Pharmacy Workgroup

DoD Pharmacy Enterprise Operations Update July 8, 2015

"Medically Ready Force…Ready Medical Force"

Dr. George E. Jones, Jr., PharmD, MS
Chief, Pharmacy Operations Division
Defense Health Agency

Opening Remarks

- Welcome to MHS Pharmacy World Wide Webinar
  - Collaborative product of Pharmacy Work Group
    - Service Pharmacy Consultants and DHA Pharmacy Staff
- DoD Pharmacy Enterprise – ***Sustained Excellence!***
  - Priority Alignment; Standardized Process/Metrics
- DHA – Combat Support Agency
  - In support of Services Mission Execution
  - Draft Guidance Working Through the Review Process

Agenda

Agenda Item	Presenter
Opening Remarks	Dr. Jones
Update on DoD Pharmacy Initiatives / Pharmacy Savings Index Update	Dr. Jones / Maj Folmar
MTF Spotlight: Use of Leakage Report	MAJ Krull
MTF Spotlight: MTF to TMOP Transfer Process	Roger Hirsh
Compound Rx Update	CAPT Norton
TPharm 4 Contract Update	Bill Blanche
Sole Provider Program Update	COL Spain
MTF Spotlight: Clinical Initiatives/PCMH	LTC Maneval
P&T Committee Update	CDR VonBerg
Live Model of P4i/CarePoint	Bill Davies
Questions	All

Update on DoD Pharmacy Initiatives –
Dr. George Jones, Chief Pharmacy Operations Division

- 3 March 2015 – Achieved Full Operating Capability
  - Validated by MHS Governance Process
  - DHA will reach FOC by 1 October 2015
- 5 Active Operational Initiatives – *Multiple "SubParts"*
  - Mature/Ongoing – Contract Compliant Purchasing; Formulary Management; Retail to MTF/Mail
  - New Implementations - Coverage newly FDA approved drugs; Automation Contracting actions; Transition of TFL Pilot to All Beneficiaries
    - NDAA 2015 stops Pilot/Implements same MTF/Mail guidance for all beneficiaries

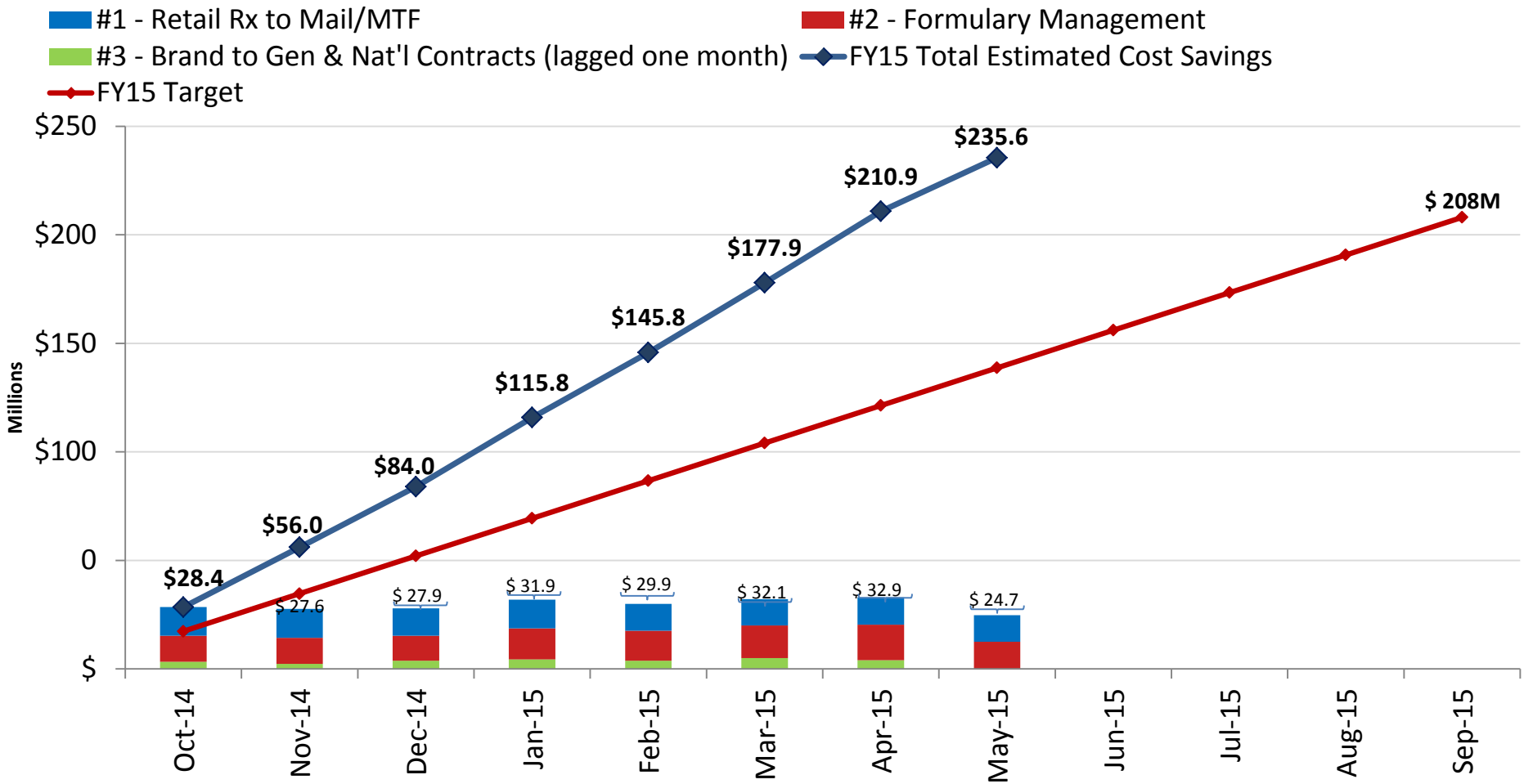
TRICARE Lactation Policy Changes

Effective July 1, 2015

- NDAA FY15 directed TRICARE to provide coverage for breast pumps and supplies
- These items are fully covered under the medical benefit as with other medical devices and durable medical equipment (not covered under the pharmacy benefit)
- Coverage began July 1, 2015, but is retroactive to December 19, 2014
- More information is available at www.tricare.mil/breastpumps

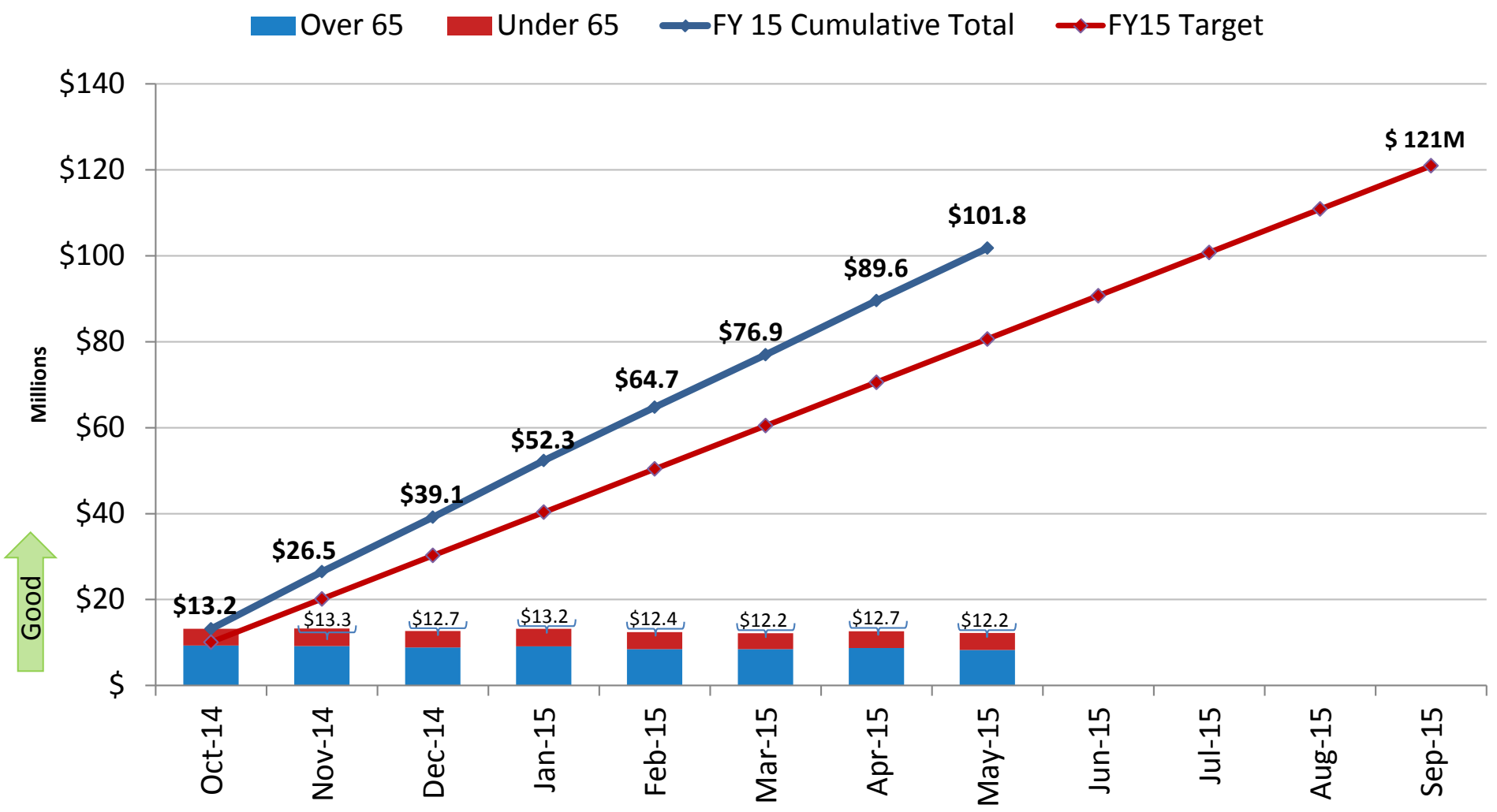
David Folmar, Major, USAF, BSC
Pharmacoeconomist
Integrated Utilization Branch
Pharmacy Operations Division

Pharmacy Savings Index (PSI)
FY15 Overall Target – $208M

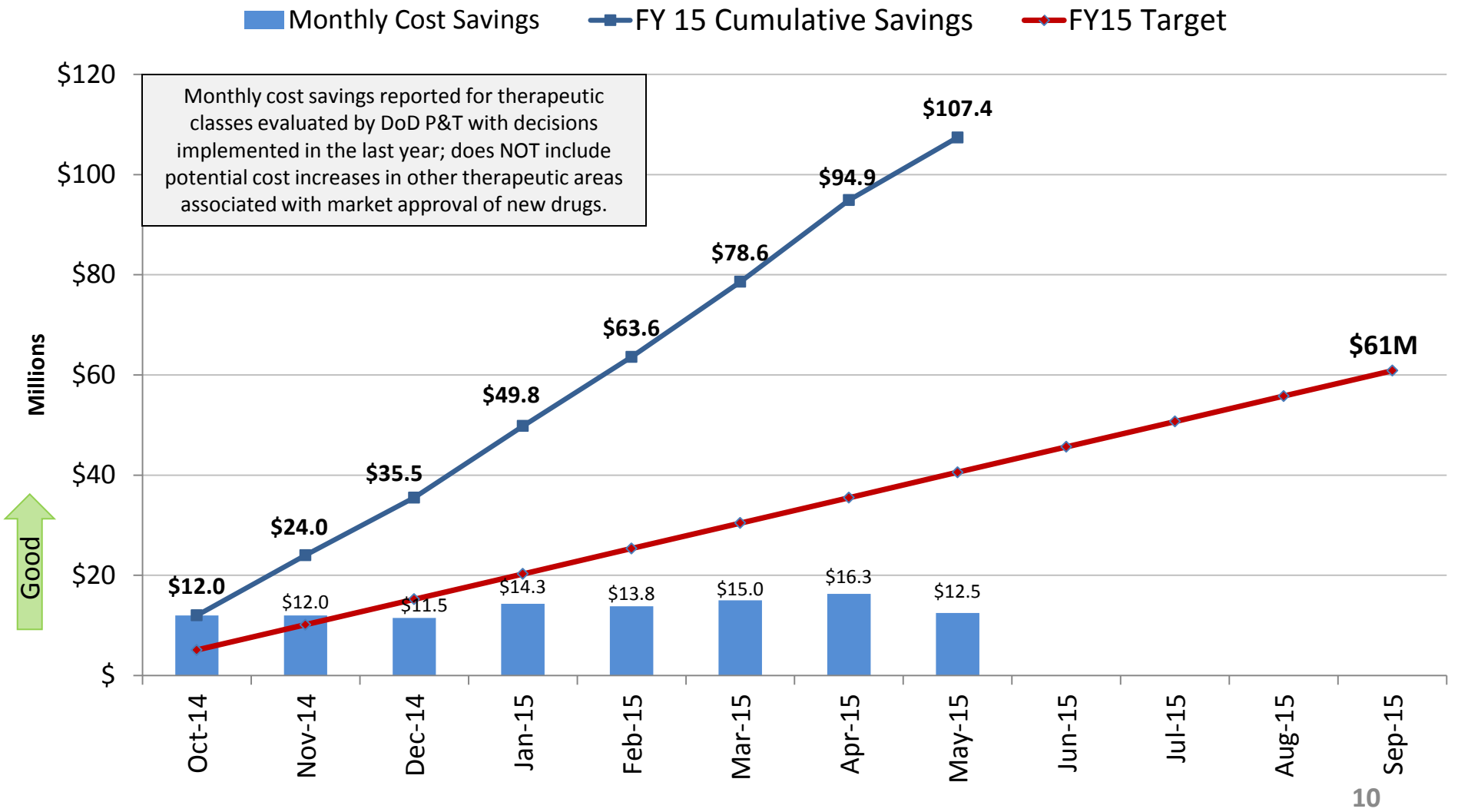


Cost Savings	$ 28.4	$ 56.0	$ 84.0	$ 115.8	$ 145.8	$ 177.9	$ 210.9	$ 235.6				

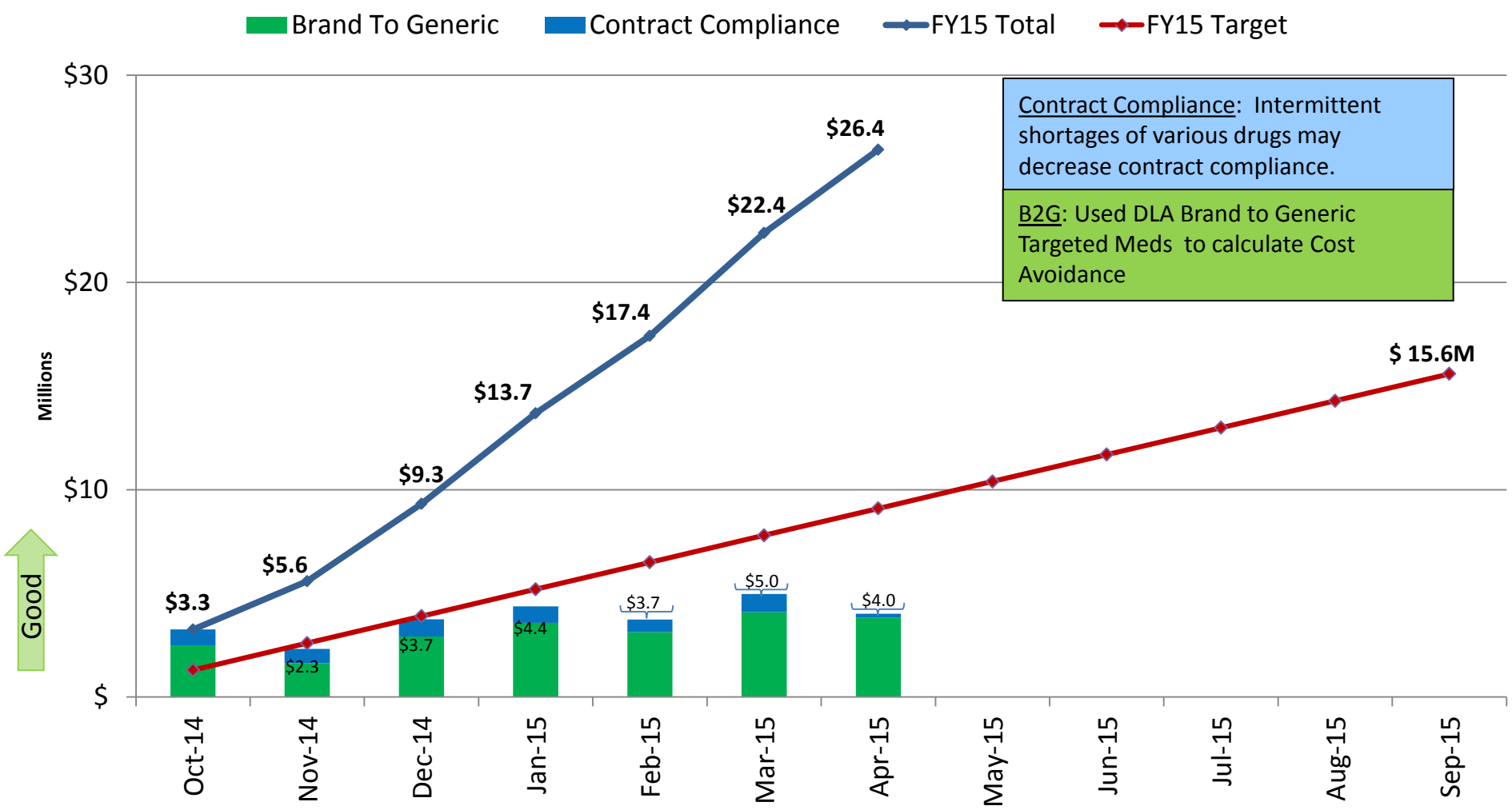
Initiative #1 - Retail Rxs to Mail/MTF Estimated Cost Savings



Initiative #2 - Formulary Management Estimated Cost Savings



Initiative #3 - Generic & Contracting Compliance, Estimated Cost Savings



MTF Spotlight: Use of Leakage Report

MAJ Matthew Krull, PharmD
Brooke Army Medical Center
Fort Sam Houston, Texas

MTF Spotlight: Use of Leakage Report

- Background
- Utilization
- Outcome
- Sustainment

MTF Spotlight: Use of Leakage Report

- Reports are obtained from the Consultant (COL Spain) using provider NPI data.
- Report shows providers by MTF and the prescriptions and cost of each prescription filled in the retail network.
  - ❑ Verify Providers on the report are assigned to your MTF
- Report does not connect prescription to patient.

