DOD PHARMACY AND THERAPEUTICS COMMITTEE RECOMMENDATIONS

INFORMATION FOR THE UNIFORM FORMULARY BENEFICIARY ADVISORY PANEL

I. UNIFORM FORMULARY REVIEW PROCESS

Under 10 U.S.C. § 1074g, as implemented by 32 C.F.R. 199.21, the DoD P&T Committee is responsible for developing the Uniform Formulary (UF). Recommendations to the Director, TMA, on formulary status, pre-authorizations, and the effective date for a drug's change from formulary to nonformulary (NF) status receive comments from the Beneficiary Advisory Panel (BAP), which must be reviewed by the Director before making a final decision.

II. UNIFORM FORMULARY CLASS REVIEWS—ANTILIPIDEMIC-1s (LIP-1s)

P&T Comments

A. Antilipidemic-1s (LIP-1s)—Relative Clinical Effectiveness

Relative Clinical Effectiveness—The P&T Committee evaluated the relative clinical effectiveness of the agents in the antilipidemic-1s (LIP-1s) drug class. This class is currently ranked number one in the Military Health System (MHS), with drug class expenditures exceeding $480 million annually. The class was last reviewed in August 2006. The individual drugs included in the LIP-1s class are listed, below:

> ***Statins*:** atorvastatin (Lipitor), amlodipine/atorvastatin (Caduet), fluvastatin (Lescol), fluvastatin extended release (ER; Lescol XL), lovastatin (Mevacor, generics), lovastatin ER (Altoprev), pravastatin (Pravachol, generics), rosuvastatin (Crestor), simvastatin (Zocor, generics), and ezetimibe/simvastatin (Vytorin)
>
> ***Statin combination products and add-on therapies*:** niacin ER (Niaspan), lovastatin/niacin ER (Advicor), simvastatin/niacin ER (SIMCOR), and ezetimibe (Zetia)

The current BCF agents are pravastatin, simvastatin, niacin ER (Niaspan), and ezetimibe/simvastatin (Vytorin). The NF agents are atorvastatin/amlodipine (Caduet) and rosuvastatin (Crestor). The remaining drugs are classified as UF agents. Generic formulations of simvastatin, pravastatin, and lovastatin are now marketed. Generic formulations of atorvastatin are expected in late 2011. The clinical evaluation for the

LIP-1s included, but was not limited to, the requirements stated in 32 C.F.R. 199.21(e)(1).

Relative Clinical Effectiveness Conclusion—The Committee recommended (14 for, 0 opposed, 0 abstained, 1 absent) the following conclusions for the LIP-1s:

1. Across equipotent doses, the statins achieve a similar percentage reduction in low-density lipoprotein (LDL), and a similar percentage increase in high-density lipoprotein (HDL).
2. All statins show a plateau and drop-off in ability to raise HDL at increasing doses.
3. Doubling the dose of a statin provides only an additional 4% to 7% reduction in LDL and 3% to 6 % reduction in non-HDL.
4. There is a strong correlation between the change in LDL and C-reactive protein (CRP). CRP appears to be a strong predictor of coronary heart disease (CHD). It is unclear what emphasis the upcoming National Heart and Lung Blood Institute Adult Treatment Panel (ATP) IV guidelines will place on CRP in managing patients with hypercholesterolemia.
5. A 1:1 log-linear relationship exists between lowering LDL and non-HDL and reduced relative risk of CHD. In one mortality study, non-HDL was a stronger predictor of CHD risk than LDL.
6. With respect to the low-to-moderate intensity statins (statins able to reduce LDL levels by $\leq$ 45%):
    - The results of one meta-analysis show Lipitor, pravastatin, and simvastatin have similar effects in providing long-term cardiovascular (CV) prevention (e.g., reducing all-cause deaths, major coronary events, CV death, and major cerebrovascular events).
    - There are fewer trials published for lovastatin and fluvastatin, but positive outcomes are still shown.
    - Simvastatin at doses $\leq$ 40 mg will remain the DoD-preferred statin.
7. The high-intensity statins (those statins able to reduce LDL levels by >45%) include Lipitor 40 and 80 mg; Vytorin 10/20, 10/40, and 10/80 mg; Crestor 10, 20, and 40 mg; and simvastatin 80 mg.
8. In trials assessing the primary prevention of CHD, statins do not appear to decrease the risk of all-cause mortality. At a dose of 20 mg, Crestor showed a decreased risk of all-cause mortality in the JUPITER trial. The benefit of Crestor in this trial was limited to patients with CRP> 2 and an

additional CHD risk factor besides age. When used in the primary prevention of CHD, statins in general decrease the risk of CV events by 22% to 30%.

9. In trials assessing the secondary prevention of CHD, statins decrease the risk of mortality and the risk of major CV events 21% to 23%. Similar benefits are conferred among patients with or without diabetes. When used in acute coronary syndrome, Lipitor 80 mg decreases the risk of a second event by 16% to 19%. There are no studies with Crestor assessing the secondary prevention of CHD.
10. Vytorin provides added efficacy in terms of LDL lowering, but still lacks clinical outcomes data showing a reduction in CV events. Positive benefits in reducing CV events have been shown with the simvastatin component of Vytorin in The Heart Protection Study and The Scandinavian Simvastatin Survival Study trials.
11. Zetia lowers LDL 15%–20% by a mechanism distinct from that of the statins.
12. Niaspan lowers LDL 5%–15%. However, Niaspan is required in the MHS, as its primary benefit is to raise HDL by 25%.
13. Since the 2006 review, there is no new compelling data for Advicor, SIMCOR, Caduet, Altoprev, or Lescol XL to change the original conclusion that these drugs do not offer additional clinical benefits over the other LIP-1s. These drugs have low utilization in the MHS.
14. With regard to safety, there is no evidence that increases in liver function tests or minor adverse events (gastrointestinal disturbances, headaches, rash, itching) are less likely to occur with one statin versus another; these adverse effects are dose-related.
15. Concerns of proteinuria remain with Crestor 40 mg, but the clinical significance of this effect is unknown.
16. The risk of statin-related myotoxicity increases with increasing dosages. There is no evidence that one statin is less likely to cause myotoxicity than another. The FDA recently updated the labeling for simvastatin 80 mg, warning of the risk of myotoxicity. The overall incidence of rhabdomyolysis is rare with all statins.
17. There is no conclusive data yet to suggest that statin therapy is associated with cognitive decline, behavioral defects, or cancer. However, there is evidence to suggest an increased risk of new onset diabetes with statin therapy (JUPITER trial and Lancet 2010 meta-analysis). The clinical implications of this finding are still unclear.

