Department of Defense
Pharmacoeconomic Center

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MCCS-GPE **7 JUNE 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 0900 hours on 7 June 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 Bill Sykora, MC	Air Force
LtCol (select) George Jones, BSC	Air Force
CAPT (select) Matt Nutaitis, MC	Navy
CDR Kevin Cook, MSC	Navy
COL Rosa Stith, MC	Army
LTC (P) Joel Schmidt, MC	Army
MAJ Brett Kelly, MS	Army
CAPT Chuck Bruner	Coast Guard
Dick Rooney	Department of Veterans Affairs
LtCol Greg Russie, BSC	Joint Readiness Clinical Advisory Board
MAJ Mickey Bellemin, BSC	Defense Supply Center Philadelphia (DSCP)
Ray Nan Berry	Health Net Federal Services
William Hudson	Humana, Inc
Gene Lakey	TriWest
Ron McDonald	Sierra Military Health Services
Trevor Rabie	Uniformed Services Family Health Plans (USFHP)

MEMBERS ABSENT

COL John R. Downs, MC	Air Force

OTHERS PRESENT

COL William Davies, MS	DoD Pharmacy Program Director, TMA
COL Ardis Meier, BSC	Air Force Pharmacy Consultant
CAPT Joe Torkildson, MC	DoD Pharmacoeconomic Center
CAPT Pat Welter, MSC	Navy Bureau of Medicine & Surgery
LTC Don De Groff, MS	DoD Pharmacoeconomic Center
MAJ Cheryl Filby, MS	Defense Supply Center Philadelphia
David Chicoine	Uniformed Services Family Health Plan
Bill Chamberlain	Defense Supply Center Philadelphia
Mark Petruzzi	Merck-Medco
Shannon Rogers	Merck-Medco
Elizabeth Scaturro	Merck-Medco
Shana Trice	DoD Pharmacoeconomic Center
Vinnie Valinotti	Defense Supply Center Philadelphia
Paul Vasquez	Defense Supply Center Philadelphia
Gina Wu	Merck-Medco

3. **ADMINISTRATIVE ISSUES** – The minutes from the last meeting were accepted as written.

4. **REPORT FROM THE DOD EXECUTIVE COUNCIL MEETING** – COL Remund reviewed materials presented at the Executive Council Meeting concerning utilization and cost trends for drugs in the top six classes (by dollar expenditure) in DoD Military Treatment Facilities (MTFs) and the National Mail Order Pharmacy Program (NMOP). COL Remund also informed the committee about the award, contract provisions, and implementation of the joint VA/DoD national pharmaceutical contract for non-sedating antihistamines.

5. **IMPLEMENTATION OF FY 00 AND FY 01 NATIONAL DEFENSE AUTHORIZATION ACTS** – COL Davies briefed the Committee on the ongoing efforts to implement the pharmacy benefit provisions of the FY 00 and FY 01 National Defense Authorization Acts.

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 the Basic Core Formulary (BCF) status for 11 new drugs (see Appendix A). Additional discussion concerning the following drugs is also summarized in Appendix A: insulin glargine (Lantus; Aventis), PEG-interferon alfa 2b (PEG Intron; Schering), fluticasone/salmeterol powder for inhalation (Advair Diskus; Glaxo SmithKline), fluoxetine 90-mg capsules (Prozac Weekly; Lilly), and imatinib mesylate (Gleevec; Novartis).

7. **NON-PREFERRED/PREFERRED DRUG PAIRS IN THE NMOP** – MAJ Mickey Bellemin and Paul Vasquez (DSCP) reported that on 1 April the NMOP contractor, Merck-Medco, ceased making calls to physicians concerning all non-preferred/preferred drug pairs in the NMOP Preferred Drug Program except diltiazem. DSCP and Merck-Medco agreed to this change in order to accommodate the increased NMOP workload from the expansion of the pharmacy benefit to all beneficiaries over 65 years of age. Phone calls for diltiazem will continue because of the national contract for diltiazem extended release (Tiazac) and the high cost avoidance per attempted provider contact associated with this non-preferred/preferred drug pair.

CAPT Joe Torkildson reported a $2.8 million cumulative cost avoidance over the 22-month duration of the NMOP Preferred Drug Program (see Appendix B). COL Remund commented that the committee should continue to monitor market shares in classes in which a non-preferred/preferred drug pair existed in order to assess the true effect of these interventions and the potential effect of similar interventions in the future.

