Department of Defense
Pharmacoeconomic Center

1750 Greeley Rd., Bldg. 4011, Rm. 217
Fort Sam Houston, TX 78234-6190

MCCS-GPE 24 February 2000

MEMORANDUM FOR Assistant Secretary of Defense (Health Affairs)

SUBJECT: Minutes of the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee Meeting

1. In accordance with Health Affairs policy 98-025, a meeting of the DoD P&T committee convened at 0800 hours on 24 February 2000, at the Naval Amphibious Base Little Creek, Portsmouth, VA.

2. MEMBERS PRESENT:

CDR Terrance Egland, MC	Co-chairman
COL Daniel D. Remund, MS	Co-chairman
COL Rosa Stith, MC	Army
LTC Judith O'Connor, MC	Army
CDR Matt Nutaitis, MC	Navy
LCDR Kevin Cook, MSC	Navy
COL (select) Bill Sykora, MC	Air Force
COL (select) John R. Downs, MC	Air Force
MAJ George Jones, BSC	Air Force
LCDR Pamela Stewart Kuhn	Coast Guard (alternate)
Ronald L. Mosier	Department of Veterans Affairs (alternate)
LTC Greg Russie, BSC	Joint Readiness Clinical Advisory Board (alternate)
LTC Steven Humburg, MC	Health Affairs
MAJ Mickey Bellemin, BSC	Defense Supply Center Philadelphia (DSCP)
Trevor Rabie	Uniformed Services Family Health Plans (USFHP)
Ray Nan Berry	Foundation Health
Kirby Davis	Anthem Alliance
William Hudson	Humana, Inc
Gene Lakey	TriWest
Ron McDonald	Sierra Military Health Services

Daniele Doyle was absent.

3. OTHERS PRESENT:

CAPT Charlie Hostettler, MSC	DoD Pharmacy Program Director, TMA
COL Mike Heath, MS	Army Pharmacy Consultant; Chair, DoD Pharmacy Board of Directors
CAPT Bob Wilkens, MSC	Navy Pharmacy Specialty Leader
CAPT (select) Betsy Nolan, MSC	TRICARE, Mid-Atlantic Region
CDR Mark Brouker, MSC	DoD Pharmacoeconomic Center (PEC)
Howard Altschwager	Deputy General Counsel, TMA
David Chicoine	Uniformed Services Family Health Plans (USFHP)
Tom Kellenberger	Merck-Medco
Mark Petruzzi	Merck-Medco
Shana Trice	DoD Pharmacoeconomic Center (PEC)
Paul Vasquez	Defense Supply Center Philadelphia (DSCP)

4. ADMINISTRATIVE ISSUES:

A. The minutes from the last meeting were accepted as written. In response to a question from MAJ Bellemin, the committee confirmed that zolpidem (Ambien®) is subject to the standard quantity limit of a 30-day supply for controlled substances.

5. OLD BUSINESS

A. Review of Interim Decisions

1. *Advances in Medical Practice (AMP) Program*—Voting members of the DoD P&T Committee met via teleconference on 26 Jan 00 to recommend drugs for coverage by the AMP program. The minutes for the interim meeting are at Appendix A. (NOTE: The minutes for the interim meeting were not previously posted on the PEC website because it would have been premature to announce the drug recommendations before AMP program officials had a chance to review them.) At the request of AMP program officials, the P&T committee co-chairs subsequently recommended more drugs for coverage by the AMP program. The consolidated list of all drugs recommended by the DoD P&T Committee for coverage under the AMP program is at Appendix B. MTFs will be informed when AMP officials, TMA officials, and service resource management officers have approved the list of drugs and finalized procedures for reimbursing MTFs for expenditures on drugs covered by the AMP program.

2. *Additions to BCF due to Program Budget Decision (PBD) No. 41*—The DoD P&T Committee met via teleconference on 26 Jan 00 to add drugs to the Basic Core Formulary (BCF) in response to additional funding for MTF pharmacies provided by the PBD No. 41. The minutes for this meeting were previously posted on the PEC website. The committee added the following drugs to the BCF:

    - metformin
    - tamoxifen

- alendronate
- citalopram
- fluoxetine
- paroxetine
- sertraline
- sumatriptan autoinjector

The committee also modified the BCF to stipulate that all MTFs must have at least one agent from each of the following classes on their formularies:

- oral serotonin 5-HT_1 receptor agonists (naratriptan, rizatriptan, sumatriptan, zolmitriptan)
- low molecular weight heparins/heparinoids (ardeparin, dalteparin, danaparoid, enoxaparin)
- leukotriene antagonists (montelukast, zafirlukast, zileuton)
- second-generation antihistamines (cetirizine, fexofenadine, loratadine)

The PEC will furnish information to MTFs to assist them in selecting agents for their formularies.

B. National Mail Order Pharmacy (NMOP) Preferred Drug Program

When the NMOP receives a new prescription for a non-preferred drug, the NMOP contractor, Merck Medco, attempts to contact the prescriber to request a switch to a preferred drug if clinically appropriate. CDR Brouker reported the switch rates and estimated cost avoidance for non-preferred/preferred drug pairs in the NMOP (see Appendix C). MAJ Bellemin reported that Merck-Medco started calling prescribers on 1 Dec 99 regarding the new non-preferred/preferred drug pairs that were approved at the Aug 99 meeting. These drug pairs are: famotidine/ranitidine (Geneva brand); nizatidine/ranitidine (Geneva brand); nitroglycerin patches other than Nitro-Dur®/Nitro-Dur®; and enalapril/lisinopril (Zestril®). Data for the new non-preferred/preferred drug pairs will be reported at the next meeting.

C. Quantity Limits

1. The PEC and the Defense Supply Center Philadelphia (DSCP) continue to check the quantity limits that Merck Medco actually applies in the NMOP to ensure that they match the official quantity limits that are listed on the PEC website at http://www.pec.ha.osd.mil/NMOP/qtylimit.htm.

2. *Report of the subcommittee on quantity limits for topicals*—Bill Hudson (Humana) and MAJ George Jones recommended quantity limits for five high-cost topicals [imiquimod (Aldara); calcipotriene (Dovonex); altitretinoin (Panretin); becaplermin (Regranex); and tazarotene (Tazorac)]. The proposed quantity limits for most of the agents were expressed in terms of the maximum number of containers of any size that would be dispensed in a given time period (30 or 90 days). Several committee members expressed concern that this might be overly restrictive and supported the concept of expressing the quantity limits in

terms of the maximum number of grams or milliliters dispensed in a given time period, with the maximum quantity set to allow for the vast majority of all use. The P&T Committee did not approve the recommended quantity limits for the topical agents listed above. The P&T Committee asked the subcommittee to provide additional information concerning the frequency distribution of quantities dispensed for these agents in the retail networks and the NMOP in order to more accurately establish 1) if any quantity limitation is necessary, and 2) if so, what a reasonable limit would be.

3. *Change in quantity limit for azithromycin*—The committee approved a recommendation by Gene Lakey (Triwest) to increase the current 6-tablet per 30 day quantity limit for azithromycin (Zithromax®) 250-mg tablets to 10 tablets per 30 days. This change in the quantity limits is necessary to accommodate dosing requirements for older children for the treatment of pharyngitis/tonsillitis.

D. *Cost-efficiency of prior authorizations in the NMOP*—MAJ Bellemin reported on the prior authorization programs for sildenafil, etanercept, rofecoxib, and celecoxib in the NMOP.

a. *Sildenafil*—Merck Medco performed 7696 prior authorizations (4865 approved and 2831 denied) at a cost of $307,840 from September 99 through December 99. Based on utilization data from June through December 1999 and the current government price for sildenafil, it is estimated that prior authorization of sildenafil will provide a $47,280 cost avoidance during the next 12-month period.

b. *Etanercept*—Merck Medco performed 161 prior authorizations (152 approved and 9 denied) at a cost of $6440 from August 99 through December 99. Based on utilization data from June through December 1999 and the current government price for etanercept, it is estimated that prior authorization of etanercept will provide a $64,084 cost avoidance during the next 12-month period.

c. *COX-2 inhibitors (celecoxib, rofecoxib)*— Merck-Medco processed 9695 prescriptions for COX-2 inhibitors from August 99 through December 99. The automated prior authorization process approved 5574 of the prescriptions; 4121 required prescriber contact. Of these, 3100 were approved and 1021 were denied at a cost of $164,840. Based on COX-2 utilization data from June through December 1999 and the current government price for these agents, it is estimated that DoD will realize a $908,026 cost avoidance during the next 12-month period.

