Department of Defense
Pharmacoeconomic Center

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Fort Sam Houston, TX 78234-5081

MCCS-GPE **12 February 2002**

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

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

1. The DoD P&T Executive Council met from 0800 to 1600 hours on 12 February 2002 at the Non-Commissioned Officers Club, Fort Sam Houston, TX.

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 Mark Nadeau, MC (Representing COL Bill Sykora, MC)	Air Force
LtCol (select) George Jones, BSC	Air Force
CAPT (select) Matt Nutaitis, MC	Navy
CDR Kevin Cook, MSC	Navy
MAJ Brett Kelly, MS	Army
LTC (P) Joel Schmidt, MC	Army
CAPT Robert Rist	Coast Guard
MAJ Mickey Bellemin, BSC	Defense Supply Center Philadelphia
Dick Rooney	Department of Veterans Affairs

MEMBERS ABSENT

COL Rosa Stith, MC	Army
LTC Mike Kieffer, MS	Joint Readiness Clinical Advisory Board

OTHERS PRESENT

COL William Davies, MS	DoD Pharmacy Program Director, TMA
Howard Altschwager	Deputy General Counsel, TMA
CAPT Betsy Nolan, MSC	Navy Pharmacy Specialty Leader
CAPT Joe Torkildson, MC	DoD Pharmacoeconomic Center
LtCol Ed Zastawny, BSC	DoD Pharmacoeconomic Center
CDR Denise Graham, MSC	DoD Pharmacoeconomic Center
LCDR Ted Briski, MSC	DoD Pharmacoeconomic Center
LTC Don De Groff, MS	DoD Pharmacoeconomic Center
LTC (P) Doreen Lounsbery, MC	DoD Pharmacoeconomic Center
LtCol (select) Barb Roach, MC	DoD Pharmacoeconomic Center
Shana Trice	DoD Pharmacoeconomic Center
Dave Bretzke	DoD Pharmacoeconomic Center
Eugene Moore	DoD Pharmacoeconomic Center
Angela Allerman	DoD Pharmacoeconomic Center
SFC Agustin Serrano	DoD Pharmacoeconomic Center
CAPT Andy Meadows, USAF	Lead Agent Region 6
Leticia Ramirez	Pharmacy Student, University of Texas at Austin Pharm.D. Program
MAJ Cheryl Filby, MS	Defense Supply Center Philadelphia
Paul Vasquez	Defense Supply Center Philadelphia
CDR Brian Kerr, MSC	Defense Supply Center Philadelphia
Vincent Valinotti	Defense Supply Center Philadelphia

3. REVIEW MINUTES OF LAST MEETING / ADMINISTRATIVE ISSUES

The Council approved the minutes of the last meeting with a correction in the last sentence of the fourth paragraph in section 10:

- Incorrect sentence: The percentage of *fatal bleeding episodes* was 2.2% for clopidogrel plus aspirin compared to 1.8% with aspirin plus placebo (a statistically non-significant difference).
- Corrected sentence: The percentage of *life-threatening bleeding episodes* was 2.2% for clopidogrel plus aspirin compared to 1.8% with aspirin plus placebo (a statistically non-significant difference).

4. ADVANCES IN MEDICAL PRACTICE (AMP) PROGRAM

AMP funds will not be used to reimburse MTF pharmacies for pharmaceutical purchases in FY 02 because Program Budget Decision (PBD) 812 is supposed to provide sufficient funding for MTF pharmacies. PBD 812 provides MTF pharmacies with 15% more funding in FY 02 than was actually spent in FY 01.

5. NATIONAL PHARMACEUTICAL CONTRACTS AND BLANKET PURCHASE AGREEMENTS (BPAs)

A. *Contract awards, renewals, and terminations*

- Contracts for Diltiazem XR, acetaminophen tablets, levobunolol ophthalmic solution, timolol ophthalmic solution, clotrimazole cream, and simvastatin were renewed.
- Contract for gemfibrozil was cancelled due to the manufacturer not being able to meet the terms of the contract.
- New contracts were awarded for cyclobenzaprine tablets, isosorbide dinitrate tablets, loperamide capsules, methocarbamol tablets, metoprolol tablets, verapamil immediate release tablets, and lactulose syrup, nitroglycerin patch, and glyburide micronized tablets.
- DoD contracts for lisinopril and hepatitis A are up for renewal.
- Joint DoD/VA contracts up for renewal: salsalate tablets, oral contraceptives, etodolac, fexofenadine, hydrochlorothiazide, insulin needle/syringes, isosorbide mononitrate, prednisone, capsaicin cream, cimetidine, ticlopidine, nicotine patches, and valproic acid.

B. *Status of Contracting Initiative for Leutinizing Hormone Releasing Hormone (LHRH) agonists* – CAPT Torkildson reported that the joint VA/DoD solicitation to select an LHRH agonist (for the treatment of prostate cancer only) has still not been released, pending completion of the update to the VA clinical review. The VA and AstraZeneca have agreed to further extend the VA's contract for Zoladex until such time as the joint VA/DoD contract has been awarded. AstraZeneca and TAP have indicated that the DoD Blanket Purchase Agreements (BPAs) for Zoladex and Lupron will remain in place until the new contract is awarded.

