Minutes of Meeting

Alabama Medicaid Agency
Pharmacy and Therapeutics Committee

August 8, 2018

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

Members Absent: None

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

Presenters: Dr. Rachel Bacon

Presenters Present via teleconference: None

1. OPENING REMARKS

Chairperson Heinze called the Pharmacy and Therapeutics (P&T) Committee Meeting to order at 9:04 a.m.

2. APPROVAL OF MINUTES

Chairperson Heinze asked if there were any corrections to the minutes from the May 9, 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 the Preferred Drug List (PDL) quarterly update occurred in July and updates were made to the web portal as of August 1st. An opioid initiative update will be provided at the end of today’s meeting.

4. ORAL PRESENTATIONS BY MANUFACTURERS/MANUFACTURERS’ REPRESENTATIVES

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

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

The pharmacotherapy class reviews began at approximately 9:07 a.m. There were a total of 10 drug class re-reviews. The Alzheimer’s Agents, Antidepressants, Cerebral Stimulants/Agents Used for ADHD, Wakefulness Promoting Agents, Anxiolytics, Sedatives, and Hypnotics – Barbiturates, Anxiolytics, Sedatives, and Hypnotics – Benzodiazepines, Anxiolytics, Sedatives, and Hypnotics – Miscellaneous, Genitourinary Smooth Muscle Relaxants: Antimuscarinics, Genitourinary Smooth Muscle Relaxants: Beta-3 Agonists, and Disease-Modifying Antirheumatic Agents were last reviewed in May 2016.

Alzheimer’s Agents: Parasympathomimetic (Cholinergic) Agents, AHFS 120400; and Central Nervous System Agents, Miscellaneous, AHFS 289200
Manufacturer comments on behalf of these products:
None

Dr. Bacon noted that the Alzheimer’s agents included in this review are listed in Table 1 on page 11. All products with the exception of the memantine-donepezil combination product are available in a generic formulation. There have been no major changes in the prescribing information, treatment guidelines, or clinical studies since this class was last reviewed.

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

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

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

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

Antidepressants: AHFS 281604
Manufacturer comments on behalf of these products:
None

Dr. Bacon noted that the antidepressants are approved to treat a variety of mental disorders, including anxiety disorders, depressive disorders, eating disorders, and premenstrual dysphoric disorder. The antidepressants included in this review are listed in Table 1 on page 89. The majority of the products are
available in a generic formulation, and there is at least one generic product available in each antidepressant subclass.

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

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

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

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

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

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

Manufacturer comments on behalf of these products:
Dyanavel XR® - Tris Pharma
Aptensio XR® - Rhodes
QuilliChew ER® - Pfizer
Quillivant XR® - Pfizer

Dr. Bacon noted that the cerebral stimulants/agents used for ADHD included in this review are listed in Table 1 on page 298. Many of the products are available in a generic formulation.

Since the last review, several new formulations of stimulants have become available. Adzenys ER®, Adzenys XR-O DT®, and Dyanavel XR® are all extended release formulations of amphetamine. Adzenys ER® and Dyanavel XR® are oral suspensions, and Adzenys XR-O DT® is an orally disintegrating tablet. Mydayis ER® is an extended release capsule of mixed salts of amphetamine. Cotimpla XR-O DT® and Quillichew ER® are both extended release methylphenidate formulations. Cotimpla® is an orally disintegrating tablet and Quillichew® is a chewable tablet.

There have been no major changes in the treatment guidelines or clinical studies since this class was last reviewed.
There is insufficient evidence to support that one brand cerebral stimulant/agent used for ADHD is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

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

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

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

**Wakefulness Promoting Agents: AHFS 282080**
**Manufacturer comments on behalf of these products:**
None

Dr. Bacon noted that the wakefulness promoting agents included in this review are listed in Table 1 on page 396. Armodafinil and modafinil are available in a generic formulation. There have been no significant changes in prescribing information, clinical guidelines, or clinical studies since the class was last reviewed.

