Drug Utilization Review Board

Oklahoma Health Care Authority
4545 N. Lincoln Suite 124
Oklahoma City, Oklahoma 73105
OHCA Board Room

June 14, 2005 @ 6:00 p.m.

THE UNIVERSITY OF OKLAHOMA

THE UNIVERSITY OF OKLAHOMA

MEMORANDUM

TO: Drug Utilization Review Board Members

FROM: Ron Graham, D.Ph.

SUBJECT: **Packet Contents for Board Meeting – June 14, 2005**

DATE: June 8, 2005

NOTE: **THE DUR BOARD WILL MEET AT 6:00 P.M.**

Enclosed are the following items related to the June meeting. Material is arranged in order of the Agenda.

Call to Order

Public Comment Forum

Action Item – Approval of DUR Board Meeting Minutes – **See Appendix A.**

Action Item – Vote to Change Meeting Date

Update on DUR/MCAU Program – **See Appendix B.**

Review and Discuss Xolair® – **See Appendix C.**

Action Item – Vote to Prior Authorize Zelnorm® – **See Appendix D.**

Action Item – Vote to Prior Authorize Niravam® – **See Appendix E.**

Action Item – Vote to Prior Authorize Symlin® – **See Appendix F.**

Review and Discuss Medicare Part D – **See Appendix G.**

Fiscal Year 2004 Utilization Summary and Comparisons – **See Appendix H.**

60 Day Notice to Prior Authorize Fenofibrates – **See Appendix I.**

30 Day Notice to Prior Authorize Zetia® – **See Appendix J.**

30 Day Notice to Prior Authorize Elidel® and Protopic® – **See Appendix K.**

FDA and DEA Updates – **See Appendix L.**

Future Business

Adjournment

Drug Utilization Review Board

(DUR Board)

Meeting – June 14, 2005 @ 6:00p.m.

Oklahoma Health Care Authority
4545 N. Lincoln Suite 124
Oklahoma City, Oklahoma 73105
Oklahoma Health Care Authority Board Room

AGENDA

Discussion and Action On the following Items:

Items to be presented by Dr. Whitsett, Chairman:

1. **Call To Order**
   A. Roll Call – Dr. Graham

Items to be presented by Dr. Whitsett, Chairman:

2. **Public Comment Forum**
   A. Acknowledgment of Speakers and Agenda Item

Items to be presented by Dr. Whitsett, Chairman:

3. **Action Item – Approval of DUR Board Meeting Minutes – See Appendix A.**
   Action Item – Vote to Change Meeting Date
   A. May 10, 2005 DUR Minutes – Vote
   B. Memorandum of May 26, 2005

Items to be presented by Dr. Flannigan, Dr. Whitsett, Chairman:

4. **Update on DUR/MCAU Program – See Appendix B.**
   A. Retrospective Drug Utilization Review Report for March 2005
   B. Medication Coverage Activity Audit for May 2005
   C. Help Desk Activity Audit for May 2005

Items to be presented by Dr. Flannigan, Dr. Whitsett, Chairman:

5. **Review and Discuss Xolair® – See Appendix C.**
   A. Current Prior Authorization Criteria
   B. Utilization Review

Items to be presented by Dr. Browning, Dr. Whitsett, Chairman:

6. **Action Item – Vote to Prior Authorize Zelnorm® – See Appendix D.**
   A. Product Summary
   B. COP Recommendations

Items to be presented by Dr. Browning, Dr. Whitsett, Chairman:

7. **Action Item – Vote to Prior Authorize Niravam® – See Appendix E.**
   A. Product Summary
   B. COP Recommendations

Items to be presented by Dr. Patel, Dr. Whitsett, Chairman:

8. **Action Item – Vote to Prior Authorize Symlin® – See Appendix F.**
   A. Product Summary
   B. COP Recommendations

Items to be presented by Dr. Nesser, Dr. Whitsett, Chairman:

9. **Review and Discuss Medicare Part D – See Appendix G.**
   A. Medicare Prescription Drug Benefit – Fact Sheet
   B. Medicare at a Glance – Fact Sheet

Items to be presented by Dr. Gorman, Dr. Whitsett, Chairman:

10. **Fiscal Year 2004 Utilization Summary and Comparisons – See Appendix H.**
    A. Comparison of Fiscal Years by Therapeutic Category
    B. Report by Number of Claims and Dollars for FY04
    C. Comparison of Fiscal Years of Top 100 Medications
    D. Report for Top 100 Medications by Dollars for FY04
    E. Report for Top 50 Medications by Dollars for FY04

Items to be presented by Dr. Gorman, Dr. Whitsett, Chairman:

11. **60 Day Notice to Prior Authorize Fenofibrates – See Appendix I**
    A. Recommendations
    B. Potential Economic Impact

Items to be presented by Dr. Gorman, Dr. Whitsett, Chairman:

12. **30 Day Notice to Prior Authorize Zetia® – See Appendix J**
    A. Recommendations
    B. Potential Economic Impact

Items to be presented by Dr. Gorman, Dr. Whitsett, Chairman:

13. **30 Day Notice to Prior Authorize Elidel and Protopic® – See Appendix K**
    A. Recommendations
    B. Potential Economic Impact

14. **FDA and DEA Updates – See Appendix L.**

15. **Future Business**
    A. Antifungal Review
    B. Estrogen Replacement Products Review
    C. Neurontin® Follow-Up Review
    D. Renal Product Review
    E. Pediculicide Product Review
    F. Synagis® Annual Review
    G. New Product Reviews
       - Byetta®
       - Focalin XR®
       - Revatio®

16. **Adjournment**

APPENDIX A

OKLAHOMA HEALTH CARE AUTHORITY
DRUG UTILIZATION REVIEW BOARD MEETING
MINUTES of MEETING of MAY 10, 2005

BOARD MEMBERS:	PRESENT	ABSENT
Dorothy Gourley, D.Ph.	X	
Cathy Hollen, D.Ph.	X	
Dan McNeill, Ph.D., PA-C	X	
Cliff Meece, D.Ph.	X	
Dick Robinson, D.Ph., Vice-Chair	X	
Thomas Whitsett, M.D., Chair	X	

COLLEGE of PHARMACY STAFF:	PRESENT	ABSENT
Leslie Browning, D.Ph./PA Coordinator	X	
Metha Chonlahan, D.Ph./Clinical Pharmacist	X	
Karen Egesdal, D.Ph./SMAC-ProDUR Coordinator/OHCA Liaison		X
Kelly Flannigan, Pharm.D../Operations Manager	X	
Shellie Gorman, Pharm.D./DUR Manager		X
Ronald Graham, D.Ph./Pharmacy Director	X	
Chris Kim Le, Pharm.D.; Clinical Pharmacist	X	
Ann McIlvain, Pharm.D.; Clinical Coordinator		X
Carol Moore, Pharm.D.; Clinical Pharmacist	X	
Neeraj Patel, Pharm.D.; Clinical Pharmacist	X	
Visiting Pharmacy Student: Nonye Okeke	X	

OKLAHOMA HEALTH CARE AUTHORITY STAFF:	PRESENT	ABSENT
Alex Easton, M.B.A./ Pharmacy Operations Manager		X
Mike Fogarty, J.D., M.S.W./Chief Executive Officer		X
Nico Gomez/Director of Governmental & Public Affairs	X	
Lynn Mitchell, M.D., M.P.H/Director of Medicaid/Medicaid Services	X	
Nancy Nesser, D.Ph., J.D./Pharmacy Director	X	
Howard Pallotta, J.D./Director of Legal Services	X	
Lynn Rambo-Jones, J.D./Deputy General Counsel III		X
Rodney Ramsey/Drug Reference Coordinator	X	
Jill Ratterman, D.Ph./Pharmacy Specialist	X	

OTHERS PRESENT:

Jonathan Klock, GSK	John Cheppo, GSK	Tammy Bullock, GSK
Mark (?), GSK	Michelle Martinez, Santarus	Joe McIntosh, Novartis
Evie Knisely, Novartis	Joe Ripperger, MD	Susan Wellman, Lilly
Toby Thompson, Pfizer	Mark DeClerk, Lilly	Toby Thomopson, Pfizer
Charlene Kaiser, Wyeth	Greg Hoke, Wyeth	Kim Underwood, Schering
Greg Hollon, Teamm	Lon Lowrey, Novartis	Jerry Witcher, Forest Labs
Ben Robinson, NAMI	John Omick, Novartis	
Mark Naylor, M.D.	Jorge Nassar, BMS	

PRESENT FOR PUBLIC COMMENT:

Dr. Michael Jones; GSK	Agenda Item No. 6
Elizabeth Hoefling, R.Ph.; Wyeth	Agenda Item No. 6
Joe Ripperger, M.D.	Agenda Item No. 6
Evie Knisely; Novartis	Agenda Item No. 11
Ben Robinson, NAMI	(general comment)
Mark Naylor, M.D.	Agenda Item No. 11

AGENDA ITEM NO. 1: **CALL TO ORDER**

1A: Roll Call

Dr. Whitsett called the meeting to order. Roll call by Dr. Graham established the presence of a quorum.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 2: **PUBLIC COMMENT FORUM**

2A: Acknowledgement of Speakers and Agenda Item

Dr. Whitsett acknowledged speakers for Public Comment, and acknowledged the resignations of Board members Dr. Brent Bell and Dr. Jim Swaim.

ACTION: NONE REQUIRED.

For Public Comment, Ben Robinson, NAMI (general comment): *Well, thank you Mr. Chairman, I am Ben Robinson and I certainly . . . first I want to say thank you to the Board for the great work that you've done for the past 16 years when I was in the Legislature. I certainly appreciate it, it's been marvelous, I'd like to ask you now to stop that. I'm just kidding . . . just kidding. I am representing NAMI at this time, the National Alliance for the Mentally Ill and I know that I'm preaching to the choir here, but I encourage you to use extreme caution when you're working with a group that is mentally ill. We are . . . they're an extremely fragile group and I just encourage you to use all the due caution and care that you use all the time, maybe even more so with that particular group and that's my comments. Thank you, Mr. Chairman and members, I appreciate you.*

AGENDA ITEM NO. 3: **LEGISLATIVE UPDATE AND BUDGET ISSUES**

Nico Gomez: *I do have a handout that I'm going to send around your way if that's OK. Mr. Chairman, Board members, thank you again for your time. I am pleased, probably more so than anybody else in this room, that we have twelve legislative days left for this session. Even more so, I got a little bit of a smile because I believe we have an agreement regarding the appropriations for a lot of the agencies' work that we do, but specifically the Health Care Authority, and what I'm handing out and whatever extra copies I have I've sent around the back of the room, but what you have in front of you is a summary of this agreement. You'll see that funding has been provided to replace some of the reduced Federal funds. I'm not going to go into great detail of each item, but funding to pay for anticipated increases in the population and utilization, pay for the new Medicare Part D drug benefit. That money is set aside for something that's also known as clawback, for those of you who are familiar with that. There is also money set aside for the prescription for savings initiative. This is also known as the drug savings card program that's being worked on by the Legislature and the Governor. The Agency will receive some money for administration of this program as the Governor and Legislature will work out the details of this program in conference. The bottom line, this $89.5 million dollars in new money will help sustain the program for the next fiscal year, provided nothing unforseen in regards to the tobacco tax funding or anything of that nature. But unfortunately, this does not include any provider rate increases, something that continues to be a priority. The Agency and the Board continue to look at ways to increase our reimbursement to our providers to maintain adequate access for our patient population. I should also note that we are still working on the Federal level to find some fiscal relief for the loss in Federal matching dollars and hopefully, we will be able to report to you sometime this Summer or Fall some progress in that arena at the Federal level. Turning to policy legislation, I'll just touch briefly on some of the things that we're watching at the Legislative, regarding policy issues . . . talking with a colleague of mine down at the Capitol the other day, there appears to be this perception that pharmaceutical manufacturers are politically weaker in the State than they have been in the past, and I'm here to tell you is absolutely a false perception. I have lost a lot of weight this session going from chamber to chamber and chasing some of these bills regarding the pharmacy program. I don't want this to sound too self-serving, but it's been very difficult educating some members about some of the pharmacy bills that we've made a decision. That doesn't mean that all the pharmacy related bills are problematic either, but what I presented to you back in February, we discussed some of these bills that could have a potential negative impact on DUR Board and the Agency's ability to run the pharmacy program that was responsive to the patient and the taxpayer, one of which unanimously passed one chamber and we had to go visit with the Chairman of the committee where this Bill landed and do our best to educate them that this Bill could have a negative impact on the Agency's ability to manage the program. Not going to go into the details of how you make sausage, but I'll just say we were very fortunate the Bill failed deadline. There was another bill that was not our request bill that we became very interested in regarding drug price disclosure requirements. This one, as no surprise, was killed very quickly before the first deadline. So it's been a very busy session as relates to pharmacy bills, and that's one reason we wanted to take this time to visit with you from time to time to talk about some of the bills that we're following and also just keep you apprised of the process. All that said, it's not over till the gavel comes down for "sine die" on May 27th. Although most of these bills may be dead or dormant for this year, they certainly can come back again next year. We'll be working hard to keep educating the legislators of potentially detrimental language that sometimes appears at the end of the session. I hope to report to you again this summer that we've had a very successful and productive session on both the appropriation side and the policy side, and I'm happy to entertain any questions you may have regarding any of the policy legislation or appropriations.*

Dr. Whitsett: *Someone had mentioned, I think the date was the first of January perhaps . . . that there will be a shift of individuals out of the Medicare/Medicaid pharmacy policies ...benefits, over to the national Medicare drug program. Is that, am I understanding that correctly?*
Mr. Gomez: *Yes Mr. Chairman. That is correct. That is the deadline for us to start, when they populate that, Medicaid dual eligible population has to come over. We're fortunate to have some of the folks who are very knowledgeable in that at both the local level, but national level as well, our own Dr. Lynn Mitchell and Dr. Nesser have been working to make sure the patient population is well transferred to that process.*
Dr. Whitsett: *How many people are we talking about?*
Dr. Nesser: *About 80,000 people, but they're you know, most of them are high drug utilizers and so it's going to change the pharmacy program the way it looks a lot. I'll be talking about that quite a bit next month at this meeting to get everybody up to speed, get on the same page. Yeah, it's going to be really, really different.*
Dr. Whitsett: *And the benefits will be . . . it's going to be a positive benefit to the patients? I mean, now they're obtaining the, whatever their scripts are . . .*
Dr. Nesser: *Right. There's no script limit, so that's one good thing you can say, so . . .*
Dr. Whitsett: *But there is an expense. Depending on your income...*
Dr. Nesser: *There's potentially an expense. Yeah . . . depending on your income. For folks in the nursing home who are on Medicaid, no copays, no premiums, no deductibles. So they'll be well taken care of financially. The problem will be that these are all going to be managed care pharmacy plans, so the formulary won't be as open as Medicaid. So there may be a lot of drug switching and you know, everybody having to move to a different formulary.*
Dr. Whitsett: *I understand you're going to be talking about that next time, but will those formularies come through us?*
Dr. Nesser: *Nope.*
Dr. Whitsett: *OK . . . I guess. Thank you very much.*
Dr. McNeill: *Is there any pressure from the Federal side to make these formularies match? When we had the HMO that was just such a nightmare. . . what you could get on straight Medicaid, what you couldn't get on Heartland. Are we being faced with that same nightmare again?*
Dr. Nesser: *Yep.*
Dr. McNeill: *Will there be more than one Federal formulary, or is it just . . .*
Dr. Nesser: *There will be at least two PDP's or prescription drug plans in the State, so there'll be at least two formularies that are out there. They probably won't talk to each other and they won't care what's on the other one, so . . .*
Dr. McNeill: *I know this sounds a bit naive, but is anyone going to educate people about these issues, since we are in May?*
Dr. Nesser: *Yeah, I was on a call with CMS, the Federal agency, today. They have just figured out that, you know, we really haven't let the providers in on all this stuff, and so they . . . but there's a bunch of letters, like 41 million letters going out, starting the end of this month, so they thought they might want to get some pharmacists on the phone before the end of May and let them know what's coming, because you know that the patients are going to go to the pharmacies and to the physicians and you know, nobody has any information at this point, because the plans won't even be announced and approved until the middle of September, so nobody will see the formularies until September, and then in October and November, that's when they're going to be getting their letters that they've been enrolled with Plan A, so it's a very tight timeline.*
Dr. McNeill: *And who makes the decisions for people that are not capable of making them for themselves?*
Dr. Nesser: *Whoever their guardian is, so if it's the nursing home administrator, then that's who it is. If it's their son, daughter, niece, whatever. Yeah, it's not going to be pretty.*
Dr. Gourley: *I'm getting questions from my physicians about e- prescribing to you. Is that a done deal, or . . .*
Dr. Nesser: *E-prescribing has some, I mean there's some time for it. I think it's, is it '07?*
Dr. Mitchell: *Each of the plans, each of the PDP's has to put forth kind of a pro forma on how to move towards e-prescribing, but it's over a time frame of a couple of years . . .*
Dr. Nesser: *Yeah, it's not January 1. And it certainly wouldn't be mandatory then.*
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 4: APPROVAL OF DUR BOARD MINUTES
4A: April 12, 2005 DUR Minutes
Dr. Meece moved to approve minutes as submitted; seconded by Dr. Gourley.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 5: UPDATE ON DUR/MCAU PROGRAM
5A: Retrospective Drug Utilization Review Report for February 2005
5B: Medication Coverage Activity Report: April 2005
5C: Help Desk Activity Report: April 2005
Materials included in agenda packet; presented by Dr. Flannigan.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 6: VOTE TO PRIOR AUTHORIZE ANTIDEPRESSANTS

For Public Comment, Dr. Michael Jones: *Thank you Mr. Chairman. I really appreciate the opportunity to come and speak to the DUR. I went to school, got my Pharm.D. right down the road here in Oklahoma and actually went around the corner and paid my pharmacy license in person, the first time in six years. It's a pleasure to be here. I'm also retired at Tinker Field. I'm an ex-US Air Force aviator, and it's just quite a pleasure to come home. What I've really . . . I've read over the minutes of the prior discussions around the antidepressants and what I'd really like to spend my time here is clearly differentiating between the extended release formulation of Wellbutrin® or Bupropion and the other sustained release or SR and their generics and how they differ. And that's really why I want to key in today. It's not about efficacy of the other antidepressants because we've hashed that over and I've read what you guys have talked about, and that's not really the issue. The issue as far as that differentiation is two-fold in my mind, from my pharmacological training. One is a pharmacokinetic issue between those two formulations, and another one, and I really appreciate my NAMI counterpart here. My dad died of mental illness and I've spent the six years of my clinician time in mental health, and we really are not talking about broken bones and lipid levels. This is a horrible disease state and it's very, very tricky. What I'd like to differentiate is some of that pharmacokinetic difference and also compliance. Not convenience, but true compliance in remitting and getting some of these patients to remission. And the first point about the XL molecule itself, or the extended release, which due to unpopular belief in many other states, does not have a generic. SR and the generics thereof are not the generic equivalents of XL. XL has a special formulation which allows one peak and one slow release pharmacokinetically over time. The SR medication was and is designed for BID dosing regimen. Now a lot of times, what you'll find is either through noncompliance or the patient not taking the medication as prescribed, as is the case in over a third of the patients that take the SR formulation, that they're really not getting, say 300 mg, i.e. 150 BID a day, because they're not compliant in taking it. And so it reverts back to really not controlling their antidepressant state because they're on an inadequate dose of medicine. And also conversely, to look at say, was I've seen some clinicians do, and some patients can handle it. I'm not disputing that. But to say dump a whole dose of like a 300 mg amount of the SR type medicine at once, if you look at it pharmacokinetically, it's totally different. It's a totally different peak and trough and when you get into peaks and troughs, we learned it with the SSRI's; we're starting to learn them with some of the non-SSRI's. The more peaks and troughs you have, the more chances you have of side effects and those patients that are a little bit naive with their neurotransmitters, etc., then you're going to have more chance of having problems and them not being compliant and staying on the medicine. So really, the bottom line is XL, Wellbutrin® XL is not the same as SR or it's generic equivalents, nor are any of them the same as the older Bupropion which is also available . . . which was a TID dosing. So what I really want to take my short time is to make that distinction and entertain questions about that and the data we have that does differentiate. And there are other psychiatrists in the room today that would attest to the difference in those modalities of medicine.*

Dr. Whitsett: *Questions? I guess if a person is noncompliant with a once-a-day formulation of a medication, then that still is an issue?*

Dr. Jones: *Oh absolutely sir. Noncompliance . . .*

Dr. Whitsett: *If there's going to be noncompliance on twice a day, you're probably going to be noncompliant on once-a-day, if you're a noncompliant type person.*

Dr. Jones: *Well, from what we've seen from most of the studies where we've gone back and looked at patients that were on the SR formulation, it's been partial noncompliance. If they take that one dose in the morning, they're more apt to take that one dose. A lot of them are asked, of that, I think it was 37% that answered yes, that they weren't compliant. Half of them said that they just forgot to take the afternoon dose. So, it's a little bit deeper issue that that. I wouldn't personally generalize it to a once-a-day noncompliance is the same as a twice-a-day noncompliance, but you're definitely right, sir. Noncompliance on either form of the medication can be detrimental to their disease state.*

Dr. Whitsett: *And so if you're noncompliant for the twice-a-day, you get half your medicine, and if you're noncompliant on the once-a-day, you get zero meds.*

Dr. Jones: *Technically that would be correct, yes sir. I can't dispute that.*

Dr. Whitsett: *Other questions? If not, thank you very much. Next we have Elizabeth Hoefling representing Wyeth Pharmaceuticals.*

For Public Comment, Elizabeth Hoefling: *Good evening. I'm a pharmacist in Global Medical Affairs at Wyeth Pharmaceuticals. I'd like to thank the committee for allowing me to speak this evening. I'm going to provide you with some medical information about Effexor® XR, of venlafaxine XR. During my brief presentation, I hope to convey at least three points to you. Venlafaxine XR is indicated in the treatment of three psychiatric conditions, with once daily dosing across all indications. There's preliminary evidence that venlafaxine provides higher remission rates that what we've seen with studied SSRI's. And venlafaxine has a low potential for drug-drug interactions. Venlafaxine, which is available as Effexor® tablets and Effexor® XR extended release capsules is a dual action antidepressant, who is the first in class serotonin and norepinephrine reuptake inhibitor and SNRI. Venlafaxine has been used in the United States for over ten years and over 10 million patients.. Although the exact etiology of mood and anxiety disorders is unknown, an imbalance of both serotonin and norepinephrine is believed to be involved. Venlafaxine blocks the reuptake of both of these monoamines in the brain. Venlafaxine XR is indicated for the short term treatment of major depressive disorder, generalized anxiety disorder and social anxiety disorder. Venlafaxine XR is the only SNRI with both mood and anxiety disorder indications. And this is important because, clinically, there exists significant comorbidity with both anxiety and depression. Venlafaxine XR is also approved for the 6-month prevention of relapse and the 1-year prevention of recurrence of depression. It's also approved for long-term use in general anxiety disorder patients, up to six months. Beginning in the late '80's, studies and publications began to emerge which suggest that dual action antidepressants may have a slight efficacial advantage over single action antidepressants in some patients with major depressive disorder. Today remission is a therapeutic goal in the treatment of depression. Preliminary evidence in the form of pooled analyses suggests that*

Venlafaxine-treated patients have higher remission rates than studied SSRI-treated patients after eight weeks of treatment. Symptom reduction versus placebo occurred earlier for venlafaxine-treated patients than for the studied SSRI-treated patients. Pooled analysis data has also shown that more Venlafaxine-treated patients than studied SSRI-treated patients had resolution of the painful physical symptoms of depression. There are limitations to these analyses and long-term prospective head-to-head studies, large studies with numerous patients, would need to be conducted to confirm these findings. Venlafaxine XR has once daily dosing across all indications in the clinically effective dosage range, the 75 to 225 mg per day. In vivo data with venlafaxine supports the inhibition of the reuptake of both serotonin and norepinephrine across this clinically effective dosage range. Venlafaxine has a low potential for drug-drug interactions. It has the lowest protein binding of all antidepressants currently on the market, about 27 to 30%, and venlafaxine exhibits mild to weak inhibition of the cytochrome P450 exoenzymes. I've provided you with written documentation which includes important treatment considerations regarding venlafaxine. Also information about adverse events and information about the black box warning which is found in all antidepressants with regards to an increased risk in suicidality in children, adolescents who use antidepressants. Venlafaxine is not indicated in patients less than 18 years of age. This concludes my prepared remarks. I again want to thank you for your time and I can answer any questions.

Dr. Whitsett: *Questions? The short-term treatment is one of your indications and that's for major depressive disorder?*

Dr. Hoefling: *Major depressive disorder, generalized anxiety disorder.*

Dr. Whitsett: *. . .and does that cure it in the short term, or do you have to abandon it and go to something else?*

Dr. Hoefling: *Well, our original clinical studies were done. They were eight to twelve weeks in duration and then we've also conducted long-term clinical trials and we've had 6-month prevention of relapse and a 1-year prevention of recurrence of depression.*

Dr. Whitsett: *So your recommendation would be that after, I guess the short-term treatment would be 12 weeks, that one stop it.*

Dr. Hoefling: *No, no. We're indicated or we have approved for the up to 6-month prevention of relapse and also 12-month prevention of recurrence. Patients who have depression normally need longer term treatment so they can be treated until remission. So our original registration studies were short-term studies, then we realized that there was a need to have long-term studies with venlafaxine in order to see if it would help get patients, past response actually, into remission, and that's why those long-term clinical studies were . . .*

Dr. Whitsett: *Are there other questions? Would it be your opinion that venlafaxine XR would be the drug of choice for people with depression?*

Dr. Hoefling: *I can't provide my opinion. I do know that venlafaxine has been used in the United States for over ten years. It's been used in over 10 million patients. There's a lot of data associated with venlafaxine and venlafaxine XR. There's a lot of safety data that's available, post marketing data, so it has been studied extensively.*

Dr. Whitsett: *Any other questions? Thank you very much. Next is Joe Ripperger representing himself. I'm remembering now. Thank you.*

For Public Comment, Joe Ripperger, M.D.: *I don't have any prepared remarks today. I had some prepared remarks last time and I just was asked to come back in case there were any questions from you regarding my comments last time. Remember my main point last time was as a practicing psychiatrist and I practice in Norman, that I wanted to see the SNRI's on Tier 1. That was the main thing that I was trying to get across last time. So I'd be happy to answer any follow-up questions. You had mentioned, Chairman, Mr. Chairman . . . you had asked the person who just spoke her drug of choice and I know she's not a treating clinician, but as a treating clinician, I would say Effexor® for a psychiatrist is considered one of the main drugs of choice, mainly it's, because of what she said, it's been around for ten years, it's an SNRI, it's the first SNRI and we really, I think as psychiatrists, we really would like to see it on Tier 1.*

Dr. Whitsett: *If someone is well controlled on another one, you wouldn't change them over to . . .*

Dr. Ripperger: *No. No we wouldn't do that.*

Dr. Whitsett: *Would you quarrel with someone who wanted to try one of the others, that in their experience seemed to be efficacious and reasonably safe, or do you think that it's far superior to the others and leave them in the dust.*

Dr. Ripperger: *Well I wouldn't, I don't think that I would say it's far superior. If you look at the data that she was describing, it's about; remission rates are about 8 to 10% advantage. So there's definitely an advantage in the literature. You know, it's not a far superior, we're not looking at a 50% or a 100% advantage, we're looking at a 10% advantage.*

Dr. Whitsett: *In your estimate, and you probably have patients referred to you that are, have very serious forms of depression. I don't know what in general public that are treated for depression which I suppose primary care physicians probably treat more, hand out, prescribe more antidepressants than psychiatrists.*

Dr. Ripperger: *That's true.*

Dr. Whitsett: *But you probably treat maybe the ones that they can't handle. So they're referred to you as a consultant. Now, so, large number who do not have, maybe the majority, at least in my experience, people who receive antidepressants do not have a life-threatening kind of, form of depression, but it's to some degree modifying their lifestyle, their relationship with the family, the relationship at work, and all the aspects of a . . . person. They, they modify that, influence that, but it's not like they're suicidal, not like they're so disruptive that they can't carry out their job. So I guess, I don't know if there's a question in here but just seems like there are a lot of people who do not have a major life-threatening form of depression that you'd better hit a home run on the first pitch or you're not going to have another chance.*

Dr. Ripperger: *Well I think that your, your point is well taken and I understand what it is you're trying to say. I mean, when we look at depression, we classify people as moderately depressed, mild, moderately or severely depressed, and I think what I'm hearing you say is that a lot of primary care physicians will treat patients that are in the mild depressed range and do they need an SNRI for mild depression. And that, that issue comes up. I mean, we, if, if, if the depression is moderate to severe, I think most psychiatrists out there would say that we're going to use an SNRI. Now your question is, what about the mild cases. And it's*

controversial. I mean I think you have to take cost into it and I know that you are, and I know that this is a lot of, it's cost driven. What do you do with a mild depression patient? Do you try something that we know is not as efficacious first? And that's the question we're asking. I think the, our opinion is you use the best drug you have and hopefully you reach remission quicker, you have less chance of permanent damage to the brain and what we're trying to, that's what I'm trying to do in maybe in this forum and in other forums, trying to educate people about the seriousness of chronic low grade depression that isn't in remission. That has been the rule in treatment and in primary care over the years, because there hasn't really been a really good measure to know when somebody has reached remission. As when I go around and talk to primary care physicians, a lot of them don't know how to know whether someone has achieved remission because I will ask that question. And what we know with, say, the SNRI's, at least the preliminary reports that were mentioned earlier, is that people reach remission quicker and they have, they have a little better remission rates, and that therefore, those studies followed up, looks at, you have less chance of relapse. Now the advantage and I want to be straight with you all, I mean the advantage isn't huge. It's about an 8 to 10% advantage. But I guess we'd like everybody to have that advantage.

