

## **Minutes of Meeting**

### **Alabama Medicaid Agency Pharmacy and Therapeutics Committee**

**May 11, 2016**

**Members Present:** Ms. Janet Allen, Dr. Lee Carter (Vice-chair), Dr. Frances Cohenour (Chair), Dr. Elizabeth Dawson, Dr. David Harwood, Dr. Kelli Littlejohn Newman, Dr. Melinda Rowe, and Dr. Robert Smith

**Members Absent:** Dr. Elizabeth Jacobson and Dr. Pilar Murphy

**Health Home/Probationary RCO Pharmacists Present via Teleconference:** Lisa Channell, Angela Lowe, Lacy Miller, Lydia Rather, Holley Rice, Machel Stiles, Kristian Testerman, and Lauren Ward

**Presenters:** Dr. Rachel Bacon and Dr. Stephanie Tran

**Presenters Present via teleconference:** None

#### **1. OPENING REMARKS**

Chairperson Cohenour called the Pharmacy and Therapeutics (P&T) Committee Meeting to order at 9:05 a.m.

#### **2. APPROVAL OF MINUTES**

Chairperson Cohenour asked if there were any corrections to the minutes from the February 10, 2016 P&T Committee Meeting.

There were no objections. Dr. Carter made a motion to approve the minutes as presented and Ms. Allen seconded to approve the minutes. The minutes were unanimously approved.

#### **3. PHARMACY PROGRAM UPDATE**

Dr. Littlejohn Newman oriented the Committee members to the Provider Alerts that are available on the Agency's website and provided the following updates:

- Several recent ALERTs related to the Integrated Provider System (IPS) program, the funding pool mechanism for the RCOs; please refer to the website.
- A recent ALERT discussing updated policy for emergency services for pregnant females was released.
- Legislative/Budget: The legislature passed a budget that did not include adequate funding for the Alabama Medicaid Agency and the RCO implementation. There was a bill passed and signed into

law that gave the Agency flexibility to postpone the October 1, 2016, RCO implementation should the need arise. More information will be forthcoming in the next few weeks as decisions are made.

- The Agency is working very closely with the legislature on a series of Medicaid program presentations to the legislature. Medicaid is presenting to the legislature on a weekly basis, providing details on each major program. So far the Medicaid overview, eligibility, and hospital programs have been presented. The pharmacy, physician, and third party liability programs are scheduled to present next week.
- Of note, this is our first meeting to include the updated Administrative Code rule to allow Medicaid to include clinical criteria for preferred agents. We wanted to remind manufacturers that this updated allowance has been in effect, and listed on the most recent letter mailing/notice of the P&T meetings. Medicaid welcomes supplemental rebate offers 24 hours a day, 7 days a week.

#### **4. ORAL PRESENTATIONS BY MANUFACTURERS/MANUFACTURERS' REPRESENTATIVES**

Five-minute verbal presentations were made on behalf of pharmaceutical manufacturers. The process and timing system for the manufacturers' oral presentations was explained. The drugs and corresponding manufacturers are listed below with the appropriate therapeutic class. There were a total of seven manufacturer verbal presentations at the meeting.

#### **5. PHARMACOTHERAPY CLASS RE-REVIEWS (Please refer to the website for full text reviews.)**

The pharmacotherapy class reviews began at approximately 9:14 a.m. There were a total of 8 drug class re-reviews. The Alzheimer's Agents, Antidepressants, Cerebral Stimulants/Agents Used for ADHD, Wakefulness Promoting Agents, Anxiolytics, Sedatives, and Hypnotics – Barbiturates, Anxiolytics, Sedatives, and Hypnotics – Benzodiazepines, Anxiolytics, Sedatives, and Hypnotics – Miscellaneous, and Genitourinary Smooth Muscle Relaxants were last reviewed in May 2014. There was one new class review: Disease-Modifying Antirheumatic Agents. There was one new drug review: Kitabis<sup>®</sup>. There was one pharmacotherapy update of the Opiate Agonists, which was last reviewed in February 2016.

