# Department of Defense
# Pharmacoeconomic Center

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**MCCS-GPE** **15 Nov 00**

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

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

1. The inaugural meeting of the DoD P&T Executive Council convened at 0800 hours on 15 November 2000, at Ft Sam Houston, TX. The DoD P&T Executive Council is responsible for performing certain inherently governmental functions relevant to the DoD pharmacy benefits program. The council focuses primarily on issues related to the Basic Core Formulary (BCF), national pharmaceutical contracts, and blanket purchase agreements. The DoD P&T Executive Council is comprised of federal employees who are members of the DoD P&T Committee.

2. **MEMBERS PRESENT:**

| | |
|---|---|
| CDR Terrance Egland, MC | P& T Committee Co-chair |
| COL Daniel D. Remund, MS | P& T Committee Co-chair |
| MAJ Brett Kelly, MS | Army |
| LTC Judith O'Connor, MC | Army |
| CDR Matt Nutaitis, MC | Navy |
| CDR Kevin Cook, MSC | Navy |
| COL (select) John R. Downs, MC | Air Force |
| COL Bill Sykora, MC | Air Force |
| MAJ George Jones, BSC | Air Force |
| CDR Robert Rist | Coast Guard |
| Ronald L. Mosier | Department of Veterans Affairs |
| LTC Greg Russie, BSC | Joint Readiness Clinical Advisory Board |
| LTC Steven Humburg, MC | Health Affairs |
| MAJ Mickey Bellemin, BSC | Defense Supply Center Philadelphia |

**MEMBERS ABSENT:**

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| COL Rosa Stith, MC | Army |

**OTHERS PRESENT:**

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| COL Mike Heath, MS | Army Pharmacy Consultant;<br>Chair, DoD Pharmacy Board of Directors |
| CAPT Joe Torkildson, MC | DoD Pharmacoeconomic Center |
| LTC (P) William Davies, MC | DoD Pharmacy Program Director, TMA |
| CDR Mark Brouker, MSC | DoD Pharmacoeconomic Center |
| LTC Don De Groff, MS | DoD Pharmacoeconomic Center |
| LCDR Fred Beale, MSC | Defense Supply Center Philadelphia |
| LCDR Mark Richerson, MSC | DoD Pharmacoeconomic Center |
| MAJ Cheryl Filby, MS | Defense Supply Center Philadelphia |
| MAJ Barbara Roach, MC | DoD Pharmacoeconomic Center |
| HM3 Cory Beckner | DoD Pharmacoeconomic Center |
| Angela Allerman | DoD Pharmacoeconomic Center |
| Howard Altschwager | Deputy General Counsel, TMA |
| Shana Trice | DoD Pharmacoeconomic Center |
| Vincent Valinotti | Defense Supply Center Philadelphia |
| Paul Vasquez | Defense Supply Center Philadelphia |

3. **IMPLICATIONS OF THE FY00 AND FY01 DEFENSE AUTHORIZATION ACTS** – COL Remund and LTC (P) Davies briefed the committee on implications of the FY00 and FY01 Defense Authorization Acts for the BCF. The BCF should be expanded to ensure uniform availability of cost-effective pharmaceuticals that will satisfy the primary care needs of the vast majority of patients served by MTF pharmacies. The DoD Pharmacoeconomic Center (PEC) will analyze drug usage data from MTF pharmacies, the NMOP and retail pharmacy networks to assist the committee in selecting additional pharmaceuticals for inclusion on the BCF at the next P&T meeting.

4. **NATIONAL PHARMACEUTICAL CONTRACTS**

A *Contract awards and renewals*

- The proton pump inhibitor (PPI) contract for omeprazole (Prilosec; Zeneca) was renewed. The price decreased from $1.40 to $1.10 per capsule.

