

Pharmacy and Therapeutics Committee Meeting Record

Date: 9/16/05 **Time:** 9:00 a.m. – 5:15 p.m. **Location:** 3232 Elder Street, Conference Room D **Moderator:** W. Terry Gipson, M.D.

Committee Members Present: W. Terry Gipson, M.D.; Bob Comstock, RPh; Catherine Gundlach, PharmD; Cindy Bunde, P.A; Mic Markuson, RPh.; Phil Petersen, M.D.; Richard Pines, D.O.; Rick Sutton, RPh; Stan Eisele, M.D.; Tami Eide, PharmD

Committee Members Absent: Stephen Montamat, M.D.; Thomas Rau, M.D.

Agenda Item	Presenter	Outcome/Action
<p>CALL TO ORDER</p> <ul style="list-style-type: none"> • Roll Call • Reading of Confidentiality Statement • Approval of Minutes from July 15, 2005 Meeting • Discussion of Key Questions for Upcoming EPC Drug Effectiveness Review Studies 	<p>W. Terry Gipson, MD</p> <p>Linda Edson</p> <p>W. Terry Gipson, MD</p> <p>Tami Eide, PharmD, BCPS, FASHP</p>	<p>Ms. Edson called the roll. One voting and one non-voting member were not present.</p> <p>The confidentiality statement was read by Dr. Gipson.</p> <p>The minutes from July 15 2005, Committee meeting was approved.</p> <p>The draft key questions for drugs for ADHA, Alzheimer's, newer Antiplatelets, and proton pump inhibitor agents were discussed.</p>
<p>DUR PROPOSED PRESENTATION</p> <ul style="list-style-type: none"> • Statins 	<p>Heather Brandt, PharmD</p>	<p>Dr. Brandt presented a review of statin outcomes conducted after the prior authorization implementation of this drug class on 8/1/2204. The purpose of this review was to obtain information regarding statin utilization. The results of this outcome study indicate that switch rates are low and that they all appear to be effective. There was no increase in office visits or hospitalization rates based on the prior authorization criteria put in place.</p>
<p>PUBLIC COMMENT PERIOD</p>	<p>W. Terry Gipson, MD</p>	<p>Nineteen people signed up to speak during the public comment period. Public comment was received from the following:</p> <ul style="list-style-type: none"> • Deland Barr, M.D. (Self) – Statins • David Abramamson (Self) – Statins • Susan Trien (AstraZenica)– Statins • Dr. Roy Palmer (Pfizer) – Statins • Dr. Robert Lee (Self) – Statins • Donald Morris (Pfizer) – Statins • Burt Jones(Glaxo Smith Kline) – Antidepressants • Barry Bennet, M.D. (Self) – Antidepressants • Grace Lawrence (Self) – Antidepressants • Richard Montgomery (Self) – Antidepressants • Jonna Nelson (Lilly) – Antidepressants • Sue Heineman (Pfizer) – Antidepressants

		<ul style="list-style-type: none"> • Scott Hoopes, MD (Self) – Antidepressants • Mija Yoon (McNeil Consumer Specialty Pharm) – ADHD • Andy Weise, PharmD (Novartis) – ADHD • Steven Asher, M.D. (Self) – ADHD • Jonna Nelson (Lilly) – ADHD • Steve Meyers, MD (Self) – ADHD
PRESENTATION OF NEW SUPPLEMENTAL REBATE CONTRACTOR <ul style="list-style-type: none"> • Provider Synergies 	Tami Eide, PharmD	Dr. Eide introduced Steve Liles, PharmD with Provider Synergies, the Idaho Medicaid supplemental rebate contractor.
	Steve Liles, PharmD	Dr. Liles presented an overview of Provider Synergies.
DRUG CLASS REVIEW <ul style="list-style-type: none"> • Antidepressants 	Steve Liles, PharmD	<p>Dr. Liles presented a review of Second Generation Antidepressant agents including indications, how the drugs work, the drug-drug interactions, availability, and dosing. This review included the following drugs:</p> <ul style="list-style-type: none"> • citalopram • fluoxetine • fluvoxamine • Lexapro (escitalopram) • paroxetine HCl • Paxil CR (paroxetine HCl controlled-release) • Pexeva (paroxetine mesylate) • Prozac Weekly (fluoxetine) • Sarafem (fluoxetine) • Zoloft (sertraline)
CLINICAL DATA REVIEW <ul style="list-style-type: none"> • Antidepressants 	Gerald Gartlehner, M.D.	Dr. Gartlehner attended via conference call and presented the RTI-UNC Evidence-based Practice Center’s report comparing the antidepressant drug class. This report was updated in May of 2005. The Committee accessed and reviewed a copy of the report prior to the meeting.
DRUG CLASS REVIEW <ul style="list-style-type: none"> • Drugs to Treat ADHD 	Steve Liles, PharmD	<p>Dr. Liles presented a review of drugs used to treat ADHD including indications, how the drugs work, the drug-drug interactions, availability, and dosing. This review included the following drugs:</p> <p><i>Stimulants</i></p> <ul style="list-style-type: none"> • Amphetamines <ul style="list-style-type: none"> ○ amphetamine salt combination - generic, Adderall XR ○ dextroamphetamine - generic • Methylphenidate <ul style="list-style-type: none"> ○ Immediate-Release - generic ○ Extended-Release - Concerta, Metadate CD, Methylin ER, Ritalin LA, Ritalin SR • dexmethylphenidate - Focalin, Focalin XR • pemoline - generic <p><i>Non-Stimulants</i></p>

