DEPARTMENT OF DEFENSE
PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS
February 2009

1. CONVENING

The Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee convened at 0800 hours on 18 February 2009 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 MEETINGS

A. **Revisions to the minutes** — There were no revisions to the November 2008 DoD P&T Committee meeting minutes.

B. **Approval of November minutes** — S. Ward Casscells, III, MD, approved the minutes of the November 2008 DoD P&T Committee meeting on 10 February 2009.

4. REVIEW OF RECENTLY FDA-APPROVED AGENTS

Self-Monitored Blood Glucose System (SMBGS) Test Strips — TRUETest Test Strip

Relative Clinical Effectiveness — The self-monitored blood glucose system (SMBGS) test strips were evaluated for Uniform Formulary (UF) placement at the August 2008 DoD P&T Committee meeting. The other SMBGS test strips designated as formulary on the UF include Accu-chek Aviva, Precision Xtra, Freestyle Lite, and Ascensia Contour. The TRUEtest SMBGS test strip was approved by the FDA in late August 2008 and, therefore, was not included in the original UF decision. The TRUEtest test strip clinical evaluation included, but was not limited to, the requirements stated in the UF rule, 32 CFR 199.21(e)(1).

The TRUEtest SMBGS test strip meets the requirements for accuracy by the FDA and the International Standard for Organization, does not require coding, is compatible with 2 SMBGS meters (TRUEresult and TRUE2go meters), requires a 0.5 microliter blood sample size, is approved for both fingertip and forearm testing, and provides results in 4 to 10 seconds. The TRUEtest SMBGS test strip employs glucose dehydrogenase pyrroloquinolinequinone (GDH-PQQ) as the reagent. Other SMBGS test strips with GDH-PQQ have been rarely associated with falsely high blood glucose readings and potential patient harm when used concurrently with products containing maltose (e.g., dialysis patients receiving icodextrin dialysate solutions). The TRUEtest package label contains warnings for this interaction.

Relative Clinical Effectiveness Conclusion — The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent): 1) the TRUEtest SMBGS test strip is similar to other SMBGS test strips included on the UF, in terms of meeting the minimum technical requirements; 2) there is a high degree of therapeutic interchangeability between TRUEtest and the other SMBGS test strips included on the UF; and 3) in

terms of safety, TRUEtest is similar to other SMBGS test strips included on the UF that also use the GDH-PQQ reagent.

Relative Cost-Effectiveness — The P&T Committee evaluated the relative cost-effectiveness of TRUEtest SMBGS test strips in relation to efficacy, safety, tolerability, and clinical outcomes of the other test strips in the SMBGS 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 TRUEtest blood glucose strips. The cost-effectiveness of TRUEtest was evaluated relative to the following agents: Accu-chek Aviva, Contour, Freestyle Lite, OneTouch Ultra, Precision Xtra, and TrueTrack. The results of the CMA showed that the projected weighted average daily cost of TRUEtest was significantly lower than the weighted average daily cost of all the other SMBGS test strips.

Relative Cost-Effectiveness Conclusion — The P&T Committee concluded (14 for, 0 opposed, 1 abstained, 0 absent) that the TRUEtest SMBGS test strip for the TRUEresult and TRUE2go meters is cost effective relative to the other SMBGS test strips 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 (14 for, 0 opposed, 1 abstained, 0 absent) that the TRUEtest SMBGS test strip remain designated as formulary on the UF.

   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 (14 for, 0 opposed, 1 abstained, and 0 absent) to recommend: 1) the TRUEtest test strips not be added to the BCF.

   Director, TMA, Decision: ☑ Approved ☐ Disapproved

   Approved, but modified as follows:

5. DRUG CLASS REVIEW — PULMONARY I AGENTS — INHALED CORTOCOSTEROIDS (ICS)

Relative Clinical Effectiveness — The P&T Committee evaluated the clinical effectiveness of the inhaled corticosteroids (ICS) as part of the Pulmonary I drug

class. The ICS are available in several dosage formulations, including pressurized metered-dose inhalers (MDIs) and dry powder inhalers (DPIs). The MDIs use either chlorofluorocarbon (CFC) or hydrofluoroalkane (HFA) as the propellant. The ICS available as oral inhalers include beclomethasone HFA MDI (QVAR), budesonide DPI (Pulmicort Flexhaler), ciclesonide HFA MDI (Alvesco), flunisolide CFC MDI (Aerobid, Aerobid-M [menthol added to improve taste]), fluticasone HFA MDI (Flovent HFA), fluticasone DPI (Flovent Diskus), mometasone DPI (Asmanex Twisthaler), and triamcinolone CFC MDI (Azmacort). Budesonide (Pulmicort Respules) is also available as an inhalation solution.

The current ICS Basic Core Formulary (BCF) products are budesonide inhalation solution (Pulmicort Respules as the specified product), fluticasone oral inhaler, and triamcinolone oral inhaler. None of the oral ICS inhalers are available as generic formulations. One authorized generic formulation of budesonide inhalation solution became available in December 2008.