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

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

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

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

**Anxiolytics, Sedatives, and Hypnotics-Barbiturates: AHFS 282404**
**Manufacturer comments on behalf of these products:**
None

Dr. Bacon noted that the barbiturates included in this review are listed in Table 1 on page 428. Phenobarbital is the only agent available in a generic formulation. There have been no significant changes in prescribing information, clinical guidelines, or clinical studies since the class was last reviewed.
There is insufficient evidence to support that one brand barbiturate is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

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

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

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

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

Manufacturer comments on behalf of these products:
None

Dr. Bacon noted that the benzodiazepines are approved for a variety of indications including treatment of anxiety, insomnia, seizures, and alcohol withdrawal. The benzodiazepines included in this review are listed in Table 1 on page 455. All of the benzodiazepines are available in a generic formulation, with the exception of clobazam. Clobazam is indicated only for the adjunctive treatment of seizures associated with Lennox-Gastaut syndrome in patients two years of age or older.

In August 2016, the FDA announced that class-wide changes to drug labeling was being required for the opioid and benzodiazepine classes because of serious risks associated with using these medications at the same time. The benzodiazepines now include a boxed warning in their labeling stating that concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. Concomitant prescribing of these drugs should be reserved for use in patients for whom alternative treatment options are inadequate.

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

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

No brand benzodiazepine is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.
Chairperson Heinze asked if the concomitant use of benzodiazepines and opioids warnings will lead to additional opioid edits. Dr. Newman answered that yes, the Agency is looking into making this addition in the future. Being no further discussion, Chairperson Heinze asked the P&T Committee members to mark their ballots.

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

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

None

Dr. Bacon noted that the miscellaneous anxiolytics, sedatives, and hypnotics included in this review are listed in Table 1 on page 517. All of the products are available in a generic formulation, with the exception of ramelteon, suvorexant, and tasimelteon. Since the last review, zolpidem has become available in a new dosage formulation, as Zolpimist® oral spray.

The American College of Physicians 2016 Guideline for Management of Chronic Insomnia Disorder in Adults recommends that all adult patients receive cognitive behavioral therapy for insomnia as the initial treatment for chronic insomnia disorder. If cognitive behavioral therapy alone is unsuccessful, a shared decision-making approach, including a discussion of the benefits, harms, and costs of short-term use of medications, should be used to decide whether to add pharmacological therapy. This guideline found insufficient evidence overall on the comparative effectiveness and safety of the various pharmacologic treatments to recommend certain therapies over others.

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

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

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

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

**Genitourinary Smooth Muscle Relaxants - Antimuscarinics: AHFS 861204**

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

None

Dr. Bacon noted that the genitourinary smooth muscle relaxants: antimuscarinics included in this review are listed in Table 1 on page 607. Darifenacin, flavoxate, oxybutynin, tolterodine, and trospium are available in a generic formulation. Previously, Myrbetriq® (mirabegron) was included in this review. It is now in a separate AHFS class, Genitourinary Smooth Muscle Relaxants: Beta-3 Agonists.
There have been no significant changes in prescribing information since the class was last reviewed. The 2018 European Association of Urology Guidelines on Urinary Incontinence state that there is limited evidence that one antimuscarinic drug is superior to an alternative antimuscarinic drug for cure or improvement of urgency urinary incontinence.

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

Therefore, all brand genitourinary smooth muscle relaxants: antimuscarinics 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 alternatives in general use.

No brand genitourinary smooth muscle relaxant: antimuscarinic 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.

**Genitourinary Smooth Muscle Relaxants - Selective Beta-3-Adrenergic Agonists: AHFS 861208**

Manufacturer comments on behalf of these products:

None

Dr. Bacon noted that the genitourinary smooth muscle relaxants: beta-3-adrenergic agonists included in this review are listed in Table 1 on page 715. Mirabegron was previously included in the Genitourinary Smooth Muscle Relaxants review. Mirabegron is not available in a generic formulation.

