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December 24, 2007

Dear Healthcare Practitioner:

Presbyterian Health Plan and Presbyterian Insurance Company's Pharmacy and Therapeutics Committee (P&T Committee) met on November 28, 2007 to promote appropriate use of drugs in maintaining the formularies. We are dedicated to supporting our network of practitioners and would like to share with you the decisions made at that meeting that affect our formularies and pharmacy benefits. Please note that online versions of all Presbyterian formularies are available on our website at [www.phs.org/pharmacy/index.htm](http://www.phs.org/pharmacy/index.htm), as well as on [www.nm-formulary.com](http://www.nm-formulary.com). All formularies are downloadable onto your handheld Palm device through the **ePocrates Rx** software.

**P&T COMMITTEE DECISIONS**  
**ADDITIONS/CHANGES TO PRESBYTERIAN FORMULARIES/PDLs**

**Symbicort inhalation aerosol:** Symbicort is an inhaled corticosteroid and long acting beta-2 agonist combination product. It is indicated for the long-term maintenance treatment of asthma in patients 12 years of age and older. The committee voted to add all formulations of Symbicort to the Presbyterian formularies with a step edit requirement. The step edit requires a prescription claim history of one inhaled corticosteroid in the past 120 days.

**If the step edit requirement is not met, a prior authorization is required and the following criteria must be met for approval:**

1. A pharmacy claim history in the previous 120 days of use of an oral inhaled corticosteroid;
- OR**
2. Documented diagnosis of severity of moderate to severe asthma as defined per the "Guidelines for the Diagnosis and Management of Asthma" developed by the National Asthma Education and Prevention Expert Panel Report 3.

Symbicort is available at the 2<sup>nd</sup> tier copay for the multi-tier formularies.

### Comparison of approved FDA indications for the ICS/LABA combination products

Indication	Advair Diskus	Advair HFA aerosol	Symbicort aerosol
Treatment of asthma (age 4+)	X		
Treatment of asthma (age 12+)		X	X
Treatment of COPD associated with chronic bronchitis	X (only the 250/50 strength)		

\*For each medication listed, data was obtained from the manufacturer's prescribing information.

### Cost comparison among available ICS/LABA combination products

PRODUCT	DOSING	STRENGTH	AWP* cost per unit
Advair Diskus Inhalation powder	1 inhalation, twice a day	100/50 mcg	\$174.60
		250/50	217.20
		500/50	296.40
Advair HFA Inhalation aerosol	2 inhalations, twice a day	45/21 mcg	\$174.72
		115/21	216.96
		230/21	296.88
Symbicort Inhalation aerosol	2 inhalations, twice a day	80/4.5 mcg	\$165.65
		160/4.5	189.31

\*AWP based on 2007 Redbook pricing guide

**Revised Prior Authorization Criteria for Januvia and Byetta:** The prior authorization criteria for both Byetta and Januvia were revised. The criteria was voted on and approved by the committee. For both products, patients must have Type 2 Diabetes Mellitus, are compliant with routine blood glucose monitoring, and meet the following criteria:

#### Januvia (sitagliptin):

- A documented HbA1c that is between 6.5% and 8.5%.
- Patient has inadequate glycemic control with at least two of the following medications: Metformin at maximum doses (1500mg/day), sulfonylureas, or TZDs. **and** requires the addition of another agent **OR** requires the addition of another agent and has contraindications to, or is unable to tolerate the alternatives.
- Januvia will not be approved for use in combination with insulin or Byetta until data on the safety and efficacy for those combinations is available.

#### Byetta (exenatide):

- The glucose abnormality primarily involves the lack of post-prandial glucose control.
- A documented HbA1c that is between 6.5% and 8.5%.
- Patient has inadequate glycemic control with at least two of the following medications: Metformin at maximum doses (1500mg/day), sulfonylureas, and TZDs **and** requires the addition of another agent **OR** requires the addition of another agent and has contraindications to, or is unable to tolerate the alternatives.
- Byetta will not be approved for use in combination with insulin or with Januvia until more data on the safety and efficacy for those combinations is available.

**P&T COMMITTEE DECISIONS  
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<b>Drug Name</b>	<b>Commercial 2-Tier</b>	<b>Commercial 4-Tier</b>	<b>Salud/SCI/NMRX</b>	<b>Medicare</b>
<b>Symbicort inhalation aerosol</b> (Budesonide/formoterol fumarate)	Formulary with Step Edit*	2 <sup>nd</sup> Tier with Step Edit*	Formulary with Step Edit*	2 <sup>nd</sup> Tier with Step Edit*
<b>Tizanidine tablets 2mg, 4mg</b> (generic Zanaflex)	Formulary	1 <sup>st</sup> Tier	Formulary	1 <sup>st</sup> Tier
<b>Leflunomide 10mg, 20mg</b> (generic Arava)	Formulary	1 <sup>st</sup> Tier	Formulary	1 <sup>st</sup> Tier
<b>Actonel 75mg #2 tablets taken on consecutive days</b> (Risedronate)	Formulary	2 <sup>nd</sup> Tier	Formulary	2 <sup>nd</sup> Tier
<b>Lantus Solostar</b> (insulin glargine)	Formulary	2 <sup>nd</sup> Tier	Formulary	2 <sup>nd</sup> Tier

\*If step edit criteria are not met, a prior authorization will be required.

