TMA DoD Pharmacoeconomic Center
Fort Sam Houston, TX

MTF Quarterly Webcast
December 13, 2012
Introduction

- Greetings from the PEC
- Purpose of the Quarterly MTF Webcast
- DCO Ground Rules
  - Type questions into the DCO system
  - Put on mute, not on hold
  - Contingency plan if DCO system stops working
Outline

- MTF Corner – Update on the DOD PEC Formulary Search Tool
- Review of August 2012 P&T Committee Meeting
- Overview of November 2012 P&T Committee Meeting
- Overview of February 2013 P&T Committee Meeting
- Utilization Management
  - New generics, shortages, BCF clarification
- Questions
MTF Corner

Update on the DOD PEC Formulary Search Tool

Jeremy Briggs, PharmD
Clinical Pharmacist
Review of August 2012
P&T Committee Meeting

Dave Meade PharmD, BCPS
Clinical Pharmacist
Uniform Formulary Class Reviews
- Testosterone Replacement Therapies (transdermal and buccal formulations)
- Low Molecular Weight Heparins

New Drugs in Previously Reviewed Classes
- Abatacept SC (Orencia)
- Famotidine/ibuprofen (Duexis)
- Ketorolac nasal spray (Sprix)
- Linagliptin/metformin (Jentadueto)
- Sitagliptin/metformin ER (Janumet XR)
- Tafluprost ophthalmic solution (Zioptan)
Uniform Formulary Class Reviews
Testosterone Replacement Therapies (transdermal and buccal formulations)
# Drugs in the Class

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Brand (Manufacturer)</th>
<th>Strengths &amp; Formulation</th>
<th>FDA Approval Date</th>
<th>Patent Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testosterone</td>
<td>Androderm (Watson Labs)</td>
<td>2 mg/24 hr, 4 mg/24 hr patches</td>
<td>Sep 1995</td>
<td>Oct 2014</td>
</tr>
<tr>
<td></td>
<td>Striant (Actient Pharma)</td>
<td>30 mg buccal tablets</td>
<td>June 2003</td>
<td>Aug 2019</td>
</tr>
<tr>
<td></td>
<td>Androgel 1% (Abbott Labs)</td>
<td>25 mg/2.5 g, 50 mg/5 g gel packets, 12.5 mg /ACT gel pump</td>
<td>Feb 2000</td>
<td>Aug 2020 – Mar 2021</td>
</tr>
<tr>
<td></td>
<td>*Androgel 1.62% (Abbott Labs)</td>
<td>20.25 mg/ACT gel pump</td>
<td>April 2011</td>
<td>Aug 2020</td>
</tr>
<tr>
<td></td>
<td>Axiron (Eli Lilly)</td>
<td>30 mg/ACT lotion pump</td>
<td>Nov 2010</td>
<td>April 2017</td>
</tr>
<tr>
<td></td>
<td>Fortesta (Endo Pharma)</td>
<td>10 mg/ACT (2%) gel pump</td>
<td>Dec 2010</td>
<td>Nov 2018</td>
</tr>
<tr>
<td></td>
<td>Testim (Auxilium Pharma)</td>
<td>50 mg/5 gm gel packets</td>
<td>Oct 2002</td>
<td>April 2023</td>
</tr>
</tbody>
</table>

Oral and injectable products are not in the class

*Androgel 1.62% packets coming soon
Overall Clinical Effectiveness Conclusion

- No clinically relevant differences in efficacy among these products.
- Products for transdermal and buccal testosterone replacement effectively raise testosterone levels in hypogonadal men to the normal range when used in accordance with product labeling.
- Risk of transference to children and women with transdermal testosterone should be minimized;
  - Buccal tablets carry the lowest risk;
  - Topical products carry the highest risk.
Systemic Adverse Events (AE) are not considered to differ clinically across products

Most frequent local AE:
- transdermal application site reactions most frequent with patches, lower with gels;
- oral application site reactions for buccal tablets; most are mild or transient