Dr. Graham: *Dr. Ripperger, the last time you were here, I think I'd asked you a question about what you used prior to SSNRI's and I think one of the things that you had related in the notes that I was looking here, that you said that psychiatrists won't give tricyclics to anybody who they think is risk for suicide, whereas with Effexor® and Cymbalta®, that suicide risk is no longer there. Is that, is that accurate?*

Dr. Ripperger: *Well, what I meant to say there is that if we see a patient who has the risk of suicide, we're not going to give them an antidepressant that is lethal in overdose. And tricyclic antidepressants are lethal in overdose. Venlafaxine and duloxetine are not lethal in overdose. That's what I meant to day.*

Dr. Graham: *OK. But the suicide risk is still there though?*

Dr. Ripperger: *The suicide risk is there in severe cases. Suicide risk is not there all the time, but you know, about, I mean the statistics are fairly dismal if you look at mood disorders in general. It's worse for bipolar disorder, but even for unipolar disorder, suicide rates for lifetime rates of mood disorders like major depressive disorder is 15%. It's a lot higher than what we recognize. I mean, if you look at just the sheer numbers, and studies vary, but we're talking about 30,000 – 40,000 people a year die from suicide in this country.*

Dr. Whitsett: *Even on treatment, or people who've gone off treatment?*

Dr. Ripperger: *Well, I don't know that the studies have broken down who got treatment and who didn't. That's just how serious the problem is. And that's why when you say, you know, people will argue with, well what's a 10% advantage? Well, 10% of 30,000, that's 3000 people.*

Dr. McNeill: *Have you seen the College of Pharmacy's recommendations this month? Have you had a chance to look at this sir?*

Dr. Ripperger: *The new tier?*

Dr. McNeill: *Right. These have changed somewhat from last month.*

Dr. Ripperger: *I know that now you only have to fail one Tier 1 drug to get to a Tier 2. And I'm thrilled about that.*

Dr. McNeill: *Well, I mean there are some other changes on here that . . . look a lot more appealing than they did last month. And I wanted to get your opinion on these changes in the context of what, what the Health Care Authority and this Board is faced with in terms of budgetary constraints and where these drugs are falling out in Tier 1 and 2. If I could get your opinion on that.*

Dr. Ripperger: *Now this looks to be similar. The only difference is the, is the number of failures, isn't it? Isn't it the same, the Tier 1 and the Tier 2, the same . . .*

Dr. Graham: *The last statement I believe is different. If you'll look at the last criteria.*

Dr. Nesser: *Yeah, the tiers are probably still the same.*

Dr. Ripperger: *Number 5.*

Dr. McNeill: *Number 5 . . . yeah.*

Dr. Ripperger: *That's good. I like 5. Does that mean like a psychiatrist could ask for it specifically?*

Dr. Whitsett: *Well, I don't think you'd have to be a psychiatrist. I think . . .*

Dr. Graham: *If you had a special case, you know.*

Dr. Ripperger: *Maybe if you had a suicidal patient or somebody who needed the Tier 2 drug then you could appeal for that? And what that require? A letter? Or . . .*

Dr. Graham: *Just a petition basically. The petition would have to have the information on it, but other than that, that's about it.*

Dr. Whitsett: *Communicate that to the pharmacist and stop re-writing it on the prescription. It would need, the pharmacist would need . . .*

Dr. Ripperger: *Think we'd want, I mean, the main thing on that would be making sure that the clinicians are aware of how exactly to do number 5. You know the doctors, my concern on this, I'm glad I know about this because I'll probably use it, but my concern of course is that doctors are so busy, they're not going to take time to stop and do that. But I guess if it's, if it's enough of a concern for them, they should. I think that's, I mean this is a huge step forward, because you're really saying, hey, we're willing to make an exception.*

Dr. Whitsett: *If this were to become a policy, certainly we'd let pharmacists know because sometimes pharmacists have wrong ideas, too. They think something's not covered when it is under special circumstances, and how often can you remind people of this? Send out a letter to doctors . . .*

Dr. Meece: *Just fill out a PA form . . .*

Dr. Whitsett: *. . . so an attempt would certainly be made to make these policies available and to, and then our pharmaceutical colleagues, and maybe colleagues also are out there reminding people and informing people that, that there are ways in order to more efficiently, more effectively, treat those individuals who have a genuine severe urgent kind of need.*

Dr. Ripperger: *You know, I have one suggestion and although I don't know if you can implement such a suggestion given, given how you would actually monitor it, but one of the things about psychiatrists as you mentioned, we see more difficult cases. Maybe*

you could have in number 5 saying not only a unique patient specific situation, say for primary care, but maybe those that are seeing psychiatrists or specialists, you know, would have. . .
Dr. Graham: *I think that would carry a lot more weight, you know . . .*
Dr. Ripperger: *Because you know, I don't think it's going to cost you that much more money to allow psychiatrists because you're looking at the percentage of prescriptions for antidepressants, we're probably at 15%. If we have the ability to be able, and we are the ones that are seeing the suicidal patients, and the ones that we really need to bring out, bring out the big guns on.*
Dr. Le: *We did consider that because it was raised by a Board member. We were afraid, some parts of Oklahoma they wouldn't have . . . access to a specialist, so we didn't want to make it too stringent.*
Dr. Ripperger: *But could you say like a unique patient specific situation, or seeing a psychiatrist?*
Dr. Whitsett: *Under the care of a psychiatrist. That would be a reasonable consideration.*
Dr. Graham: *Add that to that statement.*
Dr. Whitsett: *I suspect that you will see this patient and prescribe venlafaxine XR and they're all better, by the way, and you send them back to their primary care physician and then . . . deal with the issue that . . . that you've already initiated in your name, then we continue the perpetuity for whoever . . .*
Dr. Ripperger: *Most of the time, the way it works, those doctors, once they send them to you, we keep them . . . many times.*
Dr. Hollen: *Dr. Ripperger, on point 1, are you pretty comfortable just to get a provider's feedback with regard to the recent four week trial and how do we, how are we going to define recent?*
Dr. McNeill: *I'm not happy with that.*
Dr. Hollen: *I just would like to have, yeah . . . what are we really saying?*
Dr. Nesser: *We're saying whatever you say. You're the Board.*
Dr. McNeill: *You know what? I'd like to hear what he has to say about that. Item number one, I mean if you're on the Tier 1 and you fail, and you, I mean, you would expect you to go straight to a Tier 2 without a gap in treatment, but if there is a gap . . .*
Dr. Ripperger: *I don't number one is clear that you're talking about a failure on a Tier 1 . . . it doesn't say failure, does it?*
Dr. Meece: *No, it says trial.*
Dr. Ripperger: *It says a trial . . . it doesn't say failure.*
Dr. Whitsett: *Yeah, and that could be a little clearer. I mean, that's sort of implied I think, but . . .*
Dr. Meece: *You wouldn't prescribe a Tier 2 unless . . .*
Dr. Ripperger: *I'd say a trial failure after Tier 1 run of medication.*
Dr. McNeill: *So if you failed a trial in January, how . . .*
Dr. Hollen: *And it's May.*
Dr. McNeill: *And it's May . . . and you go back to see your physician, now are you eligible for a Tier 2, or do you have to go back to square one? That's what . . .*
Dr. Ripperger: *I read it that you would be eligible for Tier 2 at that point, because you've already failed a Tier 1. You're not saying four consecutive weeks . . .*
Dr. McNeill: *Well, failed a Tier 1 at any time in your life is what . . .*
Dr. Whitsett: *Well, that's the difficulty. I think that's why they've said probably recent there, just so you don't cover the outside possibility of some remote time. Recent could be, I think if you're going to split hairs, if you've a patient who you think . . .*
Dr. Graham: *Just about everybody's tried Elavil® at one time or another.*
Dr. Nesser: *Well, there's twenty Tier 1's and there's only five Tier 2's, so you know, there's twenty different choices even in Tier 1, so I don't, I mean I think we're putting too much emphasis on these few drugs that are on Tier 2. I think there's lots of good choices on Tier 1, so I mean I think we can make that first statement "recent", how ever you want it to be, if you want to say six months, you want to say six weeks, whatever you want to say, we can say that, but I think we need to just realize that there's twenty drugs on the Tier 1 and there's only five on Tier 2, so there's some options.*
Dr. McNeill: *Well, these guys aren't here because of the Tier 1's.*
Dr. Nesser: *Well, I know they're not, but we're not here for them either. We're here for . . .*
Dr. McNeill: *I say six months . . . six months.*
Dr. Nesser: *OK, then . . .*
Dr. Gourley: *Well what if you're treating, you could be treating like a situational depression, say. Somebody lost their spouse or something like that. That could be a temporary situation. But if you're treating truly depressed people that are going to have it all the time, they're going to seek assistance, not six months later.*
Dr. Hollen: *Not necessarily true. Patients get really frustrated and they fall through the cracks and . . .*
Dr. McNeill: *Good gosh. The people that come in our clinics?*
Dr. Ripperger: *Yeah, I would agree. I mean that, what, what people do is they'll take a . . . let's say they take a Tier 1 and they'll have really bad side effects from it . . .*
Dr. Hollen: *Adverse event.*
Dr. Ripperger: *. . . and they think all of the antidepressants are the same. They don't go back to their doctor and say hey, are the side effects different on these different antidepressants . . they just assume they're all given, have the same side effects and sometimes they'll, they won't come back for two or three months until they're really more depressed and where they feel like they're desperate and then they'll walk back in.*
Dr. Gourley: *We're still talking about recent, recent period of time though. We're not talking about years. We're not talking about like two years ago they failed a Tier 1 and now . . . you know, I mean . . .*
Dr. Nesser: *Right. And when they go to Medicare, they won't be able to get any Tier 2's anyway, so . . . everybody's changing in January, so . . . yeah.*
Dr. Meece: *It'll be what, September . . when would this . . .*

Dr. Nesser: *This will go in October.*
Dr. Hollen: *So none of the PDP's are going to carry any of the Tier 2's? Is that what you just said?*
Dr. Nesser: *We're don't know what they're going to carry, but they're all going to have the option of not carrying them.*
Dr. Hollen: *Absolutely.*
Dr. Nesser: *So . .*
Dr. Meece: *So actually we're looking at a 2-month program.*
Dr. Nesser: *Probably.*
Dr. Gourley: *Would you say six months? I mean is that what you said?*
Dr. McNeill: *. . . two months?*
Dr. Ripperger: *What you're saying is recent – parentheses – within six months?*
Dr. McNeill: *That's correct.*
Dr. Hollen: *And it's a 4-week trial, is that a good time frame?*
Dr. Ripperger: *I think that's . . . fair.*
Dr. Hollen: *OK. And then, adverse events . . . where is sexual dysfunction going to be, because a lot of times, that's going to be a major complaint that patients have with any antidepressant therapy, is sexual dysfunction going to be considered an adverse event that would justify going from Tier 1 to Tier 2?*
Dr. Le: *Regarding sexual adverse events and in the context of Effexor® XR, we would certainly consider it for Wellbutrin® because they do show a lower percentage of sexual adverse events. As for Effexor® XR, they actually have a similar to or even higher rate of sexual adverse events than SSRI's, so I wouldn't see why anyone would go to one that's pretty high to another that's pretty high. But certainly for Wellbutrin® XL, they do have lower rates and we will consider that as, as an exception.*
Dr. Hollen: *What about the other Tier 2's?*
Dr. Le: *Duloxetine? I'm not sure if the rates for duloxetine . . .*
Dr. Chonlahan: *It's similar to Effexor®.*
Dr. Le: *Yeah.*
Dr. Hollen: *Are you sure about that?*
Dr. Chonlahan: *A four to eight week trial is very short . . . so they couldn't evaluate extensively on. .*
Dr. Hollen: *You might want to go back and look at that.*
Dr. Chonlahan: *I did have one question on your comments earlier about Effexor®. You said there was . . . lethal doses were not a worry in Effexor® and duloxetine. Is that correct and can you clarify?*
Dr. Ripperger: *I'm not aware of serious overdose potential with Cymbalta® and Effexor®.*
Dr. Chonlahan: *At a high dose, doesn't it have a cardiovascular risk with the Effexor® or . . .*
Dr. Ripperger: *Are you talking about blood pressure elevation?*
Dr. Chonlahan: *Cardiac events.*
Dr. Ripperger: *The only serious side effect that I'm aware of is mild blood pressure elevation.*
Dr. Hollen: *Do ya'll know on that? With overdose with Effexor®, are there any major . . .*
Dr. Hoefling: *At this point, we've, it's, we haven't established a trend... post-marketing surveillance and that sort of thing would show increased potential with, with overdose, but there have been reports, you know in some cases there have been reports of cardiovascular events.*
Dr. Ripperger: *Much of that data, though, if you analyze it, is usually people take multiple drug overdoses. I mean when you look at these cases where someone has died from a, say a drug overdose and Effexor® is one of the drugs that they took, that's the problem is both. You know one thing, I just, I was just trying to differentiate. There's a, there is a significant difference between the tricyclic antidepressants and, and the new SNRI's, is that all the tricyclic antidepressants are lethal in overdose.*
Dr. Whitsett: *Are there other questions? If not, thank you very much. So, Dr. Chonlahan . . . you want to review these items with us?*
END OF PUBLIC COMMENT
Dr. Le: *These are the recommendations that were changed, and as you noticed, the changes were on number 1 and number 5, and we've discussed that at length. Was it right that the Board wanted to include just for psychiatrists on number 5 or," or" . . .*
Dr. Whitsett: *Item number 5, it is item number 5 . . . "when a unique client specific situation exists or prescription by a psychiatrist".*
Dr. Nesser: *Yes, "or", yeah.*
Dr. Whitsett: *And number 1 was "recent in parentheses, within six months".*
Dr. Le: *And failure.*
Dr. McNeill: *And failure, yeah.*
Dr. Whitsett: *Yes, correct.*
Dr. Le: *OK. There was a lot of discussion last time as well as this time about the efficacy of certain Tier 2 drugs compared with our Tier 1 drugs and we propose which mostly is the SSRI's because you really wouldn't start someone on TCA right now, because they are recommended as first line. So I did some looking up of some clinical evidence about the efficacy of Venlafaxine in particular, because that was the drug of interest and fluoxetine, but . . . did you have a question?*
Dr. Hollen: *I'm sorry. Is it, are we talking the Venlafaxine short acting or . . .*
Dr. Le: *Oh, oh. I have those. Venlafaxine short and long acting. There were several meta-analyses that came across but they weren't all-inclusive of all the trials that are out there and I found this. This is the Drug Effectiveness Review Project done by the Oregon Health Sciences University. They have a list of all of the trials and they've, and not a meta-analyses, so you could see each trial and a result of that trial. And as you can see, these first ones, I list them by year that they came out, the trial, and as you can tell when you're evaluating efficacy, there is, you look at the onset of response, which is a timed response, the rate of*

response, which is how many people respond to that drug, and the rate of remission is how people, how many people maintain that response. And please keep in mind that these three factors are not intertwined. Like for instance, a drug may have a faster onset of response, but may not result in a higher rate of remission. So keep in mind as you're looking at these, and first one, there are four trials and one done by Dierick found a higher rate of response for venlafaxine over fluoxetine and two, Tylee and Costa found no difference between venlafaxine versus fluoxetine and Alves found that faster onset of response of venlafaxine compared to fluoxetine. And moving on to 2000 Ballus found no difference compared to paroxetine and Mehtonen found a high response for venlafaxine compared to sertraline and De Nayer found greater improvement. I think that's overall in that, in the assessment scales . . . greater improvement with venlafaxine versus fluoxetine. And progressing through the years, these are all the venlafaxine XR's compared with paroxetine, fluoxetine and the newer ones Allard, Montgomery, and Bielski were not included in the trial because they came out after, just recently in 2004, but they were against Celexa® and Lexapro®, and those found no difference between XR and the extended release formulation, and these Tier 1 agents that we have.

Dr. Hollen: *Can you tell us with regard to dosing, now I mean the one thing about venlafaxine is oftentimes, the dose needs to be titrated, so depending on the duration of the study or the trial . . .*

Dr. Le: *Yes.*

Dr. Hollen: *. . . some of these other agents you can actually potentially start the patients at a therapeutic dose, so at no difference if enough time was not given for the study . . .*

Dr. Nesser: *They were peer reviewed.*

Dr. Le: *They were, all the trials, the reason why I chose the Oregon project was because they're, they are a group that actually performed their own intention to treat analysis to see if the trial was properly powered to find out the results they were looking for and most of these trials are on a, the physician that is treating can titrate the dose up by response, so it wasn't a fixed dose trial. Most of them weren't. And the, the regular, the immediate release for mostly 75 mg BID and XR, they started at the lower dose and they could titrate up to 150 mg. And I know the, for sure, the Celexa® and the escitalapram ones were dose titrated to response. So if the client was started on 75 mg XR and did not respond, the physician had it in their power to titrate it up to the higher dose. So this is the data about the effectiveness of venlafaxine versus the Tier 1 SSRI's. And now Metha (Dr. Chonlahan) will present the adverse effects.*

Dr. Chonlahan: *I'd just like to mention one thing. Ms. Hollen asked me about the sexual side effects and with that particular side effect you'll have some inconsistencies with reporting. That's one thing with the short-term trials and the pre-clinical; you can't really weigh a lot of the data sufficiently, because of the lack of reporting. I mean, it's an embarrassing side effect and not a lot of people are going to admit to it. So I mean, that's something you have to also concern, I mean consider, when you look at the data. I want to begin with just like a mention of the overview of the neurotransmitters involved. As you can see, it's a very complex triad of major depressive disorder. There's serotonin, norepinephrine, dopamine, that are involved here. Patients have achieved remission with single acting agents, but some require that additional mechanism to get over the hill, or push them over the edge to get to remission and they require that multi-acting antidepressant, but not all require the multi-acting antidepressant. As you can see, tricyclic or as you are aware, tricyclic antidepressants effect serotonin, norepinephrine and dopamine in some cases. Some tricyclics only affect two neurotransmitters which is an important distinction when considering side effects and long-term treatment outcomes. SSRI's, primary use selected for serotonin which is generally considered the first line agent, according to the APA and dual acting antidepressants have various combinations of effecting neurochemical targets as well as combination of neurotransmitters but most commonly they affect norepinephrine and serotonin. This chart just basically describes the relationship between selectivity and tolerability of antidepressants. As you can see, dual acting and tricyclic antidepressants affect serotonin and norepinephrine, and SSRI's affect serotonin. As an antidepressant affects more than one transmitter, you have to consider there might be a more broader side effect profile, withdrawal syndrome might be increased because you're affecting two neurotransmitters and you have to be aware that the more you affect, the more side effects, basically. And this is just a chart. It's hard to read. I apologize, but it's basically showing a chart of adverse effects that may cause a patient to discontinue therapy. We've been talking about remission, compliance . . . I think this is probably an area that is a big concern. As you can see, dual acting and tricyclic antidepressants have a cardiac component which I did bold here but you cannot see it very clearly, but there are instances of increased heart rate, hypertension and hypertension with the dual acting tricyclics. And also urinary hesitancy or urinary retention is another concern that SSRI's don't have. You have mydriasis which is concerning glaucoma with Duloxetine. Those are kind of unique side effects for those particular drugs that you should consider before recommending or prescribing these medications. And in conclusion, just safety news, Duloxetine has been withdrawn for FDA approval for stress urinary incontinence due to the lack of data package or safety and efficacy data. And also in the United Kingdom, Venlafaxine now requires labeling for cardiovascular risks and prescribing solely under a licensed psychiatrist. So obviously, there's some concern there or they wouldn't draw attention to these side effects and other compliance and remission issues. This concludes my presentation. I'll take any questions if you have any.*

Dr. Le: *And now I'll do some concluding statements. This is a tier list that you have in your handout and you notice there are twenty-two Tier 1 agents and basically only five agents on the Tier 2 list, that does not have a Tier 1 component like the serotonin has Fluoxetine and liquids of Celexa as well have a Tier 1 dosage that they can use. And the nefazodone and the MAOI's are on Tier 2 because of safety reasons. And that just leaves really Duloxetine, Venlafaxine and Bupropion. And I would like to remind everybody that no product is safer than any other when it comes to increasing the risk of suicidal tendencies. That has been established by the FDA and that therefore all these agents, every single one of them, have a black box warning on them when it comes to suicidal tendencies in pediatric patients.*

Dr. Whitsett: *Are there questions? If not, thank you very much. The recommendations have been submitted with the modifications that we have made and discussed previously. Is there a motion in that regard?*

Dr. Robinson moved to approve the PA for antidepressants as indicated by underline below; seconded by Dr. McNeill.

1. Approval of tier-2 after a recent (within 6 months) 4 week trial and failure on a tier one medication. (Remainder of criteria 1 is as submitted in the agenda packet)
2, 3, 4 as submitted in the agenda packet.
5. A petition for a tier-2 medication may be submitted for consideration when a unique client specific situation exists or prescription by a psychiatrist.
Materials included in agenda packet; presented by Drs. Le and Chonlahan.
ACTION: MOTION CARRIED.

AGENDA ITEM NO. 7: 30-DAY NOTICE OF INTENT TO PRIOR AUTHORIZE ZELNORM®
Materials included in agenda packet; presented by Dr. Browning
Board members discussed College of Pharmacy recommendations and change proposals to recommendations. Dr. McNeill requested less complicated criteria for PA requests. The College of Pharmacy will revise criteria and present it at the next meeting.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 8: 30-DAY NOTICE OF INTENT TO PRIOR AUTHORIZE NIRAVAM®
Materials included in agenda packet; presented by Dr. Browning.
Board members discussed College of Pharmacy recommendations and change proposals to recommendations.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 9: 30-DAY NOTICE OF INTENT TO PRIOR AUTHORIZE SYMLIN®
Materials included in agenda packet; presented by Dr. Patel.
Board members discussed College of Pharmacy recommendations and change proposals to recommendations. Dr. McNeill suggested that the prior authorization criteria should clarify the non-compliance of insulin use and glucose monitoring. He also suggested that the age be clarified in pediatric use. The College of Pharmacy will revise criteria and present it at the next meeting.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 10: REVIEW & DISCUSS ANTIHYPERLIPIDEMIC UTILIZATION
Materials included in agenda packet; presented by Dr. Le.
Board members discussed College of Pharmacy recommendations and change proposals to recommendations.
ACTION: NONE REQUIRED.

AGENDA ITEM NO. 11: REVIEW & DISCUSS ELIDEL® AND PROTOPIC®
For Public Comment, Dr. Mark Naylor: *Hi, I'm Mark Naylor, I was with the university for many years I'm now with the Oklahoma Medical Research Foundation, I'm a tumor biologist and a dermatologist by training. And I do experimental therapy on melanoma and tumor biology things so tumors are kind of my specialty. I would like to at least discuss the black label warning that the FDA has proposed for this drug and speak on the safety issue of these drugs. These... Elidel® / Protopic® are topical calcineurin inhibitors which are used to treat rashes ... atopic rashes, exhibitous rashes and one of the advantages of these drugs over the traditional topical steroids is they are safer drugs. So, they actually have gotten fairly popular with family practitioners and other non-dermatologists even more so than with us as specialty. The FDA had some concerns presumably about safety and proposed this black box warning against these drugs. I actually was the scientific consultant at Fujisawa before they changed their name to ... I'm not sure what Fujisawa is called, they just changed their name...what is it? Astellas? They are the makers of Protopic. So, I actually had a chance to go over the safety data in great detail over the last five years from Fujisawa which is the first company that came out with one of these drugs. And based on my review of all their data the...because the question was whether or not these drugs increased the incidence of skin cancer and cutaneous lymphomas or lymphomas related to immunosuppression. And at least Fujisawa's data did not support this, in other words, you can't tell the cases that occurred in the treated patients from the background general population cancer rate, so our conclusion, which we are trying to get published right now in peer review, is that basically they don't effect the skin cancer rate. Which makes sense because if immunosuppression, systemic immunosuppression, is the major risk here, which is what the general belief is, cyclosporine which is a calcineurin inhibitor given to transplant patients clearly causes systemic immunosuppression and clearly increases the rate of skin cancer. In fact, most immunosuppressive therapies that are given systemically do. But these topical agents don't do that. So, there is no real mechanism proposed by anyone for how this might happen other than systemic immunosuppression, which these drugs don't cause. There is no evidence that they cause systemic immunosuppression, their*

effects are just local, they do not affect the skin cancer risk rate as far as we can tell from Fujisawa's data which is more extensive than Norvartis's data. So, the FDA in spite of all that has come out with this suggested black box warning, or I guess they have actually done that, or I'm not sure if it's final yet, but... and I'm not real sure why that is, because presumably they are concerned that people getting these drugs are going to be at greater risk for skin cancer than if they don't use them and I don't think the evidence supports that. I think also organized dermatology has sort of come out against this as well. Most of our professional organizations who've looked at this don't think that this is a real issue. It appears the FDA is doing this for reasons other than public safety. That is what it looks like to us, so from the safety point of view, these drugs are probably safer than topical steroids; they are less immunosuppressive than topical steroids and have a safer side effect profile than topical steroids. There may be an issue with cost, but you know I think that's a separate thing, I mean that's maybe for you guys to talk about. But as far as safety, I don't quite see the point here with the FDA. So, from the standpoint of safety, you know if you reduce the availability of these drugs, let's say to people who have rashes or family practitioners who are treating people with rashes I'm not sure you are really enhancing public safety by making them switch to topical steroids. Or is you require they come see us for example for use of these drugs, means that family practitioners have less tools to use, and the tools that they use won't be as safe – mainly the old-fashioned topical steroids. So, and there's a shortage of dermatologists anyway, so I don't think these are necessarily good things for public health that you know you put it in a bottle and for only dermatologists to use this, prescribe these drugs for example, because one of the benefits of these is people who don't maybe have as good a skill at controlling skin rashes with other techniques can just give these drugs to people, family practitioners primarily, and you know, they are fairly safe drugs. So, I don't really support the FDA on this one and I think a black box warning ought to be given in a situation where when you use a drug you for sure are putting someone at risk of some complication like for example Vioxx®. If you use Vioxx® in a patient you know you are increasing their risk of heart disease, and so that justifies, or you know some kind of warning or withdrawal from the market, but in this case, I don't think that is really true, so from a safety point of view, organized dermatology doesn't necessarily support this black box warning, I think most of our ... you know ... like the American Academy of Dermatology are not supporting – that our official stance. So, that's really ... I just had some extemporaneous remarks. I don't really know what you guys are doing with this, but I presume you are wanting to review this because of this black box warnings.

