Meeting of the
Pharmacy and Therapeutics Committee
October 6, 2004
Minutes

Members Present:

Gill Abernathy, M.S., R.Ph.

Avtar Dhillon, M.D.
Mariann Johnson, M.D.
Mark Oley, R.Ph.
James Reinhard, M.D.
Roy Beveridge, M.D
Tim Garson, M.D.
Renita Warren, Pharm.D.
Christine Tully, M.D.

Via phone:
Randy Axelrod, M.D., Chair

Absent:
Mark Szalwinski, Pharm.D.
Sue Cantrell, M.D.
A quorum was present

Guests:

38 representatives from pharmaceutical companies, providers, advocates, associations, etc.
Manikoth Kurup, MD, Member, Board of Medical Assistance Services
Cindy Kirkwood, Pharm.D, Associate Professor of Pharmacy, VCU

DMAS Staff:
Patrick Finnerty, Agency Director
Cynthia Jones, Chief Deputy Director
Cheryl Roberts, Deputy Director of Programs and Operations
Kim Piner, Counsel to the Board, Office of the Attorney General
Adrienne Fegans, Program Operations Administrator
Javier Menendez, Pharmacy Manager
Bryan Tomlinson, Director Division of Health Care Services
Jane Woods, Secretary of Health and Human Resources (via phone)

First Health Staff:
David Adams, Pharm.D, Rebate Support
Debbie Moody, R.Ph, Clinical Manager
Donna Johnson, R.Ph, Clinical Manager

WELCOME AND INTRODUCTIONS FROM PATRICK FINNERTY, DMAS DIRECTOR

Patrick W. Finnerty stated that two main issues would be continued from last meeting. One was financial information on the Statin class that will be covered in the confidential meeting and the second was a discussion of the Vioxx market withdrawal on September 30, 2004. Vioxx was the only preferred drug in the COX2 class. The Department learned of this early on that morning of the 30th and by noon that day notification was sent that Bextra and Celebrex, the other two drugs in that class, would be covered. This ensured that Medicaid recipients would have access to appropriate drugs. The discussion of the COX2 class will also be part of the confidential meeting today and then the P&T Committee will discuss and take action on that class when the public meeting is resumed. The final issue today is the review of antidepressants and antianxiety drugs, the SSRIs and others. There will be public comment on that drug class and the decision will be made by the P&T committee on PDL eligibility. Mr. Finnerty mentioned that the Committee members have among their meeting materials a letter from Delegate Hamilton, addressed to the Committee, relating to behavioral health medications. He thanked the Committee and everyone who was participating in the meeting today.

COMMENTS FROM THE SECRETARY OF HEALTH AND HUMAN RESOURCES

Secretary Woods thanked the Committee for their expertise and their willingness for being part of the process. The process by which Virginia has implemented this action has been a sentiment to the strength and dedication of everyone on the P&T committee. She also gave thanks to everyone from the PDL Implementation Advisory Group who has been key to assuring that both providers and patients, who are the first concern, see the process as transparent as possible in their respective roles within the system. Secretary Woods assured that program guidance and the guiding principles are the work of the P&T committee, particularly with the behavioral medications to be

discussed today. The goal is to ensure the best possible medical provisions for people whose health care is paid for by Medicaid.

COMMENTS FROM RANDY AXELROD, COMMITTEE CHAIR

Dr. Axelrod thanked everyone for their attendance and called the meeting to order.

ACCEPTANCE OF MINUTES FROM SEPTEMBER 20th, 2004 MEETING

Dr. Axelrod asked if there were any corrections, additions, or deletions to the minutes from the September 20th meeting. None were noted and upon request of the Chairman, the Committee voted on a motion and a second to approve the minutes of the September 20th meeting as written. The Committee voted unanimously to approve the minutes as drafted.

COMMENTS FROM OFFICE OF THE ATTORNEY GENERAL

Ms. Kim Piner from the Attorney General's office stated that under the Virginia Freedom of Information Act (FOIA), specifically Virginia Code section 2.2-3711, a public body such as the P&T Committee, may go into a closed session for any of the 33 reasons listed in that statute. The discussion of manufacturer and wholesaler prices is not one of the 33 reasons listed.