8. PRIOR AUTHORIZATIONS

A. *Cost avoidance from NMOP prior authorizations (PAs)* – Shana Trice (PEC) reported on the estimated cost avoidance due to PAs in the NMOP. The cost avoidance per prescription is based on the cost avoidance model that was outlined in the Aug 00 DoD P&T Committee minutes.

PA Cost Avoidance per New Prescription Submitted to the NMOP*

Drug	3rd Quarter FY 00	4th Quarter FY 00	1st Quarter FY 01	2nd Quarter FY 01
Sildenafil	$13.60	$26.46	Not calculated**	Not calculated**
COX-2 inhibitors	$11.66	$18.56	$10.95	$8.74
Etanercept	$327.20	$111.86	$7.89	$76.96

* Cost avoidance due to the PA for antifungals for onychomycosis (ciclopirox, itraconazole, terbinafine) is not calculated using this model because the PA differs substantially from the other PAs. Unlike the other PAs, which authorize dispensing of new and refill prescriptions for a year, each course of therapy with antifungal medications for the treatment of onychomycosis goes through the PA process.

** The PEC is working with Merck Medco and DSCP to revise the PA cost avoidance model to account for prior authorization of refill prescriptions.

- *Etanercept* – The progressive decline in the cost avoidance for the etanercept PA in the NMOP noted at the last meeting appears to have reversed (see table). However, considering the high cost of etanercept, the low number of prescriptions, and the even lower number of prescriptions that go through the PA process, the analysis is likely to be extremely sensitive to small changes in the number of prescriptions that are not filled because they do not meet PA criteria. The analysis of cost avoidance due to the etanercept PA in the retail network discussed at the last meeting has not yet been completed. The committee did not take any action concerning the etanercept PA.

B. *Temporary lapse in the NMOP PA program* – Paul Vasquez (DSCP) reported that the NMOP PA program was suspended from mid April 01 to early May 01 to accommodate large increases in NMOP workload due to the expansion of the pharmacy benefit to all beneficiaries over 65 years of age.

C. *Utilization of the NMOP and retail network pharmacies for drugs subject to PA* – The committee discussed the possibility of using data from the Pharmacy Data Transaction Service (PDTS) to analyze the extent to which patients who are denied prescriptions for COX-2 inhibitors in the NMOP subsequently fill these prescriptions at retail network pharmacies. The COX-2 inhibitor PA was withdrawn in the retail network in Aug 00 because federal regulations governing TRICARE currently allow prior authorizations to be applied in the retail pharmacy

networks only for clinical considerations (appropriateness of therapy), and not for cost-effectiveness considerations.

Bill Hudson (Humana) presented longitudinal data concerning utilization and costs of COX-2 inhibitors, brand name nonsteroidal anti-inflammatory drugs (NSAIDs) and generic NSAIDs in Regions 3 and 4. He reported that utilization of COX-2 inhibitors, which had decreased when the COX-2 inhibitor PA had been put into place, essentially doubled when the COX-2 inhibitor PA was discontinued.

The number of patients who opt to fill COX-2 inhibitor prescriptions in retail network pharmacies instead of the NMOP due to the presence of the COX-2 inhibitor PA is unknown. Prescriptions filled at the NMOP are less costly to DoD than those filled in the retail network. In addition, it is likely that some patients who opt to fill one prescription in the retail network rather than the NMOP will decide to fill all their prescriptions in the retail network. The committee requested that the PEC utilize data from PDTS to analyze the shift of patients from NMOP to the retail network.

C. *Antifungals for onychomycosis* – Ciclopirox topical solution (Penlac Nail Lacquer) was added to the existing NMOP PA for antifungals for onychomycosis as of 10 May 01. No problems with NMOP implementation were reported.

Bill Hudson (Humana) expressed concern about combination therapy with oral antifungals and ciclopirox being prescribed by a small number of providers. It is doubtful that this combination increases the effectiveness of onychomycosis treatment by any clinically significant degree. Product labeling for ciclopirox recommends against concurrent therapy with oral antifungals since it is not known whether ciclopirox interferes with the action of the oral antifungals. Because ciclopirox requires regular visits to remove infected nail material, use of the combination not only increases medication cost but may also increase the total cost of therapy. The committee requested more information about the incidence of combination therapy.

D. *Revision of PA forms* – Changes to clinical rationale language for the COX-2 inhibitors due to the CLASS study are in progress. The committee requested that clinical rationale language for the antifungals for onychomycosis to be changed to reflect recent safety announcements by the Food and Drug Administration (FDA) concerning terbinafine and itraconazole.