		<ul style="list-style-type: none"> • atomoxetine – Strattera • modafanil – Provigil • Others <ul style="list-style-type: none"> ○ Atypical antipsychotics <ul style="list-style-type: none"> ▪ aripiprazole, clozapine, olanzapine, quetiapine, risperidone, ziprasidone ○ Alpha-agonists <ul style="list-style-type: none"> ▪ clonidine, guanfacine ○ NDRI antidepressant <ul style="list-style-type: none"> ▪ bupropion
CLINICAL DATA REVIEW <ul style="list-style-type: none"> • Drugs to Treat ADHD 	Marian McDonagh, PharmD	Dr. McDonagh attended via conference call and presented the Oregon Evidence-Based Practice Center’s report comparing the drugs to treat ADHD. This report was finalized in September 2005. The Committee accessed and reviewed a copy of the report prior to the meeting.
DRUG CLASS REVIEW <ul style="list-style-type: none"> • Statins 	Steve Liles, PharmD	Dr. Liles presented a review of statin agents including indications, how the drugs work, the drug-drug interactions, availability, and dosing. This review included the following drugs: <ul style="list-style-type: none"> • lovastatin <ul style="list-style-type: none"> ○ Advicor (lovastatin/niacin ER) ○ Altoprev (lovastatin ER) • Lescol/Lescol XL (fluvastatin) • Pravachol <ul style="list-style-type: none"> ○ Pravigard PAC (pravachol/ASA) • Zocor (simvastatin) <ul style="list-style-type: none"> ○ Vytorin (simvastatin/ezetimibe) • Crestor (rosuvastatin) • Lipitor (atorvastatin) <ul style="list-style-type: none"> ○ Caduet (atorvastatin/amlodipine)
CLINICAL DATA REVIEW <ul style="list-style-type: none"> • Statins 	Mark Helfand, M.D. (Tami Eide, PharmD.)	Dr. Helfand was unable to attend via conference call to present the Oregon Evidence-Based Practice Center’s report comparing the statin drug class. Dr. Eide presented the report on his behalf. This report was updated in September of 2005. The Committee accessed and reviewed a copy of the report prior to the meeting.
COMMITTEE DISCUSSION AND CLINICAL CONCLUSIONS FOR SELECTED THERAPEUTIC CLASSES	W. Terry Gipson, MD	<u>Antidepressants</u> Based on the evidence that was presented, the Committee consensus was that overall there is no evidence that any of these drugs are more efficacious than another. Although the committee concluded that there are some safety issues with ticlodipine, it has a definite place in therapy and should remain available. <u>Statins</u> Based on the evidence that was presented, the Committee consensus was that there is no evidence that any of these drugs are more efficacious than another nor does any agent provide any safety advantage over any other.

		<p><u>Drugs to Treat ADHD</u> Committee consensus was that there is no evidence that any of these drugs are more efficacious than another. Based on the clinical evidence and dosage forms the Committee consensus was that long acting or once a day dosing options needed to be available and that Strattera should not be a first line agent and Provigil should not be used to treat ADHD.</p>
PUBLIC MEETING ADJOURNED	W. Terry Gipson, MD	<p>The next classes of agents to be reviewed by the Pharmacy and Therapeutics Committee on November 18, 2005 are Oral Antifungals, Topical Antifungals, Antivirals, Atopic Dermatitis, Cephalosporins & Related Antibiotics, Oral Fluoroquinolones, and Macrolides/Ketolides.</p> <p>Dr Gipson adjourned the public portion of the meeting.</p>
SUPPLEMENTAL REBATE INFORMATION (CLOSED TO PUBLIC)	Randy May, Medicaid Deputy Administrator	Mr. May presented supplemental rebate information to the Committee members for their review and discussion. This review and discussion were closed to the public.
COMMITTEE FINAL RECOMMENDATION FOR THERAPEUTIC CLASSES	W. Terry Gipson, MD	<p><u>Antidepressants</u> Based on the evidence that was presented, the Committee consensus was that overall there is no evidence that any of these drugs are more efficacious than another.</p> <p><u>Statins</u> Based on the evidence that was presented, the Committee consensus was that there is no evidence that any of these drugs are more efficacious than another nor does any agent provide any safety advantage over any other.</p> <p><u>Drugs to Treat ADHD</u> Committee consensus was that there is no evidence that any of these drugs are more efficacious than another. Based on the clinical evidence and dosage forms the Committee consensus was that long acting or once a day dosing options needed to be available and that Strattera should not be a first line agent and Provigil should not be used to treat ADHD.</p>

**Pharmacy and Therapeutics Committee
Public Comment
September 16, 2005**

Deland Barr, M.D. (Self) – Statins

Good Morning, my name is Deland Barr, I'm a family practice physician in Weiser. I am not representing anyone. I am here to make a plug for Vytorin. The challenges in medicine today as we have continually redefined disease states is directly related to the tools we have to treat those disease states. There was at time no to long ago where we didn't really recognize cholesterol as being a particular problem and it has become more and more defined and rigid as far as what requirements are for what we would consider to be good health. It becomes more and more difficult to as physicians to attain those goals. The statin class of drugs have been a remarkable progress [unintelligible] from a stand point, in my opinion they have been exceedingly successful. Unfortunately not everyone can take the statins. In my experience the side affect profile of people who can't tolerate statin is much higher than what we presented earlier. There are a lot of people that have side affects that are not necessarily [unintelligible] and a lot of patients can't take them because of aphetic dysfunction. As is true with the statins and most medications, side affects tend to be dose related. The lower you can keep the dose of the statin the less likely the patient is to have side affects. The advantage of Vytorin is by adding a second agent to the statin we can keep the level of the statin much lower. When a [unintelligible] comes to me with a new medications and says here, I want you to start using this, the question I ask are three things. Is it more efficacious, is it safer, is it cheaper? If the answer to all three of those questions is no I basically don't want to hear it. What's the point? It's a me too drug and has no advantage [unintelligible] if the answer to any one of those three questions is affirmative then I would like to know more about the medication. Vytorin I think is one of those unusual medications where you can actually say all three of those things are true. It's cheaper, it's more efficacious and it's safer. I would also, and I don't know which medications we're talking about, but I would also like to consider Zetia as a separate agent because Zetia has a unique function in that it has been feasible to those patients who absolutely can not tolerate a statin. As you know we can take Zetia and put it with Zocor and make Vytorin. It's equally efficacious; it's unfortunately terribly expensive to do it that way. So I have a large segment of Medicaid patients, striving to get those patients to go on a method is a challenge at best. Vytorin I think is a very useful tool for me. Physicians are only as good as [unintelligible] their tools that they have to use to fight disease. We have hanging in our office a picture you've all seen I'm sure, of a lady sitting beside the bed of a sick child and the physician sitting beside the bed holding the hand, face is bemoaning the loss of compassion that we use to have and I had another elderly physician mentor of mine who pointed out to me that, yeah, that's the way medicine used to be it was that way because that really was about all we could do. They didn't have many tools to use and the more tools we have the better job we can do treating our patients and Vytorin is a very effective and useful tool.