- The FDA approved the marketing of the 0.8 mg dosage of cerivastatin (Baycol; Bayer). The 0.8 mg tablet is not being added to the statin contract, but is available at a DAPA price of $0.50 per tablet. According to package labeling, 0.8 mg/day of cerivastatin reduces LDL cholesterol by 42% and raises HDL cholesterol by 9% after 8 weeks of therapy. A 0.8 mg daily dose of cerivastatin costs $183 per year and provides approximately the same percent reduction in LDL-C as simvastatin 40 mg/day, which costs $361 per year.

- Joint VA/DoD single source contracts were awarded for acetaminophen, acyclovir, azathioprine, hydroxyurea, pentoxifylline, rifampin, sucralfate, and terazosin.

- Joint VA/DoD single source contracts were renewed for ranitidine, insulin, prazosin, and cimetidine.

- Prices and effective dates for contracts are available on the DSCP website.

B. *Financial impact of contracts* – Incomplete prime vendor data impaired the accuracy of previous estimates of the financial impact of national pharmaceutical contracts. The Defense Supply Center Philadelphia (DSCP) recently provided more complete prime vendor data to the PEC. Analysis of the more complete data revealed that MTFs spent approximately $1.03 billion on pharmaceuticals through the prime vendor system in FY 00. MTF cost avoidance from national pharmaceutical contracts was approximately $62.8 million in FY 00. A summary of MTF cost avoidance from national pharmaceutical contracts is provided in Appendix A. Market share and cost avoidance data associated with national pharmaceutical contracts are also available on the PEC website.

C. *Status of joint VA/DoD solicitation for non-sedating antihistamine contract* – Pharmaceutical companies have submitted multiple GAO protests to the solicitation. The PEC is working with the VA Pharmacy Benefit Management (PBM) Strategic Healthcare Group, the VA National Acquisition Center (NAC), and DSCP to resolve the protests.

D. *Status of contracting initiatives for oral contraceptives* – LCDR Beale reported that DSCP received no bids by the closing date of the solicitation for a joint VA/DoD single source contract for 35 mcg ethinyl estradiol (EE) / 1 mg norethindrone. DSCP plans to reissue the solicitation. DSCP also plans to issue solicitations for joint VA/DoD single source contracts for 35 mcg EE / 1 mg ethynodiol diacetate; EE 30/40/30 mcg / levonorgestrel 0.05/0.075/0.125 mcg; and 0.35 mg norethindrone.

E. *Returned goods contract* – LCDR Beale reported on DSCP's efforts to establish a returned goods contract.

F. *Potential future contract initiatives* – Potential candidates for future joint VA/DoD single source contracts include spironolactone, ticlopidine, isosorbide, diclofenac, ketoconazole cream, capsaicin cream, valproic acid, and hydrochlorothiazide.

5. **FLUOROQUINOLONES** – The committee considered safety, tolerability, efficacy and other pertinent factors and concluded that fluoroquinolones are not sufficiently interchangeable for a closed class contract. Fluoroquinolones differ significantly in adverse event profiles, spectrum of activity, and FDA-approved indications. The committee was also concerned that a closed class contract would preclude the use of new fluoroquinolones that may be approved by the FDA in the near future. The new fluoroquinolones may offer significant clinical advantages over existing agents.

   The committee selected levofloxacin for the BCF. The safety, tolerability and efficacy of levofloxacin are equivalent to or better than other fluoroquinolones. MTF fluoroquinolone usage has shifted away from ciprofloxacin in favor of levofloxacin over the past two years. Levofloxacin now accounts for nearly 70% of all fluoroquinolone prescriptions dispensed at

MTFs. The shift in market share was likely spurred by a blanket purchase agreement (BPA) that offered levofloxacin at a price of $2.00 per daily dose if levofloxacin attained a 60% market share at an MTF. Levofloxacin cost $2.50 per daily dose if the 60% market share was not achieved. A recent modification of the levofloxacin BPA lowers the market share requirement to 50%, but MTFs that do not meet the market share requirement will now pay the federal ceiling price of $3.25 per day for levofloxacin.

