

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES
COLLEGE OF PHARMACY

ARKANSAS MEDICAID EVIDENCE-BASED PRESCRIPTION DRUG PROGRAM (EBR_x)

QUARTERLY REPORT - FIRST QUARTER 2006



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INTRODUCTION

OVERVIEW OF THE EVIDENCE-BASED PRESCRIPTION DRUG PROGRAM

Prescription medications are important tools in treatment and prevention of medical problems. Prescription drug coverage is an optional component of the Medicaid benefit, but Arkansas along with most other state Medicaid programs, extends some coverage to enrollees. Arkansas Medicaid drug expenditures exceeded \$400 million dollars in the last fiscal year. Spending for prescription drugs is budgeted to exceed one-half billion dollars in the current fiscal year. Over the past nine years Medicaid prescription drug spending has grown at a compound annual growth rate exceeding 16 percent. This growth has been due only in part to increases in the number of Medicaid and ARKids enrollees. The largest contributor to the increase in total medication expenditures has been increases in average medication costs. The medication cost growth rate far exceeds state revenue growth, and jeopardizes continuation of the drug benefit, or other Medicaid benefits at current levels.

The prescription benefits available under Arkansas Medicaid currently provide no limits on the number of prescription medicines per month for individuals under age 18, or in nursing homes. For other adults eligible for full Medicaid benefits, three prescription products per month are covered. With an Extension of Benefits, Medicaid covered individuals may receive up to six medications per month paid for through the Medicaid program. With each prescription dispensed, Medicaid recipients are expected to contribute a minimal co-payment, ranging between fifty cents and three dollars.

The State of Arkansas can not ensure continued access to medications for the Medicaid population if costs continue to rise at their current annual rate. Consequently, the Arkansas Department of Health & Human Services' (DHHS) Division of Medical Services and the University of Arkansas for Medical Sciences (UAMS) College of Pharmacy created the Arkansas Medicaid Evidence-based Prescription Drug Program. The major goals of this program are to create an evidence-based Preferred Drug List, to manage its implementation through a Prior Authorization (P.A.) Call Center operated by the College of Pharmacy, and to track the long term outcomes of these decisions through evaluation of medical and pharmacy claims.

After many months of planning, the program was approved by the state legislature, and authorized by the Governor. A contract between DHHS and the College of Pharmacy was executed, and the program began November 1, 2004. This report details the progress of the program from January 1, 2006 through March 31, 2006.

MEDICARE PART D

THE IMPACT ON THE PREFERRED DRUG LIST PROGRAM

On January 1, 2006, the new Medicare Part D program began. Medicare Part D is designed to provide prescription benefits to Americans who are eligible for either Medicare Part A or Medicare Part B. As such, any recipient of Arkansas Medicaid who is eligible for Medicare will now, effective January 1, 2006, receive their prescription benefit from a private Medicare Part D prescription drug plan. As a result, the Preferred Drug List program no longer applies to these Medicaid-Medicare Dual Eligibles, instead, they are bound by the formularies of the Medicare Part D prescription drug plans.

Part of the implementation of Medicare Part D involved the Dual Eligibles being automatically enrolled into a Medicare Part D plan. Despite this auto-enrollment, many of the dual eligibles, who formerly received prescription benefits from the Arkansas Medicaid Program, did not have prescription coverage on January 1st as was expected. Because of this, Governor Huckabee issued a state of emergency and ordered the State's Medicaid program to continue covering prescription medications for these recipients. The State provided payment for dual eligible patients, whose Medicare Part D coverage was not working properly, through March 17, 2006.

The utilization and cost savings included in this report is inclusive of prescriptions that were filled for dual eligibles and billed to Arkansas Medicaid during the first quarter of 2006.

PROGRESS OF COMMITTEES

DRC & DUCC MEETING UPDATES

DRUG REVIEW COMMITTEE (DRC) UPDATE

The Drug Review Committee held three public meetings in the first quarter of calendar year 2006. During these meetings the committee made recommendations to the DUCC and to DHHS. Drug classes reviewed were: Estrogens, Newer Sedative Hypnotics, and the Targeted Immune Modulators. Summary recommendations of those meetings are attached at the end of this report (Appendices A, B, and C). Full meeting minutes are available through EBRx.

DRUG UTILIZATION AND COST COMMITTEE (DUCC) UPDATE

JANUARY MEETING

Estrogens were the subject of the January DUCC meeting. At the meeting, held at DHHS, net cost prices were reviewed. No manufacturers submitted supplemental rebate bids. Therefore, the recommendation was based solely on the DRC recommendations and the current CMS net cost.