Several members commented that the cost avoidance is underestimated because the mere existence of the prior authorization program may cause physicians to write fewer prescriptions for a drug (usually referred to as the "sentinel effect"). Other members commented that the cost avoidance is overestimated because prescriptions that are initially denied are sometimes filled when resubmitted because the prescriber provides additional information that satisfies the prior authorization criteria. Cost avoidance was also overestimated because the analysis did not account for the cost of NSAIDs or other drugs that were prescribed when the prior authorization process denied the COX-2 prescription. The PEC staff will work with MAJ Bellemin to improve the validity of the cost avoidance estimates. MAJ Bellemin will continue to report on this subject as a standing report at each meeting. The report for the next meeting is due to the co-chairs by 11 Apr 00.

E. *Prior authorization for terbinafine*—The committee co-chairs finalized the prior authorization criteria for terbinafine in January, but TMA directed that implementation be held in abeyance until TMA clarified the definition of cosmetic vs. non-cosmetic use of terbinafine and its status as a covered benefit under TRICARE. CAPT Hostettler informed the committee during the meeting that TMA considers treatment of a documented infection to be a covered benefit under TRICARE and that such treatment should not be characterized as cosmetic.

The question of whether the prior authorization should apply only to terbinafine or to both terbinafine and itraconazole was reintroduced. Some committee members thought that prior authorizing only terbinafine might lead to increased use of itraconazole. Arguments favoring prior authorizing only terbinafine included:

- Prior authorization of itraconazole might be cost-inefficient. Itraconazole is used for many indications other than onychomycosis, so the NMOP might incur large prior authorization expenses with little impact on itraconazole usage.
- One MCSC director stated that, in their experience, institution of a prior authorization program focused only at terbinafine did not lead to increased usage of itraconazole.

Paul Vasquez commented that the NMOP might be able to ascertain (as a benefit issue) whether or not these medications were being prescribed for onychomycosis. The government would then incur the prior authorization fee only for prescriptions for treatment of onychomycosis. Mr. Vasquez will investigate this issue and report his findings to a subcommittee consisting of CDR Egland (chair), Paul Vasquez (DSCP), MAJ Bellemin (DSCP), and MAJ Ed Zastawny (PEC). The subcommittee will then develop a prior authorization proposal and present it at the next P&T committee meeting. An interim report is due to co-chairs by 11 Apr 99.

6. NEW BUSINESS

A. Prior Authorizations

1. *Prior authorization criteria and fax forms on the PEC website*—At the last meeting, the committee directed the PEC to post the prior authorization fax forms (instead of the prior authorization criteria) on the PEC website. MTFs and Managed Care Support Contractors (MCSCs) subsequently requested that the criteria be reinstated on the website. The committee approved the request. The PEC will post both the criteria and the fax forms on the website.

2. *Proposal for prior authorization of fertility drugs*—According to the Code of Federal Regulations (CFR) and TRICARE policy, fertility drugs are not a covered benefit when used to assist in non-coital reproduction methods. Some of the MCSCs have prior authorizations in place for fertility medications, but others do not. The NMOP does not have a prior authorization process for fertility agents and is currently filling a large number of prescriptions for these medications. The committee concluded that a prior authorization for fertility drugs should be established in order to comply with TRICARE policy. CAPT Hostettler will submit draft prior authorization criteria for fertility agents to the co-chairs. The co-chairs will finalize the criteria for approval at the May P&T Committee meeting. CDR Egland is the point of contact for this action.

3. *Proposal to modify COX-2 prior authorization criteria*—The committee discussed several proposals by Bill Hudson (Humana) concerning the prior authorization criteria for COX-2 inhibitors in the NMOP and retail network. The committee agreed that there is not enough clinical evidence to justify use of a COX-2 solely on the basis of recent use of a NSAID for the last 40 of 60 days and decided to remove this as a criterion for approval of the PA for COX-2 inhibitors. The committee also agreed to replace the phrase *"situations where the physician indicates that the patient has previously been unable to tolerate therapy with at least two different NSAIDs"* with the phrase *"situations where the physician indicates that the patient has previously failed an adequate trial with at least two different NSAIDs."* The committee made this change with the intent that "failing an adequate trial" would include both failures due to intolerance and failures due to lack of effectiveness at an dose and duration considered by the physician to constitute an adequate trial.

4. *Report of the Growth Hormone subcommittee*—Bill Hudson (Humana) submitted the subcommittee report, which included proposed criteria for prior authorization of growth hormone products. The P&T committee requested additional information before acting on the subcommittee's recommendation. The subcommittee is to finalize the prior authorization criteria and ensure that they clearly address the use of growth hormone products in adults and the off-label uses of growth hormone. The subcommittee should support the prior authorization criteria with a business case analysis that includes historical usage and cost data for growth hormone products in the NMOP and retail network pharmacies. The subcommittee should provide this information to CDR Egland by 11 Apr 00.

5. *Portability of Prior Authorizations*—Bill Hudson (Humana) proposed that prior authorizations should be portable between MCSCs and the NMOP. The committee assigned MAJ Bellemin to investigate the possibility of uploading all prior authorizations completed by the NMOP and the MCSCs to a common site that could be accessed by all parties. The committee also advised MAJ Bellemin, Merck-Medco, and the MCSCs to ensure compatibility of any such process with the Pharmacy Data Transaction Service (PDTS).

B. National pharmaceutical contracts

1. *Contracts awarded since last meeting*—New generic contracts that apply to both DoD and the VA have been awarded by the VA National Acquisition Center for: timolol maleate 0.25% and 0.5% ophthalmic solution, timolol maleate 0.25% and 0.5% ophthalmic gel; levobunolol 0.25% and 0.5% ophthalmic solution; and gemfibrozil 600-mg tablets.

2. *Albuterol inhaler contract*—Warrick is the contracted brand of albuterol inhaler. The FDA issued a Class I recall because some Warrick albuterol inhalers contained no active ingredient. Some MTFs had to purchase non-contracted brands of albuterol inhalers because the Warrick brand was not available. DSCP will take these issues under consideration in regard to renewal of the albuterol inhaler contract. The committee noted that MedWatch forms should be submitted when quality concerns are identified.

3. The PEC uses prime vendor purchase data to quantify the financial impact of national pharmaceutical contracts. COL Remund presented slides showing the cost avoidance associated with the ranitidine (Geneva brand), cimetidine (Sidmak brand), lisinopril (Zestril), diltiazem extended release (Tiazac), and albuterol inhaler (Warrick brand) contracts. These five contracts yielded nearly $6.5 million in cost avoidance for MTFs in FY 99.

4. COL Remund reported on other contracting issues:

   - *Nicotine Patches*— DoD/VA initiative (DoD lead) for 3-step product only. The contract solicitation was issued 15 Feb 00 and closes 15 Mar 00. An award is expected by 28 Apr 00. MTFs that purchase a 3-step nicotine patch will be required to purchase the contracted product. The contract does not stipulate that the nicotine patch will be listed on the BCF.

   - *Felodipine*— The VA will include DoD in the renewal of its Blanket Purchase Agreement (BPA) for felodipine (Plendil). Adding DoD utilization may decrease the BPA price for felodipine.

   - *Estrogen Replacement Therapy*—In light of proposed DAPA price reductions by Wyeth/Ayerst for PremPro and PremPhase, the committee decided not to proceed with a contracting initiative for estrogen replacement products at this time. The committee noted that the possibility should remain open in the future as new products continue to enter the market. The committee agreed that the presence of the incentive agreements should be considered in DoD's future deliberations with the VA. No changes were made to the BCF.

   - *Second Generation Antihistamines*— Pharmaceutical companies are reducing prices or developing incentive pricing agreements in response to the recent change in the BCF that requires each MTF to have at least one second generation antihistamine on its formulary. After the price reductions and/or incentive agreements are finalized, the committee will reassess the advisability of pursuing a national contract for a second generation antihistamine.