David Abramamson (Self) – Statins

Good Morning, I am the executive medical director to promote sharing [unintelligible] I have been involved in the clinical development that was both Zetia and Vytorin for the past nine years. I really appreciate the opportunity to be here to present the signs and the new signs that I think is highly relevant to this population. Currently there are about 42 million Americans that need to be treated for one of the most treatable conditions and one of the conditions where outcomes have been just phenomenal. The one thing that we are absolutely clear about in the scientific community is that there is no threshold level which LDL, bad cholesterol, stops having a benefit in terms of reduction. If fact the relative risk is now second in LDL level of ([unintelligible]). Currently in the United States who has 42 million Americans about 25 % or less than a 100 ATP 3 is currently recommending that this be a minimal goal and that the optional goal which is the preferred goal certainly with high allergy community is to get people to less than 7 and so with this in mind one needs to look at new products new compounds. Vytorin addresses both the issues of cholesterol and metabolism. The simple ness in the absorption it is now being proven comparative to every ... other to be vastly superior in terms of efficacy. Just to give you some of these number because I think it is relevant in the March American Heart Journal there is a 2000 page in comparative study of Lipitor vs. Vytorin in every dose. And basically at every dose superiority in terms of HDL superiority in terms of the elevation of the HDL but what I wanted to address to the committee the most important aspect of this study in my opinion is if you look at the start doses which is the vast majority of the way Lipitor is being used the 10 and 20 if you look at the less than 100 you have got between 47 and 69 percent of people to go with Vytorin 10-20 you have got 82% of the people to go. Every single study we've done we've gotten over 80% of the people to go at the start dose. How about less

than 70, which is where the guidelines will be moving very quickly. Less than 70 would be 2 Lipitor doses between 6 and 17% but the Vytorin 10/20 start dose about 40%. Currently less than 5% of people in the U.S. need to be less than 70 or less than 7. They are at the start dose of a drug you can get 40%. 8 fold improvement of a traditional therapy. So this is a need to drug this is truly a revolutionary breakthrough in terms of treating Cholesterol. There are about 6 million prescriptions world wide the safety is immaculate. I read the Marleses rates less than .1%. Myopathy described as CPK better than 10 fold between .2 and .3%. Liver dysfunction minimal. We have embarked on a total of 20,000 patients in outcome studies three very large outcome studies we do have a heart protection for it in the label because that is (unintelligible). So we do think this drug is deserved of this population. Which is a very high risk population and quit honestly I think it's going to give you another strategy of treating a very, very prevalent disease associated with high cost. I thank you very much indeed for your attention.

Susan Trien (AstraZenica)– Statins

Good Morning, I would like to thank the board for allowing me to present today's [Unintelligible] Senior medical scientists with AstraZenica and (unintelligible) Bare with me if I talk a little kinetics today. I would like to just address a couple of different points that my previous speakers spoke very eloquently about in terms of lower is better and looking at starting a certain Statins and the benefits of reaching that goal attainment and LDL reduction. I am going to specifically refer to the organ (unintelligible) final report that was just published in September because I believed our Dr. Mark Helfand may help and will be presenting that critical overview to you today so just three really quick main points in my very short three minutes. You will see in his review on page 8 that everything is stratified in terms of looking at per cent of patients reaching a certain per cent reduction in LDL. I think what table three will show you is on page 13 is there is no equal potent or equivalent dose to the highest (unintelligible) Statin 40 mgs. dose of rosuvastatin 40 mg., and the class review of the outcome review that you just heard, you were talking about crest wars through the Statin 40 mg Crestor rosuvastatin 40mgs., on that particular page it shows that the low starting dose of the super rosuvastatin 5- to 10 mgs. is as equivalent to the highest doses of lovastatin, to the highest dose of pravastatin, and to the 2ndsecond highest doses of simvastatin. So the LDL reductions are not the same. The question that was asked, the in that particular key question is there a difference in the ability to attain, to get to your goal attainment although? Although it was not specifically mentioned in this summary it is addressed in the actual body of the () data report and their concern is, and there have been studies to show that the rosuvastatin at the low dose significantly gets more patients to their (end [unintelligible]) ATP3 goals. I think another important point is table 4, page 14, which Dr. Helfand will talk to you about today, which, the speaker previously to me eloquently addressed the very high risk patients optimal goal of both less than 70, there was no grade for you to show what %percentage reductions you would actually would have to have and . And I did quick math, I was able to take stats in school, less than 70 of the in a patient at 130 base line you would have to have a 46% reduction. The In a patient with a 220 base line you would have to have a 68% reduction to get them to the optimal less than 70 goal, which we know that most patients are being treated too. . So I would also just like to mention some so exciting data that we are also actually looking at in comparison of a higher does of protestations doses of potent statins, there is a wealth of information that will be coming out soon that , and has already been published that is not reflected in this report. Corral that has been published, comments looking at metabolic syndrome[unintelligible] patients, Corral looking at the highest doses of Atorvistatin leaving the (unintelligible) vs. Rosuvastatin 40 mg atorvistatin 80 mg. verses rosuvastatin 40 mg. We also have had studies in African -American patients which was not addressed in the report which shows statistical significance over Atorvistatin as well, and the safety of this product duly I think dually noted from the FDA and within ([unintelligible] we] are not metabolized for study core 450-30[unintelligible] 3 out of 4 which is incredibly imperatively important for drug, /drug interaction as far interactions, as this pharmacists probably went one of the most important key factors of this particular statin being the most potent. With the left, with the less, with a really a very good safety profile and although it is it's considered new it has, it's been on the market for of over two years. We have over 24 million patients. I thank you for your time.

