeting was approved by the Director, TMA on 24 June 2007. At the August 2008 meeting, the P&T Committee reviewed an updated list of non-formulary drugs identified that were: 1) from drug classes in which UF status was NOT awarded based on condition sets that specified the number of similar agents on the UF (i.e., agents in the same class or subclass); and 2) determined to have similar relative clinical effectiveness (i.e., similar efficacy, safety and tolerability) compared to similar agents on the UF and not excluded from the UF based on clinical issues alone. The updated list is included in Appendix D.

COMMITTEE ACTION: The P&T Committee voted (14 for, 0 against, 1 abstained 0 absent) to recommend that the list of non-formulary agents in Appendix D be evaluated for UF status when pre-established criteria are met.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

9) ITEMS FOR INFORMATION

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

A. **Beneficiary Advisory Panel (BAP) Briefing** – CDR Ellzy briefed the members of the P&T Committee regarding the July 2008 BAP meeting. The P&T Committee was briefed on the BAP comments regarding the DoD P&T Committee's Uniform Formulary (UF) and implementation guidelines.

B. **Outcomes Research Reports** – *Fentanyl Patch Safety Program* – The PORT reported results of an analysis of the Fentanyl Patch Safety Program, which went into effect 1 Aug 2007. The program uses an automated prior authorization (PA) process to "look-back" at patients' pharmacy profiles; the dispensing process is stopped with a warning message if patients may not be opioid-tolerant based on prior dispensing of strong opioids. Pharmacists may override the warning using standard intervention and outcome codes after consulting with the prescriber or patient and/or taking into account information not available to the Pharmacy Data Transaction Service (PDTS) (i.e., prescriptions not paid for by DoD). Currently the program returns automated warning messages only at the retail network and mail order points of service.

   In general, the program appeared to reduce the use of fentanyl patch among seemingly opioid-naïve patients, without placing an undue burden on patients who may have been wrongly identified as opioid-naïve. Results of the analysis will be presented to the MHS Clinical Quality Forum.

C. **Implementation Status of UF Decisions** – The PEC briefed the members of the P&T Committee on the progress of implementation of drug classes reviewed for UF status since February 2005.

D. **Basic Core Formulary (BCF) / Extended Core Formulary (ECF) Review** – The PEC briefed the DoD P&T Committee on the efforts to implement electronic prescribing in the MHS. As part of the ongoing plan to systematically drugs represented on the BCF and ECF, the Committee periodically reviews recommendations for changes to the BCF and ECF, which will also assist with electronic prescribing. Further information will be presented at an upcoming meeting; no action necessary.

10)CLASS OVERVIEWS

Class overviews for the Nasal Allergy Drugs (comprised of the nasal antihistamines and nasal corticosteroids) and the inhaled Short Acting Beta Agonists were presented to the P&T Committee. The P&T Committee provided expert opinion regarding those clinical outcomes considered most important for the PEC to use in completing the clinical effectiveness reviews and developing the appropriate cost effectiveness models. The clinical and economic analyses of these classes will be completed during the November 2008 meeting.

11)ADJOURNMENT

The second day of the meeting adjourned at 1200 hours on 13 Aug 2008. The next meeting will be 18-19 Nov 2008.

Appendix A – Attendance
Appendix B – Table of Medical Necessity Criteria
Appendix C – Implementation Status of UF Recommendations/Decisions
Appendix D – Non-Formulary Agents for Re-evaluation
Appendix E – Table of Abbreviations

SUBMITTED BY:

//signed//
Col John Kugler, MC
DoD P&T Committee Chair

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.

//signed// 24 Oct 08
S. Ward Casscells, III, M.D.

Appendix A – Attendance – (continued)

Others Present	
CAPT Miles Rudd	USPHS/IHS
Cathy Kelly, PharmD	Dept of Veteran's Affairs, Pharmacy Benefits Management
Lt Col James McCrary, MC, USAF	DoD PEC
LTC Chris Conrad, MC, USA	DoD PEC
CDR Matthew Carlberg, MC, USN	DoD PEC
MAJ Misty Carlson, MC, USA	DoD PEC
Maj Josh Devine, BSC, USAF	DoD PEC
LCDR Joe Lawrence, MSC, USN	DoD PEC
Lt Dean Kang, MSC, USN	DoD PEC Pharmacy Resident
HM2 Trishonya McMihelk	DoD PEC
Angela Allerman, Pharm.D.	DoD PEC
David Meade, Pharm.D.	DoD PEC
Harsha Mistry, Pharm.D.	DoD PEC
Eugene Moore, Pharm.D.	DoD PEC
Shana Trice, Pharm.D.	DoD PEC
Jeremy Briggs, Pharm.D.	DoD PEC – Pharmacy Operations Center

Appendix B – Medical Necessity Criteria

Drug / Drug Class	Medical Necessity Criteria
Desvenlafaxine (Pristiq) (Antidepressant-1s)	• The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.
Nisoldipine geomatrix (Sular geomatrix) (Dihydropyridine Calcium Channel Blockers)	• The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.
Tolterodine IR (Detrol), Trospium (Sanctura) (Overactive Bladder Drugs)	• Use of formulary alternatives is contraindicated • The patient has experienced or is likely to experience significant adverse effects from formulary alternatives. • Formulary agents have resulted or are likely to result in therapeutic failure. • The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.
One Touch Ultra TrueTrack Accu-chek Comfort Curve Accu-chek Compact Plus Accu-chek Simplicity Ascensia Autodisk, Ascensia Breeze 2, Ascensia Elite Assure, Assure 3, Assure II, Assure Pro Bd Test Strips Chemstrip Bg Control AST Dextrostix Reagent Easygluco, Easypro Fast Take Freestyle test strips (other than Freestyle Lite) Glucofilm, Glucolab, Glucometer Dex, Glucometer Elite, Glucose Test Strip, Glucostix Optium Precision Pcx, Precision Pcx Plus, Precision Q-I-D, Precision Sof-Tact Prestige Smart System Prodigy Quicktek Sidekick Sof-Tact Surestep Surestep Pro Test Strip Relion Ultima Uni-Check Plus all other store/private label brand strips not included on Uniform Formulary (see BCF/ECF column in Appendix C) **(Self-Monitoring Blood Glucose System (SMBGS) test strips)**	• Use of formulary alternatives is contraindicated • The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.

Appendix C – Implementation Status of UF Class Review Recommendations / Decisions

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Aug 08	Self-Monitoring Blood Glucose Systems (SMBGS) test strips	▪ One Touch Ultra 2 strips (for One Touch Ultra 2, Ultra Mini, and Ultra Smart meters) ▪ TrueTrack strips (for TrueTrack meter) ▪ Accu-chek Comfort Curve strips (for Accu-chek Advantage meter) ▪ Accu-chek Compact Plus drum (for Accu-check Compact Plus meter) ▪ Accu-chek Simplicity, Ascensia Autodisk, Ascensia Breeze 2, Ascensia Elite, Assure, Assure 3, Assure II, Assure Pro, Bd Test Strips, Chemstrip Bg, Control AST, Dextrostix Reagent, Easygluco, Easypro, Fast Take, Freestyle test strips (other than Freestyle Lite), Glucofilm, Glucolab, Glucometer Dex, Glucometer Elite, Glucose Test Strip, Glucostix, Optium, Precision Pcx, Precision Pcx Plus, Precision Q-I-D, Precision Sof-Tact, Prestige Smart System, Prodigy, Quicktek, Sidekick, Sof-Tact, Surestep, Surestep Pro, Test Strip, Relion Ultima, Uni-Check ▪ Plus all other store/private label brand strips not included on Uniform Formulary (see the BCF/ECF column)	BCF	▪ Precision Xtra strips (for Precision Xtra meter) **Uniform Formulary SMBGS test strips** ▪ Accu-chek Aviva (for Accu-chek Aviva meter) ▪ Ascensia Contour (for Ascensia Contour meter) ▪ Freestyle Lite (for Freestyle Freedom Lite and Freestyle Lite meters)	pending approval	pending approval
Aug 08 (re-review; Feb 06 original review)	Overactive Bladder (OAB) Agents	▪ tolterodine IR (Detrol) ▪ trospium IR (Sanctura)	BCF	▪ tolterodine ER (Detrol LA) ▪ oxybutynin ER (Ditropan XL, generics) (Note: oxybutynin IR [generic Ditropan] removed from BCF, but still UF)	pending approval	pending approval
Aug 08 (update; reviewed Nov 05)	Antidepressants I	**Recommended for non-formulary status Aug 08** ▪ Desvenlafaxine (Pristiq)		No changes to BCF recommended Aug 08	pending approval	pending approval
		To remain NF: ▪ paroxetine HCl CR (Paxil) ▪ fluoxetine 90 mg for weekly administration (Prozac Weekly) ▪ fluoxetine in special packaging for PMDD (Sarafem) ▪ escitalopram (Lexapro) ▪ duloxetine (Cymbalta) ▪ bupropion extended release (Wellbutrin XL)	BCF	Currently BCF ▪ citalopram ▪ fluoxetine (excluding weekly regimen and special packaging for PMDD) ▪ sertraline (Zoloft) ▪ trazodone ▪ bupropion sustained release	19 Jul 06	19 Jul 06 (180 days)

Aug 08 (update; reviewed Aug 05; also updated Nov 07)	Calcium Channel Blockers	**Recommended for non-formulary status Aug 08** ▪ nisoldipine geomatrix (Sular geomatrix)		No changes to BCF recommended Aug 08	pending approval	pending approval
		Previously non-formulary, recommended for UF status Nov 07 ▪ amlodipine besylate (Norvasc generic)		Recommended for addition to BCF Nov 07 ▪ amlodipine besylate tablets	13 Feb 08	13 Feb 08
		To Remain Non-Formulary ▪ isradipine IR (Dynacirc) ▪ isradipine ER (Dynacirc CR) ▪ nicardipine IR (Cardene, generics) ▪ nicardipine SR (Cardene SR) ▪ verapamil ER (Verelan) ▪ verapamil ER for bedtime dosing (Verelan PM, Covera HS) ▪ diltiazem ER for bedtime dosing (Cardizem LA)	BCF	Currently BCF ▪ amlodipine besylate (Norvasc, generics) (Recommended at Nov 07 meeting) ▪ nifedipine ER (Adalat CC, generics) ▪ verapamil SR ▪ diltiazem ER (Tiazac, generics)	13 Oct 05	15 Mar 06 (150 days)
Jun 08	Osteoporosis Agents	▪ calcitonin salmon nasal spray (Miacalcin)	BCF	▪ alendronate (Fosamax) ▪ ibandronate (Boniva) (Note: raloxifene (Evista) removed from BCF, but still UF)	27 Aug 08	26 Nov 08 (90 days)
Jun 08	Triptans	▪ almotriptan (Axert) ▪ frovatriptan (Frova) ▪ naratriptan (Amerge)	BCF	▪ rizatriptan (Maxalt), immediate upon signing of the minutes ▪ sumatriptan oral and one injectable formulation, when multi-source generics are available	27 Aug 08	26 Nov 08 (90 days)
Jun 08 (update; reviewed May 07)	Antilipidemic Agents II	No changes to NF recommended Jun 08	BCF	**Recommended for addition to BCF Jun 08** ▪ fenofibrate meltdose (Fenoglide), to replace fenofibrate IDD-P (Triglide) (Note: fenofibrate IDD-P (Triglide) removed from BCF but still UF)	27 Aug 08	29 Oct 08 (60 days)
		To remain NF ▪ fenofibrate nanocrystallized (Tricor) ▪ fenofibrate micronized (Antara) ▪ omega-3 fatty acids (Omacor) ▪ colesevelam (Welchol)		Currently BCF ▪ gemfibrozil	24 July 07	21 Nov 07 (120 days)
Jun 08 (update; reviewed Nov 07)	Adrenergic Blocking Agents	**Recommended for non-formulary status Jun 08** ▪ nebivolol (Bystolic)	BCF	No change to BCF recommended Jun 08	27 Aug 08	29 Oct 08 (60 days)
		(No ABAs selected for NF placement at Nov 07 meeting)		Currently BCF ▪ atenolol tablets ▪ metoprolol tartrate IR tablets ▪ carvedilol IR tablets ▪ metoprolol succinate ER tablets	13 Feb 08	-

Jun 08 (update; reviewed Aug 07	Newer Antihistamines	**Recommended for non-formulary status Jun 08** ▪ levocetirizine (Xyzal)	BCF	No change to BCF recommended Jun 08	27 Aug 08	29 Oct 08 (60 days)
		To remain NF ▪ desloratadine (Clarinex) ▪ desloratadine/pseudoephedrine (Clarinex D)		▪ MTFs required to carry at least one single ingredient agent from the newer antihistamine class (loratadine, cetirizine, or fexofenadine) on their local formulary, including at least one dosage form suitable for pediatric use	17 Oct 07	16 Jan 08 (90 days)
Jun 08 (update; reviewed Aug 07)	Leukotriene Modifiers	**Recommended for non-formulary status Jun 08** ▪ Zileuton ER (Zyflo CR)	BCF	No changes to BCF rec Jun 08	27 Aug 08	29 Oct 08 (60 days)l
		To remain NF ▪ zileuton (Zyflo)		Currently BCF ▪ montelukast (Singulair)	17 Oct 07	16 Jan 08 (90 days)
Jun 08 (update) Original reviews ▪ ACE inhibitors: Aug 05 ▪ Miscellaneous antihypertensives, including ACE/CCB combos. Feb 06 ▪ ARBs: May 07 ▪ Renin inhibitors. Aug 07 ▪ CCB/ARB combos Nov 07 update	Renin Angiotensin Antihypertensives	**Recommended for non-formulary status Jun 08** ▪ olmesartan/amlodipine (Azor)	BCF	No change to BCF recommended Jun 08	27 Aug 08	29 Oct 08 (60 days)
		To remain NF ▪ valsartan amlodipine (Exforge)		No change to BCF recommended Nov 07	13 Feb 08	16 Apr 08 (60 days)
		To remain NF ACE inhibitors ▪ moexipril (Univasc), ▪ moexipril / HCTZ (Uniretic) ▪ perindopril (Aceon) ▪ ramipril (Altace) ACE/CCB combos ▪ felodipine/enalapril (Lexxel) ▪ verapamil/trandolapril (Tarka) ARBs ▪ eprosartan (Teveten) ▪ eprosartan HCTZ (Teveten HCT) ▪ irbesartan (Avapro) ▪ irbesartan HCTZ (Avalide) ▪ olmesartan (Benicar) ▪ olmesartan HCTZ (Benicar HCT) ▪ valsartan (Diovan) ▪ valsartan HCTZ (Diovan HCT)		Currently on the BCF ACE inhibitors ▪ captopril ▪ lisinopril ▪ lisinopril / HCTZ ACE/CCB combos ▪ amlodipine/benazepril (Lotrel, generics) ARBs ▪ telmisartan (Micardis) ▪ telmisartan HCTZ (Micardis HCT)	ACE inhibitors ▪ 13 Oct 05 ACE/CCB combos ▪ 26 Apr 06 ARBs ▪ 24 July 07	ACE inhibitors ▪ 15 Feb 06 ACE/CCB combos ▪ 26 Jul 06 ARBs ▪ 21 Nov 07
Nov 07	Targeted Immunomodulatory Biologics	▪ etanercept (Enbrel) ▪ anakinra (Kineret)	ECF	▪ adalimumab (Humira) injection	13 Feb 08	18 Jun 08 (120 days)
Nov 07 re-review (Aug 05 original)	BPH Alpha Blockers	▪ tamsulosin (Flomax) Automated PA requiring trial of alfuzosin (Uroxatral) applies to new users of tamsulosin (no use of uroselective alpha blockers in last 180 days)	BCF	▪ terazosin tablets or capsules ▪ alfuzosin tablets (Uroxatral)	13 Feb 08	16 Apr 08 (60 days)
Nov 07 (update,	ADHD / Narcolepsy Agents	**Recommended for non-formulary status Nov 07** ▪ lisdexamfetamine (Vyvanse)	BCF	No change to BCF recommended Nov 07	13 Feb 08	16 Apr 08 (60 days)

original review Nov 06)		To remain NF ▪ dexmethylphenidate IR (Focalin) ▪ dexmethylphenidate SODAS (Focalin XR) ▪ methylphenidate transdermal system (Daytrana)		Currently on the BCF ▪ methylphenidate OROS (Concerta) ▪ mixed amphetamine salts ER (Adderall XR) ▪ methylphenidate IR (Ritalin)	17 Jan 07	18 Apr 07
Nov 07 (update, original review May 06)	Contraceptives	**Recommended for non-formulary status Nov 07** ▪ EE 20 mcg/levonorgestrel 0.09 mg in special packaging for continuous use (Lybrel)	BCF	No change to BCF recommended Nov 07	13 Feb 08	16 Apr 08 (60 days)
		To remain NF ▪ EE 30 mcg / levonorgestrel 0.15 mg in special packaging for extended use (Seasonale) ▪ EE 25 mcg / norethindrone 0.4 mg (Ovcon 35) ▪ EE 50 mcg / norethindrone 1 mg (Ovcon 50) ▪ EE 20/30/35 mcg / norethindrone 1 mg (Estrostep Fe)		Currently on the BCF ▪ EE 20 mcg / 3 mg drospirenone (Yaz) ▪ EE 20 mcg / 0.1 mg levonorgestrel (Lutera, Sronyx, or equivalent) ▪ EE 30 mcg / 3 mg drospirenone (Yasmin) ▪ EE 30 mcg / 0.15 mg levonorgestrel (Nordette or equivalent / excludes Seasonale) ▪ EE 35 mcg / 1 mg norethindrone (Ortho-Novum 1/35 or equivalent) ▪ EE 35 mcg / 0.25 mg norgestimate (Ortho-Cyclen or equivalent) ▪ EE 25 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen Lo) ▪ EE 35 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen or equivalent) ▪ 0.35 mg norethindrone (Nor-QD, Ortho Micronor, or equivalent)	26 Jul 06	24 Jan 07
		▪ EE 30/10 mcg / 0.15 mg levonorgestrel in special packaging for extended use (Seasonique) ▪ EE 20 mcg / 1 mg norethindrone (Loestrin 24 Fe)			17 Jan 07	18 Mar 07
Aug 07	Growth Stimulating Agents	▪ somatropin (Genotropin, Genotropin Miniquick) ▪ somatropin (Humatrope) ▪ somatropin (Omnitrope) ▪ somatropin (Saizen)	ECF	▪ somatropin (Norditropin)	17 Oct 07	19 Dec 07 (60 days)
Aug 07 (new drug update, original review Nov 05)	Nasal Corticosteroids	**Recommended for non-formulary status Aug 07** ▪ fluticasone furoate (Veramyst)	BCF	▪ No change to BCF recommended Aug 07	17 Oct 07	19 Apr 06 (90 days)
		▪ beclomethasone dipropionate (Beconase AQ, Vancenase AQ) ▪ budesonide (Rhinocort Aqua) ▪ triamcinolone (Nasacort AQ)		▪ fluticasone propionate (Flonase)	19 Jan 06	19 Dec 07 (60 days)
May 07 **re-review** (Feb 05 original)	PPIs	▪ lansoprazole (Prevacid) ▪ omeprazole/sodium bicarbonate (Zegerid) ▪ pantoprazole (Protonix) ▪ rabeprazole (Aciphex) Automated PA requiring trial of omeprazole OR esomeprazole (Nexium) applies to new users of non-formulary PPIs (no use of PPIs in last 180 days)	BCF	▪ generic omeprazole 10 mg and 20 mg (excludes Prilosec 40 mg) ▪ esomeprazole (Nexium)	24 July 07	24 Oct 07 (90 days)