She stated the Attorney General strongly supports the principles of open government embodied by the FOIA and believes in the opportunity of the Commonwealth's citizens to witness the operation of government to the fullest extent.

Federal Law 42 U.S.C. 1396r-8(b)(3)(D) requires such pricing information to be kept confidential. On this point federal law supersedes the Virginia FOIA. Since the P&T Committee must discuss this pricing information as part of its duties, pursuant to federal law a confidential meeting must occur for the consideration of this pricing information she cautioned only this confidential information should be discussed.

Mark Oley, made a motion for the P&T Committee to resume the meeting in another room to discuss this confidential information regarding prices charged by the manufacturers and wholesalers of the drugs of statin drugs previously discussed on September 20th 2004 meetings. This confidential meeting is authorized by Federal Law at 42 U.S.C. § 1396r-8(b)(3)(D) that requires this information to be kept confidential.

This motion was seconded and unanimously approved by the Committee.

The meeting adjourned to the confidential meeting.

The committee returned after a few minutes.

Mark Oley asked the Committee to reconsider the vote in regards to the earlier motion as to what was to be discussed. Dr. Axelrod asked what the new motion was?

Mark Oley, made a new motion for the P&T Committee to resume the meeting in another room to discuss this confidential information regarding prices charged by the manufacturers and wholesalers of the drugs previously discussed on September 20th 2004 meetings to include the Cox2 and Satins. This confidential meeting is authorized by Federal Law at 42 U.S.C. § 1396r-8(b)(3)(D) that requires this information to be kept confidential.

This motion was seconded and unanimously approved by the Committee.

The meeting adjourned to the confidential meeting.

DISCUSSIONS FOR THE COMPLETION OF ROUND 1 ANNUAL REVIEW

Dr. Axelrod motioned to resume the public session. The motion was seconded and unanimously approved by the Committee.

Mark Oley motioned to keep the "statins" as they appear on the PDL today. This motion was seconded and unanimously approved by the Committee.

Mark Oley motioned to change the Cox-2 Inhibitors PDL to include Celebrex only as the preferred drug in this class.

Dr. Beveridge raised the question of whether the clinical issues with Vioxx were a problem with just Vioxx or a class effect problem. The Committee held a discussion centered on their concerns of the possibility that there may be a class affect concern with the COX2 class.

Dr. Axelrod led the discussion citing concern over thromboambolic events, prothrombic effects and blood pressure concerns that may be inherent to the class not just to Vioxx. It was agreed by the Committee that more information about the class as a whole was needed and that current clinical edits may be modified based on this information. The Chair suggested that Mark Oley and Dr. Beveridge continue to review this class for the Committee and return information for the Committee at a future meeting so that the edits can be discussed and reviewed.

Mark Oley motioned again to maintain the preferred status for the statins as they are and to change the Cox-2 Inhibitors to include Celebrex as the only preferred drug. This motion was seconded and unanimously approved by the Committee.

DRUG CLASS REVIEW AND PUBLIC DISCUSSION

Dr. Axelrod noted that each speaker was limited by a time clock to three minutes. Dr. Axelrod asked that each speaker make a declaration of conflict in regards to the pharmaceutical industry, at the beginning of their comments. Dr. Axelrod recognizes the importance of this clinical information and public comment to the decision making of the Committee and appreciates the time of the presenters.