     CDR Egland commented that nasal corticosteroids are more cost-effective than second-generation antihistamines for treating symptoms of allergic rhinitis. He specifically referenced a recent review of the treatment of allergic rhinitis in the *American Journal of Managed Care* (Jan 2000 supplement issue).

   - *Furosemide and hydrochlorothiazide*— Pursuing a joint DoD/VA contract (VA lead). These contracts will select specific brands of these drugs for the BCF.

   - *Returned Goods* - Joint DoD/VA initiative (DoD lead). Anticipate that the solicitation for this contract will be issued in April 00.

C. *FY00 National Defense Authorization Act*—CAPT Hostettler and Mr. Altschwager briefed the committee on the ongoing efforts to implement the provisions pertaining to the uniform formulary and the DoD P&T Committee.

D. BCF and NMOP formulary issues:

1. The following drugs that were recently approved by the FDA were added to the NMOP Formulary. None of these drugs were added to the BCF.

    a. Ethinyl estradiol / norethindrone acetate tablets (FemHRT; Parke Davis)
    b. Exemestane tablets (Aromasin; Pharmacia & Upjohn)
    c. Estradiol / norgestimate tablets (Ortho-Prefest; Ortho McNeil)
    d. Aspirin / dipyridamole extended release capsules (Aggrenox; Boehringer-Ingelheim)
    e. Moxifloxacin hydrochloride tablets (Avelox; Bayer)
    f. Gatifloxacin tablets (Tequin; Bristol Myers Squibb)
    g. Oxcarbazepine tablets (Trileptal; Novartis)

2. The following drugs were excluded from the NMOP formulary for the reasons given. Neither of these drugs was added to the BCF. Both drugs will be available through retail network pharmacies.

    a. *Oseltamivir phosphate capsules (Tamiflu; Roche)*—Oseltamivir is a neuraminidase inhibitor for the treatment of uncomplicated acute illness due to influenza A and B virus in adults who have been symptomatic for less than 2 days. Due to the narrow treatment window for this agent, the committee agreed that this drug is not well suited for dispensing through a mail order pharmacy. A similar drug, zanamivir (Relenza; Glaxo), was excluded from the NMOP formulary at the Aug 99 meeting.

    b. *Bexarotene capsules (Targretin; Ligand Pharma)*—Bexarotene is indicated for the treatment of cutaneous manifestations of cutaneous T-cell lymphoma in patients who are refractory to at least one prior systemic therapy. Bexarotene is Pregnancy Category X and carries a black box warning against use in pregnancy. Package labeling advises that a pregnancy test (for women of child-bearing age) should be obtained within one week prior to starting therapy and repeated at monthly intervals during therapy. In addition, labeling advises that "no more than a one month supply of Targretin® capsules should be given to the patient so that the results of pregnancy testing can be assessed and counseling regarding avoidance of pregnancy and birth defects can be reinforced." In light of this requirement and considering turn-around times for the mail order program, the committee decided that it was not feasible to provide bexarotene through the NMOP.

3. *Pantoprazole (Protonix; Wyeth-Ayerst)* is a new proton pump inhibitor. The national contract for omeprazole requires pantoprazole to be listed as a "non-contracted drug" on the NMOP Formulary. The national contract precludes MTFs from adding pantoprazole to their formularies.

4. *Nasal corticosteroids (BCF)—* At the May 99 meeting, the committee removed beclomethasone 42mcg/spray (Vancenase pockethaler; Schering) from the BCF due to a substantial DAPA price increase and specified that every MTF should have a nasal corticosteroid on its formulary. At the Aug 99 meeting, the committee selected fluticasone nasal spray (Flonase; Glaxo) for the BCF because it was the most cost-effective agent, it is approved for use in patients as young as 4 years old, it is dosed once a day, and allergy/immunology specialists expressed the opinion that fluticasone would be a good selection as a "workhorse" nasal corticosteroid on the BCF. Prime vendor data through the first quarter of FY00 show an increase in use of fluticasone following its selection as the BCF agent and a decrease in use of beclomethasone products following the removal of Vancenase pockethaler as the BCF selection.

   The PEC recently received prescription data from the civilian market that may affect the cost-effectiveness estimates for fluticasone and mometasone. The Aug 99 cost-effectiveness analysis was based on an adult maintenance dose of 2 puffs/day for fluticasone and 4 puffs/day for mometasone (derived from the product labeling). Civilian prescription data indicate that the prescribed puffs per day may be essentially the same for both drugs, which would make fluticasone and mometasone similar in cost-effectiveness. Mometasone was also recently approved for children as young as 3 years of age. The committee asked the PEC to analyze the dosing distribution for nasal corticosteroids within DoD and propose BCF changes if appropriate. The committee emphasized that it did not wish to make further additions to the BCF without complete information, but agreed that the presence of an additional nasal corticosteroid agent on the BCF could potentially spur competitive pricing.

5. *Consideration of Niaspan (niacin extended release; Kos Pharma) for the BCF—* Niacin is well known to have a positive effect on the lipid profile of patients with dyslipidemias and is particularly effective in raising high-density lipoprotein cholesterol (HDL-C). Patient intolerance to the common side effects of flushing and pruritis limits the usefulness of niacin in clinical practice. Sustained release forms of niacin may be tolerated better than immediate release forms, but sustained release forms have been associated with a higher incidence of liver toxicity. Niaspan is promoted as a once-daily product that is not associated with a higher incidence of liver toxicity. Niaspan costs significantly more than other sustained release forms of niacin.

   The committee is concerned that patient tolerance of niacin may be related more closely to the educational efforts regarding drug dosing than the specific dosage form that is used. Due to the limited data available, the committee also has concerns about the potential for liver toxicity with Niaspan. The committee asked the PEC to further investigate the associations between niacin dosage forms and patient tolerance and liver toxicity. The PEC will also evaluate usage patterns of all niacin products within DoD and obtain input from MTFs regarding the potential addition of Niaspan to the BCF. The PEC will provide a recommendation regarding the BCF status of Niaspan at the next meeting.

6. *Request for removal of dipivefrin ophthalmic solution (Propine, generics) from the BCF and review of ophthalmic glaucoma agents*—The committee removed dipivefrin from the BCF. Dipivefrin has been reported to have a relatively high rate of side effects relative to other available agents, which are at least equally effective. Dipivefrin represents approximately 2% of usage of glaucoma agents in DoD by number of bottles purchased, compared to timolol (Timoptic, generics) 33%, latanoprost (Xalatan) 21%, dorzolamide (Trusopt) 12%, and multiple other agents each representing 7% or less of total usage. CDR Matt Nutaitis, an ophthalmologist and allergy specialist, will undertake a review of ophthalmic glaucoma agents and make recommendations for BCF changes at the next meeting. An interim report is due to the co-chairs by 11 April.

7. *BCF status of cisapride (Propulsid; Janssen)*—The committee removed cisapride from the BCF based on recent FDA recommendations and labeling changes aimed at avoiding use of the medication in patients at known risk of rare but serious cardiac events associated with use of the drug. Labeling changes include the recommendation that an electrocardiogram, serum electrolytes, and serum creatinine be performed prior to initiation of therapy, as well as a list of contraindicated drugs and underlying conditions. With the continuing reports of heart rhythm disorders and deaths associated with use of cisapride, the committee agreed that the benefits of the drug are not likely to outweigh the known risks except for selected patients.

8. *Status of human chorionic gonadotropin injection in the NMOP*—The committee added human chorionic gonadotropin injection to the NMOP Covered Injectables list. This agent has historically been provided by the NMOP and was inadvertently omitted when the Covered Injectables list was formulated.

7. ADJOURNMENT: The meeting adjourned at 1600 hours. The next meeting will be held on Thursday, 11 May 2000, at Fort Sam Houston, Texas. All agenda items should be submitted to the co-chairs no later than 11 April 2000.