May 07 **re-review** (Feb 05 original)	ARBs	▪ eprosartan (Teveten) ▪ eprosartan HCTZ (Teveten HCT) ▪ irbesartan (Avapro) ▪ irbesartan HCTZ (Avalide) ▪ olmesartan (Benicar) ▪ olmesartan HCTZ (Benicar HCT) ▪ valsartan (Diovan) ▪ valsartan HCTZ (Diovan HCT)	BCF	▪ telmisartan (Micardis) ▪ telmisartan HCTZ (Micardis HCT)	24 July 07	21 Nov 07 (120 days)
May 07	5-Alpha Reductase Inhibitors	▪ dutasteride (Avodart)	BCF	▪ finasteride	24 July 07	24 Oct 07 (90 days)
Feb 07	Newer Sedative Hypnotics	▪ zolpidem ER (Ambien CR) ▪ zaleplon (Sonata) ▪ ramelteon (Rozerem) Automated PA requiring trial of zolpidem IR applies to new users of eszopiclone (Lunesta), ramelteon (Rozerem), zaleplon (Sonata), or zolpidem ER (Ambien CR) (new users = no use of newer sedative hypnotics in last 180 days)	BCF	▪ zolpidem IR (Ambien)	02 May 07	01 Aug 07 (90 days)
Feb 07	Monoamine Oxidase Inhibitors	▪ selegiline transdermal patch (Emsam)	ECF	▪ phenelzine (Nardil)	02 May 07	01 Aug 07 (90 days)
Feb 07	Narcotic Analgesics	▪ tramadol ER (Ultram ER)	BCF	▪ morphine sulfate IR 15 mg, 30 mg ▪ morphine sulfate 12-hour ER (MS Contin or equivalent) 15, 30, 60 mg ▪ oxycodone/APAP 5/325 mg ▪ hydrocodone/APAP 5/500 mg ▪ codeine/APAP 30/300 mg ▪ codeine/APAP elixir 12/120 mg/5 mL ▪ tramadol IR	02 May 07	01 Aug 07 (90 days)
Feb 07	Ophthalmic Glaucoma Agents	▪ travoprost (Travatan, Travatan Z) ▪ timolol maleate for once daily dosing (Istalol) ▪ timolol hemihydrate (Betimol) ▪ brinzolamide (Azopt)	BCF	▪ latanoprost (Xalatan) ▪ brimonidine (Alphagan P); excludes 0.1% ▪ timolol maleate ▪ timolol maleate gel-forming solution ▪ pilocarpine	02 May 07	01 Aug 07 (90 days)
Nov 06	Older Sedative Hypnotics	-	BCF	▪ temazepam 15 and 30 mg	17 Jan 07	-
Nov 06 (update; reviewed Nov 06)	Dermatologic Topical Antifungals*	**Recommended for non-formulary status Nov 06:** 0.25% miconazole / 15% zinc oxide / 81.35% white petrolatum ointment (Vusion)	BCF	No change to BCF recommended Nov 06	14 Jul 05	17 Aug 05 (30 days)

		▪ econazole ▪ ciclopirox ▪ oxiconazole (Oxistat) ▪ sertaconazole (Ertaczo) ▪ sulconazole (Exelderm)		▪ nystatin ▪ clotrimazole	17 Jan 07	18 Mar 07 (60 days)
Aug 06	H2 Antagonists / GI protectants	-	BCF	▪ ranitidine (Zantac) – excludes gelcaps and effervescent tablets	23 Oct 06	-
Aug 06	Antilipidemic Agents I	▪ rosuvastatin (Crestor) ▪ atorvastatin / amlodipine (Caduet)	BCF	▪ simvastatin (Zocor) ▪ pravastatin ▪ simvastatin / ezetimibe (Vytorin) ▪ niacin extended release (Niaspan)	23 Oct 06	1 Feb 07 (90 days)
May 06	Antiemetics	▪ dolasetron (Anzemet)	BCF	▪ promethazine (oral and rectal)	26 Jul 06	27 Sep 06 (60 days)
Feb 06 (re-classified Aug 07; and updated Jun 08; see above)	Misc Antihypertensive Agents (ACE/CCB combos now part of RAAs class)	(ACE/CCB combos now part of RAAs class) ▪ felodipine/enalapril (Lexxel) ▪ verapamil/trandolapril (Tarka)	BCF	(ACE/CCB combos now part of RAAs class) ▪ amlodipine/benazepril (Lotrel) ▪ hydralazine ▪ clonidine tablets	26 Apr 06	26 Jul 06 (90 days)
Feb 06	GABA-analogs	▪ pregabalin (Lyrica)	BCF	▪ gabapentin	26 Apr 06	28 Jun 06 (60 days)
Nov 05	Alzheimer's Drugs	▪ tacrine (Cognex)	ECF	▪ donepezil (Aricept)	19 Jan 06	19 Apr 06 (90 days)
Nov 05	Macrolide/ Ketolide Antibiotics	▪ azithromycin 2 gm (Zmax) ▪ telithromycin (Ketek)	BCF	▪ azithromycin (Z-Pak) ▪ erythromycin salts and bases	19 Jan 06	22 Mar 06 (60 days)
May 05	PDE5 Inhibitors	▪ sildenafil (Viagra) ▪ tadalafil (Cialis)	ECF	▪ vardenafil (Levitra)	14 Jul 05	12 Oct 05 (90 days)
May 05	MS-DMDs	-	ECF	▪ interferon beta-1a intramuscular injection (Avonex)	14 Jul 05	**-**

BCF = Basic Core Formulary; ECF = Extended Core Formulary; MN = Medical Necessity; TMOP = TRICARE Mail Order Pharmacy; TRRx = TRICARE Retail Pharmacy program; UF = Uniform Formulary
ER = extended release; IR = immediate release; SR = sustained release; IDD-P = insoluble drug delivery-microParticle

AD-1s: Antidepressant-1 Drugs; ADHD = Attention Deficit Hyperactivity Disorder; ARBs = Angiotensin Receptor Blockers; ACE Inhibitors = Angiotensin Converting Enzyme Inhibitors; BPH = Benign Prostatic Hyperplasia; CCBs = Calcium Channel Blockers; EE = ethinyl estradiol; GI = gastrointestinal; GABA = gamma-aminobutyric acid; H2 = Histamine-2 receptor; HCTZ = hydrochlorothiazide; LIP-1 = Antihyperlipidemic-1 Drugs; LIP-2 = Antihyperlipidemic-2 Drugs; MOAIs = Monoamine Oxidase Inhibitor Drugs; MS-DMDs = Multiple Sclerosis Disease-Modifying Drugs; OABs = Overactive Bladder Medications; PDE5 Inhibitors = Phosphodiesterase- type 5 inhibitors; PPIs = Proton Pump Inhibitors; RAAs = Renin Angiotensin Antihypertensives Drugs; SMBGS: Self-Monitoring Blood Glucose Systems; TIBs = Targeted Immunomodulatory Biologics; TZDs= Thiazolidinediones

*The Dermatologic Topical Antifungal drug class excludes vaginal products and products for onychomycosis (e.g., ciclopirox topical solution [Penlac])

Appendix D – Non-Formulary Drugs for Re-Evaluation

Generic Name	Brand Name	UF Class	Generic Y/N
Ciclopirox	Loprox	Antifungal – Derm	Y
Econazole	Spectazole	Antifungal – Derm	Y
Oxiconazole	Oxistat, Oxizole	Antifungal – Derm	N
Sertaconazole	Ertaczo	Antifungal – Derm	N
Sulconazole	Exelderm	Antifungal – Derm	N
Moexipril + HCTZ	Univasc, Uniretic	RAAs – ACEs	Y
Perindopril	Aceon	RAAs – ACEs	N
Ramipril	Altace	RAAs – ACEs	Y
Diltiazem ER	Cardizem LA	CCBs	N
Isradipine / CR	DynaCirc, DynaCirc CR	CCBs	N
Nicardipine / SR	Cardene, Cardene SR	CCBs	Y
Verapamil ER/HS	Verelan, Verelan PM, Covera HS	CCBs	Y
Tamsulosin	Flomax	Alpha Blocker – BPH	N
Azithromycin	Zmax	Macrolide/Ketolide Abx	N
Telithromycin	Ketek	Macrolide/Ketolide Abx	N
Beclomethasone	Beconase AQ	Nasal corticosteroids	N
Budesonide	Rhinocort aqua	Nasal corticosteroids	N
Triamcinolone	Nasacort AQ	Nasal corticosteroids	N
Bupropion	Wellbutrin XL	Antidepressant – 1s	Y
Duloxetine	Cymbalta	Antidepressant – 1s	N
Escitalopram	Lexapro	Antidepressant – 1s	N
Fluoxetine	Prozac weekly	Antidepressant – 1s	N
Fluoxetine	Sarafem	Antidepressant – 1s	Y
Paroxetine CR	Paxil CR	Antidepressant – 1s	Y
Felodipine/ enalapril	Lexxel	RAAs – ACE/CCB combos	N
Verapamil/ trandolapril	Tarka	RAAs – ACE/CCB combos	N
Pregabalin	Lyrica	GABA Analogs	N
EE 30 mcg; 0.15mg levonorgestrel	Seasonale	Contraceptives (M30)	Y
EE 35 mcg; 0.4mg norethindrone	Ovcon 35	Contraceptives (M35)	Y
EE 50 mcg; 1 mg norethindrone	Ovcon 50	Contraceptives (M50)	N
EE 20/30/35 mcg; 1mg norethindrone	Estrostep Fe	Contraceptives (Triphasic)	Y
EE 30/10mcg; 0.15mg levonorgestrel	Seasonique	Contraceptives (Extended cycle)	N
EE 20mcg; 1mg norethindrone	Loestrin 24 Fe	Contraceptives (M20)	N
Dolasetron	Anzemet	Anti-emetics	N

Abx = antibiotics; CCB = Calcium Channel Blockers; EE = ethinyl estradiol; HCTZ = hydrochlorothiazide; M = monophasic; RAAs = Renin Angiotensin Antihypertensives

Appendix E – Table of Abbreviations

AD-1	Antidepressant-1 drug class
AE	adverse event
BAP	Beneficiary Advisory Panel
BCF	Basic Core Formulary
BIA	budget impact analysis
CC	coat core
CCB	calcium channel blocker
CEA	cost effectiveness analysis
CFR	Code of Federal Regulations
CI	confidence interval
CMA	cost minimization analysis
DHP	dihydropyridine
DoD	Department of Defense
DHP CCB	Dihydropyridine Calcium Channel Blocker drug class
ER	extended release
ESI	Express Scripts, Inc
FDA	Food and Drug Administration
FCP	Federal Ceiling Price
FY	fiscal year
GDH	glucose dehydrogenase
HA	Health Affairs
IR	immediate release
ISO	International Organization for Standardization
MHS	Military Health System
MN	medical necessity
MTF	military treatment facility
OAB	Over Active Bladder drug class
P&T	Pharmacy and Therapeutics
PA	prior authorization
PEC	Pharmacoeconomic Center
PORT	Pharmaceutical Outcomes Research Team
QD	once daily
QL	quantity limit
SMBGS	Self-Monitored Blood Glucose System drug class
SNRI	Serotonin Norepinephrine Re-Uptake Inhibitor
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TRRx	TRICARE Retail Pharmacy Network
µL	microliter

DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS
June 2008

1) CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 1300 hours on 12 Jun 2008, and at 0800 hours on 13 Jun 2008 at the DoD Pharmacoeconomic Center (PEC), Fort Sam Houston, Texas.

2) ATTENDANCE

The attendance roster is found in Appendix A.

3) REVIEW MINUTES OF LAST MEETING

A. **Corrections to the minutes** – February 2008 DoD P&T Committee meeting minutes were approved as written, with no corrections noted.

B. **Approval of February minutes** – Dr. Samuel Ward Casscells, III., M.D., approved the minutes of the February 2008 DoD P&T Committee meeting on 30 Apr 2008.

4) REVIEW OF RECENTLY APPROVED AGENTS

A. Antilipidemic-II (LIP-2) – Fenofibrate meltdose (Fenoglide)

Relative Clinical Effectiveness – Fenofibrate meltdose (Fenoglide) is a new formulation of fenofibrate that is FDA-approved for treating hyperlipidemia and mixed dyslipidemia. To review the full clinical effectiveness evaluation, see the Fenoglide New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library; note that rxnet is restricted to those with a ".mil" e-mail address).

Relative Clinical Effectiveness Conclusion – The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 1 absent) that 1) there is no evidence to suggest that there are clinically relevant differences in the efficacy, safety and clinical outcomes of fenofibrate meltdose compared to other fenofibrate formulations, as they all contain the same active ingredient. 2) In terms of packaging and storage requirements, fenofibrate meltdose has advantages over fenofibrate insoluble drug delivery microparticle (IDD-P; Triglide) in that it is available in 90 count bottles and does not require dispensing in moisture-proof containers.

Relative Cost Effectiveness – The P&T Committee evaluated the relative cost effectiveness of fenofibrate meltdose in relation to efficacy, safety, tolerability, 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 CFR 199.21 (e)(2).

A cost minimization analysis (CMA) was employed to evaluate the cost effectiveness of fenofibrate meltdose (Fenoglide). The cost effectiveness of Fenoglide was evaluated relative to the following agents: Triglide (currently the most cost effective UF fenofibrate) and Tricor. The results of the CMA showed that the projected

weighted average daily cost of Fenoglide was significantly lower than the weighted average daily cost of Triglide or Tricor.

Relative Cost Effectiveness Conclusion – The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 1 absent) that fenofibrate meltdose is cost effective relative to the evaluated agents in the LIP-2 class. The weighted average cost of Fenoglide is more cost effective relative to Triglide or Tricor.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations, and other relevant factors, the P&T Committee, based upon its collective professional judgment, recommended (13 for, 0 opposed, 1 abstained, 1 absent) that: 1) fenofibrate meltdose (Fenoglide) be classified as formulary on the UF; and 2) the normal brand cost-share of $9.00 for fenofibrate meltdose (Fenoglide) be lowered to the generic formulary cost share of $3.00 in the retail and mail order points of service.

   The authority for the last recommendation is codified in 32 CFR 199.21(j)(3), which states that "when a blanket purchase agreement, incentive price agreement, Government contract, or other circumstances results in a brand pharmaceutical agent being the most cost effective agent for purchase by the Government, the P&T Committee may also designate that the drug be cost-shared at the generic rate." The objective is to maximize use of fenofibrate meltdose in the retail network and mail order, given its significantly lower cost relative to other fenofibrate products. Lowering the cost-share for brand name fenofibrate meltdose will provide a greater incentive for beneficiaries to use the most cost effective fenofibrate formulation in the purchased care arena.

Fenofibrate meltdose (Fenoglide) was covered by the UF VARR submission at or below the FCP.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

2) ***COMMITTEE ACTION: BCF RECOMMENDATION*** – Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (13 for, 0 opposed, 1 abstained, and 1 absent) to recommend that 1) fenofibrate meltdose (Fenoglide) be added to the BCF; and 2) that gemfibrozil (Lopid, generics) be maintained on the BCF. As a result of the above actions, fenofibrate IDD-P (Triglide) would no longer be designated as BCF, but maintained as formulary on the UF.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** – The P&T Committee voted (13 for, 0 opposed, 1 abstained, 1 absent) to recommend: 1) for

immediate implementation of the addition of fenofibrate meltdose (Fenoglide) to the BCF and the $3.00 co-pay reduction upon signing of the June 2008 DoD P&T Committee minutes by the Director, TMA; 2) that the special $3.00 co-pay that applied to fenofibrate IDD-P (Triglide) be terminated the first Wednesday following a 90-day implementation period in the TRICARE Mail Order Pharmacy (TMOP) and TRICARE Retail Network Pharmacy (TRRx) programs; and 3) that TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following the approval by the Director, TRICARE Management Activity (TMA).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Adrenergic Blocking Agents (ABAs) – Nebivolol (Bystolic)

Relative Clinical Effectiveness–Nebivolol is an Adrenergic Blocking Agent that is FDA-approved for treatment of hypertension. To review the full clinical effectiveness evaluation, see the Nebivolol New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion – The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) that nebivolol (Bystolic) does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcomes over other ABA agents currently included on the UF.

Relative Cost Effectiveness – The P&T Committee evaluated the relative cost effectiveness of nebivolol in relation to efficacy, safety, tolerability, and clinical outcomes of the other agents in the class, particularly to the following ABA medications: atenolol (Tenormin, generics), carvedilol extended release (Coreg CR) and metoprolol succinate extended release (Toprol XL, generics). Information considered by the P&T Committee included, but was not limited to sources of information listed in 32 CFR 199.21 (e)(2). A CMA was employed to determine the cost effectiveness of nebivolol (Bystolic) relative to atenolol, Coreg CR and metoprolol succinate ER. Results of the CMA showed that the projected weighted average daily cost of nebivolol was significantly higher than its ABA comparators.

Relative Cost Effectiveness Conclusion – P&T Committee, based upon its collective professional judgment, voted (15 for, 0 opposed, 0 abstained, 0 absent) that the weighted average daily cost of nebivolol (Bystolic) was significantly higher than the weighted average daily cost of atenolol, carvedilol extended release (Coreg CR), or metoprolol succinate extended release (Toprol XL, generics)

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness of nebivolol, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend that nebivolol (Bystolic) be designated as non-formulary on the UF. This recommendation was based on the clinical

effectiveness conclusion, and the determination that atenolol, carvedilol extended release and metoprolol succinate extended release remain the most cost effective ABA agents on the UF compared to nebivolol.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

2) ***COMMITTEE ACTION: MN CRITERIA*** – Based on the clinical evaluation of nebivolol and the conditions for establishing medical necessity of a non-formulary medication provided for in the UF rule, the P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) MN criteria for nebivolol (Bystolic). (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** – The P&T Committee voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend: 1) an effective date of the first Wednesday following a 60-day implementation period in TMOP and TRRx, and at MTFs no later than a 60-day implementation period; and 2) TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following approval by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

C. Newer Antihistamines (NAs)– Levocetirizine (Xyzal)

Relative Clinical Effectiveness – Levocetirizine is a Newer Antihistamine that is the R-enantiomer of cetirizine. It is FDA-approved in adults and in children as young as six years of age for the treatment of seasonal and perennial allergic rhinitis, and chronic idiopathic urticaria. To review the full clinical effectiveness evaluation, see the Levocetirizine New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that levocetirizine (Xyzal) did not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome over other NAs included on the UF.

Relative Cost Effectiveness – The P&T Committee evaluated the relative cost effectiveness of levocetirizine (Xyzal) in relation to efficacy, safety, tolerability, and clinical outcomes of other agents in the class. A CMA was employed to determine the cost effectiveness of levocetirizine relative to other NAs: loratadine (OTC Claritin, generics), cetirizine (OTC Zyrtec, generics), fexofenadine (Allegra,

generics), and desloratadine (Clarinex). The results of the CMA revealed that the weighted average cost per day of levocetirizine is significantly higher than loratadine, cetirizine, and fexofenadine, but is significantly lower than the non-formulary NA desloratadine (Clarinex).

Relative Cost Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that levocetirizine (Xyzal) is not cost effective relative to the other UF NAs.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of levocetirizine (Xyzal) and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, 2 absent) to recommend that levocetirizine be designated as non-formulary under the UF.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

2) ***COMMITTEE ACTION: MN CRITERIA*** – Based on the clinical evaluation of levocetirizine and the conditions for establishing medical necessity of a non-formulary medication provided for in the UF rule, the P&T Committee recommended (13 for, 0 opposed, 0 abstained, 2 absent) MN criteria for levocetirizine (Xyzal). (See Appendix B for full MN criteria).

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** – The P&T Committee voted (13 for, 0 opposed, 0 abstained, 2 absent): 1) an effective date of the first Wednesday following a 60-day implementation period in the TMOP and TRRx, and no later than a 60-day implementation period at MTFs; and 2) TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following approval by Director, TMA.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

D. Leukotriene Modifier (LM) – Zileuton extended release (Zyflo CR)

Relative Clinical Effectiveness– Zileuton extended release (Zyflo CR) is a new formulation of zileuton immediate release (Zyflo) that is dosed twice daily, rather than four times daily. It is FDA-approved for the treatment of asthma in adults and in children as young as 12 years of age. To review the full clinical effectiveness evaluation, see the Zileuton extended release New Drug in Previously Reviewed

Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that zileuton extended release (Zyflo CR) did not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome over other LMs included on the UF.

