Department of Defense
Pharmacoeconomic Center

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MCCS-GPE **15 NOVEMBER 2001**

MEMORANDUM FOR: Executive Director, TRICARE Management Activity (TMA)

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

1. A meeting of the DoD P&T committee convened at 0800 hours on 15 November 2001, at the Uniformed Services University of the Health Sciences, Bethesda, Maryland.

2. MEMBERS PRESENT

CDR Terrance Egland, MC	DoD P& T Committee Co-chair
COL Daniel D. Remund, MS	DoD P& T Committee Co-chair
COL John R. Downs, MC	Air Force
COL Bill Sykora, MC	Air Force
LtCol (select) George Jones, BSC	Air Force
CAPT (select) Matt Nutaitis, MC	Navy
CDR Kevin Cook, MSC	Navy
COL Mike Heath, MS (representing MAJ Brett Kelly)	Army
COL Rosa Stith, MC	Army
LTC (P) Joel Schmidt, MC	Army
CAPT Chuck Bruner	Coast Guard
LTC Mike Kieffer, MS	Joint Readiness Clinical Advisory Board
MAJ Mickey Bellemin, BSC	Defense Supply Center Philadelphia
William Hudson	Humana
Ron McDonald	Sierra Military Health Services
Gene Lakey	TriWest

MEMBERS ABSENT

Dick Rooney	Department of Veterans Affairs
Ray Nan Berry	Health Net Federal Services

OTHERS PRESENT

COL William Davies, MS	DoD Pharmacy Program Director, TMA
CAPT Betsy Nolan	Navy Pharmacy Specialty Leader
CAPT Joe Torkildson, MC	DoD Pharmacoeconomic Center
LCDR Ted Briski, MSC	DoD Pharmacoeconomic Center
LCDR Denise Graham	DoD Pharmacoeconomic Center
MAJ Cheryl Filby, MS	Defense Supply Center Philadelphia
MAJ Maria Ionescu	Pharmacy Benefits Division, TMA
Howard Altschwager	Deputy General Counsel, TMA
David Bretzke	DoD Pharmacoeconomic Center
David Chicoine	Uniformed Services Family Health Plan
Lisa Le Gette	DoD Worldwide TRICARE Information Center
Shirif Mitry	Pharmacy Student, TMA
Mark Petruzzi	Merck-Medco
David Spiler	Merck-Medco
Shana Trice	DoD Pharmacoeconomic Center
Paul Vasquez	Defense Supply Center Philadelphia

3. **REVIEW MINUTES OF LAST MEETING / ADMINISTRATIVE ISSUES** – The Committee approved the minutes of the last meeting with one correction: the entry for valganciclovir (Valcyte) on Page 8 (Appendix A) was changed to list Roche as the manufacturer rather than Syntex.

4. **INTERIM DECISIONS** – In September 2001, voting members of the Committee communicated via email and telephone to make an interim decision regarding the status of PPIs on the National Mail Order Pharmacy (NMOP) Formulary subsequent to the expiration of the omeprazole contract on 1 Oct 2001. The voting members decided to retain omeprazole on the NMOP Formulary, add rabeprazole and pantoprazole to the NMOP formulary, and exclude lansoprazole and esomeprazole from the NMOP formulary. The decision was communicated to the field in early October 2001.

5. **UNIFORM FORMULARY–** COL Davies reported that the draft rule for the Uniform Formulary was sent to the Office of Management and Budget (OMB) on 29 Oct 01. [Note: It was subsequently determined that a summary notification of the draft rule was sent to OMB on 29 Oct 01. The draft rule was not sent to OMB until 30 Nov 01.]

6. **BCF AND NATIONAL MAIL ORDER PHARMACY (NMOP) FORMULARY ISSUES** – The Committee determined the NMOP formulary status, NMOP or retail network formulary restrictions (quantity limits or prior authorization), and Basic Core Formulary (BCF) status for 8 new drugs (see Appendix A).

7. **PROPOSED BPA FOR LANSOPRAZOLE FOR NMOP FORMULARY STATUS** - Lansoprazole (Prevacid) and esomeprazole (Nexium) are not on the NMOP formulary. TAP is offering a BPA with the following provisions if lansoprazole is added to the NMOP formulary:

   - For the first three months of the BPA (15 Nov 01 – 15 Feb 02), TAP will provide all eligible DoD MTF and NMOP facilities a $0.99 per tablet price for Prevacid.
   - Before the expiration of the first three-month period after pricing is in place, MTF and NMOP facilities must place Prevacid on their individual formularies in order to guarantee that they will continue to receive the BPA price for Prevacid.
   - If Prevacid has not been placed on individual MTF and NMOP formularies, TAP reserves the option to increase the price of Prevacid to the current published FSS price at MTFs where Prevacid is not on formulary.

