

Summary of Public Comments on Model Guidelines Version 4.0

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
Cardiology	Cardiovascular Agents	Elevate HMG CoA Reductase Inhibitors to the level of pharmacologic class. The FKDTs in the Dyslipidemics class have unique mechanisms of action, lipid effects, and side effect profiles--these products may not be used interchangeably. The clinical advantages of statin therapy are well documented. Leaving statins with only FKDT status would open up the possibility that Part D plans would fail to offer an appropriate range of therapies for effectively and efficiently managing hyperlipidemia in a patient population with diverse needs. Including statins as a distinct class would ensure that Part D formularies offer at least two statins, thereby giving clinicians and patients a reasonable opportunity to select the most appropriate therapy for managing their condition.	No change to the Model Guidelines. The Model Guidelines Expert Committee (MGEC) does not believe that the independent effects of statins beyond LDL lowering (dyslipidemic effect) have been consistently documented.
Cardiology	Cardiovascular Agents	Recommend that the MGs include a new pharmacologic class for ARBs. This would be an appropriate recognition of the pharmacologic and clinical distinctions between ARBs and other drugs in the Renin-angiotensin-aldosterone System Inhibitors class and encourage Part D plans to provide greater access to these therapies, which could be expected to improve the clinical outcomes of Medicare beneficiaries.	No change to the Model Guidelines. ARBs are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.
Cardiology	Cardiovascular Agents	Specification of an FKDT for the new agent, aliskiren, is premature. It makes inclusion on Medicare formularies mandatory and eliminates the role of Medicare P&T Committees. Health plans, in all likelihood, will require other antihypertensive agents to be shown to be ineffective for the patient before covering this new and minimally tested agent. No data are available to demonstrate that this new agent and FKDT will prevent strokes, whereas such evidence is available for cheaper and older agents. Aliskiren clinical data has thus far failed to reveal any unique advantages over angiotensin II receptor antagonists (ARBs) and/or angiotensin converting enzyme (ACE) inhibitors.	No change to the Model Guidelines. FKDTs are created as a mechanism to provide CMS with information regarding the types of drugs that the MGEC believes should be included on all Part D formularies.
Cardiology	Cardiovascular Agents	Requests that USP review the latest clinical information that demonstrates the unique mechanism of action and place in therapy of ranolazine. Requests that one of the following actions be taken: 1) Reverse decision to eliminate the Late Sodium Current Inhibitor pharmacologic class to ensure that ranolazine is appropriately classified; or 2) distinguish ranolazine as a Late Sodium Current Inhibitor by creating a FKDT within the current Cardiovascular Agents, Other pharmacologic class.	No change to the Model Guidelines. Ranolazine is accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.
Cardiology	Cardiovascular Agents	Supports the Cardiovascular Agents therapeutic category and recommends retaining the pharmacologic classes as listed, which reflect the differences in beta blockers and are consistent with guidelines and literature.	USP thanks those whose comments were written in support of the draft.
Cardiology	Cardiovascular Agents	Omega-3 Fatty Acids FKDT has only one drug, which makes inclusion on Medicare formularies mandatory and eliminates the role of Medicare P&T Committees. Omega-3-acid ethyl esters does not provide any clinical advantages over statins or fibrates, and it increases LDL. The triglyceride reductions seen are inferior to those reported with fibrates and there is little to no data for combination use with statins.	No change to the Model Guidelines. Omega-3 fatty acids are accommodated for in the Model Guidelines and FKDTs based on the FDA-approved triglyceride-lowering, dyslipidemic effects.