18. Fluvastatin, pitavastatin (a new statin not yet marketed), pravastatin, and Crestor do not interact with CYP 3A4 and have more favorable drug-drug interaction profiles than the other statins. Pravastatin is renally metabolized and bypasses the CYP 450 system entirely.

19. The Pharmacy Outcomes Research Team (PORT) analyzed LIP-1s utilization in the MHS during a 7-month period between August 1, 2009, and March 31, 2010. Overall, approximately 1.4 million DoD beneficiaries receive lipid-lowering therapies and about 1.2 million DoD beneficiaries receive statins. The percentage of the study group classified as new statin users was 7%. Women comprised 51% of the entire study group; the mean patient age was 42.4 years (standard deviation 11.8 years).

    The majority of use is statin monotherapy (882,000 patients). The most common add-on therapy is ezetimibe (194,000), followed by fibrates (123,000), and niacin (57,000). Zetia is frequently prescribed as Vytorin (73%); only 27% of the study group received Zetia with a statin other than simvastatin. Most niacin is given separately (74%), with only 6,819 patients receiving SIMCOR or Advicor.

    About 29% of all patients receiving statin monotherapy or a statin and Zetia are receiving high-intensity statins (statins able to reduce LDL levels by >45%); 17% of this group is receiving a high-intensity statin alone; 11% are receiving a high-intensity statin plus Zetia. The most common triple therapy is a statin and Zetia and niacin (12,000). Overall, about 73,000 patients receive some combination targeting LDL and HDL/triglycerides.

To meet the clinical needs of the majority of MHS patients, the UF must include the low-to-moderate intensity statins simvastatin and pravastatin and at least one high-intensity statin.

B. Antilipidemic-1s (LIP-1s)—Relative Cost-Effectiveness

Relative Cost-Effectiveness—

***Statins*:** A series of cost-effectiveness analyses (CEAs) and budget impact analysis (BIAs) were used to determine the relative cost-effectiveness of agents in the class.

Four separate cost-effectiveness models were constructed in the analyses of low-to-moderate statins (statins able to reduce LDL levels by $\leq$ 45%) and high-intensity statins (statins able to reduce LDL levels by >45%). Analyses were based on direct and indirect comparisons of relevant trial data.

1. The Annual Cost per 1% LDL Decrease Model compared the cost-effectiveness of the high % LDL-lowering agents based on annual cost per 1% LDL reduction using a decision analytical model.
2. The Annual Cost per Patient Treated to Goal Model compared the cost-effectiveness of these agents based on annual cost per patient successfully treated to ATP III National Cholesterol Education Program goal using a decision analytical model.
3. The Annual Cost per 1% Non-HDL Decrease Model compared the cost-effectiveness of the high % non-HDL lowering agents based on annual cost per 1% non-HDL reduction using a decision analytical model.
4. The Annual Cost per 1% HDL-increase Model compared the cost-effectiveness of the high % HDL-increasing agents based on annual cost per 1% HDL increase using a decision analytical model.

***Statin combination products and add-on therapies*:** CMA and BIA were used to evaluate the cost-effectiveness of the statin combination products and add-on therapies.

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:

Statins (13 for, 0 opposed, 1 abstained, 1 absent)—

1. For the low-to-moderate % LDL-lowering agents (≤ 45% LDL reduction) evaluated: simvastatin (10, 20, and 40 mg), Lipitor 10 and 20 mg, and all strengths of pravastatin, the cost-effectiveness of the agents in this class were evaluated using each of the decision analytic models described, above. In pharmacoeconomic terms, simvastatin was considered to be dominant at all equipotent strengths, in terms of cost per LDL reduction, cost per LDL goal attainment, cost per non-HDL reduction, and cost per HDL increase. CEA results showed simvastatin was located along the cost efficiency frontier and considered to be the optimal agent.

   Note: Based on low utilization and conclusions presented at the August 2006 P&T Committee Meeting, the following agents were not evaluated in the model(s): simvastatin 5 mg, Crestor 5 mg, ezetimibe/simvastatin (Vytorin) 10/10 mg, fluvastatin IR, fluvastatin ER, lovastatin IR, and lovastatin ER were not included in the CEA.

2. For the high-intensity % LDL-lowering agents (> 45% LDL reduction) evaluated: Lipitor 40 and 80 mg, Crestor 10, 20, and 40 mg,

simvastatin/ezetimibe (Vytorin) 10/20, 10/40, 10/80 mg, and simvastatin 80 mg, the cost-effectiveness of the agents in this class were evaluated using each of the decision analytic models described, above. In pharmacoeconomic terms, the results of the first three cost-effectiveness analyses showed Lipitor 40 and 80 mg to be the overall most cost-effective high-intensity agent(s), in terms of cost per % LDL reduction, cost per % LDL goal attainment, and cost per % non-HDL reduction. Crestor 40 mg was more effective but considerably more costly compared to Lipitor at equipotent doses, but not more effective nor less costly than the equipotent dosage of ezetimibe/simvastatin (Vytorin) 10/80 mg. CEA determined Vytorin was not dominant in cost per outcome compared to Lipitor. From a price per % LDL-reduction perspective, Lipitor (all strengths) was more cost-effective than Vytorin. CEA results showed Lipitor 40 and 80mg was located along the cost efficiency frontier and considered to be the optimal agent(s).