   The Committee decided to place lansoprazole on the NMOP Formulary.

8. **PROPOSAL TO REMOVE OMEPRAZOLE FROM THE NMOP FORMULARY** – As of the first week in November 2001, the average cost per unit for proton pump inhibitors (PPIs) dispensed by the NMOP was $1.86, which is 72% higher than the $1.08 average cost per unit for PPIs dispensed by MTF pharmacies. MTFs and the NMOP pay the same prices for PPIs. The average cost per unit is higher in the NMOP because high-priced omeprazole continues to dominate PPI usage in the NMOP (72% of PPI prescription fills during the first week in November). Legal challenges continue to delay the availability of generic versions of omeprazole, so price relief is not imminent. A recent "Pink Sheet" article contained a prediction by a generic manufacturer that generic versions of omeprazole would not be available until the second half of calendar year 2002.

   The P&T Committee considered a proposal to remove omeprazole from the NMOP formulary. Patients who currently receive omeprazole from the NMOP would be "grandfathered" so that they could continue to receive omeprazole from the NMOP. Removal of omeprazole from the NMOP formulary would encourage the use of more cost-effective PPIs.

   Committee members and other attendees expressed concern that constraining availability of such a widely used drug could discourage patients from using the NMOP. Others were concerned that patients might simply get omeprazole prescriptions filled at retail pharmacies at a higher cost to the government and the patient. The Committee voted to retain omeprazole on the NMOP formulary.

9. **ANTIBIOTIC PROPHYLAXIS FOR ANTHRAX EXPOSURE** – The Committee discussed the recent memorandum from Health Affairs supporting Centers for Disease Control and Prevention (CDC) guidelines for antibiotics used for prophylaxis for anthrax exposure. They also reviewed data on the number of prescription fills for ciprofloxacin in the Managed Care Support Contractor (MCSC) retail networks, MTFs, and the NMOP. Although there were modest increases in the number of prescription fills for ciprofloxacin in early to mid October, utilization now appears to have returned to pre-September 11th levels. Increased usage was most notable in affected areas (Florida and Washington). The DoD P&T Committee, the PEC, and TMA will use Pharmacy Data Transaction Service (PDTS) data to monitor usage of ciprofloxacin and doxycycline (and other antibiotics that may be used for anthrax prophylaxis in the future) in MTFs, the NMOP, and the retail network.

10. PRIOR AUTHORIZATIONS

A. *Cost avoidance from NMOP prior authorizations (PAs)* – Cost avoidance analyses were not completed for this quarter due to lack of data for September 2001.

B. *Changes to PA criteria for COX-2 inhibitors* – In Oct 2001, celecoxib (Celebrex) 100 mg capsules received a supplemental indication from the Food and Drug Administration (FDA) for the management of acute pain in adults and treatment of primary dysmenorrhea. Existing NMOP PA criteria for COX-2 inhibitors allow use of rofecoxib for 20 days or less in patients with risk factors for GI adverse events, but not celecoxib, which previously lacked any indication for acute use. The Committee decided to table this issue until the next meeting when the following information is expected to be available: new package labeling for celecoxib; the percentage of rofecoxib prescriptions in the NMOP written for short-term use; and actions taken at the Jan 02 meeting of Merck-Medco's internal P&T committee (since the NMOP criteria were adapted from and are similar to criteria used by Merck Medco for other mail order clients).

C. *Clinical Rationale Statements on NMOP PA forms* – There are two versions of the NMOP PA request forms: (1) forms maintained on the PEC website for download by patients and providers, and (2) forms used internally by Merck-Medco to fax to providers when prior authorization is needed. A year ago the DoD P&T Committee decided that NMOP PA request forms should include a clinical rationale statement. The task of constructing the clinical rationale statements was delegated to the PEC staff.

   The PEC staff has encountered significant difficulties in constructing and updating the clinical rationale statements. Space is limited on the single-page forms, so it is difficult to construct complete, coherent clinical rationale statements that will fit on the forms. Any changes in the clinical rationale statements on the forms used by Merck Medco must go through a lengthy approval process.

