

Minutes of Meeting

**Alabama Medicaid Agency
Pharmacy and Therapeutics Committee**

May 9, 2018

Members Present: Dr. Lee Carter (Vice-Chairperson), Dr. Elizabeth Dawson, Dr. Kimberly Graham, Dr. Frances Heinze (Chairperson), Dr. Kelli Littlejohn Newman, Dr. Melinda Rowe, Dr. Robert Smith, and Dr. Ramakanth Vemuluri

Members Absent: Dr. Amber Hutchison

Health Home/Probationary RCO Pharmacists Present via Teleconference: Amy Donaldson, Angela Lowe, Lydia Rather, and Kristian Testerman

Presenters: Dr. Rachel Bacon and Dr. Sage Bagwell

Presenters Present via teleconference: None

1. OPENING REMARKS

Chairperson Heinze called the Pharmacy and Therapeutics (P&T) Committee Meeting to order at 9:00 a.m.

2. APPROVAL OF MINUTES

Chairperson Heinze asked if there were any corrections to the minutes from the February 21, 2018 P&T Committee Meeting.

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

3. PHARMACY PROGRAM UPDATE

Dr. Newman stated that there is a new DME fee schedule as a result of the 21st Century Cures Act. Today's meeting will include a presentation by Dr. Robert Moon on Alabama Medicaid Opioid Prescribing Trends and Outcomes and a discussion on potential opioid edits.

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 was a total of one manufacturer verbal presentation at the meeting.

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

The pharmacotherapy class reviews began at approximately 9:07 a.m. There were a total of 17 drug class re-reviews. The eye, ear, nose and throat preparations-antiallergic agents, eye, ear, nose and throat preparations-antibacterials, eye, ear, nose and throat preparations-vasoconstrictors, and androgens were last reviewed in November 2015. The centrally acting skeletal muscle relaxants, direct-acting skeletal muscle relaxants, GABA-derivative skeletal muscle relaxants, miscellaneous skeletal muscle relaxants, opiate agonists, opiate partial agonists, selective serotonin agonists, antihistamine antiemetics, 5-HT₃ receptor antagonist antiemetics, NK1 receptor antagonist antiemetics, miscellaneous antiemetics, and proton-pump inhibitors were last reviewed in February 2016. The complement inhibitors for the treatment of Hereditary Angioedema were reviewed for the first time.

Eye, Ear, Nose, and Throat Preparations: Antiallergic Agents: AHFS 520200

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that The EENT antiallergic agents included in this review are listed in Table 1 on page 15. Azelastine, cromolyn, epinastine, and olopatadine are available in a generic formulation. This class was last reviewed in November 2015. 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 EENT antiallergic 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 EENT antiallergic 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 eye, ear, nose, and throat (EENT) antiallergic 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 Heinze asked the P&T Committee members to mark their ballots.

Eye, Ear, Nose, and Throat Preparations: Antibacterials: AHFS 520404

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that the EENT antibacterials included in this review are listed in Table 1 on page 68. The topical antibacterials (AHFS 840404) and systemic antibacterials (AHFS 081200) were previously reviewed and are not included in this review. Many of the products are available in a generic formulation.

Two agents indicated for the treatment of otitis media have been approved since the last review. Otiprio[®] is the first and only single-dose ciprofloxacin otic suspension with thermosensitive liquid-to-gel technology indicated for the treatment of pediatric patients with bilateral otitis media with effusion undergoing tympanostomy tube placement. Otiprio[®] provides sustained exposure of ciprofloxacin to the middle ear for one to two weeks after a single intratympanic administration. Mair et al demonstrated that Otiprio[®] administration resulted in less treatment failure (defined as the presence of otorrhea, use of otic or systemic antibiotics, loss to follow-up, or missed visits) compared to sham treatment (P<0.001). Otovel[®] (ciprofloxacin and fluocinolone acetonide) is the first and only antibiotic and steroid ear drop in single-use vials, and it is indicated for the treatment of acute otitis media with tympanostomy tubes in pediatric patients (aged six months and older). In two clinical studies, Otovel[®] was shown to improve the time to cessation of otorrhea compared to each component alone (P<0.001). Otiprio[®] is administered during the tympanostomy tube placement procedure; while Otovel[®] is for use at home in children with acute otitis media who have tympanostomy tubes in place.