Available evidence suggests no detrimental effect of TRT on prostate cancer or CV risk for most patients

TRT has not been adequately studied in patients with stable sleep apnea, and should be avoided in patients with untreated or sub-optimally managed sleep apnea

Physiologic doses of testosterone have not been associated with increased aggression

TRT: Testosterone Replacement Therapies
## Testosterone Replacement Therapies
### Final Decision

<table>
<thead>
<tr>
<th>BCF</th>
<th>UF</th>
<th>NF</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Testosterone TD 2% gel pump; 10 mg/actuation (Fortesta)</td>
<td>Testosterone 50 mg/5 gm TD gel tubes (Testim)</td>
<td>Testosterone TD solution pump; 30 mg/actuation; (Axiron)</td>
<td>All current and new users of topical and buccal testosterone replacement products must go through the PA process to ensure diagnosis of hypogonadism. Fortesta 2% gel pump is the preferred product; all users of topical and buccal testosterone replacement products must have trial of Fortesta 2% gel prior to other products.</td>
</tr>
<tr>
<td>Testosterone 2 mg/24 hr, 4 mg/24 hr TD patches (Androderm)</td>
<td>Testosterone 2 mg/24 hr, 4 mg/24 hr TD patches (Androderm)</td>
<td>Testosterone 1%; 25 mg/2.5 gm, 50 mg/5 gm TD gel packets, and 12.5 mg/actuation gel pump (Androgel 1%)</td>
<td></td>
</tr>
<tr>
<td>Testosterone 30 mg buccal tablets (Striant)</td>
<td>Testosterone 30 mg buccal tablets (Striant)</td>
<td>Testosterone 1.62% TD gel pump; 20.25 mg/actuation (Androgel 1.62%)</td>
<td></td>
</tr>
</tbody>
</table>

**TD:** transdermal
Manual PA criteria should apply to all current and new users of the testosterone replacement therapies.

Coverage would be approved if the patient met any of the following criteria:

- Manual PA criteria for all transdermal and buccal testosterone replacement products:
- Patient is male and has a diagnosis of hypogonadism evidenced by 2 or more morning testosterone levels in the presence of symptoms usually associated with hypogonadism
- Patient is a female and receiving testosterone for the following uses:
  - Treatment of hypoactive sexual desire in menopausal women (whether natural or surgical); or
  - Treatment of menopausal symptoms in women also receiving FDA-approved estrogen products (with or without concomitant progesterone)
- Note that use in adolescents under the age of 17 is not approved and will be by appeal only
TRT – PA CRITERIA

- PA criteria would also apply specifically to transdermal gel tubes (Testim), transdermal patch (Androderm), buccal tablets (Striant), transdermal 1% gel pump and gel packets (Androgel 1%), transdermal 1.62% gel pump (Androgel 1.62%), and transdermal solution (Axiron):
  - Patient requires a testosterone replacement therapy that has a low risk of skin–to–skin transfer between family members (for Striant and Androderm only).
  - Patient has tried transdermal 2% gel pump (Fortesta) for a minimum of 90 days AND failed to achieve total testosterone levels above 400ng/dL (lab must be drawn 2 hours after Fortesta application) AND denied improvement in symptoms.
  - Patient has a contraindication or relative contraindication to Fortesta (e.g., hypersensitivity to a component [including alcohol]; concomitant disulfiram use) that does not apply to Testim, Androderm, Striant, Androgel 1%, Androgel 1.62%, or Axiron.
  - Patient has experienced a clinically significant skin reaction to Fortesta that is not expected to occur with Testim, Androderm, Striant, Androgel 1%, Androgel 1.62%, or Axiron.
Low Molecular Weight Heparins
# Drugs in the Class