##### **Alzheimer's Agents: Parasympathomimetic (Cholinergic) Agents, AHFS 120400; and Central Nervous System Agents, Miscellaneous, AHFS 289200**

Manufacturer comments on behalf of these products:

None

Dr. Bacon noted that the Alzheimer's agents included in this review are listed in Table 1 on page 11. Since the last review, a combination extended release capsule of memantine and donepezil (Namzaric<sup>®</sup>) was approved by the FDA. All single-entity agents are available in a generic formulation. There have been no major changes in the prescribing information, treatment guidelines, or clinical studies since this class was last reviewed.

There is insufficient evidence to support that one brand Alzheimer's agent is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand Alzheimer's agents within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand Alzheimer's agent is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

**Antidepressants: AHFS 281604**

Manufacturer comments on behalf of these products:

None

Dr. Bacon noted that the antidepressants are approved to treat a variety of mental disorders, including anxiety disorders, depressive disorders, eating disorders, and premenstrual dysphoric disorder. The antidepressants included in this review are listed in Table 1 on page 87. The majority of the products are available in a generic formulation, and there is at least one generic product available in each antidepressant subclass.

Of additional note, Brintellix<sup>®</sup> (vortioxetine) will be marketed under the new name Trintellix<sup>®</sup>. Only the name is changing.

Since the last review, duloxetine has been approved for the treatment of generalized anxiety disorder in pediatric patients seven to 17 years of age. There have been no major changes in the treatment guidelines or clinical studies since this class was last reviewed. Guidelines do not give preference to one agent over another. The choice of treatment should be based on safety, adverse events, drug interactions, prior response to treatment, and comorbid conditions.

In general, the monoamine oxidase inhibitors are not routinely used compared to the other subclasses of antidepressants due to their safety profile and associated drug interactions. These agents are typically reserved for patients not responding to other antidepressant therapies.

There is insufficient evidence to support that one brand antidepressant is more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand antidepressants within the class reviewed, with the exception of the monoamine oxidase inhibitors, are comparable to each other and to the generics in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use. The monoamine oxidase inhibitors possess an extensive adverse effect profile compared to the other brands and generics in the class (if applicable) and should be managed through the existing medical justification portion of the prior authorization process.

No brand antidepressant is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

No brand monoamine oxidase inhibitor is recommended for preferred status, regardless of cost.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

**Cerebral Stimulants/Agents Used for ADHD: Central Alpha-Agonists, AHFS 240816; Amphetamines, AHFS 282004; Respiratory and CNS Stimulants, AHFS 282032; and Central Nervous System Agents, Miscellaneous, AHFS 289200**

Manufacturer comments on behalf of these products:

Vyvanse<sup>®</sup> - Shire

Quillivant XR<sup>®</sup> - Pfizer

Dr. Bacon noted that the cerebral stimulants/agents used for ADHD included in this review are listed in Table 1 on page 295. Many of the products are available in a generic formulation.

Since the last review, two new agents have become available, including Evekeo<sup>®</sup> (amphetamine sulfate), which is a racemic mixture of amphetamine, and Aptensio XR<sup>®</sup> (methylphenidate extended release), which offers once daily dosing for patients six years and older and is composed of an immediate-release layer which contains approximately 40% of the methylphenidate dose and a controlled release layer which contains approximately 60% of the dose. Additionally, the FDA expanded the approved uses of lisdexamfetamine (Vyvanse<sup>®</sup>) to include the treatment of moderate to severe binge eating disorder. Lisdexamfetamine has demonstrated a decrease in the number of binge eating days per week and a reduction in obsessive-compulsive binge eating behaviors compared to those on placebo.

There have been no major changes in the treatment guidelines or clinical studies since this class was last reviewed.

There is insufficient evidence to support that one brand cerebral stimulant/agent used for ADHD is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand cerebral stimulants/agents used for ADHD within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand cerebral stimulant/agent used for ADHD is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

### **Wakefulness Promoting Agents: AHFS 282080**

#### Manufacturer comments on behalf of these products:

Xyrem® - Jazz Pharmaceuticals

Dr. Tran noted that narcolepsy is a sleep disorder characterized by excessive daytime sleepiness and intermittent manifestations of rapid eye movement sleep during wakefulness. Obstructive sleep apnea is the most common form of breathing-related sleep disorder, which is caused by obstruction of the airway. The wakefulness promoting agents included in this review are listed in Table 1 on page 385. Modafinil is currently the only wakefulness promoting agent that is available generically. There have been no significant changes in prescribing information, clinical guidelines, or clinical studies since the class was last reviewed.