There have been no other 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 EENT antibacterial is safer or more efficacious than another within its given indication. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand EENT antibacterials 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 eye, ear, nose, and throat (EENT) antibacterial 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 Heinze asked the P&T Committee members to mark their ballots.

Eye, Ear, Nose, and Throat Preparations: Vasoconstrictors: AHFS 523200

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that the only EENT vasoconstrictor included in this review is phenylephrine ophthalmic solution, and it is 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.

The scientific evidence regarding the efficacy of the EENT vasoconstrictors is extremely limited. There were no studies found in the medical literature that directly compared the safety and efficacy of the ophthalmic EENT vasoconstrictors.

There is insufficient evidence to support that one brand EENT vasoconstrictor 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 EENT vasoconstrictors 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 eye, ear, nose, and throat (EENT) vasoconstrictor 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 Heinze asked the P&T Committee members to mark their ballots.

Androgens: AHFS 680800

Manufacturer comments on behalf of these products:

None

Dr. Bacon stated that the androgens included in this review are listed in Table 1 on page 181. Danazol, fluoxymesterone, methyltestosterone, oxandrolone, testosterone, testosterone cypionate, and testosterone enanthate are available in a generic formulation.

The Testosterone Trials (T Trials), published in 2016-2017, were conducted at 12 sites across the country in 790 men ≥ 65 years of age with low levels of testosterone and symptoms to which low testosterone might contribute. Participants were randomly assigned to receive testosterone gel or a placebo gel applied to the skin daily. In older men with low testosterone, one year of testosterone treatment improved bone density and corrected anemia of both known and unknown causes, but also increased the volume of coronary artery plaque, according to results reported from the T Trials. Testosterone treatment had no effect on memory or other cognitive function. (starting on page 199)

There have been no other 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 androgen 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.

No brand androgen 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.

Therefore, all brand androgens 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.

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

Centrally Acting Skeletal Muscle Relaxants: American Hospital Formulary Service (AHFS) 122004
Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that the centrally acting skeletal muscle relaxants included in this review are listed in Table 1 on page 233. All of the products are available in a generic formulation. The prolonged use of carisoprodol has been associated with dependence, withdrawal, and abuse. Therefore, carisoprodol products were placed on prior authorization in 2007 through P&T and DUR review due to the abuse potential.

Although guideline updates have occurred, 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 centrally acting skeletal muscle relaxant is safer or more efficacious than another. Due to the potential risk of abuse, carisoprodol-containing products should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand centrally acting skeletal 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 centrally acting skeletal 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.

Carisoprodol and carisoprodol-containing products should not be placed in preferred status regardless of cost.

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

Direct-Acting Skeletal Muscle Relaxants: AHFS 122008
Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that dantrolene is the only direct-acting skeletal muscle relaxant that is currently available in this class, and the capsules 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.

All brand direct-acting skeletal 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 direct-acting skeletal 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 Heinze asked the P&T Committee Members to mark their ballots.

GABA-Derivative Skeletal Muscle Relaxants: AHFS 122012

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that baclofen is the only gamma aminobutyric acid (GABA)-derivative skeletal muscle relaxant that is currently available, and the tablets 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 GABA-derivative skeletal 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 GABA-derivative skeletal 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 gamma aminobutyric acid (GABA)-derivative skeletal 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 Heinze asked the P&T Committee Members to mark their ballots.

Skeletal Muscle Relaxants, Miscellaneous: AHFS 122092

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that orphenadrine is the only miscellaneous skeletal muscle relaxant that is currently available and it is 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.

All brand miscellaneous skeletal 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 miscellaneous skeletal 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 Heinze asked the P&T Committee Members to mark their ballots.