CAPT Torkildson presented an assessment of the clinical significance of the entry of triptorelin (Trelstar) into the LHRH agonist marketplace. Debio Recherche Pharmaceutique manufactures this agent in Switzerland; Pharmacia holds the marketing rights in the United States. This is another LHRH agonist that has been in use in Europe since 1985. The FDA approved the 1-month depot in June 2000; the 3-month depot was approved in June 2001. Both preparations are approved for the treatment of advanced prostate cancer. Unlike leuprolide and goserelin, triptorelin has no additional FDA-approved indications, although it is used in other countries for many of the same indications. Pharmacia has not yet begun marketing this product extensively in the United States. However, a company representative has indicated that they intend to bid on the joint VA/DoD LHRH agonist contract.

Two major clinical concerns have been raised regarding triptorelin. The first relates to the paucity of clinical trial data available for this agent. The majority of published reports were conducted and published in Europe in the mid to late 1980s. The primary study submitted for approval of the 3-month depot was an unpublished study that took place in South Africa. There are also no survival studies; efficacy was measured using the surrogate endpoint of a reduction in serum testosterone levels established as being equivalent to those seen following surgical castration. The second concern relates to the

drug's ability to continue to suppress testosterone production with repeated dosing, the so-called "acute on chronic effect". Following the initial dose of LHRH agonists, there is a surge in testosterone production that produces a disease flare in a small percentage of patients. This surge is followed by a predicable fall in serum testosterone concentrations to castrate levels. However, with some agents a second surge in testosterone production is seen following the second dose of the agent. This has led the FDA to require manufacturers of LHRH agonists to submit data with their approval applications regarding the likelihood that their product will induce this effect. Data were submitted for only 15/151 subjects enrolled in the South African trial noted above, 2/15 had secondary surges in testosterone levels above the acceptable level. As a result, in its approval letter the FDA has required the company to conduct a Phase IV pharmacology study to determine if this ratio is observed with a larger group of patients. While the clinical significance of this observation is unknown, it does create a concern regarding the ability of this agent to maintain serum testosterone levels within the range defined as acceptable.

The Council shared the concerns raised during the presentation, and voted unanimously that triptorelin should not be considered therapeutically equivalent to leuprolide and goserelin at this time. Triptorelin should not be included in a solicitation for a contract for an LHRH agonist for the treatment of prostate cancer.

C. *Non-sedating antihistamine contract* – Lt Col Zastawny informed the Council that prescriptions for fexofenadine (Allegra) continue to outnumber prescriptions for loratidine (Claritin) by a 9 to 1 margin at MTF pharmacies. The weighted average cost per tablet/capsule for non-sedating antihistamines purchased by MTFs in Dec 01 was $.53, which is 39% below the $.87 weighted average cost that existed prior to the contract.

According to Aventis, the 500 count bottles of both the 60 and 180 mg tablets will be added and the 60 mg capsules will be removed from the non-sedating antihistamine contract effective 28 Feb 2002. The contract price for the 60 mg and 180 mg tablets remains unchanged at $0.37 and $0.60 per tablet, respectively.

Cetirizine (Zyrtec) costs MTF pharmacies $.95 per day compared to only $.60 per day for fexofenadine 180 mg. MTFs fill almost as many prescriptions for cetirizine as for fexofenadine. The Council agreed that the PEC should publish an article in the PEC Update to encourage greater utilization of fexofenadine.

The FDA recently approved desloratadine (Clarinex). Desloratadine cannot be added to the BCF or MTF formularies while the contract for fexofenadine is in effect.

D. *Statin Contract* – MAJ Cheryl Filby stated that the contract for simvastatin (Zocor) was renewed for the final option year (until 19 Feb 03) as the Council recommended at the November meeting. Simvastatin and atorvastatin (Lipitor) account for 95% and 3.5% respectively of the total statin prescriptions filled at MTF pharmacies, but atorvastatin accounts for a much higher percentage at a few MTFs. An analysis of prescription data also revealed that the majority of atorvastatin prescriptions are filled for the 10 mg and 20 mg strengths. Higher dosages of atorvastatin (40 mg and 80 mg) would normally be needed if atorvastatin were used primarily for patients who failed to reach their LDL

goals on simvastatin. The PEC will provide statin usage data to MTFs and publish an article in the PEC Update that addresses the appropriate use of non-contracted statins.

E. *Status of contracting initiative for nasal corticosteroid inhalers* - The Council reiterated that neither flunisolide nor budesonide would be acceptable as the only nasal corticosteroid on the BCF because they too frequently require dosing more than once daily. The Council agreed that DoD could participate in a solicitation that may result in the addition of flunisolide or budesonide to the BCF, but neither of these drugs can be the sole nasal corticosteroid on the BCF.

F. *Potential contracting initiative for carbamazepine* – There is an opportunity to establish a joint VA/DoD single-source contract for an AB-rated generic carbamazepine. A recent analysis of carbamazepine purchases by DoD MTFs revealed that 85% of purchases were for branded Tegretol, at 5 times the cost of the available generics.

At the last DoD P&T Executive Council meeting, the PEC was asked to query the field and evaluate why there is high usage of brand name Tegretol when AB-rated generics are available. The Council also wanted a sense of how providers and pharmacists in the field would view a generic contract for this drug.