<signed>
DANIEL D. REMUND
COL, MS, USA
Co-chair

<signed>
TERRANCE EGLAND
CDR, MC, USN
Co-chair

LIST OF APPENDICES

APPENDIX A: Minutes of the Interim Meeting of the DoD P&T Committee, 26 Jan 00, concerning identification of drugs for the Advances in Medical Practice (AMP) Program;

APPENDIX B: Consolidated List of Drugs Recommended for the AMP Program by the DoD P&T Committee. **Note**: This list of drugs is **not** final. The list has been submitted to AMP officials, TMA officials, and resource management officers for final approval. MTFs will be notified of the final list of drugs and finalized procedures for reimbursement for expenditures on drugs covered by the AMP program as soon as they are approved.

APPENDIX C: NMOP Preferred Drug Program Report

APPENDIX D: Formulary Changes

APPENDIX E: Reports Due to the Committee

APPENDIX A: Minutes of the Interim Meeting of the DoD P&T Committee, 26 Jan 00, Concerning Identification of Drugs for the Advances in Medical Practice (AMP) Program

NOTE: After this interim meeting and at the request of AMP program officials, the P&T committee co-chairs subsequently recommended more drugs for coverage by the AMP program. See Appendix B for the consolidated list of all drugs recommended by the DoD P&T Committee for coverage under the AMP program.

Department of Defense
Pharmacoeconomic Center

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Fort Sam Houston, TX 78234-6190

MCCS-GPE

26 January 2000

MEMORANDUM FOR Assistant Secretary of Defense (Health Affairs)

SUBJECT: Minutes of an Interim Meeting of the Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee—Advances in Medical Practice (AMP) Program

1. In accordance with Health Affairs policy 98-025, an interim meeting of the DoD P&T Committee convened via teleconference at 1300 on 26 January 2000. The purpose of this meeting was to identify new drug usage that should be supported by Advances in Medical Practice (AMP) funds.

2. MEMBERS Participating in the Teleconference:

COL Daniel D. Remund, MS	Co-chairman
CDR Terrance Egland, MC	Co-chairman
COL Rosa Stith, MC	Army
LTC Judith O'Connor, MC	Army
Danielle Doyle	Army
LCDR Kevin Cook, MSC	Navy
LTC John R. Downs, MC	Air Force
MAJ George Jones, BSC	Air Force
CDR Robert W. Rist	Coast Guard

COL Daniel D. Remund voted as proxy for CDR Matt Nutaitis.
COL (select) Bill Sykora was absent.

3. OTHERS Participating in the Teleconference:

COL W. Michael Heath	Pharmacy Consultant, USA
COL Ardis Meier	Associate Chief, BSC for Pharmacy, USAF
CAPT Greg Hall	Director, Pharmacy Department, Portsmouth Naval Hospital

4. NEW BUSINESS

A. The AMP funds allocated for MTF pharmacies are intended to provide "seed money" to help MTFs purchase new drugs that are clinically beneficial, but which MTF pharmacies tend not to provide to patients because of insufficient funding. The plan is to use AMP money to support the usage of certain new drugs for the first year or two until funds can be programmed into the MTF budget "base" to support ongoing use of the drugs. The DoD Pharmacy Board of Directors is working with resource managers to design a mechanism to reimburse MTFs for their usage of drugs covered by the AMP program.

B. Based on recommendations provided by the PEC, the Committee recommends that AMP funds should be used to completely reimburse MTFs for FY 00 usage of the following drugs:

1. Etanercept (Enbrel)
2. Infliximab (Remicade)
3. Leflunomide (Arava)
4. Oral ribavirin / interferon alfa-2b combination (Rebetron)
5. Palivizumab (Synagis)
6. Coagulation Factor VIIa (Recombinant) (NovoSeven)

[Note: The Committee did **NOT** add these drugs to the Basic Core Formulary (BCF).]

C. Based on recommendations provided by the PEC, the Committee recommends that AMP funds should be used to reimburse MTFs for their FY 00 usage of COX-2 inhibitors as outlined below:

1. Use AMP funds to reimburse MTFs for 50% of their expenditures for COX-2 inhibitors. The reimbursement would occur regardless of the status of COX-2 inhibitors on the MTF formulary. [Note: The 50% reimbursement rate provides a financial incentive for MTFs to target the use of COX-2 inhibitors to patients who are increased risk for gastrointestinal problems secondary to NSAID use.]

2. Do not add a COX-2 inhibitor to the BCF.

3. Do not stipulate on the BCF that MTFs must have a COX-2 inhibitor on their formularies. Each MTF decides for itself whether to have a COX-2 inhibitor(s) on the MTF formulary.

4. Require MTFs to use prescribing guidelines, prior authorization, or other means to target the use of COX-2 inhibitors to patients who are at increased risk for GI problems secondary to NSAID use.

5. Pursue pricing agreements that are based on the status of COX-2 inhibitors on the MTF formulary.

6. Any new COX-2 inhibitor will be considered for addition to the list of drugs covered by AMP funds.

D. The PEC will provide cost projections for the drugs covered by the AMP program to the DoD Pharmacy Board of Directors and the AMP program managers.

5. ADJOURNMENT: The meeting adjourned at 1445 hours.

<signed>

DANIEL D. REMUND
COL, MS, USA
Co-chair

<signed>

TERRANCE EGLAND
CDR, MC, USN
Co-chair

APPENDIX B: Consolidated List of Drugs Recommended for the AMP Program by the DoD P&T Committee.

NOTE: This list of drugs is **not** final. The list has been submitted to AMP officials, TMA officials, and resource management officers for final approval. MTFs will be notified of the final list of drugs and finalized procedures for reimbursement for expenditures on drugs covered by the AMP program as soon as they are approved.

Background: The pharmacy portion of AMP funding for FY00 is intended to provide "seed money" to purchase drugs that are clinically beneficial but which MTF pharmacies tend not to provide because of insufficient funds. The drugs covered under the AMP program are newly approved, have had new indications approved since initial approval, or have an extremely high unit cost. Under current planning, AMP money will support the usage of certain new drugs for a period of two to three years until funds can be programmed into the MTF budget "base" to support the ongoing use of the drugs.

Department of Defense Pharmacy and Therapeutics (DoD P&T) Committee Recommendations: On 26 January 2000, the Department of Defense Pharmacy and Therapeutics (DoD P&T) committee recommended that the first seven drugs listed in Table 1 be funded through the AMP program. On 9 Feb 00, additional drugs were selected by an interim decision of committee co-chairs. Currently, none of the selected drugs are listed on the Basic Core Formulary (BCF). The committee recommended that none of the drugs be added to the BCF. The committee recommended using AMP funds to reimburse MTFs for 100% of their expenditures for all selected drugs with the exception of COX-2 inhibitors.

For COX-2 inhibitors, the committee recommended that AMP funds be used to reimburse MTFs for 50% of their costs (e.g., if a MTF spent $20,000 on COX-2 inhibitors for a given month, the AMP program would reimburse the MTF $10,000). The 50% reimbursement provision for COX-2 inhibitors should provide the financial incentive for MTFs to make these drugs more available to patients with a valid clinical need. Reimbursement at 100% would discourage MTF efforts to ensure appropriate use of these drugs. Lastly, the committee recommended that MTFs be required to use prescribing guidelines, prior authorization, or other means to target the use of COX-2 inhibitors to patients who are at increased risk for GI problems secondary to NSAID use.

Table 1 (continued): Consolidated List of Drugs Recommended for the AMP Program by the DoD P&T Committee.