Some MTFs report that they are unable to obtain levofloxacin at the BPA price because purchases of ciprofloxacin for readiness requirements have artificially depressed the levofloxacin market share at their facilities. This problem is more prevalent at Air Force and Coast Guard pharmacies. The committee encouraged DSCP to modify the terms of the BPA so that MTFs can more easily obtain levofloxacin at the BPA price.

The fluoroquinolone class remains open on the BCF, so MTFs may have fluoroquinolones on their formulary in addition to levofloxacin. The committee is aware that ciprofloxacin is the only fluoroquinolone approved for the treatment of anthrax. The committee stressed that the selection of levofloxacin for the BCF has no bearing on the purchase of ciprofloxacin for readiness requirements.

6. **LEUTINIZING HORMONE RELEASING HORMONE (LHRH) AGONISTS** – The committee considered the PEC clinical review (available on the PEC website) and concluded that it is not possible to establish a closed class contract for a single agent to cover all nine clinical conditions that are treated with LHRH agonists. Seven of the clinical conditions affect only woman or children and two conditions affect only men. None of the four LHRH agonists is indicated for all the clinical conditions. The PEC estimates that 58% of MTF prescriptions for LHRH agonists are for prostate cancer and this usage is fairly evenly split between goserelin and leuprolide. Leuprolide accounts for nearly all the MTF usage for conditions other than prostate cancer.

   The committee concluded that goserelin and leuprolide are equivalent in regard to safety, tolerability, efficacy and other pertinent factors in the treatment of prostate cancer, so it is theoretically possible to establish a closed class contract for the specific indication of prostate cancer. The committee decided not to seek a closed class contract at this time. Since the VA already has a closed class contract for goserelin for treatment of prostate cancer, a joint VA/DoD contract should not be pursued until the VA is ready to rebid the contract. If DoD were to establish its own closed class contract now, it would likely hinder the ability to solicit for a joint VA/DoD contract in the future. The committee also has concerns about the potential complexity of administering a closed class contract for a specific indication within the military health system.

   The committee was informed of a recent voluntary price reduction for leuprolide and an offer of a blanket purchase agreement (BPA) for goserelin (see Appendix B for price information and BPA terms). The BPA prices for goserelin are equal to the VA national contract prices and are substantially lower than the prices for equivalent doses of leuprolide for prostate cancer. The committee advised DSCP to accept the BPA for goserelin. The committee asked DSCP and the PEC to initiate an education/marketing campaign to ensure that goserelin

achieves at least an 80% overall share of the MTF prescriptions for LHRH agonists for prostate cancer as required by the BPA. The PEC will use the Uniformed Services Prescription Database (USPD) to track the market shares for LHRH agonists for prostate cancer.

7. **NASAL INHALED CORTICOSTEROIDS** – The committee reviewed a draft of the VA clinical review and MTF usage and cost data for intranasal corticosteroids. The committee made the following observations and conclusions:

   - Nasal corticosteroids are widely used as first line agents in treating nasal symptoms of seasonal and perennial allergic rhinitis.

   - Nasal corticosteroids do not differ significantly in their safety profiles. All nasal corticosteroids carry the same warning regarding potential suppression of growth in children.

   - Patients generally tolerate the aqueous formulations better than the non-aqueous formulations.

   - All nasal corticosteroids can be considered equally effective for seasonal and perennial allergic rhinitis when used in equipotent doses. Agents that are normally dosed once or twice daily are commonly classified as "high potency" agents. These agents are budesonide 32mcg/spray, fluticasone 50mcg/spray, triamcinolone 55mcg/spray, mometasone 50mcg/spray, and beclomethasone 84mcg/spray.

   - Annual MTF usage of nasal corticosteroids has remained relatively constant, but annual expenditures have nearly doubled over the past three years due to large price increases for some of the agents. Significant shifts in market share have occurred over the past two years—probably in response to the large price increases. Two years ago, beclomethasone inhalers accounted for 80% of all nasal corticosteroid prescriptions filled at MTFs—now they account for only 20% of the prescriptions. Fluticasone 50mcg/spray (the only nasal corticosteroid inhaler currently on the BCF) and mometasone 50mcg/spray now account for 60% and 20% respectively of all nasal steroid prescriptions filled at MTF pharmacies.