9. STATUS OF LOW MOLECULAR WEIGHT HEPARINS (LMWHs) IN THE NMOP AND RETAIL NETWORK – CAPT Torkildson reported on the PEC's survey of providers concerning the necessity to have the LMWHs available through the NMOP. While most providers did not feel this to be necessary, the obstetricians surveyed agreed that their patients were prescribed LMWH therapy for a long enough period of time to make acquiring the drug from the NMOP a viable option. While the volume of prescriptions is expected to be low, the committee agreed that there is no reason to not have low molecular heparins designed for self-administration available through the NMOP for those patients who might benefit. The committee added LMWHs (dalteparin, enoxaparin, and tinzaparin) to the NMOP formulary. The low molecular weight heparinoid, danaparoid, was not added because it is indicated for intravenous administration only and is unlikely to be administered as an outpatient medication.

10. REVIEW OF INJECTABLE MEDICATIONS AVAILABLE THROUGH THE NMOP - The committee clarified that the potential for self-administration is only one of the factors for considering drugs for the NMOP Covered Injectables List. Other factors include the feasibility of

dispensing the medications through mail order (Merck-Medco's mail order facilities are not set up to handle sterile compounding of parenteral products) and the relative likelihood that the medications will be needed on an outpatient basis.

One of the MCSC pharmacy directors requested removal of Zoladex from the NMOP Covered Injectables list, since it is an implant that requires an office visit and insertion under sterile conditions. It was pointed out that Lupron, although administered as an intramuscular injection rather than implanted subcutaneously, is in most cases also not suitable for self-administration. The committee requested the PEC to review the NMOP Covered Injectables list to identify items not designed for self-administration or commonly used in an outpatient setting and review the current utilization of these medications through the NMOP. The committee did not change the availability of Zoladex through the NMOP at this time, pending results of the review.

11. **CONTROLLED DISTRIBUTION OF ETANERCEPT (ENBREL) –** Since MTF pharmacies, unlike retail pharmacies, are not required to submit patient enrollment numbers to obtain etanercept, DoD beneficiaries can obtain etanercept from MTF pharmacies even if they did not enroll with Immunex. However, unenrolled patients may experience problems if they need to obtain etanercept from a source other than an MTF pharmacy. A process has been established for patients not enrolled with the manufacturer who have been receiving etanercept from a MTF and who wish to obtain their medication through the retail network, or who have separated from the military, to obtain enrollment numbers and receive etanercept through the NMOP or a retail network pharmacy. Patients who have not previously received etanercept (new starts) are subject to the same waiting list procedures as civilian patients. LTC De Groff reported that a letter addressing these procedures has been sent to the field by the pharmacy consultants/specialty leaders. A copy of the letter is available as Appendix D.

12. **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). COL Davies reported that the biggest problem is that prime patients are being forced to pay the copay for a non-network pharmacy. He reported that there is a potential for developing a new payment mechanism to handle not just dofetilide, but also the increasing number of drugs with unique distribution systems. Efforts to establish such a payment mechanism are in progress.

13. **ADJOURNMENT –** The meeting adjourned at 1400 hours. The next meeting will be held at Ft Sam Houston, TX and is tentatively scheduled for 16 Aug 01 at 0800. All agenda items should be submitted to the co-chairs no later than 20 Jul 01.

<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 or retail network formulary restrictions**	**BCF Status**
Ziprasidone capsules (Geodon; Pfizer)	5 Feb 01; atypical antipsychotic for the treatment of schizophrenia. Labeling for ziprasidone specifically notes that: "When deciding among the alternative treatments available for this condition, the prescriber should consider the finding of ziprasidone's greater capacity to prolong the QT/QTc interval compared to several other antipsychotic drugs." It is not known whether ziprasidone will cause torsade de pointes.	Added to NMOP Formulary	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **BCF drugs in this class:** antipsychotics: haloperidol oral; no atypical antipsychotics
Galantamine tablets (Reminyl; Johnson & Johnson)	23 Feb 01; acetylcholinesterase inhibitor; indicated for the treatment of mild to moderate dementia of Alzheimer's disease	Added to NMOP Formulary	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **BCF drugs in this class**: None
Bimatoprost ophthalmic solution, 0.03% (Lumigan; Allergan)	16 Mar 01; synthetic prostamide (prostaglandin analog); indicated for reduction of intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension; should be used in patients who cannot tolerate or have failed treatment with other IOP-lowering medications	Added to NMOP Formulary	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **BCF drugs in this class:** Ophthalmic agents for glaucoma: timolol, brimonidine, and pilocarpine ophthalmic solutions; no prostaglandin analogs
Travoprost ophthalmic solution, 0.004% (Travatan; Alcon)	16 Mar 01; synthetic prostaglandin analog; indicated for reduction of intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension; should be used in patients who cannot tolerate or have failed treatment with other IOP-lowering medications	Added to NMOP Formulary	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **BCF drugs in this class:** Ophthalmic agents for glaucoma: timolol, brimonidine, and pilocarpine ophthalmic solutions; no prostaglandin analogs