Relative Cost Effectiveness – The Committee evaluated the relative cost effectiveness of zileuton extended release (Zyflo CR) in relation to efficacy, safety, tolerability, and clinical outcomes of the other agents in the LM class. A CMA was employed to evaluate the cost effectiveness of zileuton extended release relative to montelukast (Singulair), zafirlukast (Accolate), and zileuton immediate release (Zyflo). The results of the CMA demonstrated that the projected weighted average daily cost of zileuton extended release was significantly higher than the weighted average daily cost of the comparators within the LM class.

Relative Cost Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that zileuton extended release (Zyflo CR) is not cost effective relative to the other agents in the LM class. The weighted average cost of montelukast (Singulair), zafirlukast (Accolate) and zileuton immediate release (Zyflo) is more cost effective relative to zileuton extended release.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of zileuton extended release (Zyflo CR) and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, 2 absent) to recommend that zileuton extended release be designated as non-formulary under the UF.

   Director, TMA, Decision: ☒ Approved ☐ Disapproved

   Approved, but modified as follows:

2) ***COMMITTEE ACTION: MN CRITERIA*** – Based on the clinical evaluation of zileuton extended release and the conditions for establishing medical necessity of a non-formulary medication provided for in the UF rule, the P&T Committee recommended (13 for, 0 opposed, 0 abstained, 2 absent) MN criteria for zileuton extended release (Zyflo CR). (See Appendix B for full MN criteria).

   Director, TMA, Decision: ☒ Approved ☐ Disapproved

   Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** – The P&T Committee voted (13 for, 0 opposed, 0 abstained, 2 absent): 1) an effective date of the first Wednesday following a 60-day implementation period in the TMOP and TRRx, and no later than a 60-day implementation period at MTFs; and 2) TMA send a letter to beneficiaries affected by this UF decision. The

implementation period will begin immediately following approval by Director, TMA.

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

E. Antilipidemic – I (Lip-1) – Simvastatin/niacin extended release (Simcor)

Relative Clinical Effectiveness – Simcor is the combination of 40 mg simvastatin (Zocor, generics) with 500-, 750- or 1000- mg of niacin extended release (Niaspan). It is approved by the FDA for patients with hyperlipidemia to raise HDL concentrations, and to lower LDL, triglyceride, non-HDL, and total cholesterol concentrations, when monotherapy is inadequate. To review the full clinical effectiveness evaluation, see the Simcor New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that there is insufficient evidence to suggest if there are clinically relevant differences between simvastatin/niacin extended release (ER; Simcor) and the other statins and niacin in terms of efficacy, and that in terms of safety and tolerability, Simcor appears comparable to giving the simvastatin and niacin components separately.

Relative Cost Effectiveness - The P&T Committee evaluated the relative cost effectiveness of simvastatin/niacin ER (Simcor) in relation to efficacy, safety, tolerability, and clinical outcomes of other agents in the LIP-1 class. A CMA was employed to evaluate the cost effectiveness of simvastatin/niacin ER relative to simvastatin (Zocor, generics), niacin ER (Niaspan), lovastatin/niacin ER (Advicor) and the combination of the individual components of Simcor (simvastatin plus Niaspan). The results of the CMA showed that the projected weighted average daily cost of Simcor was significantly less than the weighted average daily cost of its comparators.

Relative Cost Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that simvastatin/niacin ER (Simcor) is cost effective relative to the evaluated agents in the LIP-1 class.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of simvastatin/niacin ER (Simcor) and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, 2 absent) to recommend that simvastatin/niacin ER be classified as formulary on the UF.

Simvastatin/niacin ER was covered by a UF VARR submission at or below the FCP

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

F. Glaucoma Agents – Brimonidine 0.02% / timolol maleate 0.05% (Combigan)

Relative Clinical Effectiveness – Combigan is a combination ophthalmic product that contains the alpha-2 adrenergic agonist brimonidine 0.02% (Alphagan, generics) with the beta blocker timolol maleate 0.05% (Timoptic, generics). Combigan is approved for twice daily use for the reduction of elevated intraocular pressure in patients with ocular hypertension or glaucoma who require adjunctive or replacement therapy. To review the full clinical effectiveness evaluation, see the Combigan New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that while brimonidine/timolol (Combigan) offers a convenience to the patient in terms of ease of administration, there is currently insufficient evidence to suggest if there are clinically relevant differences between Combigan and the other Glaucoma Agents in terms of efficacy. In terms of safety and tolerability, Combigan appears comparable to administering brimonidine and timolol as separate products dosed twice daily.

Relative Cost Effectiveness – The P&T Committee evaluated the relative cost effectiveness of brimonidine/timolol ophthalmic solution (Combigan) in relation to efficacy, safety, tolerability, and clinical outcomes of the other agents in the class. A CMA was employed to evaluate the cost effectiveness of Combigan relative to timolol maleate (Timoptic, generics), brimonidine (Alphagan, generics), dorzolamide/timolol (Cosopt), and the single ingredient agents of Combigan (timolol maleate and brimonidine). The results of the CMA showed that the projected weighted average daily cost of Combigan was significantly lower than its comparators.

Relative Cost Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that the projected weighted average daily cost of Combigan was significantly lower than the weighted average daily cost of dorzolamide/timolol (Cosopt), or the pairings of the individual brimonidine and timolol components.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of brimonidine/timolol maleate (Combigan) and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, 2 absent) to recommend that brimonidine/timolol maleate be classified as formulary under the UF.

Brimonidine/timolol maleate was covered by the UF VARR submission at or below the FCP.

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

G. Renin Angiotensin Antihypertensives (RAAs) – Olmesartan / amlodipine (Azor)

Relative Clinical Effectiveness – Azor is the combination of the angiotensin receptor blocker (ARB) olmesartan with the dihydropyridine calcium channel blocker (DHP CCB) amlodipine. It is FDA-approved for treating hypertension. To review the full clinical effectiveness evaluation, see the Azor New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library). .

Relative Clinical Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that while olmesartan/amlodipine (Azor) offers a convenience to the patient in terms of decreased tablet burden and simplified medication regimen, it does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome over other renin angiotensin antihypertensives included on the UF.

Relative Cost Effectiveness – The P&T Committee evaluated the relative cost effectiveness of olmesartan/amlodipine (Azor) in relation to efficacy, safety, tolerability, and clinical outcomes of the other agents in the RAA class, particularly the ARBs. A CMA was employed to evaluate the cost effectiveness of olmesartan/amlodipine relative to telmisartan (Micardis), the BCF ARB; generic amlodipine (Norvasc), a BCF DHP-CCB; valsartan/amlodipine (Exforge); and to the combination of the individual components of telmisartan plus generic amlodipine. The results of the CMA demonstrated that the projected weighted average daily cost of Azor was significantly higher than the weighted average daily cost of combined individual agents (telmisartan plus generic amlodipine).

Relative Cost Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that olmesartan/ amlodipine is not cost effective relative to the other UF agents in the RAA class. The weighted average cost of combined individual agents (the BCF ARB telmisartan and BCF generic DHP CCB amlodipine) is more cost effective relative to Azor.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of olmesartan/amlodipine (Azor) and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, 2 absent) to recommend that olmesartan/amlodipine be designated as non-formulary under the UF.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

2) ***COMMITTEE ACTION: MN CRITERIA*** – Based on the clinical evaluation of olmesartan/amlodipine and the conditions for establishing medical necessity of a non-formulary medication provided for in the UF rule, the P&T Committee

recommended (13 for, 0 opposed, 0 abstained, 2 absent) MN criteria for olmesartan/amlodipine (Azor). (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

3) ***COMMITTEE ACTION: IMPLEMENTATION PERIOD*** – The P&T Committee voted (13 for, 0 opposed, 0 abstained, 2 absent): 1) an effective date of the first Wednesday following a 60-day implementation period in the TMOP and TRRx, and no later than a 60-day implementation period at MTFs; and 2) TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following approval by Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

H. Renin Angiotensin Antihypertensives (RAAs) – Aliskiren / hydrochlorothiazide (Tekturna HCT)

Background – Tekturna HCT contains the renin inhibitor aliskiren with the diuretic hydrochlorothiazide (HCTZ). It is FDA-approved for treating hypertension. Preliminary results of clinical outcomes trials with aliskiren evaluating benefits in addition to blood pressure reduction have been positive. To review the full clinical effectiveness evaluation, see the Tekturna HCT New Drug in Previously Reviewed Classes monograph found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that while aliskiren/HCTZ offers a convenience to the patient in terms of decreased tablet burden and simplified medication regimen, there is insufficient evidence to suggest that the blood pressure lowering effect of aliskiren/HCTZ would be significantly greater than that achieved with other antihypertensive fixed-dose combinations. In terms of safety and tolerability, Tekturna HCT appears comparable to administering the aliskiren and HCTZ components separately.

Relative Cost Effectiveness - The P&T Committee evaluated the relative cost effectiveness of aliskiren/HCTZ (Tekturna HCT) in relation to efficacy, safety, tolerability, and clinical outcomes of the other agents in the RAA class, particularly the ARBs. A CMA was employed to evaluate the cost effectiveness of aliskiren/HCTZ relative to the renin inhibitor aliskiren (Tekturna) and the ARBs, which were evaluated at the May and August 2007 DoD P&T Committee meetings. The results of the CMA showed that the projected weighted average daily cost of aliskiren/HCTZ was higher than the weighted average daily cost of the ARBs designated as formulary on the UF, but similar to the UF agent aliskiren (Tekturna).

Relative Cost Effectiveness Conclusion – The Committee voted (13 for, 0 opposed, 0 abstained, 2 absent) that the projected weighted average daily cost of aliskiren/HCTZ (Tekturna HCT) was comparable to the renin inhibitor aliskiren, and higher than the weighted average daily cost of ARBs designated as formulary within the RAA class on the UF.

1) ***COMMITTEE ACTION: UF RECOMMENDATION*** – Taking into consideration the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of aliskiren/HCTZ (Tekturna HCT) and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, 2 absent) that although aliskiren/HCTZ was somewhat more costly relative to the ARBs designated as formulary in the RAA class, Tekturna HCT was recommended to be classified as formulary on the UF, due to the novel mechanism of action of the aliskiren component and preliminary positive outcomes data.

Aliskiren/hydrochlorothiazide was covered by the UF VARR submission at or below the FCP.

Director, TMA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

5) DRUG CLASS REVIEW – 5-HYDROXYTRYPTAMINE AGONISTS (TRIPTANS)

Relative Clinical Effectiveness: The P&T Committee evaluated the relative clinical effectiveness of the eight marketed 5-hydroxytryptamine agonists (triptans) in the US, almotriptan (Axert), eletriptan (Relpax), frovatriptan (Frova), naratriptan (Amerge), sumatriptan (Imitrex), sumatriptan/naproxen (Treximet), rizatriptan (Maxalt), and zolmitriptan (Zomig). None of the triptans are available in generic formulations, although generic formulations of sumatriptan are expected in early 2009.

MHS expenditures for the triptans were approximately $70 million for the time period of May 2007 to April 2008. In terms of total quantity dispensed between May 2007 and April 2008, sumatriptan is the highest utilized triptan in the MHS (~150,000 tablets dispensed/month), followed by zolmitriptan (~60,000 tablets/month), and rizatriptan (~45,000 tablets/month). To review the full clinical effectiveness evaluation, see the Triptan DoD Drug Class Review found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion: The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent) to accept the following clinical effectiveness conclusion:

a) With regards to efficacy at providing pain relief at 2 hours,1) rizatriptan 10 mg (Maxalt) appears superior to the other triptans; 2) almotriptan (Axert), eletriptan (Relpax), sumatriptan (Imitrex) and zolmitriptan (Zomig) have comparable relative effectiveness; 3) frovatriptan (Frova) appears inferior to the other triptans, although these results are based on limited data; 4) naratriptan (Amerge) appears inferior to the other triptans; and 5) sumatriptan/naproxen (Treximet) appears superior to sumatriptan 85 mg, but there is insufficient evidence to suggest clinically relevant differences between Treximet and the other triptans.

b) With regards to other efficacy endpoints, 1) rizatriptan 10 mg (Maxalt) and almotriptan 12.5 mg (Axert) are superior to the other triptans for pain free response at 24 hours; and 2) rizatriptan 10 mg is superior to the other triptans for pain-free response at 2 hours.

c) With regards to safety and tolerability, almotriptan (Axert) and naratriptan (Amerge) had the most favorable adverse event profiles compared to the other triptans. There is only limited data for frovatriptan from the product labeling.

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 efficacy, safety, tolerability, 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 CFR 199.21(e)(2).

Relative Cost Effectiveness Conclusion: The cost effectiveness of the triptan agents was evaluated by CMA, cost effectiveness analysis (CEA), and by budget impact analysis (BIA). Based on the results of the cost analyses and other clinical and cost considerations, the P&T Committee concluded (14 for, 0 opposed, 0 abstained, 1 absent) the following:

a) Results from the triptan CMA revealed that sumatriptan/naproxen (Treximet) was the most cost effective agent overall. However, sumatriptan (Imitrex) is expected to become the most cost-effective triptan when generic formulations reach the market in early 2009.

b) Results from the 2 hour pain response CEA revealed that 1) sumatriptan/naproxen (Treximet), eletriptan (Relpax) and rizatriptan (Maxalt) formed the efficiency frontier and are the most cost-effective agents; and 2) when the price for generic formulations of sumatriptan (Imitrex) drops below 70% of the current price, sumatriptan and rizatriptan will become the most cost-effective agents.

c) Results from the 2 hour pain-free response CEA yielded results similar to the 2 hour pain response.

d) The BIA evaluated the potential impact of scenarios with selected triptans designated formulary or non-formulary on the UF. Results from the BIA revealed that the scenario that designated almotriptan (Axert), frovatriptan (Frova), and naratriptan (Amerge) as non-formulary under the UF was more favorable to the MHS.

A. COMMITTEE ACTION: UF RECOMMENDATION – In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the triptans, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 1 abstained, and 1 absent) to recommend that:

1) Sumatriptan (Imitrex), sumatriptan/naproxen (Treximet), eletriptan (Relpax), rizatriptan (Maxalt), and zolmitriptan (Zomig) be classified as formulary on the UF.

2) Almotriptan (Axert), frovatriptan (Frova), and naratriptan (Amerge) be designated as non-formulary under the UF, based on cost effectiveness.

All triptan drugs recommended for inclusion on the UF were covered by Uniform Formulary Voluntary Agreement for Retail Refunds (UF VARR) submissions at or below the Federal Ceiling Price (FCP). (One of the triptan drugs recommended for non-formulary status was also covered by a UF-VARR at or below the FCP, but was not considered cost-effective.)

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. COMMITTEE ACTION: MN CRITERIA – Based on the clinical evaluation for almotriptan (Axert), frovatriptan (Frova), and naratriptan (Amerge), and the conditions for establishing medical necessity for a non-formulary medication provided for in the UF rule, the P&T Committee recommended (13 for, 0 opposed, 1 abstained, 1 absent) MN criteria for almotriptan, frovatriptan, and naratriptan. (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

C. COMMITTEE ACTION: IMPLEMENTATION PERIOD –The P&T Committee recommended (13 for, 0 opposed, 1 abstained, 1 absent) 1) an effective date of the first Wednesday following a 90-day implementation period in the TMOP and TRRx, and at the MTFs no later than a 90-day implementation period. 2) That TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following the approval by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

D. COMMITTEE ACTION: BCF RECOMMENDATION – The P&T Committee considered the BCF status of the triptan agents. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (12 for, 1 opposed, 1 abstained, and 1 absent) to recommend that 1) rizatriptan (Maxalt) be designated as BCF immediately upon signing of the June 2008 DoD P&T Committee minutes by the Director, TMA; 2) sumatriptan (Imitrex oral tablets and one injectable sumatriptan formulation be designated as BCF when multi-source generic formulations that are cost effective reach the marketplace. As a result of the above actions, zolmitriptan (Zomig) would no longer be designated as BCF, but maintained as formulary on the UF.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

E. COMMITTEE ACTION: QUANTITY LIMIT (QL) RECOMMENDATIONS – The P&T Committee voted (13 for, 0 opposed, 1 abstained, 1 absent) to 1) to recommend QLs for sumatriptan 85 mg/naproxen 500 mg (Treximet) of 9 tablets per 30 days and 27 tablets per 90 days; 2) to recommend QLs for sumatriptan (Imitrex) 4 mg injection of 9 syringes per 30 days and 24 syringes per 90 days; and 3) to maintain the existing QLs for the other triptans.

Director, TMA, Decision: ☒ Approved ☐ Disapproved

Approved, but modified as follows:

6) 6) DRUG CLASS REVIEW – OSTEOPOROSIS AGENTS

Relative Clinical Effectiveness: The P&T Committee evaluated the relative clinical effectiveness of the osteoporosis agents currently marketed in the US. The individual drugs included in the class are listed below:

- *Bisphosphonates*: alendronate (Fosamax), alendronate/vitamin D (Fosamax plus D), ibandronate (Boniva), risedronate (Actonel), and risedronate/calcium (Actonel with calcium). Intravenous (IV) zoledronic acid (Reclast) and IV ibandronate (Boniva) were not part of the UF review, as they are not included as a TRICARE pharmacy benefit.

  Selective estrogen receptor modulators (SERMs): raloxifene (Evista)

- *Parathyroid hormone(PTH) 1-34 amino acids:* teriparatide (Forteo)

- *Calcitonin nasal sprays:* calcitonin-salmon (Miacalcin) and recombinant calcitonin (Fortical)

Generic formulations of alendronate 2800 IU (Fosamax) became commercially available in 2008. There are no generic formulations of any of the other osteoporosis agents. All the agents are approved for treating osteoporosis; raloxifene (Evista) is also approved for the reduction in risk of invasive breast cancer in postmenopausal women with osteoporosis or those at high risk of invasive breast cancer.

MHS expenditures from May 2007 to April 2008 exceeded $200 million, of which over $151 million was attributed to the bisphosphonates alone. In terms of 30-day equivalent prescriptions dispensed, alendronate is the highest utilized osteoporosis agent (approximately 120,000/month), followed by risedronate (approximately 40,000/month) and raloxifene (less than 40,000/month). To review the full clinical effectiveness evaluation, see the Osteoporosis DoD Drug Class Review found at https://rxnet.army.mil/ (Forum: File Library; Folder: DoD P&T library).