Drug	Indication
These drugs selected for funding through the AMP program by the DoD Pharmacy & Therapeutics Committee via teleconference, 26 Jan 00.	
Etanercept (Enbrel; Immunex / Wyeth-Ayerst)	Moderately to severely active rheumatoid arthritis (RA) and polyarticular-course juvenile rheumatoid arthritis in patients with an inadequate response to one or more disease-modifying antirheumatic drugs (DMARDs). May be used in combination with methotrexate in patients who do not respond adequately to methotrexate alone.
Infliximab (Remicade; Centocor)	Moderately to severely active Crohn's disease for the reduction of signs and symptoms in patients who have an inadequate response to conventional therapies; and treatment of patients with fistulizing Crohn's disease for the reduction in the number of draining enterocutaneous fistula(s). Recently approved in combination with methotrexate for reduction in signs and symptoms of RA in patients who have had an inadequate response to methotrexate.
Leflunomide (Arava; Hoechst Marion Roussel)	Active RA to reduce signs and symptoms and to retard structural damage as evidenced by x-ray erosions and joint space narrowing in adults
Coagulation Factor VIIa (Recombinant) (NovoSeven; Novo Nordisk)	Treatment of bleeding episodes in hemophilia A or B patients with inhibitors to Factor VIII or Factor IX.
Oral ribavirin / interferon alfa-2b combination (Rebetron; Schering)	Treatment of chronic hepatitis C in patients with compensated liver disease who have relapsed following alpha interferon therapy, approved in December 98 for patients not previously treated with interferon.
Palivizumab (Synagis; MedImmune)	Prevention of serious lower respiratory tract disease caused by RSV in pediatric patients at high risk of RSV disease
Cyclooxygenase-2 (COX-2) inhibitors— Celecoxib (Celebrex; Searle/Pfizer); Rofecoxib (Vioxx; Merck)	Celecoxib is indicated for the treatment of osteoarthritis (OA) and rheumatoid arthritis (RA), and was very recently approved for reduction in the number of adenomatous colorectal polyps in familial adenomatous polyposis (FAP), as an adjunct to usual care (e.g., endoscopic surveillance, surgery). Rofecoxib is indicated for OA, acute pain, and primary dysmenorrhea. NOTE: For COX-2 inhibitors, the committee recommended that AMP funds be used to reimburse MTFs for 50% of their costs.
These drugs selected for funding through the AMP program by an interim decision of DoD Pharmacy & Therapeutics Committee co-chairs, 9 Feb 00.	
Glycoprotein IIb/IIIa inhibitors— • Eptifibatide (Integrilin; COR) • Tirofiban (Aggrastat; Merck) • Abciximab (ReoPro; Lilly)	Abciximab indicated for use as an adjunct to PTCA, tirofiban indicated for acute coronary syndrome, and eptifibatide indicated for both acute coronary syndrome or treatment of patients undergoing percutaneous coronary intervention (PCI)

Table 1 (continued): Consolidated List of Drugs Recommended for the AMP Program by the DoD P&T Committee

Drug	Indication
Immunosuppressants— • Cyclosporine (various manufacturers) • Mycophenolate mofetil (Cellcept; Roche) • Sirolimus (Rapamune; Wyeth-Ayerst) • Tacrolimus (Prograf; Fujisawa)	Cyclosporine: Prophylaxis of organ rejection in kidney, liver, and heart transplantation. RA (Neoral only), psoriasis (Neoral only). Multiple unapproved indications. Mycophenolate mofetil: Prophylaxis of organ rejection in kidney or heart transplantation. Sirolimus: Prophylaxis of organ rejection in kidney transplantation. Tacrolimus: Prophylaxis of organ rejection in liver transplantation.
Dornase alfa (Pulmozyme)	Daily administration in conjunction with standard therapies in the management of cystic fibrosis patients to reduce the frequency of respiratory infections requiring parenteral antibiotics and to improve pulmonary function
Interferon gamma 1b (Actimmune)	Reduction of the frequency and severity of serious infections associated with chronic granulomatous disease
$Alpha_1$-proteinase inhibitor (Prolastin)	Chronic replacement in patients with congenital alpha1-antitrypsin deficiency and clinically demonstrable panacinar emphysema.
Temozolomide (Temodar)	Oral chemotherapy agent for adult patients with refractory anaplastic astrocytoma; pending NDAs for other conditions.
Trastuzumab (Herceptin)	Treatment of metastatic breast cancer in patients with tumors that overexpress the HER2 protein
Rituzimab (Rituxan)	Treatment of patients with relapsed or refractory low-grade or follicular, CD20 positive, B-cell non-Hodgkin's Lymphoma.
Drugs for MS • Interferon beta 1a (Avonex) • Interferon beta 1b (Betaseron) • Glatiramer acetate (Copaxone)	Treatment of relapsing/remitting multiple sclerosis.
Colony Stimulating Factors • Filgrastim (Neupogen) • Sargramostim (Leukine)	To reduce the incidence and duration of neutropenia-related sequelae (e.g., infection, fever) associated with myelosuppressive chemotherapy, bone marrow transplant, severe chronic neutropenia, etc., and for the mobilization of hematopoietic progenitor cells into the peripheral blood for leukapheresis collection.

Table 1 (continued): Consolidated List of Drugs Recommended for the AMP Program by the DoD P&T Committee

Drug	Indication
Irinotecan (Camptosar)	Metastatic carcinoma of the colon or rectum.
Gemcitabine (Gemzar)	First-line treatment for locally advanced or metastatic pancreatic cancer and in combination with cisplatin for first-line treatment of inoperable, locally advanced or metastatic non-small cell lung cancer
Epoetin alfa [Recombinant human erythropoietin] (Epogen, Procrit)	Reduction of allogeneic blood transfusion in surgery patients and treatment of anemia from various causes, including chronic renal failure, zidovudine therapy in HIV-infected patients, and chemotherapy.
Becaplermin (Regranex)	Treatment of diabetic neuropathic ulcers in conjunction with debridement and good ulcer care.

APPENDIX C: NMOP Preferred Drug Program Report

The NMOP Preferred Drug Program

The purpose of the NMOP Preferred Drug Program is to encourage the use of drugs that are preferred on the basis of relative effectiveness, safety, and cost. The NMOP calls the prescriber on each new prescription for a non-preferred agent and requests a switch to a preferred drug. If the prescriber declines or if the prescriber cannot be contacted, the prescription is filled as written.

Methods of Calculating Cost Avoidance

The NMOP Preferred Drug Program achieves cost avoidance by shifting prescription market share to the preferred drugs. In general, cost avoidance is estimated by subtracting the actual expenditures for preferred and non-preferred drugs from the expenditures that would have been expected if the Preferred Drug Program did not exist (cost avoidance = expected expenditures – actual expenditures). The specific method used to calculate cost avoidance for a given set of preferred and non-preferred drugs depends on the distribution of prescriptions that would have been expected for preferred and non-preferred drugs if the Preferred Drug Program did not exist.

1. *Distribution of prescriptions expected to remain constant if Preferred Drug Program did not exist*—Examples include diltiazem extended release, nifedipine extended release, and the nonsteroidal anti-inflammatory drugs (NSAIDs).

   Calculation of "expected" expenditures is straightforward because we simply apply the baseline market share percentages that existed before the Preferred Drug Program was implemented. First, calculate the expected number of prescriptions for each preferred and non-preferred drug by multiplying the actual total number of prescriptions filled during the month by the percentage of the prescription market that each drug represented before the Preferred Drug Program was implemented. Second, calculate the expected expenditures by multiplying the expected number of prescriptions for each preferred and non-preferred drug by the current cost per prescription for that drug and then sum the products. Calculate the cost avoidance by subtracting the actual expenditures from the expected expenditures. [NOTE: This method accounts for the impact of both new and refill prescriptions on cost avoidance.]

2. *Distribution of prescriptions expected to change even if Preferred Drug Program did not exist*—Urinary agents (preferred drug: oxybutynin generic; non-preferred drugs Detrol, Ditropan XL) are an example. Because Detrol and Ditropan XL are relatively new agents, market share percentages are likely to change even if the Preferred Drug Program did not exist.

   Calculation of expected expenditures is not straightforward because we cannot simply apply the baseline market share percentages that existed before the Preferred Drug Program was implemented. We do not have a method for predicting what the market share percentages would have been in the absence of the Preferred Drug Program. For this set of drugs, cost avoidance was calculated by multiplying the number of prescriptions switched for each target drug by the difference in average cost per prescription between the target drug and oxybutynin. This method only accounts for the cost avoidance for the single new prescription that was switched at the time

of the phone call. It does not account for the cost avoidance that would be associated with any prescription refills. This method underestimates the cost avoidance.

3. *Drugs/drug classes for which the quantity dispensed (and cost) per prescription is highly variable*—An example is the anti-herpes drugs (preferred drug: acyclovir generic; non-preferred drugs Valtrex, Famvir). Analysis of the cost avoidance associated with this set of drugs proved difficult. Dosing regimens and quantities dispensed per prescripton vary widely for anti-herpes drugs according to the disease being treated (herpes zoster, herpes simplex) and the reason for use (treatment, prophylaxis). The cost avoidance calculation methods described above yielded results that do not readily correlate either with reported switches or the market share of acyclovir. For this reason, a cost avoidance estimate is not provided for the anti-herpes drugs in this report. Results of continued analysis will be presented at the May 00 meeting.

