Minutes of Meeting

Alabama Medicaid Agency
Pharmacy and Therapeutics Committee

November 6, 2019

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

Members Absent: Dr. Amanda Williams and Dr. Ramakanth Vemuluri

ACHN Pharmacists Present via Teleconference: Lydia Rather, Lauren Ward, Melissa Damsky, Allana Alexander, Amy Donaldson, Kristin Testerman, Evan Boyett, Lacey Nelson, Kristin Kennamer, Lisa Lewis, and Emily Arnold

Presenters: Dr. Rachel Bacon and Dr. Soumya Vishwanath

Presenters Present via teleconference: None

1. OPENING REMARKS

Chairperson Carter called the Pharmacy and Therapeutics (P&T) Committee Meeting to order at 9:07 a.m.

2. APPROVAL OF MINUTES

Chairperson Carter asked if there were any corrections to the minutes from the August 7, 2019 P&T Committee Meeting.

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

3. PHARMACY PROGRAM UPDATE

Dr. Newman noted that the opioid edits continue to be implemented, with the next phase going into effect in December. The committee members discussed the challenges with opioid prescribing, including patients paying cash rather than billing insurance and specialists prescribing one or two day supplies then referring to primary care for further management.
4. ORAL PRESENTATIONS BY MANUFACTURERS/MANUFACTURERS’ REPRESENTATIVES

There were no manufacturer verbal presentations at the meeting.

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

The pharmacotherapy class reviews began at approximately 9:14 a.m. There were a total of 13 drug class re-reviews. The oral anticoagulants; platelet aggregation inhibitors; antiarrhythmics; cardiotonic agents; cardiac drugs, miscellaneous; bile acid sequestrants; cholesterol absorption inhibitors; fibric acid derivatives; HMG-CoA reductase inhibitors; Proteprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitors; antilipemic agents, miscellaneous; nitrates and nitrites; and renin-angiotensin-aldosterone system inhibitors, miscellaneous were all last reviewed in August 2017.

Oral Anticoagulants: AHFS 201204
Manufacturer comments on behalf of these products:
None

Dr. Bacon commented that the oral anticoagulants included in this review are listed in Table 1 on page 9. This review encompasses only oral dosage forms and strengths within the AHFS class. Warfarin is the only product available in a generic formulation.

In 2018 rivaroxaban gained the additional indication for the reduction of the risk of major cardiovascular events (cardiovascular death, myocardial infarction, and stroke) in patients with chronic coronary artery disease or peripheral artery disease, when used in combination with aspirin. Betrixaban (Bevyxxa®) has been approved since the last review and is indicated for the prophylaxis of venous thromboembolism (VTE) in adult patients hospitalized for an acute medical illness who are at risk for thromboembolic complications due to moderate or severe restricted mobility and other risk factors for VTE.

In summary, the non-vitamin K oral anticoagulants (NOACs) have been shown to be at least as effective as vitamin K antagonist (VKA) therapy. Guidelines recommend NOACs over warfarin for initial and long-term treatment of VTE in patients without cancer. Atrial fibrillation guidelines recommend NOACs over warfarin in NOAC-eligible patients with atrial fibrillation (except with moderate-to-severe mitral stenosis or a mechanical heart valve). VKA therapy is recommended for stroke prevention in AF patients with moderate-to-severe mitral stenosis or mechanical heart valves. There is insufficient evidence to conclude that one NOAC is safer or more efficacious than another for its approved indications.

NOACs may offer significant clinical advantages in VTE patients, but are comparable to each other. VKA products may offer significant clinical advantages in AF patients with mitral stenosis or mechanical heart valves, but are comparable to each other. In other patient populations with FDA-approved indications for an oral anticoagulant, all brand products within the class reviewed
are comparable to each other and to the generic products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand oral anticoagulant, with the exception of a non-vitamin K oral anticoagulant (NOAC) 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.

Alabama Medicaid should work with manufacturers on cost proposals so that at least one brand apixaban, dabigatran, edoxaban, or rivaroxaban product is selected as a preferred agent.

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

**Platelet Aggregation Inhibitors: AHFS 201218**

*Manufacturer comments on behalf of these products:*

None

Dr. Bacon commented that the platelet-aggregation inhibitors included in this review are listed in Table 1 on page 129. Cilostazol, clopidogrel, dipyridamole, prasugrel, and aspirin-dipyridamole are available generically. There have been no major changes in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed.