Responses were received from 35 primary care providers, pharmacists and neurologists. The majority of respondents (77%) were not concerned about whether the drug provided at their facility was generic or brand name. They agreed that Tegretol was prescribed because they were confident it would always be supplied by the same manufacturer. This guaranteed that the color, shape, etc. of the tablet would remain constant so as not to confuse patients or bring up questions of differences in bioavailability. Many also noted that carbamazepine is typically not the drug of choice for treating seizure disorders since safer options are now available. The drug is being used frequently for neuropathic pain control, where bioequivalence does not carry the same significance as it might for seizure control. However, since there is still some use as an antiepileptic, respondents felt a contract for an AB-rated generic would be acceptable, as long as a single manufacturer was chosen for a long-term contract to maintain consistency.

The Council learned that the proposed contract would allow facilities to use either the contracted generic or brand name Tegretol. The Council recognized that this conflicts with the desire of DoD providers to stipulate the use of a single carbamazepine product throughout the MHS. Some Council members asserted that this situation was still preferable to the current situation in the DoD, where all five generic products are currently being utilized. They also recognized the value in participating with the VA in a contracting action for this agent, and felt that it would be a first step in working toward the goal of all facilities using the contracted agent exclusively. After much discussion, the Council voted to support a joint VA/DoD solicitation for a single source of generic carbamazepine that allows MTFs to use either the contracted generic carbamazepine or brand name Tegretol (assuming that Tegretol does not in fact win the contract).

a. *Compliance with sole source contracts* - LCDR Ted Briski reported that a review of generic contract compliance revealed many instances where MTFs purchased non-contracted products. A small sampling of MTF pharmacy directors indicated that unavailability of the contracted product from the prime-vendor caused MTFs to purchase

non-contracted products. The Council views unavailability of contracted products as a patient compliance/safety issue since it may cause patients to receive different looking tablets or capsules each time they receive a prescription. LCDR Briski and Dave Bretzke will coordinate with MAJ Cheryl Filby to assess the problem and report back at the next meeting.

G. *Potential contracting initiative for fluoroquinolones* – Levofloxacin is currently on the BCF in accordance with a BPA. The Council concluded in Nov 01 that levofloxacin and gatifloxacin are therapeutically interchangeable and that either agent would be clinically acceptable as the "workhorse" oral fluoroquinolone. Ortho-McNeil has offered a modified BPA to both DoD and the VA, which removes the market share requirements and gives a uniform price of $2.00/tab system-wide. The BPA would reduce overall expenditures while avoiding the logistical and economic consequences of undergoing a product conversion that could potentially result from a contracting action. However, the Council also believes that it is still clinically acceptable to participate in a joint DoD/VA contract. Since the clinical needs of patients could be satisfied with either a contract or a BPA, the Council voted to support whichever joint action the VA/DoD contracting workgroup decides to pursue.

H. *Potential contracting initiative for triptans* – Lt Col Zastawny presented information from clinical studies and provider input regarding triptans. Clinical studies show that triptans generally will provide pain relief within 2 hours for 50-75% of patients and that 25-40% of patients will be pain free after two hours. One study showed that 45-58% of patients who did not respond to the initial triptan would respond to a different triptan. The clinical trial data suggest that patients' clinical needs would not be satisfied if a contract prohibited MTFs from having more than one triptan on their formularies. The majority of MTF providers surveyed by the PEC agreed that a contracting action would not be acceptable if it limited MTF formularies to a single triptan. The Council voted to support any contracting initiative or other pricing agreement that either allows or requires MTFs to have at least two triptans on their formularies.

I. *Potential contracting initiative for angiotensin receptor blockers (ARBs)* – LCDR Briski reported that MTF expenditures for ARBs increased from $5.7 million in FY 99 to $14.5 million in FY 01. The VA and DoD are working together on a clinical review of the ARBs. The PEC will forward the clinical review to Council members and compile additional information that will assist the Council in assessing the need for addition of an ARB to the BCF and the therapeutic interchangeability of the ARBs for a potential contracting initiative.

J. *Other contracting initiatives:* According to prime vendor data, national pharmaceutical contracts produced $16 million in cost avoidance at MTFs during the first quarter of FY 02. As for the third and fourth quarters of FY 01, prime vendor data for the first quarter of FY 02 are missing for many MTFs, so the actual cost avoidance is more than $16 million. Through Dec 01, the weighted average cost per unit for drugs covered by national pharmaceutical contracts is 33% less than the weighted average cost per unit that existed before the contracts took effect. Although MTFs are now spending much less for

proton pump inhibitors, no cost avoidance is attributed to this drug class because there is no contract in effect for proton pump inhibitors.

6. POTENTIAL IMPACT OF NEW GENERICS

A. *Fluoxetine:* CAPT Torkildson presented an update on the situation regarding generic fluoxetine. Barr Pharmaceuticals' 6-month period of exclusivity for this product expired in late January. On January 29 the FDA approved several additional generic fluoxetine products. At least two companies receiving approval have submitted the necessary paperwork to establish FSS pricing for their generic products. The prices contained in the most recent FSS pricing database for these products range from $4.49 to $5.19/100 capsules for the 10 mg and 20 mg strengths. It is uncertain at this time how soon these prices will be loaded or when they will be available to the MTFs, but they will likely be available by March 1. MTFs are advised to examine the available prices carefully before purchasing quantities of fluoxetine in the near future. If MTFs transition quickly to these significantly less expensive generic products, it is anticipated that the MHS could reduce expenditures for fluoxetine by as much as $13M over the next 12 months.