Non-Preferred/Preferred Drug Pairs

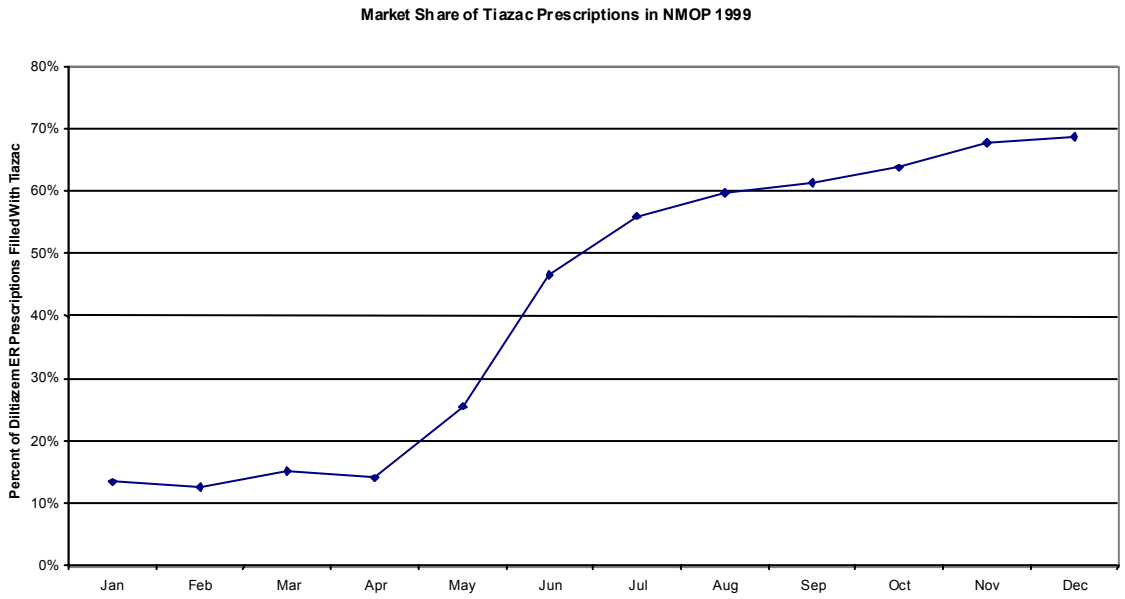
1. Extended Release Diltiazem

Tiazac was designated as the preferred diltiazem ER product in NMOP in May 99. Non-preferred diltiazem products include Cardizem CD, Diltia XT, Dilacor XR, and generic diltiazem ER.

Table 1: Prescriptions for Non-Preferred Diltiazem ER products in NMOP, Jun – Dec 99								
Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Jun-Dec**
New Rxs Received	720	661	573	395	328	291	346	**3314**
Prescriber Contacts	653	616	540	352	301	263	311	**3036**
Switches	514	495	434	255	215	189	217	**2319**
Switch Rate*	71%	75%	76%	65%	66%	65%	63%	**70%**

* Percentage of new prescriptions received for non-preferred drugs that were switched to Tiazac

Market Share Data (From NMOP adjudicated and non-adjudicated prescription claims files, Defense Supply Center Philadelphia)



Monthly Cost Avoidance

Month	**Jun 99**	**Jul 99**	**Aug 99**	**Sep 99**	**Oct 99**	**Nov 99**	**Dec 99**	**Jun-Dec 99**
Cost avoidance	$21,796	$27,287	$31,098	$29,017	$28,112	$34,592	$30,123	**$202,025**

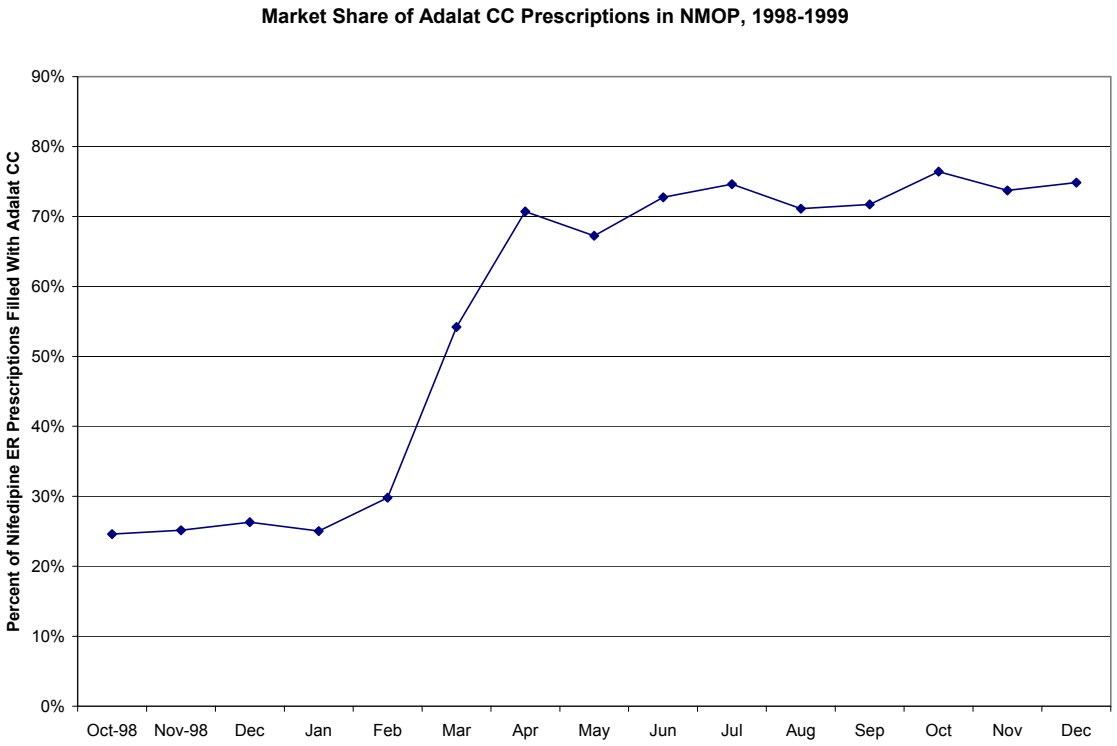
2. Extended Release Nifedipine

In Nov 98 the DOD P & T Committee selected Adalat CC as the preferred nifedipine ER product. Procardia XL is non-preferred.

Table 2: Prescriptions for Non-Preferred Nifedipine ER in NMOP, Jun – Dec 1999								
Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jun - Dec**
New Rxs Received	379	142	125	139	124	127	153	**1189**
Prescriber Contacts	345	132	102	120	114	101	129	**1043**
Switches	254	91	66	63	61	58	90	**683**
Switch Rate*	67%	64%	53%	45%	49%	46%	59%	**57%**

* Percentage of new prescriptions received for non-preferred drugs that were switched to Adalat CC

Market Share Data (From NMOP adjudicated and non-adjudicated prescription claims files, Defense Supply Center Philadelphia)



Monthly Cost Avoidance

Month	**Jun 99**	**Jul 99**	**Aug 99**	**Sep 99**	**Oct 99**	**Nov 99**	**Dec 99**	**Jun – Dec 99**
Cost Avoidance	$27,494	$26,624	$24,962	$24,510	$27,938	$26,122	$24,173	**$181,823**