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand</th>
<th>Formulations</th>
<th>FDA Approval</th>
<th>Patent Expiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfractionated Heparin (UFH)</td>
<td>various</td>
<td>various</td>
<td></td>
<td>Generics</td>
</tr>
<tr>
<td>Ardeparin</td>
<td>Normiflow</td>
<td>Vial</td>
<td>1997</td>
<td>D/C’d 2002</td>
</tr>
<tr>
<td>Dalteparin</td>
<td>Fragmin</td>
<td>Syringe + vial</td>
<td>1994</td>
<td>Expired</td>
</tr>
<tr>
<td>Enoxaparin</td>
<td>Lovenox</td>
<td>Syringe + vial (brand)</td>
<td>1993</td>
<td>Generics 2010</td>
</tr>
<tr>
<td>Fondaparinux*</td>
<td>Arixtra</td>
<td>Syringe</td>
<td>2001</td>
<td>Generics 2011</td>
</tr>
<tr>
<td>Tinzaparin</td>
<td>Innohep</td>
<td>Vial</td>
<td>2000</td>
<td>D/C’d 2011</td>
</tr>
</tbody>
</table>

* Pentasaccharide
Overall Clinical Effectiveness Conclusion

- Generic formulations of enoxaparin and fondaparinux are equivalent to Lovenox and Arixtra.
- Fondaparinux has a lower risk of HIT than enoxaparin or dalteparin. Generics are now available.
- Dalteparin is not approved for DVT/PE treatment in the US, which limits the clinical utility.
- All 3 products have similar black box warning for epidural anesthesia; bleeding risks.
- Enoxaparin and fondaparinux require dosage adjustment in renal failure.
- Enoxaparin has the widest clinical utility, due to long history of use, largest number of FDA–approved indications, availability in several dosage strengths, and large number of clinical trials overall and in special populations (pregnancy, pediatrics).

HIT = Heparin-induced thrombocytopenia
# Low Molecular Weight Heparins
## Final Decisions

<table>
<thead>
<tr>
<th>BCF</th>
<th>UF</th>
<th>NF</th>
<th>Comments</th>
</tr>
</thead>
</table>
| Enoxaparin (generic) | • Dalteparin (Fragmin)  
                      |             | None                                  | enoxaparin generic designated BCF |
|                      | • Fondaparinux (generic)               | None        |                                       |
New Drugs in Previously Reviewed Classes
Abatacept SC (Orencia)
Type of Drug:
- Fusion protein; Selective T cell co-stimulation modulator
- IV formulation (medical benefit) – available since 2005
  - FDA approved for moderate to severe RA as monotherapy or in conjunction with non-biologic DMARDs
  - Approved for JIA
- Subcutaneous injection (pharmacy benefit) – approved August 2011
  - FDA approved for moderate to severe RA in adults only as monotherapy or in conjunction with non-biologic DMARDs

JIA: Juvenile Idiopathic Arthritis
# Drugs in the Class

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>MoA</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adalimumab</td>
<td>Humira</td>
<td>TNF</td>
<td>SQ (qow-qw)</td>
</tr>
<tr>
<td>Alefacept</td>
<td>Amevive</td>
<td>CL2</td>
<td>IM (qweek)</td>
</tr>
<tr>
<td>Anakinra</td>
<td>Kineret</td>
<td>IL1</td>
<td>SQ (qday)</td>
</tr>
<tr>
<td>Certolizumab</td>
<td>Cimzia</td>
<td>TNF</td>
<td>SQ (qow-qmonth)</td>
</tr>
<tr>
<td>Etanercept</td>
<td>Enbrel</td>
<td>TNF</td>
<td>SQ (qweek)</td>
</tr>
<tr>
<td>Golimumumab</td>
<td>Simponi</td>
<td>TNF</td>
<td>SQ (q month)</td>
</tr>
<tr>
<td>Abatacept</td>
<td>Orencia</td>
<td>Tmod</td>
<td>SQ (q week)</td>
</tr>
</tbody>
</table>

### Excluded from the Pharmacy Benefit

<table>
<thead>
<tr>
<th>Generic</th>
<th>Brand</th>
<th>MoA</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abatacept</td>
<td>Orencia</td>
<td>Tmod</td>
<td>IV</td>
</tr>
<tr>
<td>Infliximab</td>
<td>Remicade</td>
<td>TNF</td>
<td>IV</td>
</tr>
<tr>
<td>Tocilizumab</td>
<td>Actemra</td>
<td>TNF</td>
<td>IV</td>
</tr>
<tr>
<td>Ustekinumab</td>
<td>Stelara</td>
<td>TNF</td>
<td>SQ (q 6 months)</td>
</tr>
</tbody>
</table>
FDA approval of SC Ocrenica was based on its demonstrated non-inferiority to IV Ocrenica with respect to ACR 20 responses following 6 months of therapy.

