

Preferred Drug List Advisory Committee Meeting
Tuesday October 13, 2009
Cheyenne, Wyoming
10 a.m. – 3 p.m.

Members present: Whitney Buckley, Lakhman Gondalia, Ralph Hayes, Scott Johnston, Rob Monger, Kevin Robinett, Marion Smith, Danae Stampfli, Dean Wunsch

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

Guests: Kerri Powell (GHS), Jeff Himmelberg (GSK), Greg Ferguson (EMD), Cheryl Seaberg (National MS Society), Felicia Fuller (Biogen), Reed Shafer MD, Rob Pearson (GSK), Don McCaffrey (Takeda), Colton Eisele (UW SoP student), Kieley Collins (UW SoP student), Pete Szymczak (Merck), Mike Baird (Merck), Lori Howarth (Bayer), Kevin Hogan (Bayer), Bill Ferguson (Amgen), Mike Sigler (Amgen), Tim Hynek (Lilly), Joe Busby (Lilly), Jeannie Kenyon (Roche), Sharon Cahoon-Metzger (Biogen), Clara Black (Biogen), John Stockton (Genentech)

Dr. Smith called the meeting to order at 10:07 a.m.

Introductions were made. Aimee announced that this is the last meeting of this group. The PDLAC process will be absorbed by the DUR Board in an effort to streamline efforts and decrease our administrative budget.

Newer Diabetic Agents

Committee Discussion:

No outcomes data on these three agents. No reason to use first-line.

Efficacy: No comparative data, no outcome data on any of these. All similar reductions on HbA1c. Compared with insulin had similar outcomes.

Safety: Less weight gain than insulin. Less incidence of hypoglycemia with monotherapy. Nausea level high in first few months with Byetta.

Clinical experience: Some evidence for Januvia use first-line when other oral agents (metformin) are contraindicated such as renal insufficiency. Rarely dispense the injectable agents (most patients do not want to add an injection to existing therapy). May be insulin sparing.

Public Comment:

Pete Szymczak (Merck) provided comments on Januvia. There were three points he wanted to make. 1. Januvia has a unique mechanism of action. It is a DDP-4 inhibitor and has no additive effect on hypoglycemia or weight gain. 2. It is endorsed by the American College of Endocrinologists. 3. It is a unique option for those who cannot take metformin (patients with renal impairment, moderate to severe congestive heart failure). 4. Merck's promotion strategy promotes use after metformin has been failed.

There was a motion, second and all were in favor of the above recommendations.

Oral Diabetic agents

Committee Discussion:

Outcomes data is available on sulfonylureas and metformin but not on the other agents. Pioglitazone has one study (PROACTIVE) though the results are not great and the group has serious adverse effects. In terms of outcomes, metformin has advantages over the others.

All data are for Type 2s. Type 1s typically should not be on these drugs. Metformin has the most outcomes data of the group. SUs have some but not as much as metformin. TZDs have two studies (PROACTIVE and RECORD) but serious adverse effects. meglitinides have no outcome data.

Efficacy: Comparable effectiveness in monotherapy in HbA1c reduction. Combo therapy was better than monotherapy for A1c reduction. Only metformin had weight reduction.

Safety: Data on metformin and renal and heart failure. Data is very obtuse. Experience does not support increased risk of lactic acidosis. Problem with phenformin but has not been a problem with metformin. SUs have higher incidence of hypoglycemic reactions (especially glyburide). Caution should be used with SUs in renal insufficiency. Data is mixed on TZDs and heart failure. Increased risk of edema. Metformin and acarbose have higher incidence of GI side effects.

Clinical experience: TZDs have been relegated to second line therapy. Type 2 diabetics should be treated with diet, exercise and weight loss first line. A variety of mechanisms of action should be available. Metformin is a first line agent, though TZDs may not be due to added risk.

Public Comment:

Robert Pearson (GlaxoSmithKline) provided information on Avandia. There is one long-term outcomes study (RECORD) which followed 4400 patients for 7 years. It met all of its primary endpoints. There was no difference between Avandia and metformin plus sulfonylureas. Avandia is the only TZD with cardiac outcomes (one recent study). It is also the most studied diabetes medication.

Don McCaffrey (Takeda) gave comments on Actos. Actos has the PROACTIVE trial showing long-term outcomes. It improves insulin resistance, improves beta cell sensitivity and hepatic insulin release. All TZDs cause or exacerbate congestive heart failure. Actos is the only TZD that is indicated for use with insulin.

There was a motion, second, and all were in favor of the above recommendations.

Anti-emetics

Committee discussion:

Efficacy: All work well. Aloxi seems to be very effective for moderate to high emetogenicity. Aprepitant seems to have longer term effect (several days later). Very little data on non-chemotherapy related nausea. Cancer is generally “carved out” of PA policy. Potential benefits of these agents over the older drugs. Older drugs contraindicated in children under age 2.

Safety: For chemotherapy and postoperative care there is no significant difference in adverse effects between the agents reviewed.

Clinical experience: No real difference in efficacy or adverse effects between Zofran and older agents in children (above age 2). Not much benefit seen with use of anti-emetics in children. Kytril dispensed more for chemotherapy-related nausea. Since ondansetron has become generic, more prescriptions being filled for all types of nausea. Use of small doses of ondansetron in infants is inappropriate. Have not seen serious adverse events in children with use of ondansetron.