There is insufficient evidence to support that one brand wakefulness promoting agent is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand wakefulness promoting agents within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand wakefulness promoting agent is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

### **Anxiolytics, Sedatives, and Hypnotics-Barbiturates: AHFS 282404**

#### Manufacturer comments on behalf of these products:

None

Dr. Tran noted that the barbiturates included in this review are listed in Table 1 on page 417. Phenobarbital is the only agent available in a generic formulation. There have been no significant changes in prescribing information or clinical studies since the class was last reviewed. Two treatment guidelines were reaffirmed within the past two years; however, there were no significant updates from previous versions.

There is insufficient evidence to support that one brand barbiturate is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand barbiturates within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand barbiturate is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

**Anxiolytics, Sedatives, and Hypnotics-Benzodiazepines: AHFS 282408**

Manufacturer comments on behalf of these products:

None

Dr. Tran noted that the benzodiazepines are approved for a variety of indications including treatment of anxiety, insomnia, seizures, and alcohol withdrawal. The benzodiazepines included in this review are listed in Table 1 on page 443. All of the benzodiazepines are available in a generic formulation, with the exception of clobazam. Clobazam is indicated only for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in patients two years of age or older.

Three treatment guidelines were reaffirmed within the past two years, however, there were no significant updates from previous versions. Adjunctive treatment with clobazam for Lennox-Gastaut syndrome resulted in decreases from baseline in rates of drop and total seizures.

There is insufficient evidence to support that one brand benzodiazepine is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all benzodiazepines within the class reviewed, with the exception of diazepam rectal gel, are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use. Diazepam rectal gel provides a beneficial route of administration compared to other agents in this class. Therefore, patients should be allowed approval for this agent through the medical justification portion of the prior authorization process.

No brand benzodiazepine is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

**Anxiolytics, Sedatives, and Hypnotics-Miscellaneous: AHFS 282492**

Manufacturer comments on behalf of these products:

None

Dr. Tran noted that miscellaneous anxiolytics, sedatives, and hypnotics are used primarily for the treatment of anxiety disorders and insomnia. Some of the miscellaneous agents are also approved for the management of acute alcohol withdrawal, for use as a sedative (e.g., preoperative, prior to procedures, and in intubated or mechanically ventilated patients), for the management of nausea/vomiting from surgical/diagnostic procedures and for the treatment of pruritus. The miscellaneous anxiolytics, sedatives, and hypnotics included in this review are listed in Table 1 on page 503. All of the products are available in a generic

formulation, with the exception of ramelteon, suvorexant, and tasimelteon. Chloral hydrate, meprobamate, eszopiclone, suvorexant, zaleplon, and zolpidem are classified as Schedule IV controlled substances by federal regulation because of their abuse potential.

Since the last review, Hetlioz<sup>®</sup> (tasimelteon) was FDA approved for treatment of Non-24-Hour Sleep-Wake Disorder (non-24). Tasimelteon is a melatonin receptor agonist with effects at the melatonin type 1 (MT1) and type 2 (MT2) receptors. Although the precise mechanism of tasimelteon in non-24 is unknown, these receptors are thought to be involved in the control of circadian rhythms. This is the first FDA approval of a treatment for non-24, a chronic circadian rhythm disorder which occurs almost exclusively in persons who are completely blind, and the effectiveness of tasimelteon was evaluated in this population. Suvorexant (Belsomra<sup>®</sup>) was FDA approved in 2014 for the treatment of insomnia characterized by difficulties with sleep onset and/or sleep maintenance. Suvorexant is a selective antagonist of orexin receptors (OX1R and OX2R). Orexin A and orexin B are neuropeptides that promote wakefulness. Blocking the binding of orexin to the orexin receptors is thought to suppress wakefulness. Suvorexant is a Schedule IV controlled substance, producing similar effects as zolpidem in an abuse liability study.