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Cardiology	Cardiovascular Agents	Urges rejection of comments opposing inclusion of Omega-3 Fatty Acids as an FKDT in the MGs. Responds to the assertions that omega-3-acid ethyl esters: 1) does not provide any clinical advantages over statins or fibrates; 2) has clear disadvantages, e.g., increases in LDL; 3) has triglyceride reductions that are inferior to those reported with fibrates; 4) shows little to no data for combination use with statins; 5) causes increases in LDL and other atherogenic lipid biomarkers that may negate the potential cardioprotective effects; 6) has no long-term outcomes data; and 7) is very similar to OTC products available.	No change to the Model Guidelines. Omega-3 fatty acids are accommodated for in the Model Guidelines and FKDTs based on the FDA-approved triglyceride-lowering, dyslipidemic effects.
Cardiology	Cardiovascular Agents	Commends USP for including Direct Renin Inhibitors as an FKDT. Aliskiren expands the therapeutic options to treat hypertension in individuals with chronic kidney disease.	USP thanks those whose comments were written in support of the draft.
Cardiology	Cardiovascular Agents	Suggests that the MGs include fixed dose combinations of antihypertensive drugs. Such combination drugs should facilitate patient adherence to the course of treatment recommended by their health care providers.	No change to the Model Guidelines. The MGEC believes that combination products are eligible for coverage under the Part D benefit when at least one component of the combination is a Part D-eligible drug and the product as a whole is not excluded from coverage. To avoid creation of extraneous categories, classes, and FKDTs, combination products are considered in the Model Guidelines only when an exclusive clinical benefit has been established such as when the individual components of the product are not commercially available or when they combine to form a unique chemical entity.
Cardiology	Cardiovascular Agents	Responds to MG V3.0 assertions regarding BiDil: 1) There has been no exclusive clinical benefit established; 2) there is no convincing evidence that BiDil's mechanism of action is different from that of a combination of isosorbide dinitrate and hydralazine taken simultaneously; 3) neither the Heart Failure Society of America nor the American College of Cardiology/American Heart Association guidelines for treatment of chronic heart failure specify the use of BiDil over the use of isosorbide dinitrate and hydralazine taken simultaneously; 4) the formulation that was compared to isosorbide dinitrate and hydralazine in the pharmacokinetic study demonstrating lack of bioequivalence is not commercially available; and 5) there are no studies that document better compliance and effectiveness with BiDil than with the individual drug components taken together.	The new data were reviewed by the Cardiology Expert Committee, but it was determined that a change in the Model Guidelines is not justified. In addition, combination products are considered in the Model Guidelines only when an exclusive clinical benefit has been established such as when the individual components of the product are not commercially available or when they combine to form a unique chemical entity.
Clinical Toxicology	Antidotes, Deterrents, and Toxicologic Agents	Elevate Smoking Cessation Agents from an FKDT within the Deterrents class to a new therapeutic category. The current structure does not adequately represent the value and significance of smoking cessation therapy as treating a chronic, relapsing medical condition. Currently, there are smoking cessation treatment options of differing pharmacology with varying degrees of efficacy, and there is ongoing research and development of novel treatments that underscores the need to bring this new therapeutic category to the forefront. These factors warrant the creation of a new therapeutic category: Smoking Cessation Agents.	No change to the Model Guidelines. Smoking cessation agents are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.

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Clinical Toxicology	New	Establish three classes within the new Smoking Cessation Agents category to reflect the distinctions between various nicotine and non-nicotine agents: 1) $\alpha_4\beta_2$ nicotinic acetylcholine receptor partial agonists, 2) Antidepressants, and 3) Nicotine Replacement Therapies. The pharmacology of varenicline, a partial agonist at the $\alpha_2\beta_4$ nicotinic acetylcholine receptor, results in a dual effect whereby it blocks the action of nicotine and simultaneously provides a low level of dopaminergic tone to reduce the urge to smoke. This merits the distinctions of a separate pharmacologic class.	No change to the Model Guidelines. Smoking cessation agents are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.
Endocrinology	Blood Glucose Regulators	Applauds USP for maintaining the FKDTs, Incretin Mimetics and Amylinomimetics, and urges maintaining these FKDTs in MG V4.0.	USP thanks those whose comments were written in support of the draft.