Yaacov Pushkin, MD, President Psychiatric Society of Virginia

Dr. Pushkin is a psychiatrist with no conflict in regards to the pharmaceutical industry. He represents the Psychiatric Society of Virginia, where he currently serves as its president. His comments are submitted on behalf of the National Mental Health Association and the National Alliance for Mental Illness (NAMI) and the American Psychiatric Association. These three organizations have been working together to maintain access to needed treatment to persons with mental illness. The key premises of the group are; 1) access to clinically appropriate medications by persons with mental illness is a critical public health policy; and 2) appropriate pharmacy benefit structure and management mechanisms are essential. Patients with serious mental illness taking these medications can and do improve their conditions. PDLs and prior authorization systems are not tailored to the needs of individuals with serious mental illness. Unlike many

medications that treat other illness, medication used to treat depression and anxiety cannot be used interchangeably. Each medication has a unique pharmacological profile; depression and anxiety are complex, each person responds individually. There are specific data that need to be reviewed clinically when examining patients. For example, symptoms, ethnicity, side effects, age, co morbidity and other factors need consideration in order to determine the best medication for the individual. Additionally, some of these medications take weeks to take effect, and, without prudent and reasoned choices, the likelihood of success maybe limited. The three organizations he represents advocate for the appropriate use of and access to medically indicated medications. Access to appropriate drugs is integral to successful and cost effective treatment. For people who are mentally ill PDLs and prior authorization systems can result in clinical problems. He agrees that costs are an important issue; in 2003 alone Virginia spent $29 million on the medication classes that the P&T Committee is reviewing today. Dr. Pushkin states that the cost of limited formularies must also be considered. The quality of care cannot be compromised because the health of all Virginians is critically important. He offered a few alternatives to consider: 1) physician profiling and education as in Missouri, 2) research disease management programs using clinical guidelines and care coordination to enhance patient outcomes, and 3) clinical algorithms such as seen in TMAP, the Texas Medication Algorithms project. A joint report from the National Association of State Medicaid Directors and National Association of State Mental Health Directors recommends against policies that restrict access to psychotropic medications. There are numerous alternative techniques that address cost and quality that are available rather than limiting medication alternatives for people with complex mental illness such as depression and anxiety. Dr. Pushkin urged the Committee not to resort to restricted techniques like PDLs and prior authorization that waste valuable treatment time, which are not cost effective in this population, and are potentially harmful.

Gill Abernathy asked which program Dr. Pushkin would pick and why. Dr Pushkin replied that this would need to be studied-- he was not sure which one would benefit Virginia the most.

Gill Abernathy asked, in his opinion, if you polled 10 psychiatrists would they all agree on the same medication for a patient. Response from Dr. Pushkin was that it is hard for him to answer for other physicians. He went on to say that when he prescribes for his patients, he has to consider what medications the patient is on and all of the other vital information for that patient.

Dr. Axelrod asked for studies that are published that cite separate arms for gender and toxicity with this class. Dr. Pushkin stated that he could not speak specifically to this but could speak for the patients that were medically ill themselves.

Dr. Beveridge asked if Dr. Pushkin favored restricting, which physicians can write for the antidepressants? Dr. Pushkin replied, ”no” he was not advocating a restriction on which physicians can prescribe the drug. Dr. Beveridge commented that this is what some states have done. Dr. Pushkin replied that he is not for that restriction.

Aradhana Bela Sood, M.D., F.A.A.C.A.P. VCU Health Systems

Dr. Sood is a child and adolescent Psychiatrist at VCU and Division Chair of Child and Adolescent Psychiatrist at MCV. She has no conflict in regards to the pharmaceutical industry. Dr. Sood indicated she came to give the Committee background on the use of SSRIs in children and adolescents. This has been an area of great controversy over the past year. Dr. Sood states

there has been an increase of suicidal idealities with the use of SSRIs. There has been great progress in the diagnosis and treatment of children with mental illness. Some of the components of depression are low self-esteem, despair, and poor academic achievement and these can spiral down into suicidal idealities. People trained in this field understand that there is no causal relation between suicides and SSRIs. Physicians must do thorough baseline evaluations to determine aggression and suicidal tendencies before selecting a drug. Dr. Sood stated that when you treat individuals with mental illness you must develop an individualized treatment plan; "one-size fits all" does not work. The practitioner uses the side effect profile of medications to determine which antidepressant the patient is prescribed; in terms of efficacy, they are all similar. Unfortunately, when limited by the choices, a decision must be made which may not constitute good care. Dr. Sood emphasized this concern and appealed to the Committee to carefully review limitations placed on physicians.