Dr. Roy Palmer (Pfizer) – Statin

Thank you for the opportunity to speak to you today my name is DR. Roy Palmer. I am part of the medical team at Pfizer and I am here to talk about Lipitor and also a combination product we have called Caduet which is a combination of Lipitor and calcium channel blocking Norvasc. There's two major points that I would like for you to take away from my talk today on Lipitor and that's the demonstration of efficacy and the demonstration of safety. And when I talk about efficacy I am not just talking about LDL lowering we are in luxurious position of having demonstrated that LDL lowering with Lipitor leads to an absolute benefit. You can choreograph the outcomes on several of the other agents in this class have not been () of that to this point and ultimately choreographs out comes has to be the highest level of evidence. Assuming all agents are the same is contrary to the principles of evidence based medicine when you have one

agent that has demonstrated a significant amount of poly-vascular benefit across 10's of thousands of patients over all different types that includes primary prevention, secondary prevention, diabetics and acute chronic syndrome patients. One thing when Dr. Helfand talks that are often in the most recent evidence practice with poor they excluded TNT study which was presented in the American College of Cardiology meeting. Published in (unintelligible) just this last March and I would like to, I am going to be contacting him to try and find out why that was excluded 10,000 patients study, a very compelling study demonstrating new information about the stable calling patient. I would like you to if you have the ability to ask him about that I would be very interested in his answer. In terms of safety the crucial issue of safety is in order to have a firm grasp on the safety profile of the drug you need to study large numbers of patients for large periods of time and preferably at the largest doses available. We have done that with TNT study we looked at 10,000 patients with 80 mg the proven study looked at 4,000 with 80 mgs. And the safety profile shows no dose relationship to adverse events with Lipitor. We believe we have provided enough information for people to be very confident about safety at 80 mgs. That is not true of many of the other agents who have only low doses for 12 weeks or 24 weeks they have been studying. You saw that 62% people are currently are on Lipitor in Id or Medicaid were taking Statin. That has severe implications if you want to switch those patients in terms of office visits and LFT tests and I would like you to consider that today. It tells you Caduet the principle behind Caduet the culmination of Lipitor and calcium channel blocker is the patients taking one pill instead of two makes a lot of since for compliance presents some very nice data about the impact of compliance and office visits. I would like you to consider all of this together the outcome data together with the proof and safety of the high dose of Lipitor when you make that decision this afternoon. Thank you very much.

Thank you for the opportunity to speak to you today. My name is Dr. Roy Palmer. I'm part of the medical team at Pfizer and I'm here to talk about Lipitor and also a combination product we have called Caduet, which is a combination of Lipitor and calcium channel blocker, Norvasc. There are two major points I would like you to take away from my talk today on Lipitor and that's the demonstration of efficacy and the demonstration of safety. And when I talk about efficacy I'm not just talking about LDL lowering, we are in a luxurious position of having demonstrated that LDL lowering with Lipitor leads to an absolute benefit in clinical cardiovascular outcomes. Several of the other agents in this class have not been [unintelligible] to this point and ultimately cardiovascular outcomes has to be the highest level of evidence and assuming that all agents are the same is contrary to the principles of evidence based medicine when you have one agent that has demonstrated a significant amount of cardiovascular benefit across tens of thousands of patients of all different types. And that includes primary prevention, secondary prevention, diabetics and acute coronary syndrome patients. One thing when Dr. Helfand talks later this after, in the most recent evidence practice report they excluded T and T study which was presented at the American College of Cardiology meeting, and published in [unintelligible] in just this last March, and I'm going to be contacting him to try and understand better why that was excluded, it was a 10, 000 patient study, a very compelling study demonstrating new information about the stable [unintelligible] patient. I'd like you to, if you have the ability to ask him about that, I'd be very interested in his answer. In terms of safety, the crucial issue with safety is, in order to have a firm grasp on the safety profile of a drug you study large numbers of patients for large periods of time and preferably at the largest doses available. And we've done that with the T and T study we looked at 10,000 patients with 80 mgs., the Pruett study looked at 4,000 patients with 80 mgs. and the safety profile shows no dose relationship to adverse events with Lipitor, so we believe we provided enough information for people to be very confident about the safety of 80 mgs. And that's not true for many of the other agents where only low doses for 12 weeks and 24 weeks have been studied. You saw that 62 % of the people are currently on Lipitor in Idaho Medicaid where taking a statin, that has severe implications if you want to switch those patients in terms of office visits and LFT tests and I would like you to consider that later today. In terms of Caduet the principle behind Caduet, the combination of Lipitor and a calcium channel blocker, is the patients taking one pill instead of two makes a lot of sense for compliance, presents some very nice data about the impact of compliance on office visits and so I would like you to consider all this together. The outcomes data together with the proven safety of high dose Lipitor when you make your decision this afternoon. Thank you very much.

Dr. Robert Lee (Self) – Statins

Good morning I am a practicing intervention cardiologist in Boise. I'm here to speak about Lipitor. The previous speaker brought up several very important points with, but the point that I would like to raise is the fact that Lipitor, Atorvastatin, or atorvastatin has the background for us as practicing physicians to practice evidence based medicine. Most of the competitors, as the previous speaker said, do not have that data to really support the highest dose use of their medications. The studies that have supported the extreme lowering of LDL to levels of below 70 and now, as another speaker has said to levels of 40 as a base line based on studies using atorvastatin. So we know that atorvastatin at high doses and can lower and LDL to lower low levels is beneficial to patients. It saves

lives. And that is that's what we as practicing physician's emphasis in evidence based medicine. The other statins are kind of tagging along on that, they are basically saying We think that lower is better so you know we can get down low too, but those studies have not been performed so they preformed so we really don't know that Zocor in at high doses and particularly Crestor at even moderate to high doses, although we do know it lowers LDL we don't know that it saves lives. And we are out to save lives, that is our primary goal. The other point of the vast numbers of patients that are on atorvastatin at this point I think is really important. I mean if we have to change, as practicing physicians, if we have to change all those patient patients from atorvastatin to something else it's going to be an absolute disaster. We, it's going to be, we are going to have multitudes of patients in our offices who are going to have multiple visits for drug titrations, we are going to have multiple drug tests lab test for liver functions. We have patients that are on stable doses of Atorvastatin we're going to atorvastatin who are going to switch those to what, Crestor, rosuvastatin, we are going to have again problems with patients with myopathies and muscle pain. Wes, we are going to change them to another drug and we are going to end up with us going back to the same drug anyway after having to get preauthorization. So I think that it is going to be very important to maintain atorvastatin on the formulary because of these conditions.