Generic name (Trade name; manufacturer)	FDA approval date, drug class, FDA-approved indication	NMOP Formulary Status	NMOP or retail network formulary restrictions	BCF Status
Insulin glargine [rDNA origin] injection (Lantus; Aventis)	20 Apr 00 (launched 21 May 01); long-acting (basal) insulin; indicated for once daily SQ administration at bedtime for treating adult and pediatric patients with type 1 diabetes mellitus, or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia. **Note:** Insulin glargine is a clear solution that should not be mixed with other insulin products; use of insulin glargine does not eliminate the need for mealtime coverage.	Added to NMOP Formulary **Note**: The NMOP Covered Injectables list includes all forms of insulin and insulin analog products (i.e., Humalog)	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **BCF drugs in this class:** Human insulin [rDNA origin} NPH, regular, 70/30 (Novolin brand only). There is a DoD/VA single source contract for the 10 mL bottles of these products (the contract also includes human lente insulin). The contract does not affect formulary status of other insulin products.
Comments about insulin glargine: The committee agreed that, while insulin glargine represents an advance in diabetes therapy and may be rapidly adopted by clinicians, it is too early to add it to the BCF. The PEC will monitor usage and will bring the item back to the committee for reconsideration if usage and demand for the product increase markedly and when clinicians have had a chance to become familiar with the product. The true potential advantage of basal insulin may only be realized when intranasal insulin becomes available, since this combination may allow even insulin dependent diabetics to limit subcutaneous injections to one daily.				
PEG-interferon alfa-2b powder for SC injection (PEG-Intron; Schering)	19 Jan 01; interferon product; indicated as once-weekly monotherapy of chronic hepatitis C in patients not previously treated with interferon alpha who have compensated liver disease, and who are at least 18 years old	Added to the NMOP Formulary **Note**: Interferon alfa products (Infergen, Roferon-A, Intron A) and combination interferon alfa/ribavirin (Rebetron) are on NMOP Covered Injectables list	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF **BCF drugs in this class:** None
Comments about Hepatitis C treatment: The VA representative, Mr. Dick Rooney, reported on the VA Chicago Health System's protocol for treatment of hepatitis C with ribavirin/interferon alfa 2b (Rebetron). Approximately 70% of patient with hepatitis C in North America are infected with genotype 1, which is less likely to respond to interferon treatment than genotypes 2 or 3. The VA performs a genotype test (which costs approximately $70) after the patient and provider have reached intention to treat. Patients with genotype 1 are then treated for one year, compared to six months for other genotypes. This both prevents unnecessary exposure to treatment that is unlikely to result in benefit and is cost-effective (cost savings of approximately $15,800 per 10 patients tested, not including avoidance of drug side effects and reduced provider visits and laboratory monitoring).				