In an indirect comparison with Humira, SC Ocrenica demonstrated non-inferiority in proportion of patients achieving ACR 20 responses following 12 months of therapy.

An indirect comparison of ACR 50 response across major RCTs suggests similar response rates for SC Ocrenica as the anti-TNF agents.

ACR= American College of Rheumatology
In general, abatacept’s safety profile is similar to that of the anti–TNF biologics. When compared to adalimumab, less injection site reactions were observed.

Although SC abatacept provides a non–TNF biologic option for the treatment of RA and offers patient convenience over the abatacept IV formulation, there is currently insufficient data to conclude that abatacept offers improved efficacy, safety, or tolerability compared to the anti–TNF agents in the TIB class.
Famotidine/ibuprofen (Duexis) & Ketorolac nasal spray (Sprix)
# Drugs in the Class

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Duexis</th>
<th>Sprix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Drug</strong></td>
<td>• Fixed–combination of ibuprofen (NSAIDs) and famotidine (H2RA)</td>
<td>• Intranasal formulation of ketorolac</td>
</tr>
<tr>
<td><strong>FDA Indications</strong></td>
<td>• Relief of s/sxs of RA and OA • Decrease risk of UGI ulcers</td>
<td>• Short–term (≤5 days) management of moderate to moderately severe acute pain</td>
</tr>
<tr>
<td><strong>Strengths</strong></td>
<td>• 800mg/26.6mg Ibuprofen/famotidine tablets</td>
<td>• 15.75 mg/ nasal spray</td>
</tr>
<tr>
<td><strong>Dosing</strong></td>
<td>• One tablet three times per day • Famotidine total dose: 80 mg</td>
<td>• Adult patients &lt; 65 years: 31.5 mg (one 15.75 mg spray in each nostril) every 6 – 8 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ≥ 65 years, renally impaired patients, and patients &lt; 50 kg (110 lbs): 15.75 mg (one spray in only one nostril) every 6 – 8 hours</td>
</tr>
</tbody>
</table>

NSAIDs: Nonsteroidal anti-inflammatory drug, H2RA: H2-receptor antagonist, RA: rheumatoid arthritis and OA: osteoarthritis
Overall Clinical Effectiveness Conclusion – Duexis

- Duexis is the first fixed-dose combination of a non-selective NSAID with an H2 antagonist
  - Other gastroprotective agents on the UF include Vimovo, Arthrotec, and Celebrex
- In 2 phase III trials enrolling low risk patients, Duexis resulted in significantly reduced incidence of NSAIDs associated ulcer
- No studies evaluating clinically important UGI events (eg., bleeding, perforation, or obstruction)
- Compared to H2RA, coprescribing of PPIs with NSAIDs was associated with a lower risk of DU and GU (AHRQ 2011)
- Compared to misoprostol, coprescribing of PPIs with NSAIDs was associated with lower risk of DU and a similar risk of GU (AHRQ 2011)
- COX-2 inhibitor + PPI offers the greatest GI safety in high risk patients (Cochrane 2010)
- Ibuprofen 200 mg and famotidine 10 mg, 20mg are available OTC
In REDUCE–1 and REDUCE–2 trials, the incidence of dyspepsia was slightly higher with ibuprofen than with Duexis.

In the follow–on safety study, greater number of patients in the Duexis group experience dyspepsia compared to ibuprofen group.
- Famotidine appeared to decrease the incidence of dyspepsia but this effect did not appear to persist into the safety follow–on population.