The DUCC recommendation stated that generic estradiol and generic estropipate should be available to the recipients of Arkansas Medicaid.

The Estrogen preferred agents were implemented on April 17, 2006.

FEBRUARY MEETING

The DUCC met in February at the DHHS offices to consider the Newer Sedative Hypnotics after the DRC Committee meeting. The DRC concluded that the agents do not differ in terms of safety considerations or frequency of adverse events. However, the DRC did recommend that two agents should be available and at least one of those agents should be zolpidem or eszopiclone. The DUCC reviewed net price contract bids from multiple sedative hypnotic manufacturers. Once the bids were opened, net price bids were reviewed.

The DUCC recommended placing zolpidem CR (Ambien CR), ramelteon (Rozerem), and zaleplon (Sonata) on the PDL as preferred agents.

The Newer Sedative Hypnotic preferred agents are scheduled for implementation on May 9, 2006.

MARCH MEETING

The DUCC acted on the DRC recommendations for Targeted Immune Modulators in March. The DRC considered that these agents were used to treat multiple conditions, as indicated in Appendix C.

The manufacturers of several products submitted rebate bids, which were opened in the DUCC meeting. The DUCC looked at the net costs as well as the recommendations provided by the DRC and made the following recommendation, infliximab (Remicade), etanercept (Enbrel), and adalimumab (Humira) should be placed on the PDL.

After the DUCC meeting, the manufacturer of infliximab (Remicade) withdrew their supplemental rebate bid. As a result, the State will not place infliximab on the preferred drug list, instead, the State has elected to only place Enbrel and Humira on the PDL.

The Targeted Immune Modulator PDL implementation is scheduled for June 13, 2006.

FINANCIAL IMPACT OF COMMITTEE'S DECISIONS

COST SAVINGS TO THE STATE BECAUSE OF THE PDL

This report provides estimated cost savings to the State of Arkansas using available claim and rebate data. Please note that the cost savings presented in this section attempt to include the CMS rebates that are a part of all state Medicaid prescription drug programs. The CMS rebate data used in the calculation of each of these drug classes comes from the information provided to the DUCC by DHHS.

To standardize the computation of savings among all the classes we will utilize the following method: average net prescription price for the quarter immediately preceding the implementation of that class on the PDL will be multiplied by the actual prescription volume experienced post PDL implementation, finally this amount will be subtracted by the net amount actually spent following the implementation of the PDL. This provides a conservative estimate of savings based on actual prescription volume. From time to time, the average prescription price prior to the PDL implementation will be adjusted to reflect inflation that would have occurred in prescription drug prices.

SECOND GENERATION ANTIHISTAMINES

The second generation antihistamines were fully implemented on March 25, 2005 with loratadine products (tablets, reditabs, and syrups) as the preferred products. In addition, Zyrtec Syrup® and Clarinex Syrup® are available for children ages six to 24 months of age through the SmartPA system. All other second generation antihistamine claims now are denied at the point of sale and must have a prior authorization for Medicaid to cover these medications.

Because the preferred product, loratadine, was a generically available medication that did not offer any supplemental rebates, the cost savings in this category are obtained by moving market share from the more expensive non-sedating antihistamines to the equally effective, less expensive loratadine products.

As a result of the PDL implementation, the average cost per non-sedating antihistamine prescription has been reduced by 57 percent. Table 1 demonstrates estimated savings based on the method described above.

TABLE 1

NON SEDATING ANTIHISTAMINE ARKANSAS MEDICAID COSTS

| | January | February | March | Total |
|--|------------------|------------------|------------------|------------------|
| Actual Volume times pre PDL Cost per Rx | \$346,000 | \$324,000 | \$407,000 | \$1,077,000 |
| Post PDL Net Cost | \$198,000 | \$184,000 | \$237,000 | \$619,000 |
| PDL Savings | \$148,000 | \$140,000 | \$170,000 | \$458,000 |

PROTON PUMP INHIBITORS

The proton pump inhibitor PDL recommendations became effective May 18, 2005 with Prevacid® (lansoprazole) capsules and Nexium® (esomeprazole) capsules as preferred products. In addition, Prevacid SoluTabs® gained preferred status for children under the age of seven and for patients with nasogastric tubes. All other proton pump inhibitor claims now require a prior authorization for Medicaid to purchase these medications.