Endocrinology	Blood Glucose Regulators	Supports the Blood Glucose Regulators therapeutic category as proposed in the draft and recommends continued listing of agents in the Antidiabetic Agents class. Continued differentiation of blood glucose regulating agents into FKDTs is consistent with appropriate treatment of diabetes described in practice guidelines, peer-reviewed scientific literature, and standard medical practice.	USP thanks those whose comments were written in support of the draft.
Endocrinology	Blood Glucose Regulators	Amylinomimetics FKDT has only one drug, which makes inclusion on Medicare formularies mandatory and eliminates the role of Medicare P&T Committees. Pramlintide provides little incremental benefit when combined with insulin in terms of reducing A1C levels and is associated with significant hypoglycemic reactions. It is unique among antidiabetic agents because it carries a black box warning about hypoglycemic risk.	No change to the Model Guidelines. FKDTs are created as a mechanism to provide CMS with additional information regarding the types of drugs that the MGEC believes should be included on Part D formularies.
Endocrinology	Hormonal Agents, Stimulant/ Replacement/ Modifying (Thyroid)	Drug products that are not listed on the CMS Formulary Reference File cannot be added to Part D Plan formularies without intervention from CMS. Recommend removal of thyroid from the drug list.	It is the MGEC's understanding that the Formulary Reference File is not a coverage list for Part D drugs.
Endocrinology	Hormonal Agents, Suppressant (Parathyroid)	Designate Calcimimetics as a class, thereby reflecting the unique therapeutic value and attributes already recognized by the scientific and clinical communities, as well as protecting patient access to medically important therapy. This change would reflect widely accepted clinical practice guidelines and prevent significant impediments to appropriate beneficiary access.	No change to the Model Guidelines. The MGEC believes that patient access is sufficiently protected by the current structure of the "Hormonal Agents, Suppressant (Parathyroid)" therapeutic category.
Endocrinology	Metabolic Bone Disease Agents	Urges reclassification of Bisphosphonates, Oral and Bisphosphonates, Parenteral into separate pharmacologic classes. This change would improve patient access to these drugs because Part D plans are required to include a minimum of two drugs per class as compared to a minimum of one drug per FKDT. It would also provide plans with greater flexibility in managing this category and broaden negotiations between drug plans and manufacturers.	No change to the Model Guidelines. The MGEC believes that patient access is sufficiently protected by the current structure of the "Metabolic Bone Disease Agents" therapeutic category.
Endocrinology	New	Requests consideration of a new therapeutic category for covered diabetic supplies to include insulin syringes, pen needles, alcohol, and gauze, so that beneficiaries are better informed about coverage of these supplies.	No change to the Model Guidelines. The MGEC understands that medical supplies associated with the injection of insulin are eligible for coverage under the Part D benefit. However, the MGEC does not consider supplies to be appropriate as part of a listing of traditional categories and classes of drugs.

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Gastroenterology	Antiemetics	Supports the Antiemetics therapeutic category as proposed. Based on the National Comprehensive Cancer Network Clinical Practice Guidelines in Oncology, Medicare beneficiaries should have access to both NK1 and 5-HT ₃ antagonists. Therefore, continued inclusion of these two FKDTs is supported.	USP thanks those whose comments were written in support of the draft.
Gastroenterology	Gastrointestinal Agents	Recommends creation of a new pharmacologic class titled Peripherally Acting Mu Opioid Receptor Antagonists. Two such agents are in review by the FDA. The mechanism of action of these agents is significantly different than that of laxative agents and is expected to offer important clinical advantages. A new class will ensure that seniors with advanced illness will have access to a therapy that may help relieve opioid-induced constipation when other agents do not. Absent a new class, this agent would be placed in the existing class, Gastrointestinal Agents, Other.	No change to the Model Guidelines. Classification of these new drugs within the structure of the Model Guidelines and FKDTs will be considered following FDA approval.