Mirabegron is a β-3 adrenergic receptor agonist. Based on this mechanism of action, a potential advantage of mirabegron compared to the other agents is the low incidence of any anticholinergic adverse events; however, the agent is associated with an increased incidence of hypertension. In clinical studies, the agent demonstrated safety and efficacy in reducing overactive bladder symptoms with an adverse event profile similar to placebo. The consensus recommendations for overactive bladder are from the 2014 American Urological Association guideline, which indicates that first line treatment consists of behavioral therapies (e.g., bladder training, bladder control strategies). Antimuscarinic agents or β-3 adrenergic receptor agonists are recommended as second line and no specific agent is indicated as a preferred. The European Association of Urology’s Guidelines on Urinary Incontinence (2018) suggest considering the use of mirabegron in elderly patients if additional antimuscarinic load is to be avoided. They also state that mirabegron demonstrates greater efficacy than placebo and similar efficacy to antimuscarinics for improvement of urgency urinary incontinence symptoms, with adverse event rates similar to placebo. Patients inadequately treated with solifenacin 5 mg may benefit more from the addition of mirabegron than dose escalation of solifenacin. In patients with urgency urinary incontinence and an inadequate response to conservative treatments, offer mirabegron unless they have uncontrolled hypertension.
There is insufficient evidence to support that one brand genitourinary smooth muscle relaxant: beta-3 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.

Therefore, all brand genitourinary smooth muscle relaxants: beta-3 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 genitourinary smooth muscle relaxant: beta-3 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.

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

Manufacturer comments on behalf of these products:

Xeljanz® - Pfizer

Xeljanz XR® - Pfizer

Dr. Bacon noted that the disease-modifying antirheumatic drugs (DMARDs) are used for a variety of inflammatory and immunologic conditions which include: rheumatoid arthritis, neonatal-onset multisystem inflammatory disease, psoriatic arthritis, plaque psoriasis, juvenile idiopathic arthritis, ankylosing spondylitis, Crohn’s disease, ulcerative colitis, and hidradenitis suppurativa. Agents included in this review are listed in Table 1 on page 743. Leflunomide is the only product available in a generic formulation. Infliximab is available in two biosimilar formulations, Inflectra® and Renflexis®. Because many of the DMARDs are biologic agents made from living organisms and are extremely difficult to duplicate, regulations to approve generic versions of these agents have been difficult to create. Currently, none of the injectable agents in this class are available generically. However, Congress, through the Biologics Price Competition and Innovation Act (BPCI Act) of 2009, created an abbreviated licensure pathway for biological products that are demonstrated to be biosimilar to or interchangeable with an FDA-approved biological product. A biosimilar product is defined as a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product. Currently, the FDA has approved 10 biosimilar products and no interchangeable biologic products.

Since the last review, abatacept and tofacitinib have gained the Food and Drug Administration (FDA)-approved indication for the treatment of psoriatic arthritis, certolizumab for plaque psoriasis, and tofacitinib for ulcerative colitis. Actemra® (tocilizumab) has become the first FDA-approved treatment for both giant cell arteritis and chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome (CRS).

The FDA has also approved Humira® (adalimumab) for use in patients with non-infectious intermediate and posterior uveitis and panuveitis. Adalimumab is the first FDA-approved noncorticosteroid therapy for this indication. The approval was based on results from two phase III studies, which showed that adults with noninfectious intermediate and posterior uveitis and panuveitis treated with adalimumab every other week
had a significantly lower risk for treatment failure (a combination of uveitic flare and decrease in visual acuity) compared with placebo.

Kevzara® (sarilumab), which has been approved in the last review of this class, is an interleukin-6 (IL-6) receptor antagonist indicated for the treatment of adult patients with moderate to severe active rheumatoid arthritis who have had an inadequate response or intolerance to one or more DMARDs. It binds soluble and membrane-bound IL-6 receptors and thereby inhibits the release of proinflammatory cytokines and chemokines. IL-6 is produced by synovial and endothelial cells in joints affected by rheumatoid arthritis. Two phase III trials have demonstrated efficacy of sarilumab in terms of ACR20 improvement response, Health Assessment Questionnaire Disability Index and Sharp van der Heijde Score to placebo in TNF-alpha-naïve patients (MOBILITY) and TNF-alpha-experienced patients (TARGET).