3. BIA was used to assess the potential impact of cost scenarios where selected LIP-1s were designated formulary or NF on the UF. Cost scenarios evaluating the impact of designating agents on the BCF were also considered. BIA results for LIP-1s revealed that the scenarios placing Lipitor at all strengths on the BCF and as the step-preferred product in front of a step-therapy requirement and placing all generic agents in front of a step-therapy requirement were the most cost-effective scenarios.

4. BIA results showed that Lipitor was less costly than the other brand agents Crestor and Vytorin in all scenarios evaluated. All scenarios placing Lipitor in the step-preferred position were less costly than all nonstep-scenarios and all other scenarios involving multiple step-preferred branded agents.

Statin combination products and add-on therapies (13 for, 0 opposed, 1 abstained, 1 absent)—

1. CMA results revealed that SIMCOR was the most cost-effective add-on product, based on an analysis of the cost per day of therapy. Cost per day of therapy was calculated using cost per tablet adjusted by daily average consumption (DACON) rates for SIMCOR, Niaspan, Advicor, and Zetia.

2. BIA was used to assess the potential impact of cost scenarios where selected statin combination products and add-on agents were designated formulary or NF on the UF. Scenarios evaluating the impact of designating agents on the BCF were also considered. BIA

results revealed the most cost-effective scenario overall would designate Niaspan with BCF and UF status, designate Zetia with UF status, and designate SIMCOR and Advicor NF. However, designating SIMCOR NF may result in increased usage of Niaspan and increase overall costs. Sensitivity analyses show no individual scenario was dominant after considering the margin for error present in all cost projections. Therefore, the cost avoidance of the aforementioned most cost-effective scenario was within the margin of error.

C. Antilipidemic-1s (LIP-1s)—Uniform Formulary 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 the following:

(1) Ezetimibe/simvastatin (Vytorin), Atorvastatin (Lipitor), simvastatin (Zocor, generics), fluvastatin (Lescol), fluvastatin ER (Lescol XL), lovastatin (Mevacor, generics), lovastatin ER (Altoprev), and pravastatin (Pravachol, generics) remain classified as formulary on the UF; and atorvastatin/amlodipine (Caduet) and rosuvastatin (Crestor) be designated formulary on the UF, with prior authorization (PA) for the LIP-1s drug class requiring a trial of atorvastatin (Lipitor) and the generic formulations of simvastatin or pravastatin for new patients (12 for, 0 opposed, 2 abstained, 1 absent);

(2) Ezetimibe (Zetia), niacin ER (Niaspan), lovastatin/niacin ER (Advicor), and simvastatin/niacin ER (SIMCOR) remain designated as UF (13 for, 0 opposed, 1 abstained, 1 absent);

(3) As a result of the above recommendations, there are no LIP-1s designated NF on the UF.

D. Antilipidemic-1s (LIP-1s)—Prior Authorization Criteria

The Committee recommended (13 for, 1 opposed, 1 abstained, 0 absent) the following PA criteria should apply to the LIP-1s other than generics and Lipitor. Coverage would be approved if the patient met any of the following criteria:

(1) Automated PA criteria:

(a) The patient has received a prescription for a preferred agent targeting similar LDL reduction at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

(2) PA criteria, if automated criteria are not met:

(a) The patient has tried the preferred agent and was unable to tolerate treatment due to adverse effects.

(b) The patient is taking a concurrent drug that is metabolized by CYP3A4.

(c) The patient requires >55% LDL lowering.

(d) The patient requires primary prevention with rosuvastatin (Crestor) and is not able to take atorvastatin (Lipitor).

E. Antilipidemic-1s (LIP-1s)—Uniform Formulary Implementation Plan

The P&T Committee recommended (13 for, 1 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday 1 week after the minutes are signed, following a 60-day implementation period in the retail network and mail order, 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 of the DoD P&T Committee minutes.

III. UNIFORM FORMULARY CLASS REVIEWS—ANTILIPIDEMIC-1s (LIP-1s)

BAP Comments

A. Antilipidemic-1s (LIP-1s)—Uniform Formulary Recommendation

In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the Antilipidemic-1s (LIP-1s), the P&T Committee voted to recommend:

(1) Ezetimibe/simvastatin (Vytorin), Atorvastatin (Lipitor), simvastatin (Zocor, generics), fluvastatin (Lescol), fluvastatin ER (Lescol XL), lovastatin (Mevacor, generics), lovastatin ER (Altoprev), and pravastatin (Pravachol, generics) remain classified as formulary on the UF; and that atorvastatin/amlodipine (Caduet) and rosuvastatin (Crestor) be designated formulary agents on the UF, with prior authorization (PA) for the LIP-1s drug class requiring a trial of atorvastatin (Lipitor) and the generic formulations of simvastatin or pravastatin for new patients (12 for, 0 opposed, 2 abstained, 1 absent);

(2) Ezetimibe (Zetia), niacin ER (Niaspan), lovastatin/niacin ER (Advicor), and simvastatin/niacin ER (SIMCOR) remain designated as UF (13 for, 0 opposed, 1 abstained, 1 absent);

(3) As a result of the above recommendations, there are no LIP-1s designated as nonformulary on the UF.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

B. Antilipidemic-1s (LIP-1s)—Prior Authorization Criteria

The Committee recommended (13 for, 1 opposed, 1 abstained, 0 absent) the following PA criteria should apply to the LIP-1s other than generics and Lipitor. Coverage would be approved if the patient met any of the following criteria:

(1) Automated PA criteria:

(a) The patient has received a prescription for a preferred agent targeting similar LDL reduction at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

(2) PA criteria, if automated criteria are not met:

(a) The patient has tried the preferred agent and was unable to tolerate treatment due to adverse effects.