Opiate Agonists: AHFS 280808

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that the opiate agonists included in this review are listed in Table 1 on page 311. These agents are considered to be the most potent analgesics available and are frequently prescribed for the treatment of acute pain, chronic pain, and palliative care. They are available in a variety of dosage forms and combination products. All of the products are available in a generic formulation, with the exception of remifentanyl and tapentadol. The oral sustained-release opiate agonists are not included in this review as they are included in the Alabama Medicaid Prior Authorization Program, which is outside of the Preferred Drug Program. This class was last reviewed in February 2016 and was updated in May 2016. Since the last review, a new dosage formulation of oxycodone, Oxaydo[®], has been approved by the FDA. Oxaydo[®] is designed to discourage intranasal abuse by containing an inactive ingredient that may cause nasal burning if Oxaydo[®] is manipulated.

There have been many labeling changes and guideline updates for the use of opiate agonists. Current treatment guidelines that incorporate the use of the opiate agonists are summarized in Table 2. For the treatment of chronic noncancer pain, guidelines recommend nonpharmacologic therapy and non-opioid therapy as initial treatments. Opioid therapy should be considered only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. When opioids are initiated, the lowest effective dosage should be prescribed. Opioid doses over 90 mg morphine equivalent daily dose are not recommended for treating chronic pain according to the Veterans Affairs and Centers for Disease Control guidelines. Opiate agonists may be an appropriate therapeutic option in patients with moderate to severe pain. In general, no single opioid or opioid formulation is preferred over the others. Implementing risk mitigation strategies upon initiation of long-term opioid therapy is recommended, starting with an informed consent conversation covering the risks and benefits of opioid therapy as well as alternative therapies. Risk mitigation strategies may include urine drug testing, checking prescription drug monitoring programs, monitoring for overdose potential, and/or providing naloxone.

In 2017, the FDA announced labeling changes to products containing tramadol, which include a contraindication to treating pain in children under 12 years of age, a contraindication to use in children

under 18 years of age to treat pain after surgery to remove the tonsils and/or adenoids, a warning against use in adolescents between 12 and 18 years who are obese or have conditions such as obstructive sleep apnea or severe lung disease, and a warning to restrict use in mothers who are breastfeeding. In January 2018, the FDA announced that they are requiring safety labeling changes for prescription cough and cold medicines containing codeine or hydrocodone to limit the use of these products to adults 18 years and older because the risks of these medicines outweigh their benefits in children younger than 18. They are also requiring the addition of safety information about the risks of misuse, abuse, addiction, overdose, death, and slowed or difficult breathing to the Boxed Warning of the drug labels for prescription cough and cold medicines containing codeine or hydrocodone. The updated boxed warnings begin on page 351 of your packet.

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. Moon presented “Alabama Medicaid Opioid Prescribing Trends and Outcomes,” which is available on the Medicaid website. Dr. Newman gave an overview of the proposed opioid edits. Short-acting opioids will have a days’ supply limit in treatment-naïve patients, with a maximum of 7 days for adults and 5 days for children (≤ 18 years of age). A maximum morphine milligram equivalents (MME) per day will be phased in. First Data Bank is implementing a MME module which will be utilized. There will be certain exclusions (e.g., oncologists) to the opioid edits.

The P&T members discussed the utility of the prescription drug monitoring program (PDMP), noting that it is useful that it calculates the MME automatically. Dr. Smith asked if HSAs and insurance companies/Medicaid are able to coordinate to monitor for opioid use. Dr. Newman replied that unfortunately Alabama Medicaid can only see prescriptions that were paid for through Medicaid. The PDMP is the only resource to get a more comprehensive idea of patient opioid fills. Dr. Dawson recommended that patient education be made available on the risk of >5 days’ supply in initial opioid prescriptions in relation to continued opioid usage, as shown in Dr. Moon’s presentation. The committee members agreed that this data may impact a patient’s perception of the risks of using opioids.