Mark Oley asked - since safety and efficacy in children has not been established, is Prozac the leading SSRI of choice?

Dr. Sood replied that this is the basis of the problem with SSRIs -- not enough studies and research has been done with children. Evidence based studies are needed for children. Dr. Sood states that she bases her therapy on the individual child and what they will respond to.

Dr. Axelrod noted that with Prozac, now a generic, the drug companies would not fund the necessary studies to promote it. It may take decades to have the questions answered.

Dr. Axelrod noted that despite open access of antidepressants in the Medicaid population, we are not seeing appropriate management in 2/3 of the patients. This was according to reports by HEDIS 2001 to 2005. Dr. Sood feels that this speaks to how complex this issue is.

Gill Abernathy requested clarification of Dr. Sood's prior statement: That there is no causal connection between the SSRIs and completed suicides and the black box warning. These drugs are effective yet you are saying that there are very few studies that have been done.

Dr. Sood replied that there is no data that can tie completed suicides with kids taking SSRIs. There has been no push to do studies on children. It is a difficult population that makes people uncomfortable to conduct study trials with kids with mental health illness.

Further discussion was held on the need for further studies in the pediatric population concerning SSRIs.

Diane Weakley, RPh, FASCP Consultant pharmacist for NeighborCare Pharmacy.
Ms. Weakley is the clinical services manager for NeighborCare Pharmacy. No conflict in regards to the pharmaceutical industry.

Ms. Weakley discussed the advantage of the orally disintegrating mirtazapine in the nursing home populations. She cited that the elderly nursing home populations face many challenges in the management of depression. Depression and related symptoms such as reduced appetite, weight loss, and difficulty sleeping are all significant problems in the nursing home population. By treating depression with medications like orally disintegrating mirtazapine, other medications with serious side effect profiles may not have to be used.

She closed with a request to the Committee to add the orally disintegrating mirtazapine to the PDL.

Judy Castleman VA Executive Director Quality Healthcare Network

The Quality Healthcare Network is supported by member dues, but does receive a number of grants for educational programming and some of these grants do come from a variety of pharmaceutical manufacturers. Their network represents 4 million patients and 40 advocacy groups.

Ms. Castleman asked the group to look beyond the immediate decision being made to limit access to medication for the state's most vulnerable population. Her opinion is that to subject antidepressant and antianxiety medication to a pick and choose process is naive and counter productive. Any limitations on any of these medications to any citizens will only lead to increased hospitalization, ER visits, and incidences of noncompliance with a greater constraint on an already overburdened public safety and social services system. Her concern is that we might totally reverse any cost savings that we are trying to receive. She commented that recently a local paper had a publication about mental health patients and the lack of access to treatment and medication in the community and that the police have to deal with these situations. However, the VQHN voices their concerns as we look forward to 2006, when Medicare patients will move to a national prescription drug coverage system. Once this takes place in less than a year and a half, Virginia will be forced to find different avenues to sustain the current $10 million cost savings that the PDL was designed to support. A fear is as the fee-for service elderly are removed from the mix, the Commonwealth's budget planners will be forced to look for other patient populations and other classes of medications to supplant this lost revenue. The fear is that the currently exempt patient populations will have their medications subject to the PDL. As with today's discussion, patients with mental illness like depression were previously exempt. Will other patients with other conditions such as epilepsy and other brain disorders, cancer, HIV or AIDs be considered in the future? Ms. Castleman believes that the time has come to look at other avenues within Medicaid and the health system that can improve patient outcomes and control cost, and reduce the state's financial obligation once Part D takes hold. Struggling today to debate the pros and cons of limiting significant medications to a desperate part of our population seems inconsequential when we will have to come up with extra money to replace these lost revenues.

Gill Abernathy asked if she was starting from the viewpoint that all patients today are optimally treated, and if any change will be a negative change?