MTF Spotlight: Use of Leakage Report

Site MTF	Prescriber Name	Drug/Strength/Form	Values Sum of # RX	Net Cost to Government (Refunds Subtracted)
Ft Sam Houston AMC	**Doe, John**	CICLOPIROX 8 % SOLUTION	1	$1.97
		CLONAZEPAM 0.5 MG TABLET	1	$9.92
		Compound Medication (Pseudo NDC)	1	$5,821.17
		FUROSEMIDE 40 MG TABLET	1	$10.00
		LISINOPRIL 40 MG TABLET	1	$4.00
		MOMETASONE FUROATE 50 MCG SPRAY/PUMP	1	$351.48
		PENCICLOVIR 1 % CREAM (G)	1	$477.93
	Doe, John Total		**7**	**$6,676.47**
	Doe, John Jr.	CELECOXIB 200 MG CAPSULE	1	$270.76
		CYCLOBENZAPRINE HCL 10 MG TABLET	1	$0.00
		ETANERCEPT 50 MG/ML SYRINGE	1	$2,099.01
		PRAMIPEXOLE DI-HCL 0.5 MG TABLET	1	$4.75
		TRAMADOL HCL 200 MG TAB ER 24H	1	$21.23
		ZOLPIDEM TARTRATE 12.5 MG TAB MPHASE	1	$4.15
	Doe, John Jr. Total		**6**	**$2,399.90**

MTF Spotlight: Use of Leakage Report

- JBSA Uses
  - ❑ Actively re-capture by contact patients (requires additional DHA reports to get patient-specific info)
  - ❑ Engage with Providers
    - Encourage filling at MTF or mail order
    - Review MTF Non-Formulary process
- Excellent tool for tracking compounds and engaging providers and clinics writing them
- Review formulary status of medications leaked from MTF

MTF Spotlight: Use of Leakage Report

- BAMC Pharmacy was able to streamline Non-Formulary processes to make it less cumbersome for MTF Providers
- Pharmacy continues to tailor formulary IAW DoD Formulary to meet beneficiaries needs
- Engaging with patients and receiving their feedback has resulted in Performance Improvement projects for the Pharmacy Dept.
- After a brief discussion with a Provider about a patient getting blood factors at a network pharmacy, BAMC Pharmacy was able to provide care for 2 hemophiliac patients, and save taxpayers over $50k compared to the network pharmacy.

MTF Spotlight: Use of Leakage Report

- Continue to use for recapture effort
  - ❑ Having patient-specific info included would be a great addition
- Continue to engage with Providers
  - ❑ Identification of what medication(s) were compounded would be a great addition
- Continue to engage with beneficiaries on how we can improve our service
- Continue to adjust the formulary IAW DoD Formulary to meet beneficiaries' needs

MTF to TMOP Transfer Process:
MTF SPOTLIGHT: NMC Portsmouth VA

Roger N. Hirsh RPh MS MBA

CAPT MSC USN ret

Pharmacy Informatics

MTF to TMOP TRANSFERS

Current Methods at NMC Portsmouth

- Original: Patient or Provider Snail Mail, Provider Fax, or Civilian Provider e-Prescribing
- 2008 MTF Prescription Transfer Form via fax
- 2012 Virtual MAIL>TRICARE HOME DELIVERY site utilizing fax transfer
- 2013 CHCS Autotransfer
- 2014 AudioCARE Refill Line Autotransfer

FAX TRANSFERS

- Original adhoc MTF transfer form – 1 page
  - Patient data sufficient for ESI registration
  - Prescription data meeting AZ and VA guidelines
  - Provider data, including NPI, DEA, contact info
  - Pharmacy data with NPI, phone, address
  - Also used for transfers to other MTF and retail.
- Use driven by patient request
- Promoted via email, flyers, front window techs
- Requires pharmacist to pharmacist verbal

Virtual Outpatient Pharmacy Site

- Provider-initiated transfers at patient visit
- Choose MAIL>TRICARE HOME DELIVERY as the dispensing pharmacy
- Auto batch print labels for review and transfer
- Screen drugs, directions, quantity, provider
- Initially completed by using MTF transfer fax
- CHCS database build for TMOP Mailable and <MAIL> in the comment field

CHCS Autotransfer

- Initial release notes to CHCS in 2009
- Testing and modifying began May 2013
- Implementation late 2013
- Drug database mapping to ESI
- Provider database improvements with NPI, phone, address, fax numbers
- Set up for NMCP primary division only, but accessible to all CHCS server users

AudioCARE Refill Line Option

- Virtual refill pharmacy XTMOPRF 7/8/14
- Home Delivery option offered if drug and patient are eligible.
- Immediate processing as autotransfer to ESI
- Information campaign to mitigate unintentional transfers and copays

Results and Challenges

- 1 YR: Over 10,000 transfers, est 40,000 fills
- SCR: Modify drug pick list to show MAIL: Yes/No/Unk
- SCR: Modify Provider file to require DEA and/or NPI minimum v. License
- SCR: Centralize drug data file and use FDB fields.
- Provide drug file modification support, which can be done via MS Access, the PEC master database, and the MTF CHCS host file.
- Provide process monitoring report similar to NMCP PDRX Report. Shows status, activity, non-transmits, rejects, and warnings.

CONTACT

Questions and Contact:

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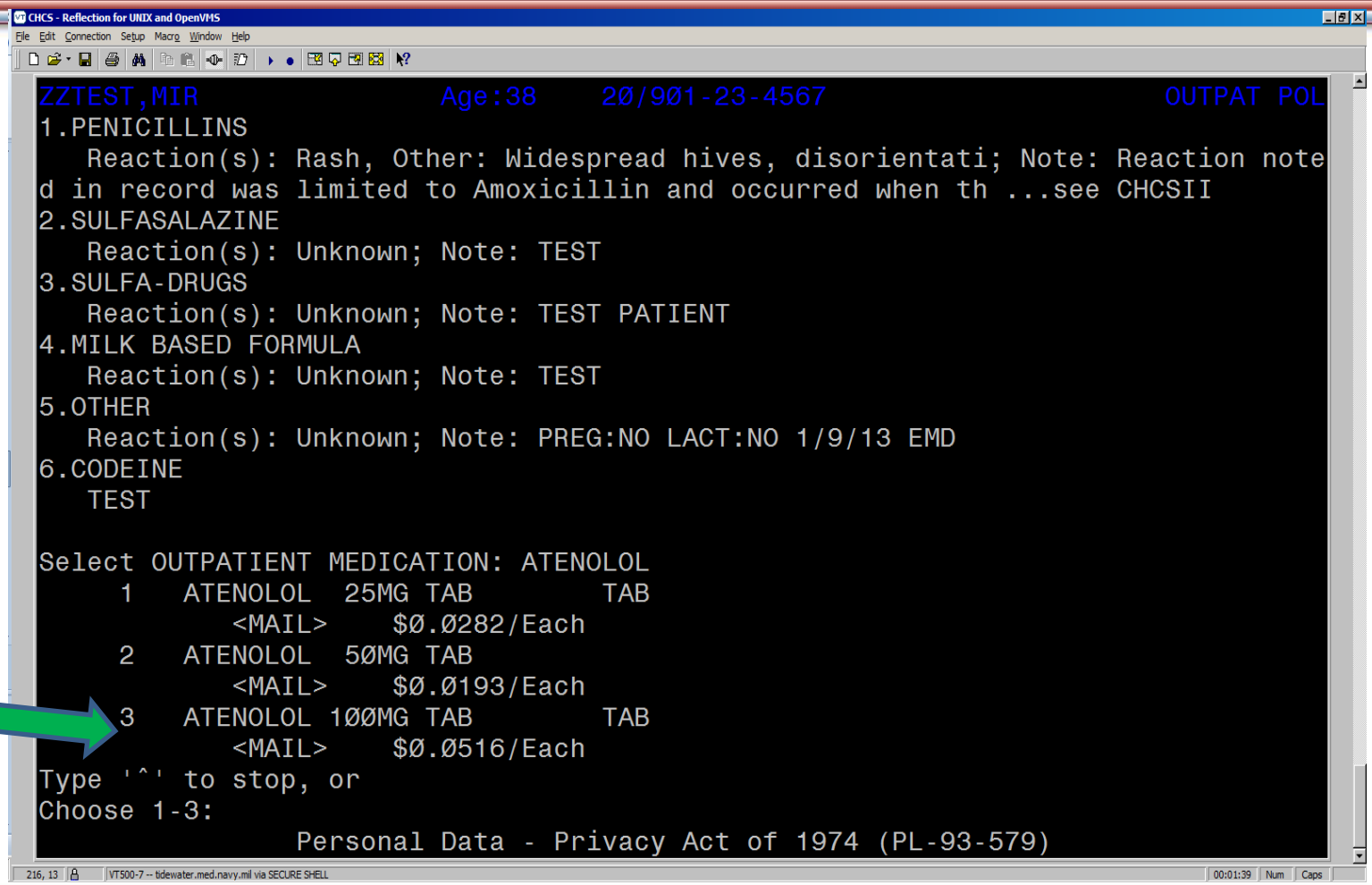