Dr. Whitsett: *Well, using it prior to...you know...for the need to prior authorization. Would you think there are patients out there who you would go directly to one of these agents and bypass topical steroids?*

Dr. Naylor: *Yeah, I think, generally what family practitioners do in case of mild atopic dermatitis is they're going to start one these drugs before they would refer them to us, or ...you know...I think that may be the real issue. The FDA was a little bit concerned with the success with Novartis's sort of direct to consumer advertising, I think if there's an issue here, it may be along those lines, cause the FDA was not thinking of these as first line drugs, but actually I think safety wise...I mean money is a different issue, but safety wise, it's okay to do that.*

Dr. Whitsett: *But topical steroids haven't lost there efficacy?*

Dr. Naylor: *No, they haven't.*

Dr. Whitsett: *And, uh, the safety factor must be reasonably safe. I know ...*

Dr. Naylor: *You're talking about the steroids, you mean? Yeah, they're not drugs that kill people or things like that. I mean most of the side effects are disfiguring stria, steroid thinning of the skin. I mean usually you can't even see much of a problem with suppression of the adrenal cortex and axis. So you don't have major problems with that. We worry mostly about just cutaneous disfigurement with these drugs and bad stria, which can be a problem when people use these drugs willy-nilly without being aware of this stuff. These drugs have less of those issues, which is why they are safer, money aside, they tend to be safer drugs in terms of side effects.*

Dr. Gourley: *The way I read the background information on the cause for this black box warning was the FDA wanted to establish that.*

Dr. Naylor: *Yeah, in other words, they are saying even though the evidence doesn't support this they are worried that maybe in the future...I suppose that is the only way you can justify it.*

Dr. Gourley: *Well, like some your studies that you are wanting to have published and that kind of stuff, once the safety is established, I mean, a lot of this is being used on the pediatric population. But we don't you know...*

Dr. Naylor: *That's true because kids, of course, are the ones you worry more about side effects, although to me, you know, if you're using topical steroids, these are safer drugs, if it was my child, I mean that's just my own personal feelings.*

Dr. Gourley: *Well, I think the way it was detailed was that it was safer and so, it really, the general practitioner saw it as no risk, no concern at all and I think the FDA was concerned about that, as far as it may have some concern. And I am very conservative so I would like to see that it's not a problem.*

Dr. Naylor: *Yeah, it is more a concern that possibly you could...sure...I mean that's, I think that probably is going to be their official stance. I mean, does anybody have any further questions? I'm just a tumor biologist really; I don't really know what it is you want hear.*

For Public Comment, Dr. Evie Knisely: *I want to thank you for the opportunity to talk to you about Elidel®. We appreciate your concerns concerning safety with the population you all serve. Novartis is committed to safety as well and we want the drugs that prescribed that are made by our company to be used appropriately and to be used safely. It is my goal tonight to try to alleviate any of the concerns that you have voiced and to give you the information and the data that you need to make an informed decision. First I want to talk about efficacy and safety. And in the hand out that John passed out. This is an overview of efficacy and safety, but if you will look at the first part talking about efficacy, the drug works very well when all of the different tools that have been used to asses atopic dermatitis or eczema. We have good data to support our efficacy. It also reduces the number of flares and when you talk about steroid use, generally the doctors will give patients a script for both Elidel® and a steroid. And you use the Elidel® for maintenance and when you have a flare, then you go to the steroid. So, generally patients are using both*

and again they are using the steroid for flares and the use of Elidel® greatly reduces the number of flares and we've shown that it in our clinical trials. Quality of life is also significant with this particular disease state because these patients are very uncomfortable and maybe feeling disfigured and feeling unattractive because of the way this disease is displayed on their skin. And certainly the scratching affects what they do, how they sleep, etc. With regards to safety, Dr. Naylor did a great job talking about some of the FDA concerns and I just want to expound on that a little bit. But the adverse event profile with these drugs is comparable to placebo in the clinical trials. Blood concentrations were routinely undetectable. That's less than 0.5 nanograms per ml. And there is no sign of systemic accumulation with topical use over time. The clinical experience with Elidel® is on the second page of your handout if you will look there. You can see that this drug has been widely used, 19,000 patients in the clinical trials and in clinical practice and currently the numbers up to about six million scripts. And also of interest is the point that most of the use in our data is intermittent, 45 days out of a calendar year, so most patients aren't using this drug continually. The next thing in your packet is a statement from the American Academy of Dermatology and I think Dr. Naylor eluded to the fact that most of the consensus groups are not in support of what the FDA's doing and you can read in that first paragraph that they say that despite the fact there is no data that proves topical use of Pimecrolimus and Tacrolimus are dangerous to people. They can't support what the FDA is doing. The next thing in your packet is a letter and this is from Dr. Paul Thomas who is affiliated with one of the clinics at St. Francis in Tulsa. And he says, and I quote, if you can read this I know it's a little blurry, "As you know eczema can start early in life and generally affects the face and the groin. Steroids which are effective are not indicated in these areas because they can cause skin thinning Elidel® is an excellent product which does an excellent job controlling eczema and does not carry the risks of skin thinning." The next letter is from Dr. Pamela Anderson who is at the OU Health Sciences Center and she treats multiple Medicaid patients they have clinics that see these patients on a daily basis and she says "not one of these clinics goes by without writing at least five or more prescriptions for Elidel® for Medicaid patients. Its proven safety in the treatment of mild to moderate eczema is compelling and undeniable verses the risk of chronic topical steroids, none of which occur with Elidel® many patients are able to use Elidel® alone especially for facial eczema when topical corticosteroids are limiting. Elidel® aides in transitioning patients off steroids. As maintenance therapy, Elidel® decreases the number of eczema flares thus decreasing the needs for topical steroids." The next thing in your packet is a letter from Dr. Naylor he's already spoken so I won't cover that and then there is also a letter from Dr. Doug Vaughn who is a dermatologist in Tulsa. The last thing I wanted to show you is the SEER data. We talked about the number of cases. And if you will look at the SEER data and that is "Surveillance, Epidemiology, and End Result". And what that shows is the number of Non-Hodgkins Lymphoma cases, what you would expect in the general population, and then what you're seeing with Elidel®. And what you can see is our numbers are not anywhere near what you would expect in the general population. So with regards to the FDA, you have to remember that the committee was impounded to look at...actually to look at pediatric use and they were looking at topical steroids. We would certainly support using our product on label. So, the committee's contention of the FDA was to not use this drug in patients under the age of two. And that is off-label for Elidel®, we do not promote that, and we would certainly support the use of this product. We hope you would keep it first line, but we would certainly support using it on label or via the package insert. Any questions?

Materials included in agenda packet; presented by Dr. Chonlahan.

Board members discussed College of Pharmacy recommendations and change proposals to recommendations. Dr. Whitsett indicated that the approved age for use should be included in the recommendations.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 12: **FDA AND DEA UPDATES**

Materials included in agenda packet; presented by Dr. Graham.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 13: **FUTURE BUSINESS**

13A: Antifungal Review
13B: Estrogen Replacement Products Review
13C: Neurontin® Follow-Up Review
13D: Renal Product Review
13E: Utilization Review Comparisons for Previous Fiscal Years
13F: New Product Reviews

Materials included in agenda packet; submitted by Dr. Graham.

ACTION: NONE REQUIRED.

AGENDA ITEM NO. 14: **ADJOURNMENT**

The meeting was declared adjourned.

The University of Oklahoma College of Pharmacy

Pharmacy Management Consultants
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Oklahoma City, OK 73190
(405)-271-9039

Memorandum

Date: May 26, 2005

To: Nancy Nesser, DPh, JD
Pharmacy Director
Oklahoma Health Care Authority

From: Ron Graham, DPh
Pharmacy Director
Pharmacy Management Consultants

Subject: DUR Board Recommendations from Meeting of May 10, 2005.

Recommendation 1: Vote on Prior Authorization Status of Anti-depressants.
The college of pharmacy recommends placing the suggested dual-acting anti-depressants on tier-2 pending results of long-term clinical trials assessing the long-term efficacy and safety as compared to the older anti-depressants.

Criteria:

1. Approval of tier-2 medication after a recent (within 6 months) 4 week trial and failure on a tier-1 medication. Tier-1 selection can be from any tier-1 anti-depressant classification.
2. Approval of tier-2 medication if there is a documented adverse effect, drug interaction, or contraindication to tier-1 products.
3. Approval of tier-2 medication if there is prior stabilization on the tier-2 medication documented within the last 100 days.
4. Approval of tier-2 medication if there is a unique FDA-approved indication not covered by any tier-1 products.
5. A petition for a tier-2 medication may be submitted for consideration when a unique client specific situation exists or prescription by a psychiatrist.

MOTION CARRIED by unanimous approval.

*Refer to page 2 for table on Tier structure.

Antidepressants*	
Tier-1	*Tier-2*
Dual Acting Antidepressants	
Mirtazapine (Remeron®)	Duloxetine (Cymbalta®)
Mirtazapine (Remeron Soltab®)	Venlafaxine (Effexor, Effexor XR®)
Trazodone (Desyrel®)	Bupropion (Wellbutrin XL®)
Bupropion (Wellbutrin, Wellbutrin SR®)	Nefazodone (Serzone®)**
Selective Serotonin Re-Uptake Inhibitors* **	
Fluoxetine (Prozac®)	Fluoxetine (Sarafem®) Fluoxetine Tablets and 40 mg Capsules
Fluvoxamine (Luvox®)	
Paroxetine (Paxil®)	
Paroxetine (Paxil CR®)	
Paroxetine mesylate (Pexeva®)	
Sertraline (Zoloft®)	
Citalopram (Celexa®)	Citalopram (Celexa®) Liquid
Escitalopram (Lexapro®)	Escitalopram (Lexapro®) Liquid
Secondary Amine Tricyclics	
Desipramine (Norpramin®)	
Nortriptyline (Pamelor®)	
Protriptyline (Vivactil®)	
Tertiary Amine Tricyclics	
Amitriptyline (Elavil®)	
Clomipramine (Anafranil®)	
Doxepine (Sinequan®)	
Imipramine (Tofranil-PM®)	
Trimipramine (Surmontil®)	
Tetracyclics	
Amoxapine (Asendin®)	
Maprotiline (Ludiomil®)	
Monoamine Oxidase Inhibitors	
	Phenelzine (Nardil®)
	Tranylcypromine (Parnate®)

APPENDIX B

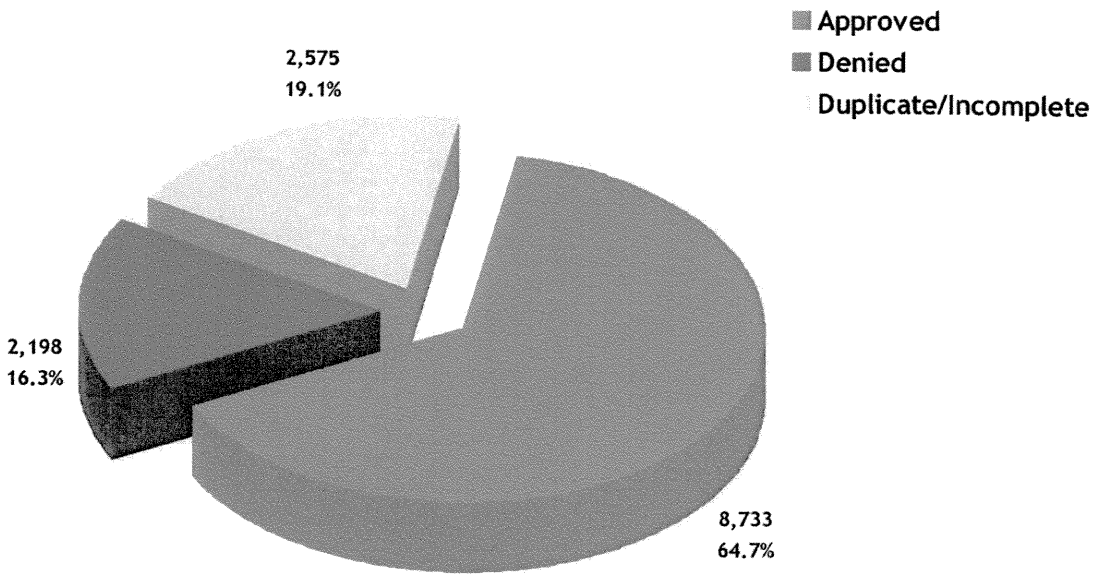
Retrospective Drug Utilization Review Report

Claims Reviewed for March 2005

Module	Drug Interaction	Duplication of Therapy	Drug-Disease Precautions	Dosing & Duration
Total # of messages returned by system when no limits were applied	107,678	106,516	881,604	53,042
Limits which were applied	Established, major, males 50-64 yrs old	Leukotriene Modulators	Contraindicated, pregnant females 13-17 yrs old	High dose, MS Copolymers
Total # of messages after limits were applied	117	54	388	27
Total # of clients reviewed after limits were applied	117	54	259	27

LETTERS			
Prescribers		**Pharmacies**	
Sent	**Responded**	**Sent**	**Responded**
18	4	10	6

PRIOR AUTHORIZATION ACTIVITY REPORT
May 2005



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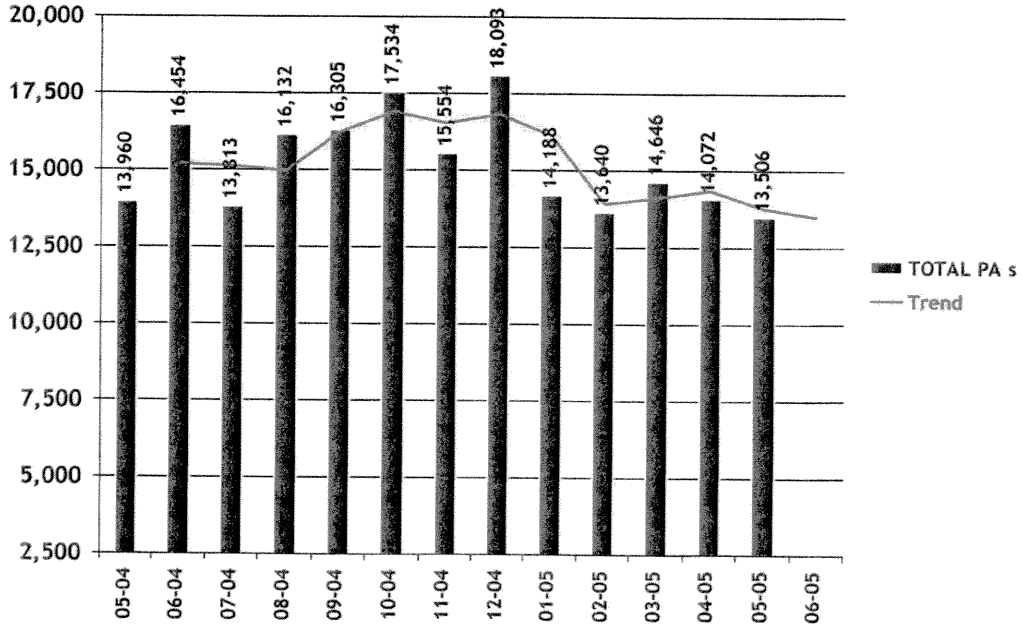
PRIOR AUTHORIZATION REPORT
May 2004 - May 2005



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Activity Audit for

May 01 2005 Through May 31 2005

Date	Antiulcers app.	Antiulcers den.	Anxiolytic/ Hypnotics app.	Anxiolytic/ Hypnotics den.	Antihistamine app.	Antihistamine den.	Growth Hormones app.	Growth Hormones den.	Stimulant app.	Stimulant den.	Nsaids app.	Nsaids den.	ACE Inhibitors app.	ACE Inhibitors den.	HTN Combos app.	HTN Combos den.	Calcium Channel Blockers app.	Calcium Channel Blockers den.	Plavix app.	Plavix den.	ARB app.	ARB den.	Anti-depressants app.	Anti-depressants den.	Daily Total
App.	24		4181		1182		43		875		100		50		6		87		730		28		138		
Den.		6		476		625		1		193		128		44		2		162		102		9		45	
Average Length of Approvals in Days		8		97		97		174		218		305		183		124		311		353		180		106	

Changes to existing PA's	996
Total (Previous Year)	13960

*** Denial Codes**

762 = Lack of clinical information	8.74%
763 = Medication not eligible	2.18%
764 = Existing PA	5.60%
772 = Not qualified for requested Tier	4.96%
773 = Requested override not approved	11.69%

SUPER PA's

Admitted to Nursing Home	132
Early Refill Attempts	51752
Dosing Change	691
Lost/Broken Rx	103
Stolen	31
Other	115
Wrong D.S. on Previous Rx	40
Quantity vs. Days Supply	294
Brand	209
-- Approved	83
-- Denied	52

Monthly Totals

	Number	Percent of Total
Approved	8656	64.09%
Additional PA's	67	0.50%
Emergency PA's	10	0.07%
Duplicates	565	4.18%
Incompletes	2010	14.88%
Denied *	2198	16.27%
Total	13506	100.00%

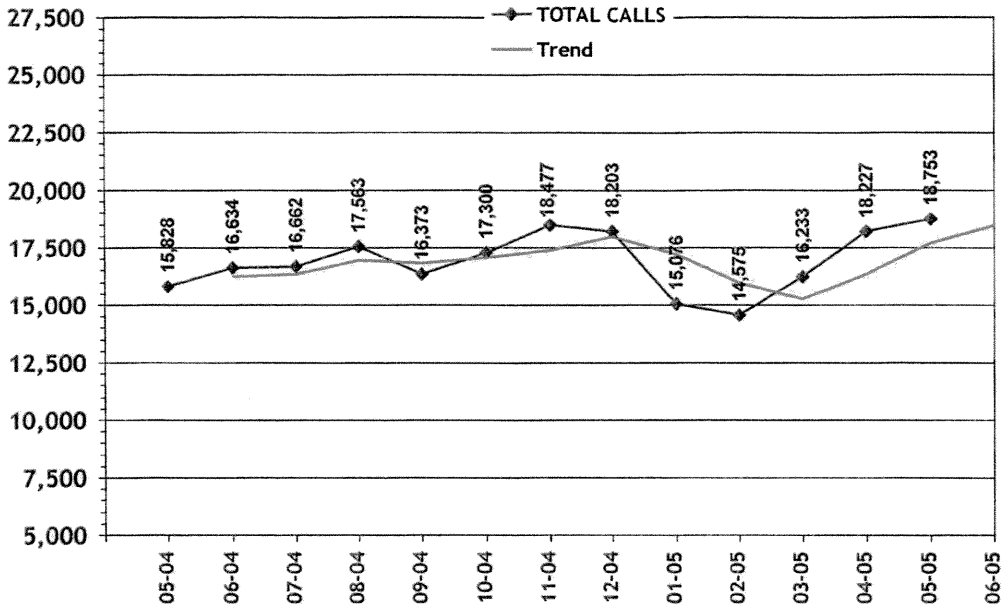
Daily Average of 540.24 for 25 Days

Changes to existing PA's: Backdates, changing units, end dates, etc.

Additional PA's: Done by the help desk (doctor letter responses, PA ran for the wrong person)

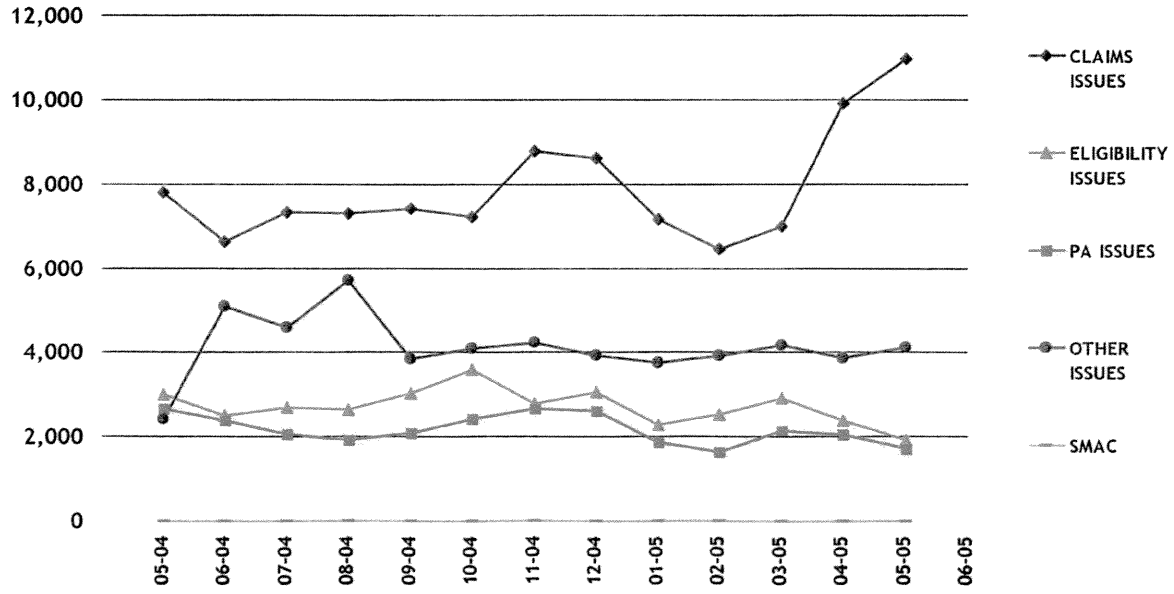
Incompletes: Missing necessary information (NDC, SIG, Diagnosis, etc.)

CALL VOLUME MONTHLY REPORT
May 2004 - May 2005



PHARMACY Management Consultants

CALL VOLUME ISSUES
May 2004 - May 2005



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APPENDIX C

Xolair® Follow Up

Oklahoma Medicaid
June 2005

Current Prior Authorization Category

Prior Authorization of this category was implemented on February 17, 2004. All clients on the medication at that time had to submit a petition for prior authorization to continue treatment.

The criteria are as follows:

1. Client must be between 12-75 years of age.
2. Client must have a diagnosis of severe persistent asthma (as per NAEPP guidelines).
3. Client must have a positive skin test to at least one perennial aeroallergen. Positive perennial allergens must be listed on the petition.
4. Client must have a pretreatment serum IgE level between 30-700 IU/ml.
5. Client weight must be between 30-150kg.
6. Client must have been on high dose ICS (as per NAEPP Guidelines) for at minimum the past 3 months.
7. Medication must be prescribed by either a pulmonary or an allergy/asthma specialist.
8. Client must have been in the ER or hospitalized, due to an asthma exacerbation, twice in the past 6 months. Date of visits must be listed on petition.

Petitions meeting criteria for coverage will be approved for 12 months of therapy. Renewal petitions after 12 months will be assessed for client compliance. If two or more doses have been missed, the client will not be approved for continuing therapy.

Utilization from April 2004 to March 2005

For the period of April 2004 through March 2005, a total of 4 clients received Xolair® through the Medicaid fee-for-service program.

Product	# of Claims	Total Units	Total Days	Units/ Day	Total Cost	Total Clients	Per Diem
Xolair®	28	90	784	0.11	$ 44,872.21	4	$ 57.23
Total	**28**	**90**	**784**	**0.11**	**$ 44,872.21**	**4**	**$57.23**

Total Cost April '04 – March '05	**$ 44,872.21**
Total Cost FY '04	*$ 147,027.15*
Total Claims April '04 – March '05	**28**
Total Claims FY '04	*90*
Total Clients April '04 – March '05	**4**
Total Clients FY '04	*19*
Per Diem April '04 – March '05	**$ 57.23**
Per Diem FY '04	*$ 57.75*

Total petitions submitted in for this category during specified time period:

April '04 – March '05	
Approved	*4*
Denied	19
Incomplete	16

Fiscal Year 2004	
Approved	*0*
Denied	26
Incomplete	13

The table below shows individual clients that were denied for Xolair® and the criteria which were not met.

Authorization Criteria	Client											
	1	2	3	4	5	6	7	8	9	10	11	12
Client age 12-75 yrs	N	D/A			I	I		I		N		N
Diagnosis severe persistent asthma		D/A	N	N	I	I		I			N	
Positive test to perennial aeroallergen		D/A			I	I	N	I			N	
Pretreatment IgE level 30-700 IU/ml		D/A			I	I		I	N	N	N	N
Weight between 30-150kg		D/A	N		I	I		I				
Compliant on high dose ICS for past 3 months		D/A		N	I	I		I	N	N	N	N
Prescribed by pulmonary, allergy/asthma specialist	N	D/A		N	I	I	N	I			N	
ER or hospitalizations		D/A	N	N	I	I		I			N	N

N = criteria not met
I = incomplete, letter of medical necessity not received even after requested.
D/A = client originally denied but approved upon appeal

Claims were reviewed to determine the age/gender of the clients.

Age	FY '04	April '04- March '05
0 to 9	10	0
10 to 19	6	2
20 to 34	2	2
35 to 49	1	0
50 to 64	0	0
65 to 79	0	0
Totals	**19**	**4**

ER and Hospitalization Costs CY'04 for Clients* with Severe Persistent Asthma**

Emergency Room Costs	
Clients	303
Total Cost	$ 29,850.00
Average Cost/Client	$ 98.51
Maximum Cost/Client	$ 1,750.00
Minimum Cost/Client	$ 50.00
Hospital Costs	
Clients	445
Total Cost	$ 681,150.52
Average Cost/Client	$ 1,530.68
Maximum Cost/Client	$ 35,055.84
Minimum Cost/Client	$ 5.68

*Does not include clients in long term care
**Diagnosis of Severe Persistent Asthma was inferred by high dose inhaled corticosteroid use.

Projected Annual Xolair® Costs for Currently Approved Clients*

Projected Xolair® Costs	
Clients	5
Annualized Total Cost	$ 110,524.94
Average Cost/Client	$ 22,104.99
Maximum Cost/Client	$ 38,008.80
Minimum Cost/Client	$ 6,501.47

*Includes cost for client approved after March 2005.

Recommendation

The College of Pharmacy recommends that the prior authorization criteria remain as previously approved.

APPENDIX D

Vote to Prior Authorize Zelnorm®

Oklahoma Medicaid
June 2005

Manufacturer Novartis

Classification FDA classification: 5-HT_4 receptor partial agonist
Status: prescription only

Summary Tegaserod is a 5-HT_4 receptor partial agonist indicated for the treatment of IBS with constipation in women and chronic idiopathic constipation in patients under 65 years of age.

Recommendations

The College of Pharmacy recommends prior authorization be placed on Zelnorm® with the following criteria:

1. Constipation-Predominate IBS in women.
2. Chronic Idiopathic Constipation in males and females who meet the following criteria:
   a. Patient is between 19 and 65 years of age.
   b. Have documentation that constipating therapies for other disease states have been discontinued.
   c. Documented and updated Colon Screening (>50 years of age).
3. For both diagnoses, hydration and treatment attempts with a minimum of three alternate products must be documented.
4. Initial approval for 12 weeks of therapy. An additional year approval may be granted if physician documents client is responding well to treatment.

APPENDIX E

Vote to Prior Authorize Niravam® (alprazolam)

Oklahoma Medicaid
June 2005

Manufacturer Schwarz

Classification FDA classification: Schedule IV, benzodiazepine
Status: prescription only

Summary Niravam® is an orally disintegrating form of alprazolam. It is indicated for the treatment of anxiety (up to 4mg/day) and panic disorder (up to 10mg/day).

Recommendations

The College of Pharmacy recommends prior authorization be placed on Niravam® with the following criteria:

1. Require a PA with:
    a. an FDA approved diagnosis for the use of Niravam®,
    b. a diagnosis indicating that the client has a condition that prevents them from swallowing tablets,
    c. and the physician's signature.