In May 2014, a safety communication was issued for eszopiclone, based on data that the 2 and 3 mg doses may be associated with impairment of driving skills, memory, and coordination lasting more than 11 hours without subjective awareness in some patients; a starting dose of 1 mg is now recommended in all patients.

Suvorexant was studied in patients 18 years and older with insomnia, and it was found that similar proportions of patients treated with suvorexant or placebo discontinued because of adverse events. Over the first month, the suvorexant group showed significant improvements in subject reported total sleep time and subjective time to sleep onset compared with the placebo group. The improvements were maintained throughout the one-year phase. Two studies, SET and RESET, found that a greater proportion of patients treated with tasimelteon maintained entrainment, or timing of circadian rhythms to the daily light-dark cycle, compared to treatment with placebo.

There is insufficient evidence to support that one brand miscellaneous anxiolytic, sedative, or hypnotic agent is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand miscellaneous anxiolytic, sedative, or hypnotic agents within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand miscellaneous anxiolytic, sedative, or hypnotic is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

### **Genitourinary Smooth Muscle Relaxants: AHFS 861200**

Manufacturer comments on behalf of these products:

Toviaz<sup>®</sup> - Pfizer

Dr. Tran noted that the genitourinary smooth muscle relaxants are primarily antimuscarinic agents utilized in the treatment of urinary incontinence and overactive bladder. The genitourinary smooth muscle relaxants included in this review are listed in Table 1 on pages 590 and 591. Flavoxate, oxybutynin, tolterodine, and trospium are available in a generic formulation.

There have been no significant changes in prescribing information since the class was last reviewed. Five new guidelines were updated since the last review. The European Association of Urology, American Urological Association, and American College of Obstetricians and Gynecologists note lifestyle and behavioral therapy measures and that anticholinergic drugs are the mainstay of treatment for urgency urinary incontinence, but that there is no evidence that one antimuscarinic drug is more efficacious to others for cure or improvement of urgency urinary incontinence. In pediatric patients, the European Association of Urology/European Society for Pediatric Urology notes that oxybutynin, tolterodine, trospium, and propiverine are the most frequently used drugs for the treatment of neurogenic bladder but that the use of medication to facilitate emptying in children with neurogenic bladder has not been well studied. Recently published trials found that fesoterodine 8 mg results in significantly greater improvement compared to 4 mg, and that mirabegron 50 mg was associated with a significantly greater change from baseline in the mean number of micturitions/24 hour compared with placebo.

There is insufficient evidence to support that one brand genitourinary smooth muscle relaxant is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand genitourinary smooth muscle relaxants within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand genitourinary smooth muscle relaxant is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee Members to mark their ballots.

## **6. PHARMACOTHERAPY CLASS REVIEWS (Please refer to the website for full text reviews.)**

### **Disease-Modifying Antirheumatic Agents: AHFS Class 923600**

#### Manufacturer comments on behalf of these products:

Orencia<sup>®</sup> - Bristol Myers Squibb

Humira<sup>®</sup> - AbbVie

Xeljanz<sup>®</sup> - Pfizer

Dr. Bacon noted that the disease-modifying antirheumatic drugs (DMARDs) are used for a variety of inflammatory and immunologic conditions. This is the first review of this class. The DMARDs that are included in this review are listed in Table 1 on page 699. The agents achieve their therapeutic effect via several different mechanisms of action. The majority of oral and injectable agents inhibit the effect of

proinflammatory cytokines, specifically interleukins or tumor necrosis factor (TNF)- $\alpha$ . Interleukin (IL) inhibitors include anakinra (Kineret<sup>®</sup>) and tocilizumab (Actemra<sup>®</sup>), while the TNF- $\alpha$  inhibitors are adalimumab (Humira<sup>®</sup>), certolizumab pegol (Cimzia<sup>®</sup>), etanercept (Enbrel<sup>®</sup>), golimumab (Simponi<sup>®</sup>, Simponi ARIA<sup>®</sup>), and infliximab (Remicade<sup>®</sup>). Abatacept (Orencia<sup>®</sup>) is a T-cell activation inhibitor, apremilast (Otezla<sup>®</sup>) is a phosphodiesterase-4 (PDE-4) inhibitor, leflunomide (Arava<sup>®</sup>) is a pyrimidine synthesis inhibitor, and tofacitinib (Xeljanz<sup>®</sup>) is a Janus kinase inhibitor. Leflunomide is the only product available in a generic formulation.