**Overview of Commercial Plan Pharmacy Benefit/Formularies Changes effective January 1<sup>st</sup>, 2008.**

In addition to the formulary changes mentioned above, the Pharmacy and Therapeutics Committee approved the following Commercial Plan pharmacy benefit changes. In all instances, there are therapeutically equivalent alternatives, many of which were brand medications that have recently become available as generics. Patients as of January 1<sup>st</sup>, 2008, who are currently on Nasonex, Lipitor 10mg, 20mg, and 40mg, Zyrtec, and Singulair will be able to refill these medications until March 1<sup>st</sup>, 2008 in order to give them time to converse with their physician about the formulary change.

**Nasonex** – a prior authorization requirement will be implemented requiring the use of a generic inhaled nasal steroid before Nasonex, will be covered. Nasonex will no longer be covered for adults and children over 4 years of age. Nasonex will continue to be covered for children between the ages of 2 and 4.

**Generic Statins first requirement** – the use of two generic statins such as simvastatin, pravastatin, or lovastatin will be required as first line agents before Lipitor will be covered. All patients currently on Lipitor 80mg as of January 1<sup>st</sup>, 2008 will be grandfathered.

**Comparative Potencies of Statins for LDL Reduction**

LDL Reduction	Pravastatin	Lovastatin	Simvastatin	Ezetimibe/ Simvastatin	Atorvastatin
<25%	10-20 mg	10-20 mg	5 mg	10/10	10 mg
25-35%	20-40 mg	20-40 mg	10-20 mg	10/10	10 mg
35-45%	80 mg	80 mg	20-40 mg	10/10	10-20 mg
45-55%			80 mg	10/20-10/40	20-40 mg
55-60%				10/80	80 mg

\*For each medication listed, data was obtained from the manufacturer’s prescribing information.

**Comparative Efficacy of Statins for Mean Percent Change from Baseline**

Parameters	Pravastatin 10-40 mg	Lovastatin 10-80 mg	Simvastatin 10-80 mg	Ezetimibe/ Simvastatin 10/10-10/80 mg	Atorvastatin 10-80 mg
TC	16-29 ↓	16-29↓	22-36 ↓	34-43 ↓	28.2-45 ↓
<b>LDL-C</b>	<b>21.0-40 ↓</b>	<b>21-40↓</b>	<b>14-47 ↓</b>	<b>46-59 ↓</b>	<b>26.5-60 ↓</b>
APO-B	NA	NA	NA	38-49 ↓	32-50 ↓
TG	11-24 ↓	6-10 ↓	10-36 ↓	26-35 ↓	19-51.8 ↓
HDL-C	7-12 ↑	2-9.5 ↑	8-12 ↑	8-12 ↑	5-13.8 ↑

TC- total cholesterol, LDL-C- low-density lipoprotein cholesterol, APO-B- apolipoprotein B, TG- triglyceride  
HDL-C- high-density lipoprotein cholesterol, NA- not available

\*For each medication listed, data was obtained from the manufacturer’s prescribing information.

**Suggested dosing conversion from Lipitor (Atorvastatin)  
to Simvastatin, Pravastatin, or Lovastatin**

<b>Current dose of statin</b> (once a day dosing)	<b>Recommended dose of alternative statin</b> (once a day dosing)
Lipitor (atorvastatin) 10mg	Simvastatin 5, 10, or 20mg
	Pravastatin 10, 20, or 40mg
	Lovastatin 10, 20, or 40mg
Lipitor (atorvastatin) 20mg	Simvastatin 20 or 40mg
	Pravastatin 80 mg
	Lovastatin 80 mg
Lipitor (atorvastatin) 40mg	Simvastatin 80mg
Lipitor (atorvastatin) 80mg	No conversion suggested

**Generic SSRI’s first requirement** – the use of two generic antidepressants such as fluoxetine, paroxetine, citalopram, or sertraline will be required as first line agents before a branded antidepressant such as Effexor XR or Lexapro will be covered. All patients currently taking Effexor XR or Lexapro, as of January 1<sup>st</sup>, 2008, will be grandfathered.

**Zyrtec** – a prior authorization requirement will be implemented requiring the use of fexofenadine and loratadine before Zyrtec will be covered.