B. *Metformin:* The FDA approved generic formulations of metformin (Glucophage) on 25 Jan 01. At least six generic companies will market metformin, and five of them have approval for all three strengths (500-, 850-, and 1000 mg). The extended release metformin preparation (Glucophage XR) and combination product with glyburide (Glucovance) are still under patent.

Current FSS prices for Glucophage are $0.32 for the 500 mg tablet, $0.55 for the 850 mg tablet, and $0.58 for the 1000 mg tablet. MTFs spent approximately $20 million on Glucophage during the past 12 months. While FSS prices have not yet been established for generic metformin, a hypothetical example can illustrate the magnitude of potential cost savings. For example, MTFs could potentially save about $15 million annually if the generic metformin price is 75% less than the Glucophage price.

7. SUBCOMMITTEE REPORT: OBTAINING INPUT FROM PROVIDERS

LCDR Briski reported on the latest efforts by the PEC staff to obtain input from MTF-based providers, which is an important factor in pharmaceutical contracts and formulary management. The email groups put together by MAJ Roach have been effective, but do not reach all MTFs. Since the DoD P&T is a TMA chartered organization, using the TMA infrastructure is a logical mechanism to communicate with MTFs. The PEC initiated monthly teleconferences with lead agent medical directors and lead agent pharmacists. The PEC's goal is to tap into the already existing networks these senior Lead Agency staffers have established. Close contact with the service-specific chains of command will continue to be maintained via the Chief Pharmacy and Chief Clinical Consultants to each Surgeon General. In addition, the PEC is exploring the options for creating a Chat room/Bulletin Board section of the PEC web site to facilitate consistent and timely communication. P&T minutes will continue to be distributed through service and TMA lanes.

8. MTF REQUESTS FOR BCF CHANGES

A. *Request to add Advair (fluticasone/salmeterol) to the BCF* – An Air Force allergist provided the following rationale for the request:

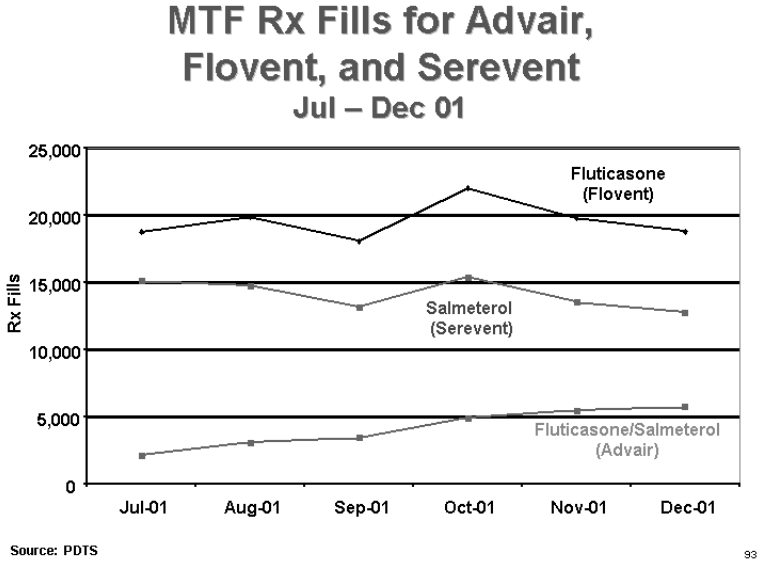
- Nine studies have proven that the addition of a long acting beta-agonist is superior to doubling the dose of inhaled corticosteroid (ICS) in the treatment of uncontrolled asthma in the patient already on an ICS.
- The evidence also suggests that long acting beta-agonists should never be used as mono-therapy and should always be used in conjunction with ICS.
- Compliance with asthma controller medication decreases when more than one inhaler is used.
- Advair offers mandatory combination therapy and a single inhaler of 1 puff twice a day (vs. 2 inhalers, 4 puffs twice a day).

Safety and tolerability of the combination product are similar to the same dosages of the products administered by separate inhalers. The FDA allowed the removal of the box warning about adrenal insufficiency surrounding the use of inhaled corticosteroids class because no cases were reported. Efficacy of the combination product is similar to the same dosages of the products administered by separate inhalers. An article by Aubier et al. comparing Advair vs. the two single agents demonstrated that the two arms were equal for morning Peak Expiratory Flow (PEF).