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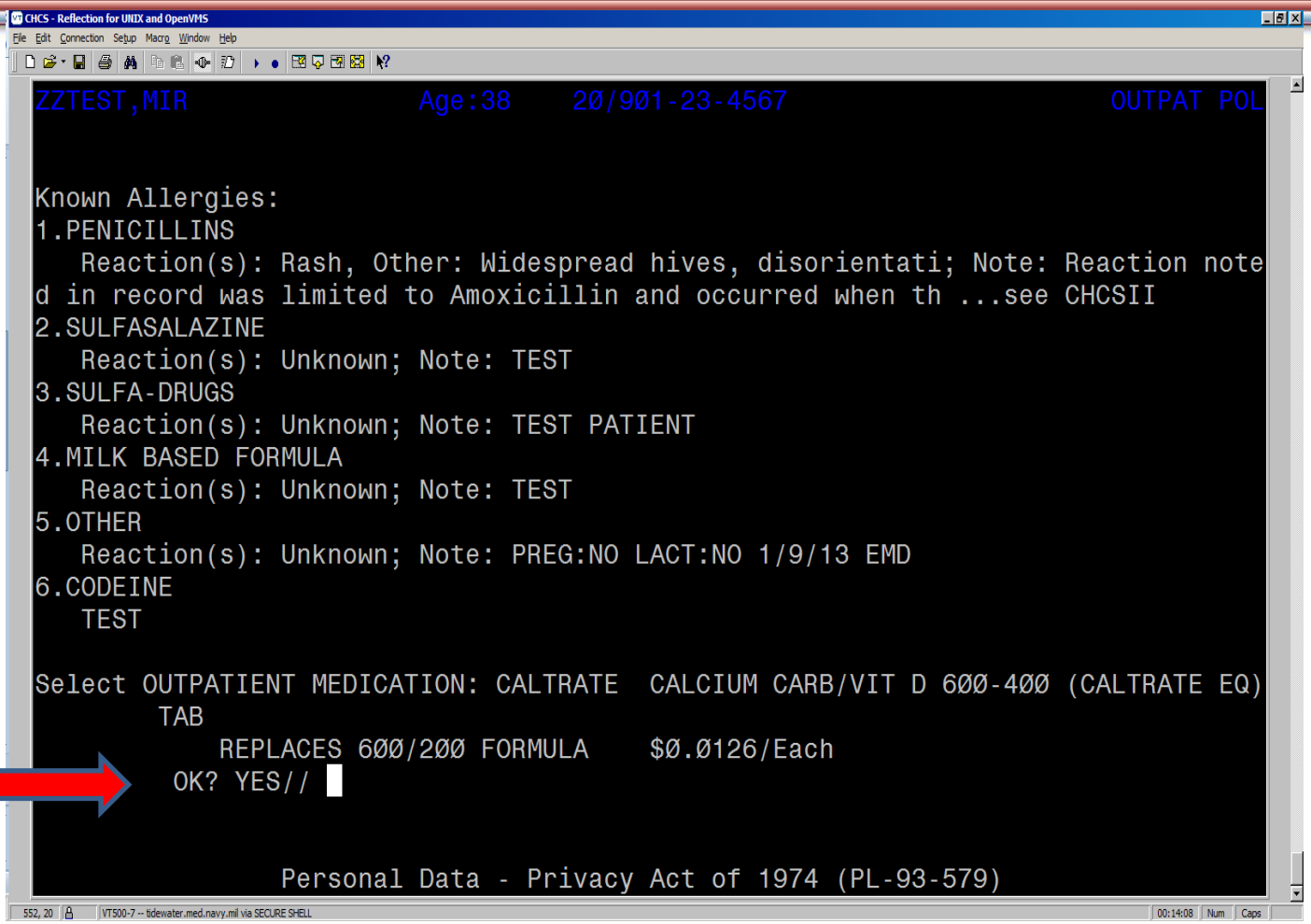
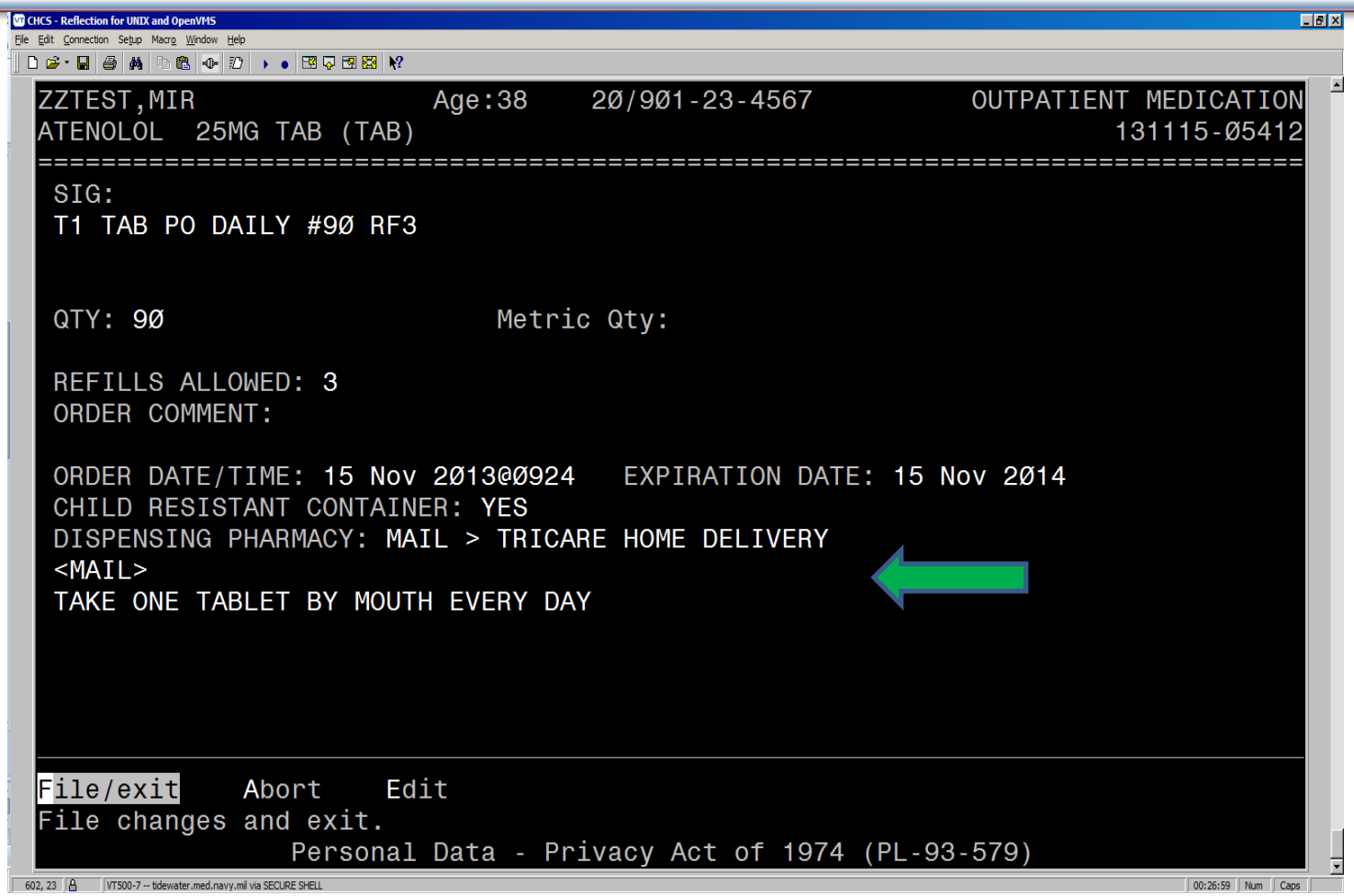
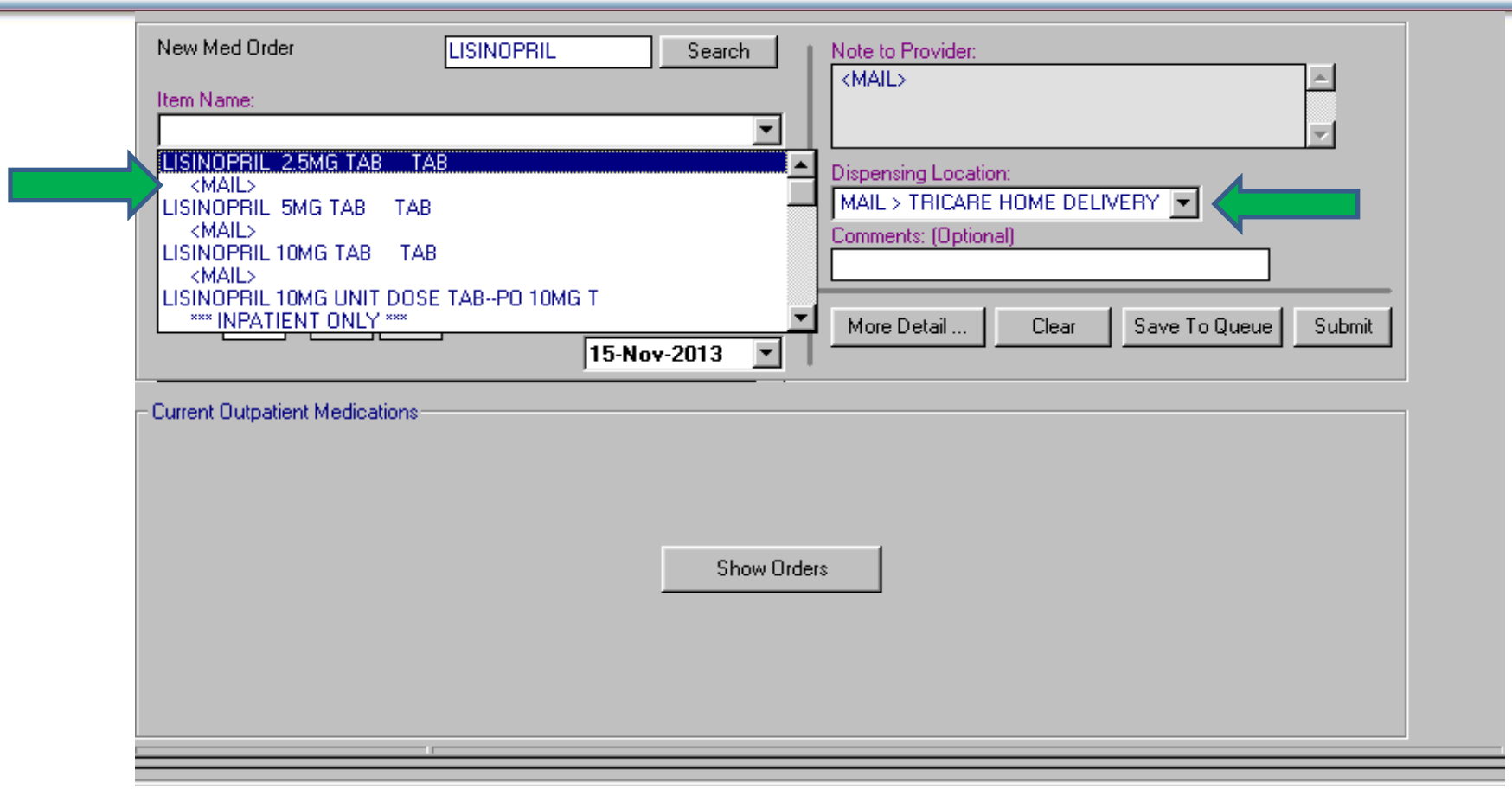


CHCS: Pharmacy



AHLTA: Order Med



Drug eligible for TMOP

MAIL Pharmacy selected

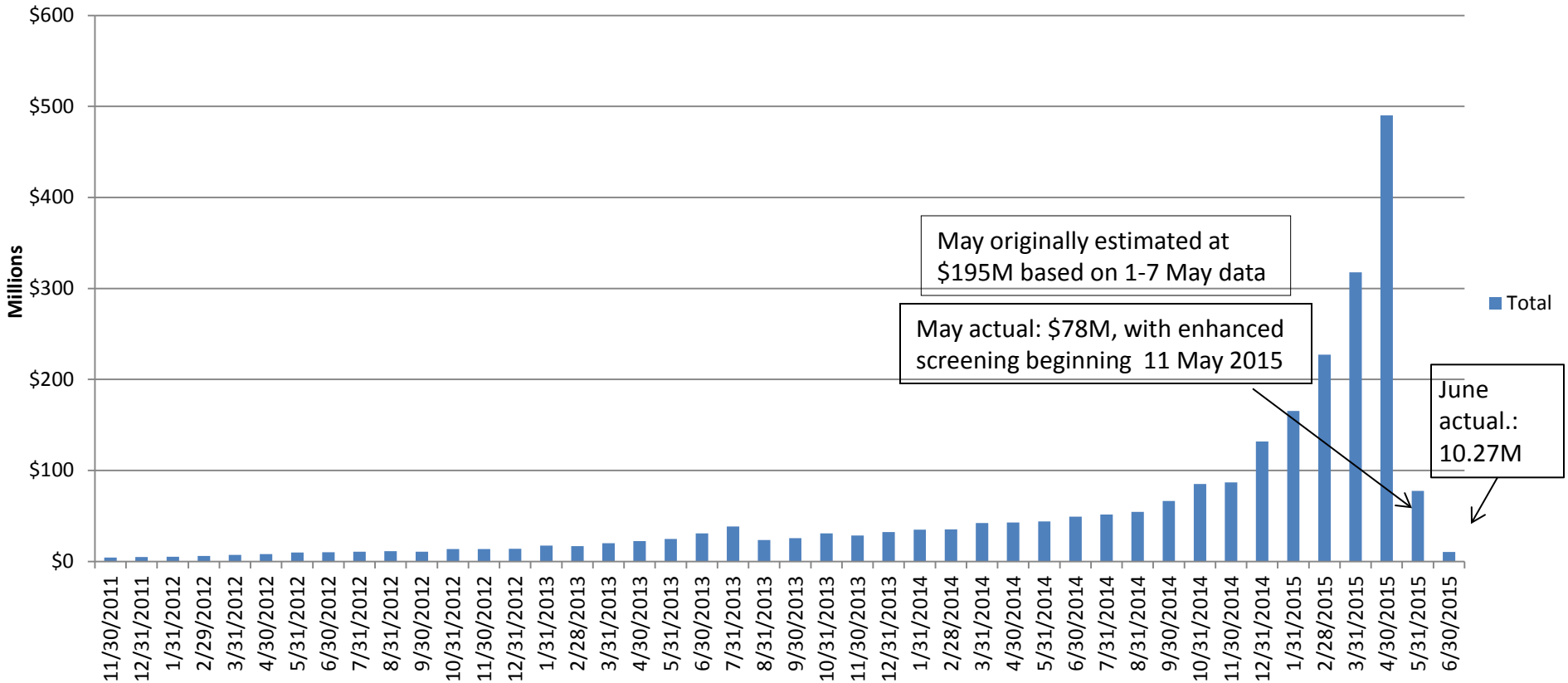
Compound Prescriptions

CAPT Ed Norton, MSC, USN
Acting Deputy Chief
Pharmacy Operations Division

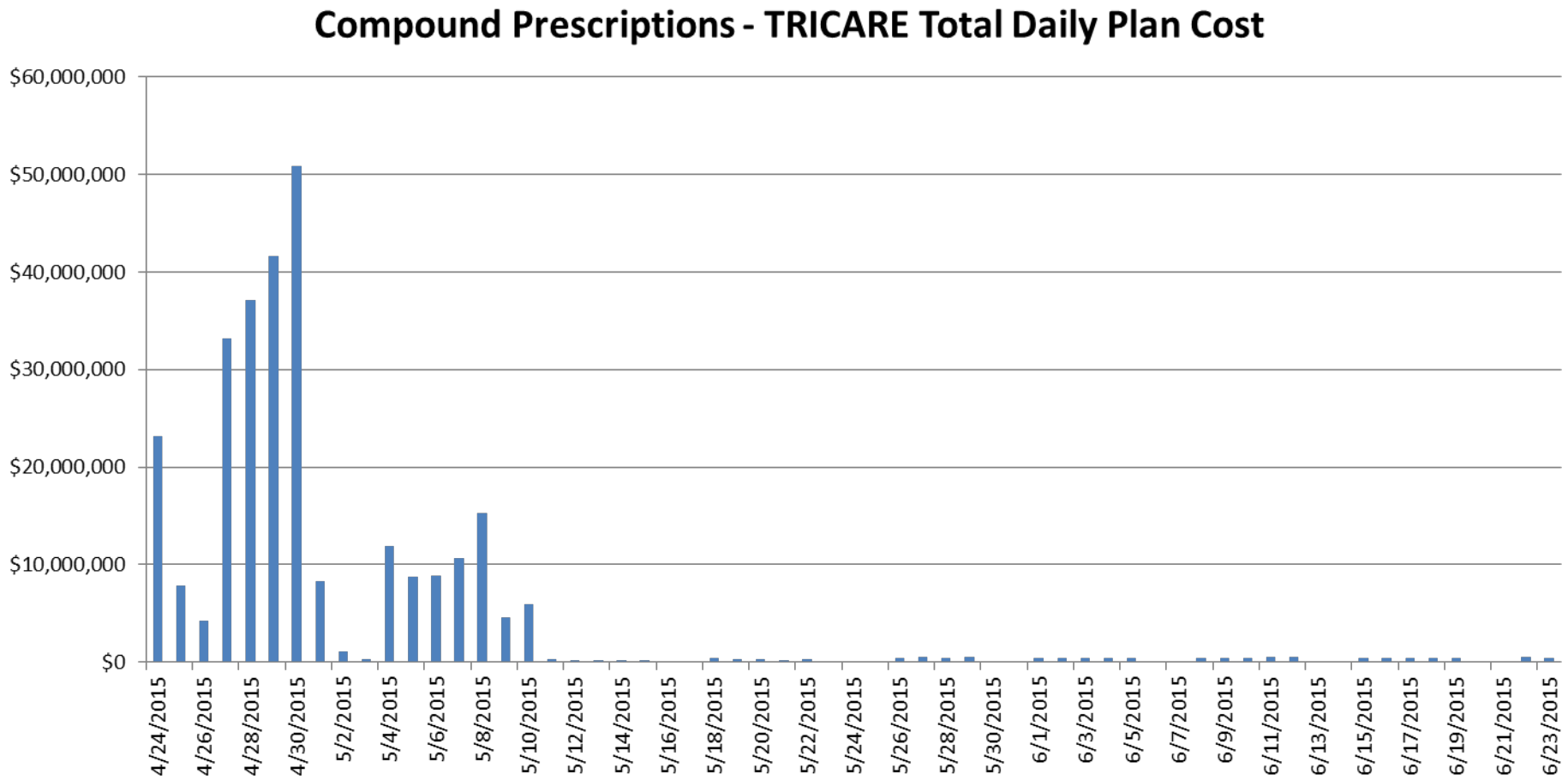
Compound Drugs
Improve Safety/Stewardship

- Initial screening of compound drug ingredients began 01 May 2015, enhanced screening began 11 May 2015
- Access maintained: 41,800 compound claims covered in May compared to 39,000 in May 2014
- Enhanced screening is working
  - Claims with unproven ingredients down
  - Last week in April: $28m/day, $6,900/Rx
  - Currently averaging about $350K/day about $350 per compound Rx
- Prior authorization process working – 47 approved in May
  - 330 Reviewed; Non-compound alternatives covered for many denied PAs
- TRICARE now closely aligned with CMS/Commercial Plans

Compound Drugs
Cost Impact of Screening



Compound Drugs
Daily Cost Impact of Screening



TPharm4 Contract Update

Defense Health Agency

Bill Blanche
Purchased Operations Branch
Pharmacy Operations Division

TPharm4 Contract Update:

MTF Claims Processing

- Recently Resolved Issues:
  - PDTS Interface-Batch Refills not processing; fix implemented on 6/11/15
  - Auto Cancel- some prescriptions are automatically cancelled in PTDS, fix implemented on 7/1/15
- Open Issues:
  - Duplicate DUR messaging

Reminder! log a ticket with local CHCS/AHLTA office in addition to calling ESI Help Desk when issues are identified

TPharm4 Contract Update:

MTF Claims Processing

- Data Integrity and Reject reports will resume in mid July

Report	Description	Action
Daily Validity Rejects Report	List of rejected claims (broken out by MTF) sent to the pharmacy contact.	MTF pharmacy has 3 business days to correct these claims (reverse entirely or reverse and resubmit)
Weekly High Cost Claims Report	List of all completed MTF claims exceeding the $2,000 pricing threshold.	MTF has 7 business days to correct any incorrect claims (reverse or resubmit)
Weekly Data Integrity Report	List of completed MTF claims that generated the following ProDUR warnings: High Dose Alerts and Invalid Provider.	