Both manufacturers of the preferred products submitted supplemental rebate bids. As a result, cost savings will be from supplemental rebates *and* moving market share to the preferred products. As a result of the PDL implementation, the average cost per proton pump inhibitor prescription has been reduced by 74 percent. Table 2 demonstrates estimated savings based on the method previously described.

TABLE 2

PROTON PUMP INHIBITORS ARKANSAS MEDICAID COSTS

| | January | February | March | Total |
|--|------------------|------------------|------------------|--------------------|
| Actual Volume times pre PDL Cost per Rx | \$851,000 | \$683,000 | \$729,000 | \$2,263,000 |
| Post PDL Net Cost | \$230,000 | \$184,000 | \$202,000 | \$616,000 |
| PDL Savings | \$621,000 | \$499,000 | \$527,000 | \$1,647,000 |

HMG COENZYME-A REDUCTASE INHIBITORS (THE STATINS)

The PDL recommendation for cholesterol reducing ‘statin’ products was implemented on June 8, 2005 with Zocor® (simvastatin) tablets being selected as the preferred product. Lipitor® 80mg tabs are also available to patients previously treated with that product who consistently adhered to their treatment regimen. All other statins now are denied at the point of sale and require a prior authorization to authorize Medicaid payment for these medications.

The manufacturer of Zocor provided a supplemental rebate bid. As a result, cost savings will be from supplemental rebates *and* moving market share to the preferred product. As a result of the PDL implementation, the average cost per statin prescription has been reduced by 30 percent. Table 3 demonstrates estimated savings based on the method previously described.

TABLE 3

STATINS ARKANSAS MEDICAID COSTS

| | January | February | March | Total |
|--|------------------|-----------------|-----------------|------------------|
| Actual Volume times pre PDL Cost per Rx | \$376,000 | \$267,000 | \$260,000 | \$903,000 |
| Post PDL Net Cost | \$262,000 | \$183,000 | \$179,000 | \$624,000 |
| PDL Savings | \$114,000 | \$84,000 | \$81,000 | \$279,000 |

CALCIUM CHANNEL BLOCKING AGENTS

The calcium channel blocker recommendations became effective July 12, 2005 with Norvasc® (amlodipine) tablets, Dynacirc CR® (isradipine) tablets, generic nifedipine extended-release tablets, generic verapamil extended-release tablets, and generic diltiazem capsules (AB rated to Dilacor XR only) being selected as the preferred products. All other calcium channel blockers now are denied at the point of sale and require prior authorization for Medicaid coverage of these medications.

The manufacturer of Norvasc and Dynacirc CR provided supplemental rebate bids. As a result, cost savings will be from supplemental rebates *and* moving market share to the preferred products. As a result of the PDL implementation, the average cost per calcium channel blocker prescription has been reduced by 11 percent. Table 4 demonstrates estimated savings based on the method previously described.

TABLE 4

CALCIUM CHANNEL BLOCKERS ARKANSAS MEDICAID COSTS

| | January | February | March | Total |
|--|-----------------|-----------------|-----------------|-----------------|
| Actual Volume times pre PDL Cost per Rx | \$233,000 | \$161,000 | \$157,000 | \$551,000 |
| Post PDL Net Cost | \$201,000 | \$139,000 | \$138,000 | \$478,000 |
| PDL Savings | \$32,000 | \$22,000 | \$19,000 | \$73,000 |

BETA BLOCKERS

The beta blocker recommendations became effective October 5, 2005 with generic atenolol, metoprolol tartrate, and propranolol immediate-release being selected as preferred products. Additionally, generic bisoprolol and Toprol XL® (metoprolol succinate) were selected as preferred agents for patients with Congestive Heart Failure. All other beta blockers now are denied at the point of sale and require prior authorization for Medicaid coverage of these medications.

The manufacturer of Toprol XL provided a supplemental rebate bid. As a result, cost savings will be from supplemental rebates *and* moving market share to the preferred product. As a result of the PDL implementation, the average cost per beta blocker prescription was reduced by 55 percent. Table 5 demonstrates estimated savings based on the method previously described.