Ms. Castleman replied that drug decisions should be left with the patient and doctor. Ms. Castleman went on to say that, in many diseases, the drug choices should be between doctors and patients. She was not saying that every doctor and every patient make the right decision, but she did not think that managed care, as a whole, makes better decisions.

Dr. Axelrod asked her to be more specific to the class we were discussing that we were not here to debate managed care.

Dr. Axelrod restated Gill Abernathy's question.

Ms. Castleman responded that there is concern that by restricting a doctor's choice that it may impact patient care.

Harry L. Gewanter, MD, FAAP, FACR Speaking behalf of Virginia Richmond Pediatric

Dr. Gewanter is a pediatrician for children with special health care needs and disabilities. No conflict in regards to the pharmaceutical industry. He discussed the current problem with access to care for children with behavioral health problems and brain disorders. The American Academy of Pediatrics at a national level has recommended that pediatricians learn to manage the initial treatment of children with depression and other behavior health problems. The SSRIs are a valuable medication for these children. Dr. Gewanter stated in his opinion a PDL limits access to medication, which can have a significantly dire consequence. The children with these problems affect everyone around them, family, and school. There is a wide range of individual responses to SSRIs. No class affect for response. It is important not to limit the appropriate care to the Medicaid and foster care kids. While Dr. Gewanter understands children are not small adults, the SSRIs are very effective for them and he requests that they not be limited in their ability to care for children.

Mark Oley asked Dr. Gewanter his opinion concerning the FDA's decision to warn patients of the risk of suicide while taking SSRIs. Dr. Gewanter replied that there is a causal relationship between these medications and suicide. The important thing is to monitor patients closely -- Don't just walk away.

Mark Oley asked if there is concern about one medication over another in the SSRI class. Dr. Gewanter replied that he does not think that one specific drug is worse than the other.
It is a class problem. His views were that indications were more driven by the drug company than a difference in product.

Dr. Axelrod cited that he believed the group was struggling with the same problems as they had with every class reviewed for PDL, the complexity of disease and the abysmal care recommendation compliance. The RAM study showed that in regards to depression that only 58% of the time was the care recommendations by evidence based guidelines followed. There are many directions to drive improved care.

Dr. Gewanter noted that this is a moving target. Not a static event, we must constantly monitor and make decisions, a very fluid situation. Limits should not be placed on these drugs.

Michael Pendrak, Mental Health Consumer, Mental Health Association in VA

Mr. Pendrak is a mentally ill patient who came to share his experience. After three attempts with different medications, he was tried on Prozac. This was the first time in his life he knew what it felt like to be normal. After seven years of success, the Prozac stopped working, which created negative social and economic effects on his life. Mr. Pendrak has continued to work with his physicians over the years to remain stabilized on medication.

He has become an advocate for mental health patients, training others to become advocates.
Mr. Pendrak stated that one of his drugs is (a non-preferred medication) and it is difficult for him to get. For a while, the doctor was giving him samples. Many people find themselves in a situation where they have a hard time getting medication because they cannot afford them and the doctors cannot write them because they are not on the preferred list.

Valerie Marsh, Executive Director National Alliance for the Mentally Ill-Virginia Affiliate

Ms. Marsh represents 450,000 consumers and family members across the state. NAMI supports open access to all mental health drugs. All of the patients on Virginia Medicaid who are mentally

ill are very ill. The co morbidity of having more than one illness is very high. For example, about half of the people who suffer with schizophrenia also suffer from depression and anxiety. These mood disorders are potentially lethal diseases. The potential rate for suicides and personal harm in this population is alarming; between 15% and 20% attempt suicide. Ms. Marsh stated that CMS supports open access and quoted a letter she stated Pat Finnerty received from CMS dated August 30, 2004. She referred to this letter.

Ms. Marsh came to tell her personal story. Seven years ago she had to do a suicide assessment on her own son who was 15 years old at the time. They tried several medications before they found one that raised him out of his depression. But this medication made him numb. It took four attempts to find the right medication for him. Ms. Marsh feels passionately about allowing access to medications.

Dr. Reinhard asked how we could get people to manage mental health medications like other illness.