Public Comment:

No public comment was offered.

There was a motion, second and all were in favor of the above recommendations.

Osteoporosis (Bisphosphonates)

Committee discussion:

Clinical experience: Not sure once weekly or once monthly drug has clear advantage over once daily. Need to make sure patients have enough Calcium and Vitamin D to use these drugs. Use for fracture healing is not supported in literature and is probably harmful. Tend to see jaw necrosis more in cancer-related use. Mostly an issue with injectable drugs, oral drugs do not have the issue. Amount of actual necrosis is very small. Didronel is not commonly used in osteoporosis today.

Efficacy: Alendronate and Actonel have good data in vertebral, non-vertebral and hip fractures. Paucity of evidence showing any real difference in any of these drugs.

Safety: Paucity of evidence showing a difference.

Public comment:

Jeannie Kenyon (Roche) provided information on Boniva. It is a once monthly formulation. There are three outcome studies (BONE, MOBILE and VIBE) showing a decrease in fractures. Monthly was superior to daily at one and two years. There is no hip fracture data for Boniva.

There was a motion, second and all were in favor of the above recommendations.

Review of Minutes

Dr. Smith realized that we had not approved the minutes from the April 14, 2009 meeting. There was a motion, second and all were in favor of approving the minutes as submitted.

Multiple Sclerosis

Committee Discussion:

Safety: Novantrone and Tysabri should be reserved for those who have failed other therapies. Tysabri has side effect of PML.

Efficacy: Evidence shows little difference between drugs except in specific populations.

Clinical experience: More than one drug should be available/preferred. Concur with National MS Society guidelines.

Public comment:

Sharon Cahoon-Metzger (Biogen) gave comment on Avonex and Tysabri. Biogen believes in open access to all MS drugs. Avonex is the only interferon to show a decrease in disability progression (37%). It is the only one approved for prevention of relapse, Clinically Isolated Syndrome and prevention of disability. Long-term studies show that patients at 15 years continue to do very well over time. A ten year CIS study advocates for early intervention. MS affects the gray matter resulting in cognitive effects. Most people don't want to inject daily, therefore Avonex has higher compliance.

The Committee asked about Tysabri and PML. Sharon indicated that these agents that intersect the immune system may change the system in a way that increases the incidence of PML. They are working to determine what predisposes patients to this adverse event.

Cheryl Seaberg (National MS Society) came on behalf of the 1100 individuals in Wyoming with MS. She asks for open and equal access to all MS drugs. She assists patients in navigating the system, including choice of drug. She believes this choice should be left up to the physician and the individual.

Greg Ferguson (EMD/Sorono) gave comment on Rebif. Like the others, he advocates for equal access. There are two pivotal trials for Rebif (PRIZM and EVIDENCE). Rebif decreases the relapse rate (32%), progression in disability and MRI lesions. Rebif was more effective than Avonex in 24 and 48 week exacerbation free rates.

Reed Shafer provided his insight as a neurologist with around 140 MS patients. He is also in favor of open access. He referred to the "bad old days" before there were any drugs for MS. In those days, he had 6 – 10 patients in a nursing home because of MS. Now he has 2 who were diagnosed before medications were available. Exacerbations were very common and were treated with hospitalizations. He would like to have all medications available without going through hoops. The American Academy of Neurologists have stated that interferons should be used first. Following failure (defined by two clinical attacks or intolerance) Copaxone should be tried. Following failure of Copaxone, then Tysabri is tried. Novantrone is no longer used regularly. In terms of the interferons, Rebif starts sooner and hits harder which is important in brand new illness or high activity. Over time, their effectiveness is about the same. It is truly an issue of doctor and patient preference. The drugs are really safe. He has not found problems. Tysabri should only be used when patients have failed other agents. Its effectiveness is approximately 95% vs. 35 – 45% for interferons.

Kevin Hogan (Bayer) provided comment on Betaseron. She indicated that patient should be treated individually and requests that all be included. Betaseron is an older drug. Long-term follow-up data is available out to 20 years. It is the only high dose, high frequency approved at the first event. These have the strongest evidence of efficacy for interferons. Treating early has shown better effects than those who delay treatment. Betaseron has the thinnest needle (30G) which results in good compliance. Approximately 99% of patients say they are more satisfied with the thinner needle. There is no need for refrigeration before reconstitution (up to 30 days).

A representative from TEVA Neuroscience provided comment on Copaxone. Copaxone has a different mechanism of action. It is a non-interferon and is not associated with adverse events requiring continuous lab monitoring. It is a Pregnancy Category B. Interferons and Copaxone are considered first-line therapy. In three head to head trials, Copaxone was similar to the interferons. Copaxone is the only drug with a prospective long-term study (out to 15 years now) and 8/10 patients are still walking unassisted. Copaxone also has the indicated for Clinically Isolated Syndrome.

The Committee noted that there was no conflict of interest statement on the National MS Society Guidelines. Relationships with industry are unknown.

There was a motion, second and all were in favor of the above recommendations.

There being no further business, Dr. Smith adjourned the meeting at 1:00 p.m.

Respectfully submitted,

Aimee Lewis, PharmD
DUR Manager