Generic name (Trade name; manufacturer)	FDA approval date, drug class, FDA-approved indication	NMOP Formulary Status	NMOP or retail network formulary restrictions	BCF Status
Fluticasone / salmeterol powder for inhalation **100/50, 250/50, and 500/50 mcg per inhalation** (Advair Diskus; Glaxo SmithKline)	18 Aug 00; combination product containing an oral inhaled corticosteroid and a long-acting beta agonist; indicated for the long-term, twice-daily, maintenance treatment of asthma in patients 12 years of age and older. Advair is not indicated for the relief of acute bronchospasm.	Added to NMOP Formulary	**Quantity Limits** 1 inhaler (60 blisters) per 30 days (retail), 3 inhalers (180 blisters) per 90 days (NMOP) **Prior Authorization** No	Not added to BCF **BCF drugs in this class:** No other oral inhaled corticosteroid/beta agonist combination products exist; both fluticasone and salmeterol oral inhalers are on the BCF
Comments about fluticasone/salmeterol oral inhaler: The committee agreed that there is no evidence to support a clinically significant advantage (in terms of improved safety or efficacy) for the combination product compared to the two component products given separately. The combination product may be more convenient than two individual inhalers and may result in better compliance with therapy. On the other hand, the fixed dose combinations may make titration (including temporary increases in fluticasone dose during peak seasons, respiratory infections, etc.) more difficult. Advair is a dry powder Diskus device, which is substantially different from metered dose inhaler devices. Most use of fluticasone products in DoD is for the metered dose inhaled product, with minimal use of the currently available Flovent Diskus device. There is no price advantage to Advair compared to fluticasone and salmeterol given separately, although there may be cost efficiencies to MTF pharmacies (fewer prescriptions to fill) and patients (one less copay at NMOP or retail). Patent protection on fluticasone, the oral inhaled corticosteroid with the largest market share in DoD, is expected to expire in the latter part of 2003, although an "A-rated" generically substitutable product is unlikely due to environmental restrictions on production of chlorofluorocarbons (CFCs). The committee decided not to add this combination product to the BCF. The PEC will continue to monitor usage in this rapidly changing drug class.				
Formoterol fumarate powder for inhalation (Foradil; Novartis)	16 Feb 01; long-acting beta agonist; indicated for long-term, twice daily (morning and evening) administration in the maintenance treatment of asthma and in the prevention of bronchospasm in adults and children 5 years of age and older with reversible obstructive airways disease, including patients with symptoms of nocturnal asthma, who require regular treatment with inhaled, short-acting, beta2-agonists. It is not indicated for patients whose asthma can be managed by occasional use of a short-acting beta2-agonist. **Note:** formoterol has a more rapid onset of action than salmeterol (2-3 minutes vs. 10-15 minutes), previously the only available long-acting oral inhaled beta agonist. However, it is NOT a substitute for albuterol as a quick-relief medication.	Added to NMOP Formulary	**Quantity Limits** 1 inhaler (60 capsules) per 30 days (retail), 3 inhalers (180 capsules) per 90 days (NMOP) **Prior Authorization** No	Not added to the BCF **BCF drugs in this class:** salmeterol oral inhaler

Generic name (Trade name; manufacturer)	FDA approval date, drug class, FDA-approved indication	NMOP Formulary Status	NMOP or retail network formulary restrictions	BCF Status
Fluoxetine HCl 90-mg capsule (Prozac Weekly; Lilly)	26 Feb 01; selective serotonin reuptake inhibitor; indicated for the maintenance treatment of depression after an initial antidepressant response is obtained with once daily fluoxetine	Added to NMOP Formulary	**Quantity Limits** 4 capsules (one blister pack) per 30 days (retail); 12 capsules (3 blister packs) per 90 days (NMOP) **Prior Authorization** No	Excluded from BCF listing for fluoxetine. MTFs are not required to add Prozac Weekly to their formularies, but may do so if they so desire. **BCF drugs in this class:** citalopram, fluoxetine (excludes Sarafem), paroxetine, sertraline
Comments about fluoxetine 90-mg once-weekly capsule: Weekly administration of fluoxetine may represent a convenience advantage over once daily dosing, although this remains to be proven. The implications of once weekly dosing of medications for patient adherence to therapy are unknown. Plasma concentrations fluctuate to a much greater degree with once weekly dosing; the effect of patients missing once weekly doses or taking them a few days late may effectively equate to interruptions in therapy, even with the long half-life of fluoxetine. The pharmacokinetic effects, clinical consequences, and adverse effects associated with once weekly doses greater than 90 mg are unknown. The 90-mg capsule appears to be associated with more diarrhea than the 20-mg capsule, despite its delayed release formulation. The weekly formulation does not appear to be any more effective, and may be less effective, than once daily dosing. It is indicated only for maintenance treatment of depression. Prozac Weekly 90 mg once weekly costs less per month than Prozac 20 mg once daily. However, impending generic availability of fluoxetine (expected in Aug 01) and anticipated price decreases render this cost difference irrelevant, even without considering the uncertain clinical utility of this formulation of fluoxetine.				
Esomepra-zole (Nexium; AstraZeneca)	20 Feb 01; proton pump inhibitor (PPI); indicated for 1) short-term healing of confirmed erosive esophagits; 2) maintenance of healing of erosive esophagitis; 3) treatment of symptomatic gastroesophageal reflux disease (GERD); and 4) combination therapy with clarithromycin and amoxicillin for the eradication of Helicobacter pylori in patients with duodenal ulcer disease or a history of duodenal ulcer disease	Excluded from the NMOP Formulary as a non-contract drug. Prescriptions for esome-prazole may be filled through the NMOP only if documented medical necessity is established.	**Quantity Limits** General rule applies **Prior Authorization** No	Not added to the BCF. The PPI drug class is closed on the BCF. MTFs are required to have the contract agent (omeprazole) on their formularies and may not have any non-contract PPIs, including esomeprazole, on their formularies. Prescriptions for esomeprazole may be filled at MTFs only if documented medical necessity is established. **BCF drugs in this class:** omeprazole