Ms. Marsh believes that it may take several attempts to find the right medication for any illness.

Dr Axelrod thanked the Committee and the speakers.

Mr. Finnerty introduced Cindy Kirkwood, Pharm.D, BCPP, Associate Professor of Pharmacy, and Vice Chair for Education, Virginia Commonwealth University. Dr. Kirkwood's responsibilities are to work with the Committee as an expert in mental health drugs and consult with the Committee to ensure that patients will receive proper care and consideration. Dr. Kirkwood will do the presentation of the drug class.

Dr. Kirkwood cited from the clinical packet provided to the P&T Committee as stated below:
Since the development of selective serotonin reuptake inhibitors (SSRIs), antidepressants are being used to treat milder forms of depression and anxiety disorders due to a more tolerable/favorable side effect profile over conventional therapy (TCAs/MAOIs). The efficacy of SSRIs has been shown in many clinical trials, meta-analysis, and systematic reviews to be similar to that of the TCAs.
Studies show that all of the SSRIs share comparable efficacy in the treatment of depression. Fluvoxamine (Luvox®) is the only SSRI that is not FDA-approved for the treatment of depression; however, it has been used successfully as an antidepressant in Europe for many years.
Fava et al. Compared fluoxetine, sertraline, and paroxetine in efficacy and tolerance in depressed patients and evaluated the impact of baseline insomnia on outcome. No differences in efficacy or tolerability between groups were noted. Also, there is no difference for subgroups of patients with high or low severity insomnia.
Although there may be some differences among use of one SSRI versus another in a particular patient, authors of several reviews stated generally that efficacy among the SSRIs is similar. Therefore in the absence of patient specific factors, selection of an SSRI agent would be expected to have equivalent outcomes.
There are some differences in the pharmacodynamic/kinetic profiles of these agents. However, these differences are of variable importance and it is considered that in the vast majority of patients, these differences are of little to no clinical importance.
In patients with depression who either have not responded or have not tolerated one particular SSRI, a second SSRI has been shown to be as effective and/or better tolerated.

Studies have shown that patients can be safely and effectively switched from one SSRI to another (though not all medications have been studied).

Mark Oley asked Dr. Kirkwood if SSRIs are equally effective for depression.

Dr. Kirkwood responded that yes, for the management of depression they are.

Dr. Tully asked if this was also true in the pediatric and adolescent population.

Dr. Kirkwood noted that most of the evidence is based on adult patients. There are some studies that have been done with children and most of these studies were with fluoxetine. Other SSRIs have been studied in children but they are smaller studies. These smaller studies did find that all of the drugs studied were effective.

Dr. Tully expressed concern that other speakers today have stated that in children and adolescents that these drugs are not comparable.

Dr. Kirkwood replied that in pediatric population the physicians use patient specific factors to choose the SSRIs.

Dr. Tully asked Dr. Kirkwood in her review of the literature, is there sufficient over lap in the pediatric and adolescent population that the SSRIS class can be considered therapeutic equivalents.

Dr. Kirkwood deferred the question to the Psychiatrists on the Committee.

Dr. Dhillon answered that if a person is doing well on a medication, he questions the efficacy of switching to another. If a person is not responding, changing drugs is acceptable and one is as good as the other. Switching medications because of insurance coverage often results in problems. If the drugs are on the PDL then he wants to look at all the variables to make a decision.

Dr. Beveridge asked if sufficient data in children or adolescents exist to make the SSRIs a PDL class.

Dr. Dhillon expressed that there are not sufficient data to make a decision in this age group.

Dr Axelrod said that he saw 3 to 4 questions that the Committee needs to answer.
1) Is this class PDL eligible?
2) Answer questions to determine the appropriate guidelines.
3) How does the Committee address the issues of inappropriate use, poly-pharmacy, and unlabeled use?
4) If we do consider these as PDL eligible, then there is the question of do we grandfather existing patients?

Mark Oley moved that SSRIs are PDL eligible with the need to investigate the clinical criteria and examine the P450 effects along with other variables in pediatrics.