Donald Morris (Pfizer) – Statins

I'm Donald Morris I am a practicing nephrologist in Boise. I would like to thank you for the opportunity to speak. I would like to echo some to of the points that were just made here by Dr. Lee, and that is that we need to when you look at drug efficacy we really want hard in point data. Because a lot of times the things that we are targeting are not necessarily impact on outcome. Although it is And, although it's true that lower LDL reduces risk I am, I'm not entirely convinced that the effect of the statin is certainly limited to that it and may have other anti-inflammatory effect. When you take that into consideration you have to think about whether or not it is a true class effect or if it is it's individualized per depending on each statin. When you compare pravastatin to Lipitor you are looking at really a fairly different drug. One that is completely synthetic and the other is not. So again I would caution you to extrapolate data as a class effect and again to really emphasize that we need hard in point data. Because really that is what the patients want to hear. They do not want to take another drug they would prefer not to take it, but if you can tell them that it is going to reduce their risk for death, if it is going to reduce their risk of for MI or hospitalization then they are a little more keen to take it. And so I take care of a high risk population or chronic kidney disease patients are very high risk and certainly [unintelligible] renal disease patients are of the highest risk. And so I use a lot of statin, in particular Lipitor, predominantly again because of the end point data and because of safety and as has been eluded earlier I think when you read the study and look at a side effects you will see that it is a fairly low %percentage of patients have side effects. When you are actually in the clinic taking care of patients you will find that a fair number of more patients will complain of these side effects. And I think that is another reason to caution against switching to different another agent because as he pointed out you are going to have a fair number of people who that are tolerating a dose of Lipitor and when you switch them to another statin they may not necessarily tolerate it and. And again with regard to long term safety I think Lipitor has that add on, where as the other agents in particular Crestor, that can be questioned and. And finally, with regard to the combination agent and [unintelligible] Zetia solely, it is a good agent I've used it, but again we need that hard end point data because if it is LDL that is that's driving the reduction and in risk, that's great, if it is the statin itself reducing that risk, I think then we need that hard end point data to prove that. Thanks for your time.

Burt Jones(Glaxo Smith Kline) – Antidepressants

Good Morning, My name is Burt Jones I am the director of Government affairs. I am standing in for Dr. William Schmidt who couldn't be here today. Tyler I just want to check with you his testimony was mailed to you earlier (unintelligible) I just want to highlight just a couple of points on Paxil CR and Welbutrin XL. There is nothing I don't think that I am going to tell you that you do not already know. I want to point out something that wasn't in the early tests () report. They did not examine the differences between drugs with respect to compliance or long term adherence. I think that it is very important and when you look at Paxil CR the reason we came out with it is it's a unique SSRI that bypasses the stomach and is absorbed in the lower GI track in 4-5 hours. Now what does that mean? Lower side effects, as it relates to nausea and vomiting. You have better compliance. Let me just give you some data on that based on results from a national [unintelligible] depression data based study published in 2003 with at population of more than 20,000 patients. Actual CR's associated with 28 % lower risk of discontinuation. I guess, bottom line is patient doesn't take it they don't get better. It's a better mouse trap. Let me shift my remarks to Welbutrin XL again what we were hearing from Physicians is that they wanted a once a day medication they were using Welbutrin SR and what the data said was that 36.8% did not take their medication with the same frequency as prescribed by the physicians. And 26% which I think is an amazing number had missed a dose in the last 24 hours. So let me conclude by giving you the benefit of compliances that relates to Welbutrin XL. And what you see with the Welbutrin XL you're rapid and decreases in plasma levels are significantly reduced. What that means is compliance improves and possible side affects like insomnia from the late second

dose are reduced. I think that from a policy prospective what this translates to you as you go into your executive sessions you start looking at prices is you get fewer office visits, less switching, less time and money wasted, and I think that is what we all want. That concludes my remarks. Any questions?

Barry Bennett, M.D. (Self) – Antidepressants

I am Barry Bennett family Physician, from Idaho Falls. The immediate past president of Adult Academy and Family Physicians I am here representing my own views to the antidepressant market I would request that in your reviews you would consider leaving lost of prolong formulary it is the most used antidepressant in my practice and amongst many of my peers I find that it has a faster onset of action clinically from my own experience with my patients I see less side effects in it's us and utilization it does have similar sexual side effects the other SSRI's but I do not think there is really a class effect difference in sexual side effects amongst any of the drugs. I do think there is a distinct difference between Celesta or generic Sycaliprin and Lexapro I clearly see less sedation I see difficulty in changing patients from Lexapro to Celesta and a significant % of patients I tried to transition in that direction have not been successful they have not liked the medication. The cheapest way to manage your patient with depression is to keep them stable and switching around does clearly create more visits and more difficulty for the patients. In the improvement points I think it is very important. I do find a significant amount of success using Lexapro in patients with irritable bowel syndrome of a significant (unintelligible) on Serotonins specifically found good use off label in areas with Lexapro. Again I would just recommend from my perspective view please consider leaving Lexapro and formulary not requiring a switch to generic citalopram because I think there are enough significant differences. I thank you for your time.

Grace Lawrence (Self) – Antidepressants

- Hello I am Grace Lawrence, I have a Bachelor of Science and a PHD in Pharmacy and I am a certified Geriatric Pharmacist. I am here not on behalf of the pharmaceutical companies but I am an independent assisted living and retail pharmacy specializing in Geriatrics and that whole population. I guess really that I would like to address, I jotted down a few things that I am thinking as I am listening to all of this conversation that there is a lot of competition in this country. I am glad that the pharmaceutical companies have encouraged competition. We have a wide variety of antidepressant agents to choose from. As pharmacists we are concerned with drug/drug interactions, drug side effects. All the profiles, how that drug works with geriatric patients and their other co-morbidities and having open access to antidepressant agents allows us to make those recommendations. For example Zoloft as we know is will be going generic soon. As a committee I would strongly encourage and as practitioners the continuity of care having our patients on an agent. Zoloft has a very broad range and (unintelligible) of activity has a long FDA approval in its long term use. When I have Students thru Idaho State University the college of Pharmacy and they are on my Geriatric rotation I tell them it is not the pill it is the patient. Having open access will allow us to as for example our non responders to SSRI's or our partial responders we can have augmentation with other agents as in Bupropion or looking at alternative agents as in our SNRI'S using bemofaxine and also fluoxetine. And looking at some of those agents remembering that these duel acting antidepressants as well looking at those remission rates 40% , 60%, respectively at 6 weeks and 12 week interventions. I would just highly encourage just the continued use and the open access of having these antidepressant agents available for the prescribing Doctors out there in our community. Thank you.