TABLE 5

BETA BLOCKERS ARKANSAS MEDICAID COSTS

| | January | February | March | Total |
|--|-----------------|-----------------|-----------------|------------------|
| Actual Volume times pre PDL Cost per Rx | \$121,000 | \$88,000 | \$86,000 | \$295,000 |
| Post PDL Net Cost | \$50,000 | \$36,000 | \$35,000 | \$121,000 |
| PDL Savings | \$71,000 | \$52,000 | \$51,000 | \$174,000 |

LONG ACTING OPIOIDS

The long-acting opioid recommendations became effective October 26, 2005 with generic methadone and generic extended-release morphine sulfate tablets being selected as preferred products. Additionally, DHHS chose to make exempt from this implementation all patients that were eligible for long term care and patients who had a diagnosis of metastatic cancer. All other long-acting opioids now are denied at the point of sale and require prior authorization for Medicaid coverage of these medications.

Because the preferred products, methadone and extended-release morphine sulfate, are both generic, there are no supplemental rebates for these products. As a result, cost savings will be solely from moving patients from higher cost medications to equally effective, less expense medications. As a result of the PDL implementation, the average cost per long-acting opioid prescription was reduced by 61 percent. Table 6 demonstrates estimated savings based on the method previously described.

TABLE 6

LONG ACTING OPIOIDS ARKANSAS MEDICAID COSTS

| | January | February | March | Total |
|--|------------------|------------------|------------------|------------------|
| Actual Volume times pre PDL Cost per Rx | \$240,000 | \$201,000 | \$213,000 | \$654,000 |
| Post PDL Net Cost | \$106,000 | \$81,000 | \$83,000 | \$270,000 |
| PDL Savings | \$134,000 | \$120,000 | \$130,000 | \$384,000 |

ACE INHIBITORS

The ACE Inhibitor recommendations became effective November 16, 2005 with generic captopril and Altace® (ramipril) being selected as preferred products. Additionally, DHHS chose to make exempt from this implementation all Medicaid/Medicare Dual Eligibles. All other ACE Inhibitors now are denied at the point of sale and require prior authorization for Medicaid coverage of these medications.

The manufacturer of Altace provided a supplemental rebate bid. As a result, cost savings will be from supplemental rebates *and* moving market share to the preferred products. As a result of the PDL implementation, the average cost per ACE Inhibitor prescription has been reduced by 35 percent. Table 7 demonstrates estimated savings based on the method previously described.

TABLE 7

ACE INHIBITORS ARKANSAS MEDICAID COSTS

| | January | February | March | Total |
|--|-----------------|-----------------|-----------------|------------------|
| Actual Volume times pre PDL Cost per Rx | \$136,000 | \$112,000 | \$112,000 | \$360,000 |
| Post PDL Net Cost | \$87,000 | \$71,000 | \$72,000 | \$230,000 |
| PDL Savings | \$49,000 | \$41,000 | \$40,000 | \$130,000 |

TRIPTANS

The Triptan class was implemented on February 7, 2006 with Maxalt and Maxalt MLT (rizatriptan) being selected by DHHS as preferred products. Additionally, DHHS chose to keep existing quantity limits in place for this class of medications. All other Triptans now are denied at the point of sale and require prior authorization for Medicaid coverage of these medications.

The manufacturer of Maxalt provided a supplemental rebate bid. As a result, cost savings will be from supplemental rebates *and* moving market share to the preferred products. As a result of the PDL implementation, the average cost per Triptan prescription has been reduced by 30 percent. Table 8 demonstrates estimated savings based on the method previously described.

TABLE 8

TRIPTANS MEDICAID COSTS

| | January | February* | March | Total |
|--|-----------------|------------------|-----------------|-----------------|
| Actual Volume times pre PDL Cost per Rx | \$93,000 | \$75,000 | \$84,000 | \$252,000 |
| Post PDL Net Cost | \$79,000 | \$55,000 | \$58,000 | \$192,000 |
| PDL Savings | \$14,000 | \$20,000 | \$26,000 | \$60,000 |

* Class implemented on February 7, 2006

ANGIOTENSIN RECEPTOR BLOCKERS (ARBS)

The ARB recommendations became effective February 21, 2006 with Diovan (valsartan) and Cozaar (losartan) being selected as preferred products. Additionally, DHHS also chose to make preferred Diovan HCT (valsartan & HCTZ) and Hyzaar (losartan & HCTZ) which are the preferred ARBs in combination with HCTZ. Additionally, SmartPA criteria was established that allows patients with Congestive Heart Failure to receive Atacand (candesartan) at the point of sale without a prior authorization. All other ARBs are now denied at the point of sale and require prior authorization for Medicaid coverage of these medications.

The manufacturers of Diovan/Diovan HCT and Cozaar/Hyzaar provided supplemental rebate bids. As a result, cost savings will be from supplemental rebates *and* moving market share to the preferred products. As a result of the PDL implementation, the average cost per ARB prescription has been reduced by almost 28 percent. Table 9 demonstrates estimated savings based on the method previously described.