Dr. Beveridge wants the Committee to discuss this further. Dr. Axelrod asked Dr. Beveridge if he was removing the motion? Dr. Beveridge said yes that he was moving to strike the motion.

Dr. Dhillon moved to strike the motion also.

Mark Oley agreed to strike the motion.

Dr. Beveridge asked if decisions were being made for a specific disease such as depression. Are all SSRIs the same for everyone or just adult depression?

Dr. Axelrod reminded the Committee that it was their decision. They could manage it the way they thought best, for example with an edit or criteria.

Dr. Reinhard stated that differences do exist depending on the disease state.

Dr. Axelrod reminded the Committee that PDL does not mean inaccessible.

Dr. Dhillon said that he sees two different tasks, one is the disease state part and the other is having a drug for each class of medication ex: a SSRI, a SNRI and a TCA.

Dr. Axelrod said the first thing we have to do is decide if this is a PDL eligible medication. If it is then we have to come back and decide all the rest.

Gill Abernathy asked are there are no clear winner drugs here? Can we say that in this situation we would always give this medication because we are sure it will work and give us better outcomes than other drugs?

Dr. Dhillon replied that all we really have is that if someone responded well to drug A in the past then they may respond to it again. If the person responds three times to drug A then they will probably respond to the drug A again.

Dr. Beveridge commented that the Committee needed to look at using another tool with the PDL like the Missouri Medication management program.

Dr. Axelrod said that our goal is to raise the maximum efficiency within a class of medication. We should not be limiting ourselves to cost driven issues. We should use components, cost and guidelines to maximize efficiency. Dr. Axelrod reminded the Committee that Virginia excluded the anti-psychotic medications from the list of possible PDL medications.

Dr. Beveridge recommended that patients under 18 or 21 should be exempt and that a grandfather clause should be developed. He just does not feel comfortable with switching medications.

Dr. Axelrod agreed.

Dr. Johnson expressed difficulty deciding what to do with this class. She sees two different groups. One group of patients that have a minor problem, with this group the use of SSRIs is short term, i.e., when the person gets better they are able to discontinue the medication. The other group of patients is much more severe. Yet we do not want to create a process where everyone has to see a psychiatrist.

Gill Abernathy noted that what she heard from the discussion was that in patients with more severe illness there is still no one drug that is known to work for all patients.

Dr. Dhillon suggested that the Committee needed a good clinical criteria created by a clinical committee.

Dr. Axelrod informed the Committee that Dr. Szalwinski served on a panel in the Tidewater area that reviewed mental health medications. The consensus of that panel was that a patient should try generics before brands.

Mark Oley motioned again to include the SSRIs as a PDL class.

Dr. Axelrod asked that the motion be clarified.

Mark Oley restated the motion to include all antidepressants as a class as being PDL eligible.

Dr. Axelrod suggested that he include the other antidepressants and antianxiety drugs in the motion. Mark Oley agreed.

Dr. Beveridge seconded the motion.

Dr. Axelrod asked that the vote be measured by a count of hands. He asked for all in favor. All Committee members present raised their hands. Dr. Axelrod asked for a show of hands by all opposed. No hands were raised.

It was noted that the motion was agreed to unanimously.

Dr. Axelrod said it was a great discussion and excellent work. Passion and concern were expressed by everyone. He asked DMAS to put together what other states are doing with these classes. He wants the details of each program, not just general information but the “nitty-gritty” on clinical criteria and profiling. We need to work with Dr. Reinhard so as to not duplicate services. Dr. Beveridge asked that the Committee address issues such as grandfathering and if agreed that it be implemented with the recommendations. This will be discussed at another P&T meeting in December where the details of the program will be decided including issues related to pediatrics, grandfathering, and persistency and practice guidelines. Dr. Beveridge asked that the Committee choose an age cutoff from clinical data. Once the P&T has determined its recommendation, a document will be drafted by DMAS to be presented to the General Assembly.

Next meeting will be the first week in December 2004

Chairman Axelrod adjourned the meeting at 3:43 p.m.