Although the fixed–dose combination of famotidine and ibuprofen offers the convenience of a gastroprotective agent with the NSAID, TID dosing may impact compliance.

Additionally, other fixed–dose combination drugs (NSAID with PPI [Vimovo] or NSAID with misoprostol [Arthrotec]) are preferred in systematic reviews or national professional guidelines for reducing GI ulcers.

Duexis offer no distinct clinical advantages to combination NSAIDs/gastroprotective agents already on the UF.
Overall Clinical Effectiveness Conclusion – Sprix

- Ketorolac nasal spray is the first intranasal NSAID
- Allows for alternate route of administration for patients who require pain control after surgery and may be unable to tolerate oral medication
- SPID score was significantly higher in the ketorolac group compared with placebo but uncertain clinical relevance
- In 3 placebo comparison studies, morphine use was significantly lower in the ketorolac group for the first 48 hours
  - Debatable whether ketorolac nasal spray is the preferred option. Other opioid-sparing drugs on the UF include other NSAIDs and tramadol

SPID = summed pain intensity difference
Overall Clinical Effectiveness Conclusion – Sprix

- Associated with high incidence of local symptoms such as nasal discomfort or irritation
- Similar to other ketorolac formulations, total duration of Sprix use should not exceed 5 days
- Well known warnings not seen with other NSAIDs, included bleeding and renal dysfunction.
- Sprix offers no distinct clinical advantages to oral NSAIDs already on the BCF and UF
Linagliptin/metformin (Jentaduetto) & Sitagliptin/metformin ER (Janumet XR)
<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>Brand (Manufacturer)</th>
<th>Strengths</th>
<th>FDA Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitagliptin</td>
<td>Januvia (Merck)</td>
<td>25mg, 50mg, 100mg</td>
<td>10/16/2006</td>
</tr>
<tr>
<td>Sitagliptin/Metformin</td>
<td>Janumet (Merck)</td>
<td>50mg/500mg, 50mg/1000mg</td>
<td>03/30/2007</td>
</tr>
<tr>
<td>Sitagliptin/Metformin ER</td>
<td>Janumet XR (Merck)</td>
<td>50mg/500mg, 50mg/1000mg, 100mg/1000mg</td>
<td>02/02/2012</td>
</tr>
<tr>
<td>Sitagliptin/Simvastatin</td>
<td>Juvisync (Merck)</td>
<td>100mg/10mg, 100mg/20mg, 100mg/40mg</td>
<td>10/07/2011</td>
</tr>
<tr>
<td>Saxagliptin</td>
<td>Onglyza (BMS)</td>
<td>2.5mg, 5mg</td>
<td>07/31/2009</td>
</tr>
<tr>
<td>Saxagliptin/Metformin ER</td>
<td>Kombiglyze XR (BMS)</td>
<td>2.5mg/1000mg, 5mg/500mg, 5mg/1000mg</td>
<td>11/05/2010</td>
</tr>
<tr>
<td>Linagliptin</td>
<td>Tradjenta (Boehringer Ingelheim)</td>
<td>5mg</td>
<td>05/02/2011</td>
</tr>
<tr>
<td>Linagliptin/Metformin</td>
<td>Jentadueto (Boehringer Ingelheim)</td>
<td>2.5/500mg, 2.5mg/850mg, 2.5mg/1000mg</td>
<td>01/30/2012</td>
</tr>
</tbody>
</table>
# Jentadueto & Janumet XR