- The PASS continues to support MTF data reporting and requests including:
  - PDTS Standard Reports
  - CD-MART, P-MART, Poly-MART, WTU P-MART
    210-536-6650 or email at
    dha.jbsa.pharmacy.list.pass-dmt@mail.mil

Expanded MTF and Mail

- NDAA FY15 directed the end of the TFL pilot program on September 30, 2015
- Beginning October 1, 2015, all beneficiaries (excluding Active Duty) are required to obtain select brand-name maintenance mediations from the MTF or mail order pharmacy
  - The expanded program will be similar to TFL pilot; beneficiaries will have up to two courtesy fills at a retail pharmacy
  - Beneficiaries do not have the option to opt-out
  - Waivers will be allowed on a case-by-case basis (nursing home residents, etc)
  - Implementation will begin pending publication of the Interim Final Rule in the Federal Register

COL John Spain
Pharmacy Consultant to the Army SG

Sole Provider Program Update

Army's new policy governing Sole Providers Programs aims to track the following measures:

# of beneficiaries enrolled in the Sole Provider Program (Lock-in)

# of non-compliant patients enrolled in the lock-in program

# of non-compliant prescribing providers with the lock-in program

The Pharmacy Workgroup is exploring expanding and standardizing this program across the Services

Polling Question

Do you have a sole provider policy at your MTF?

A. Yes

B. No

Polling Question

Do you use lock outs at your MTF?

A. Yes

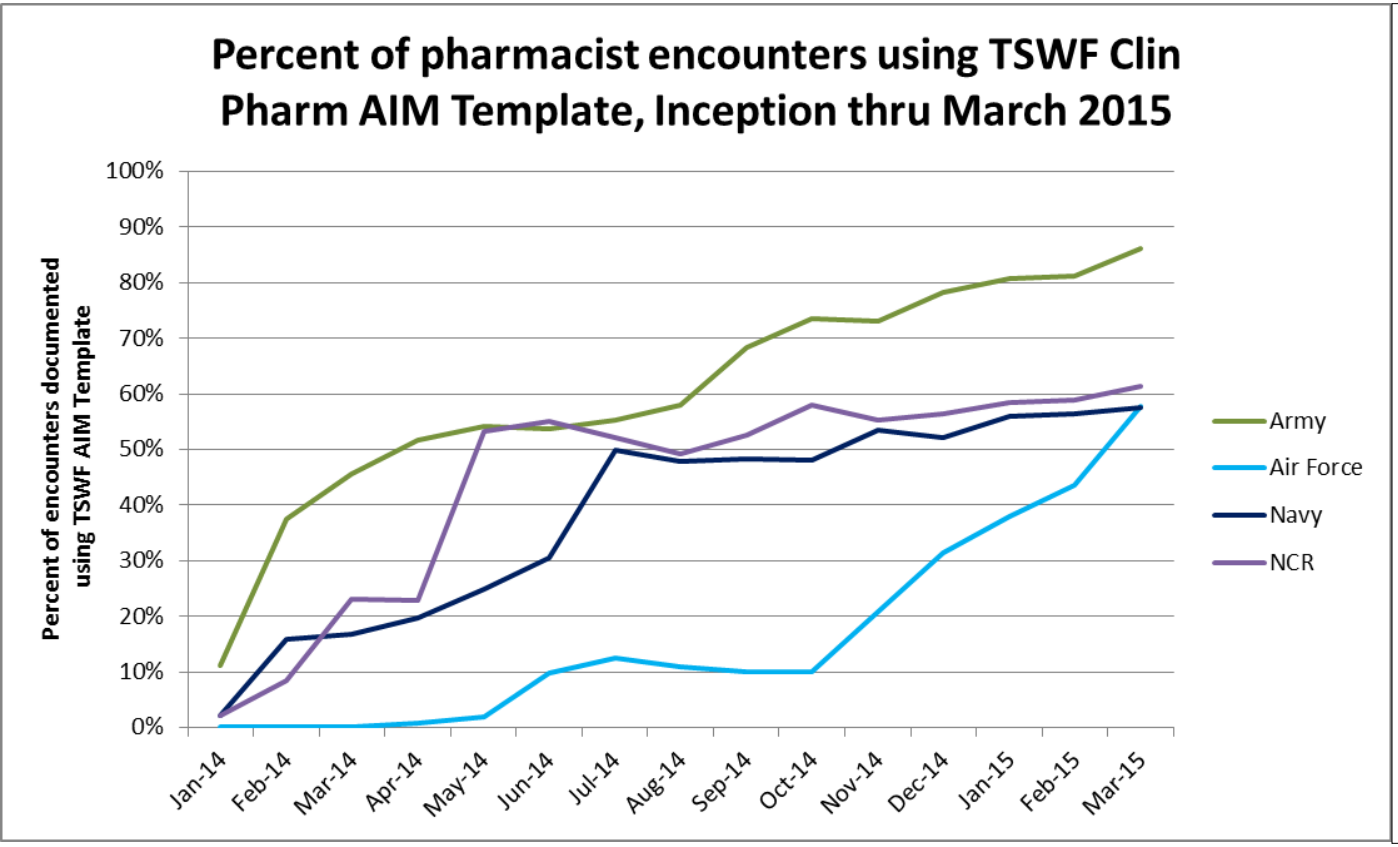
B. No

LTC Mark S. Maneval, PhD, RPh, MS
Pharmacy Department
Tripler Army Medical Center

MTF Spotlight: Clinical Initiatives/PCMH: T+365: from cost avoided to?

- What is impact:
  - Pharmacist Interventions
  - Improvements in performance measures (HEDIS, NCQA, PQA, etc.)
  - Improvements in Access to Care (right care from right provider at right time)
  - Improvements in health (patient level biomarkers and endpoints)
- Data requirements to quantify impact:
  - Standardized documentation of care provided
  - Standardized coding of that care
  - High compliance with TSWF Clin Pharm Template tool = robust analyses and results
- Where are we headed:
  - Shift away from previous “Cost Avoided” measures of value
  - Utilize validated COTS decision support predictive modeling tools to quantify long term improvements in health and associated economic benefits
  - Prospective risk identification to efficiently target pharmacy services where benefits outweigh the costs

Standardized Documentation: TSWF Clin Pharm AIM Template



Comments

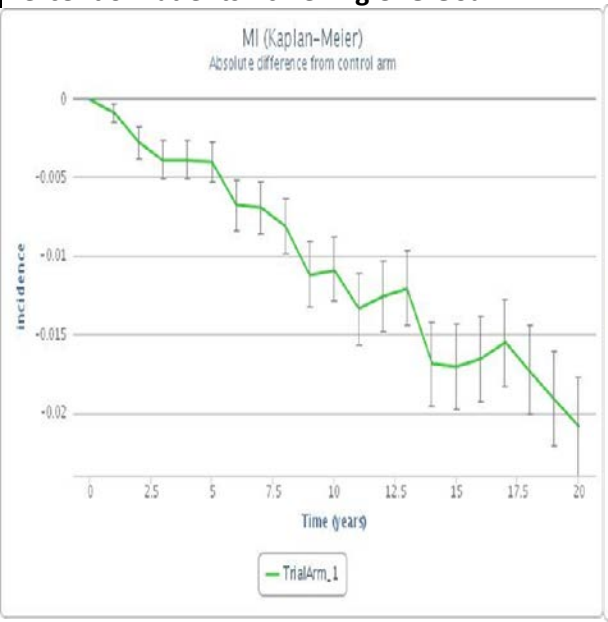
- Missing data undermines robustness of results
- Army's goal > 90%; MAR 15: Army at 86%
- All services trending up
- Army PA&E approved pharmacy data analyst to provide Army-level analysis

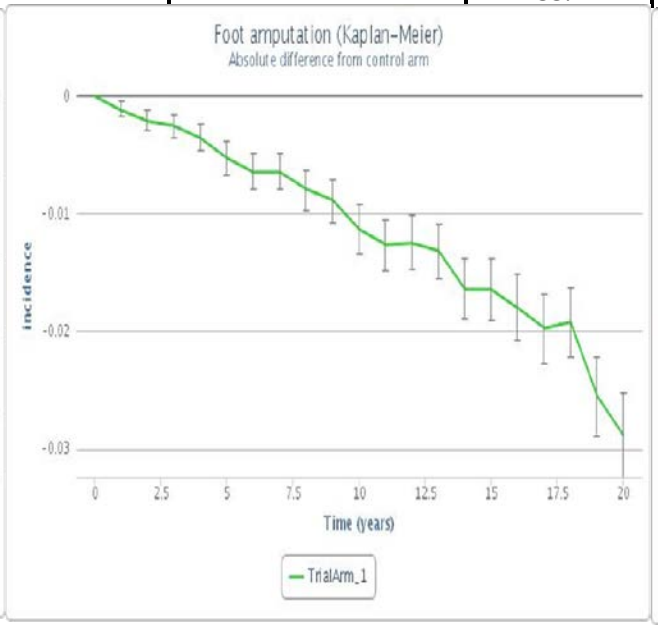
Impact on Outcomes: Diabetes

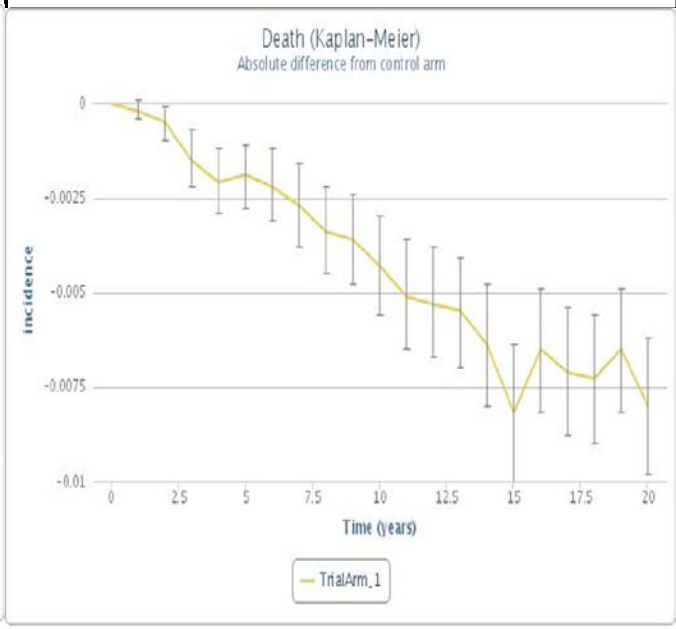
Clinical Outcome Improvement in Diabetics Seen by PCMH Clinical Pharmacists Over 1 Year, TAMC 1 Apr 2014 - 31 Mar 2015	All Diabetics who were Not at CPG Goal and had an Opportunity to Improve	Subset of All Diabetics who Achieved CPG Goal
Number of Diabetic Patients	364	121
Baseline HgbA1C (average)	8.7	8.1
Follow-up HgbA1C (average)	8.0	6.9
Absolute HgbA1C Reduction (average)	0.7	1.2
Average Absolute HgbA1C Reduction Needed to Achieve Goal	1.7	1.1
****Percent Closure of HgbA1C To Goal**	41% (=0.7/1.7)	100%
Percent of Patients Achieving CPG Goal		33%

Comments

- VA collaboration
- Predictive modeling matched to TAMC data
- Kaplan-Meier graphs illustrate significant reductions in incidence of MI, amputation, and death in patients engaged by clinical pharmacists vs. standard of care







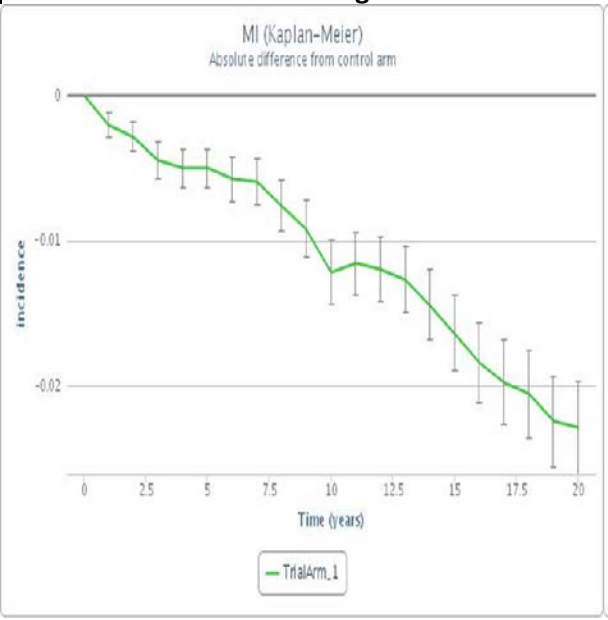
http://archimedesanalytics.com/sites/default/files/Managing-Risk-ACO-Archimedes-IndiGO-Whitepaper-2013.pdf

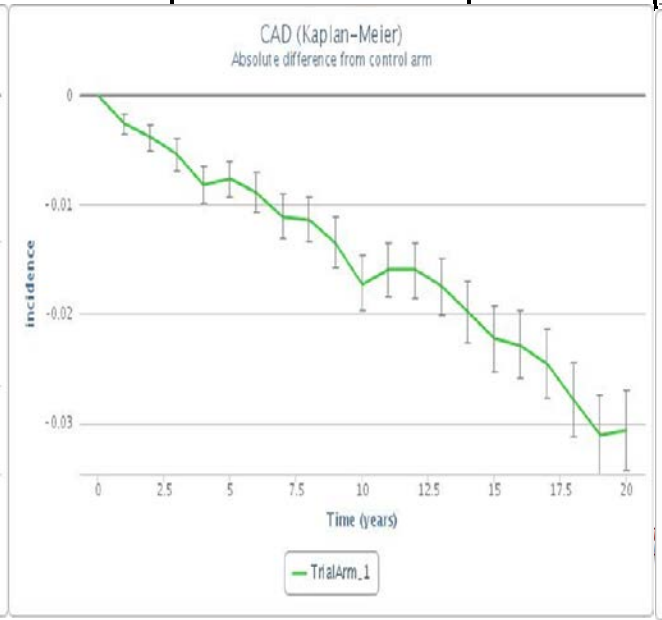
Impact on Outcomes : Dyslipidemia

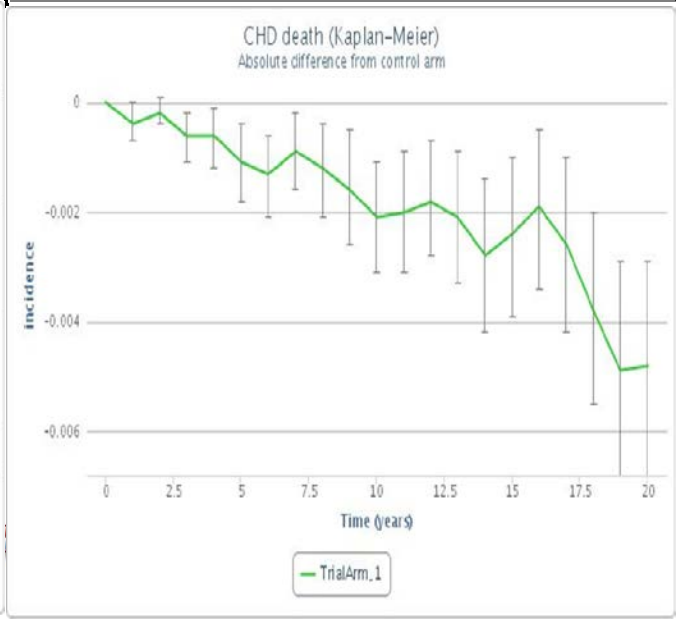
Clinical Outcome Improvement in Dyslipidemia Patients Seen by PCMH Clinical Pharmacists Over 1 Year, TAMC 1 Apr 2014 - 31 Mar 2015	were Not at CPG Goal and had an Opportunity to Improve	Subset of All Dyslipidemics who Achieved CPG Goal
Number of Dyslipidemia Patients	388	194
Baseline LDL (average)	133	123
Follow-up LDL (average)	110	94
Absolute LDL Reduction (average)	23	29
Average Absolute LDL Reduction Needed to Achieve Goal	33	23
**Percent Closure of LDL To Goal	70% (=23/33)	100%
Percent of Patients Achieving CPG Goal		50%

Comments

- VA collaboration
- Predictive modeling matched to TAMC data
- Kaplan-Meier graphs illustrate significant reductions in incidence of MI, CAD, and CHD in patients engaged by clinical pharmacists vs. standard of care (control group)







Using NNT's to Calculate Cost Benefit of Outcomes in the VA (2014 ASHP MidYear Clinical Meeting Federal Pharmacy Symposium keynote presentation by Dr Anthony Morreale, Asst Chief Consultant for Clinical Pharmacy Services)