Because many of the DMARDs are biologic agents made from living organisms and are extremely difficult to duplicate, government organizations have struggled to create regulations to approve generic versions of these agents. Currently, none of the injectable agents in this class are available generically; however, the recently upheld Patient Protection and Affordable Care provides a legal framework for regulatory approval of biosimilar drugs.

Current clinical guidelines support the use of the DMARDs with respect to their Food and Drug Administration (FDA)-approved indications, particularly in conditions where patients were unresponsive or refractory to traditional treatments, which usually include nonsteroidal anti-inflammatory drugs (NSAIDs) and/or methotrexate depending on the disease state. As more recent guidelines are published, the recommendations for use TNF- $\alpha$  inhibitors earlier in therapy is becoming a more common occurrence. The adverse event profiles are similar across the TNF- $\alpha$  inhibitors; however, routes of administration and dosing frequency may vary. In general, no one TNF- $\alpha$  inhibitor is preferred over another. Leflunomide is FDA-approved for use in rheumatoid arthritis. Guidelines for rheumatoid arthritis, psoriatic arthritis, and juvenile idiopathic arthritis recommend leflunomide as an alternative treatment to methotrexate. Clinical trials directly comparing methotrexate and leflunomide have shown mixed results.

Humira<sup>®</sup> (adalimumab) was granted orphan drug designation for the treatment of moderate to severe hidradenitis suppurativa (Hurley Stage II and Hurley Stage III disease), a chronic inflammatory skin disease which affects fewer than 200,000 patients in the United States. Current literature supports topical or oral antibiotics, intralesional steroids, retinoids, zinc, anti-androgens or laser surgery for mild (stage I) disease. Stage II disease should generally be treated similar to Stage I with the addition of rifampin plus clindamycin, dapsone, and prednisone. Stage III disease is treated with similar measures as Stages I and II; however, the use of anti-inflammatory agents is recommended, with TNF- $\alpha$  inhibitors, adalimumab and infliximab, having the most positive data.

Most research with these agents is for the treatment of rheumatoid arthritis. In these trials, the DMARD was compared directly to placebo or methotrexate, either as monotherapy or in combination with methotrexate. Consistently, DMARDs have shown greater improvement in symptoms over the comparator. To date, the majority of trials conducted have been placebo-controlled, with very few trials directly comparing two DMARDs head-to-head for any of the FDA-approved indications. In those that have been conducted, most have shown comparable results. In one trial in rheumatoid arthritis patients who were either intolerant or were not candidates for methotrexate treatment, significantly greater improvements were observed in patients treated with tocilizumab compared to adalimumab. In another trial in rheumatoid arthritis patients with inadequate response to methotrexate, similar responses were observed in patients treated with abatacept and adalimumab. The lack of direct head-to-head trials available prevent clearly determining superiority of one agent over another. Recently anakinra was FDA-approved for neonatal-onset multisystem inflammatory

disease, the only agent FDA-approved for this indication. The approval was based on the results of a single trial demonstrating sustained improvements in affected patients over 60 months.

There is insufficient evidence to support that one brand disease-modifying antirheumatic agent is safer or more efficacious than another within its FDA-approved indication(s). The drugs in this AHFS class are used in a specific patient population. Because these agents have narrow indications with limited usage and serious adverse events, these agents should be managed through the medical justification portion of the prior authorization process.

Therefore, all disease-modifying antirheumatic agents within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand disease-modifying antirheumatic agent is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Chairperson Cohenour asked the P&T Committee Members to mark their ballots.

## 7. NEW DRUG REVIEWS (Please refer to the website for full text reviews.)

### **Kitabis<sup>®</sup>**

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that Kitabis<sup>®</sup> Pak (tobramycin solution for inhalation) is the most recently approved of five currently available inhaled tobramycin preparations. All of the products have the same FDA-approved indication of management of cystic fibrosis adults and pediatric patients six years of age and older with *Pseudomonas aeruginosa*. Kitabis<sup>®</sup> Pak was FDA approved using the same clinical trial data as TOBI<sup>®</sup> (tobramycin solution for inhalation). Kitabis<sup>®</sup> Pak is the only agent that co-packages the generic tobramycin inhalation solution with a reusable nebulizer (PARI LC Plus<sup>™</sup>).