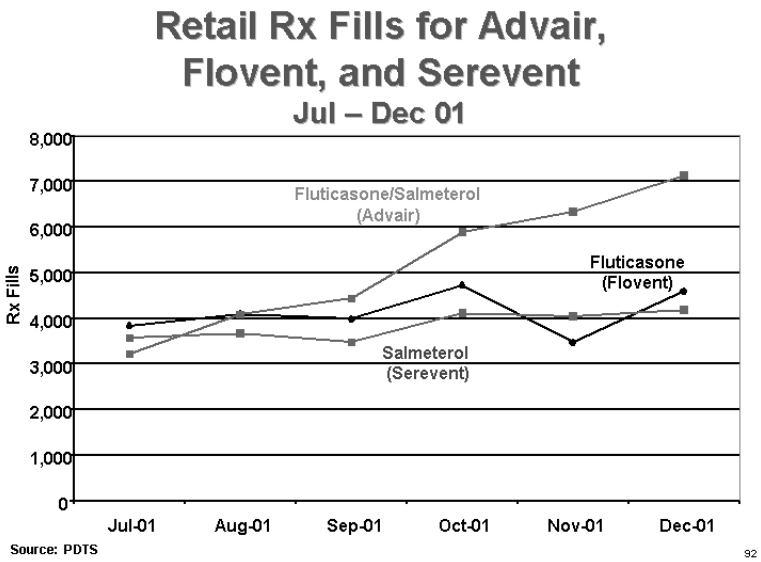
The PEC requested provider (physician and pharmacist) input on this issue and received 63 responses: 56 favoring addition to the BCF; 4 against addition to the BCF; and 3 inconclusive regarding addition of Advair to the BCF. Providers made several key points:

- Advair provides perceived symptom improvement within 30 minutes (from the Serevent). Researchers have speculated that the patient's perception of the benefit of the treatment rather than the dosage form itself may be the more critical factor. Some patients using the separate inhalers will identify Serevent as the agent that causes improvement, stop the inhaled steroid, and then end up on Serevent monotherapy. One large MTF survey showed that 200 patients were on Serevent monotherapy.
- The greatest benefit would be to our teenage population. The death rate of asthma in children has risen 150% between 1980 and 1996 – the age group with the highest mortality is 15-24 years of age. Asthma deaths today are preventable and we need to support combination therapy of inhaled corticosteroids and long-acting beta-agonists.
- Advair can be administered in 1/20 of the time it takes to use the 2 separate inhalers. How could this not improve compliance?

Fluticasone and salmeterol are on the BCF as individual agents. As shown in the following graph, prescription fills for Advair are rising steadily at MTFs (up 60% from Jul 01 to Dec 01), while usage of the individual agents is flat or declining slightly.



Prescription fills for Advair are rising even faster in the retail network pharmacies (more than doubled from Jul 01 to Dec 01)



The FSS pricing as of January 2002 for Advair and the individual products is presented in the following table:

Item Description		Doses/container	FSS Price As of Jan 2002
Advair Diskus Inhaler	fluticasone 100 mcg/salmeterol 50 mcg	60	$64.27
	fluticasone 250 mcg/salmeterol 50 mcg	60	$80.54
	fluticasone 500 mcg/salmeterol 50 mcg	60	$102.82
Serevent	salmeterol 25 mcg MDI	120	$42.72
	salmeterol 50 mcg diskus	60	$45.32
Flovent	fluticasone 110 mcg MDI	120	$39.60
	fluticasone 220 mcg MDI	120	$60.10

The cost of Advair is compared to the cost of the individual products in the following table:

Item Description	Advair cost/day Using twice daily dosing	Cost/day for equivalent dose of individual products	Additional cost per day for Advair
fluticasone 100 mcg/salmeterol 50 mcg	$2.14/day	$2.09/day	$0.05/day
fluticasone 250 mcg/salmeterol 50 mcg	$2.68/day	$2.43/day	$0.25/day
fluticasone 500 mcg/salmeterol 50 mcg	$3.43/day	$3.43/day	$0.00/day

Addition of Advair to the BCF could improve patient satisfaction and compliance. There is also a potential reduction in waste, since most fluticasone and salmeterol use is of MDI inhalers that are hard to estimate remaining doses. Advair Diskus gives number of doses remaining. The Council added all strengths of the fluticasone/salmeterol (Advair) to the BCF.

B. *Request to add Plan B (emergency contraceptive) to the BCF* – An MTF provider offered the following rationale in support of the request:

- Use of an emergency contraceptive is the only method available to prevent pregnancy after unprotected sexual intercourse or after a contraceptive "accident."

- It can provide emergency treatment for victims of sexual assault who were not protected by an effective contraceptive.
- A couple or a single female may suffer economic hardship as well as significant psychological and social costs from an unintended pregnancy.
- Although relatively higher in cost than some combination formulary contraceptives, the cost of Plan B is well within the range of the most commonly used preparations for this purpose, and the volume or frequency of use would be relatively low.
- The lower side effect profile of Plan B would decrease the use and cost of anti-emetics usually prescribed with the combination regimens, and the cost and necessity of return visits for adverse effects or therapeutic failure.
- The greater clinical efficacy, lower adverse effects, and simplified patient dosing regimen make Plan B the drug of choice for emergency contraception.
- Data indicate a rapid return of normal ovulation and fertility following discontinuation of either combined estrogen-progestin or progestin-only tablets for emergency contraception.
- Emergency contraceptives should be uniformly and immediately available in order to maximize their effectiveness in preventing unintended pregnancies and thereby reducing the number of women who seek elective abortions.