The US Food and Drug Administration (FDA) recommended the removal of ICS metered-dose inhalers containing a CFC propellant (flunisolide and triamcinolone) by 31 December 2009. A final decision regarding this proposed date is pending.

The Military Health System (MHS) spent over $35M on oral ICS inhalers and over $13M on ICS inhalation solutions in FY 2008. In FY 2008, for the oral ICS inhalers, expenditures in the Military Treatment Facilities (MTFs) were $16.6M, expenditures in the TRICARE Retail Network (TRRx) were $15.2M, and expenditures in the TRICARE Mail Order Pharmacy (TMOP) were $3.5M. Expenditures for the inhalation solutions in FY 2008 are as follow: MTF $2.4M, TRRx $10.0M, and TMOP $0.8M. In terms of numbers of prescriptions dispensed, fluticasone (Flovent) is the highest utilized ICS in the MHS, followed by triamcinolone (Azmacort).

Information regarding the safety, effectiveness, and clinical outcomes of the ICS 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.

Relative Clinical Effectiveness Conclusion — The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent), as part of the Pulmonary I overall relative clinical effectiveness conclusion, to accept the following regarding the clinical effectiveness of the ICS products:

A. With regard to efficacy/clinical effectiveness of the ICS, the following conclusions were made:

- FDA-approved indications — The Committee recognized that the ICS products are approved only for the maintenance treatment of asthma, and FDA-approved age ranges for pediatric patients differ between the products.

- Clinical Practice Guidelines — Evidence-based guidelines from the National Asthma Education and Preventive Program (NAEPP) consider the ICS the preferred treatment for the maintenance treatment of persistent asthma. Guidelines for the use of ICS in Chronic Obstructive Pulmonary Disease (COPD) generally recommend an ICS for severe or very severe disease. The Guidelines do not state a preference for one ICS over another.
- Pharmacodynamic/pharmacokinetic properties — The Committee concluded that despite differences in topical potency, receptor binding affinity, pulmonary bioavailability, and systemic bioavailability, the overall clinical response does not appear to vary significantly between the ICS, when equipotent doses are compared.
- Overall clinical efficacy for asthma — The Committee concluded that for asthma, there is fair-to-moderate evidence that ICS do not differ with regards to symptom control, need for rescue medication, and exacerbations in patients with asthma.
- Overall clinical efficacy for COPD — The Committee concluded that for COPD, there is insufficient evidence to conclude there are clinically relevant differences regarding the efficacy of ICS in patients with COPD.

B. With regards to safety and tolerability, the following conclusions were made:

- Minor adverse events — There do not appear to be clinically relevant differences in the incidence and severity of common adverse events associated with the ICS, such as dysphonia and oral candidiasis.
- Pharmacodynamic/pharmacokinetic properties — Differences in binding affinity, lipophilicity, pulmonary bioavailability, and systemic bioavailability between the ICS products have not correlated to clinically relevant differences in safety.
- Systemic adverse effects — For systemic adverse effects of hypothalamic-pituitary-adrenal (HPA) axis suppression, growth suppression, cataract formation, fracture risk, and pneumonia risk in COPD, there is insufficient evidence to determine whether one ICS is more likely to cause these effects than another. When given in recommended doses, the ICS are not generally associated with clinically significant systemic adverse effects. Providers and patients must assess the risks and benefits if higher than recommended doses are required.
- Overall safety/tolerability — The Committee concluded there is insufficient evidence to determine whether there are clinically relevant differences between ICS in terms of minor adverse events or systemic adverse events

C. With regards to differences in other factors, the following conclusions were made:

- Special Populations – Pregnancy — Budesonide is the only ICS with a pregnancy category B rating (low evidence of risk) from the FDA; the other ICS are rated pregnancy category C. The pregnancy category B rating for

budesonide was granted based on information from 3 Swedish registries and 1 prospective study. However, national guidelines for asthma from the NAEPP state there is no data to indicate the other ICS preparations are unsafe during pregnancy, and that untreated asthma in pregnancy poses a risk to the fetus, including intrauterine growth retardation, premature delivery, and low birth weight.

- Special Populations – Children — Budesonide inhalation solution (Pulmicort Respules) is approved for treating asthma in children ranging between the ages of 1 and 8 years. Fluticasone (Flovent Diskus and Flovent HFA) and mometasone (Asmanex) are approved for treating asthma in children 4 years of age and older.
- Clinical Coverage — Responses from a survey of MTF providers revealed that to meet the needs of the majority of MHS beneficiaries, both HFA metered-dose inhalers and dry powder inhalers are required for inclusion on the UF.
- Therapeutic Interchangeability — There is a high degree of therapeutic interchangeability between the ICS products.

Relative Cost-Effectiveness — In considering the relative cost-effectiveness of pharmaceutical agents in the ICS as part of the Pulmonary I 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 ICS.

ICS 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 of the CMA revealed that beclomethasone DPI (QVAR) was the most cost-effective ICS based on acquisition cost; and

B. Results of the BIA revealed that the ICS formulary scenario that included budesonide inhalation solution, fluticasone HFA metered-dose inhaler (Flovent HFA), fluticasone dry powder inhaler (Flovent DPI), and mometasone dry powder inhaler (Asmanex Twisthaler) was the most cost-effective overall.