   The Committee decided to remove the clinical rationale statements from the NMOP PA request forms, but make them available on the PEC website. The NMOP PA forms maintained on the PEC website will contain links to the clinical rationale on the PEC website. The Committee also decided that it would review and approve changes to the clinical rationale statements on the PEC website on an ongoing basis. The Committee reviewed and revised the clinical rationale statements for each of the drugs subject to prior authorization. The information on the PEC website will be updated to reflect these changes.

D. *Combination antifungal therapy for onychomycosis* – Prescription data from one MCSC indicated that only 9 patients received concurrent therapy with ciclopirox and a systemic antifungal during the 21-month time period from Jan 2000 to Sep 2001. The Committee concluded that the incidence of concomitant use is too low to warrant changing PA criteria for the antifungals for onychomycosis.

E. *Status of the PA for sildenafil (Viagra) in the NMOP and retail network* –MAJ Bellemin presented data from the NMOP assessing the potential impact of removing the sildenafil PA. He reported that the cost avoidance attributable to the PA for sildenafil in the NMOP over the 1-year time period April 2000 to March 2001 was about $14.00 per prescription using the same

model routinely used to monitor cost avoidance from the NMOP PA program. He recommended that the PA for sildenafil be continued.

Bill Hudson (Humana) also recommended that the sildenafil PA be continued. He presented data concerning the impact of the prior authorization for sildenafil in the TRICARE regions managed by Humana Military Healthcare Services (HMHS).

HMHS has required prior authorization for sildenafil in Regions 3/4 since mid June of 1998. Upon implementation of the PA requirement, utilization declined from over 1200 prescriptions per month to approximately 200 scripts per month. During 2000 through March 2001, utilization and prior authorization requests leveled off at approximately 500 scripts and 100 requests per month. Upon implementation of the TRICARE Senior Pharmacy program in April 2001, utilization approximately doubled, but the rate of denials remained constant at about 20%.

A distinctly different pattern is seen in Regions 2/5, which did not require prior authorization for sildenafil prior to April 2001. HMHS acquired the contract to manage these regions in June 2001. Sildenafil utilization was two to three times greater in Regions 2/5 than in Regions 3/4, even though the population of Regions 2/5 is about 20% smaller than Regions 3/4. During this time, Regions 3/4 had about 900 fewer claims per month than Regions 2/5 even though only about 30 requests for sildenafil were denied each month. The differences between Regions 3/4 and 2/5 in sildenafil utilization support the existence of a "sentinel effect" due to the presence of the PA program in Regions 3/4.

The PA may also enhance patient safety by assessing whether patients are currently receiving nitrates. The interaction between sildenafil and nitrates is one of the drug interactions most commonly detected by PDTS.

The Committee decided not to change the sildenafil PA in the NMOP or retail network.

11. **CLARIFICATION OF GROWTH HORMONE ON NMOP COVERED INJECTABLES LIST** – The Committee clarified the listing for somatropin, a human growth hormone, on the NMOP Covered Injectables list to include all of the brand names for this product. MAJ Mickey Bellemin confirmed that the NMOP is filling prescriptions for all brands of somatropin.

12. **CLARIFICATION OF HUMAN CHORIONIC GONADOTROPIN (HCG) PRODUCTS ON NMOP COVERED INJECTABLES LIST** – HCG is currently on the NMOP Covered Injectables List as "Human Chorionic Gonadotropin injection." The Committee added the recombinant HCG product Ovidrel (choriogonadotropin alfa) to the NMOP Covered Injectables List.

13. **ACCUTANE QUANTITY LIMIT** – Mark Petruzzi confirmed that the NMOP is complying with new FDA requirements for dispensing of Accutane, including limiting dispensing to a months supply and requiring a new prescription bearing a special sticker (which certifies that female patients have a negative pregnancy test and have received counseling on pregnancy prevention) prior to dispensing each months supply.

14. SUBCOMMITTEE REPORT: PROVISION OF INJECTABLE DRUGS IN THE NMOP OR RETAIL NETWORK PHARMACIES – LtCol (select) George Jones reported on the work of the subcommittee regarding provision of injectable drugs in the NMOP and retail network pharmacies. The subcommittee's goal was to optimize patient access, outcome, and satisfaction balanced with safety and cost efficiency. A guiding principle was that legislation or policy should not take the place of clinical judgment.