There is insufficient evidence to support that one brand platelet-aggregation 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 platelet-aggregation 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 platelet-aggregation 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 Carter asked the P&T Committee members to mark their ballots.

**Antiarrhythmics: AHFS 240404**

*Manufacturer comments on behalf of these products:*

None

Dr. Bacon commented that the antiarrhythmic agents included in the review are listed in Table 1 on page 269. All of the antiarrhythmic agents are available in a generic formulation with the exception of dronedarone. There have been no major changes in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed.
There is insufficient evidence to support one brand antiarrhythmic agent 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 antiarrhythmic agents within the class reviewed are comparable to each other and to the generic products in the class (if applicable) and offer no significant advantage over other alternatives in general use.

No brand antiarrhythmic 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 Carter asked the P&T Committee members to mark their ballots.

**Cardiotonic Agents: AHFS 240408**

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

None

Dr. Bacon commented that the only cardiotonic agent is digoxin. There have been no major changes in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed.

All brand cardiotonic 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 cardiotonic 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 Carter asked the P&T Committee members to mark their ballots.

**Cardiac Drugs, Miscellaneous: AHFS 240492**

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

None

Dr. Bacon commented that the miscellaneous cardiac drugs included in this review are listed in Table 1 on page 383. Ranolazine is available in a generic formulation. Since the last review, Ivabradine has gained FDA-approved for the treatment of stable symptomatic heart failure due to dilated cardiomyopathy in pediatric patients aged six months and older, who are in sinus rhythm with an elevated heart rate. Tafamidis (Vyndaqel®) is the first FDA-approved treatment for cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis in adults. In clinical studies, treatment with tafamidis was associated with reductions in all-cause mortality and
cardiovascular-related hospitalizations and reduced the decline in functional capacity and quality of life. Clinical guidelines reference the studies and data supporting the use of tafamidis.

There is insufficient evidence to support that one brand miscellaneous cardiac drug is safer or more efficacious than other agents commonly used for the approved indication. Due to their limited FDA-approved indications, ivabradine and tafamidis should be available through the medical justification portion of the prior authorization process for their respective indications.

Therefore, all brand miscellaneous cardiac drugs 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 cardiac drug 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 Carter asked the P&T Committee members to mark their ballots.

**Bile Acid Sequestrants: AHFS 240604**

Manufacturer comments on behalf of these products:

None

Dr. Vishwanath commented that the bile acid sequestrants included in this review are listed in Table 1 on page 419. All agents are available in a generic formulation. There have been no major changes the in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed.

There is insufficient evidence to support that one brand bile acid sequestrant 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 bile acid sequestrants 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 bile acid sequestrant 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 Carter asked the P&T Committee members to mark their ballots.
Cholesterol Absorption Inhibitors: AHFS 240605
Manufacturer comments on behalf of these products:
None

Dr. Vishwanath commented that ezetimibe is the only the cholesterol absorption inhibitor and it is available in a generic formulation. There have been no major changes in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed.

All brand cholesterol absorption 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 cholesterol absorption 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 Carter asked the P&T Committee members to mark their ballots.

Fibric Acid Derivatives: AHFS 240606
Manufacturer comments on behalf of these products:
None

Dr. Vishwanath commented that the fibric acid derivatives that are included in this review are listed in Table 1 on page 560. All fibric acid derivatives are available in a generic formulation. There have been no major changes in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed.

There is insufficient evidence to support that one brand fibric acid derivative 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 fibric acid derivatives 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 fibric acid derivative 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 Carter asked the P&T Committee members to mark their ballots.
HMG-CoA Reductase Inhibitors: AHFS 240608
Manufacturer comments on behalf of these products:
None

Dr. Vishwanath commented that the HMG-CoA reductase inhibitors, or statins, included in this review are listed in Table 1 on page 631. Zypitamag® is a new formulation of pitavastatin. FDA approval of Zypitamag® (pitavastatin magnesium) was based on the results of trials with Livalo® (pitavastatin calcium) and no new efficacy trials were required. All agents with the exception of lovastatin and pitavastatin are available generically. There have been no major changes in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed. Numerous clinical trials have demonstrated the beneficial effects of statins on lipids and cardiovascular disease and recently published clinical trials evaluating the statins have not produced clinically different results compared to trials included in the previous class review.