Disease Cohort	Clinical Outcome	NNT	Visits	$Cost/ Visit (Avg cost)	Estimated 2 year Cost /Event*	Benefit/ Cost **
DM	MI	32 (29:36)	2-4	$75-150 ($112)	$30,000	5.5:1
	CHF	31 (28:35)	2-4	$75-$150 ($112)	$40,000	7.6:1
	Foot Amp	35 (31:39)	2-4	$75-$150 ($112)	$81,000	13.8:1
	Foot Ulcer	18 (16:19)	2-4	$75-$150 ($112)	$13,000	4.5:1
	CHD Death	63	2-4	$75-$150 ($112)		Priceless

Calculations for benefit: cost ratio used the max visits, the worst 95% confidence intervals

Ref: Population Health Management Volume 14, Number X 2011; J Vasc Surg 2010;52:17S-22S; Diabetes Care 22:382-387, 1999; J Bone Joint Surg Am. 2007 Aug;89(8):1685-92

CDR Edward VonBerg, PharmD, MA
Formulary Management Branch
Pharmacy Operations Division

Uniform Formulary Class Review

- Oral Oncology Agents; Prostate I & II Subclass
- Transmucosal Immediate Release Fentanyl Agents
- Pulmonary Arterial Hypertension

Oral Oncology Agents
Prostate I & II Subclass
Formulary Status

Basic Core Formulary	Uniform Formulary	Non-formulary
Subclass I Anti-androgens • Casodex (bicalutamide)	Subclass I Anti-androgens • Eulexin (flutamide) • Nilandron (nilutamide)** Subclass II Survival Prolonging • Zytiga (abiraterone acetate)** • Xtandi (enzalutamide)**	**N/A** No Prostate Cancer drugs are designated non-formulary
**Prior authorization criteria apply to Nilandron (nilutamide), Zytiga (abiraterone acetate), and Xtandi (enzalutamide)		

- All agents are on UF to meet needs of MHS population
- Choice depends on clinical considerations, pt preferences, prior tx, visceral disease, symptoms & potential SE profiles
- Prior authorization criteria:
  - Abiraterone and enzalutamide maintained & reflect FDA indications;
  - Nilutamide - fail/AE's to bicalutamide/flutamide or undergone surgical castration

Oral Oncological Agents
Prostate I & II Subclass
Key Points

- Subclass I agents indicated for use with add'l androgen suppression via med/surg castration
  - Bicalutamide as effective as flutamide & preferred in terms of safety & dosing
  - Nilutamide sole Subclass I agent with FDA indication for surgical castration
- Similar AE profiles: hot flashes, gynecomastia, & breast pain; particularly w/ med castration
  - Flutamide GI SE at a higher rate compared to bicalutamide based on a head to head study that led to ↑'d withdrawal
  - Nilutamide has a black box warning for pulm toxicity & issues with light dark adaptation that can limit its use
- Subclass II: abiraterone (Zytiga) & enzalutamide (Xtandi) new additions to armamentarium
  - Zytiga CYP17 enzyme complex inhibitor, while Xtandi is an advanced anti-androgen
  - Independently improve OS & PFS vs placebo irrespective of chemotherapy status
  - Zytiga requires prednisone to help mitigate mineralocorticoid excess resulting from MOA
  - Xtandi does not require steroids, but 30-47% pts in phase 3 studies were on steroid therapy
  - The 2 Subclass II agents have differing safety profiles
    - Zytiga can cause adrenocortical insufficiency, hypertension, hypokalemia, and edema & requires close monitoring for those complications
    - Xtandi has had unique issues with seizures as well as hypertension when compared to placebo

Transmucosal Immediate Release Fentanyl Agents Formulary Status

Basic Core Formulary	Uniform Formulary	Non-formulary
None	Fentanyl Transmucosal Lozenge (Actiq, generics)	Fentanyl sublingual tablet (Abstral) Fentanyl buccal tablet (Fentora) Fentanyl pectin nasal spray (Lazanda) Fentanyl sublingual spray (Subsys)

In the absence of head-to-head trials, TIRF selection should be based on individual patient characteristics, likelihood of adherence, patient preference as well as cost

Transmucosal Immediate Release Agents Key Points

- No head-to-head trials have been conducted to date
- All TIRFs provide rapid onset analgesia with clinically meaningful pain relief achieved 30 minutes post dose. Minor differences in pharmacokinetics do not result in clinically relevant differences in pain relief
- TIRFs are not interchangeable on a mcg per mcg basis. Patients being switched from a TIRF should be initiated at the lowest dose of the new product following the recommended dose titration protocol
- A shared REMS access program for all the TIRF products ensures use in opioid-tolerant patients only, prevents inappropriate conversion between fentanyl products and prevents accidental exposure to children and others. Providers and patients are also educated on the potential for misuse, abuse, addiction, and overdose
- Adverse effects were similar for all the TIRFs and consistent with opioid therapy in cancer patients with the exception of unique application site reactions: dental caries (Actiq) and nasal irritation (Lazanda)

Transmucosal Immediate Release Agents Key Points

- Unique advantages:
  - administration of Actiq can be interrupted in case of toxicity and it is approved for adolescents 16 years and older
  - The sublingual formulations Abstral and Subsys have faster dissolution than the oral and buccal formulations, Actiq and Fentora
  - Lazanda, the nasal spray, is convenient and can be administered by caregivers
- Unique disadvantages:
  - Actiq is associated with variable absorption; training is also required to ensure correct use (move lozenge along the inside of cheek until complete dissolution); takes about 15 minutes to dissolve completely; lollipop may be considered childish; sugar content has resulted in formation of dental caries and tooth loss
  - Lazanda may be unsuitable for patients with respiratory illnesses; co-administration of a vasoconstrictive nasal decongestant, such as oxymetazoline, to treat allergic rhinitis leads to reduced fentanyl plasma concentrations in patients taking Lazanda

Pulmonary Arterial Hypertension Formulary Status

Basic Core Formulary (BCF)	Uniform Formulary (UF)	Non-formulary (NF)
Nitric Oxide Agents • Sildenafil 20mg tabs • Revatio	**Nitric Oxide Agents** • Riociguat (Adempas) • Tadalafil (Adcirca) **Endothelin receptor antagonists** • Bosentan (Tracleer) • Ambrisentan (Letairis) • Macitentan (Opsumit) **Prostacyclins** • Treprostinil (Tyvaso & Orenitram ER) • Iloprost (Ventavis)	None

Pulmonary Arterial Hypertension
Key Points of PAH Nitric Oxide Agents

- Nitric oxide agents include the Phosphodiesterase-5 (PDE-5) inhibitors and the soluble guanylate cyclase stimulator riociguat (Adempas)
  - Step therapy exists in this class which requires a trial of a preferred agent first before using other drugs
  - **Step Preferred agents include sildenafil 20mg tabs and brand Revatio**
  - Sildenafil 20mg tabs and brand Revatio are now Extended Core Formulary (ECF) & step-preferred
  - Tadalafil (Adcirca) is now uniform formulary but not step-preferred (behind the step)
  - Riociguat is uniform formulary but not step-preferred (behind the step)
    - Approved via manual PA for CTEPH

Pulmonary Arterial Hypertension
PAH AHRQ/CHEST Systematic Review

- There are no head to head comparisons among different agents, therefore no evidence-based first line treatment can be proposed
- In one systematic review (CHEST 2014), all agents increased the 6-minute walk distance (6MWD) (27.9m-39.9m) when compared to placebo however comparisons between agents are inconclusive (SOE = Moderate)
  - ERA and PDE-5 monotherapy showed lower hospitalization rates but not with combination therapy (SOE = Moderate)
  - No mortality benefit with combination therapy compared to monotherapy
- Combination therapy is attractive because of different targets of therapy however combination therapy with an ERA or PDE-5 or both did NOT significantly increase the 6MWD (+10 M) (p=0.089)
- When used as monotherapy, Orenitram ER increased the 6MWD (+23 m) significantly when compared to placebo (p=0.013)
  - Mortality benefits have not been proven with Orenitram ER

Pulmonary Arterial Hypertension
Key Points – Macitentan and Riociguat

- Results of the SERAPHIN trial with macitentan showed a 30% reduction in the TTCW in the macitentan groups compared to placebo [HR 0.70 (0.52-0.96)]
  - Worsening of PAH was the most frequent primary endpoint event (24-28%)
  - 6MWD decreased an avg 9.4m (placebo group), increased 7.4m (3mg group) and 12.5m (10mg group)
- Riociguat significantly improved exercise capacity and secondary efficacy end points in patients with PAH
  - Mortality benefits have not been proven with riociguat
  - Riociguat has an additional indication for CTEPH
  - Riociguat increased 6MWD ~ 30m in the 2.5mg group and decreased ~ 6m in the placebo group (LSMD 36m; 95% CI 20-52; $p<0.001$)
  - Patients in WHO functional class III or IV had a greater benefit than did those in functional class I or II

Pulmonary Arterial Hypertension
Key Points – PAH Drugs Safety & Tolerability

- The most commonly assessed and reported ADEs from the AHRQ/CHEST systematic review
  - Headaches: PDE-5 and inhaled prostanoids
  - Cough: inhaled prostanoids
  - Jaw pain: inhaled prostanoids
  - Peripheral edema: PDE-5
  - Flushing: PDE-5 and prostanoids
- The ERAs and riociguat are pregnancy category X
- Choice of the drug depends on a variety of factors including indication, labeling, mechanism of action, route of administration, side effect profile, drug interactions, patient preference, and physician experience

New Drugs in Previous Reviewed Class

New Drugs in a Previously Reviewed Class Summary

- Drugs designated as non-formulary: Failed to show a clinical or cost effectiveness advantage over formulary agents
  - Tasimelteon (Hetlioz)– a melatonin receptor agonist indicated solely for treatment of the non-24 sleep wake disorder. Manual **Prior Authorization** criteria apply – must try melatonin first
  - Empaglifozin (Jardiance) – 3rd FDA approved SGLT2 inhibitor. **Prior Authorization** criteria applies to the SGLT2 inhibitor class
  - Vorapaxar (Zontivity) – a new antiplatelet agent with a novel mechanism of action
  - Avanafil (Stendra) – 4th PDE-5 inhibitor for ED
  - Esomeprazole Strontium – 8th PPI for GERD
- Drugs designated as Uniform Formulary
  - None

Self-Monitoring Blood Glucose System (SMBGS) Test Strips Update and MTF Conversion Efforts

SMBGS Test Strips: Final Formulary Status Implementation by Aug 5, 2015

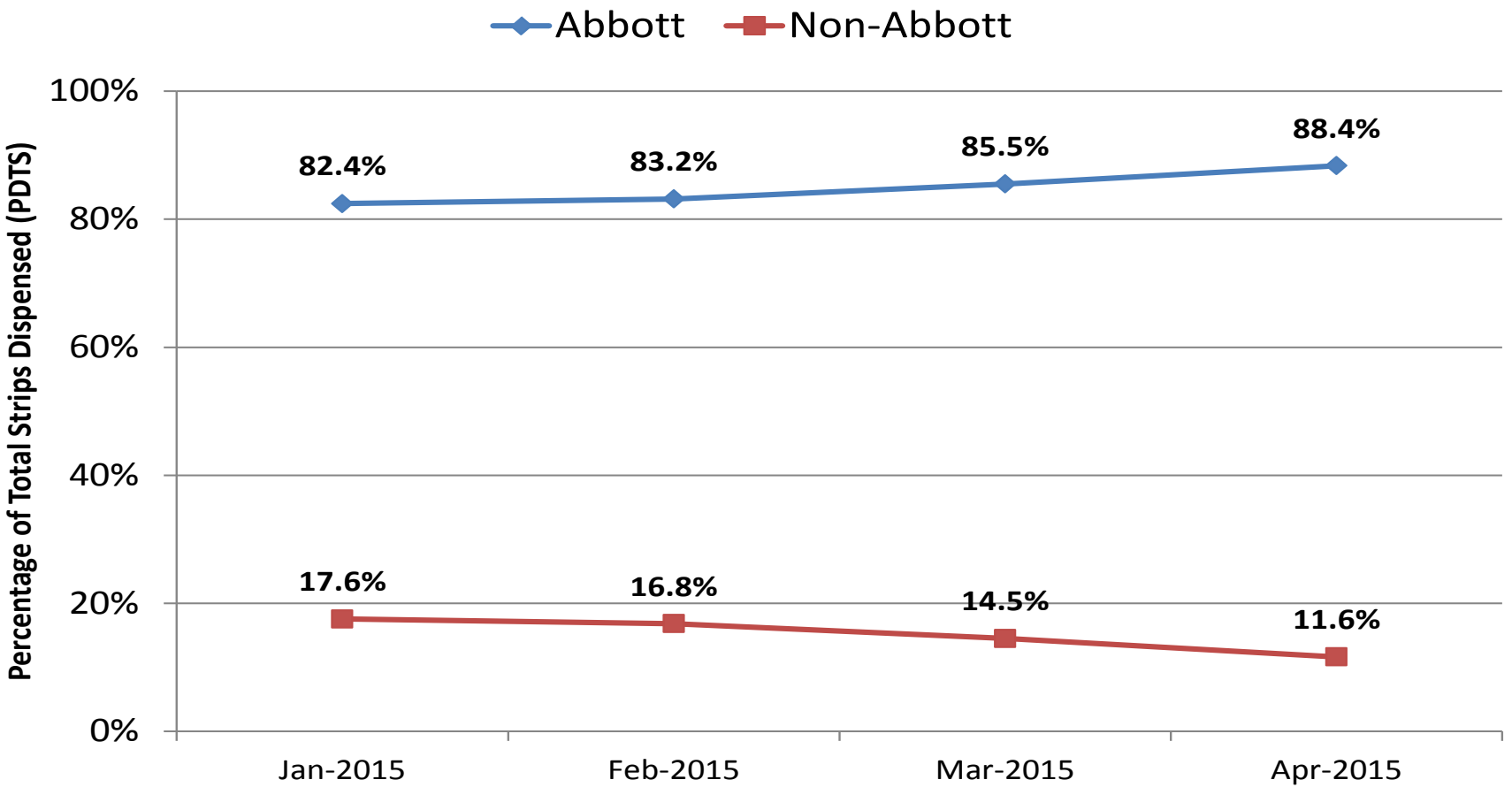
Basic Core Formulary	Uniform Formulary	Non-formulary
<u>Step-preferred:</u> • Precision Xtra (Abbott) -Precision Xtra meter • FreeStyle Lite (Abbott) - FreeStyle Freedom Lite meter	N/A – see BCF items	<u>Non step-preferred:*</u> • Accu-Chek Aviva Plus (Roche) • Glucocard 01-Sensor (Arkray) • Glucocard Vital (Arkray) • Contour NEXT (Bayer) • FreeStyle Insulinx (Abbott) • Nova Max (Nova) • One Touch Ultra Blue (Lifescan) • One Touch Verio (Lifescan) • TRUEtest (Nipro) • Plus any test strip other than BCF selections, including earlier versions of FreeStyle Lite and Precision test strips

*** Step therapy applies to all new users and current users of a test strip – must try Precision Xtra or FreeStyle Lite first**

(SMBGS) Test Strips Formulary Status

- Precision Xtra test strips **remain** on the Basic Core Formulary (BCF). FreeStyle Lite test strips were added to the BCF
  - ❑ These two are the most cost-effective test strips at $0.11/strip
- Patients currently using Precision Xtra test strips should continue to receive them. FreeStyle Lite for those facilities not currently using Abbott test strips; for new patients; or those with dexterity issues
- All test strips except Precision Xtra and FreeStyle Lite are non-formulary and non-preferred
- Prior Authorization (step therapy) now applies to all current and new users of a non-formulary test strip – "no grandfathering"
  - ❑ Current users of non-preferred strips must try FreeStyle Lite or Precision Xtra first, or meet PA criteria for the Non-formulary strips
- New Quantity Limits apply; #100 strips/30 days and #300 strips/90 days