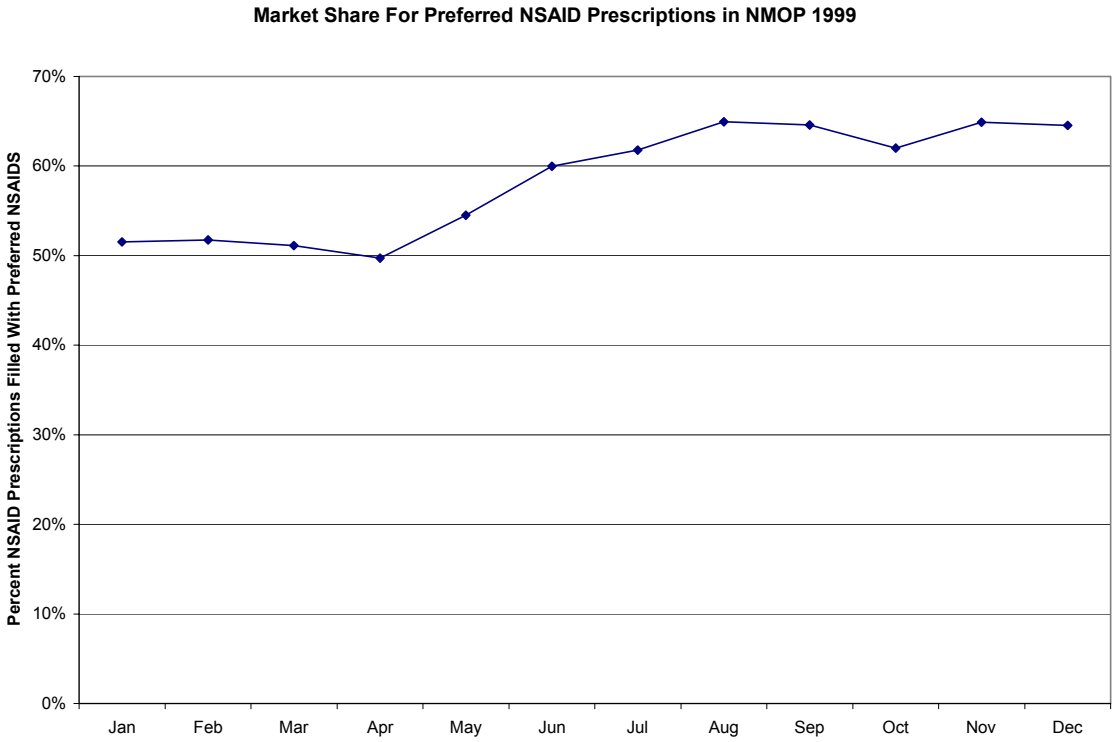
3. NSAIDS

Generic NSAIDs are preferred. Daypro, Relafen, Voltaren XR, Lodine XL, and Naprelan are non-preferred. Program started mid-May 99

Table 3: Prescriptions For Non-Preferred NSAIDs in NMOP, Jun – Dec 1999								
Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Jun - Dec**
New Rxs Received	617	596	549	456	432	361	434	**3445**
Prescriber Contacts	525	504	492	385	367	304	384	**2961**
Switches	244	220	248	153	150	140	136	**1291**
Switch Rate*	40%	37%	45%	34%	35%	39%	31%	**37%**

* Percentage of new prescriptions received for non-preferred drugs that were switched to generic NSAIDs

Market Share Data (From NMOP adjudicated and non-adjudicated prescription claims files, Defense Supply Center Philadelphia)



Monthly Cost Avoidance

Month	**Jun 99**	**Jul 99**	**Aug 99**	**Sep 99**	**Oct 99**	**Nov 99**	**Dec 99**	**Jun – Dec 99**
Cost Avoidance	$21,771	$19,929	$27,670	$29,294	$25,052	$36,465	$29,364	**$189,584**

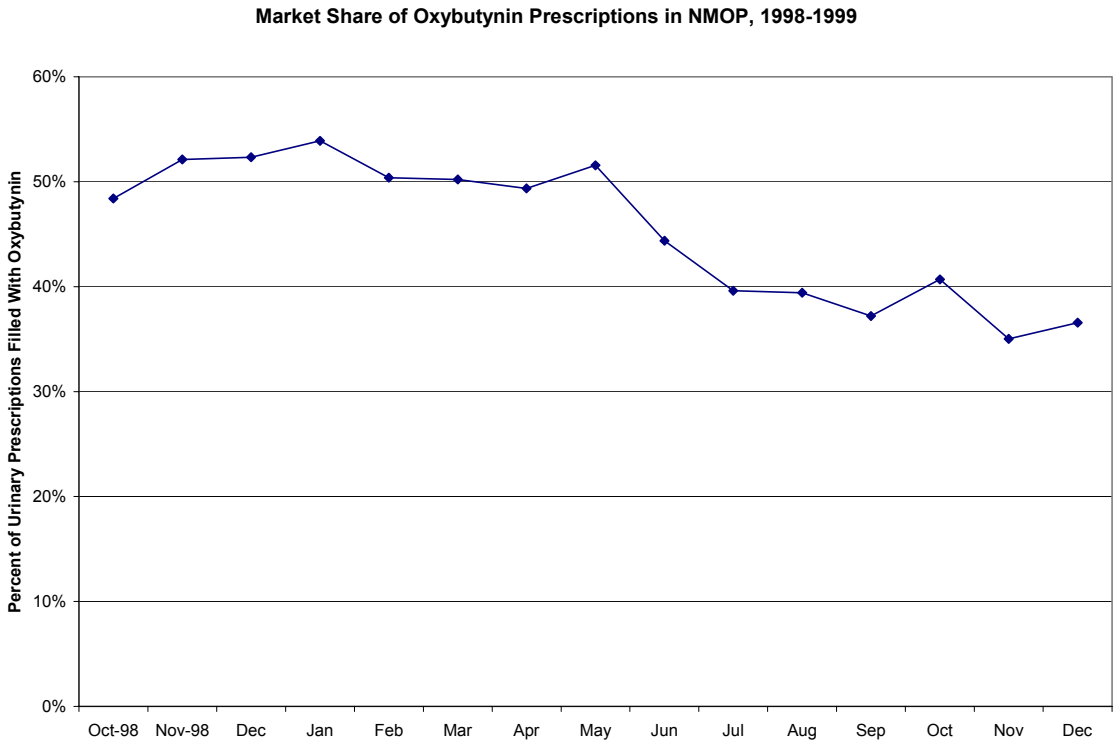
4. Urinary Agents

In November 1998, the DOD P & T Committee selected oxybutynin generic as the preferred urinary agent. Detrol and Ditropan XL are non-preferred.

Table 4: Prescriptions for Non-Preferred Urinary Drugs in NMOP, Jun – Dec 99								
Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Jun – Dec**
New Rxs Received	224	183	270	271	308	325	363	**1944**
Prescriber Contacts	195	158	233	236	270	256	331	**1679**
Switches	80	40	76	69	95	88	105	**553**
Switch Rate*	36%	22%	28%	25%	31%	27%	29%	**28%**

* Percentage of new prescriptions received for non-preferred drugs that were switched to oxybutynin generic

Market Share Data (From NMOP adjudicated and non-adjudicated prescription claims files, Defense Supply Center Philadelphia)



Monthly Cost Avoidance

Month	**Jun 99**	**Jul 99**	**Aug 99**	**Sep 99**	**Oct 99**	**Nov 99**	**Dec 99**	**Jun – Dec 99**
Cost Avoidance	$7,735	$4,355	$6,823	$6,575	$8,769	$8,414	$10,271	**$52,942**