**Advair step therapy requirement** – prior use of an oral inhaled corticosteroid such as Flovent HFA, Qvar, and Pulmicort Flexhaler/Turbuhaler, or prior use of Spiriva or Atrovent in the previous 120 days will be required as step therapy in order for all formulations of Advair to be covered. All patients currently on Advair, as of January 1<sup>st</sup>, 2008, will be grandfathered.

**If the step-therapy requirement is not met, a prior authorization is required for Advair and the following criteria must be met for approval:**

1. A pharmacy claim history in the previous 120 days of use of an oral inhaled corticosteroid, Spiriva or Atrovent.  
**OR**
2. Documented diagnosis of severity of moderate to severe asthma as defined per the “Guidelines for the Diagnosis and Management of Asthma” developed by the National Asthma Education and Prevention Expert Panel Report 3.  
**OR**
3. Documented Stage III or Stage IV COPD.

**Singulair Prior Authorization or Step Edit requirement** – Singulair will be covered for its asthma indication only. Criteria for prior authorization or step edit will require a pharmacy claim history of prior use of an oral inhaled corticosteroid in the previous 120 days. Singulair will not be covered for allergic or seasonal rhinitis.

**Celebrex** – a prior authorization requirement will be implemented requiring the failure of all three of the following before Celebrex will be approved:

- Failure of meloxicam (Mobic)  
**AND**
- Failure of nabumetone (Relafen)  
**AND**
- Failure of at least one other generic NSAID.

Patients currently on Celebrex, as of January 1<sup>st</sup>, 2008, will be grandfathered.

The changes to the formularies, as outlined above, are based on requests from our practitioners and the recommendations of the P&T Committee. We value your input. If you have any concerns, please contact Larry Georgopoulos, R.Ph, by e-mail at **[lgeorgop@phs.org](mailto:lgeorgop@phs.org)** or by phone at (505) 923-5530, or Julie DiTucci-Reiter, R.Ph, by e-mail at **[jditucci@phs.org](mailto:jditucci@phs.org)** or by phone at (505) 923-5404. We can be reached Monday through Friday from 8:00 a.m. to 5:00 p.m. As always, thank you for partnering with us to improve the health of individuals, families and communities

In addition to the formulary changes, we would like to remind you that our phone numbers have changed. The new numbers are (505) 923-5757 (in the Albuquerque area) or 1-888-923-5757 (outside the Albuquerque area). Pharmacy department hours are Monday through Friday from 8:00 a.m. to 5:00 p.m. Pres Online is also available for you to verify eligibility and submit prior authorizations. Please visit the Provider page of [www.phs.org](http://www.phs.org) for more information.

Sincerely,



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## Medications for Diabetes

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Glyburide	1.25mg	100	12.44	Generic	1.5%
Glyburide	2.5mg	100	18.93*	Generic	1.5%
Glyburide	5mg	100	28.31*	Generic	1.5%
Glyburide MCR	1.5mg	100	18.75	Generic	1.5%
Glyburide MCR	3mg	100	21.75*	Generic	1.5%
Glyburide MCR	6mg	100	35.00*	Generic	1.5%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Glipizide	5mg	100	6.99*	Generic	1.5%
Glipizide	10mg	100	11.92*	Generic	1.5%
Glipizide ER	2.5mg	100	32.33	Generic	1.5%
Glipizide ER	5mg	100	32.32	Generic	1.5%
Glipizide ER	10mg	100	32.53	Generic	1.5%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Glimepiride	1mg	100	13.41*	Generic	1.5%
Glimepiride	2mg	100	21.74*	Generic	1.5%
Glimepiride	4mg	100	41.00*	Generic	1.5%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Metformin	500mg	100	35.57*	Generic	1.5%
Metformin	850mg	100	38.63*	Generic	1.5%
Metformin	1000mg	100	45.97*	Generic	1.5%
Metformin XR	500mg	100	30.55*	Generic	1.5%
Metformin XR	750mg	100	94.99	Generic	1.5%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Precose	25mg	100	93.56	Brand	0.7%-1%
Precose	50mg	100	105.85	Brand	0.7%-1%
Precose	100mg	100	120.66	Brand	0.7%-1%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Avandia	2mg	100	264.00	Brand	0.7%-1%
Avandia	4mg	100	392.00	Brand	0.7%-1%
Avandia	8mg	100	712.00	Brand	0.7%-1%
Actos	15mg	100	431.00	Brand	0.7%-1%
Actos	30mg	100	689.60	Brand	0.7%-1%
Actos	45mg	100	747.80	Brand	0.7%-1%

\*Medication can be found on the participating \$4.00 pharmacy lists. (Quantity limits apply).