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

Opiate Partial Agonists: AHFS 280812

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that the opiate partial agonists included in this review are listed in Table 1 on page 465. Since the last review, three new formulations of buprenorphine have been approved: Belbuca[®], Probuphine[®], and Sublocade[®]. Belbuca[®] is a buccal film indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate. Belbuca[®] uses a dissolving film that is absorbed through the inner lining of the cheek. Probuphine[®] is an implant for subdermal administration and is indicated for the maintenance treatment of opioid dependence in patients who have achieved and sustained prolonged clinical stability on low-to-moderate doses of a transmucosal buprenorphine-containing product (i.e., doses of no more than 8 mg per day of Subutex or Suboxone sublingual tablet or generic equivalent). Four implants are inserted subdermally in the upper arm for six months of treatment and are removed by the end of the sixth month. New implants may be inserted subdermally in an area of the inner side of either upper arm that has not been previously used at the time of removal, if continued treatment is desired. After one insertion in each arm, most patients should be transitioned back to a transmucosal buprenorphine-containing product for continued treatment. Neither re-insertion into previously-used administration sites, nor into sites other than the upper arm, has been studied. Because the product must be administered surgically, only health care providers who have completed the Probuphine Risk Evaluation and Mitigation Strategy (REMS) are authorized to insert and remove the implants. Sublocade[®] is an extended-release, monthly, subcutaneous injection which is indicated for the treatment of moderate to severe opioid use disorder in patients who have initiated treatment with a transmucosal buprenorphine-containing product, followed by dose adjustment for a minimum of seven days. Sublocade[®] is a drug-device combination product that utilizes buprenorphine and the Atrigel

Delivery System in a pre-filled syringe and should only be prepared and administered by healthcare providers.

For the maintenance treatment of opioid dependence, guidelines recommend the use of methadone or buprenorphine/naloxone as first-line therapy. Qualified office-based physicians may prescribe buprenorphine-containing products for the treatment of opioid dependence. Clinical trials have demonstrated that buprenorphine (with or without naloxone) reduces opioid use, retains patients in treatment and is associated with minimal adverse events when used for the detoxification and maintenance treatment of opioid dependence. Studies directly comparing buprenorphine (with or without naloxone) to methadone have shown mixed results, which is thought to be due to differences in the dosing regimens used. Compared to methadone, buprenorphine has a lower potential for abuse and is safer in an overdose situation. However, it can still produce euphoria and physical dependence. The fixed-dose combination of buprenorphine and naloxone has less potential for abuse and diversion than buprenorphine monotherapy. Currently available guidelines for the treatment of opioid use disorder generally support that buprenorphine/naloxone should be used for the induction, stabilization and maintenance phases of treatment for most patients. Preference for any formulation over another is not established. These guidelines do not discuss the use of the long-acting buprenorphine products.

There is insufficient evidence to support that one brand opiate partial agonist is safer or more efficacious than another. Due to the potential risk of abuse, buprenorphine and buprenorphine and naloxone should be managed through the medical justification portion of the prior authorization process. Approval should only be granted for patients with a diagnosis of opioid dependence. Treatment should only be prescribed by a licensed physician who qualifies for a waiver under the Drug Addiction Treatment Act (DATA) and has notified the Center for Substance Abuse Treatment of the intention to treat addiction patients and has been assigned a DEA 'X' number.

Therefore, all brand opiate partial 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 partial 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.

No brand or generic buprenorphine containing product should be placed in preferred status. Alabama Medicaid may accept cost proposals from manufacturers to designate one or more preferred agents. Preferred agents may be managed through the preferred with clinical criteria program.

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

Selective Serotonin Agonists: AHFS 283228

Manufacturer comments on behalf of these products:

None

Dr. Bagwell commented that the selective serotonin agonists (triptans) that are included in this review are listed in Table 1 on page 539. All agents included in this review have a generic formulation available. All included agents are approved for the acute treatment of migraine attacks with or without aura. Two new sumatriptan products, Onzetra Xsail® nasal powder and Zembrace SymTouch® subcutaneous injection, have been approved since the last review. The subcutaneous formulations of sumatriptan, with the exception of Zembrace SymTouch®, are also approved for the treatment of cluster headaches. 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 selective serotonin agonist is safer or more efficacious than another when administered at equipotent doses. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand selective serotonin 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 selective serotonin 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.