Most research with DMARDs is for the treatment of rheumatoid arthritis. In these trials, the DMARD was compared directly to placebo or methotrexate, either as monotherapy or in combination with methotrexate. Consistently, DMARDs have shown greater improvement in symptoms over the comparator. To date, the majority of trials conducted have been placebo-controlled, with few trials directly comparing two DMARDs head-to-head for any of the FDA-approved indications. In those that have been conducted, most have shown comparable results. In one trial in rheumatoid arthritis patients who were either intolerant or were not candidates for methotrexate treatment, significantly greater improvements were observed in patients treated with tocilizumab compared to adalimumab. In another trial in rheumatoid arthritis patients with inadequate response to methotrexate, similar responses were observed in patients treated with abatacept and adalimumab. The inclusion of an adalimumab arm in one phase 3 trial of tofacitinib allowed establishing relative safety and efficacy of tofacitinib; however, formal noninferiority comparison was not performed. The MONARCH trial compared sarilumab and adalimumab in patients with active rheumatoid arthritis. At 24 weeks, patients treated with sarilumab achieved a greater improvement from baseline in DAS28-ESR at -3.28 for the sarilumab group and -2.20 for the adalimumab group (P<0.0001). The EXCELEERATE trial compared certolizumab and adalimumab in patients with active rheumatoid arthritis. The results of the primary analysis showed no significant difference in week 12 ACR20 response (69 and 71%; P=0.467) or week 104 DAS28-ESR low disease activity (35 and 33%; P=0.532) between certolizumab pegol plus methotrexate and adalimumab plus methotrexate, respectively. The few direct head-to-head trials available prevent clearly determining superiority of one agent over another.

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

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

No brand disease-modifying antirheumatic agent is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.
There were no further discussions on the agents in this class. Chairperson 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

Dr. Newman reviewed the short-acting opioid limits for treatment naïve patients and the morphine milligram equivalent (MME) cumulative edit that have been approved by the DUR Board. The Agency is currently testing the algorithms prior to implementation. Dr. Heinze asked about the education being provided prior to the changes going live. Education will include Alerts, Provider Insider articles, coordination with provider stakeholder groups, and academic detailing. The go-live date will be phased in and is currently scheduled for this fall with education beginning a month ahead. Dr. Smith asked if top prescribers will be identified and if patient counseling will be documented. Dr. Newman responded that the prescribers will be required to attest that they have reviewed the PDMP, provided a pain contract, and counseled the patient about concomitant use of benzodiazepines. The DUR Board also addressed timely refills. Currently a patient is allowed to refill when 75% of the supply should be depleted. This threshold will be 85% for opioid agents beginning later this year. This change will need to go through the administrative code process and may be effective in December.

The dates for the 2019 Alabama Medicaid P&T Meetings are as follows: February 6, May 8, August 7, and November 6.

8. NEXT MEETING DATE

The next P&T Committee Meeting is scheduled for November 7, 2018 at the Medicaid Building in the Commissioner’s Board Room.

9. ADJOURN

There being no further business, Dr. Carter moved to adjourn and Dr. Hutchison seconded. The meeting adjourned at 10:49 a.m.
Appendix

RESULTS OF THE BALLOTING
Alabama Medicaid Agency
Pharmacy and Therapeutics Committee
August 8, 2018

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

[Signatures]

Approved □ Approve as amended □ Disapprove □ No action

Medical Director

Approved □ Approve as amended □ Disapprove □ No action

Deputy Commissioner

Approved □ Approve as amended □ Disapprove □ No action

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

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

[Signatures]

Medical Director

Deputy Commissioner

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

[Signatures]

Medical Director

Deputy Commissioner

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

[Signatures]

Medical Director

[Signatures]

Deputy Commissioner

[Signatures]

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

[Signatures]

Medical Director

[Signatures]

Deputy Commissioner

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Medical Director

Deputy Commissioner

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

Medical Director

Deputy Commissioner
H. **Recommendation:** No brand genitourinary smooth muscle relaxant: antimuscarinic 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

[Signature]

Medical Director

[Signature]

Deputy Commissioner

[Signature]

Commissioner

I. **Recommendation:** No brand genitourinary smooth muscle relaxant: beta-3 adrenergic 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

[Signature]

Medical Director

[Signature]

Deputy Commissioner

[Signature]

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

**Amendment:** None

**Vote:** Unanimous to approve as recommended

[Signatures]

[Signatures]

[Signatures]

Respectfully submitted,

Rachel Bacon  
August 14, 2018

Rachel Bacon, PharmD  
Date