Richard Montgomery (Self) – Antidepressants

I am Richard Montgomery I'm in private practice here, I'm not representing anyone but myself. I'm here basically [unintelligible] clinical observations. And probably augment what you have already heard in the end. I'm new to Idaho I practiced both in California and Penn. My training one of the best aspects of my

practice here is I see people in all social and economic levels both in patient and out patient environments. I worked at the health and welfare adult clinic and I also see private clients in my office. I see all age groups and I work at three different in patient hospitals here. I would like to talk to you about the importance of leaving antidepressants the whole spectrum of antidepressants available to psychiatrists for use. What's really clear I think that everybody here who has experienced in the psychiatric care phys ed there is a critical match between a patient and (unintelligible) When somebody has a depression either unresponsive to any medication and you finally write one where they can tolerate the side effects this will make them compliant to the medication. Compliance is critical and keeping someone out of the Hospital. Another thing I think that you have to keep in mind was Psychiatry apart from other drugs and other categories and other aspects of medicine consider is that we can't reduce Psychiatry in response to purely quantitative measures. Psychiatry does (unintelligible) as I go forth in my practice I regularly see that more and more. I think winding down that in eliminating formularies we are essentially contributing to what I see of all ages a polarization of the health care system between the funded and unfunded the haves and the have nots. In keeping the formulary open we have options available for all people in all levels. Idaho has so far been a fantastic state to practice in. I think that many, many options are available for all the people I have seen in all the clinics. And I hope we can keep it that way. In closing everybody here has a similar interest in medicine giving the absolute best care to the people of this state. I know that everybody is working towards this same goal as this. My fear is that we are using what is akin to cutting off a foot to treat a plain (unintelligible) wart if we are not very careful about how we make restrictions and fix problems that could otherwise fix less broad measures. I thank you for your time.

Jonna Nelson (Lilly) – Antidepressants

I'm Jonna Nelson, I'm a PharmD with the outcomes research department of Eli-Lilly and Company. I want to spend just a few minutes talking about Cymbalta. Cymbalta is a selected serotonin and norepinephrine reuptake inhibitor. It is indicated for both major depressive disorder and it is the only antidepressant indicated for diabetic [unintelligible] neuropathic pain. It is very potent and has nearly equal affinity or inhibition for both serotonin and nor norepinephrine at that dose of 60 mgs. one daily. And it addresses both the physical and emotional components of depression. Later on today you are going to review a report on antidepressants. And I would like to focus on key information that is not included in that report. With major depressive disorder, remission is the goal of therapy, but what happens if you don't achieve your mission? You can see a three fold increase in the risk of relapse, a three fold increase in the time it takes to relapse, and increase in use of medical services. So Cymbalta demonstrated remission rates as high as 44% in about 9 weeks [unintelligible] clinical trials pool data [unintelligible] separation from placebo as soon as 5 weeks. Painful physical conditions associated with depression were not addressed in the report as well, yet many depressed patients, one article quotes a rate of 69%, they present with painful physical symptoms and an article by [unintelligible] last year suggested that improvements in these painful physical symptoms have been associated with higher remission rates. Cymbalta demonstrated significant improvement in overall aches and pains, including back and shoulder pain, as early as week one during clinical trials using a vegible analog scale. Other excluded studies included a head to head study this year with fluoxetine verses benofaxine which showed response in remission rates were similar. A recently published article showing that patients receiving either Cymbalta or fluoxetine had a significantly higher incidence of sexual dysfunction, however when you look at the incidence of Cymbalta compared to fluoxetine it was significantly lower. And then unpublished data this year, most recently, a head to head study showing the onset of antidepressant action of fluoxetine is as fast as citalopram. So I would like to wrap up by just talking about some safety items. The most commonly observed side effects were nausea, which was resolved in about 7 days, dry mouth and constipation. Cymbalta has a low potential of drug/drug interactions. It has minimal effects on blood pressure and a low incidence of sustained hypertension and it relatively latent as well. Thank you very much for your time.

Sue Heineman (Pfizer) – Antidepressants

Good Morning, my name is Sue Heineman, I am a pharmacist with Pfizer. [Unintelligible] on behave of Pfizer [unintelligible] Zoloft. And [unintelligible] depression is a significant burden on our society and 83 billion dollars is associated with that disease. Most of it due to indirect cost [unintelligible] I know the goal of Medicaid is not only to support the person with a medical condition with their medication but to get them back functioning so they can work. We have heard a lot about medication adherence and [unintelligible] and tolerable will make that person adherent to their medication that's going to get them functioning

and back to their home life and back to work. Within Idaho Medicaid it appears that based on the data that is available from the website about 9% of the cost associated with antidepressant [unintelligible] it is about 9% of all of the cost. Having the ability to choose whichever agent works for the patient [unintelligible] only 9% of the cost it would be great to have that open access and not have to choose just one agent for a small percentage of the cost with the pharmacy reimbursement. Within Idaho Medicaid as well 72% of the recipients are children, which is important although they don't make up the majority of the cost, Zoloft does have an indication for pediatric [unintelligible] of antidepressant [unintelligible] not for depression but for LCD. So there is safety being done on the trial that showed more suicide within adolescence and pediatric populations. As a pharmacist I am very, I want to make sure that the medications are used appropriately; I want to make sure that the patients are receiving the most efficacious, the most safe drug one that has less drug interactions, something that they are going to be adherent to. And Zoloft does have this safety [unintelligible] show that both in the geriatric population it has an FDA safety statement supporting it's use post acute coronary syndrome in those patients with depression, has again the pediatric indication for safety as well. Each person does respond differently to medications and finding that medication that is safe and effective is very important. With an article in Medicaid looking at 2004 data [unintelligible] depression, Zoloft was the one used most often, 19%, which was followed by Lexapro and Vexera with 17% each. So it is a significant group of the patients are on this medication. The safety data shows that there has been a higher response sponsoring with Zoloft, it worked well in a geriatric population by increasing functioning and increased mental functioning, there is less weight gain associated with it verses the other agents. Again, ultimately if a patient is not taking their medication they are not be [unintelligible] and be functioning. Half the patients that take their medications don't take it appropriately. So finding that medication that they will take that is safe and effective is paramount. Thank you for your time.

