

Preferred Drug List Advisory Committee Meeting  
Wednesday, April 11, 2007  
Cheyenne, Wyoming  
10 a.m. – 2 p.m.

Members present: Marion Smith, Bill Harrison, W. Joseph Horam, Natasha Gallizzi, Dean Winsch, Kevin Robinett

Members excused: Christie Graham, Renee Gamino, Scott Johnston

Ex-officio: Roxanne Homar, Antoinette Brown, Donna Artery, James Bush

Guests: Brent Sherard, Gerald Gartlehner, Alison Little, Brenda Stout, Sheila Clement, Benjamin Varva, Stephen Brown, Jiri Danczik, Matt Johnston (Takeda), Tim Hynek (Eli Lilly), Johnna Nelson (Eli Lilly), Jeff Jenkins (Merck), Stan Sampson (Pfizer), Michael Schultz (Forest), Elson Kim (Forest)

Dr. Smith called the meeting to order at 10:04 a.m.

Review of Minutes

The minutes of the October 11, 2006 meeting were approved as submitted.

Announcements

Aimee Lewis announced that Dr. Kevin Robinett has been added to the committee.

An overview of the PDL process as well as the purpose of the committee was provided.

Second generation antidepressants

Dr. Gerald Gartlehner gave an overview of the Drug Effectiveness Review Project report. Slides are available upon request.

In response to committee questions, Dr. Gartlehner indicated that there is no evidence regarding prescribing antidepressants at higher than indicated doses or combining two antidepressants with similar mechanisms.

Public Comment:

Johnna Nelson (Lilly) provided comments on Cymbalta. Cymbalta is an SNRI approved for Major Depressive Disorder, General Anxiety Disorder, and diabetic peripheral neuropathy. It is important to treat to remission, not response. Cymbalta has been shown to treat both the emotional and physical components of depression. Those with pain and depression have higher medical costs than those with depression alone. Cymbalta has the same boxed warning as the other antidepressants and should not be prescribed in

children, those with hepatic issues, renal disease, alcohol abuse or in combination with MAOIs or serotonergic medications such as the triptans.

Elson Kim (Forest) provided comments on Lexapro. Elson quoted a section of the DERP report that indicated that escitalopram showed greater efficacy for the treatment of major depressive disorder than citalopram.

Dr. Danczik provided comments based on his personal observations as a psychiatrist. Dr. Danczik left New Mexico due to the increasing use of formularies and uncaring attitude towards patients. He is grateful for the generics that are on the market but cannot treat all his patients with those options. Dealing with formulary exceptions takes time from his practice. He estimates that in New Mexico he saw one to two less patients per day due to the number of prior authorization requests he had to complete. He finds drug formularies a great disappointment in this country. There is a good article from the American Journal of Psychiatry that indicates that patients enrolled in randomized controlled trials represent no more than 15% of real life patients. Comorbidities, drug-drug interactions, etc are excluded from studies but very important in real life practice.

Dr. Gartlehner clarified the evidence quoted by Elson Kim from Forest regarding escitalopram and citalopram. Mr. Kim was correct in quoting the DERP findings, however, these findings have been further clarified through meta-analysis which showed that while the difference is statistically significant, it is not clinically significant.

#### Committee Discussion:

Aimee Lewis indicated that the Department of Health intends to grandfather those currently stabilized on an antidepressant. The PDL will apply to treatment naïve patients. There were several questions regarding the process and how the Department will know that a patient is stabilized. This will be handled through Smart PA to the extent possible. In cases where the history is not available electronically, a manual PA request will be required.

Roxanne Homar and Dr. Brent Sherard gave additional information about the Department's intent with regard to mental health drug classes. The intent is to improve quality of care and be fiscally responsible to ensure that we are able to continue to provide prescription drug services to our Medicaid population.

#### Committee Recommendations:

##### Effectiveness:

No evidence in adults that one is more effective than the others

Some evidence in children that fluoxetine is effective in children

Small, but not compelling, difference between Effexor and SSRIs

Safety:

Differences in side effects, but overall not a significant difference in safety

Drug-drug interactions are important in adults

No difference in side effect profile that would compel us to prefer one over another

Nefazodone has increased risk of hepatotoxicity; not generally considered first-line

Suicide risk: fluoxetine preferred due to studies; data is questionable, not supporting black box warning

Paroxetine is Pregnancy Category D

Other:

Should be SSRI, SNRI, etc available (allow mirtazipine and bupropion due to unique mechanism)

Fluoxetine should be considered due to established efficacy in children

As many drugs as possible should be made available if cost differences are within reason

Cymbalta for diabetic neuropathy

Geriatrics, use shorter half-life; mirtazipine causes sedation

Paroxetine should not be used in children

Following lunch, the committee amended the recommendations to include allowance of fluvoxamine through Smart PA for the indication of Obsessive Compulsive Disorder.

#### Public Comment Disclosure Form

The Public Comment Disclosure Form was reviewed and approved as submitted. It will be required for the October 2007 PDLAC meeting and will be reviewed and implemented upon approval by the DUR Board as well.

#### NSAIDs

Kim Peterson provided an overview of the Drug Effectiveness Review Project report. Slides are available upon request.

Public Comment:

No public comment was provided.

Committee Discussion/Recommendations:

The evidence does not warrant changes to the previous recommendations.