



U.S. Pharmacopeia
The Standard of Quality™

**2005–2010 Model Guidelines Expert Committee (MGEC)
Meeting #8
Wednesday, November 8, 2006
USP Headquarters, Rockville, Maryland**

Public Record of Meeting

Goals and Anticipated Outcomes

1. Presentation of issues and concerns expressed by the Centers for Medicare and Medicaid Services (CMS) during the USP/CMS annual meeting held October 12, 2006
2. Presentation of findings of the CMS formulary review process for CY 2007
3. Review and discussion of Medicare Part B versus Part D issues
4. Review of revised draft Model Guidelines (MGs), Formulary Key Drug Types (FKDTs), and drug list
5. Review of comments received from CMS on the draft MGs
6. Consideration of revisions based upon CMS comments
7. Discussion of the release of the draft MGs for public comment November 10 though December 10, 2006

Opening and Procedural Matters

After establishing that a quorum was present, the meeting was called to order. MGEC Members were given the opportunity to review and update their Conflict of Interest Statements.

The minutes from the previous meeting held on August 21, 2006 were reviewed and approved.

The meeting agenda was reviewed and approved.

Review of Meeting with CMS

The notes pertaining to the October 12, 2006 meeting of USP and the Centers for Medicare and Medicaid Services (CMS) were reviewed. Key topics in the discussion included:

- CMS's request that USP staff stop participating in the formulary review process due to a perceived potential conflict of interest.
- CMS's request that USP and the MGEC stop producing the drug list table, i.e., the columns that include examples of drugs and their salts/esters that might be included under each therapeutic category, pharmacologic class, and formulary key drug type (FKDT).
- The scope of USP's responsibilities and activities under the law, and how these relate to USP's contractual agreement with CMS.

Discussion

- Even if the drug list is not included with the MGs and FKDTs as a deliverable to CMS, USP may still publish it on the USP website as a service to the public.
- In recommending that drugs on the Beers and HEDIS lists not be included on the MGEC drug table, CMS may be thinking in terms of drugs that are primarily used by the elderly. Patients who are not elderly are also covered by Medicare.
- USP is responsible for fulfilling the contract with CMS and also for satisfying the public's need for information and ensuring the integrity of its own processes.
- Some of the areas of confusion may be resolved by communicating with CMS.
- The Oregon Health and Science University Center for Evidence Based Policy has joined with Consumer Reports to develop a list of drug choices based on a systematic review of the literature. USP's list could be adapted to include drugs of choice based on age.

Formulary Review Findings CY 2007 and Discussion of Part B versus Part D Issues

CMS's 2007 formulary review process and findings were presented. Highlights of the presentation are listed below.

- CMS reviews Part D formularies to ensure that beneficiaries have access to the drugs they need and that formulary designs are not discriminatory. There are several sub-reviews. The formularies are compared to the content of the USP MGs as a check for formulary robustness.
- Plans submit their formularies in April and go through two to three series of review checks. CMS communicates with them in writing throughout the process. In some cases, plans are

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asked to resubmit their formularies or give clinical justification for not including required drugs. Communication proceeds back and forth until all potential issues have been addressed.

- In 2006, plans could submit any National Drug Code (NDC) from formulary files independent of the drugs in the Medicare Prescription Drug Plan Finder. Additional work was needed to assure consistency. For 2007, plans used the Formulary Reference File, which created a level playing field.
- In 2006, approximately 500 formularies were submitted for review. These were linked to contracts and then linked to individual plans. In 2007, 86% of formularies that were reviewed were used by specific plans.
- 74% of submitted formularies utilize a specialty tier, 70% have at least one drug in step therapy, and 98% have at least one drug that requires prior authorization or a quantity restriction.
- A comparison of formularies from 2006 and 2007 found a 37% increase in Part B items.

Discussion ensued regarding the MGEC drug list, including the ways in which it differed from the Formulary Reference File used by CMS and the usefulness of the MGEC list to health plans and others.