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Starlix	60mg	100	152.86	Brand	0.1%-0.7%
Starlix	120mg	100	158.80	Brand	0.1%-0.7%

Prandin	1mg	100	168.00	Brand	1.5%
Prandin	2mg	100	168.00	Brand	1.5%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Januvia	25mg	100	631.19	Brand/PA	0.6%-0.8%
Januvia	50mg	100	631.19	Brand/PA	0.6%-0.8%
Januvia	100mg	100	631.19	Brand/PA	0.6%-0.8%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Byetta	5mcg	1.2ml	210.38	Brand/PA	0.5%-1%
Byetta	10mcg	2.4ml	246.89	Brand/PA	0.5%-1%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Novolin N	Vial	10ml	41.25	Brand	1.5%-2.5%
Novolin N	Penfill	15ml	130.65	Brand	1.5%-2.5%
Novolin N	Innolet	15ml	87.75	Brand	1.5%-2.5%
Levemir	Vial	10ml	90.31	Brand	1.5%-2.5%
Levemir	Flexpen	15ml	174.45	Brand	1.5%-2.5%
Lantus	Vial	10ml	88.16	Brand	1.5%-2.5%
Lantus	Opticlick	15ml	184.95	Brand	1.5%-2.5%
Lantus	Solostar	15ml	184.95	Brand	1.5%-2.5%

MEDICATION	STRENGTH	QUANTITY	COST	COPAY	AVG % DECREASE IN A1C
Novolin 70/30	Vial	10ml	41.25	Brand	1.5%-2.5%
Novolin 70/30	Penfill	15ml	130.65	Brand	1.5%-2.5%
Novolin 70/30	Innolet	15ml	87.75	Brand	1.5%-2.5%
Novolin R	Vial	10ml	41.25	Brand	1.5%-2.5%
Novolin R	Penfill	15ml	130.65	Brand	1.5%-2.5%
Novolin R	Innolet	15ml	87.75	Brand	1.5%-2.5%
Novolog	Vial	10ml	95.71	Brand	1.5%-2.5%
Novolog	Penfill	15ml	163.28	Brand	1.5%-2.5%
Novolog	Flexpen	15ml	184.89	Brand	1.5%-2.5%
Novolog Mix 70/30	Vial	10ml	95.71	Brand	1.5%-2.5%
Novolog Mix 70/30	Penfill	15ml	163.28	Brand	1.5%-2.5%
Novolog Mix 70/30	Flexpen	15ml	184.89	Brand	1.5%-2.5%

Cost based on 2007 online Medispan pricing guide, Average decrease in A1C based on manufacturer product information

**FIGURE 3-4c. CLASSIFYING ASTHMA SEVERITY IN YOUTHS ≥12 YEARS OF AGE AND ADULTS**

- **Classifying severity for patients who are not currently taking long-term control medications.**

Components of Severity		Classification of Asthma Severity (Youths ≥12 years of age and adults)			
		Intermittent	Mild	Persistent	
Impairment	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3-4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting beta <sub>2</sub> -agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not >1x/day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	<ul style="list-style-type: none"> <li>• Normal FEV<sub>1</sub> between exacerbations.</li> <li>• FEV<sub>1</sub> &gt;80% predicted</li> <li>• FEV<sub>1</sub>/FVC normal</li> </ul>	<ul style="list-style-type: none"> <li>• FEV<sub>1</sub> ≥80% predicted</li> <li>• FEV<sub>1</sub>/FVC normal</li> </ul>	<ul style="list-style-type: none"> <li>• FEV<sub>1</sub> &gt;60% but &lt;80% predicted</li> <li>• FEV<sub>1</sub>/FVC reduced 5%</li> </ul>	<ul style="list-style-type: none"> <li>• FEV<sub>1</sub> &lt;60% predicted</li> <li>• FEV<sub>1</sub>/FVC reduced &gt;5%</li> </ul>
Risk	Exacerbations requiring oral systemic corticosteroids	0-1/year (see note)	≥2/year (see note)		

← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. →

Relative annual risk of exacerbations may be related to FEV<sub>1</sub>.

- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2-4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

- **Classifying severity in patients after asthma becomes well controlled, by lowest level of treatment required to maintain control.\***

Lowest level of treatment required to maintain control (See figure 4-5 for treatment steps.)	Classification of Asthma Severity			
	Intermittent	Persistent		
		Mild	Moderate	Severe
	Step 1	Step 2	Step 3 or 4	Step 5 or 6

Key: EIB, exercise-induced bronchospasm; FEV<sub>1</sub>, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit

**\*Notes:**

- For population-based evaluations, clinical research, or characterization of a patient's overall asthma severity after control is achieved. For clinical management, the focus is on monitoring the level of control (See figure 3-5c.), not the level of severity, once treatment is established.
- See figure 3-5c for definition of asthma control.