



STATE MEDICAID DUR BOARD MEETING
 THURSDAY, Apr 10, 2007
 7:00 a.m. to 8:30 a.m.
 Cannon Health Building
 Room 125



MINUTES

Board Members Present:

Mark Balk, PharmD.
Derek Christensen, R. Ph.
Dominic DeRose, R. Ph.

Wilhelm Lehmann, M.D.
Colin VanOrman, M.D.
Joseph Yau, M.D.

Board Members Excused:

Neal Catalano, R.Ph.
Joseph Miner, M.D.
Tony Dalpiaz, PharmD.

Don Hawley, D.D.S.
Bradley Pace, PA-C
Bradford Hare, M.D.

Dept. of Health/Div. of Health Care Financing Staff Present:

Lisa Hulbert	Tim Morley
Jennifer Zeleny	Suzanne Allgaier
Merelynn Berrett	Brenda Strain

RaeDell Ashley
Rick Sorenson

Other Individuals Present:

Kara Anderson, MHAU	Chad MacGregor, BMS
Kevin Carson, Alharma	Reed Murdoch, Wyeth
Paul Pixton, Novartis	Joel Ferry, LEC
Jonathan Raap, Amgen	Pierre Thoumlin, Amgen
Andy Stubbs, Abbott	John Stockton, Genentech
Jeff Buel, J&J	David Hannah, Centour
Felicia Fuller, Biogenidex	Craig Boody, Lilly
Kay Barry, Shire HGT	Cap Ferry, LEC

Sherry Oneida, BMS
Barbara Boner, Novartis
Brett Brewer, EMD Serono
James Gaustad, Purdue
Roy Linfield, Schering
Shawn Prince, Elan
Tony Molchan, Abbott
Alan Bailey, Pfizer

Meeting conducted by: Colin VanOrman

1. Minutes for March 13, 2008 were reviewed, corrected and approved.
2. P&T Committee Update: An update will be given at a later time.
3. Immunomodulators Review: Dr. Kristina Callis Duffin addressed the Board. She provided handouts to the Board to summarize her discussion. She has been a dermatologist at the University of Utah for seven years. She is very active in the treatment of psoriatic disease. She was asked to examine the current prior authorization criteria and write a letter to the Board by Amgen and Abbott. One frustrating thing about the criteria is some of the

wording. She disagrees with it, and made 3 major requests.

Currently, the PA criteria for etanercept for plaque psoriasis requires the diagnosis and a dermatology consultation within the last 60 days. This is not a problem since patients with bad psoriasis need to be seen by a dermatologist for proper diagnosis and management. But the Board should consider changing the second and third criteria. The first concerns the definition of moderate to severe plaque psoriasis. She recommends that this criteria either be removed or broadened. It is somewhat cumbersome and doesn't necessarily encompass what moderate to severe psoriasis is. Based on the other definitions in the criteria, it is also unnecessary. She provided some photographs in the handouts to illustrate what she means. Psoriasis is a devastating lifelong condition that affects the skin, and in 30% of patients, also the joints. Up to 30% of the patients with psoriasis are considered to have moderate to severe disease, depending on how it is defined. It is a disease that impairs quality of life. The patient in the third photo had only the elbows and knees affected, which is less than 2% of the body surface area, but that plaque is very thick and prone to fissuring and impairs his quality of life. Psoriasis impairs the quality of life on many levels. It impairs ability to get employment and good income. Activities of daily living are impaired, particularly in patients with palmar/plantar disease, genital disease, and scalp disease. There is emerging data that there are a number of medical comorbidities associated with psoriasis, such as obesity, diabetes, hypertension, and heart disease. The other two photos are patients with about 5% body surface area, but they certainly do not look like mild disease. Moderate to severe disease is also defined by the need for systemic therapy or photo therapy. The willingness of patients to take on those treatments really defines them as being moderate to severe. The therapies that are used for moderate to severe disease include light therapy with the risk of skin cancer, methotrexate, acitretin, cyclosporin, and all of the biologic agents, none of which are without significant risk. If Medicaid feels the need to keep the criteria, at least it could be broadened.