The subcommittee analyzed data from PDTS for MTFs, retail network pharmacies, and the NMOP to determine what injectable medications are being filled in each point of service. The subcommittee discussed the trend in the civilian sector to move high cost injectable drugs that were historically provided through provider offices into pharmacy distribution systems in an attempt to attain more control and information about injectable use and decrease costs through volume purchasing strategies.

LtCol (select) Jones commented that the subcommittee had not found any civilian plan that had a usable method of categorizing drugs into those that could be self-administered vs. those that should only be provided through provider offices. Plans differed drastically on what injectable drugs were covered as part of the pharmacy benefit, ranging from insulin and allergy kits only to an extensive list (basically everything except investigational drugs). Many plans have a positive list of drugs that are provided through the pharmacy benefit. Most plans have a system to handle exceptions and special needs. An industry report highlighted one plan that "optimized" distribution of injectables by directing patients to use mail order as their primary source for chronically used injectables.

The subcommittee made preliminary recommendations:

- Continue to provide injectables through the pharmacy benefit in the current manner. No significant misadventures or problems have been reported.
- Expand the number of injectables available through the NMOP. MAJ Bellemin and Mark Petruzzi (Merck-Medco) reported that the subcommittee would review Merck-Medco standard formulary planning list of injectable products as to what is usually covered. The subcommittee will review for next meeting and make specific recommendations. Mark Petruzzi noted that the idea of providing injectables to provider offices is something that Merck Medco is looking at for its commercial clients.
- MTFs continue to meet the needs of their patients through formulary addition or special purchases of injectable products.

15. CONTROLLED DISTRIBUTION OF DOFETILIDE (TIKOSYN) – Because of specialized educational requirements mandated by the FDA, dofetilide is only available for outpatient use through Stadtlander's Pharmacy/CVS Procare (which is a non-network pharmacy for DoD beneficiaries). LCDR Ted Briski reported that a plan has been worked out between Pfizer and DSCP to establish a centralized policy and financing procedure that should allow the drug to be obtained for DoD patients at federal pricing and prevent DoD patients from potentially having to pay the copay for a non-network pharmacy. Members commented that more drugs requiring controlled distribution systems are being approved and that similar issues are likely to continue to arise.

16. CONTROLLED DISTRIBUTION OF PEGINTERFERON ALFA 2B (PEG-INTRON; SCHERING) – Schering has instituted a special-distribution process for PEG-Intron due to concerns that unregulated distribution of the product could lead to shortages. Patients must begin the entire course of therapy again if it is interrupted.

Patients using retail network pharmacies or the NMOP will use the same process as Schering's commercial customers. Patients will call 888-437-2608 to self-enroll into the PEG-Intron Access Assurance program and receive an identification number. Patients will supply the identification number to the pharmacy along with their prescription or refill request. The pharmacy will place an order through its usual wholesaler, using the patient's ID number. The wholesaler will ship the product to the pharmacy to arrive within 5 days.

Patients using MTF pharmacies will not have to supply an identification number. MTF pharmacies will input the prescription into CHCS. The PDTS Customer Service Support Center will generate a weekly report of DoD patients newly started on PEG-Intron (using masked patient identifiers) and provide this to the PEG-Intron Access Assurance program. Schering will internally assign an ID number. No order authorization will be required. Schering is in the process of working out details of the program. Schering expects to submit a Memorandum of Understanding to DoD for approval before the end of the year.

17. ADJOURNMENT – The meeting adjourned at 1200 hours. The next meeting will be held at the Non-Commissioned Officers Club, Fort Sam Houston, TX starting at 0800 on Wednesday, 13 February 2002. All agenda items should be submitted to the co-chairs no later than 11 January 2002.