2. Dosing regimens that involve splitting of tablets will not be covered.

APPENDIX F

[redacted]

Vote to Prior Authorize Symlin® (pramlintide acetate)

Oklahoma Medicaid
June 2005

Manufacturer Amylin Pharmaceuticals, Inc

Classification FDA classification: Antihyperglycemic
Status: Prescription only

Summary Symlin® is an injectable antihyperglycemic drug for use in type 1 and type 2 diabetic patients, as adjunctive treatment in patients who use mealtime insulin therapy and who have failed to achieve desired glucose control despite optimal insulin therapy. It is a synthetic analog of human Amylin, a naturally occurring hormone synthesized by pancreatic beta cells that contributes to glucose control during the postprandial period.[1]

Recommendations

The College of Pharmacy recommends the following:

- Require prior authorization for Symlin®
- Patients must meet FDA approved selection criteria:

Patients with type 1 and 2 diabetes using insulin must:

1. have failed to achieve adequate glycemic control;
2. are receiving ongoing care under the guidance of a health care professional

Patients meeting the following criteria should **NOT** be considered for Symlin® therapy:

1. poor compliance with insulin regimen
2. poor compliance with self-blood glucose monitoring
3. HbA1c> 9%
4. recurrent severe hypoglycemia requiring assistance in past 6 months
5. presence of hypoglycemia unawareness
6. diagnosis of gastroparesis
7. require use of drugs that stimulate GI motility
8. pediatric patients (< 15 years old)

APPENDIX G

FACT SHEET

MEDICARE

THE MEDICARE PRESCRIPTION DRUG BENEFIT

March 2005

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L.108-173) gives elderly and disabled people on Medicare access to drug coverage beginning in 2006. Until then, it provides temporary help through Medicare-approved drug discount cards and transitional assistance for low-income beneficiaries. The net federal cost of the new benefit is projected to be $37.4 billion in 2006 and $724 billion from 2006 to 2015 (HHS, February 2005).

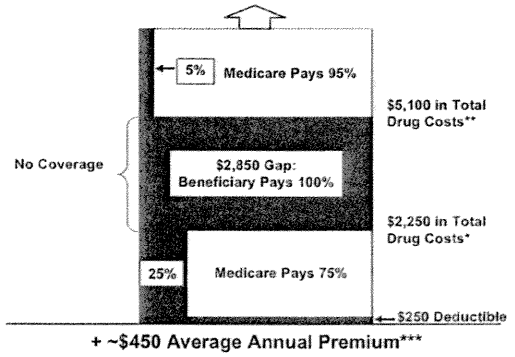
The Part D Prescription Drug Benefit

Beginning in 2006, beneficiaries will have access to two or more plans that contract with Medicare to provide the new drug benefit. Beneficiaries can enroll in new prescription drug plans (PDPs) and get all other Medicare benefits from the traditional fee-for-service (FFS) program, or they can enroll in Medicare Advantage (MA) plans, such as HMOs or regional PPOs, that cover all Medicare benefits, including drugs.

Medicare drug plan enrollees will pay a monthly Part D premium, in addition to the monthly Part B premium, that is set to cover about 25% of the cost of the standard drug benefit (Figure 1). The Part D premium for the standard benefit is estimated by HHS to average $37 per month in 2006 but will vary across plans. Plans can offer either the standard benefit or an alternative benefit design that is actuarially equivalent to the standard benefit and does not increase the standard deductible or the catastrophic threshold.

Figure 1

Standard Medicare Part D Drug Benefit, 2006



*Equivalent to $750 in out-of-pocket spending. **Equivalent to $3,600 in out-of-pocket spending. ***Annual amount based on $37.37 monthly Part D premium estimate from 2005 Medicare Trustees report.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit described in the MMA of 2003.

Standard amounts for deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending. The coverage gap between partial and catastrophic coverage is projected to increase from $2,850 in 2006 to $4,984 in 2014 (Figure 2).

Figure 2

Medicare Part D Premiums and Cost-Sharing Amounts for Selected Years

	2006	2010	2014
Monthly Premium (Estimated Average)	$37.23	$48.94	$64.26
Annual Deductible	$250	$331	$437
Initial Coverage Limit	$2,250	$2,980	$3,934
Coverage Gap (difference between initial coverage limit and catastrophic threshold)	$2,850	$3,774	$4,984

SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Part D Plan Design

Medicare will contract with risk-bearing drug plans in each of 34 regions to provide the new benefit. If two or more risk-bearing plans are not available (including at least one PDP), Medicare will contract with a "fallback" plan to serve beneficiaries in that area.

Plans must cover at least two drugs in each therapeutic class or category of covered Part D drugs, but can establish formularies and tiered cost-sharing amounts as long as they do not "substantially discourage enrollment by certain Part D eligible individuals" (MMA Final Rule, Section 423.272). Part D plans can also establish networks of preferred pharmacies that charge lower cost-sharing than out-of-network pharmacies.

Plans are expected to produce savings by negotiating price discounts and rebates with drug companies; the MMA prohibits Medicare from negotiating drug prices.

Low-Income Assistance

Medicare will provide premium and cost-sharing subsidies to assist low-income beneficiaries (Figure 3). Medicare beneficiaries with Medicaid drug coverage, and QMBs and SLMBs, are automatically deemed eligible for these subsidies. Other low-income beneficiaries will have to meet both an income and asset test to receive additional assistance. Of the 7.8 million non dual eligible beneficiaries with incomes below 150% of poverty ($14,355 for an individual in 2005) who would otherwise qualify for assistance in 2006, CBO estimates that 1.8 million beneficiaries will not qualify as a result of the asset test.

Beneficiaries may apply for low-income assistance at local Social Security or state Medicaid offices.

Figure 3

Overview of Low-Income Part D Benefits, 2006

Low-Income Subsidy Levels	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligible; Income up to 100% FPL ($9,570/individual in 2005)	$0	$0	$1/generic $3/brand-name; no copays after total drug costs reach $5,100
Full-benefit dual eligible; Income greater than 100% FPL	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income less than 135% FPL ($12,920/individual in 2005) and assets <$6,000/individual; $9,000/couple	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income 135%–150% FPL ($12,920–$14,355/individual in 2005 and assets <$10,000/indiv; $20,000/couple	sliding scale up to $35	$50	15% of total costs up to $5,100 catastrophic limit; $2/generic $5/brand-name thereafter
All others (non-subsidy eligible)	$35	$250	25% up to initial coverage limit; 100% up to $3,600 out-of-pocket spending

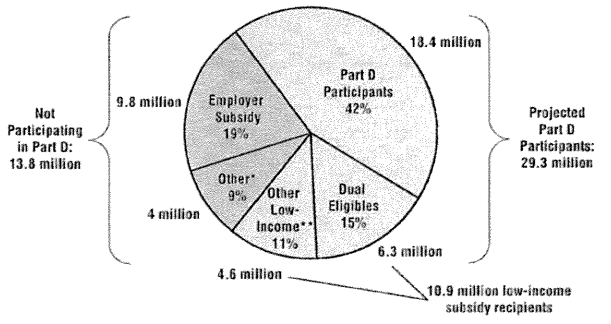
SOURCE: Kaiser Family Foundation summary of Part D low-income subsidies in 2006.

Participation

Of the estimated 43.1 million Medicare beneficiaries, 29.3 million are expected to enroll in Part D plans in 2006 (Figure 4). Of 14.5 million beneficiaries eligible for low-income subsidies in 2006, HHS expects 10.9 million to receive them. Another 9.8 million are expected to receive drug coverage comparable to Part D under an employer plan.

Figure 4

Estimates of Medicare Part D Participation, 2006



Total = 43.1 million Medicare beneficiaries

*"Other" non-participants includes federal retirees with drug coverage through FEHBP or TRICARE, and those who lack drug coverage. **"Other Low-Income" includes non-dual eligibles with incomes <150% FPL.
SOURCE: HHS OACT, MMA Final Rule, January 2005.

Enrollment in Medicare Part D plans is voluntary, however, individuals who delay enrollment after their initial eligibility enrollment period will pay a lifetime premium penalty equal to 1% of the base premium for each month they delay enrollment.

Interaction With Other Coverage

Employer-sponsored plans currently cover drugs for more than 11 million beneficiaries. To encourage employers to maintain these benefits, Medicare will provide tax-free subsidies equal to 28% of costs between $250 and $5,000 in drug expenses per retiree to employers providing drug benefits that are at least comparable to the standard Part D benefit.

Medicaid provides drug coverage for 6.3 million Medicare beneficiaries, known as "dual eligibles." As of January 1, 2006, dual eligibles will get drug coverage from Medicare Part D plans, rather than Medicaid. The HHS Secretary is responsible for automatically enrolling individuals into Part D plans if they do not sign up on their own.

Medicare Advantage plans are a source of coverage for nearly 5 million beneficiaries in 2004 and will be required to offer standard drug coverage in 2006 (except private FFS and Medicare Savings Account plans).

Medigap plans provide drug coverage to less than 10% of the Medicare population. Beginning in 2006, Medigap insurers may not issue new policies that include drug coverage or supplement Part D.

State Pharmaceutical Assistance Programs can continue to provide coverage and can supplement Part D coverage for eligible enrollees.

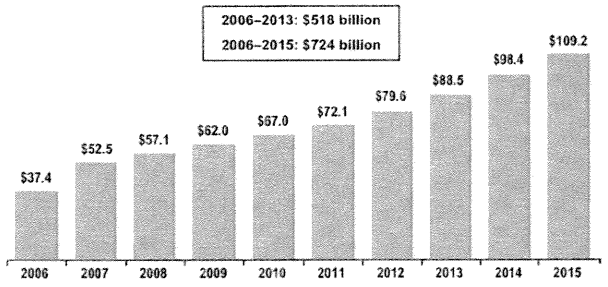
Expenditures and Financing

The net federal cost of the new Medicare drug benefit is estimated to be $724 billion between 2006 and 2015 (Figure 5). Financing for the Medicare drug benefit will come from several sources, including premiums paid by beneficiaries, receipts from states (known as the "clawback"), Medicaid savings, and general revenues.

Future Challenges

Figure 5

Net Federal Cost of the Medicare Prescription Drug Benefit (HHS 2005 Projections)
(in billions)



SOURCE: Administration's FY 2006 Budget.

The Medicare drug benefit offers help to beneficiaries with rising out-of-pocket drug costs, especially those with low incomes, but implementation poses significant challenges for CMS, drug plans, and beneficiaries. Successful implementation will depend on whether new drug plans emerge throughout the country and provide beneficiaries with access to needed medications and a stable, affordable source of drug coverage over time, while controlling rising drug costs. Beneficiary education and counseling will be critical to promote informed decision-making and a smooth transition as the new drug benefit is implemented.

THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

MEDICARE AT A GLANCE

April 2005

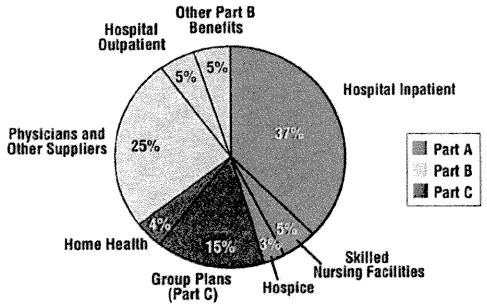
Overview of Medicare

Medicare is the federal health insurance program covering nearly 42 million Americans—35.4 million seniors and 6.3 million people under age-65 with permanent disabilities. Most individuals 65 and older are entitled to Medicare Part A if they or their spouses are eligible for Social Security payments and have made payroll tax contributions for 10 years. People under 65 who receive Social Security Disability Insurance (SSDI) payments generally become eligible for Medicare after a two-year waiting period.

Medicare benefits are expected to total $325 billion in 2005, accounting for 13% of the federal budget (CBO).

Figure 1

Medicare Benefit Payments by Type of Service, 2005



Total = $325 billion

Note: Does not include administrative expenses such as spending for implementation of the Medicare drug benefit and the Medicare Advantage program. Excludes low-income subsidy payments and items not assigned to particular services.
SOURCE: Congressional Budget Office, Medicare Baseline, March 2005.

Medicare's Structure

- **Part A**, the Hospital Insurance program, pays for inpatient hospital, skilled nursing facility, and hospice care. Accounting for 45% of spending in 2005, Part A is funded by a dedicated tax of 2.9% of earnings paid by employers and employees (1.45% each).
- **Part B**, Supplementary Medical Insurance, pays for physician, outpatient, and preventive services. Part B accounts for over 35% of spending in 2005 and is funded by general revenues and beneficiary premiums.
- **Part C** refers to private Medicare Advantage plans, such as HMOs, that provide Part A and B benefits to enrollees (Part D beginning in 2006), and accounts for 15% of benefit spending in 2005.
- **Part D** refers to the outpatient prescription drug benefit that will begin January 2006 and is funded by general revenues, beneficiary premiums, and state payments.

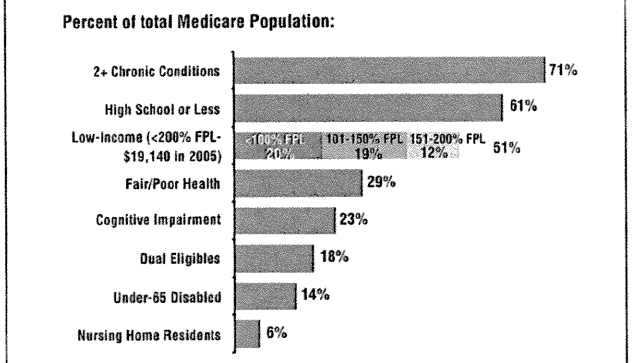
Characteristics of People on Medicare

Medicare covers a diverse population: 71% of beneficiaries have two or more chronic conditions, 29% are in fair/poor health, and 23% have cognitive impairments. A relatively small share of beneficiaries (10%) account for a large share (69%) of total spending.

Many on Medicare live with modest incomes and assets; 51% have incomes below 200% of poverty ($19,140/single and $25,660/couple in 2005); and 48% of non-institutionalized Medicare beneficiaries have countable assets (savings accounts, stocks, bonds, etc.) below $10,000.

Figure 2

Characteristics of the Medicare Population



SOURCE: Medicare Current Beneficiary Survey, Access to Care File, 2002 and 1999 (cognitive only); Income data based on CBO, July 2004.

Medicare and Prescription Drugs

Beginning in January 2006, beneficiaries will have access to private plans that contract with Medicare to provide the new Part D prescription drug benefit. Beneficiaries will be able to enroll in prescription drug plans (PDPs) and get all other benefits from traditional Medicare, or they can enroll in Medicare Advantage plans, such as HMOs or PPOs, for all Medicare benefits, including drug coverage.

Medicare will provide additional help for beneficiaries with limited incomes and assets under the new drug benefit. HHS estimates that 14.4 million beneficiaries will be eligible for premium and cost-sharing subsidies in 2006 and that 10.9 million will receive them.

The Role of Supplemental Coverage

Medicare covered less than half (45%) of beneficiaries' total health care services in 2002. Gaps in coverage (notably long-

term care, dental, and until 2006, prescription drugs) combined with relatively high cost-sharing requirements resulted in seniors spending an estimated 22% of their income on health care services and premiums in 2003 (AARP, 2004). To help with Medicare's gaps, most have some form of supplemental insurance like retiree health benefits from a former employer (35%), Medigap (22%), or Medicaid (14%) for those with extremely low incomes. For 6.4 million people on Medicare, Medicaid pays Medicare premiums and cost-sharing requirements and covers benefits, such as prescription drugs (until Part D begins in 2006) and long-term care.

Medicare Premiums and Cost-Sharing

Medicare beneficiaries generally pay a monthly premium for Part B services ($78.20 in 2005) in addition to deductibles and other cost-sharing requirements. Beginning in 2006, individuals who enroll in Part D will also pay a monthly premium for drug coverage (estimated average $37.37/month). Beginning in 2007, those with incomes over $80,000 ($160,000 per couple) will pay a higher, income-related monthly Part B premium.

Figure 3

Projected Medicare Premiums and Deductibles, 2005–2010

	2005	2006	2007	2008	2009	2010
Premiums (monthly)						
Part A	$375	$386	$403	$421	$438	$457
Part B	$78.20	$87.70	$87.70	$87.70	$89.30	$92.00
Part D (est. average)	--	$37.37	$41.22	$43.73	$46.31	$48.94
Deductibles						
Part A	$912	$956	$1,004	$1,056	$1,108	$1,164
Part B	$110	$123	$123	$123	$125	$129
Part D	--	$250	$270	$290	$310	$331

Note: Premium for Part A only required of those with less than 40 quarters of work required to automatically qualify for Medicare Part A.
SOURCE: 2005 Annual Report of the Board of Trustees of the Medicare Trust Funds, March 2005.

Medicare Advantage

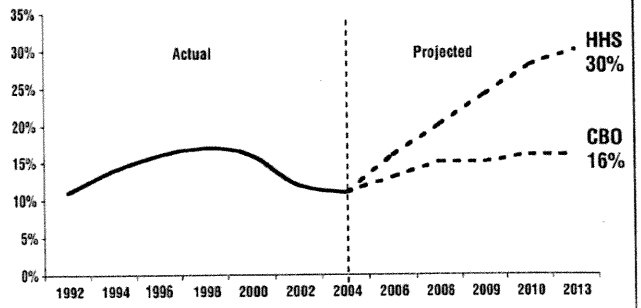
Today, 12% of beneficiaries are enrolled in Medicare Advantage plans, such as HMOs and PPOs, while 88% have traditional fee-for-service Medicare coverage.

After a period of steady growth in plan participation and enrollment in the 1990s, changing payment rates and other factors led to a decline in the number of participating plans from 346 in 1998 to 143 in 2004. Today, 4.8 million Medicare beneficiaries are enrolled in Medicare HMOs, down from a peak of 6.3 million in 2000.

In the future, Medicare Advantage plans are expected to play a larger role in covering people on Medicare and in providing the new drug benefit. By 2013, enrollment in Medicare Advantage plans is projected to range from 16% (CBO, 2005) to nearly 30% (HHS, 2005) of the Medicare population.

Figure 4

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans



Note: All actual data are from December of the given year, except 2004 from March.
SOURCE: Actual: CMS, Medicare Managed Care Contract (MMCC) Plans Monthly Summary Report.
Projections: President's FY 2006 Budget, Office of Management and Budget, February 7, 2005;
CBO from CBO Medicare Baseline, March 2005.

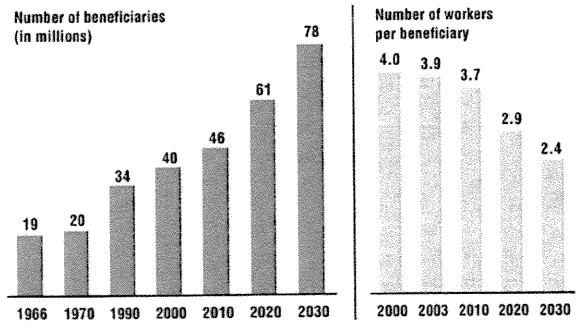
Medicare Spending and Future Outlook

Net federal spending on Medicare is estimated to grow from $290 billion in 2005 to $444 billion in 2010 (CBO). Annual growth in Medicare spending is influenced by factors that affect health spending generally, including increasing volume and utilization of services, increasing prices of health care services, expensive new technologies, and also the new drug benefit beginning in 2006. HHS projects the net federal cost of the drug benefit to be $724 billion between 2006 and 2015.

Implementation of the Medicare drug benefit is the most immediate challenge facing the program. Over the long-term, Medicare will face the fiscal challenges of an aging baby-boom generation and a declining number of workers per beneficiary.

Figure 5

Historical and Projected Number of Medicare Beneficiaries and Number of Workers per Beneficiary



SOURCE: 2001 and 2005 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Assets in the Part A Hospital Insurance trust fund are projected to exceed income beginning in 2012 and trust fund reserves are projected to be exhausted in 2020. Over time greater resources will be required to maintain benefits and meet the needs of the Medicare population.

Additional copies of this publication (#1066-08) are available on the Kaiser Family Foundation's website at www.kff.org.

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APPENDIX H

Drug Utilization Review

OKLAHOMA HEALTH CARE AUTHORITY

PAID PHARMACY CLAIMS WITH A DATE-OF-SERVICE FROM JULY 1, 2000 THROUGH JUNE 30, 2004 BY THERAPEUTIC CATEGORY

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
I. ANTI-INFECTIVE AGENTS								
A. Penicillins (01)	**137,092**	**3,003,884**	**149,185**	**3,527,247**	**160,977**	**3,934,222**	**211,206**	**5,169,871**
1. Penicillin G (0110)	8,072	47,641	9,193	55,298	10,182	89,543	15,015	162,493
2. Ampicillins (0120)	91,716	669,538	97,322	722,983	105,633	858,778	139,839	1,234,250
3. Penicillinase-resistant (0130)	748	17,629	905	41,012	813	27,262	1,117	50,851
4. Extended Spectrum (0140)	143	33,262	96	11,015	84	11,169	42	7,134
5. Penicillin Combinations (0199)	36,413	2,235,814	41,669	2,696,939	44,265	2,947,470	55,193	3,715,144
B. Cephalosporins (02)	**82,266**	**2,970,241**	**87,856**	**3,133,824**	**90,969**	**3,772,031**	**112,001**	**4,423,221**
1. Cephalopsorins - 1st Generation	45,011	620,226	49,157	761,954	51,585	1,103,014	63,950	1,082,535
2. Cephalosporins - 2nd Generation	24,663	1,210,394	24,040	1,182,757	24,579	1,362,972	27,429	1,556,385
3. Cephalosporins - 3rd Generation	12,546	1,120,435	14,626	1,175,874	14,765	1,289,204	20,494	1,741,975
4. Cephalosporins - 4th Generation	46	19,185	33	13,239	40	16,840	128	42,326
C. Macrolide Antibiotics (03)	**76,177**	**2,712,819**	**83,702**	**3,045,762**	**95,478**	**3,696,166**	**122,823**	**5,129,636**
1. Erythromycins (0310)	8,961	108,685	8,569	102,917	8,069	100,523	9,817	115,377
2. Lincomycins (0330)	2,063	105,711	2,605	125,606	1,448	59,888	21	989
3. Azithromycin (0340)	56,173	1,946,457	64,235	2,269,845	78,811	3,039,490	106,636	4,516,547
4. Clarithromycin (0350)	8,511	531,026	7,906	531,476	6,855	482,899	6,316	494,406
5. Dirithromycin (0352)	469	20,940	387	15,919	295	13,366	33	2,317
D. Tetracyclines (04)	**13,119**	**163,351**	**14,967**	**231,305**	**14,973**	**274,185**	**20,404**	**401,445**
E. Fluoroquinolones (05)	**39,785**	**2,724,884**	**42,735**	**3,031,813**	**40,997**	**3,210,820**	**45,277**	**3,839,690**
F. Aminoglycosides (07)	**1,203**	**591,576**	**1,360**	**865,652**	**1,248**	**968,153**	**1,193**	**1,114,376**
G. Sulfonamides (08)	**96**	**2,982**	**67**	**2,320**	**62**	**3,049**	**81**	**2,544**
H. Antimycobacterial Agents (09)	**610**	**47,783**	**871**	**65,952**	**749**	**56,680**	**665**	**45,615**
1. Antimycobacterial Agents (0900)	610	47,783	864	64,971	738	55,137	660	44,913
2. Anti TB Combinations (0999)	0	0	7	981	11	1,543	5	701
I. Antifungals (11)	**15,565**	**1,400,317**	**17,308**	**1,574,944**	**16,454**	**1,597,084**	**21,786**	**2,392,108**
1. Antifungals (1100)	3,581	469,424	3,678	566,550	3,466	575,485	5,168	951,095
2. Imidazole - Related Antifungals (	11,984	930,893	13,615	1,006,321	12,988	1,021,599	16,599	1,424,866
3. Antifungal-Glucan Synthesis Inhibitors (1150)			15	2,074			19	16,147
J. Antiviral (12)	**12,054**	**2,689,216**	**14,675**	**4,333,861**	**16,266**	**5,519,143**	**24,482**	**8,288,060**
1. Antiretrovirals (1210)	5,390	1,891,245	7,747	2,895,434	7,848	3,270,070	9,928	4,641,320
2. CMV Agents (1220)	337	91,574	157	173,824	200	287,424	218	340,981
3. Hepatitis C Agent (1235)	36	22,828	534	524,151	1,127	1,455,210	1,754	2,504,213
4. Herpes Agents (1240)	4,073	253,005	4,552	282,756	4,542	291,084	6,792	479,166
5. Influenza-A Agents (1250)	1,877	83,994	1,353	65,595	2,493	145,854	5,779	308,278
6. Rebetron (1299)	341	346,570	332	392,101	56	69,500	11	14,102
K. Antimalarial (13)	**9,373**	**139,782**	**10,760**	**163,121**	**10,215**	**223,133**	**11,300**	**279,570**
1. Antimalarial 1	0	0	10,760	163,121	10,211	222,342	11,280	276,844
2. Antimalarial 2	0	0	0	0	4	791	20	2,726
L. Amebecides (14)	**0**	**0**	**0**	**0**	0	0	**0**	**0**
M. Anthelmintics (15)	**1,541**	**26,434**	**1,798**	**32,802**	**1,890**	**31,410**	**2,374**	**41,679**
N. Miscellaneous Anti-Infectives (16)	**39,091**	**787,844**	**41,125**	**1,023,888**	**39,994**	**1,247,444**	**58,782**	**1,823,424**
1. Miscellaneous Anti-Infectives (16	8,879	452,535	9,862	576,326	9,416	539,263	14,161	559,544
2. Polymyxins (1610)	33	818	6	344	8	416	15	1,675
3. Carbapenum Antibiotic (1615)	19	14,805	90	63,299	67	62,913	180	176,673
4. Clindamycin (1622)	0	0	0	0	0	0	1	233
5. Chloramphenicol (1620)	11	1,181	21	1,181	8	522	4,794	142,779
6. Oxazolidinones (1623)	30	39,988	95	107,661	150	233,062	320	471,981
7. Leprostatics (1630)	261	2,497	359	3,534	387	3,820	456	4,535
8. Antiprotozoal Agents (1640)	18	13,349	20	16,083	35	27,071	94	40,419
9. Misc. Anti-Infective Combinations	29,840	262,671	30,672	255,461	29,923	380,378	38,761	425,586
O. Vaccines (17)	**552**	**34,191**	**803**	**21,644**	**600**	**34,552**	**2,481**	**70,210**
1. Viral Vaccines (1710)	390	15,473	531	14,806	483	28,765	2,070	56,771
2. Bacterial Vaccines (1720)	157	18,332	271	6,782	117	5,787	411	13,438
3. Haemophilus B Vaccines (1799)	5	386	1	56	0	0	0	0