1) ***COMMITTEE ACTION:*** The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent) to accept the cost-effectiveness conclusions stated above.

2) ***COMMITTEE ACTION: UF RECOMMENDATION*** — In view of the conclusions from the relative clinical effectiveness and relative cost-effectiveness determinations of the ICS products and other relevant factors, the P&T

Committee, based upon its collective professional judgment, voted (8 for, 5 opposed, 2 abstained, 0 absent) to recommend:

a) Budesonide inhalation solution (Pulmicort Respules, generic), fluticasone HFA MDI (Flovent HFA), fluticasone DPI (Flovent Diskus), and mometasone DPI (Asmanex Twisthaler) be classified as formulary under the UF; and

b) Beclomethasone HFA MDI (QVAR), budesonide DPI (Pulmicort Flexhaler), ciclesonide HFA MDI (Alvesco), flunisolide CFC MDI (Aerobid, Aerobid M) and triamcinolone CFC MDI (Azmacort) be designated as non-formulary on the UF, based on cost-effectiveness.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

3) ***COMMITTEE ACTION: MEDICAL NECESSITY (MN) CRITERIA*** — Based on the clinical evaluation for beclomethasone HFA MDI (QVAR), budesonide DPI (Pulmicort Flexhaler), ciclesonide HFA MDI (Alvesco), flunisolide CFC MDI (Aerobid, Aerobid M), triamcinolone CFC MDI (Azmacort), 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 beclomethasone HFA MDI (QVAR), budesonide DPI (Pulmicort Flexhaler), ciclesonide HFA MDI (Alvesco), flunisolide CFC MDI (Aerobid, Aerobid M) and triamcinolone CFC MDI (Azmacort). (See Appendix B for full MN criteria).

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

4) ***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 following a 120-day implementation period in the TMOP and TRRx, and at the MTFs no later than a 120-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:

5) ***COMMITTEE ACTION: BCF RECOMMENDATION*** — The P&T Committee considered the BCF status of the ICS agents. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted 14 for, 0 opposed, 1 abstained, 0 absent) to recommend: 1) fluticasone HFA MDI and DPI (Flovent HFA and Flovent Diskus) oral inhalers remain designated as BCF; and 2) mometasone DPI (Asmanex Twisthaler) be designated as BCF immediately upon signing of the February 2009 DoD P&T Committee minutes by the Director, TMA. As a result of the above actions, budesonide inhalation solution (Pulmicort Respules) 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 — PULMONARY I AGENTS – LONG-ACTING BETA AGONISTS (LABAs)

Relative Clinical Effectiveness — The P&T Committee evaluated the clinical effectiveness of the long-acting beta agonists (LABAs), as part of the Pulmonary I drug class. The LABAs include 2 DPIs, salmeterol (Serevent Diskus) and formoterol (Foradil Aerolizer), and 2 inhalation solutions, formoterol solution (Perforomist) and arformoterol solution (Brovana). There are no generic formulations available for the LABAs. The current BCF LABA is salmeterol DPI (Serevent Diskus).

MHS expenditures for the LABAs in FY 2008 in the entire MHS exceeded $9.1M ($1.6M in the MTFs, $5.8M in the TRRx, and $1.7M in the TMOP). Salmeterol DPI (Serevent Diksus) is the most frequently used LABA in the entire MHS with approximately 250,000 prescriptions dispensed monthly. However overall, there is a trend for decreasing LABA use in the MHS.

Relative Clinical Effectiveness Conclusion — The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent), as part of the Pulmonary I overall relative clinical effectiveness conclusion, to accept the following regarding the clinical effectiveness of the LABA products:

A. With regard to efficacy/clinical effectiveness between the LABA oral inhalers, salmeterol DPI (Serevent Diskus) and formoterol DPI (Foradil Aerolizer), the following conclusions were made:

- FDA-approved indications — Salmeterol and formoterol have similar FDA-approved indications (asthma, COPD, and exercise-induced bronchospasm [EIB]), with the exception that their pediatric-approved ages for asthma differ.
- Pharmacokinetics — Formoterol has a faster onset of action than salmeterol, but clinical efficacy is similar for changes in forced expiratory volume in one second (FEV_1) and peak expiratory flow (PEF).

- Guidelines — Evidence-based guidelines from the NAEPP for asthma and the Global Initiative for Obstructive Lung Disease (GOLD) for COPD do not state a preference for one LABA over another.
- Asthma — For treating asthma, both salmeterol and formoterol have been shown to reduce the occurrence of asthma symptoms and reduce the need for rescue medications, when compared to placebo. Head-to-head studies show no difference between salmeterol and formoterol in relieving asthma symptoms, reduced use of rescue medications, or improvement in spirometry measures.
- COPD and EIB — There is insufficient evidence to determine if clinically relevant differences exist when treating COPD or EIB.

B. With regard to efficacy/clinical effectiveness between the LABA-inhaled solutions, formoterol solution (Perforomist), and arformoterol solution (Brovana), the following conclusions were made:

- COPD — There is insufficient evidence to determine if clinically relevant differences exist when treating COPD.
- Place in therapy — The LABA inhalation solutions are relatively new additions to the market. Recommendations regarding their most appropriate use in patients with COPD have not been discussed in national guidelines.