(b) The patient is taking a concurrent drug that is metabolized by CYP3A4.

(c) The patient requires >55% LDL lowering.

(d) The patient requires primary prevention with rosuvastatin (Crestor) and is not able to take atorvastatin (Lipitor).

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

C. Antilipidemic-1s (LIP-1s)—Uniform Formulary Implementation Plan

The P&T Committee recommended (13 for, 1 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday 1 week after the minutes are signed, following a 60-day implementation period in the retail network and mail order, 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 of the DoD P&T Committee minutes.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

IV. UNIFORM FORMULARY CLASS REVIEWS—ALPHA BLOCKERS FOR BENIGN PROSTATIC HYPERPLASIA (BPH)

P&T Comments

A. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Relative Clinical Effectiveness

The P&T Committee evaluated the relative clinical effectiveness of the alpha blockers used for BPH currently marketed in the United States. The class is comprised of three non-uroselective agents: terazosin (Hytrin, generics), doxazosin immediate release (IR; Cardura; generics), and doxazosin ER (Cardura XL); and three uroselective agents: alfuzosin (Uroxatral), tamsulosin (Flomax), and silodosin (Rapaflo).

Generic formulations of tamsulosin were launched in March 2010. The BPH alpha blocker drug class was first reviewed in August 2005 and reviewed again in November 2007. The newest agent, Rapaflo, was reviewed in August 2009. Current annual expenditures for the BPH alpha blockers are $52 million.

There is an existing automated PA process for the uroselective alpha blockers, which requires a trial of Uroxatral as initial therapy. All the alpha blockers are FDA-approved for treating BPH. The clinical evaluation for the BPH alpha blockers included, but was not limited to, the requirements stated in 32 C.F.R. 199.21(e)(1).

Relative Clinical Effectiveness Conclusion—The P&T Committee recommended (15 for, 0 opposed, 0 abstained, 0 absent) the following clinical effectiveness conclusions regarding the BPH alpha blockers:

1. There are limited head-to-head trials comparing the BPH alpha blockers; the available placebo-controlled trials and meta-analyses were reviewed. Although all the alpha blockers are superior to placebo, variability in study design and demographics preclude the ability to designate one agent as clinically superior.
2. Based on randomized placebo-controlled trials, terazosin, doxazosin, tamsulosin, alfuzosin, and silodosin produce clinically significant and comparable symptom improvements when compared to placebo.
3. Uroselective agents are well tolerated, with a few differences in safety considerations.
4. Uroselective agents appear to be better tolerated than non-uroselective agents, as measured by withdrawals due to adverse events and discontinuation of therapy.
5. Non-uroselective alpha blockers exhibit a higher rate of vasodilatory adverse effects relative to uroselective alpha blockers
6. All agents have similar warnings regarding intraoperative floppy iris syndrome.
7. The PORT analyzed the rejected claims attributable to the existing automated PA process (step-therapy edit) for the BPH alpha blockers from April 16, 2008, to December 31, 2009.
    a) Over the study period, 154,691 patients received uroselective alpha blockers for BPH in the retail or mail points of service; 43% of the patients encountered the step-therapy edit reject. Step therapy was highly effective at causing switches to preferred products; 81% of the patients who received a selective alpha blocker received the preferred product, alfuzosin, within 90 days. However, a substantial percentage of patients did not receive an alpha blocker within 90 days; 30% of patients did not receive a selective alpha blocker and 26% did not receive any alpha blocker (selective or non-selective).
    b) About 7% of the patients affected by the step therapy edit were female. Results for the women were similar to the overall results: 81% of women receiving a selective alpha blocker were switched to alfuzosin. However, the majority of women (64%) encountering the reject did not receive a selective alpha blocker within 90 days.
    c) When the alpha blocker step-therapy results were compared to previous analyses of UF drugs with step edits, similar results were noted. The percentages for those patients who did not receive a prescription after the step-edit reject were 35% in the newer sedative hypnotics class and 31%

in the proton pump inhibitor class, versus 26%–30% in the alpha blocker class.

8. A review of the clinical literature since the previous UF reviews did not add substantial new information or support changes in clinical practice.
9. Terazosin, doxazosin, and doxazosin ER have a low degree of therapeutic interchangeability with alfuzosin, tamsulosin, and silodosin in terms of safety and tolerability, due to the higher incidence of discontinuation rates and vasodilatory effects seen with the non-uroselective alpha blockers.
10. Alfuzosin, tamsulosin, and silodosin have a high degree of therapeutic interchangeability; any of these drugs could be expected to meet the needs of the majority of MHS BPH patients requiring an uroselective agent.

B. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Relative Cost-Effectiveness

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:

1. CMA results for the non-uroselective agents revealed that generic terazosin and generic doxazosin IR were the most cost-effective agents based on the weighted average cost per day of therapy.

2. CMA results for the uroselective agents revealed that generic tamsulosin was the most cost-effective agent and Rapaflo (silodosin) was the least cost-effective agent based on the weighted average cost per day of therapy.

3. BIA results revealed the scenario that placed generic tamsulosin alone in front of a step on the UF and the scenario that included generic tamsulosin and Uroxatral (alfuzosin) on the UF in front of a step were the most cost effective.

C. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Uniform Formulary 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, voted to recommend (11 for, 3 opposed, 1 abstained, 0 absent) that:

(1) tamsulosin (generic Flomax) and alfuzosin (Uroxatral) be designated as the

uroselective UF alpha blockers; terazosin (Hytrin, generics) and doxazosin IR (Cardura) be maintained as the non-uroselective UF alpha blockers;

(2) silodosin (Rapaflo) remain classified as NF with a PA requiring a trial of alfuzosin or generic tamsulosin for new patients; and

(3) doxazosin ER (Cardura XL) be classified as the NF non-uroselective alpha blocker for BPH.

D. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Prior Authorization Criteria

The automated PA (step therapy) currently in effect requires alfuzosin (Uroxatral) before other NF alpha blockers for BPH, unless there is therapeutic failure, intolerance, or hypersensitivity. The automated PA criteria will now include generic tamsulosin as a preferred BPH alpha blocker, along with alfuzosin (Uroxatral). The P&T Committee voted (13 for, 0 opposed, 2 abstained, 0 absent) to recommend the PA criteria outlined, below, should apply to silodosin (Rapaflo); there is no change to the criteria for silodosin previously in effect. Coverage would be approved if the patient met any of the following criteria:

(1) Automated PA criteria:

(a) The patient has received a prescription for either silodosin (Rapaflo), tamsulosin (generic Flomax), or alfuzosin (Uroxatral) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

(2) PA criteria if automated criteria are not met:

(a) The patient has tried alfuzosin (Uroxatral) or tamsulosin and had an inadequate response or was unable to tolerate treatment due to adverse effects.

(b) Treatment with alfuzosin (Uroxatral) or tamsulosin is contraindicated.

(c) The patient requires an alpha blocker that can be crushed and sprinkled on food.

E. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Uniform Formulary Implementation Plan

The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday 1 week after the minutes are signed, following a 60-day implementation period in the retail network and mail order, 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 of the DoD P&T Committee minutes.

V. UNIFORM FORMULARY CLASS REVIEWS— ALPHA BLOCKERS FOR BENIGN PROSTATIC HYPERPLASIA (BPH)

BAP Comments

A. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Uniform Formulary Recommendation

In view of the conclusions from the relative clinical effectiveness and relative cost effectiveness determinations of the Alpha Blockers for Benign Prostatic Hyperplasia (BPH), the P&T Committee voted to recommend:

(1) tamsulosin (generic Flomax) and alfuzosin (Uroxatral) be designated as the uroselective UF alpha blockers; terazosin (Hytrin, generics) and doxazosin IR (Cardura) be maintained as the non-uroselective UF alpha blockers;

(2) silodosin (Rapaflo) remain classified as NF with a PA requiring a trial of alfuzosin or generic tamsulosin for new patients; and

(3) doxazosin ER (Cardura XL) be classified as the NF non-uroselective alpha blocker for BPH.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

B. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Prior Authorization Criteria

The automated PA (step therapy) currently in effect requires alfuzosin (Uroxatral) before other NF alpha blockers for BPH, unless there is therapeutic failure, intolerance, or hypersensitivity. The automated PA criteria will now include generic tamsulosin as a preferred BPH alpha blocker, along with alfuzosin (Uroxatral). The P&T Committee voted (13 for, 0 opposed, 2 abstained, 0 absent) to recommend the PA criteria outlined, below, should apply to silodosin (Rapaflo); there is no change to the criteria for silodosin previously in effect. Coverage would be approved if the patient met any of the following criteria:

(1) Automated PA criteria:

(a) The patient has received a prescription for either silodosin (Rapaflo), tamsulosin (generic Flomax), or alfuzosin (Uroxatral) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days.

(2) PA criteria if automated criteria are not met:

(a) The patient has tried alfuzosin (Uroxatral) or tamsulosin and had an inadequate response or was unable to tolerate treatment due to adverse effects.

(b) Treatment with alfuzosin (Uroxatral) or tamsulosin is contraindicated.

(c) The patient requires an alpha blocker that can be crushed and sprinkled on food.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

C. Alpha Blockers for Benign Prostatic Hyperplasia (BPH)—Uniform Formulary Implementation Plan

The P&T Committee recommended (14 for, 0 opposed, 1 abstained, 0 absent) 1) an effective date of the first Wednesday 1 week after the minutes are signed, following a 60-day implementation period in the retail network and mail order, 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 of the DoD P&T Committee minutes.

BAP Comment: □ Concur □ Non-concur Additional Comments and Dissentions:

VI. RECENTLY APPROVED U.S. FOOD AND DRUG ADMINISTRATION (FDA) AGENTS—NARCOTIC ANALGESICS—FENTANYL CITRATE TRANSMUCOSAL SOLUBLE FILM (ONSOLIS)

P&T Comments

A. Fentanyl Citrate Transmucosal Soluble Film (Onsolis)—Relative Clinical Effectiveness

Fentanyl citrate transmucosal soluble film (Onsolis) is a pure opioid agonist available in a new transmucosal delivery system. It is FDA-approved for the treatment of breakthrough pain in adults with cancer who are opioid tolerant. Onsolis contains the same active drug (fentanyl) via the same route of administration (oral mucosa) as the UF products Actiq (fentanyl transmucosal lozenge; generics) and Fentora (fentanyl transmucosal tablet). It differs from Actiq and Fentora as fentanyl is delivered through a soluble film that adheres to the mucosal membrane and provides protection from the saliva. The film dissolves completely over 15–30 minutes.

There are no direct comparative clinical trials between Onsolis and the other transmucosal fentanyl products. Onsolis is not bioequivalent with other transmucosal fentanyl products. The safety and tolerability profile for Onsolis

appears comparable to other transmucosal fentanyl products. The new delivery system offers more efficient absorption with less swallowing of the drug, which could possibly result in less gastrointestinal (GI) adverse effects. Other potential benefits of the new delivery system include reduced ability for diversion and less risk of dental caries.

Onsolis has a restricted distribution risk evaluation and mitigation strategy (REMS) program that requires enrollment by both the physician and patient, limits dispensing to a single retail pharmacy, and provides delivery of the drug via traceable courier. The FDA is requiring, but has not determined an effective date, for similar REMS programs for Actiq and Fentora.