Relative Clinical Effectiveness Conclusion: The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) that:

a) With regard to changes in bone mineral density (BMD), all the drugs in the bisphosphonates, SERMs, PTH derivative, and calcitonin subclasses increase

BMD, but superiority of one drug over another cannot be determined by BMD changes alone.

b) With regard to fracture risk reduction, 1) the supporting evidence for the bisphosphonates is stronger than that available for raloxifene (Evista), teriparatide (Forteo) and the calcitonin nasal sprays (Fortical and Miacalcin); and 2) there is insufficient evidence to determine if there are clinically relevant differences between the drugs in each osteoporosis subclass.

c) With regard to the orally administered bisphosphonates, 1) the bisphosphonates reduce the risk of vertebral fractures to a similar degree, but the data is limited to daily dosing and there is insufficient evidence to determine if there are clinically relevant differences in fracture risk reduction with extended interval dosing regimens; 2) risedronate (Actonel) and IV zoledronic acid have evidence from adequately powered clinical trials that they reduce the risk of non-vertebral and hip fractures compared to the other bisphosphonates; and 3) there is insufficient evidence to suggest clinically relevant differences between the orally administered bisphosphonates in preventing fractures.

d) With regard to the SERM raloxifene (Evista) and the calcitonin nasal sprays, 1) both subclasses reduce the risk of vertebral fractures, but the data is more limited than that available with the bisphosphonates; and 2) there is no data to suggest clinically relevant efficacy differences between calcitonin-salmon (Miacalcin) and recombinant calcitonin (Fortical).

e) With regard to the PTH derivative teriparatide (Forteo), 1) there is evidence from one clinical trial supporting vertebral and non-vertebral fracture risk reduction; and 2) teriparatide is potentially beneficial in reducing fracture risk in patients experiencing fractures despite bisphosphonate therapy.

f) With regard to safety of the oral bisphosphonates, 1) there is no evidence to suggest that there are clinically relevant differences between alendronate (Fosamax), risedronate (Actonel) and ibandronate (Boniva) in the incidence of gastrointestinal complaints; 2) the overall incidence of osteonecrosis of the jaw with the oral agents is low; and 3) long-term safety data extending out to 10 years is available with alendronate (Fosamax).

g) With regard to tolerability of the oral bisphosphonates, a retrospective observational cohort analysis of 23,044 DoD beneficiaries performed by the Pharmacy Operations Outcomes Team (PORT) compared medication persistence between weekly vs. monthly dosing regimens, based on prescription claims during the year following the initial prescription. The study included all DoD beneficiaries filling initial prescriptions for bisphosphonates at the retail and mail order points of service from 1 Aug 06 to 31 Jan 07. Results of the multivariate logistic regression model were adjusted for age, gender, point of service, TRICARE region, and number of concomitant maintenance medications. The odds of a patient being persistent with treatment (≥80% of days covered based on cumulative days supply) were 18% higher among monthly users compared to weekly users of bisphosphonates (OR 1.18; 95% CI 1.12-1.25). Improved persistence on bisphosphonate therapy has been shown to be associated with a

reduced risk of fracture based on observational data, although data from randomized controlled trials supporting a causal relationship are not yet available.

h) With regard to safety and tolerability of the other osteoporosis subclasses, each subclass (SERM, calcitonin and PTH derivative) has unique adverse event profiles.

i) With regard to other factors of the calcitonin nasal sprays, there are no clinically relevant differences between calcitonin-salmon (Miacalcin) and recombinant calcitonin (Fortical), with the exception of differences in the preservative and ease of administration.

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 efficacy, safety, tolerability, 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 CFR 199.21(e)(2).

The relative clinical effectiveness evaluation concluded that: 1) the bisphosphonates are highly clinically interchangeable with each other for the treatment of osteoporosis; 2) there is evidence that the extended dosing interval (monthly) bisphosphonates may yield greater rates of persistence than the weekly formulations; 3) the two calcitonin products are formulated with identical molecules and are highly clinically interchangeable for their osteoporosis indications; and 4) teriparatide and raloxifene occupy treatment niches for selected patients. As a result, CMAs were conducted for the bisphosphonate and calcitonin subclasses to compare the relative cost effectiveness of these agents. Additionally a CEA was performed to evaluate the extended dosing interval bisphosphonates. The SERM and parathyroid agents were compared to the other subclasses in a further cost analysis.

Relative Cost Effectiveness Conclusion: The P&T Committee concluded (14 for, 1 opposed, 0 abstained, 0 absent) the following:

a) Results from the bisphosphonate CMA revealed that ibandronate (Boniva) was the most cost effective agent overall. However, generic formulations of alendronate (Fosamax) have recently become available, and alendronate is expected to become the most cost effective oral bisphosphonate when the generic exclusivity period ends in the third quarter, 2008.

b) Results from the nasal calcitonin CMA revealed that recombinant calcitonin (Fortical) is significantly more cost effective than salmon-calcitonin (Miacalcin).

c) Results from the extended dosing interval bisphosphonate CEA revealed: 1) based on available published literature, improved persistence with extended cycle bisphosphonates would likely result in a small decrease in the risk of fractures; 2) the incremental annual cost per patient using extended dosing interval bisphosphonates is modest; and 3) while extended dosing interval products are slightly more costly, these agents remain cost effective for the treatment of osteoporosis.

d) The cost comparison of teriparatide (Forteo) and raloxifene (Evista) to the other osteoporosis subclasses concluded that 1) raloxifene is slightly more costly than

the bisphosphonates and calcitonin; and 2) teriparatide is significantly more costly than bisphosphonates and calcitonin.

e) The BIA evaluated the potential impact of scenarios with selected bisphosphonates, teriparatide (Forteo), and calcitonin products designated formulary or non-formulary on the UF. The BIA results showed that the scenario that designated the salmon-calcitonin (Miacalcin) as non-formulary on the UF was more favorable to the MHS.

*A. **COMMITTEE ACTION: UF RECOMMENDATION*** – In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the osteoporosis agents, and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (12 for, 1 opposed, 2 abstained, and 0 absent) to recommend that: 1) alendronate (Fosamax), alendronate/vitamin D (Fosamax plus D), risedronate (Actonel), risedronate with calcium (Actonel with calcium), ibandronate (Boniva), raloxifene (Evista), teriparatide (Forteo), and recombinant calcitonin (Fortical) be maintained as formulary on the UF and that 2) salmon-calcitonin (Miacalcin) be designated as non-formulary on the UF. The Committee member casting the dissenting vote felt that an additional agent, teriparatide, should also be classified as NF, due to existing low MHS utilization (less than 5,000 patients); that its clinical niche would allow for unique MN criteria specific to this agent; and that NF placement would allow for additional cost avoidance.

Despite the higher cost of raloxifene (Evista) and teriparatide (Forteo) compared to the other osteoporosis agents, the Committee recommended designating these agents as formulary on the UF, due their clinical niche (reduction in risk of invasive breast cancer; and non-oral administration route and approval for severe osteoporosis, respectively), and the expectation that several SERMs and PTH hormone derivatives currently under investigation will reach the marketplace in 2009-2010.

All osteoporosis drugs recommended for inclusion on the UF were covered by Uniform Formulary Voluntary Agreement for Retail Refunds (UF VARR) submissions at or below the Federal Ceiling Price (FCP), with the exception of raloxifene, teriparatide, and recombinant calcitonin. These three osteoporosis agents were recommended for inclusion on the UF without UF VARR quotes, due to their unique indications and place in therapy.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

*B. **COMMITTEE ACTION: MN CRITERIA*** – Based on the clinical evaluation for salmon-calcitonin (Miacalcin) and the conditions for establishing medical necessity for a non-formulary medication provided for in the UF rule, the P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) MN criteria for Miacalcin. (See Appendix B for full MN criteria).

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

*C. **COMMITTEE ACTION: IMPLEMENTATION PERIOD*** –The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday following a 90-day implementation period in the TMOP and TRRx, and at the MTFs no later than a 90-day implementation period. 2) That TMA send a letter to beneficiaries affected by this UF decision. The implementation period will begin immediately following the approval by the Director, TMA.

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

*D. **COMMITTEE ACTION: BCF RECOMMENDATION*** – The P&T Committee considered the BCF status of the osteoporosis agents. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (9 for, 4 opposed, 2 abstained, and 0 absent) to recommend that alendronate (Fosamax) and ibandronate (Boniva) be designated as BCF. As a result of the above actions, raloxifene (Evista) would no longer be designated as BCF, but maintained as formulary on the UF.

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

7) UTILIZATION MANAGEMENT - PRIOR AUTHORIZATIONS (PA)/ QL / MEDICAL NECESSITY (MN)

A. Targeted Immunomodulatory Biologics (TIBs)

Adalimumab (Humira) Juvenile Idiopathic Arthritis (JIA) new indication - Administrative Action – Adalimumab received an additional indication from the FDA for children aged 4 to 17 years to reduce the signs and symptoms of moderate to severely active polyarticular JIA. Adalimumab may be used with or without methotrexate for this indication. The FDA-approved JIA indication will be added to the PA for Humira.

B. Phosphodiesterase type 5 inhibitors (PDE5s)

Tadalafil (Cialis) QL – Administrative Action – Tadalafil was recently approved in 2.5 mg and 5 mg dosages for daily use for erectile dysfunction (ED). Health Affairs Policy 98-04 was rescinded in Nov 2003 to state that prior authorization was no longer required for PDE-5 inhibitors in the treatment of ED for males older than 50 years of age. The HA policy still maintains QLs collectively for all strengths of sildenafil, tadalafil and vardenafil of no more than 18 tablets of any combination of these medications per 90-day supply in the TMOP, and no more than 6 tablets of any

combination of these medications per 30-day supply in the Retail Network. The existing QLs for tadalafil will apply to the new 2.5 mg and 5 mg dosages.

C. **LIP-2s – Colesevelam (Welchol) MN Criteria** – The Committee discussed the MN criteria for colesevelam with regard to a new FDA-approved indication for use as an adjunct to diet and exercise to improve glycemic control in adult patients with type 2 diabetes mellitus (T2DM). The LIP-2 drug class was previously reviewed for UF placement in May 2007; at the time of the meeting, colesevelam was solely approved for lowering elevated LDL concentrations in primary hyperlipidemia. The clinical trial used to gain FDA-approval of colesevelam for T2DM evaluated the drug as adjunctive therapy to other glucose-lowering drugs, and did not evaluate colesevelam use as monotherapy. The Committee agreed that there were other treatments for T2DM with greater efficacy than colesevelam.

COMMITTEE ACTION: The P&T Committee voted (14 for, 0 opposed, 0 abstained, 1 absent) to **maintain the current MN criteria for colesevelam.**

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

D. **Aprepitant (Emend) – QL** – Aprepitant was approved by the FDA in a new 40 mg strength solely indicated for prevention of post-operative nausea and vomiting. Currently, QLs apply to the aprepitant formulation approved for prevention of chemotherapy-induced nausea and vomiting; QLs also apply to other antiemetics.

COMMITTEE ACTION: The P&T Committee voted (14 for, 0 opposed, 0 abstained, 1 absent) to approve the QLs for aprepitant 40 mg of 1 capsule/prescription fill at the retail and mail order points of service.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

8) ITEMS FOR INFORMATION

A. Outcomes Research Reports

1) *Step Therapy* – To support the P&T Committee's consideration of a potential step therapy requirement in the triptan drug class, the PORT reported results of an analysis of changes in medication usage attributable to step therapy/prior authorization requirements for newer sedative hypnotics (effective date 1 Aug 07) and proton pump inhibitors (effective date 24 Oct 07). The step therapy / prior authorization program, which requires new users of non-preferred medications to try a preferred agent before receiving a non-preferred agent, appears highly effective at promoting use of preferred agents. However, the Committee agreed that more information is needed concerning the effect of the program on beneficiaries. A study of outcomes associated with step therapy interventions is

under development and is currently being considered by the MHS Scientific Advisory Panel.

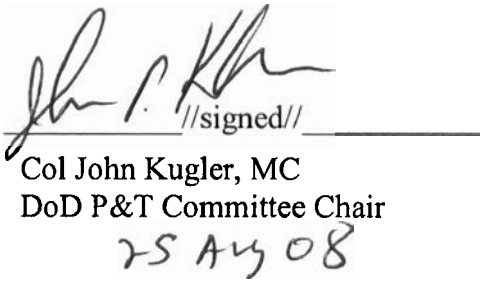
2) *Fentanyl Patch Safety Program* – The PORT notified the P&T Committee of implementation issues detected during data collection for a study of the Fentanyl Patch Safety Program. These issues were corrected, bringing the program into line with requirements previously set by the P&T Committee. Preliminary results of the analysis are scheduled for the next P&T meeting.

9) ADJOURNMENT

The second day of the meeting adjourned at 1400 hours on 13 Jun 2008. The next meeting will be 12-13 Aug 2008.

Appendix A – Attendance
Appendix B – Table of Medical Necessity Criteria
Appendix C – Implementation Status of UF Recommendations/Decisions
Appendix D – Table of Abbreviations

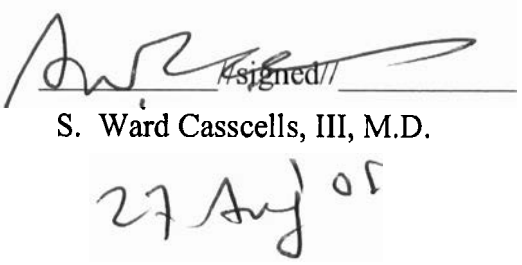
SUBMITTED BY:



//signed//
Col John Kugler, MC
DoD P&T Committee Chair
25 Aug 08

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.



//signed//
S. Ward Casscells, III, M.D.
27 Aug 08

Appendix A – Attendance

Voting Members Present	
Col John Kugler, MC, USA	DoD P&T Committee Chair
LTC Brett Kelly, MSC, USA	DoD P&T Committee Recorder
Major Jeremy King, MC	Air Force, OB/GYN Physician
Major William Hannah, MC	Air Force, Internal Medicine Physician
Lt Col Brian Crownover, MC	Air Force, Physician at Large
Col Everett McAllister, BSC	Air Force, Pharmacy Officer
LCDR Scott Akins, MC	Navy, Pediatrics Physician
CAPT Stephanie Simon, MSC	Navy, Pharmacy Officer
COL Doreen Lounsbery, MC	Army, Internal Medicine Physician
Col Karl R. Kerchief, MC *for* Major Roger Brockbank, MC	Army, Family Practice Physician
COL Ted Cieslak, MC	Army, Physician at Large
LTC (P) Peter Bulatao, MSC *for* COL Isiah Harper, MSC	Army, Pharmacy Officer
CAPT Vernon Lew, USPHS	Coast Guard, Pharmacy Officer
Lt Col Thom Bacon *for* CAPT William Blanche, MSC, USN	DoD Pharmacy Operations Directorate, TMA
Mr. Joe Canzolino, RPh.	Department of Veterans Affairs
Voting Members Absent	
CDR David Tanen, MC	Navy, Physician at Large
LCDR Michelle Perelló, MC	Navy, Internal Medicine Physician
Non-Voting Members Present	
COL Kent Maneval, MSC, USA	Defense Medical Standardization Board
Lt Col Paul Hoerner, BSC, USAF	Deputy Director, DoD Patient Safety Center
CDR Kim Lefebvre, MSC	Defense Supply Center Philadelphia
Ms. Carol Cooper	Deputy General Counsel, TMA
LCDR Thomas Jenkins, MSC, USN	TMA Aurora
Non-Voting Members Absent	
Martha Taft	Health Plan Operations, TMA

Appendix A – Attendance – (continued)

Others Present	
CDR James Ellzy, MC, USN	Vice DoD P&T Committee Chair
CDR Matthew Carlberg, MC, USN	DoD PEC
Lt Col James McCrary, MC, USAF	DoD PEC
LTC Chris Conrad, MC, USA	DoD PEC
Maj Josh Devine, BSC, USAF	DoD PEC
CPT Josh Napier, MC, USA	DoD PEC
Angela Allerman, Pharm.D.	DoD PEC
David Meade, Pharm.D.	DoD PEC
Harsha Mistry, Pharm.D.	DoD PEC
Eugene Moore, Pharm.D.	DoD PEC
Shana Trice, Pharm.D.	DoD PEC
Dean Valibhai, Pharm.D.	DoD PEC – Pharmacy Operations Center
Jeremy Briggs, Pharm.D.	DoD PEC – Pharmacy Operations Center
Major Mike Lee, BSC	Air Force, Alternate Pharmacist Officer
LCDR Timothy Thompson	Navy, Pharmacy Officer Alternate
CAPT Travis Watts	USPHS/HIS
Lisa McNair	DoD Pharmacy Operations Directorate – TMA

Appendix B – Medical Necessity Criteria

Drug / Drug Class	Medical Necessity Criteria
Levocetirizine (Xyzal) **Newer Antihistamines**	• Use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from formulary alternatives. • Formulary agents have resulted in therapeutic failure.
Nebivolol (Bystolic) **Adrenergic Blocking Agent**	• Use of formulary alternatives is contraindicated • The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.
Olmesartan / amlodipine (Azor)	• Use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from formulary alternatives.
Calcitonin-salmon nasal spray (Miacalcin) **Osteoporosis Agents**	• Use of formulary alternatives is contraindicated • The patient has experienced or is likely to experience significant adverse effects from formulary alternatives. • Formulary agents have resulted or are likely to result in therapeutic failure. • The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.
Almotriptan (Axert), Frovatriptan (Frova), Naratriptan (Amerge) **Triptans**	• Use of formulary alternatives is contraindicated • The patient has experienced or is likely to experience significant adverse effects from formulary alternatives. • Formulary agents have resulted or are likely to result in therapeutic failure. • The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.
Zileuton extended release (Zyflo CR) **Leukotriene Modifiers**	• Use of formulary alternatives is contraindicated • The patient has experienced significant adverse effects from formulary alternatives. • Formulary agents have resulted in therapeutic failure. • The patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk.

Appendix C – Implementation Status of UF Class Review Recommendations / Decisions

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Jun 08	Osteoporosis Agents	▪ calcitonin salmon nasal spray (Miacalcin)	BCF	▪ alendronate (Fosamax) ▪ ibandronate (Boniva) ▪ (Note: raloxifene (Evista) removed from BCF, but still UF)	Pending approval	Pending approval
Jun 08	Triptans	▪ almotriptan (Axert) ▪ frovatriptan (Frova) ▪ naratriptan (Amerge)	BCF	▪ rizatriptan (Maxalt), immediate upon signing of the minutes ▪ sumatriptan oral and one injectable formulation, when multi-source generics are available	Pending approval	Pending approval
Jun 08 (update; reviewed May 07)	Antilipidemic Agents II		BCF	**Recommended for addition to BCF Nov 07** ▪ fenofibrate meltdose (Fenoglide), to replace fenofibrate IDD-P (Triglide)	Pending approval	Pending approval
		To remain NF ▪ fenofibrate nanocrystallized (Tricor) ▪ fenofibrate micronized (Antara) ▪ omega-3 fatty acids (Omacor) ▪ colesevelam (Welchol)		Currently BCF ▪ gemfibrozil ▪ (Note: fenofibrate IDD-P (Triglide) removed from BCF but still UF)	24 July 07	21 Nov 07 (120 days)
Jun 08 (update; reviewed Nov 07)	Adrenergic Blocking Agents	**Recommended for non-formulary status Jun 08** ▪ nebivolol (Bystolic)	BCF		Pending approval	Pending approval
				Currently BCF ▪ atenolol tablets ▪ metoprolol tartrate IR tablets ▪ carvedilol IR tablets ▪ metoprolol succinate ER tablets	13 Feb 08	-
Jun 08 (update; reviewed Aug 07	Newer Antihistamines	**Recommended for non-formulary status Jun 08** ▪ levocetirizine (Xyzal)	BCF		Pending approval	Pending approval
		To remain NF ▪ desloratadine (Clarinex) ▪ desloratadine/pseudoephedrine (Clarinex D)		▪ MTFs required to carry at least one single ingredient agent from the newer antihistamine class (loratadine, cetirizine, or fexofenadine) on their local formulary, including at least one dosage form suitable for pediatric use	17 Oct 07	16 Jan 08 (90 days)
Jun 08 (update; reviewed Aug 07)	Leukotriene Modifiers	**Recommended for non-formulary status Jun 08** ▪ Zileuton ER (Zyflo CR)	BCF		Pending approval	Pending approval