Test Strips Dispensed (PDTS)
January – April 2015, in all DoD MTFs



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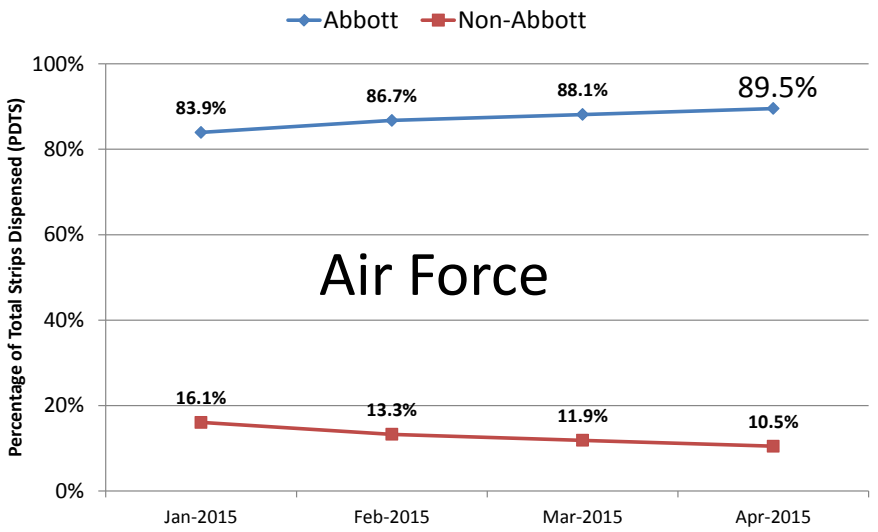
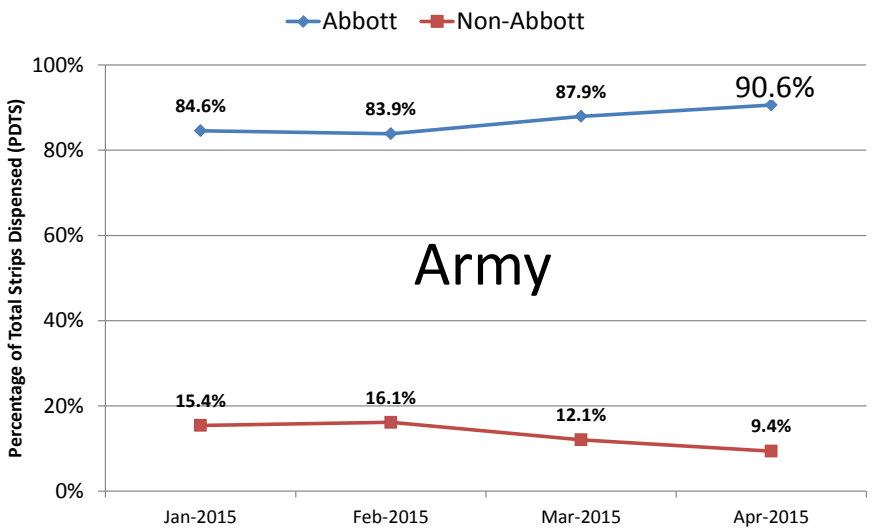
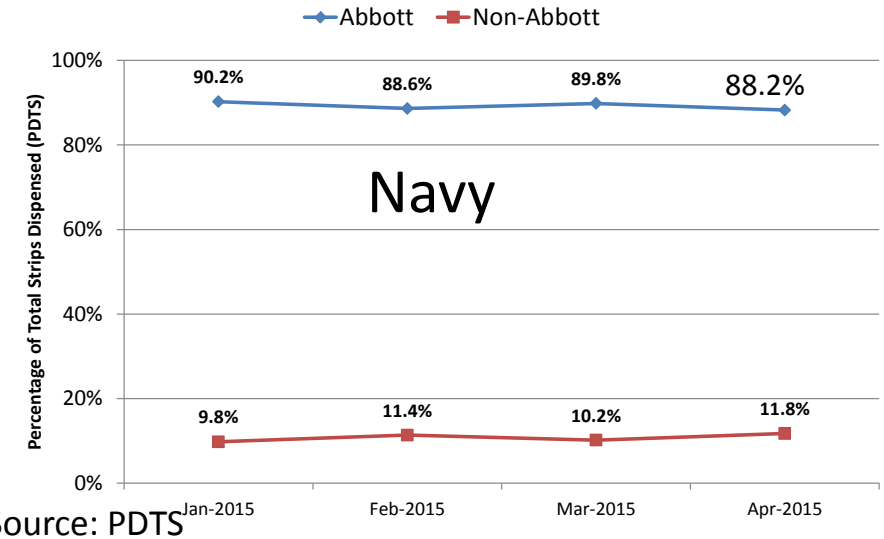
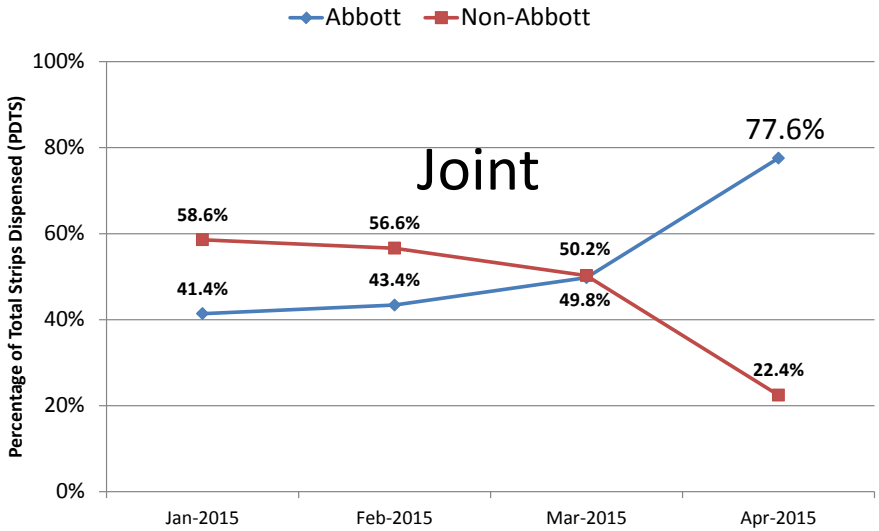








Source: PDTS

DoD P&T Committee
May 2015 Meeting

- UF Class reviews
  - Oral Anticoagulants
  - Hepatitis C Virus (HCV) Drugs; Direct Acting Antiviral (DAAs)

- New drugs
  - News Sedatives Hypnotics (SED1s): suvorexant (Belsomra)
  - Multiple Sclerosis (MS) Drug: peginterferon beta-1a (Plegridy)
  - Antiemetics/Antivertigo Agents: doxylamine succinate & pyridoxine hydrochloride (Diclegis)

DoD P&T Committee
Upcoming Evaluations

August 2015

- UF Class reviews
  - CML
  - SGLT-2 Inhibitors
  - GLP-1 Receptor Agonists
  - Narcotic Analgesics Long Acting
- New drugs
  - COPD drugs: umeclidinium (Incruse Ellipta)
  - TIBs: secukinumab (Cosentyx)

November 2015

- UF Class review
  - ADHD stimulants
  - DMARDs
  - GI-2 misc
  - Acne isoretinoids
- New Drugs
  - Namenda XR
  - Namzaric
  - Arnuity Ellipta
  - Asmanex HFA
- 120 day Innovator Drugs

Polling Question

What is your most common action with a non-formulary e-Rx?

A. Fill the Rx
B. Refer the patient to TMOP
C. Refer the patient to retail
D. Contact the provider

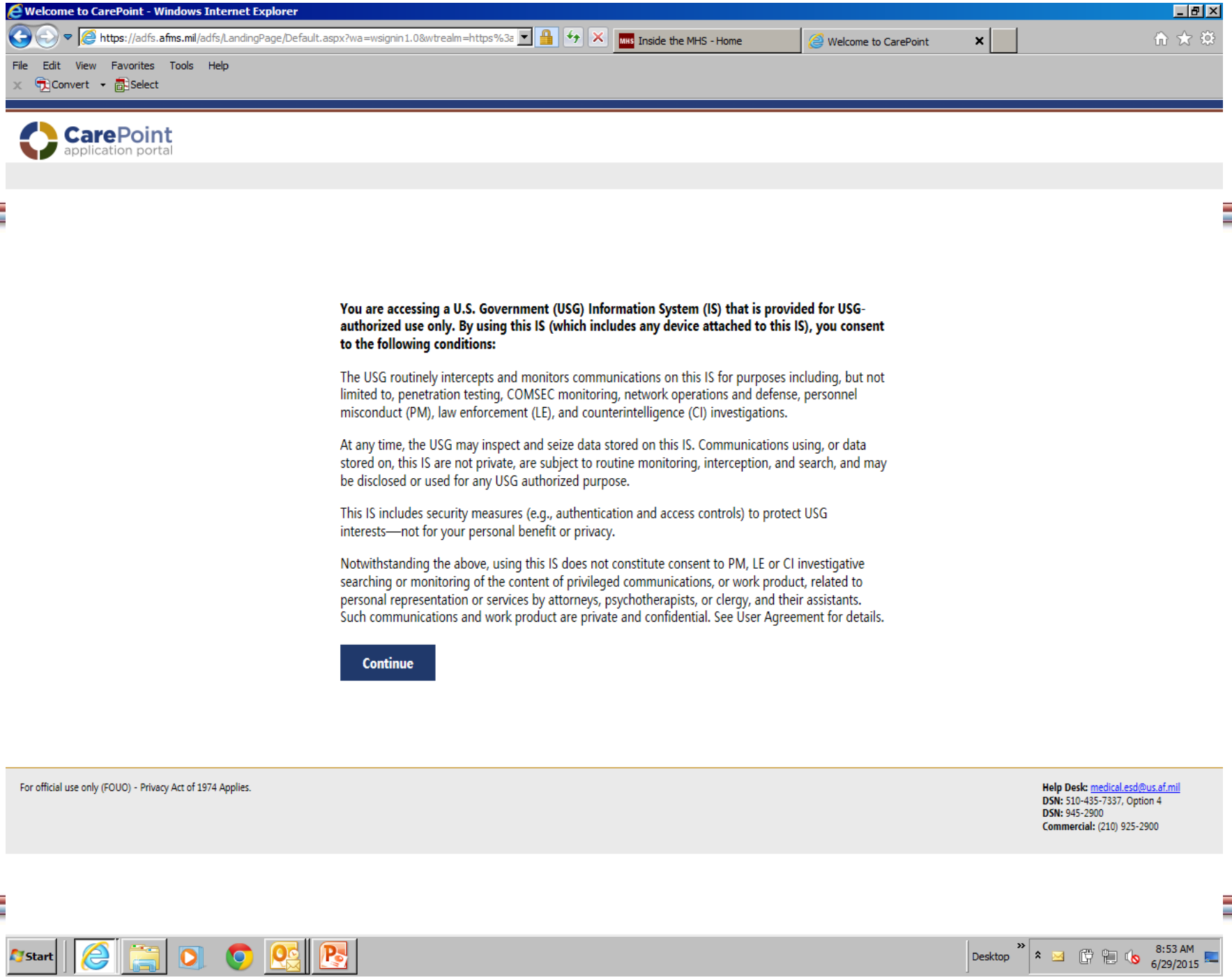
Live Demo of Partnership for Improvement (P4I)/CarePoint Application Portal