The chronic use of inhaled tobramycin is recommended for patients six years of age and older with cystic fibrosis colonized with *Pseudomonas aeruginosa* regardless of the severity of lung disease. Treatment with tobramycin has been associated with improvements in pulmonary function, improved quality of life, decreased requirement for intravenous anti-pseudomonal antibiotics, and a decrease in hospitalizations compared to placebo. Open-label studies following patients for up to two years have also demonstrated continued benefit over time. There is no clinical evidence of differences in efficacy with the various inhaled tobramycin formulations, and the Cystic Fibrosis Foundation guidelines do not give preference to one inhaled tobramycin formulation over another.

Therefore, all brand aminoglycosides products within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use. Tobramycin inhalation solution and inhalation powder has been shown to

improve lung function and reduce exacerbations in cystic fibrosis patients colonized with *Pseudomonas aeruginosa*. Therefore, these patients should be allowed approval for inhalation solution and inhalation powder through the medical justification portion of the prior authorization process. No brand tobramycin inhalation product is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on this agent. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

## **8. PHARMACOTHERAPY UPDATE (Please refer to the website for full text reviews.)**

### **Opiate Agonists: AHFS Class 280808**

Dr. Bacon noted that opioid abuse, misuse, dependence, and overdose are significant health problems in the United States. In response to this growing issue, many organizations have released strategies for mitigating prescription drug abuse, with the Food and Drug Administration (FDA), Centers for Medicare and Medicaid Services (CMS), and Centers for Disease Control and Prevention (CDC) all addressing opioid use in recent communications.

The FDA has developed an action plan to take steps toward reducing the impact of opioid abuse on American families and communities. These actions include expanding the use of advisory committees, developing warnings and safety information for labeling of immediate-release (IR) opioids, strengthening postmarket requirements, updating the scope of the existing Risk Evaluation and Mitigation Strategy (REMS) program, expanding access to abuse-deterrent formulations to discourage abuse, supporting improved overdose and pain treatments, and reassessing the risk-benefit approval framework for opioid use. Class-wide labeling changes for all extended-release and long-acting (ER/LA) opioid analgesics occurred in April 2014, addressing the risks of misuse, abuse, hyperalgesia, addiction, overdose, death, and neonatal opioid withdrawal syndrome. On March 22, 2016 the FDA announced required class-wide safety labeling changes for IR opioid pain medications. Among the changes, the FDA requires a new boxed warning about the serious risks of misuse and abuse, which can lead to addiction, overdose, and death.

In January 2016, CMS released an informational bulletin addressing prescription opioid overdoses, misuse, and addiction. The purpose of the bulletin was to highlight strategies for preventing opioid-related harms. CMS emphasizes that methadone accounts for a disproportionate share of opioid-related overdoses and deaths, and encourages states to consider additional steps to reduce the use of methadone prescribed for pain relief. The pharmacokinetic and pharmacodynamic parameters of methadone make it a complex medication to prescribe for pain relief. Of note, its elimination half-life is longer than its duration of analgesic action, there is high interpatient variability in absorption, metabolism, and relative analgesic potency, it is retained in the liver with repeat dosing, and it has a narrow therapeutic index. CMS recommends removing methadone from preferred drug lists and limiting its use only to patients for whom treatment with other pain medications is ineffective.

On March 18, 2016 the CDC published guidelines for prescribing opioids for chronic pain. This guideline provides recommendations for primary care clinicians who are prescribing opioids for chronic pain outside of active cancer treatment, palliative care, and/or end-of-life care. This guideline states that

nonpharmacologic and nonopioid pharmacologic therapies are preferred for chronic pain. When opioid therapy is initiated for chronic pain, IR opioids should be used before ER/LA agents. ER/LA opioids should be reserved for severe, continuous pain and should be considered only for patients who have received IR opioids daily for at least a one-week duration. The guideline states that methadone has been associated with disproportionate numbers of overdose deaths relative to the frequency with which it is prescribed for chronic pain. Methadone should not be the first choice for an ER/LA opioid.