The third criteria also reads "a history of incomplete response to methotrexate, cyclosporin, and acitretin." The word "and" is the problem. This is a statement that is outside the standard of care. The American Academy of Dermatology actually states that patients with moderate to severe disease are candidates for biological treatments as first-line. Psoriasis is not something that is treated in a stepwise fashion; it is tailored to the individual patient. A young woman could not be treated with acitretin, a person with liver disease or a person who drinks could not be treated with methotrexate. Cyclosporin is only used for emergencies. One letter that she wrote was on behalf of a patient that has tried and failed on methotrexate, and could not use a light box because of his location. Cyclosporin was not appropriate therapy for this patient, and acitretin is not a very good drug. The proposed revision is to broaden the criteria to state "a history of incomplete response or intolerance to at least one appropriate systemic therapy or photo therapy". It is unreasonable to ask people to do all drugs.

The third request is for the psoriatic arthritis criteria for Humira be changed. The requirement for second-line therapy lists drugs that are not approved or contraindicated in psoriatic arthritis. This disease is associated with significant morbidity, deformity, and disability. About 30% of people with psoriasis develop psoriatic arthritis in the first 10 years. Psoriasis patients are monitored very closely. Over 50% develop an erosive arthropathy, almost 1/5 of the patients develop joint deformity, and over 20% of them develop functional disability. This is a very serious disease like rheumatoid arthritis. The goal of rheumatologists and those who care for people with psoriasis is to watch for joint involvement, and joint deformity, and then refer to a rheumatologist to prevent joint

destruction. The only drugs that really have been shown to prevent joint destruction are the anti-TNF agents. There are no good data on methotrexate or the other drugs.

It is important for the Board to review the criteria agents and consider the anti-TNF patients who have psoriatic arthritis after they have failed methotrexate, and not require a second DMARD. Furthermore, it is not reasonable to lump rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis all together. On the proposed Humira criteria, ankylosing spondylitis was left off - it now has an indication for that. A separate PA should be created for each of those diseases. After review, the requirement for a second-line DMARD should be removed.

Tim Morley asked about the FDA approved indication for Enbrel. The FDA approved indication reads that it is approved for the treatment of adult patients with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy or photo therapy. What if they are NOT candidates for systemic therapy or photo therapy? Is there a psoriasis patient who is not a candidate after a trial, or is that determined pre-treatment? Dr. Duffin stated that she determines that based on their disease and medical history. A patient who has a few small plaques on their elbows and knees, covering a body surface area of less than 1% who responds readily to topical agents and is willing to use them, and does not have side effects would be considered to have mild disease. They would not want to take on the risk of photo therapy or systemic therapy. But if a patient walked in with the type of disease that was in the photographs presented, and they do not respond to topical treatments then they are a candidate for systemic therapy or photo therapy.

Mark Balk asked if there was a situation where a patient with moderate disease would not be a candidate for oral systemic agents or photo therapy where she would prescribe the anti-TNF agent as first-line. There is no good screening test to determine which patients will respond to what treatment. Very often, she will start a patient on methotrexate or photo therapy and tailor the treatment to their individual needs. Patients who have centimeter-thick plaques on their elbows would not be likely to respond to photo therapy, and should not take on the risk of exposure to UV light. She would be likely to try methotrexate first for these patients. Around 10% of people will do extremely well on methotrexate. But in a recent trial of adalimumab versus methotrexate called CHAMPION, it was determined that only about 36% of patients get to the benchmark of 75% improvement on methotrexate. 70-80% of the people on Humira got to the goal in this trial. For the small subset of patients that do well on methotrexate, it is a very effective drug and very inexpensive. However, people sometimes have problems with not being able to tolerate it, have to come in every month or two to be monitored, and at the end of two years may require a liver biopsy.

Dr. VanOrman asked her for comments about the safety and tolerability of the biologics. They are much better than the standard therapies. Safety and tolerability are very well documented. As long as patients are screened appropriately for anti-TNF therapy, they don't tend to have problems. The long term safety is well established.

Dr. VanOrman asked about how one would define moderate to severe disease, since that is what the FDA labeled indication contains as a definition for an appropriate candidate for the drugs. He asked if there is a recommendation on what can define moderate to severe disease. There are a number of ways to define moderate to severe disease. Requiring a failure on systemic or photo therapy already puts one into the category into moderate to severe disease. Body surface area, failure of topicals, quality of life, being in critical areas can all go into

defining the disease as moderate to severe.