## Background

<table>
<thead>
<tr>
<th></th>
<th>Linagliptin/Metformin (Jentadueto)</th>
<th>Sitagliptin/Metformin XR (Janumet XR)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Drug</strong></td>
<td>DPP-4 Inhibitor and metformin immediate-release</td>
<td>DPP-4 Inhibitor and metformin extended-release</td>
</tr>
<tr>
<td><strong>FDA Approval Type</strong></td>
<td>505(b)(2)</td>
<td>505(b)(2)</td>
</tr>
<tr>
<td><strong>FDA Approval Date</strong></td>
<td>01/30/2012</td>
<td>02/02/2012</td>
</tr>
<tr>
<td><strong>Patent Expiration</strong></td>
<td>01/30/2015</td>
<td>2016-2026</td>
</tr>
<tr>
<td><strong>FDA Approved Indications</strong></td>
<td>Management of type 2 diabetes mellitus as an adjunct to diet and exercise in patients not adequately controlled on monotherapy</td>
<td>None</td>
</tr>
<tr>
<td><strong>Off-Label Uses</strong></td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Janumet XR and Jentadueto are indicated as adjunct to diet and exercise to improve glycemic control in patients with T2DM.

Janumet XR is dosed as either one or two tablets once daily, and Jentadueto is given as one tablet BID.

Janumet XR provides a once-daily combination option.

Both agents have similar A1c-lowering effects.

Janumet XR and Jentadueto, like all DPP-4 inhibitors, are considered lipid neutral.

When added to metformin, sitagliptin and linaglaptin have shown a decrease in weight ranging from 0.4–1.4kg.
Although safety and tolerability have not been studied with Janumet XR or Jentadueto, they are generally well-tolerated.

Common side effects are expected to be upper respiratory and GI-related.

Due to metformin and the risk of lactic acidosis, both Janumet XR and Jentadueto require renal dose adjustments, and should be avoided in hepatic insufficiency.

Although no outcomes studies have been performed with Janumet XR or Jentadueto, the TECOS and CAROLINA trials will address long-term outcomes.
Tafluprost (Zioptan)
Tafluprost ophthalmic solution

- **Background**
  - 0.0015% solution
  - Supplied in 30 and 90 count single-use ampules

- **Indication**
  - Reduces elevated intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OH)

- **Potential Off Label Uses**
  - Treatment for hypotrichosis (short eyelashes)
## Drugs in the Class

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade name</th>
<th>Manufacturer</th>
<th>Generic available</th>
<th>Strength, package size</th>
<th>FDA Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bimatoprost</td>
<td>Lumigan</td>
<td>Allergan</td>
<td>No</td>
<td>0.01%, 0.03% 2.5, 5, 7.5 ml</td>
<td>Mar 2001</td>
</tr>
<tr>
<td>Travoprost</td>
<td>Travatan Z</td>
<td>Alcon</td>
<td>No</td>
<td>0.004% 2.5 and 5 ml</td>
<td>Sept 2006</td>
</tr>
<tr>
<td>Latanoprost</td>
<td>Xalatan</td>
<td>Pfizer</td>
<td>Yes</td>
<td>0.005% 2.5 ml</td>
<td>June 1996</td>
</tr>
<tr>
<td>Tafluprost</td>
<td>Zioptan</td>
<td>Merck</td>
<td>No</td>
<td>0.0015% 30, 90 unit dose</td>
<td>Feb 2012</td>
</tr>
</tbody>
</table>
Tafluprost ophthalmic solution 0.0015% is effective in reducing IOP; reduces IOP between 6–8 mmHg as do the other prostaglandins.

In one head–to–head trial, IOP–lowering with tafluprost was less than that of latanoprost.

The association of preservative–free tafluprost with decreased AEs remains to be determined.

Theoretically, a preservative–free formulation may enhance compliance, but no studies are available with tafluprost.

IOP = intraocular pressure
# New Drugs in a Previously Reviewed Class Final Decisions