The narcotic analgesic drug class was last reviewed in February 2007. The clinical evaluation for Onsolis included, but was not limited to, the requirements stated in 32 C.F.R.199.21(e)(1).

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (15 for, 0 opposed, 0 abstained, 0 absent) the plausible, yet unproven, benefits of the transmucosal fentanyl buccal film (Onsolis) new delivery system include less GI side effects, less risk of diversion, and less risk of dental caries, compared to other UF transmucosal fentanyl products. The clinical relevance of the proposed advantages is unclear at this time. The FDA-mandated REMS program will ensure use is limited to opioid-tolerant patients.

B. Fentanyl Citrate Transmucosal Soluble Film (Onsolis)—Relative Cost-Effectiveness

The P&T Committee, based upon its collective professional judgment, voted (15 for, 0 opposed, 0 abstained, 0 absent) that fentanyl citrate transmucosal soluble film (Onsolis) is more costly than generic fentanyl products in the narcotic analgesic drug class. In comparison to generics in this class, the P&T Committee determined that the higher daily cost for Onsolis was offset by its unique delivery system and the strict REMS program, which will limit inappropriate prescribing.

C. Fentanyl Citrate Transmucosal Soluble Film (Onsolis)—Uniform Formulary 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 (12 for, 2 opposed, 1 abstained, 0 absent) fentanyl citrate transmucosal soluble film (Onsolis) be designated as formulary on the UF.

D Fentanyl Citrate Transmucosal Soluble Film (Onsolis)—Uniform Formulary Implementation Plan: Not Applicable

VII. RECENTLY APPROVED U.S. FOOD AND DRUG ADMINISTRATION (FDA) AGENTS—NARCOTIC ANALGESICS—FENTANYL CITRATE TRANSMUCOSAL SOLUBLE FILM (ONSOLIS)

BAP Comments

A. Fentanyl Citrate Transmucosal Soluble Film (Onsolis)— Uniform Formulary 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 (12 for, 2 opposed, 1 abstained, 0 absent) fentanyl citrate transmucosal soluble film (Onsolis) be designated as formulary on the UF.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

B. Fentanyl Citrate Transmucosal Soluble Film (Onsolis)— Uniform Formulary Implementation Plan: Not Applicable

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

VIII. RECENTLY APPROVED U.S. FOOD AND DRUG ADMINISTRATION (FDA) AGENTS—TRIPTANS—SUMATRIPTAN NEEDLE-FREE INJECTION (SUMAVEL DOSEPRO)

P&T Comments

A. Triptans—Sumatriptan Needle-free Injection (Sumavel DosePro)—Relative Clinical Effectiveness

Relative Clinical Effectiveness—Sumatriptan needle-free injection (Sumavel DosePro) is a new single-use delivery system for administering sumatriptan subcutaneously. Sumatriptan (Imitrex) is available in oral tablets, a nasal spray, and a traditional needle-containing injection device; all are available in generic formulations. The triptans drug class was last reviewed for UF placement in June 2008. Sumatriptan oral tablets and injection (Imitrex STATdose; generics) are currently included on the BCF.

Sumavel DosePro is FDA-approved for treating migraines and cluster headaches. The sumatriptan dose is delivered by a high pressure burst of nitrogen gas, which propels the drug through the subcutaneous space. Pharmacokinetic studies comparing Sumavel DosePro with Imitrex STATdose demonstrated bioequivalence between the two products. Sumavel DosePro obtained FDA approval via section 505(b)(2) of the Federal Food, Drug, and Cosmetic (FDC) Act using data submitted from the original Imitrex STATdose submission. Thus, there are no clinical trials with Sumavel DosePro that measure efficacy for providing pain relief from migraine headaches. Following administration, initially there is a higher incidence of bleeding, swelling, and bruising with Sumavel DosePro than with Imitrex STATdose; these adverse effects dissipate, and show no difference in severity with Imitrex STATdose 8 hours after administration. Potential benefits of Sumavel DosePro compared to sumatriptan needle-containing injection include that the device is easy to use, it provides an alternative injection option to patients with severe needle phobia, and it does not require special biohazard disposal (e.g., disposal in household refuse).

The clinical evaluation for Sumavel DosePro included, but was not limited to, the requirements stated in 32 CFR 199.21(e)(1).

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (14 for, 0 opposed, 0 abstained, 1 absent) that although sumatriptan needle-free injection (Sumavel DosePro) is easy to use, particularly for patients with dexterity issues, and can be disposed of without special precautions, it does not have a significant, clinically relevant therapeutic advantage in terms of effectiveness,

safety, and clinical outcomes compared to the existing UF product, sumatriptan needle-containing injection.

B. Triptans—Sumatriptan Needle-free Injection (Sumavel DosePro)—Relative Cost-Effectiveness

The P&T Committee, based upon its collective professional judgment, voted (15 for, 0 opposed, 0 abstained, 0 absent) that sumatriptan needle-free injection (Sumavel DosePro) is more costly compared to current UF agents except the Imitrex STATdose proprietary formulation.

C. Triptans—Sumatriptan Needle-free Injection (Sumavel DosePro)—Uniform Formulary Recommendation

Taking into consideration the conclusions from the relative clinical effectiveness, 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) sumatriptan needle-free injection (Sumavel DosePro) be designated NF on the UF.

D. Triptans—Sumatriptan Needle-free Injection (Sumavel DosePro)—Uniform Formulary Implementation Plan

Taking into consideration the conclusions from the relative clinical effectiveness, 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) sumatriptan needle-free injection (Sumavel DosePro) be designated NF on the UF.