Scott Hoopes, MD (Self) – Antidepressants

I am glad to be here. I would like to make a couple of points. I have been a principle investigator [unintelligible] psychiatric medication. We need on average to screen inpatients in order to obtain, one, their personal [unintelligible]. We treat either [unintelligible] patients not the one that's in the study. Evidence is based medicine is very important and I'm certainly committed to [unintelligible] look at as a beginning. [Unintelligible] individual and as we get to know that individual we treat that individual need. That said, I would like to share my personal experience and hope it will be of value in the choice you have to make. We choose to treat vocational rehabilitation patients in my practice and many of those patients are your beneficiaries. Many of these patients are coming out of prison. They have life histories that are very unfortunate and it is surprising [unintelligible] multiple diagnosis and are frequently the most [unintelligible] ADHD that has seriously affected their lives. Maybe with patients [unintelligible] again we don't have studies, we don't have evidence based medicine on treating bipolar disorder, ADHD and [unintelligible] substance abuse. Individual experience however is that many of these patients, when we treat them properly and address their needs for often the first time in their lives go forward in a productive life and many of them get off of the roles of other assisted programs [unintelligible] tool in that regard because then patients have felony convictions and substance abuse that [unintelligible] to stimulants other indications [unintelligible] people with anxiety disorders and again we have no studies, but I would propose patients with bipolar disorder generally do much better [unintelligible]. So please, I would ask you to take that into account [unintelligible] my experiences is [unintelligible] more affectively than [unintelligible]. Thank you very much.

Mija Yoon (McNeil Consumer Specialty Pharm) – ADHD

Good Morning, my name is Mija Yoon I'm a PharmD and a medical scientist with liaison with McNeil Consumer and Specialty Pharmaceutical. First I would like to thank you today for giving me the opportunity to speak. I'll be speaking on behave of Concerta today. Concerta is indicated for the treatment of ADHD and it used methylphenidate as its active ingredient and it is categorize as controlled substance Class II. For the limited time given I would like to focus on just the three points that make Concerta unique and why this should be on the Idaho Medicaid PDL system. Concerta is proven to provide 12 hour efficacy with just one morning dose. [Unintelligible] treatment for ADHD study conducted by NIMH indicated that 12 hour medication coverage resulted in the most ADHD symptom treatment. And for children Concerta provides coverage while in school and after school. Participating in after school activities is very important because this is when children learn to interact with others. And sitting through the dinner table is also important this is where you teach the [unintelligible]. For adolescents there are three driving studies conducted by [unintelligible] that indicates that the adolescent treated with ADHD who are treated with Concerta they demonstrate that their driving performance improves significantly not only throughout the day, but later in the evening and into the night. So these are just a few examples why the proper efficacy is very important. The second point I would like to make is Concerta uses a very unique drug delivery system that is called

OROS, [unintelligible] Release Oral Delivery System. Basically, this drug system provides a smooth ascending [unintelligible] profile which eliminates the peak [unintelligible] fluctuations. Without peak [unintelligible] fluctuations patients don't have to worry about the ADHD symptoms rebound. And the third point, the final point I would like to make is Concerta being a control substance II, Concerta has much less potential for abuse. The American Academy of Child and Adolescents by psychiatry practice parameter that is the evidence based medicine approach identifies Concerta is less prone to abuse in diversion because it is given once in the morning and it does not necessitate multiple doses throughout the day where it can be given away or sold. Furthermore, the formulary [unintelligible] the methylphenidate in the tablet form is very difficult to extract. The Concerta tablet contains the high molecule polymers that is mixed with methylphenidate if it is crushed and mixed with water it has to be, the tablet comes in a gel form, because it turns into gel, the gel has to be mixed with a high volume of water and it has to be stirred for a long period of time in order for the content to be separated from the polymer. So these are the reasons that lower the abuse potential. So I just mentioned a few points that Concerta is unique and why Concerta should be on the Idaho PDL system. Thank you.

Andy Weise, PharmD (Novartis) – ADHD

I'm Andy Weise from Novartis Pharmaceuticals, I am the original scientific director, and I'm a PharmD. I just want to make a couple of points about our product Focalin XR. Commercially available methylphenidate products marketed in many different brands really consist of a mixture of dexamethylphenidate isomers of methylphenidate. Methylphenidate acts by binding [unintelligible] norepinephrine transporters and blocks the reuptake of these neurotransmitters into the presynaptic neuron. I think that there is enough evidence out there from a wide variety of testing [unintelligible] available from micro dialysis to imaging and radiographic binding studies that shows that dexmethylphenidate is the active isomer [unintelligible] for a methylphenidate, actually competes with poor receptor sites without any significant pharmacological effect. Focalin XR is a long acting methylphenidate preparation containing only dexmethylphenidate [unintelligible] isomer. It is indicated for the treatment of ADHD in patients six years of age or older. It is the only methylphenidate stimulant given once daily with an approved indication for children, adolescents and adults. It does use a patented delivery system called SODIS, which I won't go into because it would bore you, but suffice it to say it delivers 50% of the dose within one hour and 50% of the dose four hours later. The safety and efficacy of Focalin XR has been demonstrated in randomized double blind placebo controlled trials in children and adults which [unintelligible] have a beneficial effect on signs and symptoms of ADHD including positive effects on behavior, academic ratings and [unintelligible] improvement. The drug is well tolerated with no discontinuations through adverse effects in the pediatric study an over discontinuation rate similar to placebo in an adult study. More importantly two cross over design studies assessing the efficacy of the drug throughout the school day at least as defined in the studies showed statistically significant symptom control within one hour and at all time point throughout the 12 hour school day as defined in the studies. There is a clear advantage of working within an hour, that's important if you're a mom or a dad trying to get you ADHD kid out the door to school or if you are an adult with ADHD who needs to get to work on time. Our studies suggest that the extended release technologies allows for these effects to be continued throughout that 12 hour period. In closing, just a few points. It's indicated for children, adolescents and adults with demonstrated efficacy across these patient groups. For a once daily symptom control within one hour and being a capsule it has the advantage of being able to open the capsule and sprinkling it on applesauce for patients who are unable to take tablets or capsules. And it is well tolerated as previously described in clinical trials. Thank you very much for the opportunity.