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

Antiemetics, Antihistamines: AHFS 562208

Manufacturer comments on behalf of these products:

None

Dr. Bagwell commented that the antihistamine antiemetics included in this review are listed in Table 1 on page 640. These agents are approved for the treatment of postoperative nausea and vomiting (PONV), general nausea and vomiting, motion sickness, and vertigo. Prochlorperazine is also approved for the treatment of schizophrenia and short-term treatment of generalized non-psychotic anxiety. The combination product doxylamine succinate and pyridoxine is currently indicated for the treatment of nausea and vomiting in pregnancy. All of the products with the exception of the fixed dose combination product are available in a generic formulation. There have been no major changes in the prescribing information or clinical studies regarding these agents since this class was last reviewed. There have been updates to several consensus guidelines included in Table 2; however, there were no major changes to note.

There is insufficient evidence to support that one brand antihistamine antiemetic 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 antihistamine antiemetics 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 antihistamine antiemetic 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 Heinze asked the P&T Committee Members to mark their ballots.

Antiemetics, 5-HT₃ Receptor Antagonists: AHFS 562220

Manufacturer comments on behalf of these products:

None

Dr. Bagwell commented that the 5-HT₃ receptor antagonists included in this review are listed in Table 1 on page 683. They are approved for the prevention and treatment of chemotherapy-induced nausea and vomiting (CINV), PONV, and radiation-induced nausea and vomiting (RINV). All agents with the exception of dolasetron have a generic formulation available. Of note, the generic formulation of palonosetron recently became available in April 2018. A new extended-release injection formulation of granisetron, Sustol[®], has been approved since the last review.

Current treatment guidelines that incorporate the use of the 5-HT₃ receptor antagonists are summarized in Table 2. The use of multiple antiemetic agents is generally required for the prevention of CINV. The selection of therapy depends on the emetogenic potential of the chemotherapy regimen. Guidelines recommend the use of 5-HT₃ receptor antagonists in combination with other agents to prevent acute nausea and vomiting associated with moderately or highly emetogenic chemotherapy. Clinical trials have demonstrated similar efficacy and safety with the 5-HT₃ receptor antagonists for the prevention of CINV. Intravenous and oral formulations are equally effective when used at the appropriate dose. However, the National Comprehensive Cancer Network guidelines specifically recommend intravenous palonosetron or subcutaneous granisetron in combination with dexamethasone for CINV prevention in moderate emetic risk chemotherapy. In contrast, the European Society of Medical Oncology/Multinational Association of Supportive Care in Cancer guidelines state that there is no definitive evidence demonstrating an advantage of the use of palonosetron with respect to the other 5-HT₃ receptor antagonists, when both are combined with dexamethasone. Clinical trials have demonstrated similar efficacy and safety among the 5-HT₃ receptor antagonists for the prevention and treatment of PONV.

There is insufficient evidence to support that one brand 5-HT₃ receptor antagonist 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 5-HT₃ receptor antagonists 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 5-HT₃ receptor antagonist 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 Heinze asked the P&T Committee Members to mark their ballots.

Antiemetics, Neurokinin-1 Receptor Antagonists: AHFS Class 562232

Manufacturer comments on behalf of these products:

None

Dr. Bagwell commented that the neurokinin-1 receptor antagonists included in this review are listed in Table 1 on page 774. This review represents a new AHFS class. With the previous review, these agents were included under antiemetics, miscellaneous. These agents are approved for the prevention and treatment of CINV, and aprepitant is also indicated for prevention of PONV. Aprepitant is the only agent available in a generic formulation. There is one new oral agent, rolapitant, which has been added since the last review.

There have been no major changes in the prescribing information or clinical studies regarding these agents since these agents were last reviewed. There have been updates to several consensus guidelines included in Table 2; however, there were no major changes to note. Guidelines recommend the use of a neurokinin-1 antagonist to prevent acute nausea and vomiting associated with moderately or highly emetogenic chemotherapy in combination with other agents. Guidelines do not currently recommend one specific regimen over another. The guidelines also state that aprepitant is similar to ondansetron in achieving complete response for 24 hours after surgery. However, aprepitant demonstrated a greater effect than ondansetron for preventing vomiting at 24 and 48 hours after surgery and in reducing nausea severity in the first 48 hours after surgery.