IX. RECENTLY APPROVED U.S. FOOD AND DRUG ADMINISTRATION (FDA) AGENTS—TRIPTANS—SUMATRIPTAN NEEDLE-FREE INJECTION (SUMAVEL DOSEPRO)

BAP Comments

A. Triptans—Sumatriptan Needle-Free Injection (Sumavel DosePro)— Uniform Formulary Recommendation

Taking into consideration the conclusions from the relative clinical effectiveness, 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) sumatriptan needle-free injection (Sumavel DosePro) be designated NF on the UF.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

B. Triptans—Sumatriptan Needle-Free Injection (Sumavel DosePro)—Uniform Formulary Implementation Plan

Taking into consideration the conclusions from the relative clinical effectiveness, 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) sumatriptan needle-free injection (Sumavel DosePro) be designated NF on the UF.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

X. UTILIZATION MANAGEMENT—QUININE SULFATE PRIOR AUTHORIZATION

P&T Comments

A. Quinine Sulfate Prior Authorization – Background

Quinine sulfate has been used off-label for years to treat nocturnal leg cramps. The only quinine product approved by the FDA (marketed under the trade name Qualaquin) is only approved for treating malaria; however, the FDA recognizes that the majority of its use is for leg cramps.

In the MHS, between April 1, 2009, and March 31, 2010, over 10,300 patients were prescribed quinine, with over 70% of the prescriptions dispensed from the retail network. The majority of patients receiving quinine sulfate prescriptions are older than 45 years. The current MHS usage is 80% lower than that reported in a

DoD P&T Committee analysis from 2004. Results from an analysis of MHS quinine prescriptions during fiscal year 2009 found that out of 11,341 patients, 24% had one or more ICD-9 codes associated with leg cramps and 0.1% had ICD-9 codes associated with malaria; 76% of patients did not have ICD-9 codes for either malaria or leg cramps.

Meta-analyses and professional guidelines conclude that quinine is likely effective in reducing the frequency of muscle cramps, but the magnitude of benefit is small. No drug is currently FDA-approved for leg cramps, and there are no clearly effective pharmacological or nonpharmacological alternatives. A 2006 post-marketing FDA surveillance study reported that since 1969 there have been 665 reports of adverse events involving quinine sulfate, including 93 deaths. Serious adverse events reported with quinine sulfate include thrombocytopenia, hemolytic-uremic syndrome/thrombotic thrombocytopenic purpura (HUS-TTP), chronic renal impairment associated with HUS-TTP, hypersensitivity reactions, and QT prolongation. The product labeling for Qualaquin was updated in 2009 to state that the risk associated with quinine sulfate when used for nocturnal leg cramps outweighs any potential benefit

B. Quinine Sulfate Prior Authorization – Recommendation

Due to continued safety concerns and FDA advisories recommending against use of quinine sulfate for leg cramps, the P&T Committee recommended (13 for, 1 opposed, 1 abstained, 0 absent) a PA be required for quinine sulfate (Qualaquin) that limits use to the FDA-approved indication of malaria. The PA would apply to both existing and new users of quinine sulfate.

C. Quinine Sulfate Prior Authorization –Implementation Plan

The P&T Committee voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend the quinine sulfate PA should have an effective date of the first Wednesday 1 week after the minutes are signed, following a 60-day implementation period in the retail network and mail order, and at the MTFs, no later than a 60-day implementation date. The implementation period will begin immediately following the approval by the Director, TMA.

XI. UTILIZATION MANAGEMENT—QUININE SULFATE PRIOR AUTHORIZATION

BAP Comments

A. Quinine Sulfate Prior Authorization – Recommendation

Due to continued safety concerns and FDA advisories recommending against use of quinine sulfate for leg cramps, the P&T Committee recommended (13 for, 1 opposed, 1 abstained, 0 absent) a PA be required for quinine sulfate (Qualaquin) that limits use to the FDA-approved indication of malaria. The PA would apply to both existing and new users of quinine sulfate.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

B. Quinine Sulfate Prior Authorization –Implementation Plan

The P&T Committee voted (14 for, 0 opposed, 1 abstained, 0 absent) to recommend the quinine sulfate PA should have an effective date of the first Wednesday 1 week after the minutes are signed, following a 60-day implementation period in the retail network and mail order, and at the MTFs, no later than a 60-day implementation date. The implementation period will begin immediately following the approval by the Director, TMA.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

XII NATIONAL DEFENSE AUTHORIZATION ACT, SECTION 703— INCLUSION OF TRICARE RETAIL PHARMACY PROGRAM IN FEDERAL PROCUREMENT OF PHARMACEUTICALS UPDATE

P&T Comments

The P&T Committee reviewed drugs that have been established on a DoD Retail Refund Pricing Agreement; these drugs are now compliant with Fiscal Year 2008

National Defense Authorization Act, Section 703. By law, these drugs were designated NF on the UF and subject to pre-authorization prior to use in the retail point of service (POS) and medical necessity in MTFs. These drugs are now eligible to return to their previous formulary status without a pre-authorization requirement. Drugs with pricing agreements were systematically classified according to therapeutic and pharmacologic lines. The classification system was based on the American Hospital Formulary System Classification and First Data Bank classification.

The DoD P&T Committee recommended the following:

A. The P&T Committee recommended by consensus the drugs listed in Table 1, below, return to formulary status on the UF.

Table 1.