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
		To remain NF ▪ zileuton (Zyflo)		Currently BCF ▪ montelukast (Singulair)	17 Oct 07	16 Jan 08 (90 days)
Jun 08 (update) Original reviews ▪ ACE inhibitors: Aug 05 ▪ Miscellaneous antihypertensives, including ACE/CCB combos. Feb 06 ▪ ARBs: May 07 ▪ Renin inhibitors. Aug 07 ▪ CCB/ARB combos Nov 07 update	Renin Angiotensin Antihypertensives	**Recommended for non-formulary status Jun 08** ▪ olmesartan/amlodipine (Azor)	BCF	-		
		To remain NF ▪ valsartan amlodipine (Exforge)			13 Feb 08	16 Apr 08 (60 days)
		To remain NF ACE inhibitors ▪ **moexipril (Univasc),** ▪ **moexipril / HCTZ (Uniretic** ▪ **perindopril (Aceon)** ▪ **quinapril (Accupril)** ▪ **quinapril / HCTZ (Accuretic)** ▪ **ramipril (Altace)** ACE/CCB combos ▪ **felodipine/enalapril (Lexxel)** ▪ **verapamil/trandolapril (Tarka)** ARBs ▪ **eprosa tan (Teveten)** ▪ **eprosa tan HCTZ (Teveten HCT)** ▪ **irbesar an (Avapro)** ▪ **irbesar an HCTZ (Avalide)** ▪ **olmesa tan (Benicar)** ▪ **olmesa tan HCTZ (Benicar HCT)** ▪ **valsart n (Diovan)** ▪ **valsart n HCTZ (Diovan HCT)**		Currently on the BCF ACE inhibitors ▪ captopril ▪ lisinopril ▪ lisinopril / HCTZ ACE/CCB combos ▪ amlodipine/benazepril (Lotrel) ARBs ▪ telmisartan (Micardis) ▪ telmisartan HCTZ (Micardis HCT)	ACE inhibitors ▪ 13 Oct 05 ACE/CCB combos ▪ 26 Apr 06 ARBs ▪ 24 July 07	ACE inhibitors ▪ **15 Feb 06** ACE/CCB combos ▪ **26 Jul 06** ARBs ▪ **21 Nov 07**
Nov 07	Targeted Immunomodulatory Biologics	▪ etanercept (Enbrel) ▪ anakinra (Kineret)	ECF	adalimumab (Humira) injection	13 Feb 08	18 Jun 08 (120 days)
Nov 07 re-review (Aug 05 original)	BPH Alpha Blockers	▪ tamsulosin (Flomax) Automated PA requiring trial of alfuzosin (Uro tral) applies to new users of tamsulosin (no use of uroselective alpha blockers in last 180 days)	BCF	▪ terazosin tablets or capsules ▪ alfuzosin tablets (Uroxatral)	13 Feb 08	16 Apr 08 (60 days)
Nov 07 (update, original review Aug 05)	Calcium Channel Blockers	**Currently non-formulary, recommended for UF status Nov 07** ▪ amlodipine (Norvasc generic)	BCF	**Recommended for addition to BCF Nov 07** ▪ amlodipine besylate tablets	13 Feb 08	13 Feb 08

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
		To Remain Non-Formulary ▪ isradipine IR (Dynacirc) ▪ isradipine ER (Dynacirc CR) ▪ nicardipine IR (Cardene, generics) ▪ nicardipine SR (Cardene SR) ▪ verapamil ER (Verelan) ▪ verapamil ER for bedtime dosing (Verelan PM, Covera HS) ▪ diltiazem ER for bedtime dosing (Cardizem LA)		Currently on the BCF ▪ nifedipine ER (Adalat CC) ▪ verapamil SR ▪ diltiazem ER (Tiazac)	13 Oct 05	15 Mar 06 (150 days)
Nov 07 (update, original review Nov 06)	ADHD / Narcolepsy Agents	**Recommended for non-formulary status Nov 07** ▪ lisdexamfetamine (Vyvanse)	BCF		13 Feb 08	16 Apr 08 (60 days)
		To remain NF ▪ dexmethylphenidate IR (Focalin) ▪ dexmethylphenidate SODAS (Focalin XR) ▪ methylphenidate transdermal system (Daytrana)		Currently on the BCF ▪ methylphenidate OROS (Concerta) ▪ **mixed amphetamine salts ER (Adderall XR)** ▪ methylphenidate IR (Ritalin)	17 Jan 07	18 Apr 07
Nov 07 (update, original review May 06)	Contraceptives	**Recommended for non-formulary status Nov 07** ▪ EE 20 mcg/levonorgestrel 0.09 mg in special packaging for continuous use (Lybrel)	BCF		13 Feb 08	16 Apr 08 (60 days)
		To remain NF ▪ **EE 30 mcg** / levonorgestrel 0.15 mg in special packaging for extended use (Seasonale) EE 25 mcg / norethindrone 0.4 mg (Ovcon 35) ▪ EE 50 mcg / norethindrone 1 mg (Ovcon 50) ▪ EE 20/30/35 mcg / norethindrone 1 mg (Estrostep Fe)		Currently on the BCF ▪ EE 20 mcg / 3 mg drospirenone (Yaz) ▪ EE 20 mcg / 0.1 mg levonorgestrel (Lutera, Sronyx, or equivalent) ▪ EE 30 mcg / 3 mg drospirenone (Yasmin) ▪ EE 30 mcg / 0.15 mg levonorgestrel (Nordette or equivalent / excludes Seasonale) ▪ EE 35 mcg / 1 mg norethindrone (Ortho-Novum 1/35 or equivalent) ▪ EE 35 mcg / 0.25 mg norgestimate (Ortho-Cyclen or equivalent) ▪ EE 25 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen Lo) ▪ EE 35 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen or equivalent) ▪ 0.35 mg norethindrone (Nor-QD, Ortho Micronor, or equivalent)	26 Jul 06	24 Jan 07
		▪ EE 30/10 mcg / 0.15 mg levonorgestrel in special packaging for extended use (Seasonique) ▪ EE 20 mcg / 1 mg norethindrone (Loestrin 24 Fe)			17 Jan 07	18 Mar 07

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Aug 07	Leukotriene Modifiers	▪ zileuton (Zyflo)	BCF	▪ montelukast (Singulair)	17 Oct 07	16 Jan 08 (90 days)
Aug 07	Growth Stimulating Agents	▪ somatropin (Genotropin, Genotropin Miniquick) ▪ somatropin (Humatrope) ▪ somatropin (Omnitrope) ▪ somatropin (Saizen)	ECF	▪ somatropin (Norditropin)	17 Oct 07	19 Dec 07 (60 days)
Aug 07 (new drug update, original review Nov 05)	Nasal Corticosteroids	▪ beclomethasone dipropionate (Beconase AQ, Vancenase AQ) ▪ budesonide (Rhinocort Aqua) ▪ triamcinolone (Nasacort AQ)	BCF	▪ fluticasone propionate (Flonase)	19 Jan 06	19 Apr 06 (90 days)
		Recommended for non-formulary status Aug 07 ▪ fluticasone furoate (Veramyst)			17 Oct 07	19 Dec 07 (60 days)
May 07 re-review (Feb 05 original)	PPIs	▪ lansoprazole (Prevacid) ▪ omeprazole/sodium bicarbonate (Zegerid) ▪ pantoprazole (Protonix) ▪ rabeprazole (Aciphex) Automated PA requiring trial of omeprazole OR esomeprazole (Nexium) applies to new users of non-formulary PPIs (no use of PPIs in last 180 days)	BCF	▪ generic omeprazole 10 mg and 20 mg (excludes Prilosec 40 mg) ▪ esomeprazole (Nexium)	24 July 07	24 Oct 07 (90 days)
May 07 re-review (Feb 05 original)	ARBs	▪ eprosartan (Teveten) ▪ eprosartan HCTZ (Teveten HCT) ▪ irbesartan (Avapro) ▪ irbesartan HCTZ (Avalide) ▪ olmesartan (Benicar) ▪ olmesartan HCTZ (Benicar HCT) ▪ valsartan (Diovan) ▪ valsartan HCTZ (Diovan HCT)	BCF	▪ telmisartan (Micardis) ▪ telmisartan HCTZ (Micardis HCT)	24 July 07	21 Nov 07 (120 days)
May 07	5-Alpha Reductase Inhibitors	▪ dutasteride (Avodart)	BCF	▪ finasteride	24 July 07	24 Oct 07 (90 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Feb 07	Newer Sedative Hypnotics	▪ zolpidem ER (Ambien CR) ▪ zaleplon (Sonata) ▪ ramelteon (Rozerem) Automated PA requiring trial of zolpidem IR applies to new users of eszopiclone (Lunesta), ramelteon (Rozerem), zaleplon (Sonata), or zolpidem ER (Ambien CR) (new users = no use of newer sedative hypnotics in last 180 days)	BCF	▪ zolpidem IR (Ambien)	02 May 07	01 Aug 07 (90 days)
Feb 07	Narcotic Analgesics	▪ tramadol ER (Ultram ER)	BCF	▪ morphine sulfate IR 15 mg, 30 mg ▪ morphine sulfate 12-hour ER (MS Contin or equivalent) 15, 30, 60 mg ▪ oxycodone/APAP 5/325 mg ▪ hydrocodone/APAP 5/500 mg ▪ codeine/APAP 30/300 mg ▪ codeine/APAP elixir 12/120 mg/5 mL ▪ tramadol IR	02 May 07	01 Aug 07 (90 days)
Feb 07	Ophthalmic Glaucoma Agents	▪ travoprost (Travatan, Travatan Z) ▪ timolol maleate for once daily dosing (Istalol) ▪ timolol hemihydrate (Betimol) ▪ brinzolamide (Azopt)	BCF	▪ latanoprost (Xalatan) ▪ brimonidine (Alphagan P); excludes 0.1% ▪ timolol maleate ▪ timolol maleate gel-forming solution ▪ pilocarpine	02 May 07	01 Aug 07 (90 days)
Nov 06	Older Sedative Hypnotics		BCF	▪ temazepam 15 and 30 mg	17 Jan 07	
Aug 06	TZDs		BCF	▪ rosiglitazone (Avandia) ▪ rosiglitazone / metformin (Avandamet)	23 Oct 06	
Aug 06	H2 Antagonists / GI protectants		BCF	▪ ranitidine (Zantac) – excludes gelcaps and effervescent tablets	23 Oct 06	
Aug 06	Antilipidemic Agents I	▪ rosuvastatin (Crestor) ▪ atorvastatin / amlodipine (Caduet)	BCF	▪ simvastatin (Zocor) ▪ pravastatin ▪ simvastatin / ezetimibe (Vytorin) ▪ niacin extended release (Niaspan)	23 Oct 06	1 Feb 07 (90 days)
May 06	Antiemetics	▪ dolasetron (Anzemet)	BCF	▪ promethazine (oral and rectal)	26 Jul 06	27 Sep 06 (60 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Feb 06	OABs	▪ tolterodine IR (Detrol) ▪ oxybutynin patch (Oxytrol) ▪ trospium (Sanctura)	BCF	▪ oxybutynin IR (Ditropan tabs/soln) ▪ tolterodine SR (Detrol LA)	26 Apr 06	26 Jul 06 (90 days)
Feb 06	Misc Antihypertensive Agents	▪ felodipine/enalapril (Lexxel) ▪ verapamil/trandolapril (Tarka)	BCF	▪ amlodipine/benazepril (Lotrel) ▪ hydralazine ▪ clonidine tablets	26 Apr 06	26 Jul 06 (90 days)
Feb 06	GABA-analogs	▪ pregabalin (Lyrica)	BCF	▪ gabapentin	26 Apr 06	28 Jun 06 (60 days)
Nov 05	Alzheimer's Drugs	▪ tacrine (Cognex)	ECF	▪ donepezil (Aricept)	19 Jan 06	19 Apr 06 (90 days)
Nov 05	Macrolide/ Ketolide Antibiotics	▪ azithromycin 2 gm (Zmax) ▪ telithromycin (Ketek)	BCF	▪ azithromycin (Z-Pak) ▪ erythromycin salts and bases	19 Jan 06	22 Mar 06 (60 days)
Nov 05	Antidepressants I	▪ paroxetine HCl CR (Paxil) ▪ fluoxetine 90 mg for weekly administration (Prozac Weekly) ▪ fluoxetine in special packaging for PMDD (Sarafem) ▪ escitalopram (Lexapro) ▪ duloxetine (Cymbalta) ▪ bupropion extended release (Wellbutrin XL)	BCF	▪ citalopram ▪ fluoxetine (excluding weekly regimen and special packaging for PMDD) ▪ sertraline (Zoloft) ▪ trazodone ▪ bupropion sustained release	19 Jan 06	19 Jul 06 (180 days)
Aug 05	ACE Inhibitors & ACE Inhibitor / HCTZ Combinations	▪ moexipril (Univasc), ▪ moexipril / HCTZ (Uniretic) ▪ perindopril (Aceon) ▪ quinapril (Accupril) ▪ quinapril / HCTZ (Accuretic) ▪ ramipril (Altace)	BCF	▪ captopril ▪ lisinopril ▪ lisinopril / HCTZ	13 Oct 05	15 Feb 06 (120 days)
May 05	PDE5 Inhibitors	▪ sildenafil (Viagra) ▪ tadalafil (Cialis)	ECF	▪ vardenafil (Levitra)	14 Jul 05	12 Oct 05 (90 days)
May 05 (updated Nov 06)	Topical Antifungals*	▪ econazole ▪ ciclopirox ▪ oxiconazole (Oxistat) ▪ sertaconazole (Ertaczo) ▪ sulconazole (Exelderm)	BCF	▪ nystatin ▪ clotrimazole	14 Jul 05	17 Aug 05 (30 days)
		Recommended for non-formulary status Nov 06: ▪ 0.25% miconazole / 15% zinc oxide / 81.35% white petrolatum ointment (Vusion)			17 Jan 07	18 Mar 07 (60 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
May 05	MS-DMDs		ECF	▪ interferon beta-1a intramuscular injection (Avonex)	14 Jul 05	

BCF = Basic Core Formulary; ECF = Extended Core Formulary; MN = Medical Necessity; TMOP = TRICARE Mail Order Pharmacy; TRRx = TRICARE Retail Pharmacy program; UF = Uniform Formulary
ER = extended release; IR = immediate release; SR = sustained release; IDD-P = insoluble drug delivery-microParticle
ADHD = Attention Deficit Hyperactivity Disorder; ARBs = Angiotensin Receptor Blockers; ACE Inhibitors = Angiotensin Converting Enzyme Inhibitors; BPH = Benign Prostatic Hyperplasia; CCBs = Calcium Channel Blockers; EE = ethinyl estradiol; GI = gastrointestinal; GABA = gamma-aminobutyric acid; H2 = Histamine-2 receptor; HCTZ = hydrochlorothiazide; MS-DMDs = Multiple Sclerosis Disease-Modifying Drugs; OABs = Overactive Bladder Medications; PDE5 Inhibitors = Phosphodiesterase- type 5 inhibitors; PPIs = Proton Pump Inhibitors; TZDs= Thiazolidinediones
*The topical antifungal drug class excludes vaginal products and products for onychomycosis (e.g., ciclopirox topical solution [Penlac])

Appendix D – Table of Abbreviations

ABA	Adrenergic Beta Antagonist drug class
AE	adverse event
ARB	angiotensin receptor blocker
BAP	Beneficiary Advisory Panel
BCF	Basic Core Formulary
BIA	budget impact analysis
BID	twice daily
BMD	bone mineral density
BP	blood pressure
CCB	calcium channel blocker
CEA	cost effectiveness analysis
CFR	Code of Federal Regulations
CI	confidence interval
CMA	cost minimization analysis
CR	controlled release (extended release)
DHP	dihydropyridine
DoD	Department of Defense
CI	confidence interval
ED	erectile dysfunction
FCP	Federal Ceiling Price
FDA	Food and Drug Administration
FY	fiscal year
GA	Glaucoma Agent drug class
HA	Health Affairs
HCTZ	hydrochlorothiazide
HDL	high density lipoprotein cholesterol
IDD-P	Insoluble drug delivery microparticle
IR	immediate release
IU	international unit
JIA	juvenile idiopathic arthritis
LDL	low density lipoprotein cholesterol
LIP-1s	Antilipidemic -1 drug class
LIP-2s	Antilipidemic -2 drug class
LM	Leukotriene Modifier drug class
MHS	Military Health System
MN	medical necessity
MTF	military treatment facility
OR	odds ratio
P&T	Pharmacy and Therapeutics
PA	prior authorization
PDE5	phosphodiesterase type 5
PEC	Pharmacoeconomic Center
PORT	Pharmaceutical Outcomes Research Team
PTH	parathyroid hormone
QD	once daily
QL	quantity limit
SERM	selective estrogen receptor modulator
TC	total cholesterol
T2DM	Type 2 diabetes mellitus
TMA	TRICARE Management Activity
UF VARR	Uniform Formulary Voluntary Agreement for Retail Refund

DECISION PAPER
DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS
February 2008

1) CONVENING

2) ATTENDANCE

3) REVIEW MINUTES OF LAST MEETING

4) ITEMS FOR INFORMATION

A. National Defense Authorization Act (NDAA) 2008 Sec. 703. Inclusion of TRICARE Retail Pharmacy Program In Federal Procurement Of Pharmaceuticals - LTC Kelly provided the P&T Committee an overview of NDAA 2008 Sec. 703, which addresses the inclusion of TRICARE Retail Pharmacy Program (TRRx) in Federal Procurement of Pharmaceuticals. This law requires that "any prescription filled on or after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2008, the TRICARE retail pharmacy program shall be treated as an element of the Department of Defense for purposes of the procurement of drugs by Federal agencies under section 8126 of title 38 to the extent necessary to ensure that pharmaceuticals paid for by the Department of Defense that are provided by pharmacies under the program to eligible covered beneficiaries under this section are subject to the pricing standards in such section 8126.'' The presentation included: 1) NDAA 2008 Section 703 background; 2) a description and estimate of Federal Ceiling Price (FCP) relative to other prices paid by DoD to manufacturers for brand-name medications; 3) the evolution of FCP in the TRRx; and 4) formulary management strategy going forward in light of NDAA 2008 Section 703 legislation.

B. Outcomes Research Initiatives – Lt Col Bacon briefed the P&T Committee on the establishment of an Outcomes Research Team, the Team's objectives, ongoing research projects, and potential outcomes research initiatives.

C. Re-Evaluation of Quinapril and Quinapril/Hydrochlorothiazide(HCTZ)'s UF Status

The P&T Committee re-evaluated the UF status of quinapril (Accupril) and quinapril/HCTZ (Accuretic), in light of recent price reductions in the generic formulations across all three points of service. This marked the first re-evaluation of a non-formulary agent for 1st tier UF status using the P&T Committee's process for the re-evaluation of non-formulary agents, which was established at the May 2007 meeting and approved by the Director, TMA on 24 June 2007. The Pharmacoeconomic Center (PEC) identified quinapril and quinapril/HCTZ as candidates for UF consideration upon application of the process criteria to the approved list of non-formulary drug agents for re-evaluation of UF status (See Table 1).

Clinical Effectiveness Conclusion - At the August 2005 P&T Committee meeting, the Committee concluded that, in general, quinapril and quinapril/HCTZ had similar clinical effectiveness relative to other angiotensin converting enzyme (ACE) inhibitors in regards to efficacy, safety, tolerability, and clinical outcomes.

Cost Effectiveness Conclusion – The P&T Committee voted (13 for, 0 opposed, 0 abstained, 4 absent) that quinapril and quinapril/HCTZ have similar cost-effectiveness relative to the other UF ACE inhibitors.

COMMITTEE ACTION: UF DECISION – In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the ACE inhibitor and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, and 4 absent) that quinapril and quinapril/HCTZ be immediately reclassified as generic on the UF. (See paragraph 4E on page 9 of the P&T Committee minutes). This agent was on the "list of non-formulary drugs for re-evaluation of UF status" presented to the BAP in January 2008 and approved by Director, TMA on 13 February 2008. As such, no further approval is needed.

5) REVIEW OF RECENTLY APPROVED AGENTS

A. Recently Approved Agents in Classes Not Yet Reviewed for the UF

The P&T Committee was briefed on one new drug recently approved by the FDA (see Appendix B). The P&T Committee determined that this new drug fell into a drug class that has not yet been reviewed for UF status. Therefore, UF consideration was deferred until the drug class review is completed. The P&T Committee discussed the need for a days supply quantity limit (QL) (no multiple fills for multiple co-pays) for sapropterin tablets (Kuvan) based on dosing and laboratory monitoring recommendations in the package insert.

COMMITTEE ACTION: QL – The P&T Committee voted (13 for, 0 opposed, 0 abstained, 4 absent) to recommend a QL for sapropterin tablets of a 45 days supply in the TRICARE Mail Order Pharmacy Program (TMOP) and a 30 days supply in the TRRx (no multiple fills for multiple co-pays). (See paragraph 5A on page 10 of the P&T Committee minutes).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Recently Approved Agents in Classes Previously Reviewed for the UF

The Committee was briefed on newly approved drugs that fall into classes previously reviewed for the UF. The clinical and economic analyses of these classes will be completed for a future meeting. The Committee took no action.

6) UTILIZATION MANAGEMENT – PRIOR AUTHORIZATIONS (PAs)/(QLs)/ MEDICAL NECESSITY (MNs)

A. Renin-Angiotensin Antihypertensives (RAAs) – Valsartan MN Criteria – The Committee discussed the MN criteria for valsartan with regard to a new FDA-approved indication for use for pediatric hypertension. The Angiotensin Receptor Blocker (ARB) drug class was previously reviewed for UF placement in May 2007. At the time of the meeting, losartan (Cozaar) was the only FDA-approved ARB for treating hypertension in children aged 6 – 16 years of age. Valsartan (Diovan) is now FDA-approved for treating children aged 6 – 16 years with hypertension; it is not approved for treating children with heart failure. FDA approval for valsartan was based on a study in 261 children with hypertension who received valsartan for two weeks. At the end of the two week study period, valsartan treatment resulted in statistically significant reductions in both systolic and diastolic blood pressure.

The Committee recommended that MN be approved for children between the ages of 6 and 16 years who have failed to respond adequately to treatment with losartan or who have experienced adverse effects to losartan.

COMMITTEE ACTION: The P&T Committee voted (9 for, 3 opposed, 1 abstained, 4 absent) to approve the MN criteria for valsartan. (See paragraph 6A on page 11 of the P&T Committee minutes).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Targeted Immunomodulatory Biologics (TIBs)

1) Administrative Action - PA for Adalimumab (Humira)

At the November 2007 DoD P&T committee meeting, adalimumab (Humira) was chosen as the Extended Core Formulary (ECF) agent, as it was the most cost effective TIB with multiple FDA-approved indications. Alefacept (Amevive) and efalizumab (Raptiva) were placed on the UF. Etanercept (Enbrel), the other multi-indication TIB, was made non-formulary along with anakinra (Kineret). Infliximab (Remicade), abatacept (Orencia), and rituximab (Rituxan) were not affected by the UF decision, since these medications fall under the TMA medical benefit and are not part of the pharmacy benefit, given their route of intravenous (IV) administration. The TIB UF decisions have a scheduled implementation date of June 18th 2008.

In January 2008, the FDA approved Humira for treatment of plaque psoriasis. At the time of the November 2007 Committee meeting, Humira was FDA-approved for rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), and Crohn's disease (adults). Enbrel is FDA-approved for RA, juvenile RA, AS, PsA, and plaque psoriasis.

The FDA approved Humira's indication for plaque psoriasis based on two recently published clinical trials; the CHAMPION trial, published in December 2007, and Menter, et al published in January 2008. The CHAMPION trial was a randomized, placebo- and methotrexate-controlled trial in 261 patients with mild to moderate plaque psoriasis. The primary endpoint was Psoriasis Areas and

Severity Index (PASI) 75% response. At the end of 16 weeks, 79.6% of Humira-treated patients achieved a PASI 75 response, compared to only 35.5% and 18.9% of the methotrexate- and placebo-treated patients, respectively.

The Menter et al study included 1,212 patients with moderate to severe psoriasis randomized to receive either Humira or placebo for an initial 16 week double-blinded treatment phase. At the end of that period, 71% of Humira-treated patients achieved a PASI 75% response, compared to 7% of placebo-treated patients. With regard to safety and tolerability, both studies demonstrated a similar safety profile to that established in previous Humira clinical trials.

The FDA-approved plaque psoriasis indication will be added to the PA for Humira.

2) *QL for TIBs*

Currently, quantity and/or days supply limits apply to Enbrel (etanercept), Humira (adalimumab), and Kineret (anakinra), as outlined in Appendix C. In general, patients are limited to a 4-week supply of these medications at retail network pharmacies at any one time with no multiple fills for multiple copays. Patients are slso limited to a 6- to 8-week supply at the TMOP, based on product labeling and packaging. The intent of the QL is to limit potential wastage in the event medications are discontinued or changed.

A change in the QLs for the TIBs was recommended to establish consistent and uniform amounts supplied in the TRRx and TMOP points of service across the drug class. Currently only Enbrel, Humira and Kineret have QLs at TRRx and TMOP. A four-week supply for Enbrel and Humira is allowed at the TRRx, with a six week supply allowed in the TMOP. However, for Kineret, an 8 week supply is allowed at TMOP. A change in the QL was proposed to allow a QL for Humira, Amevive, Raptiva, Enbrel, and Kineret of four weeks supplied at TRRX. In the TMOP, the proposal was a QL for Humira, Raptiva, Enbrel and Kineret of an 8 week supply. No QL is proposed for Amevive in the TMOP, since it is not supplied through that point of service. The number of syringes/vials supplied under these limits is reflected in Table 2.

COMMITTEE ACTION: The P&T Committee voted (13 for, 0 opposed, 0 abstained, 4 absent) to approve the QLs outlined above in Table 2 to allow adalimumab (Humira), etanercept (Enbrel), and anakinra (Kineret) a four weeks supply via TRRx and 8 weeks supply via TMOP. The Committee voted to add the same limits to efalizumab (Raptiva). A four weeks supply limit was agreed for Alefacept (Amevive) at TRRx, with no QL in the TMOP, as Amevive is not available through the TMOP. (See paragraph 6B on page 12 of the P&T Committee minutes).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

7) BCF / ECF REVIEW

A. Clarification of Basic Core Formulary (BCF) Listing - As part of an ongoing plan to systematically review drug classes represented on the BCF, the P&T Committee made recommendations for clarifying BCF listings in four BCF drug classes: antibiotics (nitrofurantoin monohydrate/macrocrystals [MacroBid]), proton pump inhibitors (esomeprazole [Nexium] powder packets), cough and cold preparations (chlorpheniramine 8 mg/pseudoephedrine 120 mg sustained release [Deconamine SR]), and miscellaneous migraine medications (isometheptene 65 mg/dichloralphenazone 100 mg/ acetaminophen 325 mg [Midrin]).

COMMITTEE ACTION: The P&T Committee recommended (votes on Table 3) the following changes to the current BCF drug classes as outlined in Table 3. (See paragraph 7 on page 13 of the P&T Committee minutes and Appendix D on page 24).

Table 3 - Recommended BCF / ECF Changes

Drug class or potential drug class	Current BCF/ECF listing	Recommendation	Vote			
			For	Opposed	Abstained	Absent
Antibiotics	Nitrofurantoin macrocrystals oral (Does not include MacroBid)	Clarify BCF listing to: "Nitrofurantoin oral (50 mg macrocrystals, 100 mg monohydrate/macrocrystals)"	13	0	0	4
Cough and Cold Preparations	Chlorpheniramine 8 mg / pseudoephedrine 120 mg sustained release (Deconamine SR)	Remove BCF listing: "Chlorpheniramine 8 mg / pseudoephedrine 120 mg sustained release" (specific brand name is Deconamine SR)	13	0	0	4
Miscellaneous Migraine Medications	Isometheptene 65 mg / dichloralphenazone 100 mg / acetaminophen 325 mg (Midrin)	Remove BCF listing:" Isometheptene 65 mg / dichloralphenazone 100 mg / acetaminophen 325 mg" (specific brand name is Midrin)	10	3	0	4
Proton Pump Inhibitors	Esomeprazole (Nexium)	Clarify BCF listing to: "esomeprazole (Nexium) 20 and 40 mg capsule"	13	0	0	4

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Administrative Action - The PEC obtained recommendations from members of the P&T Committee regarding clarification of the BCF listing for the following medications: antibiotics (amoxicillin oral, doxycycline oral, and cephalexin oral), antifungals (nystatin oral), inhaled asthma agents (albuterol oral inhaler), contraceptives, miscellaneous respiratory medications (insect allergy kits), and ophthalmic antibiotics and combinations (sulfacetamide sodium 10% ophthalmic ointment). Administrative changes will include removal of obsolete medications and more comprehensive delineation of BCF listings. (See Appendix D on page 24 of the P&T Committee minutes).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

8) UPDATE ON SIMVASTATIN/EZETIMIBE – ENHANCE STUDY

The P&T Committee was briefed on the "effect of combination ezetimibe and high-dose simvastatin vs. simvastatin alone on the atherosclerotic process in subjects with heterozygous familial hypercholesterolemia" (ENHANCE) study. The ENHANCE study compared simvastatin/ezetimibe (Vytorin) 80/10 mg with simvastatin 80 mg in patients with heterozygous familial hypercholesterolemia who had baseline low-density lipoprotein levels exceeding 300 mg/dL. The primary endpoint of the trial was the change in carotid intima media thickness (CIMT). The trial did not evaluate clinical outcomes (e.g., mortality, myocardial infarction). There was no significant difference between the two groups with regard to changes in CIMT. Three ongoing studies are addressing outcomes with simvastatin/ezetimibe. No action necessary.

Appendix A – Implementation Status of UF Recommendations / Decisions

Appendix B – Newly Approved Drugs

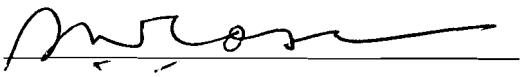
Appendix C – Existing Quantity Limits and Recommended QLs for TIBS

Appendix D – BCF/ECF Review

Appendix E – Table of Abbreviations

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.



S. Ward Casscells, III, M.D.

Department of Defense
Pharmacy and Therapeutics Committee Minutes
February 2008

1) CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 1000 (EST) hours on 13 Feb 2008 via a teleconference hosted by the DoD Pharmacoeconomic Center (PEC), Fort Sam Houston, Texas.

2) ATTENDANCE

A. Voting Members Present

Col John Kugler, MC, USA	DoD P&T Committee Chair
LTC Brett Kelly, MSC, USA	DoD P&T Committee Recorder
Capt Jeremy King, MC	Air Force, OB/GYN Physician
Lt Col Brian Crownover, MC	Air Force, Physician at Large
Col Everett McAllister, BSC	Air Force, Pharmacy Officer
CDR Walter Downs, MC *for* LCDR Michelle Perelló, MC	Navy, Internal Medicine Physician
CDR David Tanen, MC	Navy, Physician at Large
CAPT David Price, MSC	Navy, Pharmacy Officer
COL Doreen Lounsbery, MC	Army, Internal Medicine Physician
Col Karl R. Kerchief, MC	Army, Family Practice Physician
COL Ted Cieslak, MC	Army, Physician at Large
LTC (P) Peter Bulatao, MSC *for* COL Isiah Harper, MSC	Army, Pharmacy Officer
CAPT Vernon Lew, USPHS	Coast Guard, Pharmacy Officer

B. Voting Members Absent

Major William Hannah, MC	Air Force, Internal Medicine Physician
CAPT William Blanche, MSC, USN	DoD Pharmacy Programs, TMA
LCDR Scott Akins, MC	Navy, Pediatrics Physician
Mr. Joe Canzolino, RPh.	Department of Veterans Affairs

C. Non-Voting Members Present

COL Kent Maneval, MSC, USA	Defense Medical Standardization Board
Lt Col Paul Hoerner, BSC, USAF	Deputy Director, DoD Patient Safety Center
CDR Kim Lefebvre, MSC	Defense Supply Center Philadelphia
Mr. Howard Altschwager	Deputy General Counsel, TMA
LT Thomas Jenkins, MSC, USN	TMA Aurora

D. Non-Voting Members Absent

Martha Taft	Health Plan Operations, TMA

E. Others Present

CDR Matthew Carlberg, MC, USN	DoD PEC
Lt Col James McCrary, MC, USAF	DoD PEC
LTC Chris Conrad, MC, USA	DoD PEC
Maj Wade Tiller, BSC, USAF	DoD PEC
Maj Josh Devine, BSC, USAF	DoD PEC
CPT Josh Napier, MC, USA	DoD PEC
Angela Allerman, Pharm.D.	DoD PEC
Julie Liss, Pharm.D.	DoD PEC
David Meade, Pharm.D.	DoD PEC
Harsha Mistry, Pharm.D.	DoD PEC
Eugene Moore, Pharm.D.	DoD PEC
Shana Trice, Pharm.D.	DoD PEC
Nancy Misel, RPh	Director, Air Force High Dollar Program
LCDR James Ellzy, MC, USN	Vice DoD P&T Committee Chair
Lt Col Thom Bacon	TMA Pharmaceutical Operations Directorate
CDR Rob Hayes	USPHS/IHS
Major Peter Trang, BSC, USAF	Defense Supply Center Philadelphia
Major Mike Lee, BSC	Air Force, Alternate Pharmacist Officer
Carol Cooper	Associate General Counsel, TMA

3) REVIEW MINUTES OF LAST MEETING

A. Corrections to the Minutes – Nov 2007 DoD P&T Committee meeting minutes were approved as written, with no corrections noted.

B. Approval of Nov Minutes – Dr. Samuel Ward Casscells, III., M.D., approved the minutes of the Nov 2007 DoD P&T Committee meeting on February 13, 2008.

4) ITEMS FOR INFORMATION

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

A. **Beneficiary Advisory Panel (BAP) Briefing** – LCDR Ellzy, Lt Col Bacon, and LTC Kelly briefed the members of the P&T Committee regarding the Nov 2007 BAP meeting. The P&T Committee was briefed on BAP comments regarding the DoD P&T Committee's Uniform Formulary (UF) and implementation recommendations.

B. **Implementation Status of UF Decisions** – The PEC staff briefed the members of the P&T Committee on the progress of implementation for drug classes reviewed for UF status since August 2007 (Appendix A).

C. **National Defense Authorization Act (NDAA) 2008 Sec. 703. Inclusion of TRICARE Retail Pharmacy Program In Federal Procurement Of Pharmaceuticals** - LTC Kelly provided the P&T Committee an overview of NDAA 2008 Sec. 703, which addresses the inclusion of TRICARE Retail Pharmacy Program (TRRx) in Federal Procurement of Pharmaceuticals. This law requires that "any prescription filled on or after the date of the enactment of the National Defense Authorization Act for Fiscal Year 2008, the TRICARE retail pharmacy program shall be treated as an element of the Department of Defense for purposes of the procurement of drugs by Federal agencies under section 8126 of title 38 to the extent necessary to ensure that pharmaceuticals paid for by the Department of Defense that are provided by pharmacies under the program to eligible covered beneficiaries under this section are subject to the pricing standards in such section 8126." The presentation included: 1) NDAA 2008 Section 703 background; 2) a description and estimate of FCP relative to other prices paid by DoD to manufacturers for brand-name medications; 3) the evolution of FCP in the TRRx; and 4) formulary management strategy going forward in light of NDAA 2008 Section 703 legislation.

D. **Outcomes Research Initiatives** – Lt Col Bacon briefed the P&T Committee on the establishment of an Outcomes Research Team, the Team's objectives, ongoing research projects, and potential outcomes research initiatives.

E. **Re-Evaluation of Quinapril and Quinapril/Hydrochlorothiazide (HCTZ)'s UF Status**

The P&T Committee re-evaluated the UF status of quinapril (Accupril) and quinapril/HCTZ (Accuretic), in light of recent price reductions in the generic formulations across all three points of service. This marked the first re-evaluation of a non-formulary agent for 1st tier UF status using the P&T Committee's process for the re-evaluation of non-formulary agents, which was established at the May 2007 meeting and approved by the Director, TMA on 24 June 2007. The PEC identified quinapril and quinapril/HCTZ as candidates for UF consideration upon application of the process criteria to the approved list of non-formulary drug agents for re-evaluation of UF status (Table 1).

Table 1 – Non-Formulary Agents for Re-Evaluation

Generic Name	Brand Name	UF Class	Generics Shipping
EE 30 mcg; 0.15 mg levonorgestrel	Seasonale	BCs (M30)	Y
EE 30/10 mcg; 0.15 mg levonorgestrel	Seasonique	BCs (M20)	N
EE 35 mcg; 0.4 mg norethindrone	Ovcon-35	BCs (M35)	Y
EE 50 mcg; 1 mg norethindrone	Ovcon-50	BCs (M50)	N
EE 20 mcg; 0.1 mg norethindrone	Loestrin 24 FE	BCs (M20)	N
ciclopirox	Loprox	AF-DERMs	Y
econazole	Spectazole	AF-DERMs	Y
moexipril	Univasc	ACEs	Y
ramipril	Altace	ACEs	N
quinapril, quinapril/HCTZ	Accupril, Accuretic	ACEs	Y
amlodipine	Norvasc	CCBs	Y
nicardipine	Cardene	CCBs	Y
nicardipine SR	Cardene SR	CCBs	N
isradipine IR	Dynacirc	CCBs	Y
isradipine CR	Dynacirc CR	CCBs	N
diltiazem ER HS	Cardizem LA	CCBs	N
verapamil ER HS	Verelan /Covera HS	CCBs	N
bupropion XL	Wellbutrin XL	AD1s	Y (300mg only)
paroxetine CR	Paxil CR	AD1s	N
escitalopram	Lexapro	AD1s	N
verapamil ER / trandolapril	Tarka	Misc HTNs	N
tramadol ER	Ultram ER	Narcotic analgesics	N
timolol maleate	Istalol	EYE-1s	N
timolol hemihydrate	Betimol	EYE-1s	N
tolterodine IR	Detrol IR	OABs	N

Clinical Effectiveness Conclusion - At the August 2005 P&T Committee meeting, the Committee concluded that, in general, quinapril and quinapril/HCTZ had similar clinical effectiveness relative to other angiotensin converting enzyme (ACE) inhibitors in regards to efficacy, safety, tolerability, and clinical outcomes.

Cost Effectiveness Conclusion – The P&T Committee voted (13 for, 0 opposed, 0 abstained, 4 absent) that quinapril and quinapril/HCTZ have similar cost-effectiveness relative to the other UF ACE inhibitors.

COMMITTEE ACTION: UF DECISION – In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the ACE inhibitor and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (13 for, 0 opposed, 0 abstained, and 4 absent) that quinapril and quinapril/HCTZ be immediately reclassified as generic on the UF.

5) REVIEW OF RECENTLY APPROVED AGENTS

A. Recently Approved Agents in Classes Not Yet Reviewed for the UF

The P&T Committee was briefed on one new drug recently approved by the FDA (see Appendix B). The P&T Committee determined that this new drug fell into a drug class that has not yet been reviewed for UF status. Therefore, UF consideration

was deferred until the drug class review is completed. The P&T Committee discussed the need for a days supply quantity limit (QL) (no multiple fills for multiple co-pays) for sapropterin tablets (Kuvan) based on dosing and laboratory monitoring recommendations in the package insert.

COMMITTEE ACTION: QL – The P&T Committee voted (13 for, 0 opposed, 0 abstained, 4 absent) to recommend a QL for sapropterin tablets of a 45 days supply in the TRICARE Mail Order Pharamcy Program (TMOP) and a 30 days supply in the TRRx (no multiple fills for multiple co-pays).

B. Recently Approved Agents in Classes Previously Reviewed for the UF

The Committee was briefed on newly approved drugs that fall into classes previously reviewed for the UF. The clinical and economic analyses of these classes will be completed for a future meeting. The Committee took no action.

6) UTILIZATION MANAGEMENT – PRIOR AUTHORIZATIONS (PAs)/(QLs)/ MEDICAL NECESSITY (MNs)

A. Renin-Angiotensin Antihypertensives (RAAs) – Valsartan MN Criteria – The Committee discussed the MN criteria for valsartan with regard to a new FDA-approved indication for use for pediatric hypertension. The Angiotensin Receptor Blocker (ARB) drug class was previously reviewed for UF placement in May 2007. At the time of the meeting, losartan (Cozaar) was the only FDA-approved ARB for treating hypertension in children aged 6 – 16 years of age. Valsartan (Diovan) is now FDA-approved for treating children aged 6 – 16 years with hypertension; it is not approved for treating children with heart failure. FDA approval for valsartan was based on a study in 261 children with hypertension who received valsartan for two weeks. At the end of the two week study period, valsartan treatment resulted in statistically significant reductions in both systolic and diastolic blood pressure.