<table>
<thead>
<tr>
<th>BCF</th>
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<th>Comments</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Abatacept SQ (Orencia)</td>
<td>PA limiting use to FDA-approved indications was approved in Nov 2011</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ibuprofen/famotidine (Duexis) Ketorolac nasal spray (Sprix)</td>
<td>QLs approved in Nov 2011 Retail: 4 syringes/28 days Mail Order: 8 syringes/56 days</td>
</tr>
<tr>
<td>Sitagliptin/metformin ER (Janumet XR) Linagliptin/metformin IR (Jentadueto)</td>
<td></td>
<td>Quantity Limits for ketorolac nasal spray (Sprix): 5 bottles for 30-day supply in both the Retail Network and Mail Order Pharmacy Must try metformin and sulfonylurea 1st before any DPP-4 drug Must try sitagliptin containing product 1st before Tradjenta, Jentadueto, Onglyza, or Kombiglyze XR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tafluprost (Zioptan)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Overview of November 2012
P&T Committee Meeting
Uniform Formulary Class Reviews
- Gastrointestinal Antibiotics (GI-2s)
  - Rifaximin, metronidazole, vancomycin, Dificid, Alinia, neomycin
- Glucagon Like Peptide-1 Receptor Antagonists (GLP-1)
- Hepatitis C drugs
- Overactive Bladder (OAB) Drugs

New Drugs in Previously Reviewed Classes
- Oxycodone Immediate Release (Oxecta)

Utilization Management
- Ipratropium/albuterol (Combivent Respimat)
- Azelastine/fluticasone nasal spray (Dymista)
- Adalimumab (Humira)
- Enzalutamide (Xtandi); Abiraterone (Zytiga)
Overview of February 2013 P&T Committee Meeting
Uniform Formulary Class Reviews

- COPD
  - Inhalers
  - Oral
- Anticoagulants
  - Warfarin
  - Pradaxa
  - Xarelto
- Topical Pain (non-opioid)
  - Lidoderm
  - Topical diclofenac products
Utilization Management
Cost-effective generic formulations now available for
  • Plavix
  • Xalatan ophthalmic solution
  • LMWH (Lovenox and Arixtra)
  • Maximize purchasing of the generic formulations for these medications

Combivent respimat – not BCF
  • Will be reviewing COPD in Feb 2013

Smoking cessation
  • Unknown implementation date
  • May P&T meeting decisions still on hold
Tricor Update

Tricor will be available on 12/12/12; temporarily unavailable due to production delays

<table>
<thead>
<tr>
<th>Tricor 145 mg is equivalent to</th>
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<tbody>
<tr>
<td>Antara 130 mg</td>
</tr>
<tr>
<td>Fenoglide 120 mg</td>
</tr>
<tr>
<td>Fibricor 105 mg</td>
</tr>
<tr>
<td>Lipofen 150 mg</td>
</tr>
<tr>
<td>micronized Lofibra 200 mg</td>
</tr>
<tr>
<td>non micronized Lofibra 160 mg</td>
</tr>
<tr>
<td>Triglide 160 mg</td>
</tr>
<tr>
<td>Trilipix 135 mg</td>
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</tbody>
</table>
Guidance for Antiplatelet Drugs

- Clopidogrel remains BCF
  - For Acute Coronary Syndrome, stroke and TIA: clopidogrel is $1^{\text{st}}$-line

- Candidates for prasugrel (PCI only)
  - STEMI
  - DM
  - < 75 yo, > 60 kg, no history of stroke/TIA

- Candidates for ticagrelor
  - PCI and Medical Management
  - Need for CABG
Miscellaneous items

- New PEC website
  - Some technical issues
  - Email questions to PECUF@amedd.army.mil

- PECUF@amedd.army.mil
  - For other questions, formulary clarification, etc

- Next webcast will be held on the 14th of March, 2013 at 0900 and 1700 EST
Questions?
Webcast Evaluations

- Please assist us in improving the webcast presentations by completing an anonymous, 5–question survey
- Link: http://www.zoomerang.com/Survey/WEB22CTVSNWFRP
- Thank you!
PEC Contact Info

- 210–295–1271 (DSN 421–1271)
  - For PEC Clinical Staff
- 1–866–ASK 4 PEC (275–4732)
  - Pharmacy Operation Center
  - PECWEB@amedd.army.mil
    - Website issues
  - pdts.ameddcs@amedd.army.mil
    - Questions, assistance with PDTS, Business Objects
  - PECUF@amedd.army.mil
    - Clinical, formulary questions