The Council considered the following information regarding emergency contraceptives in general and Plan B in particular:

- The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Family Practice (AAFP) recommend and endorse the use of emergency contraception.
- ACOG estimates that use of emergency contraceptives could prevent as many as half of the approximately 3 million unintended pregnancies that occur each year in the United States, including as many as 700,000 pregnancies that are terminated by abortion.
- Emergency contraception counseling should be provided during every annual health maintenance examination per BUMED NOTE 6320 (26 Oct 99) and Article 15-76 of the Manual of the Medical Department, Section VI; Family Planning, Contraceptive Counseling, and Sexually Transmitted Disease Prevention Counseling.
- The OB/GYN consultants for the three services support the addition of Plan B to the BCF.
- Ethics consultants for the three services concluded that there are no apparent reasons to preclude the use of Plan B at MTFs, since it is an FDA-approved contraceptive and not, as some argue, an abortifacient. Service regulations and TRICARE policy do not prohibit the coverage of emergency contraceptives. The presence of Plan B on the BCF would not "force" providers to prescribe Plan B. As with all other drugs on the BCF, the decision to prescribe Plan B would be left to the discretion of the individual provider.
- MTFs already provide emergency contraceptive therapy. Most MTFs use regular oral contraceptives in an "off label" fashion, while some MTFs use Plan B.
- The first dose of an emergency contraceptive should be taken within 72 hours of unprotected sex, preferably during the first 24 hours, followed by a second dose 12 hours later. The earlier the emergency contraceptive is given, the more likely it is to prevent pregnancy. The need for timely administration supports the argument that the emergency contraceptive should be on the MTF formulary in order to preclude delays that might

occur if the medication had to be obtained through a non-formulary or special order request.

- MTF providers and pharmacists responded to a survey regarding the proposal to add Plan B to the BCF. 38 respondents supported the addition, 15 respondents did not support the addition, and 14 respondents did not clearly express their position.
- Plan B is more efficacious than the Yupze regimen (ethinyl estradiol 100 mcg and levonorgestrel 0.5 mg taken twice, twelve hours apart). A large-scale clinical trial conducted at 21 treatment centers in 14 countries found a pregnancy rate of 1.1% (95% CI 0.6-2.0) for Plan B versus a pregnancy rate of 3.2% (95% CI 2.24.5) for the Yupze regimen.
- The incidence of nausea and vomiting associated with Plan B is less than half the incidence of nausea and vomiting associated with the Yupze regimen.
- The Plan B regimen requires the patient to ingest a total of 2 tablets, which is much more tolerable than the 20 tablets that a patient must ingest when using progestin-only tablets.
- The costs per regimen of the various emergency contraceptive alternatives are:
    - Plan B: $11.63
    - Preven: $3.91
    - Yupze regimen: $9.92
    - Progestin-only tablets (norethindrone): $9.20

The Council voted to add Plan B to the BCF. However, the Council decided that the addition of Plan B to the BCF would not be official until the Council verifies with TMA that this action is consistent with existing DoD policy.

9. REVIEW OF BCF

A. *Follow-up of anxiolytic review – potential BCF addition of venlafaxine extended release (Effexor XR)* – The Council recommended tabling this topic until the meeting in May.

B. *Analysis of midday dosing with methylphenidate dosage forms.* The following table displays the results of analyses of midday dosing associated with random samples of methylphenidate-SR prescriptions filled between Oct 99 and Sep 00 and Concerta prescriptions filled between Oct 00 and Dec 01.

Midday Dose	Methylphenidate-SR Rxs	Concerta Rxs
Yes	78 (40%)	17 (8%)
No	115 (60%)	178 (92%)
Total	193 (100%)	195 (100%)

The analyses indicate that the addition of Concerta to the BCF improved a humanistic outcome of drug therapy by decreasing the frequency of midday dosing of methylphenidate products for ADHD patients.

C. *Potential additions to BCF based on usage review*: Medications reviewed for BCF addition based usage criteria/analysis: 1) Top 200 list from PDTS; 2) High use in retail network; 3) Significant formulary status at MTFs; and 4) High dollar items.

- *Conjugated estrogens/medroxyprogesterone acetate (Prempro)* – Safety, tolerability and efficacy are similar for Prempro and the same dosages of the

drugs administered as separate tablets. Most providers think that the potential for improved compliance with Prempro may increase effectiveness. Based on prime vendor data, the average daily cost of Prempro is $0.32, while the average daily cost of providing the same dosage of medroxyprogesterone and conjugated estrogens via separate tablets is $0.39, so Prempro is actually less expensive than the individual products.

Prempro 0.625/2.5 is on the formulary at 63 (59%) of 107 MTFs. Prempro 0.625/5 is on formulary at 37 (35%) of 107 MTFs. Prempro 0.625/2.5 was ranked #5 in dollars spent, #24 in prescriptions, and #53 in unique users at retail network pharmacies.

The PEC requested provider (physician and pharmacist) input. Of 141 responses, there were 108 in favor, 17 opposed, and 16 indecisive regarding the addition of Prempro to the BCF.

The Council added all strengths of Prempro to the BCF.

- *Gabapentin (Neurontin)* – Gabapentin was evaluated for potential addition to the BCF based on the fact that gabapentin was in the top 200 in PDTS, high usage rate in retail network, and is a high dollar item. MTF expenditures for FY 01 were $12 million. Anticonvulsants rank #12 in all DoD expenditures, with ½ of that being gabapentin. Gabapentin 300mg strength ranks #17 in expenditures and #69 in unique users in the retail network.