The Committee recommended that MN be approved for children between the ages of 6 and 16 years who have failed to respond adequately to treatment with losartan or who have experienced adverse effects to losartan.

COMMITTEE ACTION: The P&T Committee voted (9 for, 3 opposed, 1 abstained, 4 absent) to approve the MN criteria for valsartan.

B. Targeted Immunomodulatory Biologics (TIBs)

1) Administrative Action - PA for Adalimumab (Humira)

At the November 2007 DoD P&T committee meeting, adalimumab (Humira) was chosen as the Extended Core Formulary (ECF) agent, as it was the most cost effective TIB with multiple FDA-approved indications. Alefacept (Amevive) and efalizumab (Raptiva) were placed on the UF. Etanercept (Enbrel), the other multi-indication TIB, was made non-formulary along with anakinra (Kineret). Infliximab (Remicade), abatacept (Orencia), and rituximab (Rituxan) were not affected by the UF decision, since these medications fall under the TMA medical benefit and are not part of the pharmacy benefit, given their route of intravenous (IV) administration. The TIB UF decisions have a scheduled implementation date of June 18th 2008.

In January 2008, the FDA approved Humira the treatment of plaque psoriasis. At the time of the November 2007 Committee meeting, Humira was FDA-approved for rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), and Crohn's disease (adults). Enbrel is FDA-approved for RA, juvenile RA, AS, PsA, and plaque psoriasis.

The FDA approved Humira's indication for plaque psoriasis based on two recently published clinical trials; the CHAMPION trial, published in December 2007, and Menter, et al published in January 2008. The CHAMPION trial was a randomized, placebo- and methotrexate-controlled trial in 261 patients with mild to moderate plaque psoriasis. The primary endpoint was Psoriasis Areas and Severity Index (PASI) 75% response. At the end of 16 weeks, 79.6% of Humira-treated patients achieved a PASI 75 response, compared to only 35.5% and 18.9% of the methotrexate- and placebo-treated patients, respectively.

The Menter et al study included 1,212 patients with moderate to severe psoriasis randomized to receive either Humira or placebo for an initial 16 week double-blinded treatment phase. At the end of that period, 71% of Humira-treated patients achieved a PASI 75% response, compared to 7% of placebo-treated patients. With regard to safety and tolerability, both studies demonstrated a similar safety profile to that established in previous Humira clinical trials.

The FDA-approved plaque psoriasis indication will be added to the PA for Humira.

2) *QL for TIBs*

Currently, quantity and/or days supply limits apply to Enbrel (etanercept), Humira (adalimumab), and Kineret (anakinra), as outlined in Appendix C. In general, patients are limited to a 4-week supply of these medications at retail network pharmacies at any one time withno multiple fills for multiple copays. Patients are also limited to a 6- to 8-week supply at the TMOP, based on product labeling and packaging. The intent of the QL is to limit potential wastage in the event medications are discontinued or changed.

A change in the QLs for the TIBs was recommended to establish consistent and uniform amounts supplied in the TRRx and TMOP points of service across the drug class. Currently only Enbrel, Humira and Kineret have QLs at TRRx and TMOP. A four-week supply for Enbrel and Humira is allowed at the TRRx, with a six week supply allowed in the TMOP. However, for Kineret, an 8 week supply is allowed at TMOP. A change in the QL was proposed to allow a QL for Humira, Amevive, Raptiva, Enbrel, and Kineret of four weeks supplied at TRRX. In the TMOP, the proposal was a QL for Humira, Raptiva, Enbrel and Kineret of an 8 week supply. No QL is proposed for Amevive in the TMOP, since it is not supplied through that point of service. The number of syringes/vials supplied under these limits is reflected in Table 2.

Table 2 - Recommended Maximum Quantities Dispensed at One Time: TIBs

Point of Service / Notes	Adalimumab (Humira)	Etanercept (Enbrel)	Anakinra (Kineret)	Alefacept (Amevive)	Efalizumab (Raptiva)
Retail Network	4 wks supply (2 packs of 2 syringes)	4 wks supply (based on instructions for use)	4 wks supply (1 pack of 28 syringes)	4 wks supply (1 pack 4 syringes)	4 wks supply (based on instructions for use)
TMOP	8 wks supply (4 packs of 2 syringes)	8 wks supply (based on instructions for use)	8 wks supply (2 packs of 28 syringes)	Not supplied through TMOP	8 wks supply (based on instructions for use)
Other Issues	Crohn's disease starter pack includes 6 pens for 1st 4 wks, no refills	--	--	--	Not to exceed 200 mg/week 8 vials/ 4 wks 16 vials/ 8 wks

COMMITTEE ACTION: The P&T Committee voted (13 for, 0 opposed, 0 abstained, 4 absent) to approve the QLs outlined above in Table 2 to allow adalimumab (Humira), etanercept (Enbrel), and anakinra (Kineret) a four weeks supply via TRRx and 8 weeks supply via TMOP. The Committee voted to add the same limits to efalizumab (Raptiva). A four weeks supply limit was agreed for Alefacept (Amevive) at TRRx, with no QL in the TMOP, as Amevive is not available through the TMOP.

7) BCF / ECF REVIEW

A. Clarification of Basic Core Formulary (BCF) Listing - As part of an ongoing plan to systematically review drug classes represented on the BCF, the P&T Committee made recommendations for clarifying BCF listings in four BCF drug classes: antibiotics (nitrofurantoin monohydrate/macrocrystals [MacroBid]), proton pump inhibitors (esomeprazole [Nexium] powder packets), cough and cold preparations (chlorpheniramine 8 mg/pseudoephedrine 120 mg sustained release [Deconamine SR]), and miscellaneous migraine medications (isometheptene 65 mg/dichloralphenazone 100 mg/ acetaminophen 325 mg [Midrin]).

Esomeprazole powder packets were determined to not be cost-effective, thus the current BCF listing for esomeprazole was revised to specifically include only the 20 and 40 mg capsules. Chlorpheniramine 8 mg/pseudoephedrine 120 mg SR (Deconamine SR) was removed from the BCF due to availability issues from the wholesaler, resulting in low utilization (less than 300 prescriptions dispensed monthly at the MTFs). Midrin was also removed from the BCF due to ongoing shortages which will likely persist due in part to the FDA's campaign to halt the manufacturing of unapproved products containing ergotamine. The BCF listing for nitrofurantoin was revised to include nitrofurantoin monohydrate/macrocrystals (MacroBid), due to availability of cost-effective generic products, and decreasing availability of nitrofurantoin macrocrystals (Macrodantin). Details are outlined in Appendix D.

COMMITTEE ACTION: The P&T Committee recommended the following changes to the current BCF drug classes as outlined in Table 3. (See Appendix D for rationale).

Table 3 - Recommended BCF / ECF Changes

Drug class or potential drug class	Current BCF/ECF listing	Recommendation	Vote			
			For	Opposed	Abstained	Absent
Antibiotics	Nitrofurantoin macrocrystals oral (Does not include MacroBid)	Clarify BCF listing to: "Nitrofurantoin oral (50 mg macrocrystals, 100 mg monohydrate/macrocrystals)"	13	0	0	4
Cough and Cold Preparations	Chlorpheniramine 8 mg / pseudoephedrine 120 mg sustained release (Deconamine SR)	Remove BCF listing: "Chlorpheniramine 8 mg / pseudoephedrine 120 mg sustained release" (specific brand name is Deconamine SR)	13	0	0	4
Miscellaneous Migraine Medications	Isometheptene 65 mg / dichloralphenazone 100 mg / acetaminophen 325 mg (Midrin)	Remove BCF listing:" Isometheptene 65 mg / dichloralphenazone 100 mg / acetaminophen 325 mg" (specific brand name is Midrin)	10	3	0	4
Proton Pump Inhibitors	Esomeprazole (Nexium)	Clarify BCF listing to: "esomeprazole (Nexium) 20 and 40 mg capsule"	13	0	0	4

B. Administrative Action - The PEC obtained recommendations from members of the P&T Committee regarding clarification of the BCF listing for the following medications: antibiotics (amoxicillin oral, doxycycline oral, and cephalexin oral), antifungals (nystatin oral), inhaled asthma agents (albuterol oral inhaler), contraceptives, miscellaneous respiratory medications (insect allergy kits), and ophthalmic antibiotics and combinations (sulfacetamide sodium 10% ophthalmic ointment). Administrative changes will include removal of obsolete medications and more comprehensive delineation of BCF listings. Details are outlined in Appendix D.

8) UPDATE ON SIMVASTATIN/EZETIMIBE – ENHANCE STUDY

The P&T Committee was briefed on the "effect of combination ezetimibe and high-dose simvastatin vs. simvastatin alone on the atherosclerotic process in subjects with heterozygous familial hypercholesterolemia" (ENHANCE) study. The ENHANCE study compared simvastatin/ezetimibe (Vytorin) 80/10 mg with simvastatin 80 mg in patients with heterozygous familial hypercholesterolemia who had baseline low-density lipoprotein levels exceeding 300 mg/dL. The primary endpoint of the trial was change in carotid intima media thickness (CIMT); clinical outcomes (e.g., mortality, myocardial infarction) were not evaluated. There was no significant difference between the two groups with regard to changes in CIMT. Three ongoing studies are addressing outcomes with simvastatin/ezetimibe. No action necessary.

9) ADJOURNMENT

The meeting adjourned at 1330 hours on 13 Feb 2008. The next meeting will be 12-13 June 2008.

John Kugler, M.D.
Colonel, Medical Corps, U.S. Army
Chairperson

Appendix A – Implementation Status of UF Class Review Recommendations / Decisions

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Nov 07	Targeted Immunomodulatory Biologics	▪ etanercept (Enbrel) ▪ anakinra (Kineret)	ECF	▪ adalimumab (Humira) injection	13 Feb 08	18 Jun 08 (120 days)
Nov 07 re-review (Aug 05 original)	BPH Alpha Blockers	▪ tamsulosin (Flomax) Automated PA requiring trial of alfuzosin (Uroxatral) applies to new users of tamsulosin (no use of uroselective alpha blockers in last 180 days)	BCF	▪ terazosin tablets or capsules ▪ alfuzosin tablets (Uroxatral)	13 Feb 08	16 Apr 08 (60 days)
Nov 07	Adrenergic Beta-Blocking Agents	-	BCF	▪ atenolol tablets ▪ metoprolol tartrate IR tablets ▪ carvedilol IR tablets ▪ metoprolol succinate ER tablets	13 Feb 08	-
Nov 07 (update, original review Aug 05)	Calcium Channel Blockers	**Currently non-formulary, recommended for UF status Nov 07** ▪ amlodipine (Norvasc generic)	BCF	**Recommended for addition to BCF Nov 07** ▪ amlodipine besylate tablets	13 Feb 08	13 Feb 08
		To Remain Non-Formulary ▪ isradipine IR (Dynacirc) ▪ isradipine ER (Dynacirc CR) ▪ nicardipine IR (Cardene, generics) ▪ nicardipine SR (Cardene SR) ▪ verapamil ER (Verelan) ▪ verapamil ER for bedtime dosing (Verelan PM, Covera HS) ▪ diltiazem ER for bedtime dosing (Cardizem LA)		Currently on the BCF ▪ nifedipine ER (Adalat CC) ▪ verapamil SR ▪ diltiazem ER (Tiazac)	13 Oct 05	15 Mar 06 (150 days)
Nov 07 (update, original review Nov 06)	ADHD / Narcolepsy Agents	**Recommended for non-formulary status Nov 07** ▪ lisdexamfetamine (Vyvanse)	BCF	-	13 Feb 08	16 Apr 08 (60 days)
		To remain NF ▪ dexmethylphenidate IR (Focalin) ▪ dexmethylphenidate SODAS (Focalin XR) ▪ methylphenidate transdermal system (Daytrana)		Currently on the BCF ▪ methylphenidate OROS (Concerta) ▪ mixed amphetamine salts ER (Adderall XR) ▪ methylphenidate IR (Ritalin)	17 Jan 07	18 Apr 07
Nov 07 (update, original review May 06)	Contraceptives	**Recommended for non-formulary status Nov 07** ▪ EE 20 mcg/levonorgestrel 0.09 mg in special packaging for continuous use (Lybrel)	BCF	-	13 Feb 08	16 Apr 08 (60 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
		To remain NF ▪ EE 30 mcg / levonorgestrel 0.15 mg in special packaging for extended use (Seasonale) ▪ EE 25 mcg / norethindrone 0.4 mg (Ovcon 35) ▪ EE 50 mcg / norethindrone 1 mg (Ovcon 50) ▪ EE 20/30/35 mcg / norethindrone 1 mg (Estrostep Fe)		Currently on the BCF ▪ EE 20 mcg / 3 mg drospirenone (Yaz) ▪ EE 20 mcg / 0.1 mg levonorgestrel (Lutera, Sronyx, or equivalent) ▪ EE 30 mcg / 3 mg drospirenone (Yasmin) ▪ EE 30 mcg / 0.15 mg levonorgestrel (Nordette or equivalent / excludes Seasonale) ▪ EE 35 mcg / 1 mg norethindrone (Ortho-Novum 1/35 or equivalent) ▪ EE 35 mcg / 0.25 mg norgestimate (Ortho-Cyclen or equivalent) ▪ EE 25 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen Lo) ▪ EE 35 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen or equivalent) ▪ 0.35 mg norethindrone (Nor-QD, Ortho Micronor, or equivalent)	26 Jul 06	24 Jan 07
		▪ EE 30/10 mcg / 0.15 mg levonorgestrel in special packaging for extended use (Seasonique) ▪ EE 20 mcg / 1 mg norethindrone (Loestrin 24 Fe)			17 Jan 07	18 Mar 07
Nov 07 (update) Original reviews ▪ ACE inhibitors: Aug 05 ▪ Miscellaneous antihypertensives, including ACE/CCB combos. Feb 06 ▪ ARBs: May 07 ▪ Renin inhibitors. Aug 07	Renin Angiotensin Antihypertensives	**Recommended for non-formulary status Nov 07** ▪ valsartan/amlodipine (Exforge)	BCF	-	13 Feb 08	16 Apr 08 (60 days)
		To remain NF ACE inhibitors ▪ moexipril (Univasc), ▪ moexipril / HCTZ (Uniretic) ▪ perindopril (Aceon) ▪ quinapril (Accupril) ▪ quinapril / HCTZ (Accuretic) ▪ ramipril (Altace) ACE/CCB combos ▪ felodipine/enalapril (Lexxel) ▪ verapamil/trandolapril (Tarka) ARBs ▪ eprosartan (Teveten) ▪ eprosartan HCTZ (Teveten HCT) ▪ irbesartan (Avapro) ▪ irbesartan HCTZ (Avalide) ▪ olmesartan (Benicar) ▪ olmesartan HCTZ (Benicar HCT) ▪ valsartan (Diovan) ▪ valsartan HCTZ (Diovan HCT)		Currently on the BCF ACE inhibitors ▪ captopril ▪ lisinopril ▪ lisinopril / HCTZ ACE/CCB combos ▪ amlodipine/benazepril (Lotrel) ARBs ▪ telmisartan (Micardis) ▪ telmisartan HCTZ (Micardis HCT)	ACE inhibitors ▪ 13 Oct 05 ACE/CCB combos ▪ 26 Apr 06 ARBs ▪ 24 July 07	ACE inhibitors ▪ 15 Feb 06 ACE/CCB combos ▪ 26 Jul 06 ARBs ▪ 21 Nov 07

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Aug 07	Newer Antihistamines	▪ desloratadine (Clarinex) ▪ desloratadine/pseudoephedrine (Clarinex D)	BCF	▪ MTFs required to carry at least one single ingredient agent from the newer antihistamine class (loratadine, cetirizine, or fexofenadine) on their local formulary, including at least one dosage form suitable for pediatric use	17 Oct 07	16 Jan 08 (90 days)
Aug 07	Leukotriene Modifiers	▪ zileuton (Zyflo)	BCF	▪ montelukast (Singulair)	17 Oct 07	16 Jan 08 (90 days)
Aug 07	Growth Stimulating Agents	▪ somatropin (Genotropin, Genotropin Miniquick) ▪ somatropin (Humatrope) ▪ somatropin (Omnitrope) ▪ somatropin (Saizen)	ECF	▪ somatropin (Norditropin)	17 Oct 07	19 Dec 07 (60 days)
Aug 07 (new drug update, original review Nov 05)	Nasal Corticosteroids	▪ beclomethasone dipropionate (Beconase AQ, Vancenase AQ) ▪ budesonide (Rhinocort Aqua) ▪ triamcinolone (Nasacort AQ)	BCF	▪ fluticasone propionate (Flonase)	19 Jan 06	19 Apr 06 (90 days)
		Recommended for non-formulary status Aug 07 ▪ fluticasone furoate (Veramyst)			17 Oct 07	19 Dec 07 (60 days)
May 07 re-review (Feb 05 original)	PPIs	▪ lansoprazole (Prevacid) ▪ omeprazole/sodium bicarbonate (Zegerid) ▪ pantoprazole (Protonix) ▪ rabeprazole (Aciphex) Automated PA requiring trial of omeprazole OR esomeprazole (Nexium) applies to new users of non-formulary PPIs (no use of PPIs in last 180 days)	BCF	▪ generic omeprazole 10 mg and 20 mg (excludes Prilosec 40 mg) ▪ esomeprazole (Nexium)	24 July 07	24 Oct 07 (90 days)
May 07	Antilipidemic Agents II	▪ fenofibrate nanocrystallized (Tricor) ▪ fenofibrate micronized (Antara) ▪ omega-3 fatty acids (Omacor) ▪ colesevelam (Welchol)	BCF	▪ gemfibrozil ▪ fenofibrate IDD-P (Triglide)	24 July 07	21 Nov 07 (120 days)
May 07 re-review (Feb 05 original)	ARBs	▪ eprosartan (Teveten) ▪ eprosartan HCTZ (Teveten HCT) ▪ irbesartan (Avapro) ▪ irbesartan HCTZ (Avalide) ▪ olmesartan (Benicar) ▪ olmesartan HCTZ (Benicar HCT) ▪ valsartan (Diovan) ▪ valsartan HCTZ (Diovan HCT)	BCF	▪ telmisartan (Micardis) ▪ telmisartan HCTZ (Micardis HCT)	24 July 07	21 Nov 07 (120 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
May 07	5-Alpha Reductase Inhibitors	▪ dutasteride (Avodart)	BCF	▪ finasteride	24 July 07	24 Oct 07 (90 days)
Feb 07	Newer Sedative Hypnotics	▪ zolpidem ER (Ambien CR) ▪ zaleplon (Sonata) ▪ ramelteon (Rozerem) Automated PA requiring trial of zolpidem IR applies to new users of eszopiclone (Lunesta), ramelteon (Rozerem), zaleplon (Sonata), or zolpidem ER (Ambien CR) (new users = no use of newer sedative hypnotics in last 180 days)	BCF	▪ zolpidem IR (Ambien)	02 May 07	01 Aug 07 (90 days)
Feb 07	Narcotic Analgesics	▪ tramadol ER (Ultram ER)	BCF	▪ morphine sulfate IR 15 mg, 30 mg ▪ morphine sulfate 12-hour ER (MS Contin or equivalent) 15, 30, 60 mg ▪ oxycodone/APAP 5/325 mg ▪ hydrocodone/APAP 5/500 mg ▪ codeine/APAP 30/300 mg ▪ codeine/APAP elixir 12/120 mg/5 mL ▪ tramadol IR	02 May 07	01 Aug 07 (90 days)
Feb 07	Ophthalmic Glaucoma Agents	▪ travoprost (Travatan, Travatan Z) ▪ timolol maleate for once daily dosing (Istalol) ▪ timolol hemihydrate (Betimol) ▪ brinzolamide (Azopt)	BCF	▪ latanoprost (Xalatan) ▪ brimonidine (Alphagan P); excludes 0.1% ▪ timolol maleate ▪ timolol maleate gel-forming solution ▪ pilocarpine	02 May 07	01 Aug 07 (90 days)
Nov 06	Older Sedative Hypnotics	-	BCF	▪ temazepam 15 and 30 mg	17 Jan 07	-
Nov 06 (updated Nov 07)	ADHD / Narcolepsy Agents	▪ dexmethylphenidate IR (Focalin) ▪ dexmethylphenidate SODAS (Focalin XR) ▪ methylphenidate transdermal system (Daytrana)	BCF	▪ methylphenidate OROS (Concerta) ▪ mixed amphetamine salts ER (Adderall XR) ▪ methylphenidate IR (Ritalin)	17 Jan 07	18 Apr 07 (90 days)
Aug 06	TZDs	-	BCF	▪ rosiglitazone (Avandia) ▪ rosiglitazone / metformin (Avandamet)	23 Oct 06	-
Aug 06	H2 Antagonists / GI protectants	-	BCF	▪ ranitidine (Zantac) – excludes gelcaps and effervescent tablets	23 Oct 06	-