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
II. BIOLOGICALS								
A. Toxoids (18)	**66**	**1,345**	**28**	**904**	**11**	**270**	**94**	**2,574**
1. Toxoids (1800)	48	773	19	621	8	207	5	234
2. Toxoid Combinations (1899)	18	572	9	283	3	63	89	2,340
B. Antisera (19)	**1,904**	**2,169,520**	**2,135**	**2,358,479**	**2,828**	**3,072,753**	**4,568**	**5,708,980**
1. Immune Serums (1910)	212	265,569	241	287,420	271	293,629	331	392,334
2. Monoclonal Antibody (1950)	1,692	1,903,952	1,894	2,071,059	2,557	2,779,124	4,237	5,316,646
III. ANTINEOPLASTIC AGENTS								
A. Antineoplastic (21)	**23,190**	**3,617,958**	**27,122**	**4,445,796**	**26,346**	**4,405,384**	**25,231**	**4,796,919**
1. Alkylating Agents (2110)	276	33,152	397	89,313	362	209,781	356	372,106
2. Antiestrogens (2115)	0	0	0	0	0	0	0	0
3. Antieoplastic Antibiotics (2120)	0	0	0	0	0	0	3	190
4. Antimetabolites (2130)	2,734	178,211	3,614	281,186	3,658	334,698	3,970	346,865
5. Antineoplastic Hormones (2140)	18,610	2,476,395	21,436	3,049,263	21,079	3,130,991	19,896	3,180,680
6. Antieoplastic Immunomodulator (	5	353	0	0	1	43	0	0
7. Mitotic Inhibitor (2150)	38	25,041	38	35,768	44	23,148	22	14,186
8. Iressa (2153)	0	0	0	0	0	0	261	551,436
9. Antineoplastics Miscellaneous (21	1,481	898,888	1,562	982,672	1,131	701,516	664	327,710
10. Chemotherapy Rescue/Antidote	46	5,917	75	7,594	71	5,208	59	3,747
IV. ENDOCRINE AND METABOLIC DRUGS								
A. Corticosteroids (22)	**47,737**	**527,398**	**55,444**	**591,732**	**55,565**	**582,318**	**77,099**	**793,461**
1. Glucocorticoids (2210)	46,324	486,850	53,863	544,263	54,071	532,165	75,493	739,435
2. Mineralocorticoids (2220)	1,413	40,548	1,581	47,469	1,494	50,153	1,606	54,026
B. Androgen-Anabolic (23)	**591**	**54,129**	**731**	**73,492**	**763**	**99,619**	**773**	**115,110**
1. Androgens (2310)	591	54,129	731	73,492	763	99,619	773	115,110
2. Anabolic Steroids (2320)	0	0	0	0	0	0	0	0
C. Estrogens (24)	**69,088**	**1,921,115**	**74,041**	**2,327,668**	**54,059**	**2,134,536**	**44,308**	**2,078,000**
1. Estrogens (2400)	55,833	1,474,144	59,787	1,766,018	44,600	1,675,159	37,293	1,664,105
2. Estrogen Combinations (2499)	13,255	446,971	14,254	561,650	9,459	459,376	7,015	413,895
D. Contraceptives, Oral (25)	**24,404**	**841,826**	**28,296**	**1,062,566**	**30,382**	**1,249,041**	**52,697**	**2,407,017**
1. Progestin OC's (2510)	1,162	46,196	1,286	54,977	1,438	70,966	2,569	123,483
2. Progestin Contraceptives - Inject	3,036	160,599	3,594	200,157	3,873	213,361	5,086	336,555
3. Progesterone IUD (2520)	1	238	0	0	1	395	2	839
4. Progestin Implants (2530)	0	0	0	0	1	451	0	0
5. Contraceptives - Emergency (254	2	44	3	101	9	174	54	1,297
6. Ortho Evra (2596)	0	0	0	0	0	0	11,411	538,980
7. Nuvaring (2597)	0	0	0	0	0	0	835	39,057
8. Combination Contraceptives - Inj	112	3,661	546	17,200	142	4,514	1	28
9. Combinations OC's (2599)	20,091	631,088	22,867	790,130	24,918	959,181	32,739	1,366,777
E. Progestins (26)	**4,968**	**76,870**	**5,052**	**71,236**	**3,626**	**60,927**	**3,610**	**67,613**
F. Antidiabetics (27)	**168,482**	**8,662,431**	**190,596**	**10,594,849**	**187,040**	**12,266,151**	**209,101**	**14,759,088**
1. Insulin (2710)	50,656	2,141,339	56,825	2,773,916	56,379	3,467,044	64,468	4,801,463
2. Sulfonylureas (2720)	55,842	1,571,762	55,983	1,251,265	51,354	1,290,579	53,676	1,403,155
3. Meglitinides - Starlix (2723)	111	8,003	1,114	80,773	1,482	120,104	1,677	155,421
4. Biguanides (2725)	33,702	1,952,115	36,997	2,124,574	36,435	1,920,390	41,986	1,086,861
5. Meglitinides - Prandin (2728)	1,885	124,197	1,829	127,628	1,522	123,818	1,287	128,143
6. Diabetic Other (2730)	467	41,836	693	66,084	862	90,564	1,294	149,001
7. Alpha-Glucosidase Inhibitor (275	1,063	49,850	824	40,514	640	35,415	607	36,744
8. Thiazolidinediones (2760)	21,702	2,619,427	27,797	3,624,482	27,728	4,427,441	30,759	5,676,066
9. Antidiabetic Combinations (2799	3,054	153,903	8,534	505,614	10,638	790,796	13,347	1,322,235
G. Thyroid (28)	**72,817**	**831,640**	**81,676**	**1,088,335**	**78,904**	**1,274,087**	**85,198**	**1,578,689**
1. Thyroid Hormones (2810)	72,330	818,768	81,131	1,072,556	78,258	1,251,705	84,459	1,556,831
2. Antithyroid Agents (2830)	487	12,872	545	15,779	646	22,381	739	21,858
H. Oxytocics (29)	**278**	**6,047**	**295**	**6,226**	**364**	**4,192**	**637**	**7,298**
1. Uterine Active Agents (2900)	264	2,421	283	2,695	362	3,650	636	7,093
2. Abortifacients/Agents for Cervica	14	3,626	12	3,531	2	543	1	205
I. Miscellaneous Endocrine (30)	**38,927**	**3,690,883**	**46,670**	**4,775,871**	**50,375**	**5,963,582**	**53,169**	**8,198,311**
1. Adrenal Steroid Inhibitors (3002)	9	1,530	0	0	0	0	0	0
2. Calcium Regulators (3004)	26,802	1,643,157	32,077	2,069,788	33,948	2,475,239	35,409	3,165,624
3. Selective Estrogen Receptor (30	5,296	349,574	6,561	469,765	7,778	686,082	7,337	782,455
4. Fertility Regulators (3006)	10	725	8	342	6	429	8	1,259
5. Gonadotropin Release Hormones	2	846	13	14,829	0	0	32	17,776
6. Growth Hormone (3010)	462	771,736	579	1,068,384	764	1,403,220	1,083	2,266,815
7. Somostatic Agents (3017)	64	74,225	112	143,222	96	160,720	76	249,877
8. Posterior Pituitary (3020)	5,940	809,165	6,941	961,342	7,329	1,175,520	8,622	1,597,954
9. Corticotropin (3030)	0	0	2	97	2	1,899	5	10,420
10. Synthetic Ergot Deriv - Dopamin	58	22,133	72	27,796	69	29,191	85	42,022
11. Ucephen (3090)	284	17,792	305	20,306	383	31,282	512	64,108

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
V. CARDIOVASCULAR AGENTS								
A. Cardiotonics (31)	**57,343**	**561,266**	**54,438**	**507,207**	**43,671**	**444,310**	**39,674**	**407,935**
1. Phosphodiesterase Inhibitors (31	9	47,753	0	0	0	0	0	0
2. Digitalis (3120)	57,334	513,513	54,438	507,207	43,671	444,310	39,674	407,935
3. Cardioprotective Agent (3180)	0	0	0	0	0	0	0	0
B. Antianginal Agents (32)	**67,510**	**2,240,429**	**66,131**	**2,038,362**	**54,570**	**1,697,296**	**50,539**	**1,207,371**
1. Nitrates (3210)	66,810	2,235,346	66,084	2,038,008	54,552	1,697,147	50,539	1,207,371
2. Antianginals, Other (3220)	700	5,084	47	354	18	149	0	0
C. Beta Blockers (33)	**73,400**	**1,570,917**	**90,193**	**2,062,088**	**94,774**	**2,619,598**	**115,234**	**3,474,913**
1. Beta Blockers Non-Selective (331	19,590	803,021	22,694	1,120,484	23,019	1,356,637	15,976	521,210
2. Beta Blockers Cardio-Selective (3	50,654	684,408	64,031	854,595	68,456	1,184,217	84,056	1,630,212
3. Alpha-Beta Blockers (3330)	3,156	83,488	3,468	87,009	3,299	78,745	15,202	1,323,491
D. Calcium Blockers (34)	**119,384**	**6,028,001**	**119,557**	**6,217,646**	**99,456**	**5,570,776**	**92,590**	**5,331,053**
E. Antiarrhythmic (35)	**8,325**	**629,365**	**9,127**	**675,487**	**9,071**	**649,490**	**9,123**	**368,205**
1. Antiarrhythmics Type 1 - Nonspe	6	445	11	635	1	74	0	0
2. Antiarrhythmics Type 1-A (3510)	2,380	92,119	1,921	83,641	1,510	74,802	1,127	63,459
3. Antiarrhythmics Type 1-B (3520)	453	16,482	323	11,971	264	9,073	186	9,189
4. Antiarrhythmics Type 1-C (3530)	1,227	149,805	1,265	169,160	1,138	154,906	1,128	118,597
5. Antiarrhythmics Type III (3540)	4,258	370,339	5,607	410,081	6,157	410,544	6,682	176,960
6. Antiarrhythmics Type IV (3550)	1	175	0	0	1	91	0	0
F. Antihypertensive (36)	**240,285**	**8,829,022**	**260,245**	**10,057,679**	**244,640**	**9,145,565**	**262,045**	**8,971,400**
1. ACE Inhibitors (3610)	119,002	4,101,126	128,426	4,758,506	118,717	3,499,412	123,180	2,488,712
2. Angiotensin II Receptor Antagoni	21,042	1,041,057	24,408	1,327,340	25,311	1,661,417	28,372	2,141,288
3. Adrenolytic Antihypertensives (3(	56,172	1,604,472	58,889	1,518,756	56,211	1,347,877	61,378	1,382,486
4. Alpha Blockers (3630)	35	14,145	5	1,510	5	525	3	249
5. Vasodilators (3640)	2,724	56,193	3,293	53,678	3,184	64,670	3,906	68,432
6. Iversine (3660)	0	0	0	0	0	0	11	1,555
7. Antihypertensive Combinations (	41,310	2,012,030	45,224	2,397,890	41,212	2,571,664	45,195	2,888,677
G. Diuretics (37)	**184,617**	**1,968,164**	**195,777**	**2,198,069**	**176,884**	**2,278,955**	**193,675**	**2,450,031**
1. Carbonic Anhydrase Inhibitors (3	1,220	32,121	1,170	30,443	1,034	30,643	1,106	29,971
2. Loop Diuretics (3720)	125,935	1,200,282	131,620	1,332,414	115,745	1,349,033	120,293	1,366,483
3. Osmotic Diuretics (3740)	2	348	3	64	0	0	0	0
4. Potassium Sparing Diuretics (375	10,536	224,211	13,259	285,368	13,094	306,050	14,509	324,695
5. Thiazides (3760)	27,414	291,727	30,347	348,168	29,865	411,695	40,486	558,561
6. Combination Diuretics (3799)	19,510	219,476	19,378	201,614	17,146	181,534	17,281	170,321
H. Pressors (38)	**992**	**93,146**	**1,399**	**136,264**	**1,548**	**188,314**	**2,131**	**273,571**
1. Pressors (3800)	405	61,940	559	86,005	677	131,361	874	183,158
2. Emergency Kits (3890)	587	31,207	840	50,260	871	56,952	1,257	90,413
I. Antihyperlipidemic (39)	**70,874**	**5,908,127**	**89,769**	**8,350,620**	**89,826**	**10,434,938**	**102,606**	**13,596,503**
1. Bile Sequestrants (3910)	1,946	88,847	2,405	128,843	2,410	155,945	2,335	163,083
2. Fibric Acid Derivatives (3920)	5,664	155,220	7,395	259,505	7,784	371,555	9,130	544,000
3. HMG CoA Reductase Inhibitors (3	62,871	5,650,086	79,296	7,934,351	78,678	9,855,468	87,781	12,545,282
4. Nicotinic Acid Derivatives (3945	393	13,974	673	27,922	954	51,971	968	73,283
5. Misc. Antihyperlipidemics (3950)	0	0	0	0	0	0	2,392	270,854
J. Miscellaneous Cardiovascular (40)	**1,033**	**99,779**	**953**	**126,546**	**702**	**118,640**	**701**	**330,429**
1. Peripheral Vasodilators (4010)	989	7,431	889	6,430	659	8,034	535	9,620
2. Endothelin Receptor Antagonists	0	0	0	0	0	0	76	216,698
3. Vasodilators, Misc. (4017)	29	90,153	46	117,180	33	108,701	19	98,046
4. Impotence Agents (4030)	15	2,194	18	2,935	10	1,906	71	6,065
VI. RESPIRATORY AGENTS								
A. Antihistamines (41)	**94,778**	**3,711,943**	**119,386**	**5,092,976**	**94,909**	**3,893,857**	**99,811**	**2,607,013**
1. Antihistamines - Alkylamines (41	2	23	2	16	12	253	36	1,085
2. Antihistamines - Ethanolamines (	887	7,012	683	7,547	369	2,306	483	4,155
3. Antihistamines - Ethylenediamine	0	0	0	0	0	0	0	0
4. Antihistamines - Phenothiazines (	29,525	570,475	35,595	752,787	37,653	884,001	52,989	1,159,506
5. Antihistamines - Piperidines (415	4,567	46,964	4,107	64,293	3,737	78,910	3,911	68,360
6. Antihistamines - Non-Sedating (4	59,781	3,087,263	78,995	4,268,282	53,137	2,928,380	42,388	1,373,799
7. Antihistamine Combinations (419	16	206	4	52	1	7	4	108
B. Decongestants (42)	**27,906**	**1,338,876**	**32,794**	**1,724,342**	**34,665**	**2,108,719**	**47,639**	**3,180,834**
1. Nasal Decongestants (4210)	0	0	3	56	52	1,083	498	11,308
2. Nasal Steroids (4220)	26,223	1,267,448	31,092	1,648,945	32,553	1,999,569	44,811	3,040,611
3. Anticholinergics (4225)	37	1,877	71	3,996	101	6,287	172	12,078
4. Nasal Anticholinergics (4230)	847	33,139	792	31,466	812	38,560	673	29,450
5. Misc. Antihistamines (4240)	799	36,413	836	39,879	1,147	63,220	1,482	87,351
6. Miscellaneous Nasal Preparations	0	0	0	0	0	0	3	35
C. Cough/Cold (43)	**12,406**	**518,973**	**14,206**	**686,999**	**7,403**	**419,425**	**2,296**	**69,281**
1. Antitussives (4310)	62	6,478	95	15,463	85	7,132	164	23,307
2. Expectorants (4320)	83	1,332	74	1,018	11	161	10	60
3. Mucolytics (4330)	361	20,583	330	15,638	246	15,310	241	13,932
4. Miscellaneous Respiratory Inhala	1,183	16,390	1,317	16,699	1,251	18,008	1,315	20,215
5. Cough/Cold Combinations (4399	10,717	474,191	12,390	638,182	5,810	378,814	566	11,766

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
D. Antiasthmatics (44)	**216,718**	**9,728,048**	**249,398**	**13,279,516**	**249,907**	**15,715,446**	**334,786**	**22,440,697**
1. Anticholinergics (4410)	17,028	1,405,429	17,079	1,449,674	13,246	1,152,563	11,458	539,514
2. Anti-Inflammatory Agents (4415	3,464	162,669	2,953	134,635	2,085	92,192	1,549	82,506
3. Sympathomimetics (4420)	127,228	3,923,519	151,974	6,198,112	157,029	7,742,585	214,330	11,073,734
4. Xanthines (4430)	14,341	267,612	13,104	276,839	10,251	248,513	9,588	225,622
5. Steroid Inhalants (4440)	26,706	1,881,944	27,440	2,202,838	25,339	2,505,276	32,893	3,795,794
6. Leukotriene Modulators (4450)	27,336	2,073,086	36,355	3,005,415	41,442	3,962,128	64,653	6,715,951
7. Asthma Combinations (4499)	615	13,789	493	12,004	515	12,189	315	7,576
E. Miscellaneous Respiratory (45)	442	589,604	**507**	**674,776**	**575**	**819,781**	**556**	**866,971**
1. Alpha-Proteinase Inhibitor (Huma	0	0	0	0	0	0	12	76,486
2. Hydrolytic Enzymes (4530)	442	589,604	507	674,776	575	819,781	544	790,485
VII. GASTROINTESTINAL AGENTS								
A. Laxatives (46)	**13,664**	**298,939**	**19,028**	**431,100**	**24,038**	**639,060**	**30,227**	**845,024**
1. Saline Laxatives (4610)	0	0	11	333	4	114	1	42
2. Stimulant Laxatives (4620)	11	644	15	779	1	61	0	0
3. Laxatives (4630)	7	66	0	0	0	0	0	0
4. Lubricant Laxatives (4640)	0	0	4	25	4	25	5	33
5. Surfactant Laxatives (4650)	0	0	1	8	0	0	0	0
6. Miscellaneous Laxatives (4660)	13,646	298,229	18,997	429,956	24,029	638,860	30,221	844,950
B. Antidiarrheals (47)	**10,135**	**145,584**	**10,594**	**148,142**	**9,900**	**101,792**	**10,301**	**80,590**
1. Antiperistaltic Agents (4710)	10,135	145,584	10,594	148,142	9,900	101,792	10,301	80,590
2. Miscellaneous Antidiarrheal Agen	0	0	0	0	0	0	0	0
C. Antacids (48)							**21**	**825**
D. Ulcer Drugs (49)	**177,614**	**10,590,028**	**203,728**	**13,598,729**	**203,029**	**14,861,935**	**219,331**	**14,676,742**
1. GI Antispasmodics -Anticholinerg	15,053	303,281	16,332	316,408	14,928	258,573	17,643	331,196
2. H-2 Antagonists (4920)	96,998	2,872,366	105,164	3,130,616	103,275	2,662,890	108,318	1,940,690
3. Prostaglandins (4925)	1,279	69,532	980	59,495	805	51,848	704	40,090
4. Proton Pump Inhibitors (4927)	55,621	6,850,717	71,850	9,561,410	74,818	11,307,864	83,263	11,812,525
5. Miscellaneous Anti-Ulcer (4930)	8,008	361,197	8,662	372,890	8,457	401,675	8,505	319,559
6. H. Pylori Combination Agents (49	655	132,934	740	157,910	746	179,085	898	232,683
E. Antiemetics (50)	**13,817**	**579,448**	**14,242**	**841,901**	**12,358**	**1,127,533**	**14,444**	**2,036,273**
1. Antiemetics - Antidopaminergic (	56	1,319	34	924	24	846	2	30
2. Antiemetics - Anticholinergic (50	12,715	99,544	12,521	107,916	10,380	123,270	10,850	147,663
3. 5-HT3 Receptor Antagonists (502	856	401,486	1,306	620,249	1,616	888,530	2,916	1,657,393
4. Antiemetics Miscellaneous (5030	190	77,099	381	112,813	338	114,887	676	231,187
F. Digestive Aids (51)	**2,762**	**433,504**	**2,827**	**523,310**	**2,600**	**575,155**	**2,561**	**658,582**
1. Digestive Enzymes (5120)	436	31,167	25	1,160	0	0	0	0
2. Digestive Aids - Mixtures (5199)	2,326	402,337	2,802	522,149	2,600	575,155	2,561	658,582
G. Miscellaneous GI Agents (52)	**46,437**	**1,078,223**	**23,352**	**1,172,469**	**21,336**	**1,499,626**	**51,195**	**2,216,571**
1. Gallstone Solubizing Agents (521	833	127,539	980	162,560	988	165,626	1,185	174,575
2. Antiflatulents (5220)	0	0	0	0	0	0	0	0
3. GI Stimulants (5230)	25,081	251,653	0	0	0	0	28,229	274,122
4. Lactulose (5240)	14,275	291,724	14,963	296,161	12,422	375,378	10,886	167,087
5. Inflammatory Bowel Agents (525	2,745	191,137	3,173	268,980	3,189	346,148	3,414	437,264
6. Irritable Bowel Syndrome Agents	311	35,854	0	0	458	61,340	2,600	382,388
7. Electrolytes (5280)	3,192	180,316	4,236	444,767	4,279	551,134	4,881	781,136
VIII. GENITOURINARY PRODUCTS								
A. Urinary Anti-Infectives (53)	**15,915**	**479,912**	**17,579**	**565,322**	**17,783**	**732,099**	**22,084**	**946,508**
1. Urinary Anti-Infectives (5300)	14,917	452,326	16,576	535,634	16,748	700,234	20,578	905,207
2. Combination Urinary Anti-Infecti	998	27,587	1,003	29,688	1,035	31,865	1,506	41,301
B. Urinary Antispasmodics (54)	**31,050**	**1,777,597**	**36,938**	**2,515,170**	**35,223**	**2,928,873**	**35,722**	**3,378,024**
1. Urinary Antispasmodics (5400)	30,914	1,773,010	36,782	2,508,021	35,115	2,924,171	35,606	3,373,542
2. Interstitial Cystitis Agents (5499	136	4,587	156	7,148	107	4,702	116	4,482
C. Vaginal Products (55)	**6,234**	**239,072**	**6,369**	**262,833**	**6,281**	**291,233**	**7,669**	**408,276**
1. Vaginal Anti-Infectives (5510)	3,922	131,355	3,891	140,856	3,911	159,942	5,273	251,220
2. Spermicides (5530)	13	93	8	41	1	9	8	60
3. Vaginal Estrogens (5535)	2,244	105,586	2,408	120,473	2,301	128,980	2,290	153,282
4. Vaginal Progesterone (5537)	11	1,011	0	0	6	812	13	1,599
5. Miscellaneous Vaginal (5540)	44	1,028	62	1,464	62	1,490	85	2,115
D. Miscellaneous Genitourinary Products (5	**19,870**	**861,363**	**21,192**	**831,980**	**20,970**	**980,310**	**22,057**	**1,255,562**
1. Acidifiers (5610)	4	47	0	0	12	153	11	195
2. Alkalinizers (5620)	750	23,537	701	23,726	769	25,680	968	33,993
3. Urinary Analgesics (5630)	3,079	38,169	3,308	41,860	3,125	42,972	3,833	48,934
4. Cystinosis Agents (5640)	0	0	0	0	0	0	0	0
5. Interstitial Cystitis Agents (5650	42	6,116	73	12,791	93	18,532	177	37,320
6. Urinary Stone Agents (5660)	29	1,912	27	1,670	20	1,388	19	971
7. GU Irrigants (5670)	7,743	329,494	6,612	103,534	5,585	76,556	4,593	132,227
8. Cytoprotective Agents (5680)	0	0	0	0	0	0	0	0
9. Prostatic Hypertrophy Agents (56	8,223	462,087	10,471	648,400	11,366	815,029	12,456	1,001,921

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
IX. CENTRAL NERVOUS SYSTEM DRUGS								
A. Antianxiety Agents (57)	**118,284**	**3,314,852**	**125,595**	**3,232,849**	**120,810**	**2,599,993**	**151,946**	**2,175,862**
1. Benzodiazepines (5710)	76,922	1,426,757	82,202	1,424,051	78,704	1,046,944	102,356	1,025,148
2. Miscellaneous Antianxiety Agents	41,362	1,888,095	43,393	1,808,798	42,106	1,553,049	49,590	1,150,714
B. Antidepressants (58)	**269,208**	**17,166,386**	**310,298**	**21,286,561**	**317,720**	**22,792,778**	**372,467**	**27,144,465**
1. Tetracyclic Compounds (5803)	17,287	1,245,325	25,661	1,926,029	27,235	2,207,287	28,667	1,376,278
2. MAO Inhibitors (5810)	37	2,115	38	2,234	42	2,376	38	2,422
3. Modified Cyclics (5812)	31,078	632,590	31,931	748,803	29,699	443,981	36,441	453,556
4. SSRI's (5816)	149,696	12,334,930	174,985	14,696,617	184,914	15,434,206	215,543	18,405,476
5. Tricyclic Agents (5820)	40,706	496,606	40,445	528,635	35,353	400,363	41,023	472,921
6. Miscellaneous Antidepressants (5	30,404	2,454,820	37,238	3,384,242	40,477	4,304,564	50,755	6,433,812
C. Antipsychotics (59)	**163,201**	**23,902,028**	**184,213**	**32,578,848**	**194,862**	**41,121,921**	**229,828**	**55,938,927**
1. Benzisoxazole (5907)	56,501	8,767,376	64,806	11,017,676	66,415	12,994,042	67,479	15,072,996
2. Butyrophenones (5910)	14,740	344,012	12,544	418,392	10,683	374,746	11,339	429,079
3. Dibenzodiazepine (5915)	56,808	13,762,990	75,274	19,678,915	87,932	25,659,554	105,442	32,738,134
4. Moban (5916)	0	0	0	0	0	0	214	38,657
5. Phenothiazines (5920)	24,248	677,481	18,784	509,042	14,695	442,620	14,100	366,742
6. Abilify (5925)	0	0	0	0	0	0	12,049	4,702,094
6. Thioxanthines (5930)	2,166	32,225	1,891	33,289	1,696	39,148	1,552	34,771
7. Miscellaneous Antipsychotics (59	1,558	183,213	3,894	784,672	6,284	1,460,465	8,466	2,352,447
8. Lithium (5950)	7,180	134,730	7,020	136,861	7,157	151,346	9,187	204,008
D. Hypnotics (60)	**47,331**	**1,279,788**	**50,170**	**1,467,941**	**48,416**	**1,668,170**	**55,691**	**2,162,426**
1. Barbiturate Hypnotics (6010)	14,310	98,456	14,368	99,158	13,477	97,275	14,418	104,624
2. Non-Barbiturate Hypnotics (6020	33,003	1,180,854	35,800	1,368,694	34,939	1,570,895	41,273	2,057,802
3. Hypnotic Combinations (6099)	18	478	2	88	0	0	0	0
E. Stimulants (61)	**47,474**	**2,056,068**	**53,791**	**3,119,388**	**58,588**	**3,922,642**	**96,004**	**7,483,406**
1. Amphetamines (6110)	25,387	1,216,042	28,864	1,953,646	29,167	2,159,979	37,962	2,748,582
2. Anorexiants, Non-Amphetamine	5	32	13	316	0	0	11	444
3. Anorexiant (6125)	8	706	10	922	1	106	8	870
4. Stimulants - Analeptics (6130)	76	11,309	55	14,641	42	12,536	74	34,000
5. Strattera (6135)	0	0	0	0	0	0	19,229	2,145,773
6. Miscellaneous Stimulants (6140)	21,998	827,979	24,849	1,149,863	29,378	1,750,021	38,720	2,553,738
F. Miscellaneous Psychotherapeutic (62)	**22,404**	**2,574,427**	**29,215**	**3,858,340**	**33,222**	**5,813,884**	**41,685**	**8,302,263**
1. Miscellaneous Psychotherapeutic	818	41,015	720	45,306	591	45,498	486	35,568
2. Antidementia (6205)	18,666	2,200,809	25,352	3,101,381	29,130	3,950,363	35,581	5,106,761
3. Smoking Deterrents (6210)	229	20,208	215	18,763	187	18,143	1,298	118,705
4. MS Copolymers (6240)	310	238,457	638	618,633	1,282	1,726,886	2,016	2,835,828
5. Agents for Chemical Dependency	46	1,386	61	1,989	43	1,711	50	2,694
6. Combination Psychotherapeutics	2,335	72,551	2,229	72,269	1,989	71,284	2,254	202,707
X. ANALGESICS AND ANESTHETICS								
A. Analgesics - Nonnarcotic (64)	**10,982**	**249,589**	**10,349**	**265,915**	**9,404**	**254,600**	**12,687**	**276,663**
1. Salicylates (6410)	3,046	86,213	2,623	80,614	2,144	74,376	2,004	73,638
2. Analgesic Other (6420)	0	0	0	0	0	0	2	13
3. Analgesic Combinations (6499)	7,936	163,376	7,726	185,302	7,260	180,224	10,681	203,012
B. Analgesics - Narcotic (65)	**269,570**	**9,332,416**	**316,519**	**12,486,473**	**328,640**	**14,167,185**	**444,881**	**19,472,177**
1. Narcotic Agonists (6510)	58,836	5,993,562	69,550	8,447,898	70,284	9,543,620	90,342	14,014,676
2. Narcotic Partial Agonists (6520)	2,507	225,488	2,547	245,948	2,362	247,676	2,811	232,931
3. Narcotic Antagonists (6540)	529	81,826	596	93,324	497	84,818	440	67,224
4. Narcotic Combinations (6599)	207,698	3,031,541	243,826	3,699,303	255,497	4,291,071	351,288	5,157,347
C. Anti-Rheumatic (66)	**128,699**	**6,750,315**	**137,193**	**7,425,649**	**131,162**	**7,588,549**	**148,814**	**9,285,567**
1. Nonsteroidal Anti-Inflammatory	127,353	5,886,003	135,620	6,435,247	129,660	6,482,774	146,359	6,598,752
2. Gold Compounds (6620)	81	10,708	89	10,982	70	11,062	50	9,352
3. Anti-Rheumatic Antimetabolite (6	26	2,823	32	1,540	13	571	5	92
4. Kineret (6626)	0	0	0	0	0	0	138	169,450
5. Humira (6627)	0	0	0	0	0	0	409	644,875
6. Anti-Rheumatic -- Pyrimidine Syr	483	115,851	698	173,127	667	219,585	589	276,029
7. Anti-Rheumatic Immunologic (66	756	734,930	754	804,754	752	874,557	1,264	1,587,018
D. Migraine Products (67)	**4,384**	**703,336**	**6,068**	**941,386**	**7,129**	**1,115,194**	**12,942**	**2,070,656**
1. Migraine Products (6700)	82	7,547	50	3,446	37	4,031	48	15,508
2. Carboxylic Acid Derivatives (673	401	43,549	1,591	174,262	2,493	293,471	6,513	748,486
3. Serotonin 5-HT1 Receptor Agonis	3,481	642,660	3,886	751,830	4,009	804,695	6,020	1,293,174
4. Ergot Combinations (6799)	420	9,580	541	11,849	590	12,997	361	13,488
E. Gout (68)	**11,230**	**111,904**	**11,770**	**100,677**	**10,040**	**109,195**	**10,791**	**117,511**
1. Gout (6800)	10,515	81,562	11,187	80,496	9,450	83,050	10,221	95,128
2. Uricosurics (6810)	427	18,764	344	10,580	359	15,923	345	12,481
3. Combination Gout Drugs (6899)	288	11,578	239	9,601	231	10,222	225	9,902
F. Local Anesthetic - Parenteral (69)	**1,428**	**9,840**	**1,647**	**9,488**	**1,619**	**9,224**	**1727**	**10,177**
1. Local Anesthetic - Amides (6910	1,417	9,499	1,625	8,912	1,597	8,944	1,672	9,532
2. Local Anesthetic - Esters (6920)	8	317	19	438	20	263	52	627
3. Local Anesthetic - Combinations	3	23	3	137	2	16	3	18