Generic name (Trade name; manufacturer)	FDA approval date, drug class, FDA-approved indication	NMOP Formulary Status	NMOP or retail network formulary restrictions	BCF Status
Imatinib mesylate (Gleevec; Novartis)	10 May 01 (accelerated approval); protein-tyrosine kinase inhibitor (new drug class); oral once daily medication with a relatively favorable adverse effect profile; indicated for the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase after failure of interferon-alpha therapy	Added to the NMOP Formulary	**Quantity Limits** Limited to 45 days supply in the NMOP; general rule applies in the retail network **Prior Authorization** No, monitor usage	Not added to the BCF **BCF drugs in this class:** None (there are no other drugs in this class). The only antineoplastic agents on the BCF are tamoxifen and methotrexate.

Comments about imatinib mesylate: This drug is an entirely novel antineoplastic agent. Imatinib inhibits the abnormal protein-tyrosine kinase that results from the Bcr-Abl gene rearrangement characteristic of chronic myelogenous leukemia (CML). This mechanism of action suggests that it would only be active against tumors that express this abnormal protein; however, it also has some activity against other protein-tyrosine kinases, some of which are constitutively expressed by other tumor types. It is currently approved only for use in CML; its use should be confined to those patients who are Philadelphia chromosome positive, since this indicates the presence of the Bcr-Abl gene.

Imatinib also has activity against the c-kit protein-tyrosine kinase that is constitutively expressed in at least 70% of small cell lung cancers and in virtually all gastrointestinal stromal tumors. *In vitro* studies have suggested that imatinib may have activity against small cell lung cancer, while a recent case report described a patient with a gastrointestinal stromal tumor who experienced a good partial response to therapy following treatment with imatinib that was maintained for at least 11 months. Imatinib has also demonstrated activity against the protein-tyrosine kinase activated by platelet-derived growth factor (PDGF) receptor that is activated abnormally in many brain tumors, No data are currently available that suggest efficacy in treating this condition. Animal studies suggest that imatinib may decrease the rate of restenosis of coronary arteries following angioplasty due to its inhibition of the protein-tyrosine kinase that is normally activated by PDGF following this procedure. There are therefore several additional conditions for which there are very limited data suggesting the possibility of benefit.

Imatinib capsules are dosed once daily, and are relatively well tolerated in comparison to other chemotherapeutic regimens. The monthly cost of therapy based on FSS prices ranges from approximately $1,500 (chronic CML) to $2,200 (treatment of CML in accelerated phase or blast crisis). Because of the limited scope of the available published clinical trials, the optimal duration of treatment remains undefined.

Members of the committee expressed concern over several factors that increase the potential for this product to be used for other than FDA approved indications. These include: the publicity in the lay press surrounding imatinib's release, the possibility that this drug may have efficacy in other malignancies, and the pressure from patients with other malignancies who have failed conventional therapy and have few or no remaining alternatives for treatment. 32 CFR 199.4(g)(15) states in part: "CHAMPUS can also consider coverage of unlabeled or off-label uses of drugs that are Food and Drug Administration (FDA) approved drugs that are used for indications or treatments not included in the approved labeling. Approval for reimbursement of unlabeled or off-label uses requires review for medical necessity, and also requires demonstrations from medical literature, national organizations, or technology assessment bodies that the unlabeled or off-label used of the drug is safe, effective and in accordance with nationally accepted standards of practice in the medical community."

Concern was also expressed that unmonitored use of imatinib might result in a delay in appreciating its value in treating other conditions. The committee discussed the possibility of instituting a prior authorization for this medication in the NMOP and retail network in order to minimize inappropriate use while allowing identification of additional indications. The proposed wording of the requirement for authorization was stated as, "treatment of an FDA-approved indication, or enrollment in an NCI-approved clinical trial". However, the committee was then reminded that 32 CFR 199.4 also excludes coverage for "services and supplies provided as a part of or under a scientific or medical study, grant, or research program." It was pointed out that the lack of a prior authorization does not prevent MCSC Utilization Management Programs from ensuring that prescribed therapy complies with TRICARE rules. The Committee appreciated that strict application of TRICARE rules will likely engender strong objections from patients and prescribers in this situation. Also, with over 350 new oncology drugs currently undergoing clinical trials, it was understood that this question would likely surface repeatedly in the future. The Committee felt that input from a higher level within TMA would be valuable in assisting them in determining how best to deal with this issue.