Defense Health Agency

Bill Davies
Integrated Utilization Branch
Pharmacy Operations Division

Live Demo of Partnership for Improvement (P4I)/CarePoint Application Portal

- CarePoint hosts the Partnership for Improvement (P4I) formerly Performance Management System (PMS) application
  - New 4G Web site: https://adfs.afms.mil/adfs/LandingPage/Default.aspx?
    - Use email certificate for access
- PMS includes the Percent Retail Pharmacy Spend with drill down by Service – Major Commands – MTF – Clinics
- Current Views Include:
  - Pharmacy % Retail Spend – All Beneficiaries (in catchment area)
  - Pharmacy % Retail Spend YTD Comparison
  - Pharmacy % Retail Spend by POS Service (based on fully burden costs)
  - Pharmacy % Retail Spend by ACV Category – Prime to MTF, Reliant, TRICARE Plus, Prime to MCSC, TRICARE For Life (TFL), and Other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https://adfs.afms.mil/adfs/LandingPage/Default.aspx?wa=wsignin1.0&wtrealm=https%3a
Inside the MHS - Home
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application portal
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DSN: 510-435-7337, Option 4
DSN: 945-2900
Commercial: (210) 925-2900
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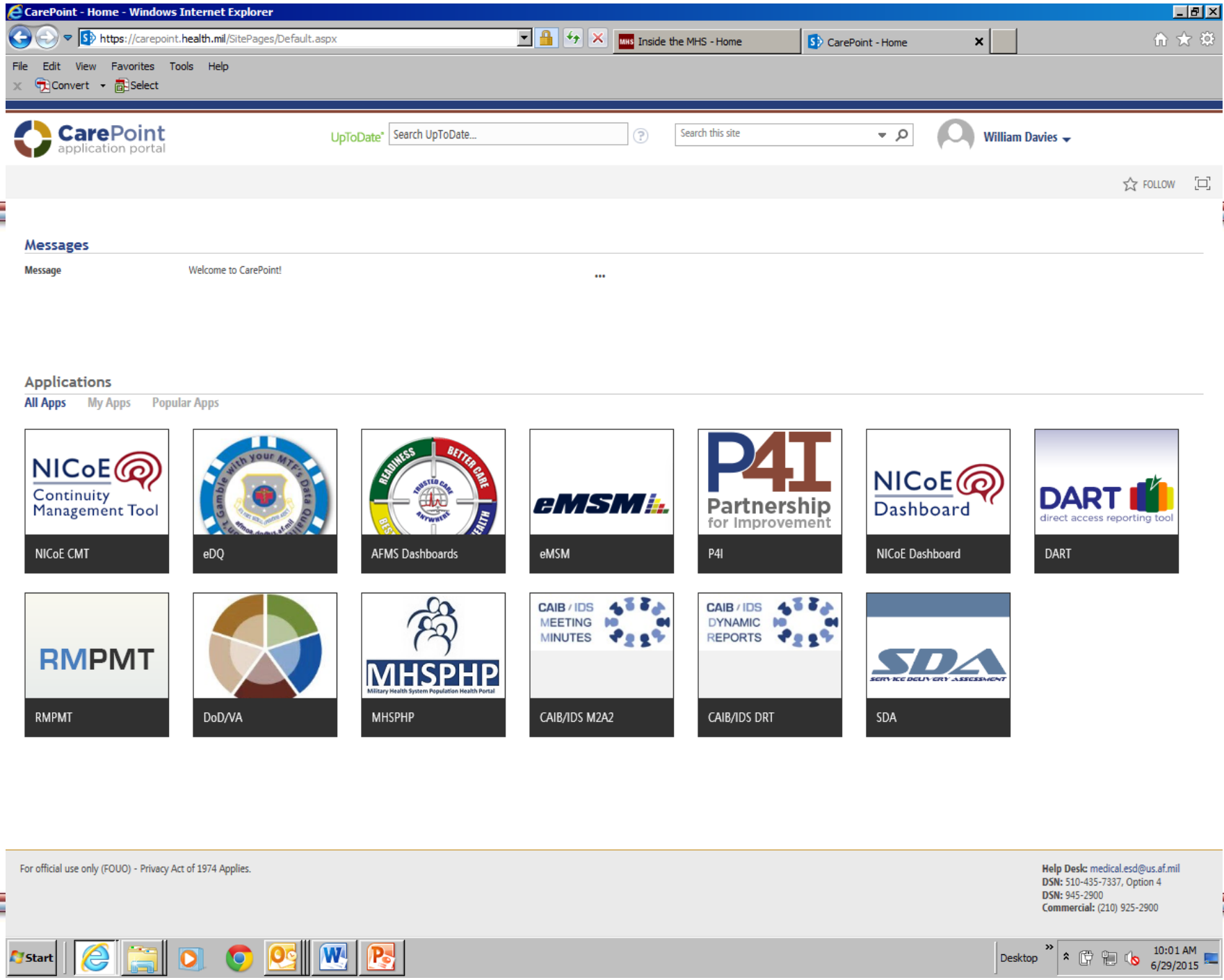
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NICoE CMT
eDQ
AFMS Dashboards
eMSM
P4I
Partnership for Improvement
NICoE Dashboard
DART
direct access reporting tool
RMPMT
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DoD/VA
MHSPHP
Military Health System Population Health Portal
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CAIB/IDS M2A2
CAIB / IDS DYNAMIC REPORTS
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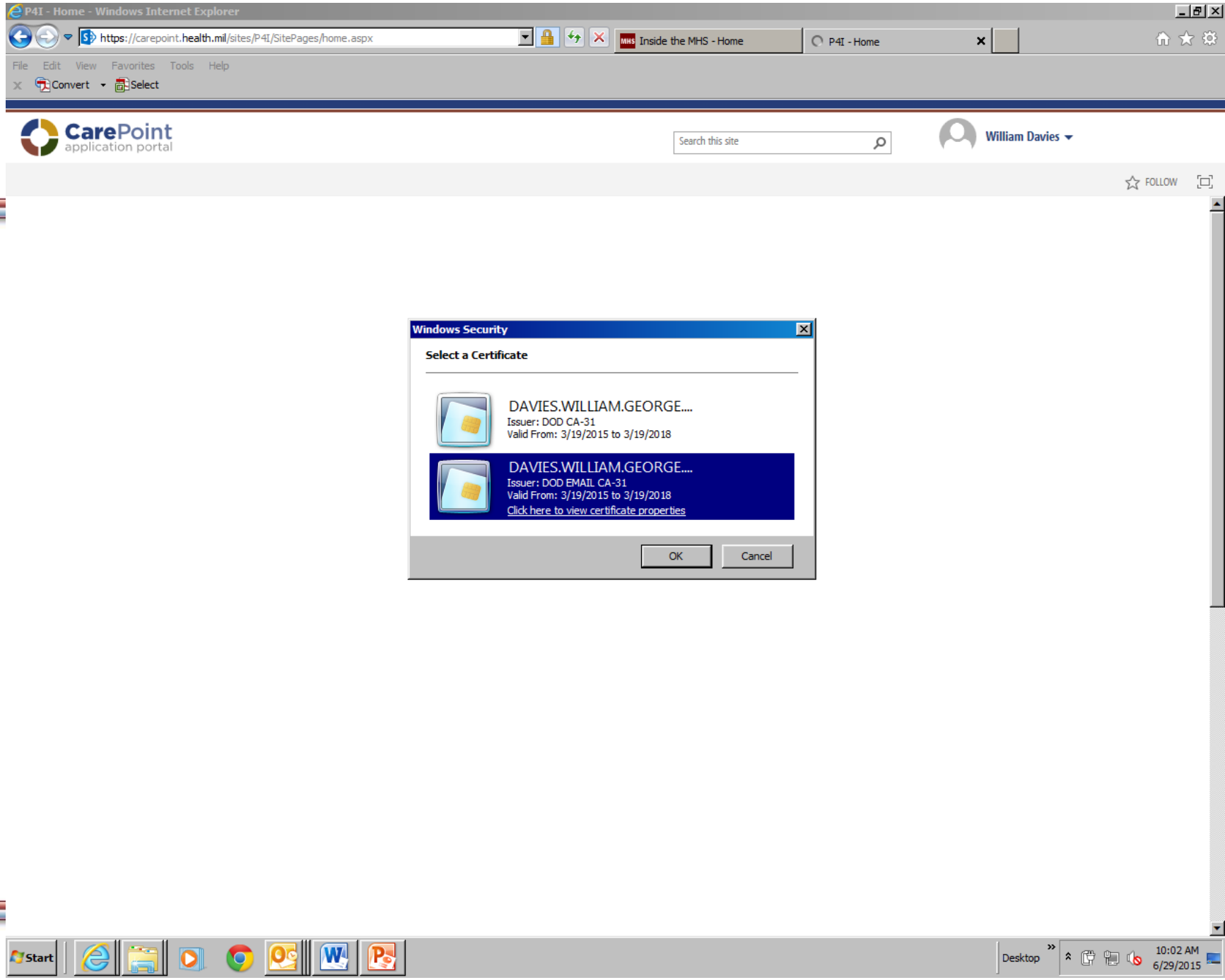
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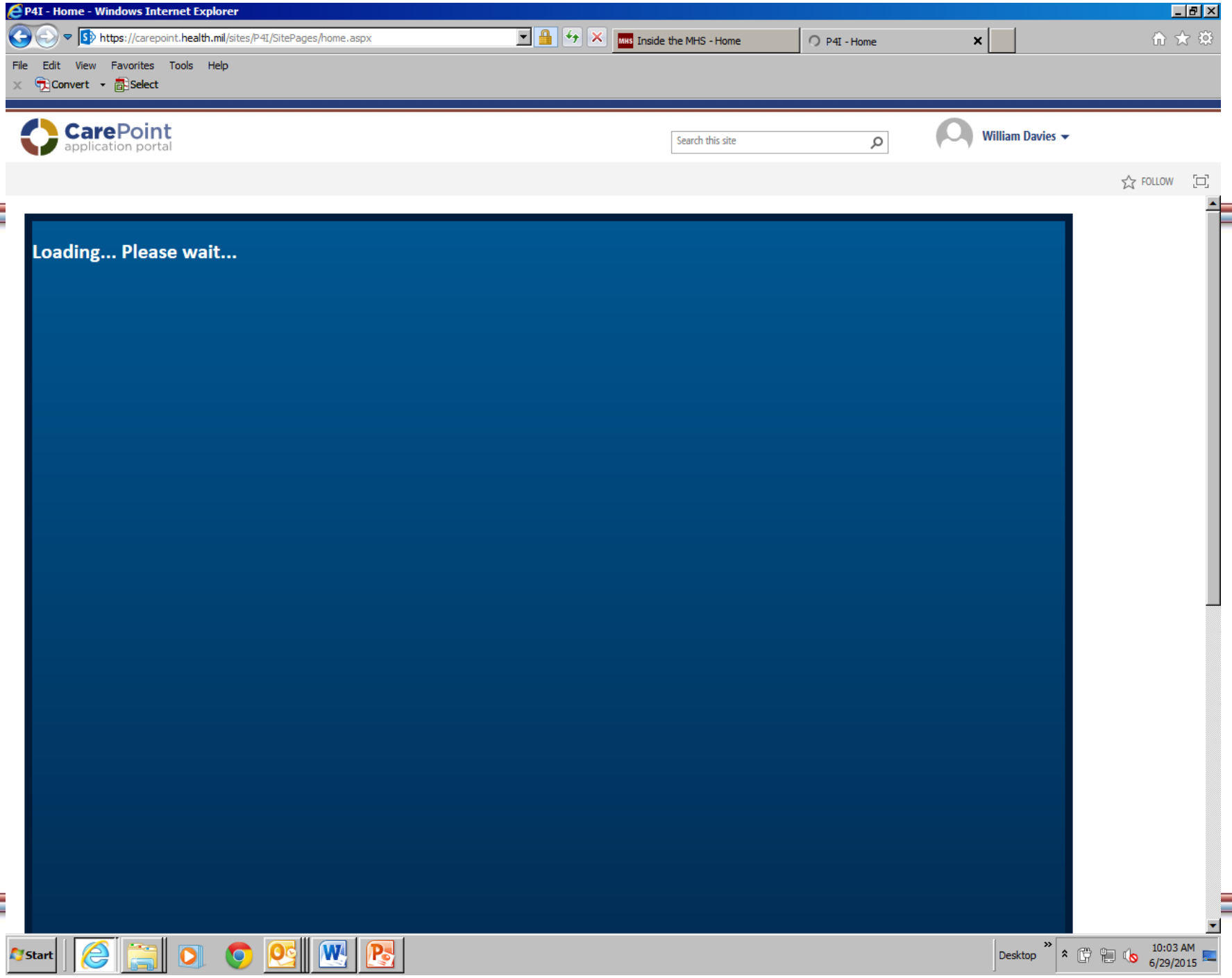
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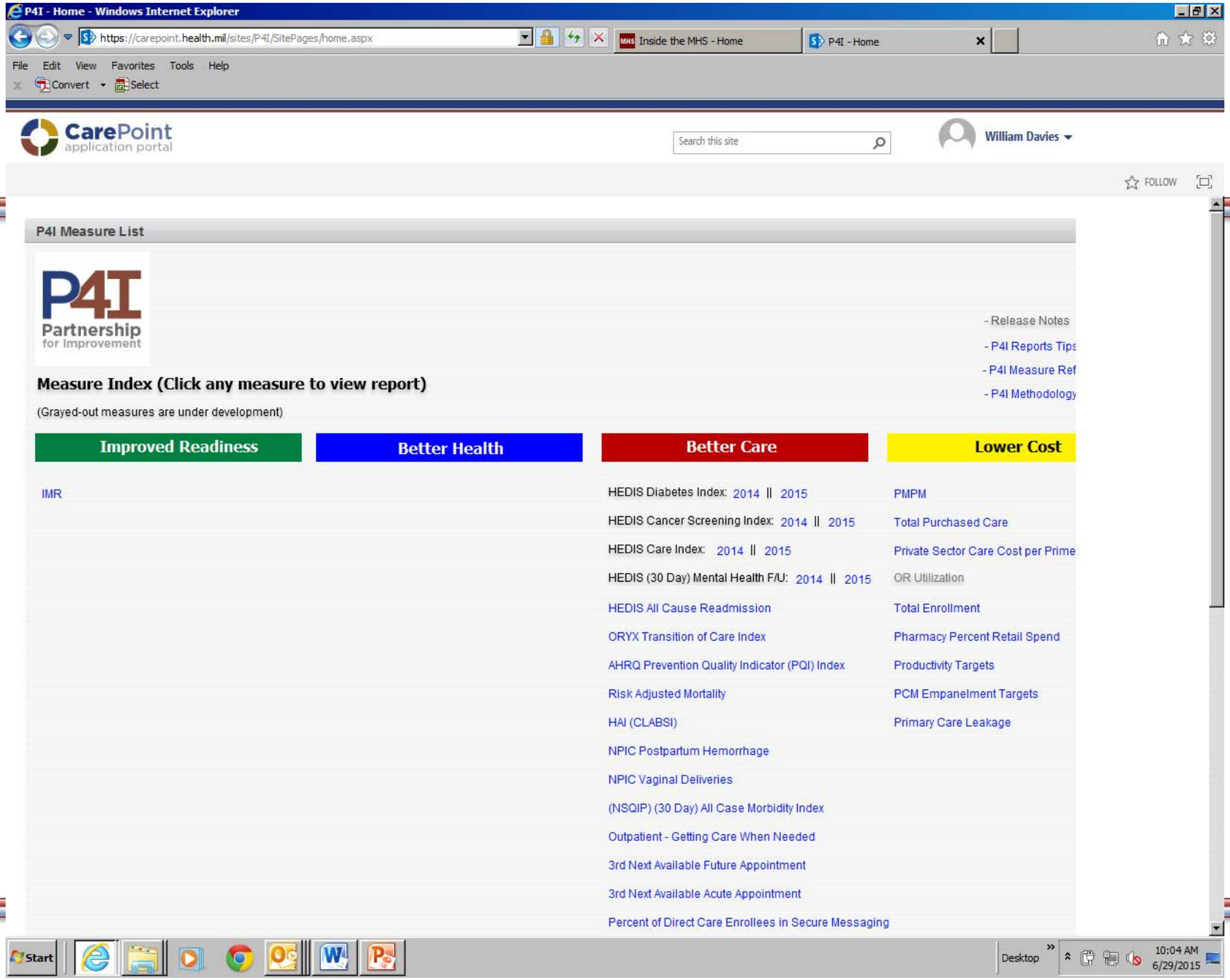
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P4I Partnership for Improvement
- Release Notes
- P4I Reports Tips
- P4I Measure Ref
- P4I Methodology
Measure Index (Click any measure to view report)
(Grayed-out measures are under development)
Improved Readiness
Better Health
Better Care
Lower Cost
IMR
HEDIS Diabetes Index: 2014 || 2015
HEDIS Cancer Screening Index: 2014 || 2015
HEDIS Care Index: 2014 || 2015
HEDIS (30 Day) Mental Health F/U: 2014 || 2015
HEDIS All Cause Readmission
ORYX Transition of Care Index
AHRQ Prevention Quality Indicator (PQI) Index
Risk Adjusted Mortality
HAI (CLABSI)
NPIC Postpartum Hemorrhage
NPIC Vaginal Deliveries
(NSQIP) (30 Day) All Case Morbidity Index
Outpatient - Getting Care When Needed
3rd Next Available Future Appointment
3rd Next Available Acute Appointment
Percent of Direct Care Enrollees in Secure Messaging
PMPM
Total Purchased Care
Private Sector Care Cost per Prime
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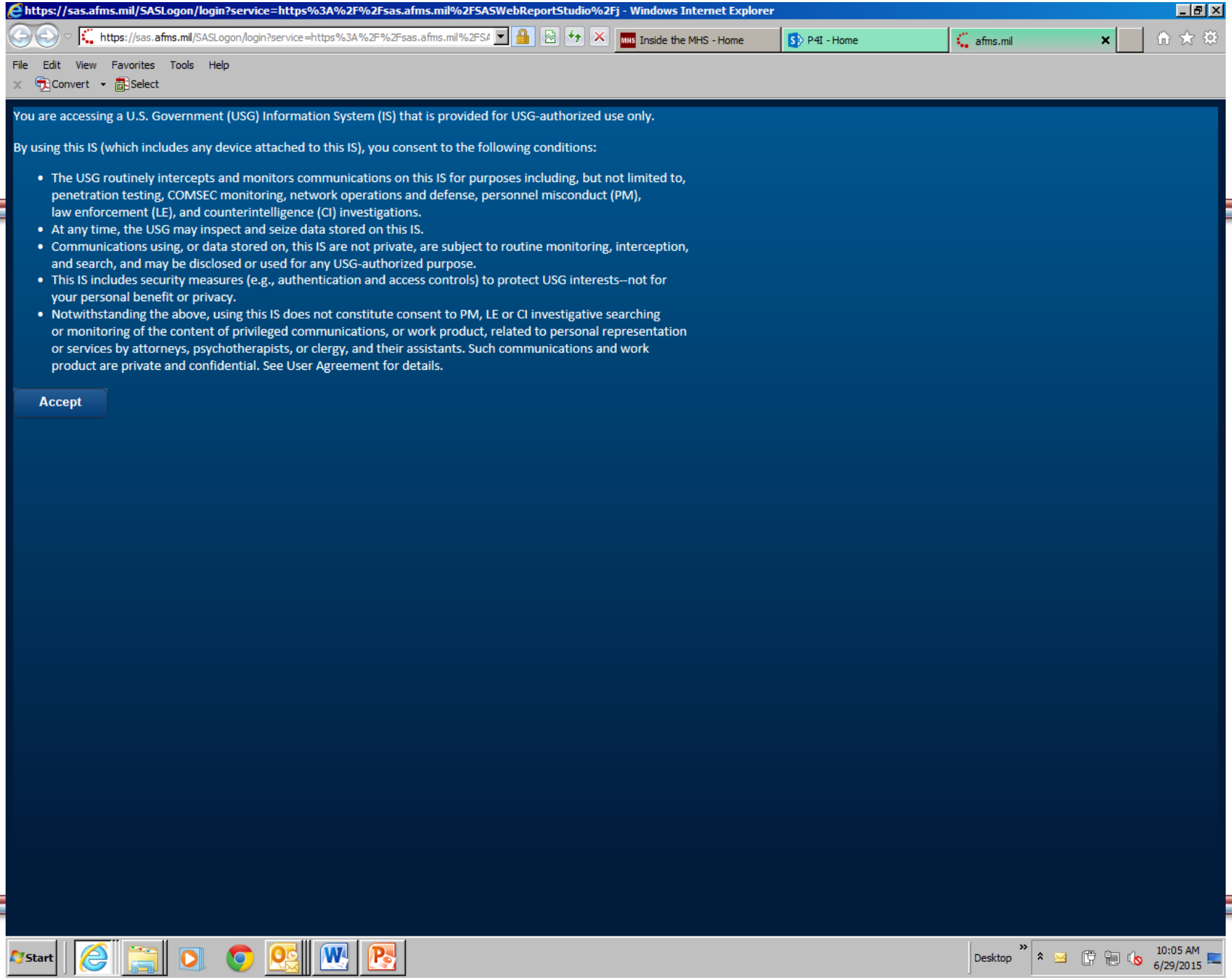
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SAS Web Report Studio • Pharmacy Percent Retail Spend