Gastroenterology	Therapeutic Nutrients/ Minerals/ Electrolytes	Part D formularies should include iron products to treat, in combination with erythropoiesis stimulating agents, the anemia that Medicare beneficiaries with chronic kidney disease experience. Iron products used to treat anemia should be recognized in a special category, and not as a vitamin/mineral. Suggests the following IV iron products, iron dextran, iron sucrose, and ferric gluconate, be included under Part D since they can be administered to beneficiaries with ESRD who live in long-term care facilities. Failure to cover iron supplementation may be cost-ineffective, potentially promoting increased utilization of erythropoiesis-stimulating agents.	No change to the Model Guidelines. Exclusion of vitamin/mineral products, such as iron, is not under the purview of USP.
Gastroenterology	Therapeutic Nutrients/ Minerals/ Electrolytes	Recommends an FKDT, titled Renal Vitamins, for the vitamin preparations that have been developed specifically for dialysis patients. Dialysis patients and patients with advanced chronic kidney disease need special vitamins because dietary restrictions may limit their intake of essential vitamins and minerals, vitamins and minerals may be depleted during dialysis, and most standard vitamins contain high levels of fat soluble vitamins and certain minerals that can be toxic to people with impaired kidney function.	No change to the Model Guidelines. Exclusion of vitamin/mineral products is not under the purview of USP.
Gastroenterology and Nephrology/ Urology	Gastrointestinal Agents and Genitourinary Agents	Drug products that are not listed on the CMS Formulary Reference File cannot be added to Part D Plan formularies without intervention from CMS. Recommends removal of hyoscyamine from the drug list.	The MGEC believes that the Formulary Reference File is not a coverage list for Part D drugs. Drugs that do not appear in the file are not necessarily excluded from coverage if they meet Part D eligibility requirements.
Hematology	Antidotes, Deterrents, and Toxicologic Agents	Reconsider categorization of deferasirox. Suggests three options: 1) Reconstitute the Iron Overload Agents class; 2) create a class for Heavy Metal Chelators; or 3) list deferasirox as an FKDT. Iron overload due to blood transfusions is a potentially life-threatening condition and it is essential that beneficiaries have access to its therapies including the only approved oral treatment agent.	No change to the Model Guidelines. Deferasirox is accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.

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Hematology	Blood Products/ Modifiers/Volume Expanders	Revise the MGs to allow for inclusion of eculizumab, indicated for reduction of hemolysis in patients with PNH. Because it is a lifelong therapy, patients receive treatments in different sites of care, including long-term nursing homes. Safety profile is comparable to or better than other parenteral complex proteins such as etanercept and rituximab.	No change to the Model Guidelines. The MGEC believes this drug is not eligible for coverage under Part D.
Hematology	Blood Products/ Modifiers/Volume Expanders	Maintain the FKDT for Adenosine Diphosphate P2Y12 Inhibitors within the Platelet Aggregation Inhibitors pharmacologic class.	USP thanks those whose comments were written in support of the draft.
Hematology	Blood Products/ Modifiers/Volume Expanders	Drug products that are not listed on the CMS Formulary Reference File cannot be added to Part D Plan formularies without intervention from CMS. Recommend removal of aminocaproic acid from the drug list.	The MGEC believes that the Formulary Reference File is not a coverage list for Part D drugs.
Hematology	Blood Products/ Modifiers/Volume Expanders	Drugs that have been discontinued from the market should not be included in the drug list. Aprotinin, included under the Coagulants pharmacologic class, should be removed.	Aprotinin was removed from the drug list table.
Immunology	Immunological Agents	Create a new class for Tumor Necrosis Factor (TNF) Inhibitors and delineate two separate FKDTs for Soluble TNF Receptors and Anti-TNF Monoclonal Antibodies. These are clinically significant categories that will help inform plans of important distinctions within apparently similar categories of products.	No change to the Model Guidelines. TNF inhibitors are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.