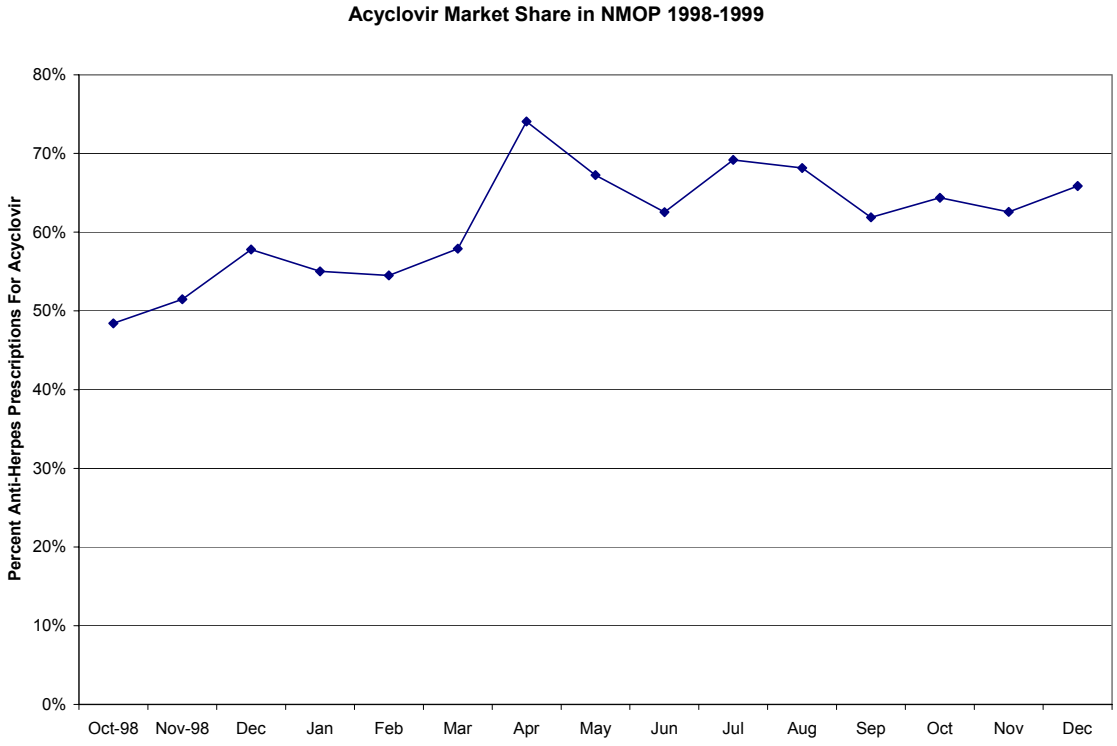
5. Anti-Herpes Drugs

Generic acyclovir is the preferred anti herpes drug. Famvir and Valtrex are non-preferred.

Table 5: Prescriptions for Non-Preferred Anti-Herpes Drugs in NMOP, Jun – Dec 1999								
Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	**Jun – Dec**
New Rxs Received	77	52	51	44	60	62	70	**416**
Prescriber Contacts	68	44	39	30	41	46	57	**325**
Switches	28	14	21	21	15	17	17	**133**
Switch Rate*	36%	27%	41%	48%	25%	27%	24%	**32%**

* Percentage of new prescriptions received for non-preferred drugs that were switched to acyclovir

Market Share Data (From NMOP adjudicated and non-adjudicated prescription claims files, Defense Supply Center Philadelphia)



APPENDIX D: FORMULARY CHANGES

I. BCF changes

A. BCF changes as a result of the 26 Jan 00 Interim Meeting:

1. Addition of the following:

a. metformin
b. tamoxifen
c. alendronate
d. citalopram
e. fluoxetine
f. paroxetine
g. sertraline
h. sumatriptan autoinjector

2. Specification that military treatment facilities (MTFs) must have at least one agent from each of the following classes on their formularies:

a. Oral serotonin 5-HT_1 receptor agonists (naratriptan, rizatriptan, sumatriptan, zolmitriptan)
b. Low molecular weight heparins/heparinoids (ardeparin, dalteparin, danaparoid, enoxaparin)
c. Leukotriene antagonists (montelukast, zafirlukast, zileuton)
d. Second-generation antihistamines (cetirizine, fexofenadine, loratadine)

B. Dipivefrin ophthalmic solution (Propine) removed from the BCF

C. Cisapride (Propulsid) removed from the BCF

II. NMOP Formulary Changes

A. Added to the NMOP Formulary:

1. Ethinyl estradiol / norethindrone acetate tablets (FemHRT; Parke Davis)
2. Exemestane tablets (Aromasin; Pharmacia & Upjohn)
3. Estradiol / norgestimate tablets (Ortho-Prefest; Ortho McNeil)
4. Aspirin / dipyridamole extended release capsules (Aggrenox; Boehringer-Ingelheim)
5. Moxifloxacin hydrochloride tablets (Avelox; Bayer)
6. Gatifloxacin tablets (Tequin; Bristol Myers Squibb)
7. Oxcarbazepine tablets (Trileptal; Novartis)

B. Excluded from the NMOP Formulary

1. Oseltamivir phosphate capsules (Tamiflu; Roche)
2. Bexarotene capsules (Targretin; Ligand Pharma)

APPENDIX D (continued): FORMULARY CHANGES

C. Pantoprazole (Protonix; Wyeth-Ayerst) listed as a "non-contracted drug" on the NMOP Formulary due to contractual requirements of the PPI contract

D. Human chorionic gonadotropin injection (various manufacturers) added to the NMOP Covered Injectables list (has historically been provided by the NMOP).

III. Quantity Limit Change (NMOP and retail network): Quantity limit for azithromycin (Zithromax) 250-mg tablets changed from 6 tablets per 30 days to 10 tablets per 30 days for both the NMOP and the retail network.

APPENDIX E: REPORTS DUE TO THE COMMITTEE

I. *Non-preferred/preferred drug pairs standing report* (see Paragraph 5B) — CDR Mark Brouker (PEC). Interim report due to co-chairs by April 11, full report to committee at the next meeting.

II. *Quantity limits for topicals* (see Paragraph 5C2)— The subcommittee will supply additional information concerning usage patterns for the five high-cost topicals identified at the last meeting [imiquimod (Aldara); calcipotriene (Dovonex); altitretinoin (Panretin); becaplermin (Regranex); and tazarotene (Tazorac)]. Subcommittee members: Bill Hudson (chair); MAJ George Jones; MAJ Mickey Bellemin; Ray Nan Berry (Foundation Health); Kirby Davis (Anthem Alliance); William Hudson (Humana); Gene Lakey (TriWest); and Ron McDonald (Sierra Military Health Services). Interim report due to co-chairs by April 11, full report to committee at the next meeting.

III. *Cost-efficiency of prior authorizations in the NMOP standing report* (see Paragraph 5D)—MAJ Bellemin. Interim report due to co-chairs by April 11, full report to committee at the next meeting.

IV. *Prior authorization for oral antifungals* (see Paragraph 5E)— A subcommittee consisting of CDR Egland (chair); Paul Vasquez (DSCP), MAJ Bellemin (DSCP), and MAJ Ed Zastawny (PEC) will develop a proposed PA program to be presented to the committee at the next meeting. An interim report is due to co-chairs by 11 Apr 99.

V. *Prior authorization for fertility drugs* (see Paragraph 6A2)—CAPT Charlie Hostettler (TMA) will submit authorization criteria for fertility agents to the co-chairs. The co-chairs will finalize the criteria for approval at the May P&T Committee meeting. CDR Egland is the point of contact for this action.

VI. *Growth hormone subcommittee* (see Paragraph 6A4)—(Bill Hudson (chair); MAJ George Jones; MAJ Mickey Bellemin; Ray Nan Berry (Foundation Health); Kirby Davis (Anthem Alliance); William Hudson (Humana); Gene Lakey (TriWest); Ron McDonald (Sierra Military Health Services)) — A business case analysis that covers off-label uses and uses for adults, as well as completed prior authorization criteria (including required forms) with supporting documentation, is due to CDR Egland by 11 Apr 00.

VII. *Portability of Prior Authorizations* (see Paragraph 6A5)—MAJ Bellemin (DSCP) will investigate the feasibility of a program to provide for portability of prior authorizations completed by the NMOP or the MCSCs and report back to the committee at the next meeting.

VIII. *Nasal Corticosteroids* (see Paragraph 6D4)—The PEC will analyze the dosing distribution for nasal corticosteroids within DoD and make recommendations if indicated, to be presented to the committee at the next meeting. An interim report is due to co-chairs by 11 Apr 99.

IX. *Niaspan (niacin extended release; Kos Pharma)* (See Paragraph 6D5)—The PEC will provide information to the committee at the next meeting regarding the associations between niacin dosage forms and patient tolerance and liver toxicity. The PEC will also describe usage patterns of niacin products within DoD and convey input from MTFs regarding the potential addition of Niaspan to the BCF.

X. *Review of Ophthalmic Glaucoma Agents* (See Paragraph 6D6) —CDR Matt Nutaitis will review the ophthalmic glaucoma agents and make recommendations for BCF changes to be submitted to the committee at the next meeting. An interim report is due to the co-chairs by 11 April.