C. With regard to safety between the LABA oral inhalers, salmeterol DPI (Serevent Diskus), and formoterol DPI (Foradil Aerolizer):

- In patients with asthma, a higher risk of death was associated with salmeterol and formoterol use. This is based on data from the Salmeterol Multicenter Asthma Research Trial, an FDA meta-analysis conducted in 2008, and 2 Cochrane reviews. The risk of death is highest in subpopulations of African American patients and children 4 to 11 years of age. Using a LABA with an ICS reduces the risk of death in asthma. The FDA Advisory subcommittee is recommending removal of the LABA indication for asthma. These recommendations are pending approval at the FDA.
- In patients with COPD, 1 meta-analyses (Rodrigo 2008) and 1 pooled analysis have reported no increased risk of death with salmeterol or formoterol.
- For other serious adverse events, there do not appear to be clinically relevant differences between salmeterol and formoterol, based on similar numbers needed to harm (188 vs. 179, respectively) from 2 Cochrane reviews.

D. With regard to safety between the LABA-inhaled solutions, formoterol solution (Perforomist) and arformoterol solution (Brovana) for treating COPD, there is insufficient evidence to determine if clinically relevant differences exist in the adverse effect profile. The LABA-inhaled solutions are not approved for treating asthma.

E. With regard to other factors between the LABAs, the following conclusions were made:

- Ease of use: The formoterol DPI (Foradil Aerolizer) is more difficult for patients to use than salmeterol DPI (Serevent Diskus).
- Special Populations: For asthma, salmeterol is approved for a younger patient population (approved for children as young as 4 years old) compared to formoterol (approved for children as young as 5 years old).
- Storage conditions: Storage conditions are more favorable with formoterol inhalation solution (Perforomist), which is stable at room temperature for up to 12 weeks vs. 6 weeks with arformoterol inhalation solution (Brovana).
- Clinical Coverage: A survey of MTF providers showed that the majority of respondents require a LABA oral inhaler to treat their patients with COPD.
- Therapeutic Interchangeability: The Committee concluded there is a high degree of therapeutic interchangeability between the two LABA inhalation solutions and, with the exception of convenience/ease of use, there is a high degree of therapeutic interchangeability between the two LABA oral inhalers.
- Use of LABAs without concomitant use of ICS in MHS:
  - Results of a preliminary analysis reported by the Pharmacy Outcomes Research Team (PORT) indicated that of the 13,533 DoD beneficiaries who filled at least 1 prescription for a LABA during a 6-month study period (June – November 2008) at any DoD point of service, 6,118 (45%) had not filled a prescription for an ICS or an ICS/LABA combination during the 180 days prior to or the 60 days following the date of their first LABA prescription during the study period. The pronounced skew in this group toward older ages (mean: 69 years [SD 14]; median age: 72 years) and the fact that about 30% had filled an anticholinergic prescription during the same time period suggested a predominantly COPD population. Patients under 55 years of age who had not filled an anticholinergic prescription (characteristics suggesting asthma rather than COPD) made up only about 11% (655 patients) of this group. The analysis included both new and previous LABA users. It did not control for use of other health insurance or starting/stopping TRICARE coverage, both of which could result in missing data regarding concomitant ICS use.
  - The Committee agreed that the great majority of DoD beneficiaries receiving LABAs without concomitant ICS are probably COPD patients, in whom "unopposed" use of LABAs has not been associated with safety concerns, and that the absolute number of asthma patients in this category is likely to be small. However, they suggested that further analysis utilize asthma or COPD diagnoses (e.g., medical claims data or patient records) to identify patient groups and that available data be analyzed to investigate anecdotal reports of asthmatic patients discontinuing use of ICS without the knowledge of their providers after being placed on a LABA (either

because of greater perceived symptom relief or because of the difficulty of keeping up with multiple inhalers).

Relative Cost-Effectiveness — In considering the relative cost-effectiveness of pharmaceutical agents in the LABAs as part of the Pulmonary I 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 LABAs.

LABA 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 of the CMA of the LABA oral inhalers revealed that formoterol DPI (Foradil Aerolizer) was the most cost-effective LABA oral inhaler overall;

B. Results of the CMA of the LABA inhalation solutions revealed that arformoterol solution (Brovana) was the most cost-effective overall; and

C. The BIA evaluated the potential impact of scenarios with selected LABA agents designated formulary or non-formulary on the UF. Results from the BIA revealed that the scenario that designated formoterol inhalation solution (Perforomist) non-formulary under the UF was most favorable to the MHS.

1) ***COMMITTEE ACTION:*** The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent) to accept the cost-effectiveness conclusions stated above.