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
XI. NEUROMUSCULAR DRUGS								
A. General Anesthetics (70)	**35**	**2,417**	**7**	**4,261**	**6**	**412**	**16**	**2,901**
1. Barbiturate Anesthetics (7010)	0	0	0	0	0	0	0	0
2. Misc. Anesthetics (7040)	35	2,417	7	4,261	6	412	16	2,901
B. Anticonvulsants (72)	**167,578**	**11,067,818**	**188,639**	**13,711,366**	**198,626**	**16,884,564**	**231,987**	**22,796,060**
1. Benzodiazepines (7210)	17,748	669,983	20,678	645,134	22,464	587,051	29,940	704,555
2. Carbamates (7212)	391	74,690	411	99,530	418	112,768	510	144,258
3. Tingabine (7217)	481	56,566	1,117	126,610	1,701	197,228	1,963	254,718
4. Hydantoins (7220)	38,419	1,084,368	39,362	1,162,225	37,723	1,195,354	39,296	1,315,287
5. Oxazolidinediones (7230)	0	0	0	0	0	0	0	0
6. Succinimides (7240)	730	55,382	671	54,899	601	50,073	709	63,625
7. Valproic Acid (7250)	38,005	3,308,584	40,543	3,616,533	41,418	4,165,555	45,260	5,213,275
8. Miscellaneous Anticonvulsants (7	71,804	5,818,244	85,857	8,006,436	94,301	10,576,535	114,309	15,100,342
C. Antiparkinsonians (73)	**39,928**	**1,364,210**	**40,892**	**1,570,799**	**38,509**	**1,767,402**	**44,841**	**1,848,630**
1. Antiparkinsonian Anticholinergics	17,715	146,178	16,997	148,590	15,501	179,512	18,845	224,164
2. Antiparkinsonism COMT (7315)	567	77,662	720	97,389	726	108,757	776	123,243
3. Antiparkinsonian Dopaminergics	20,663	1,077,510	22,456	1,270,094	21,773	1,442,856	24,810	1,484,993
4. Antiparkinsonian MOI (7330)	954	61,699	682	53,252	485	35,593	383	14,898
5. Antiparkinsonian Adjuvants (734	29	1,161	37	1,475	24	684	27	1,331
D. Neuromuscular Blockers(74)	**36**	**27,393**	**48**	**36,447**	**68**	**48,978**	**74**	**63,852**
1. Nondepolarizing Muscle Relaxant	0	0	0	0	0	0	1	886
2. Benzathiazole (7450)	36	27,393	48	36,447	68	48,978	73	62,966
E. Skeletal Muscle Relaxants (75)	**51,732**	**1,479,190**	**60,441**	**1,841,486**	**62,441**	**2,478,364**	**85,677**	**2,563,654**
1. Central Muscle Relaxants (7510)	50,264	1,361,331	59,020	1,726,903	61,114	2,359,133	84,232	2,436,429
2. Direct Muscle Relaxants (7520)	747	72,704	779	77,716	740	83,219	712	85,589
3. Hyaburonic Acid Derivatives (75	25	11,708	30	12,767	22	13,657	26	17,447
4. Muscle Relaxant Combinations (7	696	33,446	612	24,101	565	22,355	707	24,189
F. Antimyasthenic Agents (76)	**370**	**20,232**	**397**	**24,192**	**370**	**23,790**	**355**	**25,848**
XII. NUTRITIONAL PRODUCTS								
A. Vitamins (77)	**1,464**	**63,339**	**1,593**	**69,744**	**1,433**	**68,755**	**1,509**	**85,744**
1. Water Soluble Vitamins (7710)	0	0	8	22	3	4	0	0
2. Oil Soluble Vitamins (7720)	1,464	63,339	1,585	69,722	1,430	68,751	1,509	85,744
B. Multivitamins (78)	**21,468**	**401,107**	**23,206**	**448,713**	**23,418**	**495,568**	**31,650**	**710,103**
1. B-Complex w/Folic Acid (7813)	3	59	1	15	1	10	2	37
2. Multiple Vitamins (7820)	0	0	1	0	1	271	2	14
3. Multiple Vitamins w/Minerals (78	11	164	1	9	0	0	0	0
4. Pediatric Multiple Vitamins w/Min	4	26	6	43	1	9	0	0
5 Pediatric Multiple Vitamins w/Fluo	1,649	16,261	1,722	19,169	1,508	17,090	2,032	26,482
6. Pediatric Multiple Vitamins w/Fl &	894	9,399	957	10,173	892	11,232	855	11,013
7. Prenatal Vitamins (7851)	18,904	375,143	20,517	419,266	21,015	466,956	28,759	672,557
8. Iron w/Vitamins (7861)	3	56	1	37	0	0	0	0
C. Minerals - Electrolytes (79)	**111,663**	**2,009,389**	**117,710**	**2,155,195**	**106,149**	**2,119,284**	**109,447**	**1,972,267**
1. Bicarbonate (7905)	81	3,597	148	1,765	181	2,818	146	2,283
2. Calcium (7910)	12	252	3	37	5	99	25	2,197
3. Fluoride (7930)	895	7,235	1,165	9,460	1,175	9,747	1,645	14,234
4. Iodine(7935)	3	39	12	136	0	0	0	0
5. Magnesium (7940)	16	548	43	405	22	307	103	1,355
6. Phosphate (7960)	143	1,939	108	1,657	111	1,869	222	3,178
7. Potassium (7970)	107,262	1,940,263	113,006	2,087,917	102,184	2,040,964	104,205	1,801,907
8. Sodium (7975)	2,884	47,369	2,932	48,040	2,244	59,015	2,816	133,127
9. Zinc (7980)	12	818	26	1,741	23	1,555	22	1,938
10. Trace Minerals (7990)	0	0	0	0	0	0	21	5,325
11. Electrolytic Mixtures (7999)	355	7,329	267	4,037	204	2,911	242	6,723
D. Nutrients (80)	**486**	**23,909**	**549**	**13,200**	**428**	**11,174**	**536**	**15,177**
1. Carbohydrate (8010)	479	23,617	544	13,078	427	11,125	536	15,177
2. Nutritional Supplements (8020)	7	292	5	122	1	49	0	0
3. Tube Feedings (8030)	0	0	0	0	0	0	0	0
E. Dietary Products (81)	**13**	**5,941**	**13**	**4,543**	**0**	**0**	**0**	**0**
1. Infant Foods (8110)	0	0	3	834	0	0	0	0
2. Nutritional Supplements (8120)	13	5,941	10	3,709	0	0	0	0
3. Nutritional Modifiers (8190)	0	0	0	0	0	0	0	0
XIII. HEMATOLOGICAL AGENTS								
A. Hematopoetic Agents (82)	**9,098**	**1,202,572**	**10,509**	**1,723,149**	**9,408**	**1,562,009**	**11,382**	**2,707,568**
1. Cobalamines (8210)	0	0	1	4	0	0	0	0
2. Folic Acid (8220)	7,530	36,464	8,560	39,977	7,686	39,265	9,175	61,815
3. Iron (8230)	4	58	3	0	0	0	0	0
4. Colony Stimulating Factor (8240	1,549	1,165,706	1,935	1,683,048	1,719	1,522,708	2,102	2,513,859
5. Cerezyme (8270)	0	0	0	0	0	0	36	129,600
5. Hematopoetic Mixtures (8299)	15	344	10	120	3	36	69	2,295
B. Anticoagulants (83)	**41,753**	**1,353,488**	**44,284**	**1,516,411**	**41,008**	**1,709,515**	**42,216**	**2,126,013**
1. Heparin (8310)	3,499	531,710	3,438	634,539	2,988	721,284	3,770	1,201,037
2. Coumarin Anticoagulants (8320)	38,254	821,778	40,846	881,872	38,020	988,232	38,446	924,976

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
C. Hemostatics (84)	**23**	**5,189**	**22**	**3,983**	**24**	**5,450**	**31**	**8,793**
1. Hemostatics - Systemic (8410)	17	4,640	22	3,983	24	5,450	29	8,310
2. Hemostatics - Topical (8420)	6	549	0	0	0	0	2	483
D. Miscellaneous Hematological (85)	**42,293**	**7,126,844**	**51,813**	**10,122,186**	**48,134**	**10,755,084**	**43,476**	**14,003,401**
1. Antihemophilic Products (8510)	293	3,988,553	347	5,583,688	421	5,568,811	349	8,669,884
2. Platelet Aggregation Inhibitors (8	31,259	2,754,622	42,552	4,282,358	40,850	5,000,896	37,220	5,233,027
3. Hematorheological (8520)	10,724	379,080	8,902	254,782	6,857	184,610	5,891	93,759
4. Plasma Proteins (8540)	17	4,590	10	1,233	4	627	15	6,457
5. Protamine (8550)	0	0	0	0	0	0	0	0
6. Thromolytic Enzymes (8560)	0	0	2	125	2	140	1	274
XIV. TOPICAL PRODUCTS								
A. Ophthalmic (86)	**66,156**	**2,099,217**	**72,440**	**2,606,170**	**73,101**	**3,416,556**	**81,065**	**4,003,175**
1. Ophthalmic Anti-Infectives (8610	22,836	387,721	24,828	466,586	26,485	553,156	33,091	707,680
2. Artificial Tears & Lubricants (862	23	1,298	9	583	1	58	0	0
3. Beta Blockers - Ophthalmic (862	11,504	400,343	11,168	408,679	10,150	411,380	9,407	411,875
4. Ophthalmic Steroids (8630)	9,409	289,904	9,977	312,455	9,716	336,184	10,392	374,631
5. Prostaglandin Agonist (8633)	7,383	384,657	10,141	566,830	11,211	685,230	11,638	782,775
6. Cycloplegics (8635)	571	8,143	640	9,602	608	9,425	859	11,999
7. Opthalmic Decongestants (8640)	57	551	23	233	17	233	21	197
8. Miotics (8650)	1,759	30,549	1,405	22,118	1,015	16,157	866	13,475
9. Adrenergic Mydriatics (8660)	6,268	293,454	7,019	368,287	6,370	399,858	5,595	407,497
10. Restasis (8672)	0	0	0	0	0	0	528	48,473
11. Ophthalmic Local Anesthetics (8	14	208	21	267	23	217	41	452
12. Miscellaneous Ophthalmics (868	6,332	302,390	7,209	450,530	7,505	1,004,658	8,627	1,244,121
B. Otic (87)	**21,074**	**509,077**	**24,678**	**621,080**	**26,625**	**757,477**	**35,312**	**1,147,167**
1. Otic Antibiotics (8710)	2,887	110,556	4,002	163,796	5,049	224,484	7,272	381,695
2. Otic Analgesics (8720)	25	453	23	425	33	535	43	676
3. Otic Steroids (8730)	337	2,686	379	4,848	400	9,305	417	10,665
4. Otic Miscellaneous (8740)	1,144	27,923	1,317	33,515	931	25,213	334	7,418
5. Otic Cortone (8770)	102	2,282	331	7,346	651	16,023	971	31,720
6. Otic Combinations (8799)	16,578	365,177	18,626	411,148	19,558	481,918	26,275	714,993
C. Mouth - Throat (Local) (88)	**11,428**	**148,971**	**12,924**	**181,691**	**12,820**	**240,247**	**17,271**	**367,498**
1. Anti-Infectives - Throat (8810)	7,267	85,151	7,795	101,905	7,890	157,342	11,447	251,484
2. Antiseptics - Mouth/Throat (8815	2,138	21,572	2,338	20,103	2,382	22,382	2,561	26,625
3. Steroids - Mouth (8825)	453	3,362	421	3,256	417	3,221	542	9,005
4. Antiallergy Agents (8827)	0	0	27	558	65	1,313	55	1,269
5. Anesthetics Oral Topical (8835)	1,063	7,556	1,642	11,555	1,317	11,151	1,459	10,917
6. Dental Products (8840)	239	2,772	349	4,148	419	5,085	796	9,977
7. Miscellaneous Throat Products (8	268	28,557	352	40,166	330	39,753	411	58,221
D. Anorectal (89)	**1,414**	**38,526**	**1,812**	**43,723**	**1,802**	**48,260**	**2,144**	**64,701**
1. Rectal Steroids (8910)	694	7,471	1,020	10,133	953	10,081	1,176	13,471
2. Intrarectal Steroids (8915)	46	4,574	32	2,851	20	2,580	31	5,175
3. Rectal Combinations (8999)	674	26,482	760	30,738	829	35,598	937	46,055
E. Dermatological (90)	**123,927**	**4,037,140**	**131,336**	**4,523,632**	**131,338**	**4,959,371**	**165,846**	**7,416,316**
1. Acne Products (9005)	3,610	230,238	4,442	300,516	4,623	309,099	6,175	500,112
2. Antibiotics - Topical (9010)	19,395	720,162	19,340	775,076	17,011	736,123	18,464	759,887
3. Antifungals - Topical (9015)	35,239	946,232	36,682	938,230	35,307	948,265	43,567	1,090,589
4. Antiprurtics (9022)	215	8,758	211	8,332	243	11,373	173	8,260
5. Antipsoratics (9025)	839	89,487	1,090	152,710	1,098	175,626	1,526	280,078
6. Antiseborrheic Products (9030)	1,200	9,692	1,216	9,823	1,210	12,457	1,403	19,138
7. Antiviral - Topical (9035)	1,868	76,531	2,051	112,558	2,126	142,922	2,537	191,278
8. Antineoplastics Topical (9037)	411	36,963	362	33,812	344	33,474	322	34,931
9. Burn Products (9045)	5,754	75,435	6,113	82,061	6,037	79,409	6,523	93,241
10.Cauterizing Agents (9050)	0	0	0	0	0	0	2	41
11.Tar Products (9052)	0	0	0	0	0	0	0	0
12. Corticosteroids - Topical (9055)	28,796	610,347	31,492	710,544	30,104	660,167	38,983	811,292
13. Emollients (9065)	1,595	61,863	1,550	68,279	1,332	63,330	1,305	62,626
14. Enzymes - Topical (9070)	6,455	309,979	6,720	321,663	8,517	426,544	11,091	574,581
15.Androgen Hormone Inhibitor - To	2	53	0	0	1	22	0	0
16. Keratolytics (9075)	166	12,971	197	14,673	236	17,855	296	26,767
17. Immune Response Modifier (907	521	64,621	599	77,133	729	105,387	1,317	236,368
18. Immunomodulators, Topical (90	209	14,970	1,795	114,844	6,067	406,028	12,165	1,048,120
19. Local Anesthetics - Topical (908	2,197	113,347	2,362	154,014	2,087	176,588	2,606	300,584
20. Pigmenting - Depigmenting Ager	77	8,264	74	6,500	68	4,402	93	4,973
21. Scabicides & Pediculocides (909	13,317	320,361	13,071	336,562	12,916	422,989	15,321	1,138,518
22. Hydroactive Dressings (9094)	1,975	326,060	1,841	305,056	1,180	226,287	1,736	231,659
23. Miscellaneous Topical (9097)	86	807	128	1,246	102	1,026	241	3,274
XV. MISCELLANEOUS PRODUCTS								
A. Antiseptic - Disinfectant (92)	**470**	**10,122**	**459**	**11,036**	**377**	**9,165**	**532**	**14,968**
1. Antiseptics & Disinfectants (920	0	0	1	23	1	7	4	75
2. Chlorine Antiseptics (9210)	470	10,122	458	11,013	376	9,158	527	14,888
3. Iodine Antiseptics (9220)							1	6
B. Antidotes (93)	**91**	**23,686**	**103**	**39,203**	**129**	**88,942**	**156**	**121,143**
1. Antidotes (9300)	82	19,143	100	38,251	119	85,886	152	119,775
2. Chelating Agents (9310)	9	4,543	3	952	10	3,056	4	1,368

	2000-01		2001-02		2002-03		2003-04	
	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *	# of Claims	Total $ *
C. Diagnostic Products (94)	**125**	**6,589**	**280**	**15,903**	**149**	**8,193**	**96**	**5,453**
1. Diagnostic Reagents (9410)	3	0	25	256	0	0	0	0
2. Diagnostic Drugs (9420)	38	4,592	106	14,104	53	7,052	28	4,564
3. Diagnostic Biologicals (9430)	84	1,997	149	1,543	96	1,141	68	888
4. Radiographic Contrast Media (94	0	0	0	0	0	0	0	0
5. Non-Radiographic Contrast Media	0	0	0	0	0	0	0	0
D. Chemicals (96)	**41**	**5,137**	**68**	**11,717**	**54**	**3,432**	**93**	**5,840**
1. Liquids (9620)							5	112
2. Solids (9630)	1	60	12	1,160	7	570	4	36
3. Bulk Chemicals - A's (9642)	1	157	1	80	2	81	0	0
4. Bulk Chemicals - B's (9644)	0	0	0	0	4	1,160	0	0
5. Bulk Chemicals - C's (9646)	0	0	2	0	0	0	12	317
6. Bulk Chemicals - D's (9648)	0	0	1	55	4	248	3	145
7. Bulk Chemicals - G's (9654)	0	0	0	0	0	0	2	166
8. Bulk Chemicals - H's (9656)	0	0	0	0	0	0	3	88
9. Bulk Chemicals - I's (9658)	10	442	6	233	0	0	0	0
10. Bulk Chemicals - K's (9662)	14	3,404	26	8,865	1	75	12	4,356
11. Bulk Chemicals - L's (9664)	10	1,031	20	1,324	30	893	9	347
12. Bulk Chemicals - P's (9672)	0	0	0	0	1	63	4	41
13. Bulk Chemicals - S's (9678)	0	0	0	0	1	205	0	0
14. Bulk Chemicals - T's (9680)	0	0	0	0	4	137	39	232
15. Bulk Chemicals (9690)	5	43	0	0	0	0	0	0
E. Medical Devices (97)	**2,846**	**86,167**	**3,498**	**110,043**	**4,214**	**145,049**	**8,539**	**345,640**
1. Parenteral Therapy Supplies (97(	15	186	15	432	5	102	1	20
2. Respiratory Therapy Supplies (97	2,742	83,988	3,342	105,206	4,151	144,155	8,475	344,518
3. GI-GU Ostomy & Irrigation Suppl	37	1,420	40	3,501	4	272	0	0
4. Diabetic Supplies (9720)	6	31	8	43	1	4	0	0
5. Contraceptives (9740)	46	541	93	861	53	516	63	1,102
F. Pharmaceutical Adjuvants (98)	**3,949**	**110,043**	**2,619**	**67,451**	**1,685**	**35,417**	**2,062**	**52,009**
1. Pharmaceutical Excipients (9835	0	0	0	0	1	4	7	196
2. Liquid Vehicle (9840)	3,730	105,583	2,332	61,192	1,418	28,801	1,861	47,167
3. Semi-Solid Vehicles (9860)	0	0	0	0	0	0	3	67
4. Placebo (9880)	219	4,460	287	6,259	266	6,613	191	4,579
G. Unclassified (99)	**7,321**	**1,859,233**	**6,467**	**1,617,079**	**5,461**	**1,682,400**	**8,722**	**2,146,499**
1. Unclassified (9900)	99	1,570	68	1,082	40	565	33	549
2. Chelating Agents (9920)	78	7,282	81	8,893	86	8,959	59	9,074
3. Enzymes (9935)	1	26	0	0	0	0	0	0
4. Immunomodulators (9939)	61	60,247	88	115,771	80	133,516	125	301,746
5. Immunosuppressive Agents (994	4,367	1,327,198	4,467	1,334,588	4,418	1,498,637	4,502	1,718,189
6. K Removing Resin (9945)	402	30,022	605	36,595	419	30,343	502	34,915
7. Irrigation Solutions (9975)	2,313	432,888	1,158	120,150	418	10,379	335	6,150
8. OTC Claritin (9991)	0	0	0	0	0	0	3,156	75,876
XVI. UNDESIGNATED MEDICATIONS	**0**	**0**	**27,857**	**476,314**	**55,179**	**2,404,531**	**39,684**	**1,667,543**
TOTAL	**4,215,464**	**$202,533,688**	**4,700,519**	**$253,515,055**	**4,641,822**	**$288,416,383**	**5,504,540**	**$364,195,810**

* Total rounded to nearest dollar.

Drug Utilization Review

OKLAHOMA HEALTH CARE AUTHORITY
PAID PHARMACY CLAIMS WITH A DATE-OF-SERVICE FROM JULY 1, 2003 THROUGH JUNE 30, 2004
Report by Number of Claims and Dollars

Claims-Rank	Drug Name	Total Claims	Rank $		Total $
1	Hydrocodone-Acetaminophen Tab 7.5	96,500	109	$	778,666.55
2	Amoxicillin (Trihydrate) For Susp	87,232	102	$	827,929.74
3	Albuterol Inhal Aerosol 90 MCG/AC	79,871	85	$	1,017,801.22
4	Ranitidine HCl Tab 150 MG	70,492	144	$	607,113.23
5	Furosemide Tab 40 MG	59,736	231	$	371,363.79
6	Hydrocodone-Acetaminophen Tab 5-500	59,355	239	$	351,015.15
7	Propoxyphene-N w/ APAP Tab 100-65	58,747	169	$	505,717.30
8	Hydrocodone-Acetaminophen Tab 10-	47,946	80	$	1,055,975.88
9	Potassium Chloride Microencapsula	43,101	92	$	903,512.57
10	Azithromycin Tab 250 MG	41,855	34	$	1,968,429.32
11	Azithromycin For Susp 200 MG/5ML	41,787	52	$	1,499,321.42
12	Cephalexin Cap 500 MG	37,637	201	$	423,376.04
13	Amoxicillin & K Clavulanate For S	35,715	27	$	2,207,714.72
14	Amoxicillin (Trihydrate) Cap 500	34,658	331	$	225,695.86
15	Furosemide Tab 20 MG	32,072	377	$	187,959.18
16	Fluticasone-Salmeterol Powder Dis	32,041	4	$	4,428,526.04
17	Divalproex Sodium Tab Delayed Rel	30,910	6	$	4,086,556.12
18	Albuterol Sulfate Soln Nebu 0.083	30,651	167	$	512,467.75
19	Tramadol HCl Tab 50 MG	30,532	230	$	371,962.81
20	Phenytoin Sodium Extended Cap 100	29,826	89	$	937,417.27
21	Potassium Chloride Cap CR 10 mEq	28,580	154	$	553,020.72
22	Sertraline HCl Tab 100 MG	28,010	11	$	3,172,376.11
23	Metoprolol Succinate Tab SR 24HR	27,902	67	$	1,199,585.73
24	Sertraline HCl Tab 50 MG	27,655	17	$	2,732,045.15
25	Montelukast Sodium Tab 10 MG (Bas	27,360	12	$	3,134,132.27
26	Cyclobenzaprine HCl Tab 10 MG	26,955	247	$	336,689.66
27	Lansoprazole Cap Delayed Release	26,906	3	$	4,819,474.13
28	Escitalopram Oxalate Tab 10 MG (B	25,886	36	$	1,931,752.64
29	Promethazine HCl Tab 25 MG	24,954	213	$	397,381.11
30	Gabapentin Cap 300 MG	24,851	13	$	3,072,656.62
31	Metformin HCl Tab 500 MG	24,810	191	$	448,648.39
32	Clopidogrel Bisulfate Tab 75 MG (	24,729	7	$	3,956,934.61
33	Clonidine HCl Tab 0.1 MG	24,719	369	$	194,009.57
34	Acetaminophen w/ Codeine Tab 300-	24,611	329	$	228,698.23

35	Ibuprofen Tab 800 MG	24,601	416	$	164,455.91
36	Digoxin Tab 0.125 MG	24,529	330	$	226,326.47
37	Hydrochlorothiazide Tab 25 MG	24,039	518	$	115,688.98
38	Lisinopril Tab 10 MG	23,774	312	$	237,667.80
39	Sulfamethoxazole-Trimethoprim Tab	23,527	467	$	136,494.41
40	Carisoprodol Tab 350 MG	23,123	288	$	261,671.37
41	Atorvastatin Calcium Tab 10 MG (B	22,891	25	$	2,256,343.65
42	Naproxen Tab 500 MG	21,291	353	$	204,745.80
43	Metoprolol Tartrate Tab 50 MG	20,823	516	$	116,206.66
44	Levothyroxine Sodium Tab 100 MCG	20,738	232	$	368,976.49
45	Fluticasone Propionate Nasal Susp	20,619	58	$	1,389,017.67
46	Montelukast Sodium Chew Tab 5 MG	20,445	31	$	2,035,005.06
47	Lisinopril Tab 20 MG	20,418	268	$	298,029.13
48	Fluoxetine HCl Cap 20 MG	20,203	344	$	215,204.37
49	Amphetamine-Dextroamphetamine Tab	19,351	69	$	1,160,365.27
50	Polyethylene Glycol 3350 Oral Pow	19,066	136	$	630,773.75
51	Risperidone Tab 1 MG	18,347	10	$	3,282,368.08
52	Albuterol-Ipratropium Aerosol 103	18,223	50	$	1,524,771.21
53	Celecoxib Cap 200 MG	17,773	21	$	2,447,093.35
54	Azithromycin For Susp 100 MG/5ML	17,708	120	$	728,336.63
55	Isosorbide Mononitrate Tab SR 24H	17,550	262	$	306,087.39
56	Paroxetine HCl Tab 20 MG	17,200	44	$	1,700,286.00
57	Risperidone Tab 0.5 MG	16,788	18	$	2,658,794.90
58	Levofloxacin Tab 500 MG	16,742	57	$	1,412,579.16
59	Insulin Isophane & Regular (Human	16,611	75	$	1,108,628.66
60	Levothyroxine Sodium Tab 50 MCG	16,412	294	$	255,995.17
61	Alprazolam Tab 0.5 MG	16,057	510	$	118,227.63
62	Triamterene & Hydrochlorothiazide	16,053	438	$	149,740.91
63	Citalopram Hydrobromide Tab 20 MG	16,044	53	$	1,466,399.57
64	Trazodone HCl Tab 50 MG	16,041	621	$	85,364.32
65	Amphetamine-Dextroamphetamine Cap	15,878	56	$	1,455,977.33
66	Estrogens, Conjugated Tab 0.625 M	15,868	123	$	721,624.48
67	Potassium Chloride Tab CR 10 mEq	15,859	384	$	183,535.73
68	Fluticasone Propionate Inhal Aero	15,545	61	$	1,278,862.17
69	Famotidine Tab 20 MG	15,374	494	$	124,620.22
70	Loratadine Tab 10 MG	15,313	287	$	262,898.63
71	Metoclopramide HCl Tab 10 MG	15,182	459	$	139,511.04
72	Insulin Isophane (Human) Inj 100	15,048	97	$	864,787.67
73	Zolpidem Tartrate Tab 10 MG	14,998	65	$	1,237,949.20
74	Alprazolam Tab 1 MG	14,864	476	$	133,704.25
75	Atorvastatin Calcium Tab 20 MG (B	14,823	26	$	2,231,896.84
76	Carbamazepine Tab 200 MG	14,709	263	$	305,655.77
77	Diltiazem HCl Coated Beads Cap SR	14,663	96	$	866,234.27
78	Tolterodine Tartrate Cap SR 24HR	14,598	47	$	1,592,052.01
79	Donepezil Hydrochloride Tab 10 MG	14,523	30	$	2,106,331.75
80	Glyburide Tab 5 MG	14,342	357	$	203,007.18
81	Omeprazole Magnesium Delayed Rele	13,960	218	$	386,736.39
82	Atenolol Tab 50 MG	13,918	545	$	104,533.23
83	Olanzapine Tab 5 MG	13,865	8	$	3,417,846.78
84	Quetiapine Fumarate Tab 25 MG	13,793	46	$	1,686,533.87
85	Pantoprazole Sodium EC Tab 40 MG	13,519	41	$	1,760,972.56
86	Clonazepam Tab 0.5 MG	13,518	591	$	92,105.35