The committee approved placing imatinib on the NMOP formulary without a requirement for prior authorization. A quantity limit of a 45-day supply was established to minimize waste without overly burdening patients. Without a PA, the NMOP will not collect data on diagnoses of patients prescribed the drug. The PEC will monitor usage and report at the next meeting.

APPENDIX B: CUMULATIVE SUMMARY OF COST AVOIDANCE ASSOCIATED WITH THE NATIONAL MAIL ORDER PHARMACY (NMOP) PREFERRED DRUG PROGRAM

Program Summary

- Program started in June 1999 with 8 preferred/non-preferred groups and ended 31 Mar 01 as a result of increased prescription volume related to expansion of the DoD pharmacy benefit to allow all DoD beneficiaries 65 years of age or older access to the NMOP and retail network. Calls will continue for diltiazem due to the existence of the national contract for Adalat CC.
- During these 22 months, the program resulted in a total cost-avoidance of $2,841,647. A total of 31,574 attempted prescriber contacts were made to request switches from non-preferred drugs to preferred alternatives. The estimated cost-avoidance per attempted provider contact was $90.

Cumulative Table: Summary of Switch Rates and Estimated Cost Avoidances Jun 99 – Mar 01*

Non-Preferred Drug	Preferred Drug	Switch Rate	Estimated Cost Avoidance	Total Number of Attempted Provider Contacts*	Estimated Cost Avoidance per Attempted Provider Contact**	Annualized Estimated Cost Avoidance
Cardizem CD Dilacor XR, Diltia XT, Diltiazem XR	**Tiazac**	69%	$905,784	6392	$142	$494,064
Procardia XL[1]	**Adalat CC**	51%	$417,508	2097	$199	$227,732
Lodine XL, Relafen, Voltaren XR, DayPro, Naprelan	**Generic NSAIDs**	30%	$724,985	7791	$93	$395,446
H2 Blockers[2]	**Generic Ranitidine**	40%	$437,715	3749	$117	$238,754
Enalapril (Vasotec)[3]	**Zestril**	48%	$141,304	2741	$52	$77,075
Famvir, Valtrex[4]	**Acyclovir**	23%	$11,081	1670	$7	$6,044
Pletal[5]	**Pentoxifylline**	12%	$3,424	280	$12	$1,868
Ditropan XL, Detrol	**Generic oxybutynin**	29%	$199,846	6854	$29	$109,007
		Total	$2,841,647	31,574	$90	$1,549,990

* Assumes that each new prescription received for a non-preferred drug resulted in one attempted provider contact.

** Calculated as the total cost avoidance Oct 00 – Mar 01 divided by the total number of attempted provider contacts made for non-preferred drugs in this class during the same period.

1. Calls for Procardia XL diminished significantly (from 135 per month in Jun 00 to 7 per month in Dec 00), due to the introduction of generic equivalents for some strengths of Procardia XL. Calls for Procardia XL were discontinued as generic equivalents became available.
2. Implemented Dec 99
3 Implemented Feb 00. Vasotec was removed from the list of non-preferred drugs when a generic equivalent became available at a competitive price in Oct 00.
4. At the May 00 meeting, the committee changed the criteria for Famvir and Valtrex so that calls would be made only for prescriptions written for chronic use (> 30 day supply). This change took effect 1 July 00.
5. Implemented Feb 00. Removed from the list of non-preferred drugs at the Aug 00 meeting (effective Sep 00), due to a low switch rate.

APPENDIX C: 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) Fluocinonide 0.05% cream

   B. *Changes and clarifications to the BCF*

      1) The BCF listing for digoxin oral was changed to remove the specific brand designation for brand name Lanoxin.
      2) The BCF listing for doxycycline oral was clarified to exclude doxycycline 20-mg capsules (Periostat).
      3) The BCF listing for methylphenidate oral was clarified to exclude Metadate CD.
      4) The BCF listing for triamcinolone acetonide 0.1% topical was clarified to specify triamcinolone 0.1% cream.