There is insufficient evidence to support that one brand neurokinin-1 receptor antagonist 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 neurokinin-1 receptor antagonists 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 neurokinin-1 receptor antagonist 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 Heinze asked the P&T Committee Members to mark their ballots.

Antiemetics, Miscellaneous: AHFS 562292

Manufacturer comments on behalf of these products:

None

Dr. Bagwell commented that the miscellaneous antiemetics that are included in this review are listed in Table 1 on page 830. These agents are approved for the prevention and treatment of CINV, PONV, motion sickness, and acquired immunodeficiency syndrome-related anorexia. Dronabinol and scopolamine are available in a generic formulation. The dronabinol solution product, Syndros[®], was approved since the last

review. 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 miscellaneous antiemetic 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 antiemetics 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 antiemetic 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 Heinze asked the P&T Committee Members to mark their ballots.

Proton-Pump Inhibitors: AHFS 562836

Manufacturer comments on behalf of these products:

None

Dr. Bacon commented that the proton-pump inhibitors (PPI) included in this review are listed in Table 1 on page 862. All agents with the exception of dexlansoprazole and omeprazole/clarithromycin/ amoxicillin combination package are available in a generic formulation.

There have been no major changes in the prescribing information, treatment guidelines, or clinical studies regarding these agents since this class was last reviewed. Of note, in July 2017 a warning for reports of cutaneous lupus erythematosus (CLE) and systemic lupus erythematosus (SLE) patients taking PPIs was added to the package insert. These events have occurred as both new onset and an exacerbation of existing autoimmune disease. The majority of PPI-induced lupus erythematosus cases were CLE. Avoid administration of PPIs for longer than medically indicated. If signs or symptoms consistent with CLE or SLE are noted in patients receiving a PPI, discontinue the drug and refer the patient to the appropriate specialist for evaluation.

There is insufficient evidence to support that one brand proton-pump inhibitor 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 proton-pump inhibitors 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 proton-pump inhibitor 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 Heinze asked the P&T Committee Members to mark their ballots.

Complement Inhibitors for the Treatment of Hereditary Angioedema (HAE): AHFS Class 923200

Manufacturer comments on behalf of these products:

Ruconest[®] - Salix Pharmaceuticals

Dr. Bagwell commented that this is a new AHFS class that has not previously been reviewed. The complement inhibitors for the treatment of HAE that are included in this review are listed in Table 1 on page 932. Ecallantide is included in Table 1; however, this agent is not included in the remainder of the review as it is primarily administered in the institutional setting. None of these products is currently available in a generic formulation.

The complement inhibitors included in this review are administered either intravenously or subcutaneously. They are approved either for the prophylaxis of HAE attacks or for the treatment of acute HAE attacks. The human C1 esterase inhibitors Cinryze[®] and Haegarda[®] are approved for routine prophylaxis against HAE attacks. The human C1 esterase inhibitor Berinert[®], the recombinant C1 esterase inhibitor Ruconest[®], and icatibant are all approved for the treatment of acute attacks of HAE.

The consensus guidelines included in Table 2 recommend that all patients receive on-demand treatment as soon as possible for any acute HAE events that are debilitating or involve the face, neck, or abdomen. Recommended agents for on-demand treatment include C1 esterase inhibitors, icatibant, and ecallantide. Long-term prophylaxis is only recommended for patients with frequent or severe attacks. Recommended agents for prophylaxis include attenuated androgens, antifibrinolytic agents, and C1 esterase inhibitors. The choice of agent should be based on contraindications, adverse events, risk factors for adverse effects, tolerance, response to intervention, and dose required to control attacks. Numerous clinical trials have evaluated the efficacy and safety of complement inhibitors for the prophylaxis and treatment of HAE events. Several studies have demonstrated similar efficacy among the agents. There have been no head-to-head trials to evaluate the efficacy of the complement inhibitors compared to one another.

There is insufficient evidence to support that one complement inhibitor for the treatment of hereditary angioedema 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 complement inhibitors 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 complement inhibitor for the treatment of hereditary angioedema 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 Heinze asked the P&T Committee Members to mark their ballots.

6. 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.

7. NEW BUSINESS

None

8. NEXT MEETING DATE

The next P&T Committee Meeting is scheduled for August 8, 2018 at the Medicaid Building in the Commissioner's Board Room.