TABLE 9

ANGIOTENSIN RECEPTOR BLOCKERS (ARBS) ARKANSAS MEDICAID COSTS

| | January | February* | March | Total |
|--|-----------------|------------------|-----------------|-----------------|
| Actual Volume times pre PDL Cost per Rx | \$123,000 | \$86,000 | \$76,000 | \$285,000 |
| Post PDL Net Cost | \$101,000 | \$68,000 | \$55,000 | \$224,000 |
| PDL Savings | \$22,000 | \$18,000 | \$21,000 | \$61,000 |

* Class implemented on February 21, 2006

SKELETAL MUSCLE RELAXANTS

The skeletal muscle relaxant recommendations became effective March 20, 2006 with generic chlorzoxazone, cyclobenzaprine, and methocarbamol being selected as preferred products. Additionally, generic baclofen and tizanidine are preferred for patients who have a diagnosis that is associated with muscle spasticity. All other skeletal muscle relaxants are now denied at the point of sale and require prior authorization for Medicaid coverage of these medications.

All of the products selected as preferred agents are generically available. As a result, cost savings will be exclusively from moving market share to the preferred products. Because this class was not implemented until March 20, 2006, it is too soon to determine any potential cost savings associated with this class of medications.

TOTAL ESTIMATED PDL SAVINGS

FIRST QUARTER 2006

PRESENTED BY DRUG CLASS AND MONTH

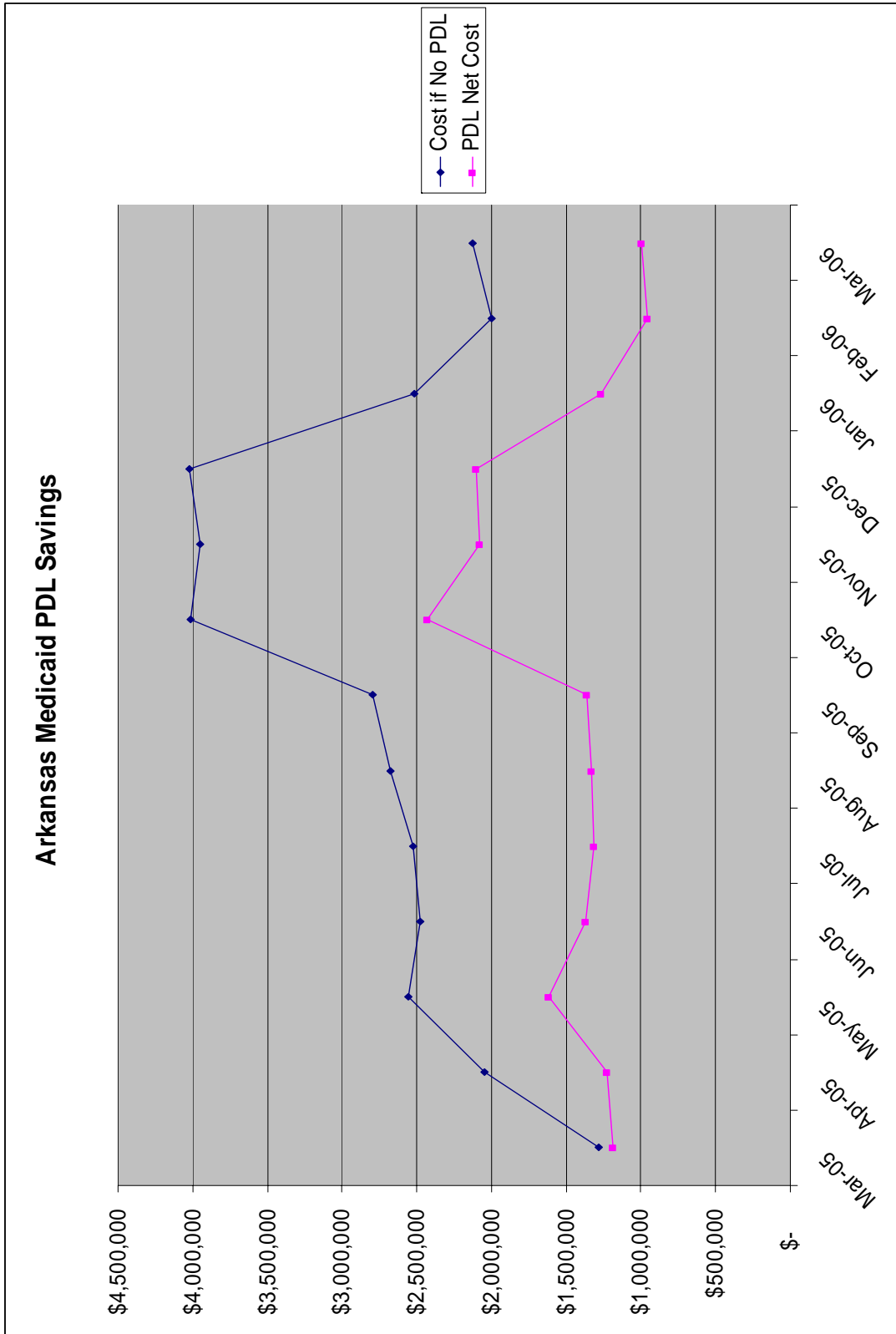
The table below (Table 10) demonstrates the cost savings by drug class and month for the first quarter of 2006. The estimated total cost savings for the entire first quarter of 2006 is \$3,458,000. Graph 1 illustrates what the cost for these medications would have been, assuming the same utilization, if there had not been a PDL in place.