  The PEC requested provider (physician and pharmacist) input on this issue and received 55 responses: 22 favored, 11 opposed (nearly all due to cost), and 12 were inconclusive regarding the addition of gabapentin to the BCF. One provider indicated that gabapentin quickly became a staple in their pain arsenal and usage would likely increase dramatically in the next few years. Another provider commented that the most beneficial aspects of gabapentin are its lack of significant interactions, lack of hepatic metabolism, and lack of need for blood work monitoring. A Pfizer report stated that the worldwide use for pain indication is 85% and is increasing by a 55% growth rate. Since the usage of gabapentin will likely continue to increase, and it is a safe, well-tolerated alternative to other agents for neuropathic pain control, the PEC recommended addition of gabapentin to the BCF.

  Council members were concerned that gabapentin is not FDA approved for pain control and that it may pose a large cost burden to small MTFs. They were also concerned that there is very little solid literature to back its use for pain control. The company has a supplemental new drug application pending for FDA approval for treatment of neuropathic pain.

  The Council decided not to add gabapentin to the BCF.

- *Azithromycin (Zithromax)* – Azithromycin is a widely used agent proven safe and effective in a broad range of infectious processes. FSS pricing as of Jan 2002 for the 250 mg strength of azithromycin is $4.00/tablet or $25.00/5 day course. Azithromycin 250 mg tablet strength is #2 by unique users and #9 by Rx fills in

the retail network. Azithromycin is on 94% of MTF formularies. Provider input was not obtained for this product. Due to high volume in retail pharmacy network and representation on a vast majority of MTF formularies the Council added azithromycin 250 mg tablets to BCF (does not require the Z-pak dosing form).

10. AVAILABILITY AND PRICING OF ORTHO NOVUM 7/7/7

Ortho Novum 7/7/7 is listed on the BCF and has been available for purchase by MTFs through the Depot or directly from Ortho-McNeil for approximately $7.70/cycle. This price is not available to MTFs via Prime Vendor (approximately $16.00/cycle) because of the packaging of the product ("clinic" packs vs. "commercial" packs). Ortho-McNeil stated that it would not renew the Depot contract, which expires at the end of February 2002. Ortho Novum 777 will no longer be available from the Depot when existing supplies are exhausted. There has been no determination on the long-term availability of the "clinic" packs directly from the manufacturer. The PEC will continue to monitor the situation and determine whether a change to the BCF is necessary.

11. BLEEDING RISKS IN THE CURE TRIAL

The Council evaluated the results from the CURE (Clopidogrel in Unstable Angina to Prevent Recurrent Events) trial at the Nov 01 meeting in consideration of a proposal to add clopidogrel (Plavix) to the BCF. The Council noted the higher incidence of bleeding reported with the combination of clopidogrel plus aspirin vs. the placebo plus aspirin group. The definition of major bleeding used in the CURE trial differed from the widely accepted definition used by the American College of CHEST Physicians (ACCP). Council members were concerned that the number of major bleeds in the CURE trial may have been even higher if the ACCP definition had been used. The Council asked the PEC to request additional information from Bristol Myers Squibb (BMS) about the bleeding rates in the CURE trial.

The PEC sent questions to BMS on 3 Jan 2002. BMS referred the questions to the CURE trial investigators. The PEC received a response from the investigators on the evening of 11 Feb 02. The PEC did not have enough time to analyze the response prior to the 12 Feb 02 P&T Executive Council meeting. At the 12 Feb 02 meeting the Council asked the PEC to analyze the response, estimate the number of major bleeds using the ACCP definition for major bleeds, and forward the analysis and estimates to the Council members so they could vote on the proposal to add clopidogrel to the BCF and report the results of the vote as part of the minutes for this meeting.

Based on the response from the CURE investigators, the PEC estimated that the number of major bleeds in the clopidogrel plus aspirin group would increase by 6 (from 231 to 237) and the number of bleeds in the placebo plus aspirin group would increase by 9 (from 169 to 178) using the ACCP definition for major bleeds. Using the ACCP definition for major bleeds did not produce a significant change in the number of major bleeds for either group in the CURE trial. A BMS representative stated that several articles are planned for publication based on the CURE study, including one devoted to bleeding episodes. Additionally, newly updated guidelines by the American Heart Association and the American College of Cardiology are expected to recommend that clopidogrel receive a type one recommendation (the highest quality recommendation) for use in patients with non-ST segment-elevation myocardial

infarction; however, the guidelines have not yet been published. The PEC forwarded this information to the Council members, and the Council members voted to add clopidogrel to the BCF.