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Aug 06	Antilipidemic Agents I	▪ rosuvastatin (Crestor) ▪ atorvastatin / amlodipine (Caduet)	BCF	▪ simvastatin (Zocor) ▪ pravastatin ▪ simvastatin / ezetimibe (Vytorin) ▪ niacin extended release (Niaspan)	23 Oct 06	1 Feb 07 (90 days)
May 06 (updated Nov 06, Nov 07)	Contraceptives	▪ EE 30 mcg / levonorgestrel 0.15 mg in special packaging for extended use (Seasonale) ▪ EE 25 mcg / norethindrone 0.4 mg (Ovcon 35) ▪ EE 50 mcg / norethindrone 1 mg (Ovcon 50) ▪ EE 20/30/35 mcg / norethindrone 1 mg (Estrostep Fe)	BCF	▪ EE 20 mcg / 3 mg drospirenone (Yaz) ▪ EE 20 mcg / 0.1 mg levonorgestrel (Alesse, Levlite, or equivalent) ▪ EE 30 mcg / 3 mg drospirenone (Yasmin) ▪ EE 30 mcg / 0.15 mg levonorgestrel (Nordette or equivalent / excludes Seasonale) ▪ EE 35 mcg / 1 mg norethindrone (Ortho-Novum 1/35 or equivalent) ▪ EE 35 mcg / 0.25 mg norgestimate (Ortho-Cyclen or equivalent) ▪ EE 25 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen Lo) ▪ EE 35 mcg / 0.18/0.215/0.25 mg norgestimate (Ortho Tri-Cyclen or equivalent) ▪ 0.35 mg norethindrone (Nor-QD, Ortho Micronor, or equivalent)	26 Jul 06	24 Jan 07 (180 days)
		Recommended for non-formulary status Nov 06 ▪ EE 30/10 mcg / 0.15 mg levonorgestrel in special packaging for extended use (Seasonique) ▪ EE 20 mcg / 1 mg norethindrone (Loestrin 24 Fe)		-	17 Jan 07	18 Mar 07 (60 days)
May 06	Antiemetics	▪ dolasetron (Anzemet)	BCF	▪ promethazine (oral and rectal)	26 Jul 06	27 Sep 06 (60 days)
Feb 06	OABs	▪ tolterodine IR (Detrol) ▪ oxybutynin patch (Oxytrol) ▪ trospium (Sanctura)	BCF	▪ oxybutynin IR (Ditropan tabs/soln) ▪ tolterodine SR (Detrol LA)	26 Apr 06	26 Jul 06 (90 days)
Feb 06	Misc Antihypertensive Agents	▪ felodipine/enalapril (Lexxel) ▪ verapamil/trandolapril (Tarka)	BCF	▪ amlodipine/benazepril (Lotrel) ▪ hydralazine ▪ clonidine tablets	26 Apr 06	26 Jul 06 (90 days)
Feb 06	GABA-analogs	▪ pregabalin (Lyrica)	BCF	▪ gabapentin	26 Apr 06	28 Jun 06 (60 days)
Nov 05	Alzheimer's Drugs	▪ tacrine (Cognex)	ECF	▪ donepezil (Aricept)	19 Jan 06	19 Apr 06 (90 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
Nov 05 (updated Aug 07)	Nasal Corticosteroids	▪ beclomethasone dipropionate (Beconase AQ, Vancenase AQ) ▪ budesonide (Rhinocort Aqua) ▪ triamcinolone (Nasacort AQ)	BCF	▪ fluticasone (Flonase)	19 Jan 06	19 Apr 06 (90 days)
Nov 05	Macrolide/ Ketolide Antibiotics	▪ azithromycin 2 gm (Zmax) ▪ telithromycin (Ketek)	BCF	▪ azithromycin (Z-Pak) ▪ erythromycin salts and bases	19 Jan 06	22 Mar 06 (60 days)
Nov 05	Antidepressants I	▪ paroxetine HCl CR (Paxil) ▪ fluoxetine 90 mg for weekly administration (Prozac Weekly) ▪ fluoxetine in special packaging for PMDD (Sarafem) ▪ escitalopram (Lexapro) ▪ duloxetine (Cymbalta) ▪ bupropion extended release (Wellbutrin XL)	BCF	▪ citalopram ▪ fluoxetine (excluding weekly regimen and special packaging for PMDD) ▪ sertraline (Zoloft) ▪ trazodone ▪ bupropion sustained release	19 Jan 06	19 Jul 06 (180 days)
Aug 05 (re-review Nov 07)	Alpha Blockers for BPH	▪ tamsulosin (Flomax)	BCF	▪ terazosin ▪ alfuzosin (Uroxatral)	13 Oct 05	15 Feb 06 (120 days)
Aug 05 (updated Nov 07)	CCBs	▪ amlodipine (Norvasc) ▪ isradipine IR (Dynacirc) ▪ isradipine ER (Dynacirc CR) ▪ nicardipine IR (Cardene, generics) ▪ nicardipine SR (Cardene SR) ▪ verapamil ER (Verelan) ▪ verapamil ER for bedtime dosing (Verelan PM, Covera HS) ▪ diltiazem ER for bedtime dosing (Cardizem LA)	BCF	▪ nifedipine ER (Adalat CC) ▪ verapamil SR ▪ diltiazem ER (Tiazac)	13 Oct 05	15 Mar 06 (150 days)
Aug 05	ACE Inhibitors & ACE Inhibitor / HCTZ Combinations	▪ moexipril (Univasc), ▪ moexipril / HCTZ (Uniretic) ▪ perindopril (Aceon) ▪ quinapril (Accupril) ▪ quinapril / HCTZ (Accuretic) ▪ ramipril (Altace)	BCF	▪ captopril ▪ lisinopril ▪ lisinopril / HCTZ	13 Oct 05	15 Feb 06 (120 days)
May 05	PDE-5 Inhibitors	▪ sildenafil (Viagra) ▪ tadalafil (Cialis)	ECF	▪ vardenafil (Levitra)	14 Jul 05	12 Oct 05 (90 days)
May 05 (updated Nov 06)	Topical Antifungals*	▪ econazole ▪ ciclopirox ▪ oxiconazole (Oxistat) ▪ sertaconazole (Ertaczo) ▪ sulconazole (Exelderm)	BCF	▪ nystatin ▪ clotrimazole	14 Jul 05	17 Aug 05 (30 days)

Meeting	Drug Class	Non-Formulary Medications	BCF/ ECF Class	BCF/ECF Medications	Decision Date (DoD P&T minutes signed, effective date for BCF/ECF medications, NF to UF changes)	Effective Date for Non-Formulary Medications (Implementation period)
		Recommended for non-formulary status Nov 06: ▪ 0.25% miconazole / 15% zinc oxide / 81.35% white petrolatum ointment (Vusion)			17 Jan 07	18 Mar 07 (60 days)
May 05	MS-DMDs	-	ECF	▪ interferon beta-1a intramuscular injection (Avonex)	14 Jul 05	-
Feb 05	ARBs – see May 07 for re-review	▪ eprosartan (Teveten) ▪ eprosartan/HCTZ (Teveten HCT)	BCF	▪ telmisartan (Micardis) ▪ telmisartan/HCTZ (Micardis HCT)	18 Apr 05	17 Jul 05 (90 days)
Feb 05	PPIs – see May 07 for re-review	▪ esomeprazole (Nexium)	BCF	▪ omeprazole ▪ rabeprazole (Aciphex)	18 Apr 05	17 Jul 05 (90 days)

BCF = Basic Core Formulary; ECF = Extended Core Formulary; MN = Medical Necessity; TMOP = TRICARE Mail Order Pharmacy; TRRx = TRICARE Retail Pharmacy program; UF = Uniform Formulary
ER = extended release; IR = immediate release; SR = sustained release; IDD-P = insoluble drug delivery-microParticle
ADHD = Attention Deficit Hyperactivity Disorder; ARBs = Angiotensin Receptor Blockers; ACE Inhibitors = Angiotensin Converting Enzyme Inhibitors; BPH = Benign Prostatic Hyperplasia; CCBs = Calcium Channel Blockers; EE = ethinyl estradiol; GI = gastrointestinal; GABA = gamma-aminobutyric acid; H2 = Histamine-2 receptor; HCTZ = hydrochlorothiazide; MS-DMDs = Multiple Sclerosis Disease-Modifying Drugs; OABs = Overactive Bladder Medications; PDE-5 Inhibitors = Phosphodiesterase-5 inhibitors; PPIs = Proton Pump Inhibitors; TZDs= Thiazolidinediones
*The topical antifungal drug class excludes vaginal products and products for onychomycosis (e.g., ciclopirox topical solution [Penlac])

Appendix B – Newly Approved Drugs. February 2008 DoD P&T Committee Meeting

Medication (Brand name; manufacturer) mechanism of action	**FDA Approval Date & FDA-Approved Indications**	**Committee Recommendation**
Sapropterin dihydrochloride tablets (Kuvan, BioMarin Pharmaceutical) Synthetic tetrahydrobiopterin, the enzyme cofactor for phenylalanine hydroxylase	Dec 07 To reduce blood phenylalanine levels in patients with hyperphenylalanemia due to tetrahydrobiopterin-responsive phenylketonuria. Kuvan is to be used in conjunction with a phenylalanine-restricted diet.	No UF recommendation at this meeting. Consideration of UF status deferred until prescription metabolic and vitamin drugs are reviewed; UF review not anticipated within the next 12 months. Quantity limits recommended: ▪ TMOP o Days supply limit of 45 days ▪ Retail Network o Days supply limit of 30 days

Appendix C – Existing Quantity Limits and Recommended QLs for Targeted Immunomodulatory Biologics

Quantity Limits	Adalimumab (Humira)	Etanercept (Enbrel)	Anakinra (Kineret)	Alefacept (Amevive)	Efalizumab (Raptiva)
Current Retail Network	Maximum quantity dispensed at any one time is 4 weeks supply (2 packs of 2 syringes). Does not apply to the Crohn's Disease starter pack (6 pens for the first 4 weeks of treatment), which is limited to 1 package (6 pens), with no refills.	4-week supply week supply in mail order (based on instructions for use on the prescription)	Maximum quantity dispensed at any one time is 4 weeks supply (1 package of 28 syringes) in retail	No current QL	No current QL
Current TMOP	Maximum quantity dispensed at any one time is 4 weeks supply (3 packs of 2 syringes). Does not apply to the Crohn's Disease starter pack (6 pens for the first 4 weeks of treatment), which is limited to 1 package (6 pens), with no refills.	6-week supply (based on instructions for use on the prescription)	Maximum quantity dispensed at any one time is 8 weeks supply (2 packages of 28 syringes)	Not supplied through TMOP	No current QL
Recommended Retail Network	4 wks supply (2 packs of 2 syringes)	4 wks supply (based on instructions for use)	4 wks supply (1 pack of 28 syringes)	4 wks supply (1 pack 4 syringes)	4 wks supply (based on instructions for use)
Recommended TMOP	8 wks supply (4 packs of 2 syringes)	8 wks supply (based on instructions for use)	8 wks supply (2 packs of 28 syringes)	Not supplied through TMOP	8 wks supply (based on instructions for use)
Other Issues	Crohn's disease starter pack includes 6 pens for first 4 wks, no refills	Not applicable	Not applicable	Not applicable	Not to exceed 200 mg/week 8 vials/ 4 wks 16 vials/ 8 wks

Appendix D– Basic / Extended Core Formulary (BCF/ECF) Review

Drug Class or Potential Drug Class	BCF listing	Recommended Action / Administrative Action

Antibiotics	Amoxicillin oral	• The current BCF listing does not clarify strengths and dosage forms.
		• Approximately 90% of MTF utilization is for the following strengths:
		  • 250 mg and 500 mg capsules
		  • 250/5 mL and 400mg/5 mL suspension
		• Administrative:
		  • Clarify BCF listing: "Amoxicillin oral (250 mg and 500 mg capsules; 250/5 mL and 400 mg/5mL suspension)"

Antibiotics	Cephalexin oral	• The current BCF listing does not clarify strengths and dosage forms.
		• Approximately 90% of MTF utilization data is for the following strengths:
		  • 250 mg and 500 mg capsules
		  • 250/5 mL suspension
		• Administrative:
		  • Clarify BCF listing: "Cephalexin oral (250 mg and 500 mg capsules; 250/5 mL suspension)"

Antibiotics	Doxycycline oral (Does not include Periostat)	• In Jun 2001 the BCF was clarified to exclude doxycycline 20 mg (Periostat), due to its mechanism in dental procedures as inhibiting collagenase, rather than antimicrobial effects.
		• In May 2006 a 40 mg formulation for rosacea (Oracea) was marketed.
		• The 100 mg strengths are used for antimicrobial effects.
		• Approximately 90% of MTF utilization data is for the following strengths:
		  • 100 mg doxycycline hyclate tablet & capsules
		• Administrative:
		  • Clarify BCF listing: "Doxycycline hyclate (100 mg tablets or capsules)"

Antibiotics	Nitrofurantoin macrocrystals oral (Does not include MacroBid)	• In Feb 2001 the BCF was clarified to exclude nitrofurantoin monohydrate/macrocrystals (MacroBid) due to cost and availability only in a proprietary formulation. • Nitrofurantoin monohydrate/macrocyrstalline (MacroBid) is now available in cost-effective generic formulations. • There are supply issues with nitrofurantoin macrocrystals (Furadantin). • A 6 month review of MTF data show that >60% of nitrofurantoin utilization is for MacroBid 100 mg. • Recommendation: • Clarify BCF listing: "Nitrofurantoin oral (50 mg macrocrystals; 100 mg monohydrate/macrocrystals)"
Antifungals	Nystatin (Does not include Mycostatin Pastilles)	• The original BCF listing for nystatin oral excluded nystatin pastilles (lozenges); the pastilles are no longer commercially available. • Administrative: • Clarify BCF listing: "Nystatin", (remove "Does not include Mycostatin Pastille")
Asthma agents, inhaled	Albuterol oral inhaler (Does not include hydrofluoralkane (HFA) products)	• The current BCF listing excludes hydrofluoralkane (HFA)-containing products. Chlorofluorocarbon (CFC)-containing albuterol inhalers will be discontinued in Dec 2008 as per an FDA Final Rule. • Most manufactures have already converted to hydrofluoralkane (HFA) as the most common propellant. • Administrative: • Clarify BCF listing: "remove (Does not include HFA products)"

Drug Class or Potential Drug Class	BCF listing	Recommended Action / Administrative Action
Contraceptives	Monophasics with 30 mcg EE; 0.15 mg levonorgestrel (Nordette or equivalent; excludes Seasonale) Monophasics with 20 mcg EE; 0.1 mg levonorgestrel (Alesse, Levlite, or equivalent)	• Proprietary formulations of monophasic contraceptives with 20 mcg ethinyl estradiol (EE) / 0.15 mg levonorgestrel (Allesse, Levlite) and 30 mcg EE / 0.1 mg levonorgestrel (Levlin) are no longer available. • There are continuing changes in the availability of branded generics, generics, and proprietary contraceptives. • Administrative: • Clarify BCF listing: "Specify hormonal content only, remove reference to product name unless designated non-formulary"
Cough and Cold Preparations	Chlorpheniramine 8 mg / pseudoephedrine 120 mg sustained release (Deconamine SR)	• There are availability issues with Deconamine SR which are not expected to resolve. • Currently there is low utilization of Deconamine SR with fewer than 300 Rxs dispensed monthly across all MTFs. • Recommendation: • Remove BCF listing for chlorpheniramine 8 mg/ pseudoephedrine 120 mg SR.
Miscellaneous Migraine Medications	Isometheptene 65 mg / dichloralphenazone 100 mg / acetaminophen 325 mg	• There are availability issues with isometheptene 65 mg / dichloralphenazone 100 mg / acetaminophen 325 mg (Midrin) which are not expected to improve, as only 2 manufacturers remain in the marketplace. • The FDA has warned several manufacturers regarding manufacturing of unapproved products containing ergotamine derivatives. • MTF utilization of Midrin dropped from 6,000 Rxs/ monthly to less than 3,000 Rxs monthly between Aug 2007 and Dec 2007, reflecting dwindling availability. • Recommendation: • Remove BCF listing
Miscellaneous Respiratory Medications	Insect Sting Kit, Injection (EpiPen is a commonly recognized brand name)	• The current BCF listing is designated as "insect sting kit" and lists one popular proprietary name. Kits containing epinephrine are used to treat multiple types of anaphylaxis (asthma, food, insects) and are called by different names. • Healthcare providers look for epinephrine (generic) or specific brand name kits (e.g., EpiPen, Twinject). • Administrative: • Clarify BCF listing: Change insect sting kit, injection to "Epinephrine auto-injection"
Ophthalmic Antibiotic and Combinations	Sulfacetamide sodium ophthalmic ointment	• The current BCF listing for sulfacetamide sodium lists both the ointment and solution. Sulfacetamide sodium ophthalmic ointment is no longer commercially available • Administrative: • Remove BCF listing: "Sulfacetamide sodium ophthalmic ointment"
Proton Pump Inhibitors	Esomeprazole (Nexium)	• May 2007 esomeprazole (Nexium) was added to the BCF. The current BCF listing does not clarify strengths or formulations. • Esomeprazole powder packets are now available, but are not cost-effective relative to the esomeprazole capsules. • Recommendation: • Clarify BCF listing: "esomeprazole (Nexium) 20 and 40 mg capsules"

Appendix E – Table of Abbreviations

ACE	angiotensin converting enzyme
AD1s	antidepressant 1 drug class
AF-DERMS	antifungal dermatologics drug class
ARB	angiotensin receptor blocker
AS	ankylosing spondylitis
ARB	angiotensin receptor blocker
BAP	Beneficiary Advisory Panel
BCF	Basic Core Formulary
CCB	calcium channel blocker
CFC	chlorofluorocarbon
CIMT	carotid intima-media thickness
CFR	Code of Federal Regulations
CR	controlled release (extended release)
DoD	Department of Defense
ECF	extended core formulary
EE	ethinyl estradiol
ER	extended release
FDA	Food and Drug Administration
FY	fiscal year
HCTZ	hydrochlorothiazide
HFA	hydrofluoralkane
IV	intravenous
IR	immediate release
MHS	Military Health System
MN	medical necessity
MTF	Military Treatment Facility
PA	prior authorization
PASI	Psoriasis Area and Severity Index
P&T	Pharmacy and Therapeutics
PEC	Pharmacoeconomic Center
RAA	renin-angiotensin antihypertensive drug class
PsA	psoriatic arthritis
OAB	overactive bladder drug class
QL	quantity limit
RA	rheumatoid arthritis
SR	sustained release
TIB	targeted immunomodulatory biologic
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy Program
TRRx	TRICARE Retail Pharmacy Program
UF	Uniform Formulary
XL	extended release