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Table of Contents Options

Pharmacy % Retail Spend - /

Section Data Options

Pharmacy Percent Retail Spend MAP 2

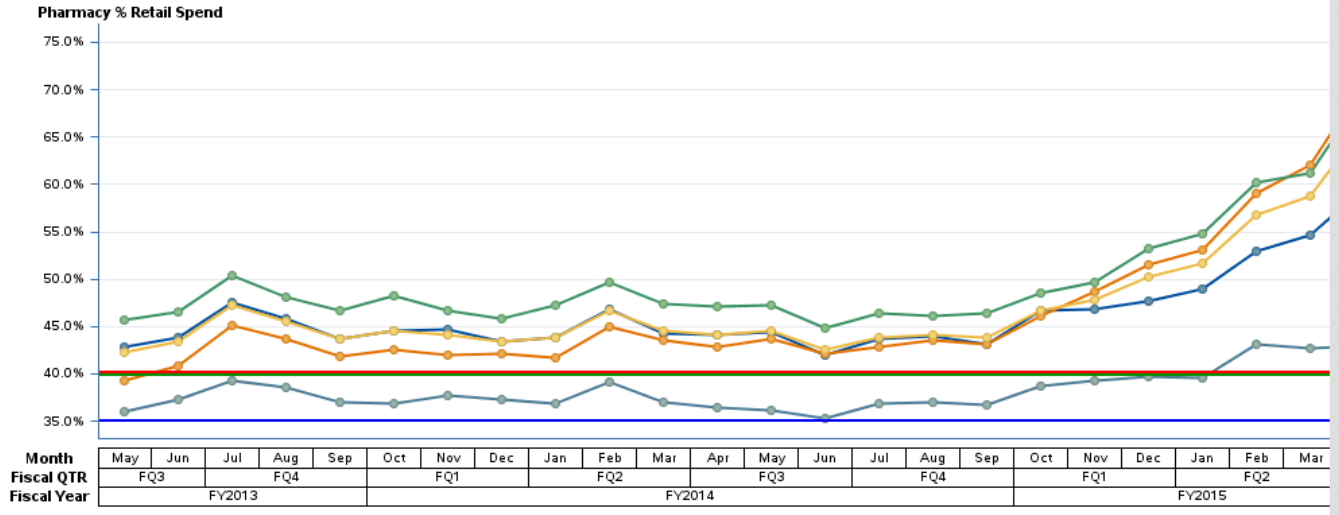
- Fiscal Date
- Facility (s/c/p/d)
- Report Months
- Pharmacy % Retail Spend
- Mail Pharmacy Cost
- MTF Pharmacy Cost
- Retail Pharmacy Cost
- Total Pharmacy Cost

Pharmacy Percent Retail Spend – All Beneficiaries

Columns 1 - 18 of 24

	Pharmacy % Retail Spend																
Fiscal Year	FY2013					FY2014											FY2015
Fiscal QTR	FQ3		FQ4			FQ1			FQ2			FQ3			FQ4			FQ1
Month	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Service																		
Air Force	42.9%	43.9%	47.6%	45.9%	43.7%	44.5%	44.7%	43.3%	43.9%	46.8%	44.3%	44.1%	44.4%	41.9%	43.6%	44.0%	43.1%	46.7%
Army	39.3%	40.9%	45.1%	43.7%	41.8%	42.5%	42.0%	42.1%	41.7%	45.0%	43.5%	42.9%	43.6%	42.1%	42.9%	43.5%	43.1%	46.1%
DHA-NCR	36.0%	37.2%	39.2%	38.5%	37.0%	36.9%	37.7%	37.3%	36.9%	39.1%	37.0%	36.5%	36.2%	35.3%	36.8%	37.0%	36.6%	38.7%
Navy	45.7%	46.6%	50.4%	48.1%	46.7%	48.3%	46.6%	45.8%	47.3%	49.7%	47.4%	47.0%	47.2%	44.9%	46.4%	46.1%	46.4%	48.5%
All MHS Services	42.2%	43.4%	47.2%	45.5%	43.7%	44.6%	44.1%	43.4%	43.8%	46.7%	44.6%	44.2%	44.6%	42.5%	43.8%	44.1%	43.8%	46.7%

Pharmacy Percent Retail Spend Methodology Document



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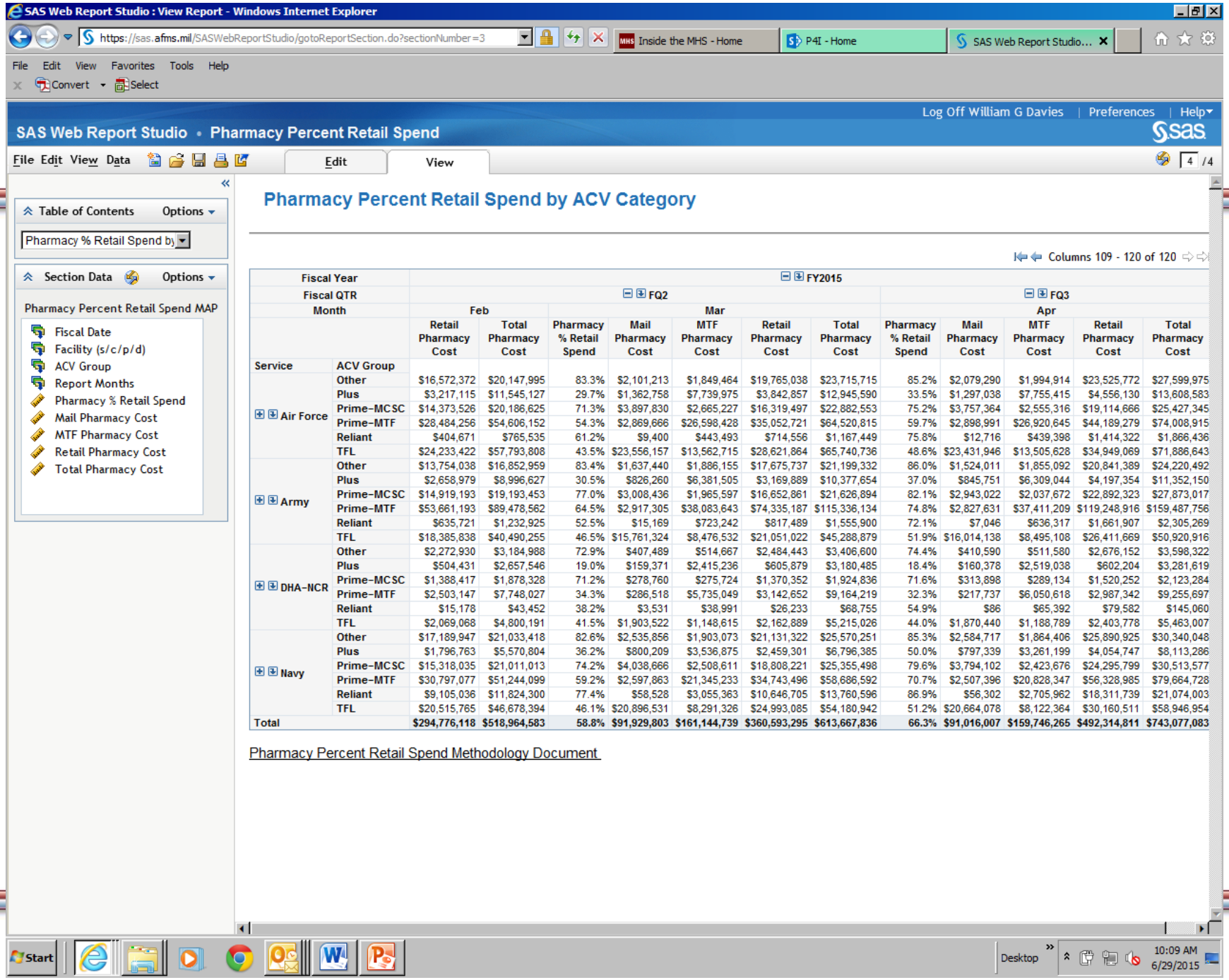

Fiscal Year		FY2015											
Fiscal QTR		FQ2							FQ3				
Month		Feb			Mar				Apr				
		Retail Pharmacy Cost	Total Pharmacy Cost	Pharmacy % Retail Spend	Mail Pharmacy Cost	MTF Pharmacy Cost	Retail Pharmacy Cost	Total Pharmacy Cost	Pharmacy % Retail Spend	Mail Pharmacy Cost	MTF Pharmacy Cost	Retail Pharmacy Cost	Total Pharmacy Cost
Service	ACV Group												
Air Force	Other	$16,572,372	$20,147,995	83.3%	$2,101,213	$1,849,464	$19,765,038	$23,715,715	85.2%	$2,079,290	$1,994,914	$23,525,772	$27,599,975
	Plus	$3,217,115	$11,545,127	29.7%	$1,362,758	$7,739,975	$3,842,857	$12,945,590	33.5%	$1,297,038	$7,755,415	$4,556,130	$13,608,583
	Prime-MCSC	$14,373,526	$20,186,625	71.3%	$3,897,830	$2,665,227	$16,319,497	$22,882,553	75.2%	$3,757,364	$2,555,316	$19,114,666	$25,427,345
	Prime-MTF	$28,484,256	$54,606,152	54.3%	$2,869,666	$26,598,428	$35,052,721	$64,520,815	59.7%	$2,898,991	$26,920,645	$44,189,279	$74,008,915
	Reliant	$404,671	$765,535	61.2%	$9,400	$443,493	$714,556	$1,167,449	75.8%	$12,716	$439,398	$1,414,322	$1,866,436
	TFL	$24,233,422	$57,793,808	43.5%	$23,556,157	$13,562,715	$28,621,864	$65,740,736	48.6%	$23,431,946	$13,505,628	$34,949,069	$71,886,643
Army	Other	$13,754,038	$16,852,959	83.4%	$1,637,440	$1,886,155	$17,675,737	$21,199,332	86.0%	$1,524,011	$1,855,092	$20,841,389	$24,220,492
	Plus	$2,658,979	$8,996,627	30.5%	$826,260	$6,381,505	$3,169,889	$10,377,654	37.0%	$845,751	$6,309,044	$4,197,354	$11,352,150
	Prime-MCSC	$14,919,193	$19,193,453	77.0%	$3,008,436	$1,965,597	$16,652,861	$21,626,894	82.1%	$2,943,022	$2,037,672	$22,892,323	$27,873,017
	Prime-MTF	$53,661,193	$89,478,562	64.5%	$2,917,305	$38,083,643	$74,335,187	$115,336,134	74.8%	$2,827,631	$37,411,209	$119,248,916	$159,487,756
	Reliant	$635,721	$1,232,925	52.5%	$15,169	$723,242	$817,489	$1,555,900	72.1%	$7,046	$636,317	$1,661,907	$2,305,269
	TFL	$18,385,838	$40,490,255	46.5%	$15,761,324	$8,476,532	$21,051,022	$45,288,879	51.9%	$16,014,138	$8,495,108	$26,411,669	$50,920,916
DHA-NCR	Other	$2,272,930	$3,184,988	72.9%	$407,489	$514,667	$2,484,443	$3,406,600	74.4%	$410,590	$511,580	$2,676,152	$3,598,322
	Plus	$504,431	$2,657,546	19.0%	$159,371	$2,415,236	$605,879	$3,180,485	18.4%	$160,378	$2,519,038	$602,204	$3,281,619
	Prime-MCSC	$1,388,417	$1,878,328	71.2%	$278,760	$275,724	$1,370,352	$1,924,836	71.6%	$313,898	$289,134	$1,520,252	$2,123,284
	Prime-MTF	$2,503,147	$7,748,027	34.3%	$286,518	$5,735,049	$3,142,652	$9,164,219	32.3%	$217,737	$6,050,618	$2,987,342	$9,255,697
	Reliant	$15,178	$43,452	38.2%	$3,531	$38,991	$26,233	$68,755	54.9%	$86	$65,392	$79,582	$145,060
	TFL	$2,069,068	$4,800,191	41.5%	$1,903,522	$1,148,615	$2,162,889	$5,215,026	44.0%	$1,870,440	$1,188,789	$2,403,778	$5,463,007
Navy	Other	$17,189,947	$21,033,418	82.6%	$2,535,856	$1,903,073	$21,131,322	$25,570,251	85.3%	$2,584,717	$1,864,406	$25,890,925	$30,340,048
	Plus	$1,796,763	$5,570,804	36.2%	$800,209	$3,536,875	$2,459,301	$6,796,385	50.0%	$797,339	$3,261,199	$4,054,747	$8,113,286
	Prime-MCSC	$15,318,035	$21,011,013	74.2%	$4,038,666	$2,508,611	$18,808,221	$25,355,498	79.6%	$3,794,102	$2,423,676	$24,295,799	$30,513,577
	Prime-MTF	$30,797,077	$51,244,099	59.2%	$2,597,863	$21,345,233	$34,743,496	$58,686,592	70.7%	$2,507,396	$20,828,347	$56,328,985	$79,664,728
	Reliant	$9,105,036	$11,824,300	77.4%	$58,528	$3,055,363	$10,646,705	$13,760,596	86.9%	$56,302	$2,705,962	$18,311,739	$21,074,003
	TFL	$20,515,765	$46,678,394	46.1%	$20,896,531	$8,291,326	$24,993,085	$54,180,942	51.2%	$20,664,078	$8,122,364	$30,160,511	$58,946,954
Total		$294,776,118	$518,964,583	58.8%	$91,929,803	$161,144,739	$360,593,295	$613,667,836	66.3%	$91,016,007	$159,746,265	$492,314,811	$743,077,083

DHA Pharmacy Operations Division

Website Changes

- DHA's Pharmacoeconomic Branch website at http://pec.ha.osd.mil/ will be deactivated this month
- Information has been moved to the new website at http://health.mil/POD

DoD Pharmacy and Therapeutics Committee: http://health.mil/PandT
Pharmacy Analytics Support Section : http://health.mil/pass
MTF Pharmacy Information: http://health.mil/MTFRxinfo
Deployment Prescription Program: http://health.mil/dpp

DHA Pharmacy Operations Division

www.health.mil/POD

Health.mil
The official website of the Military Health System and the Defense Health Agency

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        - Information for Pharmaceutical Manufacturers
        - Managed Care Pharmacy Residency Program
        - Pharmacy Analytics Support Section
        - Pharmacy Outcomes Research Team

Pharmacy Operations Division

The Department of Defense (DoD) Pharmacy Operations Division (POD) is a customer-oriented Center of Excellence implementing recognized state-of-the-art pharmacoeconomic analysis for the purpose of improving readiness by increasing value, quality, and access to medical care and pharmacotherapy within the available resources of the Military Health System (MHS).

Our Mission

Our mission is to improve the clinical, economic, and humanistic outcomes of drug therapy in support of the readiness and managed health care missions of the MHS.

What We Do

View the Presentation: Pharmacy Operations Overview

- Monitor drug usage and cost trends and performs pharmacoeconomic analyses to support DoD formulary management, national pharmaceutical contracts, and clinical practice guidelines.
- Provide administrative and technical support for the DoD Pharmacy & Therapeutics Committee, which manages the DoD Basic Core Formulary (BCF) and the TRICARE Uniform Formulary.
- The Pharmacy Analytics Support Section supports users of the Pharmacy Data Transaction Service, a centralized prescription data repository that provides a single, comprehensive patient drug profile for DoD beneficiaries across the MHS.
- Help in the development and management of information systems that support the provision of drug therapy and evaluation of the pharmacy benefit.
- Work with the Defense Logistics Agency & the VA Pharmacy Benefits Management Strategic Health Group and National Acquisition Center to establish national pharmaceutical contracts.
- Work with the VA/DoD Clinical Practice Guideline Workgroup to formulate the drug therapy components of clinical practice guidelines and associated metrics.

Recent Initiatives

- Specialty Drug Network
- Compound Drugs
- New Pharmacy Copays
- ePrescribing at Military Pharmacies
- TRICARE For Life Pharmacy Pilot

Pharmacy Related Links

- POD Secure Server (Log in Required)
- TRICARE Pharmacy Program
- TRICARE Formulary Search Tool
- Pharmacy Contractor (Express Scripts)
- DoD Pharmacy & Therapeutics Committee
- Beneficiary Advisory Panel

Contact the Pharmacy Operations Division

The Pharmacy Operations Division (POD) is located in San Antonio, TX.

For assistance:
- Call 210-536-6116
- Fax 210-536-6178
- Send an Email Message

Questions

- **Questions?**
- **For additional information, please reach out to one of the following:**
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