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

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

List of Appendices

APPENDIX A: NEWLY APPROVED DRUGS CONSIDERED FOR THE NATIONAL MAIL ORDER PHARMACY FORMULARY AND DOD BASIC CORE FORMULARY

Generic name (Trade name; manufacturer)	**FDA approval date, drug class, FDA-approved indication**	**NMOP Formulary Status**	**NMOP and/or retail network formulary restrictions**	**BCF Status**
Cefditoren pivoxil tablets (Spectracef; TAP)	29 Aug 01; third generation cephalosporin for treatment of acute exacerbations of chronic bronchitis, pharyngitis, tonsillitis, and uncomplicated skin and skin structure infections	Added to the NMOP Formulary	**Quantity Limits** 10 days supply (40 tabs) per 30 days in NMOP and retail network **Rationale for Quantity Limits:** Spectracef is **only** indicated for acute therapy. Pivalate-containing compounds have caused clinical carnitine deficiency when used over a period of months. The effect of repeat short-term courses on carnitine levels is unknown. **Prior Authorization:** No	Not added to the BCF **Similar BCF Drugs:** Amoxicillin/ clavulanic acid oral; cephalexin oral (first generation cephalosporin)
Darbepoetin alfa for injection (Aranesp; Amgen)	17 Sep 01; erythropoietin analog for treating the anemia of chronic renal failure in dialysis and non-dialysis patients; administered every 1-2 weeks by IV or SQ injection	Added to the NMOP Formulary **Note**: Erythropoietin products (Epogen, Procrit) are currently on NMOP Covered Injectables List; darbepoetin alfa may be self-administered	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **Similar BCF Drugs:** none
Tramadol + acetaminophen tablets (Ultracet; Johnson & Johnson)	15 Aug 01; short-term (5 days or less) management of acute pain	Added to the NMOP Formulary **Note**: Although Ultracet is only indicated for short-term management of acute pain, both tramadol and acetaminophen are used on a longer-term basis; in addition, excluding the product from the NMOP Formulary would further delay therapy in the unlikely event that patients submit prescriptions for short-term therapy to the NMOP.	**Quantity Limits** 240 tablets per 30 days, 720 tablets per 90 days **Rationale for Quantity Limits:** Maximum daily quantity established by labeling as 8 tabs per day; consistent with existing quantity limits for tramadol **Prior Authorization** No	Not added to the BCF **Similar BCF Drugs:** multiple analgesics; tramadol is not on the BCF
Mixed salts of a single-entity amphetamine product, immediate/ delayed release (Adderall XR; Shire)	18 Oct 01; once daily treatment of attention deficit/hyperactivity disorder	Added to the NMOP Formulary	**Quantity Limits** NMOP: General rule for Schedule II controlled substances for treatment of ADHD applies (90 days supply; no refills) **Prior Authorization** No	Not added to the BCF **Similar BCF Drugs:** Methylphenidate oral (includes Concerta, but does not include Metadate CD)

Generic name (Trade name; manufacturer)	**FDA approval date, drug class, FDA-approved indication**	**NMOP Formulary Status**	**NMOP and/or retail network formulary restrictions**	**BCF Status**
Ribavirin capsules (Rebetol; Schering-Plough)	26 July 01; anti-viral nucleoside analog capsules previously only available as a component of the combination product Rebetron, now available as a separate product indicated for combination use with interferon alfa 2b (Intron A) in chronic hepatitis C	Added to the NMOP Formulary	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **Similar BCF Drugs:** none
Albuterol solution for inhalation - 0.63 mg/3 mL, 1.25 mg/3 mL (AccuNeb; Dey)	01 May 01; pre-mixed, pre-measured reduced dosages of albuterol inhalation solution for children with asthma aged 2-12	Already included on NMOP Formulary as new formulation of existing product	**Quantity Limits** 8 boxes of 25 per 30 days (200 unit doses); 22 boxes of 25 per 90 days (550 unit doses) **Rationale for Quantity Limits:** Consistent with existing quantity limits for nebulization solutions; sufficient to provide 6 treatments per day **Prior Authorization** No	Current BCF listing for albuterol solution for inhalation clarified to not include AccuNeb **Similar BCF Drugs:** albuterol solution for inhalation; albuterol oral inhaler
Comments about AccuNeb: The Council voted to exclude the new concentrations from the existing BCF listing for albuterol solution for inhalation because it seems doubtful that the incremental benefit will exceed the incremental cost. The Council also had concerns about the potential for medication errors (underdosing) if all MTFs are required to have all three strengths on their formularies. Council members noted that because the lower vital capacity of pediatric patients decreases total drug exposure, overdosing is not typically a problem with nebulized albuterol. If lower concentrations are desired, these may be easily attained with existing products.				
Amoxicillin/ Clavulanate Potassium Powder for Oral Suspension (Augmentin ES-600; Glaxo SmithKline)	22 Jun 01; Pediatric suspension of amoxicillin/clavulanate with double the previous concentration of amoxicillin, same clavulanate concentration; indicated for the treatment of pediatric patients with recurrent or persistent acute otitis media.	Already included on NMOP Formulary as new formulation of existing product	**Quantity Limits** General rule applies **Prior Authorization** No	Current BCF listing for amoxicillin/ clavulanic acid oral will include this new formulation **Similar BCF Drugs:** amoxicillin/ clavulanic acid oral
Comments about Augmentin ES-600: The Council noted that the cost per course of therapy with Augmentin ES-600 oral suspension appears to be comparable to giving standard concentration Augmentin plus an dose of amoxicillin suspension to provide the same amounts of amoxicillin and clavulanic acid. Other oral dosage forms with double concentrations of amoxicillin are already available and are also included in the BCF listing for amoxicillin clavulanic acid oral.				
Tenofovir disoproxil fumarate (Viread; Gilead Sciences)	26 Oct 01; in combination with other antiretroviral medications for the treatment of HIV infection	Already included on NMOP Formulary following precedent for HIV drugs. Confirmed by the Committee	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **Similar BCF Drugs:** None