87	Montelukast Sodium Chew Tab 4 MG	13,514	63	$	1,267,844.72
88	Furosemide Tab 80 MG	13,287	497	$	123,424.43
89	Acetaminophen w/ Codeine Elixir 1	13,230	602	$	89,839.23
90	Methylprednisolone Tab 4 MG Dose	13,206	575	$	96,040.39
91	Oxycodone w/ Acetaminophen Tab 5-	13,152	563	$	99,572.52
92	Digoxin Tab 0.25 MG	13,070	483	$	129,149.50
93	Lorazepam Tab 0.5 MG	13,048	500	$	122,335.88
94	Nitrofurantoin Monohydrate Macroc	13,033	155	$	549,796.27
95	Alendronate Sodium Tab 70 MG	12,711	68	$	1,173,450.72
96	Sulfamethoxazole-Trimethoprim Sus	12,375	308	$	240,860.01
97	Olanzapine Tab 10 MG	12,276	2	$	5,086,843.30
98	Ciprofloxacin HCl Tab 500 MG (Bas	12,231	73	$	1,113,871.23
99	Quetiapine Fumarate Tab 100 MG	12,118	24	$	2,260,677.79
100	Omeprazole Cap Delayed Release 20	12,055	43	$	1,726,632.88
		2,439,045		**$**	**111,745,288.26**

***Report Includes ALL Generic and Brand Name Medications**

Drug Utilization Review

Oklahoma Health Care Authority
Top 100 Medications by Pharmacy Reimbursement
for Pharmacy Claims Comparison of
State Fiscal Years 2000-01, 2001-02, 2002-03, and 2003-04

00-01	01-02	02-03	03-04	MEDICATION *		03-04 $	02-03 $	01-02 $	00-01 $
**	27	4	1	Olanzapine Tab 20 MG	*Zyprexa 20 MG*	5,427,259	3,618,697	1,338,476	0
1	1	1	2	Olanzapine Tab 10 MG	*Zyprexa 10 MG*	5,086,565	4,922,178	5,192,448	4,823,947
2	2	2	3	Lansoprazole Cap Delayed Release 30 MG	*Prevacid 30 MG DR*	4,819,474	4,511,728	4,284,201	3,315,037
**	**	**	4	Fluticasone-Salmeterol Powder Disks (all strengths)	*Advair Discus*	4,428,526	0	0	0
23	9	6	5	Olanzapine Tab 15 MG	*Zyprexa 15 MG*	4,243,443	3,164,308	2,278,474	1,207,774
**	**	**	6	Divalproex Sodium Tab Delayed Release (all strengths)	*Depakote*	4,086,556			
6	3	3	7	Clopidogrel Bisulfate Tab 75 MG (Base Equiv)	*Plavix 75 MG*	3,956,935	4,004,049	3,527,555	2,274,768
8	5	5	8	Olanzapine Tab 5 MG	*Zyprexa 5 MG*	3,417,847	3,284,478	2,740,006	2,114,441
50	26	18	9	Quetiapine Fumarate Tab 200 MG	*Seroquel 200 MG*	3,324,002	2,066,446	1,365,718	799,124
3	4	7	10	Risperidone Tab 1 MG	*Risperdal 1 MG*	3,282,075	3,033,960	2,789,033	2,675,659
16	15	14	11	Sertraline HCl Tab 100 MG	*Zoloft 100 MG*	3,171,729	2,296,488	1,872,097	1,474,587
27	22	16	12	Montelukast Sodium Tab 10 MG (Base Equiv)	*Singulair 10 MG*	3,134,092	2,115,646	1,601,732	1,063,543
13	14	10	13	Gabapentin Cap 300 MG	*Neurontin 300 MG*	3,072,657	2,408,939	1,994,785	1,615,171
12	10	8	14	Risperidone Tab 2 MG	*Risperdal 2 MG*	3,034,122	2,618,588	2,211,956	1,731,404
**	**	**	15	Antihemophilic Factor (Recombinan	*Multiple Brands*	2,908,674	0	0	0
30	28	22	16	Palivizumab For Inj 100 MG	*Synagis 100 MG*	2,873,632	1,868,368	1,317,285	1,034,510
9	11	12	17	Sertraline HCl Tab 50 MG	*Zoloft 50 MG*	2,732,045	2,344,980	2,176,330	1,874,330
15	13	9	18	Risperidone Tab 0.5 MG	*Risperdal 0.5 MG*	2,658,795	2,488,221	2,079,638	1,476,190
11	12	13	19	Risperidone Tab 3 MG	*Risperdal 3 MG*	2,639,431	2,315,938	2,108,584	1,777,578
**	52	31	20	Oxycodone HCl Tab SR 12HR 80 MG	*Oxycontin 80 MG*	2,629,183	1,500,802	997,870	0
10	8	11	21	Celecoxib Cap 200 MG	*Celebrex 200 MG*	2,447,093	2,401,433	2,365,146	1,829,958
44	74	63	22	Palivizumab For Inj 50 MG	*Synagis 50 MG*	2,443,014	910,757	753,774	869,441
**	**	**	23	Antihemophilic Factor (Human) For	*Multiple Brands*	2,436,236	0	0	0
38	34	29	24	Quetiapine Fumarate Tab 100 MG	*Seroquel 100 MG*	2,260,155	1,526,990	1,196,968	936,614
32	21	21	25	Atorvastatin Calcium Tab 10 MG (Base Equivalent)	*Lipitor 10 MG*	2,256,344	1,897,834	1,626,134	1,019,369
49	33	26	26	Atorvastatin Calcium Tab 20 MG (Base Equivalent)	*Lipitor 20 MG*	2,231,897	1,638,370	1,216,972	837,831
58	**	92	27	Amoxicillin & K Clavulanate For Susp 600-42.9 MG/5ML	*Augmentin 400/5ML*	2,207,715	680,488	0	664,078
75	49	35	28	Oxycodone HCl Tab SR 12HR 40 MG	*Oxycontin 40 MG CR*	2,190,398	1,427,621	1,032,170	564,895
28	23	24	29	Simvastatin Tab 20 MG	*Zocor 20 MG*	2,160,559	1,866,643	1,551,212	1,038,298
48	37	28	30	Donepezil Hydrochloride Tab 10 MG	*Aricept 10 MG*	2,106,332	1,543,627	1,171,869	841,153
62	59	46	31	Montelukast Sodium Chew Tab 5 MG (Base Equiv)	*Singulair 5 MG*	2,035,005	1,100,668	848,190	633,291
**	**	85	32	Quetiapine Fumarate Tab 300 MG	*Seroquel 300 MG*	2,017,579	747,621	0	0
**	**	32	33	Esomeprazole Magnesium Cap Delayed Release 40 MG	*Nexium 40 MG*	2,005,510	1,453,432	0	0
33	39	33	34	Azithromycin Tab 250 MG	*Zithromax 250 MG*	1,968,384	1,450,368	1,149,721	1,006,887
**	**	**	35	Aripiprazole Tab 15 MG	*Abilify 15 MG*	1,949,644	0	0	0
**	**	**	36	Escitalopram Oxalate Tab 10 MG (B	*Lexapro 10 MG*	1,931,355	0	0	0
**	38	27	37	Antiinhibitor Coagulant Complex For Inj	*Autoplex T*	1,889,465	1,577,864	1,163,733	0
41	30	30	38	Rosiglitazone Maleate Tab 8 MG (Base Equiv)	*Avandia 8 MG*	1,883,801	1,519,389	1,271,213	905,070

**	80	47	39	Fentanyl TD Patch 72HR 100 MCG/HR	*Duragesic 100 MCG/HR*	1,856,831	1,095,362	708,415	0
24	16	19	40	Olanzapine Tab 2.5 MG	*Zyprexa 2.5 MG*	1,851,318	2,024,535	1,811,020	1,073,445
**	94	34	41	Pantoprazole Sodium EC Tab 40 MG (Base Equiv)	*Protonix 40 MG*	1,760,973	1,436,871	622,572	0
**	17	23	42	Megestrol Acetate Susp 40 MG/ML	*Megace*	1,751,187	1,867,622	1,760,058	0
5	7	17	43	Omeprazole Cap Delayed Release 20 MG	*Prilosec 20 MG CR*	1,726,629	2,113,979	2,477,348	2,318,213
7	6	15	44	Paroxetine HCl Tab 20 MG	*Paxil 20 MG*	1,700,286	2,272,708	2,504,224	2,138,848
84	55	39	45	Simvastatin Tab 40 MG	*Zocor 40 MG*	1,690,643	1,201,747	906,889	519,492
66	54	40	46	Quetiapine Fumarate Tab 25 MG	*Seroquel 25 MG*	1,686,534	1,164,319	916,062	623,394
**	84	52	47	Tolterodine Tartrate Cap SR 24HR 4 MG	*Detrol LA*	1,592,052	1,055,277	688,053	0
56	69	65	48	Etanercept For SC Inj Kit 25 MG	*Enbrel 25 MG*	1,587,018	874,557	804,754	734,930
**	**	**	49	Olanzapine Orally Disintegrating	*Zyprexa Zydis*	1,587,683	0	0	0
61	61	50	50	Albuterol-Ipratropium Aerosol 103-18 MCG/ACT (120-20MCG/A	*Combivent*	1,523,325	1,058,659	830,890	643,613
76	64	41	51	Risperidone Tab 4 MG	*Risperdal 4 MG*	1,512,054	1,163,916	823,771	559,059
74	81	58	52	Azithromycin For Susp 200 MG/5ML	*Zithromax 200/5 ML*	1,499,321	991,517	708,379	579,848
37	24	25	53	Citalopram Hydrobromide Tab 20 MG (Base Equiv)	*Celexa 20 MG*	1,466,400	1,804,088	1,528,115	945,712
**	86	61	54	Topiramate Tab 100 MG	*Topamax 100 MG*	1,462,483	929,299	673,330	0
**	**	53	55	Glatiramer Acetate Inj Kit 20 MG/ML	*Copaxone*	1,245,471	1,023,330	0	0
**	**	**	56	Amphetamine-Dextroamphetamine Cap	*Adderall XR*	1,455,977	0	0	0
36	47	43	57	Levofloxacin Tab 500 MG	*Levaquin 500 MG*	1,412,579	1,120,862	1,051,697	950,580
94	**	78	58	Fluticasone Propionate Nasal Susp 50 MCG/ACT	*Flonase 0.05%*	1,388,950	803,865	0	472,181
**	**	88	59	Gabapentin Tab 600 MG	*Neurontin 600 MG*	1,330,628	724,231	0	0
87	62	60	60	Oxycodone HCl Tab SR 12HR 20 MG	*Oxycontin 20 MG CR*	1,303,774	960,047	829,793	503,834
**	**	**	61	Fluticasone Propionate Inhal Aero (all strengths)	*Flowvent*	1,278,862	0	0	0
42	45	45	62	Rosiglitazone Maleate Tab 4 MG (Base Equiv)	*Avandia 4 MG*	1,270,239	1,103,776	1,084,748	904,904
**	**	**	63	Montelukast Sodium Chew Tab 4 MG	*Singulair 4 MG*	1,267,845	0	0	0
**	68	42	64	Risperidone Tab 0.25 MG	*Risperdal 0.25 MG*	1,241,104	1,133,610	813,100	0
80	83	69	65	Zolpidem Tartrate Tab 10 MG	*Ambien 10 MG*	1,237,949	854,781	702,038	532,325
**	**	**	66	Aripiprazole Tab 10 MG	*Abilify 10 MG*	1,233,731	0	0	0
**	**	**	67	Metoprolol Succinate Tab SR 24HR	*Toprol XL*	1,199,533	0	0	0
**	70	54	68	Alendronate Sodium Tab 70 MG	*Fosamax 70 MG*	1,173,451	1,016,985	799,837	0
**	**	**	69	Amphetamine-Dextroamphetamine Tab	*Adderall*	1,160,365	0	0	0
**	**	84	70	Desmopressin Acetate Tab 0.2 MG	*DDAVP*	1,150,649	756,447	0	0
78	72	57	71	Bupropion HCl Tab CR 150 MG	*Wellbutrin 150 MG SR*	1,150,478	994,614	792,690	547,894
**	**	90	72	Fentanyl TD Patch 72HR 75 MCG/HR	*Duragesic*	1,116,795	700,971	0	0
35	48	44	73	Ciprofloxacin HCl Tab 500 MG (Base Equiv)	*Cipro 500 MG*	1,113,871	1,107,609	1,044,057	959,083
**	98	71	74	Pioglitazone HCl Tab 30 MG (Base Equiv)	*Actos 30 MG*	1,112,899	838,264	610,444	0
**	53	59	75	Insulin Isophane & Regular (Human) Inj 100 U/ML (70-30)	*Humulin*	1,108,524	981,919	936,858	0
**	**	**	76	Atomoxetine HCl Cap 40 MG (Base E	*Strattera 40 MG*	1,089,861	0	0	0
**	**	83	77	Fentanyl TD Patch 72HR 50 MCG/HR	*Duragesic*	1,072,025	758,114	0	0
**	25	36	78	Clozapine Tab 100 MG	*Clozaril 100 MG*	1,069,137	1,328,260	1,445,701	0
**	**	**	79	Enoxaparin Sodium Inj 10 MG/0.1ML	*Lovenox*	1,067,859	0	0	0
**	**	96	80	Acetaminophen w/ Hydrocodone Tab 500-10 MG	*Lortab 500-10 MG*	1,055,976	649,651	0	0
**	**	87	81	Atorvastatin Calcium Tab 40 MG (Base Equivalent)	*Lipitor 40 MG*	1,049,921	728,482	0	0
**	**	**	82	Insulin Glargine Inj 100 Unit/ML	*Lantus*	1,031,359	0	0	0
31	36	56	83	Rofecoxib Tab 25 MG	*Vioxx 25 MG*	1,027,401	1,004,856	1,186,258	1,027,178
79	71	64	84	Tobramycin Nebu Soln 300 MG/5ML	*Tobi 300/5 ML*	1,026,378	907,196	792,854	536,368
77	40	66	85	Albuterol Inhal Aerosol 90 MCG/ACT	*Proventil/Ventolin 0.083%*	1,017,792	863,300	1,137,827	558,329
**	**	86	87	Citalopram Hydrobromide Tab 40 MG (Base Equiv)	*Celexa 40 MG*	956,145	736,980	0	0
**	**	**	88	Paroxetine HCl Tab SR 24HR 25 MG	*Paxil CR 25 MG*	946,843	0	0	0

**	67	74	89	Phenytoin Sodium Extended Cap 100 MG	*Dilantin*	937,417	827,354	815,577	0
**	**	**	90	Pioglitazone HCl Tab 45 MG (Base	*Actos 45 MG*	928,292	0	0	0
**	**	**	91	Levetiracetam Tab 500 MG	*Keppra 500 MG*	903,899	0	0	0
**	50	55	92	Potassium Chloride Tab Particles CR 20 mEq	*K-Dur 20*	903,490	1,007,264	1,031,765	0
**	**	**	93	Pimecrolimus Cream 1%	*Elidel*	899,323	0	0	0
64	78	81	94	Gabapentin Cap 400 MG	*Neurontin 400 MG*	889,927	784,533	734,864	630,067
**	**	**	95	Escitalopram Oxalate Tab 20 MG (B	*Lexapro 20 MG*	877,250	0	0	0
**	**	**	96	Diltiazem HCl Coated Beads Cap SR	*Multiple Brands*	866,234	0	0	0
**	65	70	97	Insulin Isophane (Human) Inj 100 U/ML	*Humulin N, Novolin N*	864,788	841,954	822,640	0
29	42	72	98	Amlodipine Besylate Tab 10 MG	*Norvasc 10 MG*	862,819	828,409	1,130,808	1,035,625
**	**	**	99	Budesonide Inhalation Susp 0.5 MG	*Pulmicort*	846,292	0	0	0
**	**	**	100	Amlodipine Besylate - Benazepril HCl (all strengths)	*Lotrel*	840,218			
**	**	96	**	Acetaminophen w/ Hydrocodone Tab 500-10 MG	*Lortab 500-10 MG*	0	649,651	0	0
85	99	100	**	Acetaminophen w/ Hydrocodone Tab 500-7.5 MG	*Lortab 7.5-500*	0	618,782	600,415	511,912
22	32	77	**	Amlodipine Besylate Tab 5 MG	*Norvasc 5 MG*	0	807,546	1,225,679	1,211,737
88	93	94	**	Amoxicillin & K Clavulanate Tab 875-125 MG	*Augmentin 875 MG*	0	669,482	634,827	495,899
73	**	98	**	Calcitonin (Salmon) Nasal Soln 200 IU/ACT	*Miacalcin 200 IU/AC*	0	631,170	0	582,709
25	43	38	**	Divalproex Sodium EC Tab 250 MG	*Depakote 250 MG EC*	0	1,231,838	1,125,525	1,066,773
17	19	20	**	Divalproex Sodium EC Tab 500 MG	*Depakote 500 MG EC*	0	1,990,905	1,672,093	1,474,316
40	60	73	**	Donepezil Hydrochloride Tab 5 MG	*Aricept 5 MG*	0	828,062	833,085	920,308
72	85	75	**	Dornase Alfa Inhal Soln 1 MG/ML	*Pulmozyme 1 MG/ML*	0	819,781	674,776	589,604
60	57	80	**	Estrogens, Conjugated Tab 0.625 MG	*Premarin 0.625 MG*	0	787,626	883,234	652,168
**	**	67	**	Fluticasone-Salmeterol Powder Disks 100-50 MCG/DOSE	*Advair Discus*	0	861,482	0	0
**	**	49	**	Fluticasone-Salmeterol Powder Disks 250-50 MCG/DOSE	*Advair Discus*	0	1,063,607	0	0
89	**	99	**	Interferon Beta-1a For IM Inj Kit 30MCG [33MCG(6.6 MU)/Vial	*Avonex 30 MCG*	0	622,642	0	495,701
26	44	68	**	Ipratropium Bromide Inhal Soln 0.02%	*Atrovent Inhal*	0	855,193	1,094,605	1,063,872
21	41	62	**	Metformin HCl Tab 500 MG	*Glucophage 500 MG*	0	925,810	1,136,129	1,223,583
59	58	79	**	Mirtazapine Tab 15 MG	*Remeron 15 MG*	0	794,102	876,794	659,174
53	63	89	**	Paroxetine HCl Tab 10 MG	*Paxil 10 MG*	0	714,127	829,611	773,068
**	96	82	**	Paroxetine HCl Tab 40 MG	*Paxil 40 MG*	0	773,583	617,171	0
**	**	91	**	Raloxifene HCl Tab 60 MG	*Evista 60 MG*	0	686,082	0	0
18	100	51	**	Ranitidine HCl Cap 150 MG	*Zantac 150 MG*	0	1,058,150	592,015	1,434,761
**	**	95	**	Ribavirin Cap 200 MG	*Rebatol 200 MG*	0	651,496	0	0
**	**	97	**	Tamsulosin HCl Cap SR 24HR 0.4 MG	*Flomax 0.4 MG*	0	647,824	0	0
**	**	93	**	Tizanidine HCl Tab 4 MG	*Zanaflex 4 MG*	0	677,185	0	0
14	18	76	**	Tramadol HCl Tab 50 MG	*Ultram 50 MG*	0	808,084	1,750,445	1,545,918
**	76	48	**	Venlafaxine HCl Cap SR 24HR 150 MG	*Effexor 150 MG*	0	1,072,896	744,042	0
63	46	37	**	Venlafaxine HCl Cap SR 24HR 75 MG	*Effexor XR 75 MG*	0	1,282,234	1,069,009	630,809

* Drug Name represents all generic equivalents for multi-source medications.
** Not in Top 100
Prepared by Pharmacy Management Consultants 5/14/2005

Drug Utilization Review

OKLAHOMA HEALTH CARE AUTHORITY
PAID PHARMACY CLAIMS WITH A DATE-OF-SERVICE FROM JULY 1, 2003 THROUGH JUNE 30, 2004
Top 100 Medications by Dollars

Rank $	Drug Name	TotalAmount
1	Olanzapine Tab 20 MG	$5,427,259.27
2	Olanzapine Tab 10 MG	$5,086,843.30
3	Lansoprazole Cap Delayed Release	$4,819,474.13
4	Fluticasone-Salmeterol Powder Dis	$4,428,526.04
5	Olanzapine Tab 15 MG	$4,248,821.58
6	Divalproex Sodium Tab Delayed Rel	$4,086,556.12
7	Clopidogrel Bisulfate Tab 75 MG (	$3,956,934.61
8	Olanzapine Tab 5 MG	$3,417,846.78
9	Quetiapine Fumarate Tab 200 MG	$3,324,160.76
10	Risperidone Tab 1 MG	$3,282,368.08
11	Sertraline HCl Tab 100 MG	$3,172,376.11
12	Montelukast Sodium Tab 10 MG (Bas	$3,134,132.27
13	Gabapentin Cap 300 MG	$3,072,656.62
14	Risperidone Tab 2 MG	$3,034,122.07
15	Antihemophilic Factor (Recombinan	$2,908,673.74
16	Palivizumab For Inj 100 MG	$2,873,631.58
17	Sertraline HCl Tab 50 MG	$2,732,045.15
18	Risperidone Tab 0.5 MG	$2,658,794.90
19	Risperidone Tab 3 MG	$2,639,797.82
20	Oxycodone HCl Tab SR 12HR 80 MG	$2,629,182.86
21	Celecoxib Cap 200 MG	$2,447,093.35
22	Palivizumab For Inj 50 MG	$2,443,014.25
23	Antihemophilic Factor (Human) For	$2,436,236.40
24	Quetiapine Fumarate Tab 100 MG	$2,260,677.79
25	Atorvastatin Calcium Tab 10 MG (B	$2,256,343.65
26	Atorvastatin Calcium Tab 20 MG (B	$2,231,896.84
27	Amoxicillin & K Clavulanate For S	$2,207,714.72
28	Oxycodone HCl Tab SR 12HR 40 MG	$2,190,397.57
29	Simvastatin Tab 20 MG	$2,160,559.39
30	Donepezil Hydrochloride Tab 10 MG	$2,106,331.75
31	Montelukast Sodium Chew Tab 5 MG	$2,035,005.06
32	Quetiapine Fumarate Tab 300 MG	$2,018,163.42
33	Esomeprazole Magnesium Cap Delayed	$2,005,510.25
34	Azithromycin Tab 250 MG	$1,968,429.32
35	Aripiprazole Tab 15 MG	$1,950,086.49
36	Escitalopram Oxalate Tab 10 MG (B	$1,931,752.64
37	Antiinhibitor Coagulant Complex F	$1,889,465.47
38	Rosiglitazone Maleate Tab 8 MG (B	$1,883,801.47
39	Fentanyl TD Patch 72HR 100 MCG/HR	$1,856,830.78

92	Potassium Chloride Microencapsula	$903,512.57
93	Pimecrolimus Cream 1%	$899,487.35
94	Gabapentin Cap 400 MG	$889,927.09
95	Escitalopram Oxalate Tab 20 MG (B	$877,250.46
96	Diltiazem HCl Coated Beads Cap SR	$866,234.27
97	Insulin Isophane (Human) Inj 100	$864,787.67
98	Amlodipine Besylate Tab 10 MG	$862,818.50
99	Budesonide Inhalation Susp 0.5 MG	$846,292.49
100	Amlodipine Besylate-Benazepril HC	$840,217.65

$185,822,642.35

***Report Includes ALL Generic and Brand Name Medications**

Drug Utilization Review

OKLAHOMA HEALTH CARE AUTHORITY
PAID PHARMACY CLAIMS WITH A DATE-OF-SERVICE FROM JULY 1, 2003 THROUGH JUNE 30, 2004
Top 50 Medications by Dollars

Rank $	Drug Name	TotalAmount
1	Olanzapine Tab 20 MG	$5,427,259.27
2	Olanzapine Tab 10 MG	$5,086,843.30
3	Lansoprazole Cap Delayed Release	$4,819,474.13
4	Fluticasone-Salmeterol Powder Dis	$4,428,526.04
5	Olanzapine Tab 15 MG	$4,248,821.58
6	Divalproex Sodium Tab Delayed Rel	$4,086,556.12
7	Clopidogrel Bisulfate Tab 75 MG (	$3,956,934.61
8	Olanzapine Tab 5 MG	$3,417,846.78
9	Quetiapine Fumarate Tab 200 MG	$3,324,160.76
10	Risperidone Tab 1 MG	$3,282,368.08
11	Sertraline HCl Tab 100 MG	$3,172,376.11
12	Montelukast Sodium Tab 10 MG (Bas	$3,134,132.27
13	Gabapentin Cap 300 MG	$3,072,656.62
14	Risperidone Tab 2 MG	$3,034,122.07
15	Antihemophilic Factor (Recombinan	$2,908,673.74
16	Palivizumab For Inj 100 MG	$2,873,631.58
17	Sertraline HCl Tab 50 MG	$2,732,045.15
18	Risperidone Tab 0.5 MG	$2,658,794.90
19	Risperidone Tab 3 MG	$2,639,797.82
20	Oxycodone HCl Tab SR 12HR 80 MG	$2,629,182.86
21	Celecoxib Cap 200 MG	$2,447,093.35
22	Palivizumab For Inj 50 MG	$2,443,014.25
23	Antihemophilic Factor (Human) For	$2,436,236.40
24	Quetiapine Fumarate Tab 100 MG	$2,260,677.79
25	Atorvastatin Calcium Tab 10 MG (B	$2,256,343.65
26	Atorvastatin Calcium Tab 20 MG (B	$2,231,896.84
27	Amoxicillin & K Clavulanate For S	$2,207,714.72
28	Oxycodone HCl Tab SR 12HR 40 MG	$2,190,397.57
29	Simvastatin Tab 20 MG	$2,160,559.39
30	Donepezil Hydrochloride Tab 10 MG	$2,106,331.75
31	Montelukast Sodium Chew Tab 5 MG	$2,035,005.06
32	Quetiapine Fumarate Tab 300 MG	$2,018,163.42
33	Esomeprazole Magnesium Cap Delaye	$2,005,510.25
34	Azithromycin Tab 250 MG	$1,968,429.32
35	Aripiprazole Tab 15 MG	$1,950,086.49
36	Escitalopram Oxalate Tab 10 MG (B	$1,931,752.64
37	Antiinhibitor Coagulant Complex F	$1,889,465.47
38	Rosiglitazone Maleate Tab 8 MG (B	$1,883,801.47
39	Fentanyl TD Patch 72HR 100 MCG/HR	$1,856,830.78

40	Olanzapine Tab 2.5 MG	$1,851,632.17
41	Pantoprazole Sodium EC Tab 40 MG	$1,760,972.56
42	Megestrol Acetate Susp 40 MG/ML	$1,751,186.75
43	Omeprazole Cap Delayed Release 20	$1,726,632.88
44	Paroxetine HCl Tab 20 MG	$1,700,286.00
45	Simvastatin Tab 40 MG	$1,690,643.49
46	Quetiapine Fumarate Tab 25 MG	$1,686,533.87
47	Tolterodine Tartrate Cap SR 24HR	$1,592,052.01
48	Etanercept For Subcutaneous Inj K	$1,590,648.60
49	Olanzapine Orally Disintegrating	$1,587,682.68
50	Albuterol-Ipratropium Aerosol 103	$1,524,771.21
51	Risperidone Tab 4 MG	$1,512,053.81
52	Azithromycin For Susp 200 MG/5ML	$1,499,321.42
53	Citalopram Hydrobromide Tab 20 MG	$1,466,399.57
54	Topiramate Tab 100 MG	$1,462,482.62
55	Glatiramer Acetate Inj Kit 20 MG/	$1,462,093.05
56	Amphetamine-Dextroamphetamine Cap	$1,455,977.33
57	Levofloxacin Tab 500 MG	$1,412,579.16
58	Fluticasone Propionate Nasal Susp	$1,389,017.67
59	Gabapentin Tab 600 MG	$1,330,628.29
60	Oxycodone HCl Tab SR 12HR 20 MG	$1,303,774.20
61	Fluticasone Propionate Inhal Aero	$1,278,862.17
62	Rosiglitazone Maleate Tab 4 MG (B	$1,270,483.05
63	Montelukast Sodium Chew Tab 4 MG	$1,267,844.72
64	Risperidone Tab 0.25 MG	$1,241,451.54
65	Zolpidem Tartrate Tab 10 MG	$1,237,949.20
66	Aripiprazole Tab 10 MG	$1,234,916.52
67	Metoprolol Succinate Tab SR 24HR	$1,199,585.73
68	Alendronate Sodium Tab 70 MG	$1,173,450.72
69	Amphetamine-Dextroamphetamine Tab	$1,160,365.27
70	Desmopressin Acetate Tab 0.2 MG	$1,151,062.78
71	Bupropion HCl Tab SR 12HR 150 MG	$1,150,527.33
72	Fentanyl TD Patch 72HR 75 MCG/HR	$1,116,794.77
73	Ciprofloxacin HCl Tab 500 MG (Bas	$1,113,871.23
74	Pioglitazone HCl Tab 30 MG (Base	$1,112,898.65
75	Insulin Isophane & Regular (Human	$1,108,628.66
76	Atomoxetine HCl Cap 40 MG (Base E	$1,089,860.99
77	Fentanyl TD Patch 72HR 50 MCG/HR	$1,072,025.05
78	Clozapine Tab 100 MG	$1,069,137.31
79	Enoxaparin Sodium Inj 10 MG/0.1ML	$1,067,859.42
80	Hydrocodone-Acetaminophen Tab 10-	$1,055,975.88
81	Atorvastatin Calcium Tab 40 MG (B	$1,050,092.14
82	Insulin Glargine Inj 100 Unit/ML	$1,031,750.16
83	Rofecoxib Tab 25 MG	$1,027,401.44
84	Tobramycin Nebu Soln 300 MG/5ML	$1,026,377.99
85	Albuterol Inhal Aerosol 90 MCG/AC	$1,017,801.22
86	Budesonide Inhalation Susp 0.25 M	$1,001,661.19
87	Citalopram Hydrobromide Tab 40 MG	$956,144.55
88	Paroxetine HCl Tab SR 24HR 25 MG	$946,842.57
89	Phenytoin Sodium Extended Cap 100	$937,417.27
90	Pioglitazone HCl Tab 45 MG (Base	$928,291.66
91	Levetiracetam Tab 500 MG	$903,899.38

40	Olanzapine Tab 2.5 MG	$1,851,632.17
41	Pantoprazole Sodium EC Tab 40 MG	$1,760,972.56
42	Megestrol Acetate Susp 40 MG/ML	$1,751,186.75
43	Omeprazole Cap Delayed Release 20	$1,726,632.88
44	Paroxetine HCl Tab 20 MG	$1,700,286.00
45	Simvastatin Tab 40 MG	$1,690,643.49
46	Quetiapine Fumarate Tab 25 MG	$1,686,533.87
47	Tolterodine Tartrate Cap SR 24HR	$1,592,052.01
48	Etanercept For Subcutaneous Inj K	$1,590,648.60
49	Olanzapine Orally Disintegrating	$1,587,682.68
50	Albuterol-Ipratropium Aerosol 103	$1,524,771.21

$129,676,556.62

***Report Includes ALL Generic and Brand Name Medications**

APPENDIX I

60 Day Notice of Product Based Prior Authorization of Fenofibrates

Oklahoma Medicaid
June 2005

Recommendations

The following tier table is recommended as a clinically acceptable combination for use as initial therapy for the majority of clients. The College of Pharmacy recommends this list to the Drug Utilization Review board for approval and referral to the Oklahoma Healthcare Authority for supplemental rebate consideration and final approval by the OHCA Board of Directors.