Product Name	Subclass	Manufacturer
DEPAKENE	Anticonvulsants	ABBOTT LABS
OMNICEF	3rd gen cephalosporins	ABBOTT LABS
PCE	Macrolide	ABBOTT LABS
DIPENTUM	Medications for inflammatory bowel disease	ALAVEN PHARMA
KADIAN	Higher potency single analgesic agents	ALPHARMA BPD
ALLEGRA	2nd gen antihistamines & combos	AVENTIS PHARM
CYTOXAN	Alkylating agents	BMS ONCO/IMMUN
CATAPRES	Sympatholytics	BOEHRINGER ING.
EVOXAC	Parasympathetic agents	DAIICHI SANKYO
FLOXIN	Otic medications, anti-infective	DAIICHI SANKYO
BANZEL	Anticonvulsants/antimania medications	EISAI INC.
FRAGMIN	Anticoagulants	EISAI INC.
SALAGEN	Parasympathetic agents	EISAI INC.
ZONEGRAN	Anticonvulsants	EISAI INC.
CETROTIDE	LHRH (GNRH) antagonist, pituitary suppressant agent	EMD SERONO, INC
LUVERIS	Luteinizing hormones	EMD SERONO, INC
SEROSTIM	Growth hormone	EMD SERONO, INC
ZORBTIVE	Growth hormone	EMD SERONO, INC
BRAVELLE	FSH/LH fertility agents	FERRING PH INC
ENDOMETRIN	Pregnancy facilitating/maintaining agent	FERRING PH INC
REPRONEX	FSH/LH fertility agents	FERRING PH INC
LAMICTAL ODT	Anticonvulsants/antimania medications	GLAXOSMITHKLINE
LAMICTAL ODT (BLUE)	Anticonvulsants/antimania medications	GLAXOSMITHKLINE
LAMICTAL ODT (GREEN)	Anticonvulsants/antimania medications	GLAXOSMITHKLINE
LAMICTAL ODT (ORANGE)	Anticonvulsants/antimania medications	GLAXOSMITHKLINE
LAMICTAL XR	Anticonvulsants/antimania medications	GLAXOSMITHKLINE
DERMA-SMOOTHE-FS	Topical corticosteroids	HILL DERM
PERANEX HC	Topical corticosteroids/immune modulators	KENWOOD LAB
FLEXERIL	Skeletal muscle relaxants	McNEIL CONS
UROCIT-K	Urinary agent	MISSION
LITHOSTAT	Ammonia inhibitors	MISSION PHARM
TINDAMAX	Antiprotozoal	MISSION PHARM
LINDANE	Misc topical anti-infectives	MORTON GROVE PH

ERGOLOID MESYLATES	Misc cardiovascular medications	MUTUAL PHARM CO
KERAFOAM	Keratolytics	ONSET THERAPEUT
OPTASE	Misc topical agents	ONSET THERAPEUT
SALKERA	Keratolytics	ONSET THERAPEUT
PROCRIT	RBC stimulants	ORTHO BIOTECH
METANX	Vitamin B preparations	PAN AMERICAN
DILANTIN	Anticonvulsants/antimania medications	PFIZER US PHARM
OGEN	Estrogens & estrogen/androgen combos	PHARMACIA/UPJOHN
TENEX	Sympatholytics	PROMIUS PHARMA
MS CONTIN	Higher potency single analgesic agents	PURDUE PHARMA L
DORAL	Sedative/hypnotics II	QUESTCOR
RIOMET	Biguanides	RANBAXY BRAND D
ANAPROX	NSAIDs	ROCHE LABS
ANAPROX DS	NSAIDs	ROCHE LABS

Table 1 continued

Product Name	Subclass	Manufacturer
KLONOPIN	Anticonvulsants	ROCHE LABS
KYTRIL	5HT3 antiemetics	ROCHE LABS
VALIUM	Anxiolytics	ROCHE LABS
VESANOID	Misc antineoplastics	ROCHE LABS
VIMPAT	Anticonvulsants/antimania medications	SCHWARZ PHARMA
AGRYLIN	Platelet reducing agents	SHIRE US INC.
CARBATROL	Anticonvulsants	SHIRE US INC.
FOSRENOL	Phosphate binders	SHIRE US INC.
LIALDA	Medications for inflammatory bowel disease	SHIRE US INC.
PENTASA	Medications for inflammatory bowel disease	SHIRE US INC.
PROAMATINE	Adrenergic vasopressors	SHIRE US INC.
NEOBENZ MICRO	Keratolytics	SKINMEDICA
ELDEPRYL	Parkinson's medications	SOMERSET PHARM
LOCOID	Topical corticosteroids	TRIAX PHARMACEU
MINOCIN	tetracyclines	TRIAX PHARMACEU
SULFAMYLON	Topical sulfonamides	UDL
ANDROID	Androgens/anabolic steroids	VALEANT
OXSORALEN	Hyperpigmentation agents	VALEANT
TESTRED	Androgens/anabolic steroids	VALEANT
QUIXIN	Ophthalmic antibiotics, quinolones	VISTAKON PHARMA
MUSE	Prostaglandins for ED	VIVUS
FIORICET	Analgesic combos	WATSON PHARMA
MYAMBUTOL	Antitubercular medications	X-GEN PHARMACEU

B. The P&T Committee recommended by consensus the drugs listed, below, maintain NF status but not be subject to preauthorization:

Daytrana, Kapidex, Saizen, Azor, Welchol, Cardene SR, and Vyvanse

XIII. NATIONAL DEFENSE AUTHORIZATION ACT, SECTION 703— INCLUSION OF TRICARE RETAIL PHARMACY PROGRAM IN FEDERAL PROCUREMENT OF PHARMACEUTICALS UPDATE

BAP Comments

A. The P&T Committee recommended by consensus the drugs listed in Table 1, above, return to formulary status on the UF.

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

B. The P&T Committee recommended by consensus the drugs listed, below, maintain NF status but not be subject to preauthorization:

Daytrana, Kapidex, Saizen, Azor, Welchol, Cardene SR, and Vyvanse

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions:

C. The P&T Committee recommended by consensus the following Factor VIII and Factor IX drugs be returned to formulary status on the UF upon execution of the DoD Retail Refund Pricing Agreement:

Human Factor VIII: Humate-P, Monoclate-P

Recombinant Factor VIII: Helixate FS

Human Factor IX: MonoNine

BAP Comment: □ Concur □ Non-concur

Additional Comments and Dissentions: