

Wyoming Preferred Drug List Advisory Committee  
Minutes  
October 21, 2004  
Cheyenne, Wyoming

Members Present: Scott Johnston, Becky Drnas, Bob Schultz, Joyce Dailey, Bill Marsh

Ex-officio: Gary Melinkovich, Aimee Lewis, Roxanne Homar, Deb Devereaux

Members Excused: James Broomfield, Michael DeBisschop, Chad Panning, Marion Smith

Guests: Antoinette Brown, Mark Helfand (by phone- EPC), Marion McDonagh (by phone- EPC), Debbie Kavanaugh (Pfizer), Rob Hanson (Pfizer), Larry Bridger (Pfizer), Deb Guay (Astra Zeneca), Susan Trieu (Astra Zeneca), Jeff Jenkins (Merck), Robert Calder (Merck), Dyan McGrath (Astra Zeneca), Betty Iverson (Wyeth), Kathryn Keller (Purdue), Alan Sloan (Purdue), Dana Hill (Takeda), Pat Teegarden (Schering-Plough), Jeff Nesheim (Janssen), Joan Solem (Lilly), Paul Pereira (TAP)

The meeting was called to order with introductions and comments by Aimee Lewis at 10:00 am.

Skeletal Muscle Relaxant Review:

Mark Helfand, M.D. gave an overview of the Skeletal Muscle Relaxant review by phone. Slide presentation is available upon request.

Public Comments: None

Committee Discussion:

Question 1: Is there any evidence that indicates that one or more skeletal muscle relaxant is safer than others?

Dantrolene and chlorzoxazone have evidence of serious hepatotoxicity. Is that sufficient enough to include them in the review? Yes.

Tizanidine added to list of those with safety issues, since it was monitored due to hepatotoxicity, otherwise they are all equally safe based on the evidence.

Carisoprodol's addiction potential was questioned and Dr. Helfand responded that there are no good studies in regard to this that are current. Addiction potential of carisoprodol is seen in a retail/clinical setting, and seems to be more so than the other skeletal muscle relaxants. (No data on suicidal potential available.)

Dr. Helfand indicated that one study showed carisoprodol's abuse potential due to its metabolite (meprobamate). Case reports also reflect this.

**DECISION: DANTROLENE, TIZANIDINE AND CHLORZOXAZONE ARE NOT AS SAFE AS OTHER SKELETAL MUSCLE RELAXANTS DUE TO POTENTIAL FOR HEPATOTOXICITY. ALL OTHERS ARE EQUALLY SAFE. CARISOPRODOL APPEARS TO HAVE MORE ADDICTIVE POTENTIAL THAN THE OTHERS.**

Question 2: Is there any evidence that indicates that one more skeletal muscle relaxant is more effective than others?

No evidence shows that one is more or less effective in musculoskeletal conditions and there's a lack of evidence in spasticity.

Discussion regarding lack of evidence available on long term usage of skeletal muscle relaxants. (i.e. No studies are known to be more than 6 weeks in duration.)

**DECISION: ALL SKELETAL MUSCLE RELAXANTS ARE EQUALLY EFFECTIVE. NO DATA IS AVAILABLE FOR THESE DRUGS WHEN USED LONG-TERM.**

Statin Update:

1<sup>st</sup> reviewed in April 2004.

Mark Helfand, M.D., provided an update to the review via phone. Slide presentation available upon request.

Public Comment:

Susan Trieu (Astra Zeneca) responded to Dr. Helfand and letter from nurses. Paper on use of Rosuvastatin in diabetics and those with hypertension and renal impairment. Revision of LDL outcomes are being looked at. Proteinuria in higher doses is not clinically significant due to recent studies. Use in Asian patients is being reviewed due to different pharmacokinetic outcomes. Studies were done in populations in their native countries and there were no increase in adverse effects.

Nurses letter: 1) Author of the letter was working with Pfizer (Dyan McGrath, Astra Zeneca) 2) No deaths were associated with rosuvastatin. Renal failure was seen in 2 patients who were on 80mg. Dr. Wolf is not a practicing physician, and the information did not come from evidence-based medicine.

Debbie Kavanaugh (Pfizer) indicated that Pfizer did not assist in writing the letter as mentioned previously. Atorvastatin has received vindication for MI's. Atorvastatin

doesn't require dosage decrease for renal diseased patients. CARDS trial for diabetics showed that atorvastatin decreased cardiovascular events with no significant adverse events.

Dr. Robert Calder (Merck) responded to A-Z trial and agreed with Dr. Helfand on its significance.

Committee Discussion:

The decision made in April was reviewed.

Review of how Statins are being handled currently.

**DECISION: NO NEW EVIDENCE WAS PRESENTED TO CHANGE THE DECISION MADE IN APRIL. ALL STATINS ARE EQUALLY EFFECTIVE AT EQUIVALENT DOSAGES. ALL STATINS ARE EQUALLY SAFE WITH SOME ADVANTAGE TO PRAVASTATIN AND ROSUVASTATIN. \*\*\*THIS WAS LATER CLARIFIED TO INCLUDE FLUVASTATIN.**

Long-acting Opioids Review:

Mark Helfand, M.D. gave an overview of the Long-acting Opioids review by phone. Slide presentation available upon request.

Public Comment:

Kathryn Keller (Purdue) spoke about persistent pain's impact on lives and the improvement to quality of life by long acting oral opioids. She emphasized the need for the ability to initialize more than one opioid to allow flexibility in treatment. Prior authorization can result in a delay to appropriate and necessary pain relief. Ms. Keller referred to the American Pain Society book on treatment of pain.

Question was raised regarding conflict of interest for the authors of the American Pain Society book.

Dr. Johnston asked, if there is a difference between long acting and short acting opioids, why are there not studies that show this?

Ms. Keller replied that studies would be hard to do due to difficulty with measurement of pain and patients' varying response to pain.

Jeff Nesheim (Jarssen) replied that studies are difficult to interpret due to drop out rates, measurement of pain, patient variability, etc. Mr. Nesheim emphasized that the availability of several drugs is important for proper pain management.

Committee Discussion:

Question 1: Is there any evidence that indicates that one more long-acting opioid is safer than others?

Safety is dose dependent with a wide range of dosing capabilities with these drugs. Studies are small and don't show much. Chronic pain patients don't get better no matter what you give them (clinically speaking).

Dr. Johnston indicated that he had spoken with some pain doctors who didn't think drug rotation was necessary and prior authorization of those drugs are OK, as long as the patient can receive another drug if others don't work.

No real difference in abuse potential per the DAWN study (although, there is no real good study on this). No data on comparative abuse potential. No data available on safety either. Use of methadone and levorphanol in elderly is not considered safe despite the lack of clinical data to show that their longer half-lives cause more problems in the elderly.

There is weak published clinical evidence that favors the rotation of use among this class of drug.

**DECISION: THE DATA AVAILABLE SHOWS NO SIGNIFICANT DIFFERENCES IN SAFETY. ALTHOUGH THERE IS NO EVIDENCE, DUE TO THEIR LONG HALF-LIFE, METHADONE AND LEVORPHANOL MAY NOT BE AS SAFE IN THE ELDERLY.**

Question 2: Is there any evidence that indicates that one or more long-acting opioid is more effective than others?

**DECISION: THE EVIDENCE DOES NOT SHOW A SIGNIFICANT DIFFERENCE IN EFFECTIVENESS. THE COMMITTEE WOULD LIKE ACCESS TO A NON-ORAL DOSAGE FORM TO BE CONSIDERED.**

Calcium Channel Blocker Review:

Marion McDonagh, Pharm.D., gave an overview of the Calcium Channel Blocker review by phone. Slide presentation is available upon request.

Public Comment:

Larry Bridger (Pfizer) spoke on special sub-population studies/trials which included women, diabetics, African-Americans, etc. This study showed amlodipine as being superior or a favorable choice as a calcium channel blocker.

Committee Discussion:

Question 1: Is there any evidence that indicates that one or more calcium channel blocker(s) is safer than others?

Cancer incidence with calcium channel blockers was raised. There is not a lot of evidence in regard to this, so no recommendation could be given by Dr. McDonagh.

Short acting dihydropyridine calcium channel blockers do have safety issues (nifedipine and isradipine). Evidence suggests an increase in mortality, but there is no available evidence to show a difference in safety among all the others.

There is no evidence of safety of the non-dihydropyridines in heart failure.

**DECISION: EVIDENCE SHOWS THAT SHORT-ACTING NIFEDIPINE AND ISRADIPINE CAUSE INCREASED MORTALITY. AVAILABLE EVIDENCE SHOWS NO SIGNIFICANT DIFFERENCE IN SAFETY AMONG THE OTHER AGENTS. THERE IS NO EVIDENCE THAT THE NON-DIHYDROPYRIDINES ARE SAFE IN HEART FAILURE.**

Question 2: Is there any evidence that indicates that one or more calcium channel blocker is more effective than others?

**DECISION: THE EVIDENCE SHOWS NO SIGNIFICANT DIFFERENCES IN EFFECTIVENESS. AVAILABILITY OF ONE OF EACH TYPE (DIHYDROPYRIDINE AND NON-DIHYDROPYRIDINE) SHOULD BE INCLUDED AS PREFERRED. THERE IS A BENEFIT TO ONCE DAILY DOSING.**