   The committee agreed that the nasal corticosteroid inhaler class can be divided into two categories: aqueous and non-aqueous formulations. The aqueous formulations can be further subdivided into high potency and low potency categories. The committee concluded that the BCF must contain, at a minimum, a high potency aqueous nasal corticosteroid. The committee agreed that a closed class contract could be established for a high potency aqueous corticosteroid inhaler. The committee recommended that this should be a joint VA/DoD contract if the requirements of the two agencies are conducive to such a contract. The committee also supports a closed class contract for a non-aqueous corticosteroid inhaler if those involved in the contracting process conclude that it would be beneficial to seek such a contract.

8. **ORAL INHALED CORTICOSTEROIDS** – The committee considered the PEC clinical review (available on the PEC website) and made the following observations and conclusions.

- High potency agents (budesonide and fluticasone) are not interchangeable with low potency agents (beclomethasone, triamcinolone, and flunisolide). Patients with moderate to severe asthma often prefer a high potency agent because they can obtain the necessary dosage with fewer puffs per day than with low potency agents.

- Budesonide and fluticasone are not sufficiently interchangeable because fluticasone is available as a metered dose inhaler (MDI) and a dry powder inhaler (DPI) and budesonide is available only as a DPI. Some patients do not like using the breath-actuated DPI because it lacks the tactile feedback associated with an MDI that uses a propellant to deliver the drug. Breath actuation may be particularly difficult for pediatric patients. Patients who need to use a spacer with a face mask cannot use a budesonide DPI.

- The bitter taste of flunisolide limits its interchangeability with other low potency agents.

- The triamcinolone inhaler comes with a built-in spacer. While this ensures the use of a spacer, the spacer is relatively low volume and does not work well with a face mask.

The committee concluded that oral corticosteroid inhalers are not sufficiently interchangeable for a closed class contract for the overall class or the high potency or low potency categories. The committee discussed the possibility of adding a high potency oral corticosteroid inhaler to the BCF, but concluded that the issue should be addressed in the process of selecting additional agents for the BCF at the next P&T meeting.

9. **POTENTIAL ADDITION OF A THIAZOLIDINEDIONE ("GLITAZONE") TO THE BCF**
The thiazolidinediones currently on the market are rosiglitazone and pioglitazone. Troglitazone was withdrawn in March 2000 due to cases of hepatotoxicity and liver failure, some fatal. The committee agreed that post marketing surveillance has not yet proven conclusively that rosiglitazone and pioglitazone are free from similar safety problems. The committee also discussed the side effect of edema and weight gain known to occur with the glitazones and the related contraindication in patients with New York Heart Association Class III and IV heart failure. Although the glitazones are approved for monotherapy, clinical practice guidelines (including the DoD/VA Clinical Practice Guideline for diabetes) and expert opinion currently support use of glitazones only as add-on medications following sulfonylureas, metformin, and possibly other antidiabetic agents. The committee concluded that a thiazolidinedione should not be added to the BCF at this time.

10. **SELECTION OF A TRIPTAN FOR THE BCF (EVALUATION OF BPA PRICE QUOTES)**

The committee considered the PEC class review (available on the PEC website) of oral 5-$HT_1$ receptor agonists (triptans) and concluded the following:

- There are no clinically significant differences in the overall safety profiles of the individual triptans.

- Patients probably tolerate naratriptan better than the other triptans (the incidence of adverse events experienced by patients in phase III trials was similar to placebo). No significant differences in tolerability can be discerned between the other agents

- The efficacy of triptans can be measured by how fast they relieve headaches, to what degree they relieve headaches, and how frequently the headaches reoccur. Some studies suggest that rizatriptan may be slightly more efficacious than sumatriptan and zolmitriptan, but the available evidence is insufficient to conclude that there is any clinically significant difference in efficacy between rizatriptan, sumatriptan and zolmitriptan. Naratriptan should not be considered a first line agent because of its slower onset of action.