Discussion

- Question: The drug list, which was used as an aid to plans when developing formularies, was considered to be problematic by CMS because it contained Drug Efficacy Study Implementation (DESI) less than effective (LTE) drugs and other drugs to be avoided in the elderly. Were there specific concerns about including specific examples?
Response: The drug list is a useful tool, but it included DESI LTE drugs and some products covered exclusively under Part B. CMS realized that a number of plans relied solely on the MGs drug list while CMS was using the Formulary Reference File. This caused confusion.
- Comment: DESI LTE drugs will be removed from the drug list. The concern is that removal of the examples will cause more confusion about where drugs fit in the structure. The list could be cleaned up but kept as a companion to the MGs to avoid this confusion.
Response: This issue will be discussed further.
- Question: What is the difference between the Formulary Reference File and the MG drug list?
Response: The Formulary Reference File does not include every drug that could be covered under Part D, but it intends to do that. It does not contain DESI drugs. It includes the brand name, generic name, and dosage form of each drug sorted by generic name.
- Question: Although the drug list may cause confusion, how serious is the problem when 80% of the plans adopted the USP MGs? Over time, the confusion could be resolved and the result would be a quality tool for use by physicians and pharmacists. Eliminating the list makes the process too diluted.
Response: There are ramifications of plans relying on the drug list.
- Comment: CMS is missing the opportunity to look at the list as a quality tool and not as a means for plans to game the system or something that causes difficulties for CMS. There could be a communication issue between CMS and individual plans. The drug list could help translate the quality measures to practitioners and patients in a more useful way.

The differences between Medicare Part B and Part D drugs were also reviewed by CMS, with additional discussion ensuing on this topic, including the regional variations in Part B coverage, the degree to which the setting in which a drug is administered affects its coverage, and the ongoing confusion between Part B and Part D coverage.

Discussion

- Comment: Regional variations in formulary coverage could cause confusion.
Response: CMS would need statutory involvement in order to standardize the formulary coverage across regions. It is difficult to compile a comprehensive list of Part B drugs due to this variation.
- Comment: Given the national set of disparities, perhaps the MGEC should consider adding more Part B drugs to the Part D drug list.
Response: The MGEC could become more familiar with Part B vs. Part D by reviewing the CMS document "Medicare Part B vs. Part D Issues" on the CMS website.
- Comment: The MGEC is aware of the document, but it appears that there are many drugs that could be covered under Part B or Part D depending on the situation in which they are administered. To remove them from the Part D drug list would be a disservice to the public.



- **Question:** Why are specific patient circumstances an issue? The majority of oncology patients have pre-chemotherapy antiemetics administered at a clinic and the remaining doses administered at home.
Response: It is written in the policy that drugs administered at a clinic are covered under Part B. There is an inherent problem with the policy and it presents challenges.
- **Comment:** Home infusion and chemotherapy cannot be covered without a non-Medicare source of payment. Part B can cover the services. In most cases when home infusion is encountered, the purchase of the drug should not be covered unless there is another source of payment (secondary insurance or Medicaid) for the supplies and equipment.
- **Comment:** The drug list can provide clarity to plans. Part B vs. D coverage is unclear and generates confusion. Is there a simpler way to mitigate that confusion by continuing to offer a list of drugs (i.e., the MGs drug list) when there is potential overlap?
Response: This issue will be discussed further.
- **Question:** Regarding infectious diseases, by defining the use of drugs by the location where they are dispensed, the personal component in this discussion is disenfranchised. Some populations are best treated outside of the hospital. Rather than focus on the place where the drugs are dispensed, if this is a regulatory question, is the population being served? Is there a way of clarifying the Part B vs. D issues rather than generating another guidance? Can CMS deal with the population at need rather than the source where the drug is dispensed?
Response: CMS is open to any of these types of ideas, but has to abide by the legislation and regulations, which are very structured. Drugs covered under Part B cannot be covered under D.
- **Comment:** If CMS finds those rules are not working for them, they should also assume that they are not working for the public. The regulations could be revised.
Response: That is a good point. The regulations could be reevaluated.

Review of Draft Model Guidelines Version 3.0

Suggestions for changes to the Draft MGs Version 3.0 for the 2008 benefit year made by each Information Expert Committee were reviewed.

Cardiology

- Several products that were discontinued from the market were removed from the drug list.

Clinical Toxicology

- There was one new drug, varenicline, added to this category.

Dermatology

- B vs. D is presenting challenges in creating the list.
- Globally delete “Dermatological” from all FKDTs under “Dermatological Agents”.
- Delete the “Dermatological Kaposi’s Sarcoma Agents” FKDT and move alitretinoin to the “Retinoids” pharmacologic class under “Antineoplastics”.
- Move alefacept and efalizumab from “Dermatological Psoriasis Agents” FKDT to “Tumor Necrosis Factor (TNF) Inhibitors” FKDT because, in addition to psoriasis, they also may be indicated for treatment of psoriatic arthritis [Note: this was not done because the two drugs are only indicated for treatment of psoriasis and they are not TNF inhibitors].
- Add a new FKDT under “Dermatological Agents” entitled “Genital Wart Agents” to include newly approved kunecatechins; move imiquimod from “Nonmelanoma Skin Cancer Agents” to the new FKDT.
- Move azelaic acid and benzoyl peroxide from “Miscellaneous Antibacterials” FKDT to “Dermatological Acne Agents” FKDT.