Fibric Acid Derivatives	
Tier One	***Tier Two***
Lofibra® 67mg Caps	Tricor® 48mg Tabs
Lofibra® 134mg Caps	Tricor® 145mg Tabs
Lofibra® 200mg Caps	Antara® 43mg Caps
Gefibrozil 600mg Tabs	Antara® 87mg Caps
Clofibrate 500mg Caps	Antara® 130mg Caps
	Triglide® 50mg Tabs
	Triglide® 160mg Tabs

The approval criteria for a tier-2 medication is as follows:

1. Laboratory documented failure with a tier one medication after 6 months trial with a tier one medication.
2. Documented adverse effect, drug interaction, or contraindication to tier-1 products.
3. Prior stabilization on the tier-2 medication documented within the last 100 days.

Anticipated New Product

The FDA recently approved a new formulation of fenofibrate, Triglide®, made and marketed by SkyePharma/First Horizon Pharmaceuticals. Triglide® has a comparable absorption under fed and fasting conditions, allowing patients to take the drug without regard to meals. Triglide® is expected to be on the market July 14, 2005.

Potential Ecomonic Impact

Total Reimbursed for Antihyperlipidemic Therapy – 3rd Qtr FY '05		
Class	**Total Claims**	**Total Reimbursement**
Bile Sequestrants	708	$ 47,505.16
Fibric Acid Derivatives	3,434	$ 230,638.70
Misc. Antihyperlipidemics	1,301	$ 152.542.87
HMG CoA Reductase Inhibitors	30,618	$ 4,424,759.70
Nicotinic Acid Derivatives	368	$ 34,050.35
Total	**36,429**	**$ 4,889,496.78**

Fenofibrate Client Demographics – 3rd Qtr FY '05

Table 1a. All Clients

Age	Female	Male	Totals
0 to 9	0	1	1
10 to 19	2	4	6
20 to 34	32	32	64
35 to 49	172	177	349
50 to 64	403	241	644
65 to 79	387	131	518
80 to 94	161	34	195
95 and Over	4	1	5
Totals	**1,161**	**621**	**1,782**

Table 1b. Clients in a Care Facility

Age	Female	Male	Totals
0 to 9	0	0	0
10 to 19	0	0	0
20 to 34	2	0	2
35 to 49	7	19	26
50 to 64	32	20	52
65 to 79	56	25	81
80 to 94	47	14	61
95 and Over	2	1	3
Totals	**146**	**79**	**225**

Table 1c. Waiver-Advantage Clients

Age	Female	Male	Totals
0 to 9	0	0	0
10 to 19	0	0	0
20 to 34	0	0	0
35 to 49	5	6	11
50 to 64	20	12	32
65 to 79	20	4	24
80 to 94	6	2	8
95 and Over	0	0	0
Totals	**51**	**24**	**75**

Market Analysis - 2nd Qtr FY '05

Table 2a. Market Share and Cost

Product	Total Claims	Total Days	Total Reimbursement	% Market Share	% Cost
*Tricor® Tabs**	1,410	66,982	$ 185,988.31	49.19	80.64
Lofibra® Caps	20	842	$ 1,478.05	0.62	0.64
Gemfibrozil Tabs	2,004	68,339	$ 43,172.34	50.19	18.72

*Includes all forms of Tricor® still available, but no longer being manufactured.

Table 2b. Product Cost Comparison

Product	EAC	SMAC
Tricor® 48 mg	$ 1.07	N/A
Tricor® 145 mg	$ 3.22	N/A
Lofibra® 67 mg	$ 0.75	N/A
Lofibra® 134 mg	$ 1.45	N/A
Lofibra® 200 mg	$ 2.26	N/A
Lopid® 600 mg	$ 1.68	0.28
Fenofibrate 67 mg	$ 0.65	N/A
Fenofibrate 134 mg	$ 1.46	N/A
Fenofibrate 200 mg	$ 1.94	N/A
Gemfibrozil 600 mg	N/A	0.28
Clofibrate 500 mg	$ 0.23	N/A
Antara® 43 mg	$ 0.97	N/A
Antara® 130 mg	$ 3.09	N/A

Potential Administrative Costs

Based on a potential shift of proposed tier two products to a tier one product of 15%, it is estimated that approximately 800 to 1,500 petitions would be required annually. The proposed tier changes would affect approximately 50% of the total population for this PBPA category.

Previously, it has been theorized that total cost per petition to the healthcare system (includes cost to physicians, pharmacists, and program) is between $6.75 and $12.97. Total cost of prior authorization to the healthcare system is estimated to be between $5,400 and $19,455 annually. Anticipated actual administrative cost to the program is projected to be approximately $10,000.

Potential Program Savings

Potential savings to the program based on recommended tiers and a potential shift of 15% of market share from tier two to tier one is estimated to be $141,091 annually. This is the net ingredient cost savings after accounting for rebates and dispensing fees.

Total Potential Savings*

Potential Savings:	$ 141,091.00		$ 141,091.00
Potential Administrative Cost:	5,400.00		19,455.00
Total Potential Program Savings:	**$ 135,691.00**	**to**	**$ 121,636.00**

*Additional savings through potential supplemental rebates has not been included.

APPENDIX J

30 Day Notice of Intent to Prior Authorize Zetia®

Oklahoma Medicaid
June 2005

Recommendations

The College of Pharmacy recommends a prior authorization be placed on Zetia®. The approval criteria is as follows:

1. Diagnosis:
   - Hypercholesterolemia, primary
   - Hypercholesterolemia, homozygous familial
   - Sitosterolemia, homozygous

2. Laboratory documentation that client has not met (LDL) cholesterol goals after therapeutic lifestyle changes and statin therapy for at least 6 months.

3. Not a candidate for statin therapy due to:
   - Documented active liver disease.
   - Documented unexplained, persistent elevations of serum transaminases.
   - Documented statin related myopathy.

Potential Economic Impact

Utilization for January 2004 through December 2004

Clients	Cost	Claims	Units	Days	Cost/ Unit	Cost/ Claim	Cost/ Day	Cost/ Client
1,062	$ 409,844.00	3,470	171,897	169,447	$ 2.38	$ 118.11	$ 2.42	$ 385.92

	Calendar Year 2003	*Calendar Year 2004*	*Percent Change*	
Total Clients	434	1,062	Increased	144.70 %
Total Claims	1,279	3,470	Increased	171.31 %
Total Cost	$130,826.33	$409,844.00	Increased	213.27 %
Total Days	57,989	169,447	Increased	192.26 %
Per Diem	$2.26	$2.42	Increased	7.08 %

CY04

Age	Female	Male	Totals
0 to 9	0	2	2
10 to 19	8	11	19
20 to 34	15	7	22
35 to 49	77	70	147
50 to 64	267	126	393
65 to 79	310	65	375
80 to 94	92	12	104
95 and Over	0	0	0
Totals	**769**	**293**	**1,062**

For Calendar Year 2004 a total of 625 clients were on Zetia® and a statin.

Annual Savings Estimates

Potential savings based on CY04 utilization.

Use Reduction	PA Cost[1]	Clients Approved	Projected Reimbursement	Projected Savings[2]
↓ 25 %	$ 24,111.23	797	$ 307,578.24	$ 78,154.53
↓ 33 %	$ 22,995.81	711	$ 274,389.12	$ 112,459.07
↓ 50 %	$ 20,661.21	531	$ 204,923.52	$ 184,259.27
↓ 75 %	$ 17,224.16	266	$ 102,654.72	$ 289,965.12

[1]The average cost for processing petitions is calculated at $6.75 per petition with the maximum cost at $12.97 per petition. The maximum cost was used in the estimation of administrative costs. PA Cost = 1 PA request for all clients affected plus 1 additional PA request per each approved client.

[2]Projected Savings = (Current Reimbursement - Projected Reimbursement) - PA Cost. Cost reductions were not taken for rebates or dispensing fees.

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[i] Merck & Co., Inc. Product Literature Zetia®. March 2005. Available online at: http://www.zetia.com/zetia/shared/documents/zetia_pi.pdf

APPENDIX K

30 Day Notice of Intent to Prior Authorize Elidel® (Pimecrolimus) and Protopic® (Tacrolimus)

Oklahoma Medicaid
June 2005

Therapeutic indications

- *Elidel® (Pimecrolimus)*- Short-term to intermittent treatment of mild to moderate atopic dermatitis (eczema) in non-immunocompromised patients over 2 years of age whom are not responsive or intolerant to conventional treatments.
- *Protopic® (Tacrolimus)*- Short-term to intermittent treatment of moderate to severe atopic dermatitis (eczema) in non-immunocompromised patients over 2 years of age whom are not responsive or intolerant to conventional treatments.

Unapproved or Off-label uses

Alopecia areata, vitiligo, contact dermatitis, lupus erythematosus, seborrheic dermatitis, psoriasis, acne, and blepharitis.

Recommendations

- The College of Pharmacy recommends prior authorization be placed on topical immunosuppressants Protopic® and Elidel® with the following criteria:

  - Clinically diagnosed and adherence to age restrictions:
    - Elidel® for short-term and intermittent treatment for mild to moderate atopic dermatitis (eczema)
    - Protopic® for short-term and intermittent treatment for moderate to severe atopic dermatitis (eczema)
    - Elidel® 1% ≥ 2 years of age
    - Protopic® 0.03% for ≥ 2 years of age
    - Protopic® 0.1% for ≥ 15 years of age (Approved for adult-use only)
  - Non-immunocompromised patients.
  - A failed trial of at least two topical corticosteroids with each trial lasting 6 weeks in duration within the last 90 days (~12 weeks). Trials should consist of one high-potency strength for acute episodes and one low/medium potency for maintenance therapy.
  - Limited to one authorization per year to ensure appropriate short-term and intermittent utilization advised by FDA.
  - Quantity limitation per approval for all ages: 30 gram(s) maximum for face, neck, and groin areas, 100 gram(s) maximum for all other areas.

- Clinical Exceptions:
  - Documented adverse effect, drug interaction, or contraindication to topical corticosteroid products.
  - Atopic Dermatitis on the face where physician does not want to use topical corticosteroids.

Black Box Warning – March 10, 2005

There are potential risks with the use of these topical agents as determined by recent animal studies and post-marketing case reports. Systemic formulations of these drugs have shown to be associated with systemic cancers; such as lymphoma and skin papillomas. Topical dosage forms tend to have less systemic absorption but relatively similar carcinogenic risks which increase with duration and level of exposure to these immunosuppressants. The FDA's Pediatric Advisory Committee advised that the dose-dependent risk of developing cancers warrant strict adherence to prescribing Elidel® (Pimecrolimus) and Protopic® (Tacrolimus) only as directed by package insert.

Cost Comparison of Atopic Dermatitis Treatments

Agent#	Drug	Purpose	Side-effect profile	Cost*
Topical Corticosteroid (high, medium, low potency) ***1st Line***	Clobetasol 0.05% (crm, ont, gel)	Anti-inflammatory; *super-high potency*	Skin Atrophy Hypopigmentation Systemic Effects	$32.99
	Fluocinonide 0.05% (crm, ont, gel)	Anti-inflammatory; *med-high potency*		$27.66
	Fluocinolone acetonide 0.025% (ointment)	Anti-inflammatory; *medium potency*		$9.16
	Prednicarbate 0.1% (crm,ont)	Anti-inflammatory; *medium-low potency*		$43.30
	Flurandrenolide 0.025% (crm,ont)	Anti-*inflammatory; low* potency		$22.33
	Hydrocortisone 1% (crm,ont)	Anti-inflammatory; *lowest potency*		$3.12
Topical Calcineurin Inhibitors ***2nd Line***	Pimecrolimus 1% (cream)	Anti-inflammatory; immunosuppressant	Burning, stinging, pruritis, erythema, cancer risk	$57.84
	Tacrolimus 0.1% (ointment)			$61.72
	Tacrolimus 0.03% (ointment)			$59.53

*Based on one 30 gram tube. No rebate information was incorporated. #Monotherapy or adjunctive therapy.

Potential Economic Impact

January 2004 through December 2004

Product	Clients	Cost	Claims	Units	Days	Cost/ Unit	Cost/ Claim	Cost/ Day	Cost/ Client
Elidel®	8,449	$1,376,213.05	15,186	798,986	223,276	$1.72	$ 90.62	$ 6.16	$ 162.88
Proptopic® 0.03%	323	$ 58,950.09	627	29,730	9,769	$1.98	$ 94.02	$ 6.03	$ 182.51
Protopic® 0.1%	481	$ 141,107.13	1,101	68,420	16,819	$ 2.06	$ 128.16	$ 8.39	$ 293.36

	Calendar Year 2003	*Calendar Year 2004*	*Percent Change*	
Total Clients	4,340	9,013	Increased	107.67 %
Total Claims	7,513	16,914	Increased	125.13 %
Total Cost	$ 564,700.08	$ 1,576,270.27	Increased	179.13 %
Total Days	92,119	249,864	Increased	171.24 %
Per Diem	$ 6.13	$ 6.31	Increased	2.94 %

Both Elidel® and Protopic® are approved for children 2 years of age and older.

	<1 yr	1 yr	2 yr
Female	680	586	404
Male	979	698	489
Total	1,659	1,284	893

Medical, hospital and pharmacy claims were reviewed for clients receiving Elidel® or Protopic® during calendar year 2004. Total costs for clients 2 years of age or greater with an appropriate diagnosis and/or topical steroid use are listed below.

Drugname	Total Claims	Total Units	Total Days	Clients	Total Paid
Elidel Cream 1%	4,871	270,650	72,592	2,431	$ 463,426.04
Protopic Ointment 0.03%	277	14,070	4,218	131	$ 27,975.86
Protopic Ointment 0.1%	668	42,310	9,752	268	$ 86,999.48
TOTAL	**5,816**	**327,030**	**86,562**	**2,700***	**$ 578,401.36**

*Unduplicated clients for time period.

Potential savings based on CY04 utilization.

Administrative Cost[1]	Clients Approved	Projected Reimbursement	Projected Savings[2]
$ 151,917.61	2,700	$ 578,401.36	$ 845,951.30

[1]The average cost for processing petitions is calculated at $6.75 per petition with the maximum cost at $12.97 per petition. This cost is based on total cost to the healthcare system. The maximum cost was used in the estimation of administrative costs. Administrative Cost = 1 PA request for all clients effected plus 1 additional PA request per each approved client.
[2]Projected Savings = (Current Reimbursement - Projected Reimbursement) - PA Cost. Cost reductions were not taken for rebates or dispensing fees.

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APPENDIX L

U.S. Food and Drug Administration

FDA Talk Paper

T05-23
May 20, 2005

Media Inquiries: Bradford Stone
301-827-6242
Consumer Inquiries: 888-INFO-FDA

FDA Warns Against Abuse of Dextromethorphan (DXM)

The Food and Drug Administration (FDA) is concerned about the abuse of dextromethorphan (DXM), a synthetically produced ingredient found in many over-the-counter (OTC) cough and cold remedies. The agency is working with other health and law enforcement authorities to address this serious issue and warn the public of potential harm, after five recently reported deaths of teenagers that may be associated with the consumption of powdered DXM sold in capsules.

Although DXM, when formulated properly and used in small amounts, can be safely used in cough suppressant medicines, abuse of the drug can cause death as well as other serious adverse events such as brain damage, seizure, loss of consciousness, and irregular heart beat.

DXM abuse, though not a new phenomenon, has developed into a disturbing new trend which involves the sale of pure DXM in powdered form. This pure DXM is often encapsulated by the "dealer" and offered for street use.

DXM has gradually replaced codeine as the most widely used cough suppressant in the United States . It is available OTC in capsule, liquid, liquid gelatin capsule, lozenge, and tablet forms. When ingested at recommended dosage levels, DXM is generally a safe and effective cough suppressant.

Additional information about the dangers of Dextromethorphan use and abuse can be found at the following SAMHSA National Clearinghouse for Alcohol and Drug Information links.
http://store.health.org/catalog/mediaDetails.aspx?ID=371,
http://www.family.samhsa.gov/get/otcdrugs.aspx.

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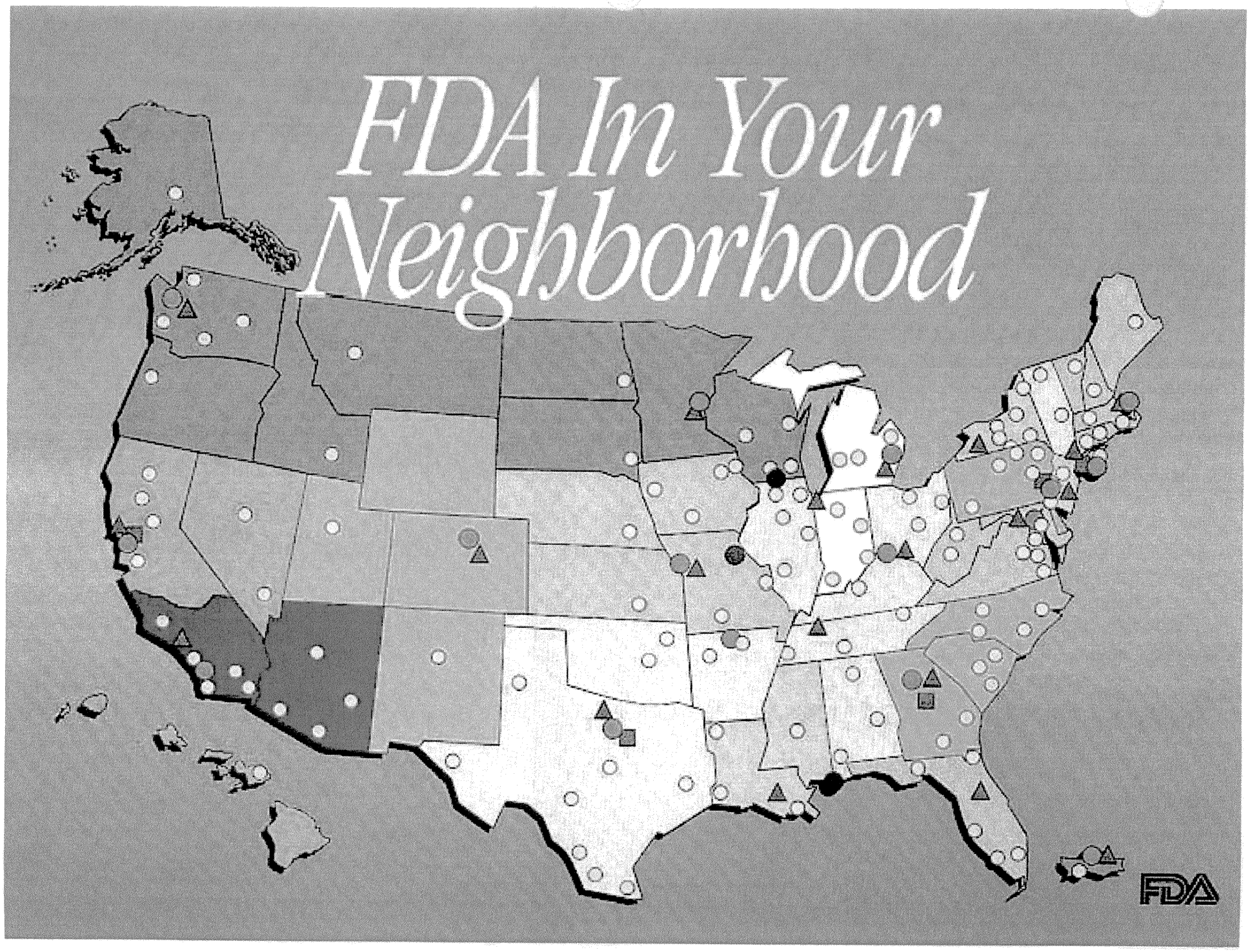
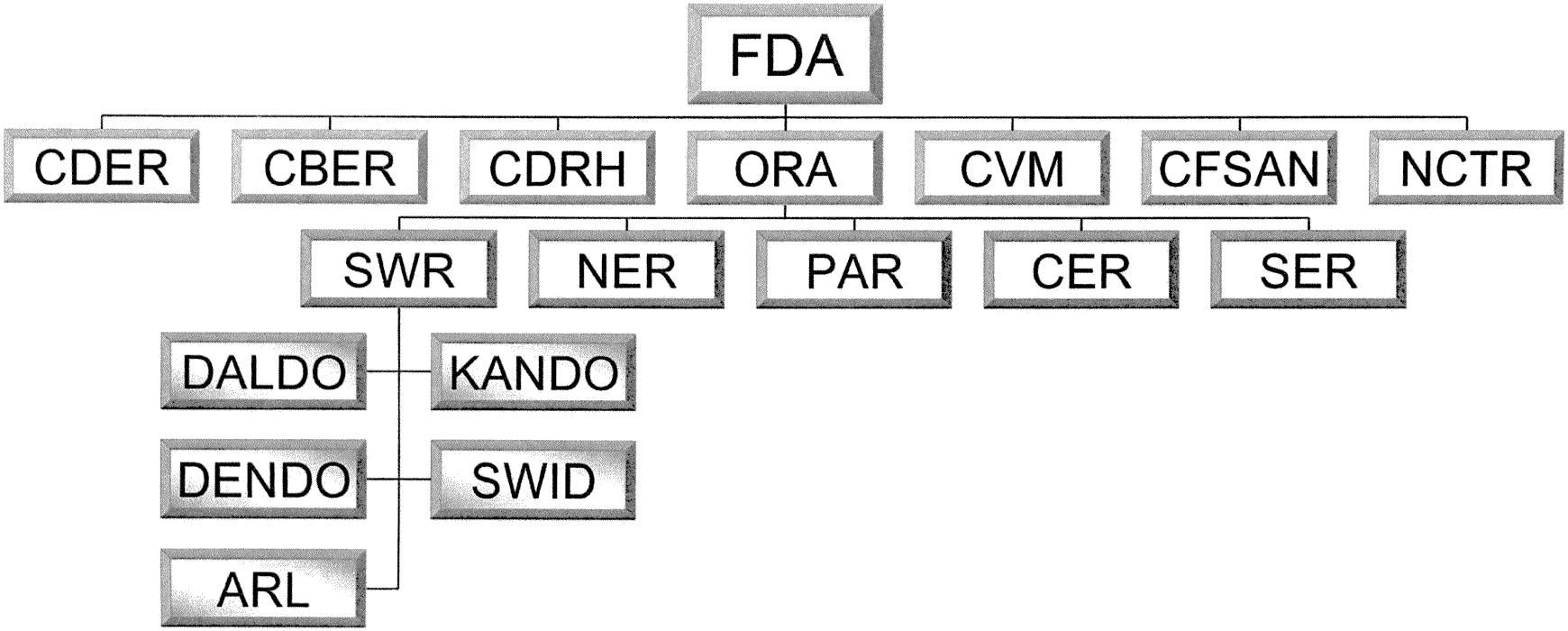

FDA In Your Neighborhood
FDA

Agency Organization



CDER

- Center for Drug Evaluation and Research
- Primary mission: to make certain that safe and effective drugs are available to the American people
  - Includes biological therapeutics

CBER

- Center for Biologics Evaluation and Research
- Regulates biological products
  - Blood and products derived from it
  - Vaccines
  - Human tissue for transplantation
  - Allergenic materials and anti-toxins

CDRH

- Center for Devices and Radiological Health
- Regulates firms that manufacture, repackage, relabel, and/or import medical devices sold in the United States
- Regulates radiation emitting electronic products (medical and non-medical)

CVM

- Center for Veterinary Medicine
- Regulates the manufacture and distribution of food additives and drugs that will be given to animals

CFSAN

- Center for Food Safety and Applied Nutrition
- Ensures that the nation's food supply is safe, sanitary, wholesome, and honestly labeled
- Ensures that cosmetic products are safe and properly labeled

NCTR

- National Center for Toxicological Research
- Conducts peer-reviewed scientific research that supports and anticipates the FDA's current and future regulatory needs
- Fundamental and applied research specifically designed to define biological mechanisms of action underlying the toxicity of products regulated by the FDA

ORA

- Office of Regulatory Affairs
- Lead office for all field activities of the FDA

FDA Regions