Tim Morley asked to clarify the changes that are being proposed. Dr. VanOrman stated that the first criterion requiring a diagnosis of plaque psoriasis would remain the same. On the second criterion, the proposed change would be to change the “and” to an “or” so that patients would be only required to fail on one of the three systemic therapies. The fourth criterion would remain the same. The third criterion that requires 10% body surface involvement needs to be reworded or deleted.

Mark Balk asked if requiring a dermatology consultation within the last 60 days would be too restrictive. Dr. Duffin felt that it is necessary to see any of these patients receiving this treatment within this time line, because they need very close monitoring.

Tim Morley asked if it makes sense to require that a patient fail on light therapy before paying for a biologic. Dr. Duffin stated that she did not feel that this is reasonable, because that would be asking the patient to take on a therapy that is known to have long-term risks of skin cancer. Furthermore, in the Utah Psoriasis Initiative database of over 750 patients, only 1/3 live in Salt Lake City.

Dr. Lehmann asked how often patients go for the light therapy. To get clear, patients usually have to go twice a week for usually 6-12 weeks.

Mark Balk moved to change the first criteria to “diagnosis of moderate to severe plaque psoriasis”, bullet 2 to “history of incomplete response or intolerance to at least one appropriate systemic agent or photo therapy”, drop bullet 3 altogether, and leave bullet 4 as is. Dr. Lehmann seconded the motion. The motion passed unanimously with votes by Mark Balk, Dr. Lehmann, Derek Christensen, Dr. VanOrman, Dominic DeRose, and Dr. Yau.

Dr. Clegg from the University of Utah wrote a letter recommending how to handle the treatment of arthritis. Copies of the letter were passed out to the members of the Board. Dr. Clegg refers to the criteria sheet for Enbrel for rheumatoid arthritis, ankylosing spondylitis, and psoriatic arthritis.

Tim Morley addressed the Board. The indication for ankylosing spondylitis reads that it is indicated for reducing signs and symptoms in patients with active ankylosing spondylitis.

Mark Balk asked if Tim is proposing to break out the criteria for ankylosing spondylitis and psoriatic arthritis to read more like the criteria for Humira, which already has it broken out. That seems to be the point that Dr. Clegg is making in his letter. The Board felt that it was inappropriate to require a count of inflamed joints for ankylosing spondylitis. The way that the Humira criteria addresses the needs for the individual disease states is better.

Mark Balk asked Dr. Duffin if she felt it would be appropriate to have a patient try methotrexate PLUS another DMARD prior to trying Enbrel. She did not feel that this was appropriate, and that the criteria should have an “or” rather than an “and” for the list of DMARDS as was done with Humira.

Mark Balk moved to change the Humira criteria under bullet 2 to state, “history of treatment, incomplete response, or intolerance to methotrexate, NSAIDS, or other DMARD or second-line therapy”. The second line for the motion would be to adopt the revised criteria for

Enbrel. Derek Christensen seconded the motion. The motion passed unanimously with votes by Mark Balk, Dr. Lehmann, Derek Christensen, Dr. VanOrman, Dominic DeRose, and Dr. Yau.

There is an additional sheet for Humira for Crohn's disease. Basically, the criteria on the Crohn's read exactly like the FDA package insert. Mark Balk moved to accept the criteria and leave it as is. Dr. Lehmann seconded the motion. The motion passed unanimously with votes by Mark Balk, Dr. Lehmann, Derek Christensen, Dr. VanOrman, Dominic DeRose, and Dr. Yau.

Dr. Andy Stubbs, clinical science manager of Abbott, was prepared to give a top-line review of Humira and all of its indications. However, the presentation at this point would be a little bit redundant. The Board has done a good job in reviewing the criteria and addressing the concerns with the way that they were written. He offered to answer specific questions about Humira if needed.

Dr. Chad McGregor, senior medical science liaison of Bristol Myers Squibb, addressed the Board. Orencia recently had a label update. The first update has been with the adult indication. The FDA has seen fit to remove the prerequisite for either an inadequate response to methotrexate or inadequate response to an anti-TNF. Orencia is now indicated for the treatment of moderate to severe rheumatoid arthritis in adults to reduce the signs and symptoms of the disease, induce a major clinical response, inhibit the progression of structural damage, as well as to improve the physical functioning in adult patients. It can be used as a first line treatment, as well as a first line biologic in this group. Orencia has also been approved for the treatment of Juvenile Idiopathic Arthritis. It can be used in patients 6 years and up. It can be utilized as a first-line biologic for this particular age group. Orencia does have a unique mechanism of action. It is a T-cell co-stimulation modulator. It helps to decrease T-cell proliferation. As such, it does decrease the amount of cytokines and inflammatory cells that occur, and helps then to reduce the sign and symptoms of arthritis. It is a weight-based dosing for the adult population, at either 2, 3, or 4 vials. For the new indication for juveniles, it will be dosed at 10mg/kg calculated dose. It can be utilized with other DMARDs; however, it is not recommended to be used with other biologic agents. It does provide consistent dosing and dose response, as well as consistent efficacy over time, as demonstrated in the trials. There is one trial now that has 5 year data, and there has been a very consistent response, consistent efficacy, at a very consistent dose. Throughout the time, there has been no dose increase or increase in the frequency of dosing to maintain the efficacy over time. It can be utilized as monotherapy, it can be utilized in combination with methotrexate, in patients who have had inadequate response to methotrexate, inadequate response to anti-TNF inhibitor, or for patients as a first-line agent. As with any immunomodulator, patients would be monitored. If they have a history of infections or conditions that make them susceptible to infections, care should be utilized. The infusion itself is a 30 minute infusion. The incident rate of hypersensitivity reactions with infusion is < 1%. The reactions to the drug that are not hypersensitivity is < 10%. Care should be utilized in the patient population with COPD. As with other biologics and immunomodulators, live vaccines should not be given within 3 months of discontinuation of the drug or starting the drug. If there are women that wish to become pregnant or are breast feeding, that should be discussed with the physician, and the risks and benefits should be considered.

Mark Balk asked about the weight-based dosing. Is it 10mg/kg up to 50kg? Is there a

maximum weight for the pediatric dose? If they start to approach the limit the top of the weight range, the maximum adult dose should not be exceeded.

Dr. Jonathan Raap of Amgen addressed the Board. Just to clarify, the indication of Juvenile Rheumatoid Arthritis on the criteria sets for all of the agents should be changed to Juvenile Idiopathic Arthritis. The age range on the etanercept should also be updated, since the age on etanercept was recently approved down to the age of 2. The criteria should read that it is indicated for the treatment of moderate to severe rheumatoid arthritis and Juvenile Idiopathic Arthritis.

Dr. VanOrman asked if the way that the third bullet, which reads “must have an inadequate response to at least one or more DMARDs such as methotrexate, or have an inadequate response to one or more anti-TNFs” is no longer appropriate for Orencia. Tim Morley and Dr. McGregor clarified that it is still appropriate for those situations, but the FDA did remove the requirement for inadequate response earlier this week.

Mark Balk recommended that the Board seek a recommendation from rheumatologists on how to handle the criteria for Orencia.

Dr. McGregor stated that the FDA reworded the indication for Orencia to bring it more in line with the other biologic agents for RA. By removing the inadequate response criteria, Orencia will have a label that is consistent with Humira, Enbrel, and Remicade.

Tim pointed out that the other medications have this criteria in place, so it would not be inappropriate to require this. Dr. Duffin agreed that it is not unreasonable to ask a physician to try a more cost-effective therapy such as methotrexate up front.

Mark Balk moved that the first bullet on Orencia be changed to age 6, and that the acceptable diagnoses include JIA. The age requirement will also be changed to age 2 on Enbrel. The third bullet will also be changed to contain the same terminology as what is contained in the Enbrel and Humira criteria. Derek Christensen seconded the motion. The motion passed unanimously with votes by Mark Balk, Dr. Lehmann, Derek Christensen, Dr. VanOrman, Dominic DeRose, and Dr. Yau.

Next meeting set for May 8, 2008
Meeting adjourned.

The DUR Board Prior Approval Subcommittee convened and considered four petitions.

Minutes prepared by Jennifer K. Zeleny