There is insufficient evidence to support that one brand HMG-CoA Reductase Inhibitors 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 HMG-CoA Reductase 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 HMG-CoA Reductase Inhibitors 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 Carter asked the P&T Committee members to mark their ballots.

Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) Inhibitors: AHFS 240624
Manufacturer comments on behalf of these products:
None

Dr. Vishwanath commented that the proprotein convertase subtilisin kexin 9 (PCSK9) inhibitors included in this review are listed in Table 1 on page 878. Both Praluent® (alirocumab) and Repatha® (evolocumab) are FDA-approved as an adjunct to diet, alone or in combination with other lipid-lowering therapies (e.g., statins, ezetimibe), for the treatment of adults with primary hyperlipidemia (including heterozygous familial hypercholesterolemia) to reduce LDL-C. Praluent® is also indicated to reduce the risk of myocardial infarction, stroke, and unstable angina requiring hospitalization in adults with established cardiovascular disease. Repatha® is also indicated to reduce the risk of myocardial infarction, stroke, and coronary revascularization in adults with established cardiovascular disease and as an adjunct to diet and other lipid lowering therapies (statins, ezetimibe, LDL-C apheresis) in patients with homozygous familial hypercholesterolemia (HoFH) who require additional lowering of LDL-C. Additionally, Repatha® 420 mg SQ once monthly is now indicated for HoFH in patients at or above the age of 13.
The American College of Cardiology/American Heart Association Guideline on the Management of Blood Cholesterol was released in 2018. In patients with clinical atherosclerotic cardiovascular disease (ASCVD) who are judged to be very high risk, maximally tolerated LDL-C lowering therapy including maximally tolerated statin therapy and ezetimibe should be utilized before considering PCSK9 inhibitor therapy. It is reasonable to add a PCSK9 inhibitor following a clinician–patient discussion about the net benefit, safety, and cost in this patient population when LDL-C is >70 mg/dL despite maximally tolerated LDL-C lowering therapy. At this time, there is insufficient data to conclude that one PCSK9 inhibitor is safer or more efficacious than other brand or generic products within its class and that it offers a significant clinical advantage over other alternatives in general use. The drugs in this AHFS class are used in a specific patient population. Because these agents have narrow indications with limited usage, and very specific criteria must be met prior to initiating therapy, these agents should be made available through the medical justification portion of the prior authorization process.

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

No brand PCSK9 inhibitor product is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

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

**Antilipemic Agents, Miscellaneous: AHFS 240692**

*Manufacturer comments on behalf of these products:*

*None*

Dr. Vishwanath commented that the miscellaneous antilipemic agents included in this review are listed in Table 1 on page 913. Niacin extended release and omega-3 acid ethyl esters are available in a generic formulation. There have been no major changes in prescribing information, treatment guidelines, or clinical studies since the class was last reviewed.

Prescription niacin products offer significant clinical advantages in general use over the other brand, generic, and OTC niacin products in the same class (if applicable), but are comparable to each other. Extended-release niacin is available in a generic formulation. Due to their limited FDA-approved indications, prescription omega-3 acid ethyl esters and icosapent ethyl should be available through the medical justification portion of the prior authorization process for adults with severe hypertriglyceridemia (≥500 mg/dL). Also due to its limited FDA-approved indications, lomitapide should be available through the medical justification portion of the prior authorization process for adjunctive use to diet and other lipid-lowering treatments in patients with HoFH.

No brand miscellaneous antilipemic 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 Carter asked the P&T Committee members to mark their ballots.

**Nitrates and Nitrites: AHFS 241208**

*Manufacturer comments on behalf of these products:*
None

Dr. Bacon commented that the nitrates and nitrites that are included in this review are listed in Table 1 on page 990, and all of the products are available in generic formulation. There have been no major changes in prescribing information, treatment guidelines, or clinical trials since this class was last reviewed.

There is insufficient evidence to support that one brand nitrate or nitrite product 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.

All brand products within the class are comparable to each other and to the generic products in the class and offer no significant clinical advantage over other alternatives in general use.

No brand nitrate or nitrite is recommended for preferred status. Alabama Medicaid should accept cost proposals 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 Carter asked the P&T Committee members to mark their ballots.

**Miscellaneous Renin-Angiotensin-Aldosterone System Inhibitors: AHFS 243292**

*Manufacturer comments on behalf of these products:*
None

Dr. Bacon commented that Entresto® (sacubitril-valsartan) is the only miscellaneous renin-angiotensin-aldosterone system (RAAS) inhibitor.

Entresto® (sacubitril-valsartan) is Food and Drug Administration (FDA)-approved to reduce the risk of cardiovascular death and hospitalization for HF in patients with chronic HF with reduced ejection fraction (HFrEF) (New York Heart Association [NYHA] Class II-IV). It is the only agent currently available that targets both the natriuretic peptide and the renin-angiotensin-aldosterone system. In the phase III PARADIGM-HF trial, this agent was shown to reduce the rate of cardiovascular death, HF hospitalizations, and all-cause mortality compared to enalapril.

The drugs in this American Hospital Formulary Service (AHFS) class are used in a specific patient population. Because specific criteria must be met prior to initiating therapy, these agents should be available through the medical justification portion of the prior authorization process.
Therefore, all brand miscellaneous renin-angiotensin-aldosterone system 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 miscellaneous renin-angiotensin-aldosterone system 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 Carter 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.

The committee members voted on the new chair and vice-chairperson. Dr. Heinze will be the new chairperson and Dr. Carter will be the new vice-chairperson.

7. NEXT MEETING DATE

The next P&T Committee Meeting is scheduled for February 5, 2020 at the Medicaid Building in the Commissioner’s Board Room.

8. ADJOURN

There being no further business, Dr. Heinze moved to adjourn and Dr. Hughes seconded. The meeting adjourned at 9:51 a.m.
Appendix

RESULTS OF THE BALLOTING
Alabama Medicaid Agency
Pharmacy and Therapeutics Committee
November 6, 2019

A. **Recommendation:** No brand oral anticoagulant, with the exception of a non-vitamin K oral anticoagulant (NOAC) 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.

Alabama Medicaid should work with manufacturers on cost proposals so that at least one brand apixaban, dabigatran, edoxaban, or rivaroxaban product is selected as a preferred agent.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

[Signature]
Assistant Medical Director

[Signature]
Deputy Commissioner

B. **Recommendation:** No brand platelet aggregation 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

[Signature]
Assistant Medical Director

[Signature]
Deputy Commissioner

[Signature]
C. **Recommendation:** No brand antiarrhythmic 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

- [x] Approve □ Approve as amended □ Disapprove □ No action

Assistant Medical Director

Deputy Commissioner

D. **Recommendation:** No brand cardiotonic 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

- [x] Approve □ Approve as amended □ Disapprove □ No action

Assistant Medical Director

Deputy Commissioner

E. **Recommendation:** No brand cardiac drug, miscellaneous 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

- [x] Approve □ Approve as amended □ Disapprove □ No action

Assistant Medical Director

Deputy Commissioner
F. **Recommendation:** No brand bile acid sequestrant 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

- [x] Approve □ Approve as amended □ Disapprove □ No action

Assistant Medical Director

Deputy Commissioner

G. **Recommendation:** No brand cholesterol absorption 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

- [x] Approve □ Approve as amended □ Disapprove □ No action

Assistant Medical Director

Deputy Commissioner

H. **Recommendation:** No brand fibric acid derivative 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

- [x] Approve □ Approve as amended □ Disapprove □ No action

Assistant Medical Director

Deputy Commissioner
I. **Recommendation:** No brand HMG-CoA reductase 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

<signature>

Assistant Medical Director

<signature>

Deputy Commissioner

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Commissioner

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J. **Recommendation:** No brand PCSK9 inhibitor product is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

**Amendment:** None

**Vote:** Unanimous to approve as recommended

<signature>

Assistant Medical Director

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Deputy Commissioner

<signature>

Commissioner

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K. **Recommendation:** No brand miscellaneous antilipemic 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

<signature>

Assistant Medical Director

<signature>

Deputy Commissioner

<signature>

Commissioner
L. No brand nitrate and nitrite 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

Deputy Commissioner

Commissioner

M. No brand miscellaneous renin-angiotensin-aldosterone system 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

Assistant Medical Director

Deputy Commissioner

Commissioner

Respectfully submitted,

Rachel Bacon

11/13/2019

Rachel Bacon, Pharm.D. Date