9. ADJOURN

There being no further business, Dr. Dawson moved to adjourn and Dr. Carter seconded. The meeting adjourned at 11:00 a.m.

Appendix

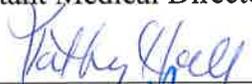
RESULTS OF THE BALLOTING
Alabama Medicaid Agency
Pharmacy and Therapeutics Committee
May 9, 2018

- A. Recommendation:** No brand eye, ear, nose, and throat (EENT) antiallergic 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


Assistant Medical Director Approve Approve as amended Disapprove No action

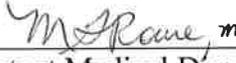

Deputy Commissioner Approve Approve as amended Disapprove No action

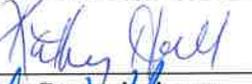

Commissioner Approve Approve as amended Disapprove No action

- B. Recommendation:** No brand eye, ear, nose, and throat (EENT) antibacterial 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


Assistant Medical Director Approve Approve as amended Disapprove No action


Deputy Commissioner Approve Approve as amended Disapprove No action


Commissioner Approve Approve as amended Disapprove No action

C. **Recommendation:** No brand eye, ear, nose, and throat (EENT) vasoconstrictor 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

M. Rowe, MD Approve Approve as amended Disapprove No action
Assistant 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 androgen 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

M. Rowe, MD Approve Approve as amended Disapprove No action
Assistant Medical Director

Kathy Hall Approve Approve as amended Disapprove No action
Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action
Commissioner

E. Recommendation: No brand centrally acting skeletal 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.

Carisoprodol and carisoprodol containing products should not be placed in preferred status regardless of cost.

Amendment: None

Vote: Unanimous to approve as recommended

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Kathy Kelly Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action
Commissioner

F. Recommendation: No brand direct-acting skeletal 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

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Kathy Kelly Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action
Commissioner

G. Recommendation: No brand gamma aminobutyric acid (GABA)-derivative skeletal 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

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Nancy Hall Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action

Commissioner

H. Recommendation: No brand miscellaneous skeletal 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

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Nancy Hall Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action

Commissioner

I. 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

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Kathy Kelly Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action

Commissioner

J. Recommendation: No brand opiate partial 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.

No brand or generic buprenorphine containing product should be placed in preferred status. Alabama Medicaid may accept cost proposals from manufacturers to designate one or more preferred agents. Preferred agents may be managed through the preferred with clinical criteria program.

Amendment: None

Vote: Unanimous to approve as recommended

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Kathy Kelly Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action

Commissioner

K. Recommendation: No brand selective serotonin 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.

Amendment: None

Vote: Unanimous to approve as recommended

Mr. Rowe, 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

L. Recommendation: No brand antihistamine antiemetic 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

Mr. Rowe, 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

M. Recommendation: No brand 5-HT₃ receptor antagonist 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

M. Ponce, MD Approve Approve as amended Disapprove No action

Medical Director

Tracy Hilly Approve Approve as amended Disapprove No action

Deputy Commissioner

Steph Approve Approve as amended Disapprove No action

Commissioner

N. Recommendation: No brand neurokinin-1 receptor antagonist 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

M. Ponce, MD Approve Approve as amended Disapprove No action

Medical Director

Tracy Hilly Approve Approve as amended Disapprove No action

Deputy Commissioner

Steph Approve Approve as amended Disapprove No action

Commissioner

O. Recommendation: No brand miscellaneous antiemetic 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

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Kathy Hays Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action

Commissioner

P. Recommendation: No brand proton-pump inhibitor 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

M. Rowe, MD Approve Approve as amended Disapprove No action

Medical Director

Kathy Hays Approve Approve as amended Disapprove No action

Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action

Commissioner

Q. Recommendation: No brand complement inhibitor for the treatment of hereditary angioedema 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

M. Powell, MD Approve Approve as amended Disapprove No action
Assistant Medical Director

Johnny Kelly Approve Approve as amended Disapprove No action
Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action
Commissioner

Respectfully submitted,

Rachel Bacon

May 21, 2018

Rachel Bacon, PharmD

Date