APPENDIX B: COMBINED SUMMARY OF FORMULARY CHANGES FROM THE DOD P&T EXECUTIVE COUNCIL MEETING AND THE DOD P&T COMMITTEE MEETING

1. **BCF CHANGES**

   A. *Additions to the BCF*

      1) Tretinoin cream, 0.025% and 0.05% [excludes products only indicated for wrinkles (e.g., Renova)]

      2) Diazepam 5 mg oral tablets

      3) Clonazepam 0.5 mg oral tablets

   B. *Deletions from the BCF*

      1) Cromolyn sodium oral inhaler

      2) Cromolyn sodium solution for inhalation

      3) Haloperidol oral

   C. *Changes and clarifications to the BCF*

      1) The current BCF listing for albuterol solution for inhalation was clarified to exclude the 0.63-mg/3 mL and 1.25 mg/3 mL strengths (AccuNeb)

      2) The current BCF listing for amoxicillin/clavulanic acid oral will include Augmentin ES-600 oral suspension

2. **NMOP FORMULARY CHANGES**

   A. *Additions to the NMOP Formulary* (See Appendix A for details)

      1) Rabeprazole oral (interim decision effective 1 Oct 2001)

      2) Pantoprazole oral (interim decision effective 1 Oct 2001)

      3) Lansoprazole oral (as of 15 Nov 2001)

      4) Choriogonadotropin alfa (Ovidrel) for injection – added to NMOP Covered Injectables List

      5) Ceftidoren pivoxil tablets (Spectracef; TAP) – quantity limits apply, see below

      6) Darbepoetin alfa for injection (Aranesp; Amgen) – added to NMOP Covered Injectables List

      7) Tramadol/acetaminophen 37.5 / 325 mg tablets (Ultracet; Johnson & Johnson) – quantity limits apply, see below

      8) Mixed salts of a single-entity amphetamine product, immediate/delayed release (Adderall XR; Shire)

      9) Ribavirin capsules (Rebetol; Schering-Plough)

      10) Tenofovir disoproxil fumarate (Viread; Gilead Sciences)

   B. *Exclusions from the NMOP Formulary*

      1) Lansoprazole oral (interim decision effective 1 Oct 2001; lansoprazole was added to the NMOP Formulary as of 15 Nov 2001)

      2) Esomeprazole oral (interim decision effective 1 Oct 2001; esomeprazole remains excluded from NMOP Formulary)

C. Clarifications to the NMOP Formulary

1) Listing for somatropin (human growth hormone) on NMOP Covered Injectable List clarified to list all of the brand names for this product

3. **QUANTITY LIMIT CHANGES (NMOP AND RETAIL NETWORK)**

A. Quantity limit for cefditoren pivoxil tablets: 10 days supply (40 tablets) per 30 days in NMOP and retail network

B. Quantity limit for tramadol/acetaminophen 37.5/325 mg tablets: 240 tablets per 30 days; 720 tablets per 90 days

C. Albuterol solution for inhalation – 0.63 mg/3 mL, 1.25 mg/3 mL: 8 boxes of 25 per 30 days (200 unit doses); 22 boxes of 25 per 90 days (550 unit doses)

4. **CHANGES TO THE PRIOR AUTHORIZATION PROGRAM (NMOP AND RETAIL NETWORK)** – None