Immunology	Immunological Agents	Establish Monoclonal Antibodies as a pharmacologic class because these agents are swiftly moving to the forefront as effective therapies for a wide variety of diseases. Recommend recategorizing natalizumab as an FKDT titled Anti-alpha 4-integrin Antibodies under this new class. Natalizumab is distinctly different in terms of clinical profile, safety and efficacy, and mechanism of action when compared to the other therapies with which it is currently categorized.	No change to the Model Guidelines. Part D—eligible monoclonal antibodies and natalizumab are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.
Immunology	Immunological Agents	MGs should include a Vaccines to Prevent Other FKDT, which would help ensure that Part D drug plans provide beneficiaries with immediate access to newly approved vaccines before the beginning of the next calendar year. Examples of vaccines that would have been expedited by this FKDT include the HPV and zoster vaccines.	No change to the Model Guidelines. Classification of new vaccines within the structure of the Model Guidelines and FKDTs will be considered following FDA approval. The MGEC believes that P&T committees are required to review new chemical entities approved during the plan year within a specified timeframe after approval and must make access to the new therapies available to beneficiaries when medically appropriate.
Immunology	Immunological Agents	CMS should include vaccines as a "class of clinical concern" in Medicare's 2009 Call Letter to Part D plans. Such a move would give credence to CMS's ongoing efforts to increase utilization of preventative services, of which vaccine coverage and access should be key components.	Designating a group of drugs as a "class of clinical concern" is not under the purview of USP.

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Immunology	Immunological Agents	Include drugs available for Part B and Part D coverage on the drug list. Numerous drugs are covered under Part B and when so covered, are not eligible for coverage under Part D. Many drugs are also covered under Part D when the beneficiary is in a long-term care facility. Recommends inclusion of all drugs that can be covered under Part B and Part D on the drug list. Also recommends that infliximab be added back to the drug list under the Tumor Necrosis Factor Inhibitors FKDT.	USP's role under the MMA is to develop a list of categories and classes for classification of Part D-eligible drugs. USP's drug list table is for information purposes only and does not in any way determine coverage of individual drugs. It is also not under the purview of USP to determine the circumstances governing the part of the benefit (B or D) under which a drug is eligible for coverage. However, because infliximab is not usually self-administered by more than 50% of all beneficiaries, the MGEC believes that it may not generally be considered eligible for coverage under Part D and was not included in the drug list.
Immunology	Immunological Agents	There is no clear therapeutic category to cover the current disease-modifying agents for multiple sclerosis. As a result of this lack of specificity, appropriate options necessary to manage this complex and progressive disease may be excluded from a plan formulary. Omission of a class for MS immunological agents creates a significant obstacle to effective treatment for some of the sickest patients.	No change to the Model Guidelines. Agents used for treatment of multiple sclerosis are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit at this time.
Immunology	Immunological Agents	Lack of clear pharmacologic classes for the MS immunomodulating therapies interferes with neurologists' chosen course of treatment for their patients with MS and could be detrimental to patient health. Recommends elevating Interferons, Beta to the level of pharmacologic class with two FKDTs: 1) Interferon Beta-1a (Avonex and Rebif), and 2) Interferon Beta-1b (Betaseron) and elevating Immunomodulators, Other to the level of pharmacologic class with two FKDTs: 1) Selective Adhesion Molecule Inhibitors (natalizumab) and 2) Selective MHC Class II Modulators (glatiramer).	No change to the Model Guidelines. Agents used for treatment of multiple sclerosis are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit at this time.
Immunology	Immunological Agents	Concerned about the decision to remove drugs to prevent rejection of transplanted organs. Part D plans may misinterpret the fact that there is only one type of anti-rejection drug included in the Immune Suppressants pharmacologic class and leave widely prescribed immunosuppressants off of their drug formularies.	No change to the Model Guidelines. The MGEC believes that agents used in immunosuppressive therapy following organ transplantation are eligible for coverage under Part B. Alternatively, immunosuppressants may be eligible for coverage under Part D as one of the six classes of clinical concern. Cyclosporine remains in the drug list table because it is approved by the FDA for uses in addition to prophylaxis of organ rejection.