There is insufficient evidence to support that one brand opiate agonist is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process. Methadone should be managed through the medical justification portion of the prior authorization process due to the potential risk of abuse and overdose, the known complexities with appropriately prescribing this medication, and the guideline recommendations for not using this medication as a first-line agent.

Therefore, all brand opiate agonists within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand opiate agonist is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Methadone should not be placed in preferred status regardless of cost.

Dr. Littlejohn Newman noted where to find the CMS Bulletin and gave a brief outline of what the bulletin highlights. Chairperson Cohenour asked the P&T Committee members to mark their ballots.

## **9. RESULTS OF VOTING ANNOUNCED**

The results of voting for each of the therapeutic classes were announced; all classes were approved as recommended. Results of voting are described in the Appendix to the minutes.

## **10. NEW BUSINESS**

This was Dr. David Harwood's final P&T meeting. The Committee and the Agency thanked him for his years of service to the state, as well as the providers and recipients we all serve, through his work on the P&T Committee.

The dates for the 2016 Alabama Medicaid P&T Meetings were provided and are as follows: August 10, 2016, and November 9, 2016.

## **11. NEXT MEETING DATE**

The next P&T Committee Meeting is scheduled for August 10, 2016 at the Medicaid Building in the Commissioner's Board Room.

## **12. ADJOURN**

There being no further business, Dr. Dawson moved to adjourn and Dr. Harwood seconded. The meeting adjourned at 10:27 a.m.

Appendix

RESULTS OF THE BALLOTING  
Alabama Medicaid Agency  
Pharmacy and Therapeutics Committee  
May 11, 2016

A. **Recommendation:** No brand Alzheimer's agent is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Howe  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hall  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

[Signature]  Approve  Approve as amended  Disapprove  No action

Commissioner

**B. Recommendation:** No brand antidepressant is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

No brand monoamine oxidase inhibitor is recommended for preferred status, regardless of cost.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Poore, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hall  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

[Signature]  Approve  Approve as amended  Disapprove  No action

Commissioner

**C. Recommendation:** No brand cerebral stimulant/agent used for attention deficit hyperactivity disorder is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Poore, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hall  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

[Signature]  Approve  Approve as amended  Disapprove  No action

Commissioner

**D. Recommendation:** No brand wakefulness promoting agent is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Rowe, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hull  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

[Signature]  Approve  Approve as amended  Disapprove  No action

Commissioner

**E. Recommendation:** No brand barbiturate is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Rowe, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hull  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

[Signature]  Approve  Approve as amended  Disapprove  No action

Commissioner

**F. Recommendation:** No brand benzodiazepine is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Rouzma  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hall  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

[Signature]  Approve  Approve as amended  Disapprove  No action  
Commissioner

**G. Recommendation:** No brand miscellaneous anxiolytic, sedative, or hypnotic is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Rouzma, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hall  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

[Signature]  Approve  Approve as amended  Disapprove  No action  
Commissioner

**H. Recommendation:** No brand genitourinary smooth muscle relaxant is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Ponce, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Day  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

Stephen A. ...  Approve  Approve as amended  Disapprove  No action  
Commissioner

**I. Recommendation:** No brand disease-modifying antirheumatic agent is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Ponce, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Day  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

Stephen A. ...  Approve  Approve as amended  Disapprove  No action  
Commissioner

**J. Recommendation:** No brand tobramycin inhalation product is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Rowe, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hull  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

Sept A  Approve  Approve as amended  Disapprove  No action

Commissioner

**K. Recommendation:** No brand opiate agonist is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Methadone should not be placed in preferred status regardless of cost.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Melinda A. Rowe, MD  Approve  Approve as amended  Disapprove  No action

Medical Director

Kathy Hull  Approve  Approve as amended  Disapprove  No action

Deputy Commissioner

Sept A  Approve  Approve as amended  Disapprove  No action

Commissioner

Respectfully submitted,

*Rachel Bacon*

May 16, 2016

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Rachel Bacon, PharmD

Date