TABLE 10

First Quarter 2006 PDL Cost Savings by Class

| | January | February | March | 1Q 2006 Total |
|--------------------------------------|----------------|-----------------|--------------|----------------------|
| Non-Sedating Antihistamines | \$148,000 | \$140,000 | \$170,000 | \$458,000 |
| Proton Pump Inhibitors | \$621,000 | \$499,000 | \$527,000 | \$1,647,000 |
| Statins | \$114,000 | \$84,000 | \$81,000 | \$279,000 |
| Calcium Channel Blockers | \$32,000 | \$22,000 | \$19,000 | \$73,000 |
| Beta Blockers | \$71,000 | \$52,000 | \$51,000 | \$174,000 |
| Long-Acting Opioids | \$134,000 | \$120,000 | \$130,000 | \$576,000 |
| ACE Inhibitors | \$49,000 | \$41,000 | \$40,000 | \$130,000 |
| Triptans | \$14,000 | \$20,000 | \$26,000 | \$60,000 |
| Angiotensin Receptor Blockers | \$22,000 | \$18,000 | \$21,000 | \$61,000 |
| Total | | | | \$3,458,000 |

Graph 1



MARKET SHARE IMPACT OF PDL RECOMMENDATIONS

PRESCRIBER AND PATIENT COMPLIANCE WITH PDL SELECTIONS

The success of the PDL depends in large part on participation by prescribers with the recommendations of the Drug Review and Drug Utilization and Cost Committees. Prescribing compliance with the Preferred Drug List is monitored by EBRx. The following table presents data on the percentage of prescriptions that were filled for preferred product(s) in each of the therapeutic categories reviewed and implemented to date. This percentage is commonly called market share in the pharmaceutical industry. Outcomes and cost savings are maximized as market share approaches 100 percent compliance with the Preferred Drug List recommendations. However, it should be noted that complete compliance with the Preferred Drug List is unlikely as there remains individual variation in response to any medicine.

Market Share of PDL Preferred Agents by Drug Class and Month

| | Mar 05 | Apr 05 | May 05 | June 05 | July 05 | Aug 05 | Sep 05 | Oct 05 | Nov 05 | Dec 05 | Jan 06 | Feb 06 | Mar 06 |
|----------------------------|--------------|-----------|--------------|--------------|--------------|-----------|-----------|--------------|--------------|-----------|-----------|--------------|-----------|
| NSAs | 17.6% | 93.4% | 91.3% | 88.0% | 87.4% | 87.5% | 88.0% | 87.4% | 86.3% | 85.2% | 85.9% | 85.9% | 86.1% |
| PPIs | 64.7% | 67.1% | 81.0% | 99.8% | 99.8% | 99.8% | 99.8% | 99.7% | 99.8% | 99.7% | 99.7% | 99.7% | 99.6% |
| Statins | 23.8% | 23.9% | 25.6% | 62.1% | 98.7% | 98.6% | 98.7% | 98.6% | 98.6% | 98.6% | 99.0% | 98.8% | 98.8% |
| CCBs | 76.7% | 76.8% | 76.8% | 76.8% | 84.7% | 96.1% | 95.9% | 96.2% | 93.8% | 96.1% | 95.8% | 96.3% | 97.0% |
| Beta Blockers | 74.7% | 74.2% | 74.8% | 74.9% | 74.9% | 74.8% | 75.4% | 86.1% | 91.7% | 91.5% | 91.2% | 91.3% | 92.0% |
| Long-acting Opioids | 27.2% | 27.4% | 26.2% | 27.0% | 28.1% | 27.8% | 32.2% | 37.4% | 68.9% | 69.6% | 79.5% | 84.3% | 83.9% |
| ACE Inhibitors | 14.2% | 13.9% | 13.9% | 14.0% | 14.0% | 13.9% | 14.6% | 17.2% | 23.6% | 39.7% | 76.5% | 77.7% | 77.9% |
| Triptans | 17.2% | 22.3% | 19.6% | 20.6% | 23.0% | 22.1% | 21.5% | 24.0% | 23.7% | 27.8% | 32.7% | 71.5% | 88.7% |
| ARBs | 69.3% | 68.4% | 68.6% | 68.4% | 67.1% | 67.5% | 67.2% | 65.9% | 66.4% | 66.3% | 67.3% | 70.8% | 98.8% |