Endocrinology

- For consistency, each of the FKDTs under “Enzyme Replacements/Modifiers” should be titled according to mechanism of action to conform to one of the fundamental rules of the MGs; alternatively, rename “Treatment for...” similar to what was done for the vaccines.
- Delete the “Bisphosphonates, Parenteral FKDT” because the drugs will be covered under Part B.

Gastroenterology

- Nabilone was re-introduced to the market; add it under the “Antiemetics, Other” FKDT;



Hematology

- There were no significant changes to this category.

Immunology

- Recombine the “Tumor Necrosis Factor (TNF) Inhibitors, Fusion Proteins” and “Tumor Necrosis Factor (TNF) Inhibitors, Monoclonal Antibodies” FKDTs into one.
- Move natalizumab from “Tumor Necrosis Factor (TNF) Inhibitors, Fusion Proteins” FKDT to “Immunomodulators, Other” FKDT.
- If official documentation, such as from the Federal Register or US Code, can be found that corroborates CMS’s comment that any vaccine prescribed for a beneficiary that is reasonable and necessary for prevention of a disease cannot be denied by a Part D sponsor regardless of whether or not it is formulary, the FKDTs can be deleted and the vaccines listed under one FKDT entitled “Medically Necessary Preventative Vaccines”.

Infectious Diseases

- Several products that were discontinued from the market were removed from the drug list.
- Add a new pharmacologic class under “Antivirals” entitled “Anti-HIV Combinations” to include the newly approved efavirenz, emtricitabine, and tenofovir combination; move all other anti-HIV combination products to this new class.

Neurology/Otorhinolaryngology/Ophthalmology

- Delete the “Ophthalmic Anti-angiogenesis Agents” pharmacologic class because the drugs will be covered under Part A or Part B.
- Change the title of “Ophthalmic Prostaglandins” to “Ophthalmic Prostaglandins and Prostaglandin Derivatives” because bimatoprost is a prostamide not a prostaglandin.
- Recent literature regarding drugs for macular degeneration was discussed.

Oncology

- Move vorinostat from the “Antineoplastics, Other” pharmacologic class to a new class entitled “Histone Deacetylase (HDAC) Inhibitors”.
- Move thalidomide and lenalidomide from the “Immunomodulators, Other” pharmacologic class to a new class under “Antineoplastics” entitled “Antiangiogenic Agents”.
- Drugs that were previously removed were reinserted due to a lack of clarity and regional differences in Part B vs. D reimbursement.
- Part B vs. D is still a concern.

Psychiatry

- Selective Serotonin Reuptake Inhibitors (SSRIs) were separated from Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) by the Psychiatry Expert Committee in response to public comments, including comments from Wyeth, and due to differences in mechanism of action, side effect profiles, and other characteristics.
- When the classes were combined into one in Version 2.0, the change was made in response to a study stating there was no significant difference in safety or efficacy between SSRIs and SNRIs (Ann Intern Med 2005; 143: 415-26). According to the Approach and Methodology document for the MGs, a clinical distinction needs to be based on available safety and efficacy information. The general rule does not negate the point that different drugs may have different side effect profiles or specific efficacy outcomes—that related to listing of preferred drugs. The larger issue is whether there is an important differential in safety and efficacy between the SNRIs and SSRIs.
- The safety profile may be less in one of the groups. If the groups are separated, plans may not be required to cover the safer products. This assertion requires further consideration.
- There is a debate within the psychiatric community as to whether these two types of drugs are actually that different.
- SNRIs and SSRIs are sometimes used for different indications.
- Coverage of all of the drugs in the Antidepressants category is required (protected category), so the separation may not be necessary.



- The MGEC voted to recombine the SSRIs and SNRIs pharmacologic classes into one based on their similar therapeutic efficacy profiles.

Pulmonary Disease and Allergy

- Zileuton will remain separated from the other antileukotrienes because it has a clinically significant different mechanism of action.
- Remove iloprost from the drug list because it is given only by nebulizer and is therefore covered under Part B.

Rheumatology

- There were no proposed changes to the Anticancer Agents therapeutic category.
- The Anti-inflammatories category title will be changed to Anti-inflammatory Agents.
- Granularity in the Immunologic Agents may impact the rheumatology drugs.
- The rheumatology community would have objections if cyclosporine were not covered under Part D. It should remain in the MGs. If it is used for transplant, it is one of the six protected categories of drugs.