Steven Asher, M.D. (Self) – ADHD

My name is Steven Asher, I'm a clinical neurologist, [unintelligible] Academy of Neurology. I am the founder of the Idaho Sleep Disorder Center and I have been in practice in Boise for 25 years. I'm here to speak to modafinil or Provigil. The FDA indications for the use of Provigil are shift work/sleep disorder, people coming off after a night at Micron, for fatigue associated with narcolepsy, a rare sleep disorder, for residual sleepiness in those with sleep apnea syndrome who are treated with CPAP with incomplete relieve and lastly with the fatigue associated with Multiple Sclerosis. Those later two groups are probably disproportionately represented on your beneficiary roles the sleep apnea person is usually obese, obesity is part of the population we are here to talk about today, and Multiple Sclerosis often because of the [unintelligible] history leads to inability to maintain a place in society and the work force. So it's those later two

groups that probably would draw your attention to this particular drug. Provigil is an alerting agent, it is to be distinguished from the simulate medications, you heard about methylphenidate this morning, the amphetamines and there was [unintelligible] between [unintelligible] because of their toxicity so you'd have basically you have three choices in terms stimulant medications used to either alert people or to make them appropriately wakeful. Provigil has the easiest dosing, it has the most benign side effect profile, short of occasional headaches after you first start taking it for two or three days, the side effects are negligible. It often is dosed once a day which markedly improves compliance. The drug has essentially no diversion desirability because it isn't fun to take, it is not fun to take but, it is simply a focusing or alerting agent without some of the desired effects of the amphetamines so it has a very different set of pharmacologic properties and principles. Because of its ease of use, because of its efficacy, there is a, in my view, a marked increase in compliance. As physicians we can either telephone that prescription in or we can write a prescription without having to require the patient come to the office to pick up a prescription for a scheduled trip to the [unintelligible]. So I believe it is my first choice in this patient population. I think it has reached a point of being a standard of community care when [unintelligible]. Thank you very much for your time.

Committee: [unintelligible] you're saying Fentinal is FDA approved for fatigue associated with MS?

Mr. Asher: Yes

Committee: You're sure about that?

Mr. Asher: I think so.

Committee: It is not.

Mr. Asher: It is for the other three? OK, thank you.

Jonna Nelson (Lilly) – ADHD

Hello again. This time I would like to talk about ADHD, Strattera and [unintelligible]. Children with ADHD face many challenges from a developmental, education and social prospective and whose symptoms make [unintelligible] up to 60% of these cases. Strattera is a non controlled, non stimulant medication for the treatment of ADHD [unintelligible] children, adolescence and adults. And recently the American Academy of Child and Adolescent Psychiatry revised their treatment guidelines to include Strattera [unintelligible] treatment. The presence of co morbid conditions can also be a treatment challenge for patients with ADHD. For instance, as many as 65% of children with ADHD will present with at least one co morbid condition. Let me give you some of the numbers on those, ticks, [unintelligible], anxiety at 34%, there is also depression and oppositional defiance disorder, ODD. Stimulates an exacerbate some of these co morbidities; however Strattera has no label contraindications or warnings for patients with co morbid ticks and anxiety. In addition, Strattera was shown to improve co morbid ODD symptoms and did not exacerbate depressive symptoms. So these co morbidities really highlight that the needs among ADHD patient's very and individualized treatment plans are crucial. Substance abuse issues frequently occur in 10 to 20% of ADHD patients and according to a 2003 national survey over 1 million persons aged 12 and over use stimulates for non medical uses, that's quite a large number. So while stimulates present an opportunity for diversion, Strattera has no appreciable abuse potential and there is no data that shows patterns of diversion. So it makes it ideal for patients who either living in a substance abusing environment or have a history of substance abuse. I again I would wrap up by talking about safety and tolerability. In children most commonly observed adverse events were nausea, dyspepsia, and vomiting. Also there was a label change earlier this year to denote that two out of two million patients recorded elevated pepatic liver enzymes [unintelligible]. And this was in the absence of any other explanatory factors. Also there is relatively no rates of insomnia associated with Strattera, and this is important at particularly [unintelligible] because you've heard the fact that insomnia is commonly associated with stimulate therapy. So wrapping up, considering all this information, the addition of Strattera to the preferred drug list may help maximize the opportunity for successful management of this disorder. Thank you.

Steve Meyers, MD (Self) – ADHD

My name is Steve Meyers. I'm from Idaho Falls, ID. I'm representing all the children in the southeast Idaho area. I have been cutting and pasting in my mind all the comments that I had prepared today and all the things have been mentioned before so I think all my clips have been kind of blowing around in my mind. I do have a couple of points. One, it has been talked about as far as medication compliance, I deal with children that are [unintelligible] brain injury, learning problems, anxiety spectrum, many of the difficult and [unintelligible] behavior areas and so we get most of the children from the regional areas. I'm concerned that my tool box that I have medications is going to be negated by utilization review issues that can surface. There are several medications that I think that need to be, I am going to put my vote in for Strattera, I use a lot of Strattera. I think also we have to think about compliance from the stand point of medication duration. Please don't go back to short acting medications. I remember those days. I remember the school teacher having to give the medications and the kids lining up in the cafeteria lines. And most of the time the kids are not getting their medications. It is hard enough to give a Ritalin LA to get kids through school and then have them take their short acting medication to have them kind of complete that day. Many times the parents would forget or the particular patient would just take off and play. Short acting medications are not the way to go. There is increased risk of substance abuse that has been mentioned. Please still consider the long acting medications Strattera, Adderall XR, Concerta 4.XR, ones that are very important and make sure we keep [unintelligible] because there are going to be less concerns about abuse, diversion and just increased compliance. We have to be thinking about that issue. One thing I [unintelligible] because he can really help you guys to really begin to understand what he needs to use. It's a 24/7 disorder, it's not a [unintelligible] 4:00 like some of these drug reps that come to my office and say well it's [unintelligible] school day, it's 24/7 disorder. Has extreme co morbidities, extreme risk factors if it's not properly treated. So as we think about those medications we have to fine tune. I had a boy that finally he decided to take another Ritalin LA after school, [unintelligible] school time, but after a third [unintelligible] accident he decided, well you're right I guess I need to take another Ritalin LA so I can get 16 hours, I come home at nine o'clock. So those are the factors that we have to think about in terms of treatment options and the co morbidity. Thank you very much.