Data in bold highlight the month PDL recommendations for the drug class became effective.

Prior Authorization Call Center Statistics

P.A. CALL CENTER OPERATIONS AS A RESULT OF THE PDL

The PDL Call Center approves or denies prior authorization requests from physicians for products that have been placed in non-preferred status. The approval, denial, and appeal of denials are handled by the clinical pharmacists and medical directors of the EBRx Program. The statistics below represent the Call Center's activity for the first quarter 2006, which includes January 1st through March 31, 2006.

| PA Call Center Statistics | Jan 2006 | Feb 2006 | Mar 2006 | Total 1Q 2006 |
|---|-----------------|-----------------|-----------------|----------------------|
| Incoming Calls from Healthcare Professionals | 722 | 625 | 835 | 2182 |
| Number of SmartPA Tickets Created | 731 | 640 | 850 | 2221 |
| Total Number of P.A. Request at the Call Center | 428 | 411 | 484 | 1323 |
| Total Number of P.A. Requests Approved at the Call Center | 289 | 264 | 282 | 835 |
| Call Center P.A. Approval Percentage | 67.5% | 64.2% | 58.3% | 63.1% |
| Point of Sale SmartPA Requests | 9556 | 7311 | 9393 | 26260 |
| Point of Sale SmartPA Approvals | 3058 | 2947 | 3956 | 9961 |
| Point of Sale SmartPA Approval Percentage | 32.0% | 40.3% | 42.1% | 37.9% |
| Average Call Duration | 2 min 45 sec | 2 min 55 sec | 2 min 45 sec | 2 min 48 sec |

Budget Update

A GENERAL OVERVIEW OF THE PROGRAM BUDGET

The current budget status for the Arkansas Medicaid Evidence-based Prescription Drug Program is presented below. The second column in the table shows total State Fiscal Year budget allocation, and the third column shows program expenditures for July 2005 through March 2006. There are a number of personnel positions which remain empty; however, if demand arises the program will work within its budget to ensure that it can meet the demand. At the end of the third quarter of SFY 06, the program is approximately \$1,300,000 under budget from July 1, 2005 through March 31, 2006.

| | SFY06 Budget | SFY06 Expenditures To Date (through March 31, 2006) |
|---|-------------------------|---|
| Personnel –(Salary and Fringes, includes DRC stipends) | \$2,183,719 | \$880,139 |
| Miscellaneous – (Supplies, Travel, etc) | \$157,650 | \$25,253 |
| Equipment – (computers, phones, furniture, renovation) | \$0 | \$0 |
| Indirect Costs | \$1,264,339 | \$488,912 |
| TOTAL | \$3,605,708 | \$1,394,305 |

Data Evaluation

TRACKING OUTCOMES OF THE PDL DECISIONS

One of the most important aspects of the EBRx program is the evaluation of Medicaid data to determine what the long term ramifications of the PDL decisions are. Through the College of Pharmacy's Pharmaceutical Evaluation and Policy (PEP) Division, the Medicaid claims database will be analyzed to determine impact to the Medicaid program, beyond simply the cost of the medications.

Programmers have been hired to help facilitate the evaluation of the data. It is our hope to begin providing some initial outcome data during the last quarter of SFY 06 or early SFY07.