Urology

- The Information Expert Committee recommended separation of the alpha 1–adrenergic blocking agents into selective and non-selective FKDTs.
- The drugs that fall into the selective group may not be very selective. If they were shown to cause less hypotension in the elderly, then the separation would be justified. However, this has not been shown.
- The MGEC voted to recombine the “Alpha 1–adrenergic Blocking Agents, Nonselective” and “Alpha 1–adrenergic Blocking Agents, Selective” FKDTs into one based on the reason listed above.

Review and Discussion of CMS Comments on Draft Model Guidelines

CMS Comment 1

“There are five listed key drug types that would generally be comprised only of drugs that would most commonly be covered under Part A or B. We expect that these key drug types will be removed from the final guidelines. They include: Antiarrhythmics; Osmotic Diuretics; Osmotic Agents, Ophthalmic; Parathyroid/Metabolic Bone Disease Agents; and Ophthalmic Anti-angiogenesis Agents.”

- The MG groupings are not being increased dramatically although the number of FKDTs has increased. This relates at least in part to the fact that new drugs, especially priority drugs, have new mechanisms of action. Over time, comparative safety and efficacy studies might result in an understanding of whether the new mechanisms of action offer therapeutic benefit.
- From the perspective of the National Organization for Rare Disorders (NORD), the increased granularity allowed by the FKDTs is valuable. This is a general aspect of the compromise that allows a floor of two drugs in each category and class in the Model Guidelines and one drug in each FKDT.
- The consensus of the MGEC is that Osmotic Diuretics; Osmotic Agents, Ophthalmic; Parathyroid/Metabolic Bone Disease Agents; and Ophthalmic Anti-angiogenesis Agents may be deleted. The specific antiarrhythmics that will be covered under Part B also may be deleted.

CMS Comment 2

“As a general matter, USP and the Expert Committees need to be aware that there are oral anti-cancer agents that have no or very limited indications available under Part D, since they are covered under Part B. These include: capecitabine, etoposide, melphalan, and temozolomide.”

- The consensus of the MGEC is that an asterisk could be added to the oral anti-cancer agents capecitabine, etoposide, melphalan, and temozolomide to indicate that these agents are sometimes covered under Part B and sometimes under D.

CMS Comment 3

“We expect that USP and the Expert Committees will not include key drug types or pharmacologic classes that are inconsistent with the HEDIS measures on drugs to avoid in the elderly.”

- The consensus of the MGEC is that an asterisk could be added to indicate drugs that are included on the Beers list. No decision was made regarding drugs that appear on the HEDIS list. The MGEC believes that control of prescribing practices via pay for performance based on quality standards should be carefully considered in the context of the patient population to be treated and the needs of an individual patient.



This is particularly true for the Part D Benefit, which may be used by many patients groups in the US, not just the elderly.

CMS Comment 4

“We expect that USP and the Expert Committees will ensure that the pharmacologic classes or key drug types included in the final guidelines do not represent less than effective DESI drugs.”

- The MGEC agreed to delete less than effective DESI drugs from the MGs.

CMS Comment 5

“We recommend that USP and the Expert Committees reconsider the nomenclature used for the categories and classes, to promote ease of understanding and use.”

- The MGEC agrees that language and terminology could be simplified.

CMS Comment 6

“We are concerned with the criteria used to establish the vaccines added as new key drug types, since we are not aware that some are widely prescribed in the elderly, for instance, anthrax or Japanese Encephalitis. We recommend that USP and the Expert Committees include as a key drug type ‘medically necessary preventative vaccines’ instead of listing vaccines individually. Perhaps it is valuable for the Expert Committees to understand that any vaccine prescribed for a beneficiary under Part D that is reasonable and necessary for prevention of a disease cannot be denied by a Part D Sponsor, regardless if it is formulary or non-formulary.”

- If vaccines are a protected class and cannot be denied, then they may not need separate FKDTs.

Release of Draft Model Guidelines for Public Comment

The consensus of the MGEC was that the MGs and FKDTs (three columns) would be posted for public comment on Friday, November 10, 2006. Column four (drug list) will be revised based on CMS and MGEC comments but not included in this posting. [Note: It was subsequently determined to be in the best interest of the public to post the drug list on the website separate from the MGs and FKDTs.]

Adjournment

The participants were thanked for a highly productive and valuable meeting and the meeting was adjourned.