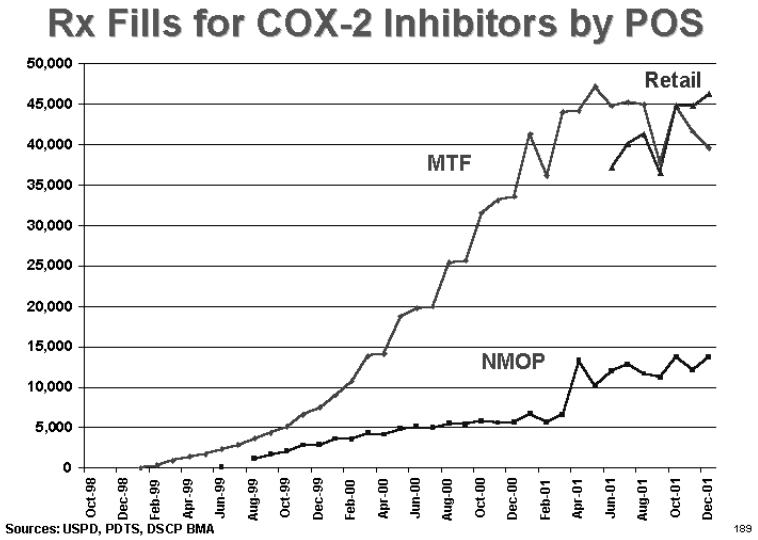
12. PROTON PUMP INHIBITORS

Rabeprazole (Aciphex) replaced omeprazole (Prilosec) on the BCF on 1 Oct 01. In Nov 01 the PEC asked MTF providers if there had been any specific problems with dosing, tolerance or patient response to Aciphex when used for common outpatient diagnoses such as GERD compared to their experience with Prilosec. Providers were also asked if the switch to Aciphex was problematic for providers, patients or pharmacists. The PEC received 41 provider responses from 32 MTFs. Most reported no problems and were very pleased with the huge decrease in the cost of proton pump inhibitor therapy. Favorable comments included the perception of a higher success rate with Aciphex and preference for the small Aciphex tablet compared to the large Prilosec capsule. A few providers reported a higher rate of treatment failures with Aciphex. One provider expressed concern about the procedure used by the MTF to convert patients from Prilosec to Aciphex.

13. COX-2 INHIBITORS

The Council considered various factors pertinent to the potential addition of a COX-2 selective inhibitor ("COX-2 inhibitor") to the BCF.

- COX-2 inhibitor usage data for the three outpatient pharmacy points of service are displayed in the graph below. After steadily increasing for 2.5 years, COX-2 prescription fills have leveled off at MTF pharmacies. COX-2 prescription fills have also leveled off somewhat in the NMOP after a sharp increase associated with the implementation of the TRICARE Senior Pharmacy Program. Limited historical data make it difficult to discern a usage trend in retail network pharmacies, but they are currently filling more COX-2 inhibitor prescriptions than MTF pharmacies.



- A survey of the COX-2 formulary status in the CHCS system at 96 MTFs revealed:
    - 41 (43%) had no COX-2 inhibitors on formulary
    - 30 (31%) had one COX-2 inhibitor on formulary
    - 25 (26%) had two COX-2 inhibitors on formulary
- Funding for MTF pharmacies in FY 02 is 15% above actual expenditures in FY 01. An objective of the increased funding is to make more drugs available at MTF pharmacies so that beneficiaries are not forced to go to a more expensive point of service (e.g. the retail network) to obtain their medications.
- Significant price reductions on certain drugs and the prospect for price reductions associated with the availability of new generic medications will substantially reduce MTF expenditures in some major drug classes, which can "free up" money for spending on other drug classes.
- A new COX-2 inhibitor, valdecoxib, is available. Approval of a fourth COX-2 inhibitor, etoricoxib, is expected in the near future. Significant price competition is unlikely at this time since the same companies that manufacture celecoxib and rofecoxib also manufacture the new agents, but more new entries in this and related drug classes are anticipated.
- The Council previously determined that celecoxib and rofecoxib are not sufficiently therapeutically interchangeable for a closed class contract.

The Council also reviewed a model constructed by the PEC that estimates the total cost to DoD of adding a COX-2 inhibitor to the BCF given assumptions about the percentage of switches from non-selective NSAIDs to COX-2 inhibitors, the absolute increase in COX-2 inhibitor prescriptions among patients not previously receiving an NSAID, the movement of COX-2 prescriptions from the retail networks to MTFs, and the anticipated percent decrease in average cost per unit for COX-2 inhibitors at MTFs and the NMOP that would result from selecting one COX-2 inhibitor for the BCF.

The Council voted that DSCP should issue a request for Blanket Purchase Agreement (BPA) price quotes to the pharmaceutical companies that market COX-2 inhibitors for the purpose of adding a COX-2 inhibitor to the BCF. The COX-2 drug class would remain "open" on the BCF. The Council will consider the price quotes, as well as the relative safety, tolerability, efficacy/effectiveness, and other relevant factors, in selecting a COX-2 inhibitor for the BCF. However, if its analysis demonstrates that it is not in the Government's best interest, the Council reserves the right to not select a COX-2 inhibitor for the BCF. The request for BPA price quotes will also ask the pharmaceutical companies to submit their plans for assisting MTFs in targeting the use of COX-2 inhibitors to the patients at greatest risk for gastrointestinal events. The Council encourages the continued use of COX-2 guidelines at MTFs in the efforts to ensure appropriate, cost-effective use of COX-2 inhibitors. The Council also requested DSCP to ask the VA if it wishes to participate in this request for BPA price quotes.

14. ADJOURNMENT

The meeting adjourned at 1600 hours on 12 Feb 2002. The next meeting will be held at the Non-Commissioned Officers Club, Fort Sam Houston, TX starting at 0800 on 8 May 2002. All agenda items should be submitted to the co-chairs no later than 8 April 2002.

<signed>	<signed>
DANIEL D. REMUND	TERRANCE EGLAND
COL, MS, USA	CDR, MC, USN
Co-chair	Co-chair