2) ***COMMITTEE ACTION: UF RECOMMENDATION*** — In view of the conclusions from the relative clinical effectiveness and relative cost-effectiveness determinations of the LABA products 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:

   1. Salmeterol DPI (Serevent Diskus), formoterol DPI (Foradil Aerolizer) and arformoterol inhalation solution (Brovana) be classified as formulary under the UF; and

   2. Formoterol inhalation solution (Perforomist) be designated as non-formulary on the UF, based on cost-effectiveness.

Director, TMA, Decision: Ellen P. Embrey ☑ Approved ☐ Disapproved

Approved, but modified as follows:

3) ***COMMITTEE ACTION: MN CRITERIA*** — Based on the clinical evaluation for formoterol inhalation solution (Perforomist) 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, 1 opposed, 1 abstained, 0 absent) MN criteria for formoterol inhalation solution (Perforomist). (See Appendix B for full MN criteria).

Director, TMA, Decision: Allen P. Rubley ☑ Approved ☐ Disapproved

Approved, but modified as follows:

4) ***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 following a 120-day implementation period in the TMOP and TRRx, and at the MTFs no later than a 120-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: Allen P. Rubley ☑ Approved ☐ Disapproved

Approved, but modified as follows:

5) ***COMMITTEE ACTION: BCF RECOMMENDATION*** — The P&T Committee considered the BCF status of the LABA agents. Based on the results of the clinical and economic evaluations presented, the P&T Committee voted (13 for, 0 opposed, 2 abstained and 0 absent) to recommend that salmeterol DPI (Serevent Diskus) remain designated as BCF.

Director, TMA, Decision: Allen P. Rubley ☑ Approved ☐ Disapproved

Approved, but modified as follows:

7. DRUG CLASS REVIEW — PULMONARY I AGENTS – INHALED CORTICOSTEROID / LONG-ACTING BETA AGONIST COMBINATIONS (ICS/LABA COMBINATIONS)

Relative Clinical Effectiveness — The P&T Committee evaluated the clinical effectiveness of the ICS/LABA combinations, as part of the Pulmonary I drug class. There are 2 ICS/LABA combinations available. Fluticasone/salmeterol (Advair Diskus) is available as both a dry powder inhaler and as an HFA metered-dose inhaler (Advair HFA). Budesonide/formoterol (Symbicort) is available as an HFA metered-dose inhaler. MHS expenditures for the ICS/LABA combinations exceeded $153M

in FY 2008 (MTF $55.2M, TRRx $75.1M, TMOP $23.4M). In terms of number of prescriptions dispensed, fluticasone/salmeterol DPI (Advair Diskus) is by far the highest utilized ICS/LABA across all 3 points of service. The current BCF product is fluticasone/salmeterol (Advair).

Relative Clinical Effectiveness Conclusion — The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent), as part of the Pulmonary I overall relative clinical effectiveness conclusion, to accept the following regarding the clinical effectiveness of the ICS/LABA combination oral inhalers:

A. With regard to efficacy/clinical effectiveness between the ICS/LABA oral inhalers, the following conclusions were made:

- FDA-approved Indications — The Committee recognized that the ICS/LABA combinations are all approved for the long-term treatment of asthma, and that pediatric age ranges differ between the products. Additionally, fluticasone/salmeterol DPI (Advair Diskus) dry powder inhaler is FDA-approved to reduce air flow obstruction and reduce exacerbations in COPD. These FDA indications for COPD apply only to the fluticasone 250 mcg /salmeterol 50 mcg Advair Diskus dosage strength. Note: Following the meeting on 27 Feb 2009, the FDA approved formoterol/budesonide DPI (Symbicort) for treating COPD.

- Efficacy/clinical effectiveness for asthma — The Committee concluded that there was fair evidence to suggest that there are no clinically relevant differences in efficacy between fluticasone/salmeterol and budesonide/formoterol for the treatment of asthma. This is based on the conclusions of 2 systematic reviews (Cochrane and the state of Oregon Drug Effectiveness Review Project) and head-to-head trials showing similar improvements in PEF, mean reduction of asthma exacerbations, and increases in the percentage of symptom-free days.

- Efficacy/clinical effectiveness for COPD — The Committee concluded that there was insufficient evidence to determine whether there are clinically relevant differences in efficacy between fluticasone/salmeterol and budesonide/formoterol for the treatment of COPD.

B. With regard to safety/tolerability:

- Product labeling — The Committee recognized that the safety information contained in the product labeling for the ICS/LABA combinations closely reflects the product labels for the individual ICS and LABA components.

- Minor adverse events — Comparative trials of the ICS/LABA combinations show that the products are generally well-tolerated. The most common adverse events are nasopharyngitis, headache, upper respiratory infection, oral candidiasis, and dysphonia. Adverse events for ICS/LABA combination are similar to those reported with an equipotent dose of the individual ICS component.