Immunology	Immunological Agents	Recommends addition of two new FKDTs under the Immune Suppressants pharmacologic class: 1) Immune Suppressants, Calcineurin Inhibitors (cyclosporine and tacrolimus); and 2) Immune Suppressants, mTOR Inhibitors (sirolimus).	No change to the Model Guidelines. Sirolimus and systemic tacrolimus are not included in the drug list table because, as agents used in immunosuppressive therapy following organ transplantation, the MGEC believes they may be eligible for coverage under Part B. Alternatively, as immunosuppressants they may be eligible for coverage under Part D as one of the six classes of clinical concern.
Immunology	Immunological Agents	All immunosuppressant drugs for prevention of organ rejection should be included on the drug list table. Only one immunosuppressant drug, cyclosporine, is included under the class Immune Suppressants. Since transplant patients are typically treated with a variety of additional immunosuppression agents, flexibility for physicians prescribing these drugs is essential. Therefore, it is important for all immunosuppressive agents indicated for prevention of transplant organ rejection to be included so they are listed in Part D formularies.	No change to the Model Guidelines. The MGEC believes that agents used in immunosuppressive therapy following organ transplantation may be eligible for coverage under Part B. Alternatively, immunosuppressants may be eligible for coverage under Part D as one of the six classes of clinical concern. Cyclosporine remains in the drug list table because it is approved by the FDA for other uses in addition to prophylaxis of organ rejection.

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Immunology	Immunological Agents	Exclusion of certain FKDTs for items anticipated to be covered primarily/predominantly by Medicare Part B is unnecessary in the case of immunosuppressives. These drug exclusions may restrict access to medicines for patients who are ineligible to receive these products under Part B due to specific program restrictions unique to this area. In a recent study prepared for the Medicare Payment Advisory Commission, immunosuppressants were found to be covered by only 85% of Part D plans despite the requirement that all do so. It is understood that the drug list table is illustrative, but there is concern that in spite of stated policies, Part D plans may interpret the exclusion of certain drugs as an indication that they are solely covered under Part B.	No change to the Model Guidelines. Agents used in immunosuppressive therapy following organ transplantation may be eligible for coverage under Part B. Alternatively, immunosuppressants may be eligible for coverage under Part D as one of the six classes of clinical concern. Enforcement of Medicare policies and guidances is not under the purview of USP.
Immunology	Immunological Agents	Requests addition of an FKDT for IL-6 Receptor Inhibitors as a placeholder within the Immune Suppressants pharmacologic class. A Biologics Licensing Application has been submitted to the FDA for tocilizumab, the first humanized IL-6 receptor inhibiting monoclonal antibody. This agent represents a novel mechanism of action to treat rheumatoid arthritis, a disease with a high unmet medical need. Approval is anticipated in late 2008.	No change to the Model Guidelines. Classification of this new drug within the structure of the Model Guidelines and FKDTs will be considered following FDA approval.
Infectious Diseases	Antibacterials	Drugs that are of questionable efficacy or safety should not be included on the drug list. Cefepime is currently the subject of ongoing safety review by the FDA, which has requested additional data to further evaluate the risk of death in patients treated with cefepime. Since there are many other options available in this class, recommends removal of the drug from the drug list.	No change to the Model Guidelines. USP's role under the MMA is to develop a list of categories and classes that may be used by drug plans to develop their formularies. The drug list table is a guide to provide examples of drugs that may be associated with each therapeutic category, pharmacologic class, and FKDT. Any FDA-approved, Part D-eligible drug may be considered for inclusion on the list. It is the role of the P&T committee, not USP, to consider safety and efficacy when making clinical decisions and selecting formulary drugs.