    - Head-to-head trials suggest that rizatriptan may provide earlier and/or more complete headache relief than either sumatriptan or zolmitriptan.

    - Two published meta-analyses of several studies found no significant differences in the "number needed to treat (NNT)" for sumatriptan, rizatriptan, and zolmitriptan. The NNT for naratriptan was significantly higher.

    - The PEC tried to compare the data from various clinical trials that measured efficacy in terms of the percentage of patients who obtained headache relief at two hours after the first dose of a triptan. In an effort to control for factors that may have varied between the trials, the PEC calculated the incremental efficacy of the triptan compared to placebo by subtracting the percentage of patients who obtained relief on placebo from the percentage of people who obtained relief on the triptan. This analysis showed a slightly higher incremental efficacy for rizatriptan. A formal statistical analysis was not performed, but it is likely that the difference between rizatriptan and the other triptans was not statistically significant.

The committee then considered the weighted average cost per prescribed dose for each triptan, which was derived from a frequency distribution of the prescribed doses and the price per tablet for each strength of each triptan. The frequency distributions of prescribed doses were obtained from the USPD. The price per tablet reflected the prices offered by pharmaceutical companies in response to a Blanket Purchase Agreement (BPA) request for price quotes issued by DSCP. The DAPA price was used if a company did not submit a price quote.

The committee concluded that sumatriptan offered the greatest value to DoD. Sumatriptan is similar in safety, tolerability and efficacy to rizatriptan and zolmitriptan. The price quote of $6.95 for sumatriptan 50 mg and 100 mg tablets reflects a 5% price reduction from the existing DAPA prices. Given the fact the sumatriptan accounts for 93% of the triptan usage at MTFs, acceptance of the sumatriptan price quote will yield the greatest cost avoidance for DoD.

The committee voted to add sumatriptan to the BCF. The triptan class remains open on the BCF. The committee emphasized that the addition of sumatriptan to the BCF is not intended to cause MTFs to delete other triptans from their formularies or to switch patients who are already using other triptans to sumatriptan.

11. **UPDATE AND REVISION OF THE ADVANCES IN MEDICAL PRACTICE (AMP) PROGRAM** – Total MTF expenditures and reimbursements in FY 00 for drugs covered by the AMP Program are given in the table below. Total expenditures were just slightly more than the $48.8 million that was programmed for pharmacy in the FY 00 AMP program.

| | MTF Expenditures | AMP Reimbursement |
|---|---|---|
| All AMP drugs other than COX-2 inhibitors | $43,377,976 | $43,377,976 |
| COX-2 inhibitors* | $13,862,741 | $6,931,370 |
| **Total** | **$57,240,717** | **$50,309,346** |

* reimbursed at 50%

Only $50.7 million in AMP funds are projected to be available for pharmacy in FY 01, which will be insufficient to cover the drugs currently included in the AMP program. During the last 3 months of FY 00, MTFs spent an average of $4 million per month on AMP drugs other than COX-2 inhibitors. It would be reasonable to project that expenditures for AMP drugs other than COX-2 inhibitors could easily exceed the $50.7 million in AMP funds programmed for pharmacy in FY 01. Expenditures for COX-2 inhibitors averaged nearly $2 million per month during the last 3 months of FY 00. Even if expenditures for COX-2 inhibitors in FY 01 leveled off at the expenditure rate observed in the last three months of FY 00, pharmacy would still require $12 million above the projected AMP program to reimburse MTFs for COX-2 inhibitors in FY 01. The committee concluded that COX-2 inhibitors should be removed from coverage under the AMP program because funds available to pharmacy are insufficient to support their reimbursement under the AMP program.