C. With regard to other factors between the ICS/LABA combination oral inhalers:

- Clinical Coverage – The Committee concluded that, to meet the needs of the majority of MHS beneficiaries, MHS providers require availability of both a metered-dose inhaler and dry powder inhaler formulation of the ICS/LABA combinations.
- Therapeutic Interchangeability — The Committee concluded that there is a high degree of therapeutic interchangeability between fluticasone/salmeterol (Advair) and budesonide/formoterol (Symbicort).
- DoD Persistence Data —
    - The PORT reported preliminary results of an analysis of persistence on treatment among DoD beneficiaries who are new users of ICS/LABA combinations (Advair or Symbicort). The study sample consisted of 3,857 patients randomly sampled from the population of DoD beneficiaries who 1) received at least 1 prescription for an ICS/LABA combination from 1 Jul 2007 to 31 Dec 2007; 2) had not received an ICS/LABA prescription in the last 365 days; 3) were between 12–55 years of age (to focus on use in adults and adolescents with asthma); and 4) were enrolled in TRICARE Prime or Plus with prescription coverage throughout the study. Persistence was measured as percentage of days covered (PDC) over 1 year. Based on ICD-9 diagnosis codes from medical claims data during the baseline and accrual periods and prescription fills for anticholinergics (indicative of COPD), 72% of the study sample had a diagnosis of asthma and 12% had a diagnosis of COPD or had received an anticholinergic prescription, with 8% of patients falling into both groups. Of the remaining 24% (n=920), about two-thirds had diagnoses for acute respiratory illness and/or allergic rhinitis, while about one-third did not have a claim coded for any study diagnosis.
    - Persistence was low compared to those found for other chronic medications, with a mean PDC over 1 year of 28.3% (SD 25.2%). Overall, only 7% of patients had a PDC of at least 80% (i.e., a cumulative days supply of at least 292 days), while 16% had a PDC of at least 50%. These findings were influenced by patients who received only an initial ICS/LABA prescription (47%), with no other fills during the 365-day follow-up period. Notably, the percentage of patients receiving only 1 ICS/LABA prescription was greatest (69%) among the 920 patients without an asthma or COPD diagnosis, compared to about 40% among the 2,957 patients who did not have asthma or COPD diagnosis. This group was also less likely than the asthma or COPD groups to be treated with any other controller medication (ICS, LABAs, leukotrienes, methylxanthines, or anticholinergics). These results suggest that a considerable proportion of ICS/LABA use may be for acute rather than chronic conditions.
    - The Committee suggested that MTFs may wish to review appropriateness of ICS/LABA combination use at their facilities,

particularly with regard to acute vs. chronic use. They also agreed that formulary management documents sent to MTFs should call attention to the potential for low persistence among new users of ICS/LABAs, even those diagnosed with chronic conditions such as asthma or COPD. They agreed with plans for further analysis in this area.

Relative Cost-Effectiveness — In considering the relative cost-effectiveness of pharmaceutical agents in the ICS/LABA combination oral inhalers as part of the Pulmonary I 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 ICS/LABA combinations.

LABA 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 of the CMA of the ICS/LABA combination oral inhalers revealed that budesonide/ formoterol (Symbicort) was the most cost-effective combination inhaler agent overall; and

B. The BIA evaluated the potential impact of scenarios with selected ICS/LABA combination agents designated formulary or non-formulary on the UF. Results from the BIA revealed that the scenario that designated budesonide/ formoterol (Symbicort) inhaler non-formulary (with an automated prior authorization) under the UF was most favorable to the MHS.

1) ***COMMITTEE ACTION:*** The P&T Committee voted (15 for, 0 opposed, 0 abstained, 0 absent) to accept the cost-effectiveness conclusions stated above.

2) ***COMMITTEE ACTION: UF RECOMMENDATION*** — In view of the conclusions from the relative clinical effectiveness and relative cost-effectiveness determinations of the ICS/LABA combination products and other relevant factors, the P&T Committee, based upon its collective professional judgment, voted (12 for, 2 opposed, 1 abstained, 0 absent) to recommend that:

   1. Fluticasone/salmeterol HFA (Advair HFA) and DPI (Advair Diskus) and budesonide/formoterol (Symbicort) inhaler be classified as formulary on the UF; and

   2. That no ICS/LABA combination agents be designated as non-formulary under the UF, based on cost-effectiveness.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

3) ***COMMITTEE ACTION: BCF RECOMMENDATION*** — The P&T Committee considered the BCF status of the ICS/LABA agents. 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 fluticasone/salmeterol DPI (Advair Diskus) and fluticasone/salmeterol HFA MDI (Advair HFA) remain designated as BCF immediately on signing of the February 2009 DoD P&T Committee minutes by the Director, TMA.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

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

A. Nasal Allergy Drugs — Quantity Limits (QLs): The Nasal Allergy Drugs were reviewed for UF placement at the November 2008 DoD P&T Committee meeting. The class is comprised of the nasal inhaled corticosteroids, nasal antihistamines, and nasal anticholinergic agents. The 2 newest products in the class are the nasal corticosteroid ciclesonide (Omnaris) and the nasal antihistamine olopatadine (Patanase). QLs are in place for the other members of the nasal allergy drug class, which take into account FDA-approved dosing. The Committee recommended QLs for ciclesonide and olopatadine nasal inhalers, consistent with the other members in the class.

1) ***COMMITTEE ACTION:*** The Committee voted (13 for, 1 opposed, 1 abstained, 0 absent) to recommend quantity limits for ciclesonide nasal inhaler (Omnaris) of 6 bottles per 90 days in the TMOP, and 2 bottles per 30 days in the TRRx; and for olopatadine nasal inhaler (Patanase) of 6 bottles per 90 days in the TMOP, and 2 bottles per 30 days in the TRRx.