Infectious Diseases	Antibacterials	Drugs that have been discontinued from the market should not be included in the drug list. Loracarbef, included under the Beta-lactam, Other pharmacologic class, should be removed.	Loracarbef was removed from drug list table.
Infectious Diseases	Antibacterials	Urges reconsideration of decision not to specifically delineate carbapenems and monobactams in the MGs. Aztreonam, the only monobactam, is a therapeutically and clinically unique antibiotic that is not cross-allergenic with other beta-lactams.	No change to the Model Guidelines. The MGEC determined that aztreonam is appropriately classified with the other carbapenems based on the information currently available and additional granularity may hinder drug plans' ability to effectively manage the benefit.
Infectious Diseases	Antibacterials	Urges CMS to designate antibiotics a "class of clinical concern" in Medicare's 2009 Call Letter in order to ensure that all new and existing antibiotics (or their therapeutic equivalents) are covered by Part D plans.	Designating a group of drugs as a "class of clinical concern" is not under the purview of USP.
Infectious Diseases	Antibacterials	Requests addition of doripenem, a new antibiotic approved by the FDA, to the Beta-lactam, Other pharmacologic class.	Doripenem was added to the drug list table under the "Antibacterials" therapeutic category and "Beta-lactam, Other" pharmacologic class.

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Infectious Diseases	Antibacterials	Ketolides FKDT has only one drug, which makes inclusion on Medicare formularies mandatory and eliminates the role of Medicare P&T Committees. Telithromycin lacks any clinical advantage, received a black box warning, and had two of its FDA indications removed. The clinical data submitted to the FDA for approval is questionable. There are numerous other antibiotics available with better efficacy and safety profiles.	The MGEC agreed that the "Ketolides" FKDT should not be retained because of the Black Box Warning and other safety concerns associated with telithromycin. Therefore, the "Erythromycins" and "Macrolides (Non-erythromycins, Non-ketolides)" FKDTs and all associated drugs, including telithromycin, were combined under the "Macrolides" pharmacologic class.
Infectious Diseases	Antimycobacterials	The MGs should include separate FKDTs for each drug and CMS should ensure access to all such drugs by designating Antituberculars as a "class of clinical concern" in Medicare's 2009 Call Letter to Part D plans. Ensuring access to effective tuberculosis treatment regimens not only is important to individuals infected with TB but also is necessary to prevent future outbreaks in the US.	Designating a group of drugs as a "class of clinical concern" is not under the purview of USP.
Infectious Diseases	Antivirals	Establish a new FKDT within the Antihepatitis Agents pharmacologic class for Antihepatitis B Agents. In the current draft, the Antihepatitis Agents class is designed to capture all antihepatitis drugs used for treatment of hepatitis types A, B, and C. These are distinct liver diseases and treatment guidelines recommend different medications for each. By not recognizing these distinct disease states and the different therapies recommended for each, the MGs do not facilitate the prevailing standard of care nor do they promote access to the appropriate available medications.	No change to the Model Guidelines. Antihepatitis agents are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.
Infectious Diseases	Antivirals	Create a new class entitled Anti-HIV Agents, Multi-class Combinations. The MGs include four different classes for anti-HIV agents, whereas the FDA recognizes seven different types of drugs used in the treatment of HIV, including the category, multi-class combination products. The August 2007 MGEC Meeting minutes state "[a] pharmacologic class should not contain a single drug. In this situation, the drug should be accommodated at the category level or in an 'other' class." There is concern that implementing such a blanket policy could lead to improper categorization of novel treatment options, such as ATRIPLA™, which are not accommodated for in the current MGs.	No change to the Model Guidelines. The MGEC believes that combination products are eligible for coverage under the Part D benefit when at least one component of the combination is a Part D-eligible drug and the product as a whole is not excluded from coverage. To avoid creation of extraneous categories, classes, and FKDTs, combination products are considered in the Model Guidelines only when an exclusive clinical benefit has been established such as when the individual components of the product are not commercially available or when they combine to form a unique chemical entity.