12. **CONSIDERATION OF COMBINATION DRUGS FOR THE BCF** – The committee discussed pros and cons of having combination drugs on the BCF. Combination drugs might offer the advantages of greater convenience and improved compliance for patients. They also could possibly reduce workload for pharmacies if a prescription for one combination product actually replaces two prescriptions for individual products. Combination products pose the disadvantages of fixed dosages that preclude adjustment in the dosage of the component drugs and the potential for unnecessary exposure to drugs if a combination product is used when a single drug would have sufficed.

The committee considered Glucovance, a newly-approved combination of metformin and glyburide. Even though Glucovance is priced slightly lower than the combined cost of the individual drugs, the committee decided not to add Glucovance to the BCF. Generic versions of metformin are expected to be available in less than a year, so the cost advantage offered by Glucovance will likely be a short-term phenomenon. The committee expects that cost of

generic versions of the individual drugs will likely be significantly less than the cost of Glucovance.

The committee considered Combivent inhaler, a combination of ipratropium and albuterol. While patients may find Combivent more convenient to use than separate inhalers, there is no conclusive evidence that patient compliance is improved significantly. Combivent costs slightly more than individual ipratropium and albuterol inhalers. The higher cost might be offset by reduced usage of albuterol inhalers, but conclusive data are not available. The committee decided not to add Combivent to the BCF.

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

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

## **Appendix A:** Estimated Cost Avoidance in DoD MTFs Due to National Pharmaceutical Contracts, Fiscal Year 2000

Total FY00 prime vendor purchases in DoD MTFs were $1,024,591,068. The total cost avoidance of $62,804,712 for FY00 was equal to 6.13% of the total FY00 prime vendor purchases.

| Drug/Drug Class | Cost Avoidance |
|---|---|
| Statins | $22,340,377 |
| PPIs | $19,297,055 |
| Lisinopril | $10,072,755 |
| Diltiazem | $6,967,368 |
| Ranitidine | $1,862,449 |
| Albuterol | $923,293 |
| Timolol Gel | $540,882 |
| Verapamil | $413,898 |
| Cimetidine | $292,913 |
| Captopril | $135,558 |
| Nortriptyline | $83,643 |
| Amoxicillin | $60,492 |
| Timolol Drops | $31,473 |
| Fluocinonide | $14,749 |
| Prazosin | $14,153 |
| Amantadine | $5,796 |
| Insulin | ( $252,142 ) |
| **TOTAL FY00** | **$62,804,712** |

## **Appendix B:** Cost Considerations – Goserelin and Leuprolide Depot for Prostate Cancer

**MAGNITUDE OF DOD EXPENDITURE:** DoD can expect to spend approximately $5 million for 17,500 LHRH agonist prescriptions in FY01. Approximately 58% of these, or 10,000 prescriptions, will be for strengths used for prostate cancer. These 10,000 prescriptions are currently split almost evenly between goserelin and leuprolide. Over 97% of the remaining LHRH agonist prescriptions are for leuprolide.

**DOD PRICING FOR GOSERELIN AND LEUPROLIDE DEPOT FORMULATIONS**

| | **Goserelin** | | | **Leuprolide** | | |
|---|---|---|---|---|---|---|
| | **Dosage Form** | **Nov 00 DAPA price** | **BPA Price*** (equals VA contract price) | **Dosage Form** | **Oct 00 DAPA Price** | **Nov 00 DAPA Price** (resulting from voluntary price reduction) |
| **1-month depot** | 3.6 mg implant | $213.80 | $140.67 | 7.5 mg depot | $257.00 | $227.21 |
| **3-month depot** | 10.8 mg implant | $611.62 | $418.70 | 22.5 mg depot | $770.99 | $681.63 |
| **4-month depot** | Not available | | | 30 mg depot | $976.58 | $908.84 |

*The BPA for goserelin provides for a direct, immediate modification of the prime vendor price, not a rebate. The requirement is that goserelin achieve >80% market share of the prostate cancer market within 9 months (by August 2001).