Director, TMA, Decision: ☑ Approved ☐ Disapproved

Approved, but modified as follows:

B. Fluticasone/salmeterol Oral HFA MDI (Advair HFA) — QLs: The ICS/LABA combination oral inhalers have QLs in place that take into account FDA-approved dosing and safety information. The fluticasone/salmeterol oral DPI (Advair Diskus) has current QLs of 3 inhalers (180 doses) per 90 days in the TMOP, and 1 inhaler (60 doses)/30 days in the TRRx.

1) ***COMMITTEE ACTION:*** The P&T Committee voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend QLs for fluticasone/salmeterol HFA MDI (Advair HFA) 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:

C. **Antifungal Prior Authorization** — The prior authorization (PA) was reviewed for terbinafine (Lamisil and generics), itraconazole (Sporanox and generics) and ciclopirox lacquer (Penlac and generics). The PA was placed due to the high cost of the drugs and potential hepatotoxic adverse effects. With the introduction of generic products, the price of the drugs has significantly fallen. COL Trinka Coster, MD, from the Pharmacovigilance Center presented data that indicated the rates for signals for these drugs in the safety databases were very low.

1) ***COMMITTEE ACTION:*** The P&T Committee voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend removing the Antifungal Prior Authorization requirement for terbinafine (Lamisil), itraconazole (Sporonax), and ciclopirox nail lacquer (Penlac).

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

9. ITEMS FOR INFORMATION

A. **Ezetimibe / Simvastatin (Vytorin) Safety Update** — LtCol James McCrary provided the Committee with an update on recent safety information for ezetimibe/simvastatin (Vytorin). The Antilipidemic I class, which includes the statins, ezetimibe, niacin and their combination products, will be re-reviewed for UF status at an upcoming meeting

B. **MTF and TMOP Pricing Update** — Contracts for products with Federal Supply Schedule prices are in the review stage of the contract cycle. The contracts are reviewed at the Veteran's Administration National Acquisition Center (VA NAC). As of 1 February 2009, the VA NAC had completed 200 out of 246 contract reviews. Drug manufacturers are able to adjust prices due to changes in market conditions. A review of the impact of price changes on spending indicated that spending in the MTFs could increase by approximately 7% and spending at the TMOP point of service could increase by 6%. These price changes should have little effect on spending in TRRx.

C. **Patient Safety / Pharmacovigilance** — COL Coster provided the Committee with information on data mining in the Adverse Event Reporting System (AERS) database. The goal of data mining is to detect increased signals of adverse events that can be further evaluated for significance. Definitions and term hierarchy of the Medical Dictionary for Regulated Activities were presented. Limitations were discussed; e.g., no denominator data, missing data, drug name errors, underreporting, over reporting

due to publicity, lack of consistent diagnostic criteria. AERS data mining information will be presented during initial drug class committee presentations.

D. Extended Core Formulary (ECF) — The PEC had previously briefed the Committee on efforts to implement electronic prescribing in the MHS. As part of the ongoing plan to systematically review 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. The Committee previously reviewed changes to the BCF at the November 2008 DoD P&T Committee meeting. Further information will be presented at an upcoming meeting for recommendations for changes to the ECF; no action necessary.

10) ADJOURNMENT

The meeting adjourned at 1700 hours on 18 February 2009. The next meeting will be 13–14 May 2009.

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:

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

DECISION ON RECOMMENDATIONS

Director, TMA, decisions are as annotated above.

~~S. Ward Casscells, III, M.D.~~
Ellen P. Embrey
(performing the Duties of
ASD/HA)

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 Carol Labadie, MSC*	Army, Pharmacy Officer, Alternate
Col Everett McAllister, BSC	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 Bruce Lovins, MC	Army, Family Practice Physician, Alternate
COL Doreen Lounsbery, MC	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
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 Carol Labadie, MSC	Army, Pharmacy Officer
Major William Hannah, MC	Air Force, Internal Medicine Physician
LCDR Scott Akins, MC	Navy, Pediatrics Physician Alternate
Nonvoting Members Present	
CDR James Ellzy	DoD P&T Vice Chairman
Ms. Carol Cooper	Deputy General Counsel, TMA
COL Kent Maneval, MSC	Defense Medical Standardization Board
Maj Peter Trang	Defense Supply Center Philadelphia
Mr. William Davies	TMOP/TRRx Contracting Officer on Record
Nonvoting Members Absent	
Lt Col Paul Hoerner, BSC	Deputy Director, DoD Patient Safety Center

Appendix A – Attendance – (continued)