Appendix A

Date: January 19, 2006

Subject: DRC Recommendations to DCC and DHHS

To: DHS, DCC, Dean's Office

From: Henry F. Simmons, Jr., MD, Ph.D.
Chairman DRC

At its 01/19/06 meeting, the Drug Review Committee considered the potential toxicity and therapeutic roles of selected estrogens for use by women with the indications listed below.

Estrogens under consideration for use in perimenopausal women and in women with natural or surgical menopause

17-beta estradiol: oral, transdermal, cream, vaginal ring

Estradiol valerate: oral

Conjugated equine estrogen: oral, cream

Synthetic conjugated estrogen: oral

Esterified estrogen: oral

Estropipate: oral

Indications under consideration

Hot flashes/flushes

Sleep disturbance/night sweats

Mood changes

Urogenital symptoms/sexual dysfunction

Quality of life issues

Prevention of osteoporosis and its complications

Based upon the bulk of the best available evidence pertaining to the aforementioned agents the Committee concluded the following:

The agents do not differ in terms of either safety considerations or frequency of adverse events during either short or long term use to the extent that one or more should be excluded from consideration.

The agents do not differ significantly in efficacy when used in equipotent doses.

At least one topical and one oral preparation should be available.

None of the agents appear to be associated with either special benefits or special risks on the basis of demographics.

Henry F. Simmons, Jr.

January 19, 2006

Appendix B

Date: February 16, 2006

Subject: DRC Recommendations to DCC and DHHS

To: DHS, DCC, Dean's Office

From: Henry F. Simmons, Jr., MD, Ph.D.
Chairman DRC

At its 02/16/06 meeting, the Drug Review Committee considered the potential toxicity and therapeutic roles of newer sedative hypnotic agents for adults with insomnia.

Newer sedative hypnotic agents under consideration include the following:

Eszopiclone [Lunesta]
Ramelteon [Rozarem]
Zaleplon [Sonata]
Zolpidem [Ambien and Ambien CR]

Indications under consideration in adults

Insomnia

Based upon the bulk of the best available evidence pertaining to the aforementioned agents the Committee concluded the following:

The agents do not differ in terms of either safety considerations or frequency of adverse events to the extent that one or more should be excluded from consideration.

At least two of the agents should be available. If only two are available, they should include no more than one of the following: ramelteon and zaleplon.

None of the agents appear to be associated with either special benefits or special risks on the basis of demographics.

Henry F. Simmons, Jr.

February 16, 2006

Appendix C

Date: March 16, 2006

Subject: DRC Recommendations to DCC and DHHS

To: DHS, DCC, Dean's Office

From: Henry F. Simmons, Jr., MD, Ph.D.
Chairman DRC

At its 02/16/06 meeting, the Drug Review Committee considered the potential toxicity and therapeutic roles of targeted immune modulators for rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis, and Crohn's disease.

Targeted immune modulators under consideration include the following:

Humira (adalimumab)
Amevive (alefacept)
Kineret (anakinra)
Raptiva (efalizumab)
Enbrel (etanercept)
Remicade (infliximab)

Based upon the bulk of the best available evidence pertaining to the aforementioned agents the Committee concluded the following:

Because there is insufficient information about alefacept and efalizumab to reach conclusions about their safety and adverse-event profiles relative to the other drugs, they should be excluded from further consideration. Of the remaining four drugs, there is insufficient evidence to conclude that one is superior to the other in terms of safety considerations or frequency of adverse events.

In the treatment of rheumatoid arthritis there insufficient information to conclude that any of the following are superior: Humira (adalimumab), Kineret (anakinra), Enbrel (etanercept) and Remicade (infliximab). At least two of these agents should be available.

In the treatment of juvenile rheumatoid arthritis, Enbrel (etanercept) should be available as there insufficient information to recommend Humira (adalimumab), Kineret (anakinra), and Remicade (infliximab). At least two of these agents should be available.

Enbrel (etanercept) and Remicade (infliximab) should be available for treatment of ankylosing spondylitis.

For the treatment of psoriatic arthritis at least two of the following should be available: Humira (adalimumab), Enbrel (etanercept) and Remicade (infliximab). Kineret (anakinra) should be excluded for this indication due to lack of evidence.

Remicade (infliximab) should be available for the treatment of Crohn's disease.

Humira (adalimumab) and Kineret (anakinra) should be available for the treatment of patients with congestive heart failure.

A majority of committee members felt that the targeted immune modulators should be prescribed only by physicians who routinely treat patients with chronic inflammatory disorders that are refractory to traditional therapy.

Henry F. Simmons, Jr.

March 16, 2006