2. **NMOP FORMULARY CHANGES**

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

      1) Low Molecular Weight Heparins (dalteparin, enoxaparin, tinzaparin)
      2) Ziprasidone (Geodon; Pfizer)
      3) Galantamine (Reminyl; Johnson & Johnson)
      4) Bimatoprost ophthalmic solution, 0.03% (Lumigan; Allergan)
      5) Travoprost ophthalmic solution, 0.004% (Travatan; Alcon)
      6) Insulin glargine [rDNA origin] injection (Lantus; Aventis)
      7) PEG-interferon alfa-2b powder for SC injection (PEG-Intron; Schering)
      8) Fluticasone/salmeterol powder for inhalation (Advair Diskus; Glaxo SmithKline)
      9) Formoterol fumarate powder for inhalation (Foradil; Novartis)
      10) Fluoxetine hydrochloride 90-mg capsule (Prozac Weekly; Lilly)
      11) Imatinib mesylate (STI-571) (Gleevec; Novartis)

   B. *Exclusions from the NMOP Formulary*

      1) Esomeprazole (Nexium; Astra Zeneca)

   C. *Changes to the NMOP Preferred Drug Program*

      1) The NMOP Preferred Drug Program was discontinued 31 Mar 01. Calls requesting switches for non-contracted brands of diltiazem extended release (e.g., Cardizem CD, Dilacor XR, Diltia XT, Cartia XT, and generics) to the contract agent (Tiazac) will continue.

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

   A. Fluticasone/salmeterol powder for inhalation (Advair Diskus; Glaxo SmithKline) - 1 inhaler (60 blisters) per 30 days (retail), 3 inhalers (180 blisters) per 90 days (NMOP)
   B. Formoterol fumarate powder for inhalation (Foradil; Novartis) - 1 inhaler (60 capsules) per 30 days (retail), 3 inhalers (180 capsules) per 90 days (NMOP)
   C. Fluoxetine hydrochloride 90-mg capsule (Prozac Weekly; Lilly) - 4 capsules (one blister pack) per 30 days (retail); 12 capsules (3 blister packs) per 90 days (NMOP)
   D. Imatinib mesylate (STI-571) (Gleevec; Novartis) - Limited to 45 days supply in the NMOP; general rule applies in the retail network

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

APPENDIX D: ENBREL ENROLLMENT LETTER

ENBREL ENROLLMENT PROCESS

The following procedures should be used when dealing with patients on Enbrel (etanercept) in the Department of Defense medical treatment system. These procedures will remain in place until the DOD is notified by Immunex and/or Wyeth that they have changed. These procedures are based on current inventories of product.

1. Patients who were on Enbrel therapy before January 1, 2001 who enrolled in the Enbrel Enrollment Program and received a registration number will keep this number in the Immunex system. These patients will not be disenrolled by Immunex, although their number will remain "inactive" if they are receiving product through an MTF pharmacy or the NMOP mail order system. In some instances the NMOP system may require this number. If this is the case, Immunex will activate the number. This number will be used if the patient is receiving product through the retail pharmacy network program.

2. Patients who are receiving Enbrel therapy from a MTF pharmacy who are required to move for military or personal reasons (i.e. PCS, TDY assignments, relocations) and who prefer to continue to receive product from either an MTF pharmacy or the NMOP mail order system should notify the pharmacy from where they are moving. This pharmacy should contact Warren H. Yeager, R.Ph., National Account Manager-Federal Government, Wyeth-Ayerst Labs @ 1-888-685-5961 ext. 76924 and notify him of the new location of the patient. This will keep track of product at the different delivery systems throughout the DOD.

3. DOD patients who choose the retail pharmacy network option for obtaining Enbrel.

   - If these patients have already enrolled in the program and have a registration number and have been receiving product there will be no change in the process.

   - Because of the portability of the prescription in the DOD, if an Enbrel patient chooses to change from an MTF or NMOP to the retail option to have their script filled and does not have an enrollment number, the dispensing pharmacist will have to "opt out" of the confirmation process. The term "opt out" is recognized by the retail pharmacy network and is put in place to have the retail pharmacy contact HDS McKesson (1-888-436-2735) when this situation presents itself. HDS McKesson personnel are aware of this scenario. If the patient has an "inactive" number, this number will be activated by HDS McKesson and the patient will receive the medication. If the patient does not have a number, HDS McKesson will assign a number and the patient will receive the medication.

4. Patients who transfer from the DoD to the private sector due to separation.

   - Because these patients are already "accounted for" in the overall enrollment process they will be given an active enrollment number at the time of separation. The patient will need to call HDS McKesson @ 1-888-436-2735 and identify themselves as an existing patient transferring from DoD to the private sector due to release from Active military service. HDS McKesson will verify DoD eligibility and assign an enrollment number that will allow the patient to continue to receive the medication. HDS McKesson can verify the patient's DoD eligibility and medication history by calling the PDTS CSSC @ 1-800-600-9332, press #1, then select option #1 a second time.

5. Wait list procedures for adding new patients to the DOD program.

   - Patients will follow the same procedures as patients in the civilian community. They will need to call 1-888-436-2735(1-888-4ENBREL). They will be placed on the waiting list and given a "inactive" registration number.