Guests	
Col Trinka Coster, MC	Pharmacovigilance Center (PVC), Army, Office of the Surgeon General
CAPT Sheri Kirshner	Fort Detrick, Defense Medical Standardization Board
LtCol Teresa Bisnett, MC	Wilford Hall Medical Center
Lt Col Don Faust	Office of the Assistant Secretary of Defense, Health Affairs
LCDR Mike Lee	Indian Health Service
Debra Khachikian, PharmD	Department of Veterans Affairs PBM
Annabel Schumacher, PharmD	Wilford Hall Medical Center
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 Pharmacy Outcomes Research Team
Shana Trice, PharmD	DoD Pharmacy Outcomes Research Team
Eugene Moore, PharmD	DoD Pharmacoeconomic Center
Angela Allerman, PharmD	DoD Pharmacoeconomic Center
David Meade, PharmD	DoD Pharmacoeconomic Center
Jeremy Briggs, PharmD	DoD Pharmacoeconomic Center
Dean Valibhai, PharmD	DoD Pharmacy Operations Center contractor
Brian Beck, PharmD	DoD Pharmacy Operations Center contractor
Roger Potyk, PharmD	DoD Pharmacy Outcomes Research Team contractor
Stephen Yarger, PhD	DoD Pharmacy Outcomes Research Team contractor
Esmond Nwokeji, PhD	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
Beclomethasone HFA MDI (Qvar) Budesonide MFA MDI (Pulmicort Flexhaler) Ciclesonide HFA MDI (Alvesco) Flunisolide CFC MDI (Aerobid, Aerobid M) Triamcinolone CFC MDI (Azmacort) **Inhaled Corticosteroids (ICS)**	• Use of formulary alternatives is contraindicated • Formulary agents have resulted or are likely to result in therapeutic failure. • No alternative formulary agent is available - specifically applies to budesonide, as it is pregnancy category B.
Formoterol (Perforomist) inhalation solution **Long-Acting Beta Agonists (LABAs)**	• 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 non-formulary agent and changing to a formulary agent would incur unacceptable risk.

CFC: chlorofluorocarbon

HFA: hydrofluroalkane

MDI: metered dose inhaler

*: CFC-containing pressurized MDIs likely will cease marketing as of 31 Dec 2009

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)
Feb 09	Inhaled Corticosteroids	▪ Beclomethasone HFA MDI (Qvar) ▪ Budesonide MFA MDI (Pulmicort Flexhaler) ▪ Ciclesonide HFA MDI (Alvesco) ▪ Flunisolide CFC MDI (Aerobid, Aerobid M) ▪ Triamcinolone CFC MDI (Azmacort)	BCF	▪ Fluticasone DPI (Flovent Diskus) ▪ Fluticasone HFA MDA (Flovent HFA)	pending approval	pending approval
Feb 09	Long-Acting Beta Agonists	▪ formoterol inhalation solution (Perforomist)	BCF	▪ Salmeterol DPI (Serevent Diskus)	pending approval	pending approval
Feb 09	Inhaled Corticosteroids / Long-Acting Beta Agonist Combinations	(No ICS/LABA combinations recommended for NF placement Feb 09)	BCF	▪ Fluticasone/salmeterol DPI (Advair Diskus) ▪ Fluticasone/salmeterol HFA MDI (Advair HFA)	pending approval	pending approval
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]	10 Feb 09	8 Apr 09 (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 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)	10 Feb 09	8 Apr 09 (60 days)
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	10 Feb 09; original signing date 24 Oct 08	7 Jan 09 (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	10 Feb 09	N/A
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	24 Oct 08;; original signing date: 27 Aug 08	26 Nov 08 (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)
Aug 08	Self-Monitoring Blood Glucose Systems (SMBGS) test strips	▪ OneTouch Ultra 2 strips (for OneTouch 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
		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)

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)	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 date: 26 Nov 08 original implementation date: 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 date: 26 Nov 08 original implementation date: 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 date: 26 Nov 08 original implementation date: 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)

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 (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 date: 26 Nov 08 original implementation date: 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 date: 26 Nov 08 original implementation date: 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; OABs = 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

AE	adverse event
AERS	Adverse Event Reporting System
BAP	Beneficiary Advisory Panel
BCF	Basic Core Formulary
BIA	budget impact analysis
CEA	Cost-effectiveness analysis
CFC	chlorofluorocarbon
CFR	Code of Federal Regulations
CMA	cost minimization analysis
COPD	chronic obstructive pulmonary disease
DoD	Department of Defense
DPI	dry powder inhaler
ECF	Extended Core Formulary
EIB	exercise-induced bronchospasm
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
GDH-PQQ	glucose dehydrogenase pyrroloquinolinequinone
GOLD	Global Initiative for Obstructive Lung Disease
HA	Health Affairs
HFA	hydrofluoroalkane
HPA	hypothalamic-pituitary-adrenal
ICS	Inhaled Corticosteroid drug class
LABA	Long-Acting Beta Agonist drug class
ICS/LABA	Inhaled Corticosteroid / Long-Acting Beta Agonist combinations 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
NAEPP	National Asthma Education and Preventive Program (NAEPP)
OMB	Office of Management and Budget
P&T	Pharmacy and Therapeutics
PA	prior authorization
PDC	percentage of days covered
PEC	Pharmacoeconomic Center
PEF	peak expiratory flow
PORT	Pharmaceutical Outcomes Research Team
Pulmonary I	Pulmonary I drug class
QL	quantity limit
SMBGS	self-monitored blood glucose system
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