Infectious Diseases	Antivirals	Make the MGs consistent with the CMS formulary guidance and recognize Multi-drug Combination Products as a pharmacologic class within the Antivirals therapeutic category. Combination products play an important role in HIV treatment by reducing pill burden and improving adherence to complex daily regimens. Because combination HIV antiretrovirals generally contain at least two drugs from two different classes, these therapies would not be included in any of the current USP classes for HIV medications.	No change to the Model Guidelines. The MGEC believes that combination products are eligible for coverage under the Part D benefit when at least one component of the combination is a Part D-eligible drug and the product as a whole is not excluded from coverage. To avoid creation of extraneous categories, classes, and FKDTs, combination products are considered in the Model Guidelines only when an exclusive clinical benefit has been established such as when the individual components of the product are not commercially available or when they combine to form a unique chemical entity.

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Infectious Diseases	Antivirals	The MGs should reflect or make note of the "all or substantially all" policy and add combination products as a class of drugs to avoid confusion among prescription drug plans that adhere to the USP guidelines and to reinforce these critical policies.	No change to the Model Guidelines. The MGEC believes that combination products are eligible for coverage under the Part D benefit when at least one component of the combination is a Part D-eligible drug and the product as a whole is not excluded from coverage. To avoid creation of extraneous categories, classes, and FKDTs, combination products are considered in the Model Guidelines only when an exclusive clinical benefit has been established such as when the individual components of the product are not commercially available or when they combine to form a unique chemical entity. Designating a group of drugs as a "class of clinical concern" is not under the purview of USP.
Infectious Diseases	Antivirals	The new Anti-HIV Agents, Entry Inhibitors class does not reflect the pharmacologic and clinical distinction of one of the new classes, chemokine co-receptor antagonists. The newest antiretroviral class, integrase inhibitors, is completely absent from the MGs.	"Anti-HIV Agents, Fusion (Entry) Inhibitors" pharmacologic class will be renamed "Anti-HIV Agents, Other" and will include example drugs enfuvirtide, maraviroc, and raltegravir.
Infectious Diseases	Antivirals	Bring MG V4.0 in line with the latest advances in HIV medicine by adding an Integrase Inhibitors pharmacologic class, represented by new FDA-approval raltegravir, to the Antivirals therapeutic category. At a minimum, the MGs should include an Antivirals, Other pharmacologic class to accommodate the availability of new anti-HIV drugs as soon as they are approved by the FDA.	"Anti-HIV Agents, Fusion (Entry) Inhibitors" pharmacologic class will be renamed "Anti-HIV Agents, Other" and will include example drugs enfuvirtide, maraviroc, and raltegravir.
Infectious Diseases	Antivirals	Concerned with the suggested nomenclature change within the Anti-HIV Agents, Fusion Inhibitors class to Anti-HIV Agents, Entry Inhibitors consolidating maraviroc with enfuvirtide. The mechanism of action of these two drug classes is different. CCR5 antagonists like maraviroc work on the surface of the CD4 cell binding to proteins on the cell. Enfuvirtide works on a portion of the virus itself at a later stage of HIV entry. Requests that these agents should remain separated as CCR5 Inhibitors and Fusion Inhibitors.	"Anti-HIV Agents, Fusion (Entry) Inhibitors" pharmacologic class will be renamed "Anti-HIV Agents, Other" and will include example drugs enfuvirtide, maraviroc, and raltegravir.
MGEC	Multiple	Comments related to product availability or Medicare coverage criteria. Attachment lists products that are not included on the CMS Reference file, LTE DESI drugs, and products usually covered under Part A or Part B.	Those products determined to be ineligible for coverage under Part D were removed from the drug list table. However, the MGEC believes that the Formulary Reference File is not a coverage list for Part D drugs. Drugs that do not appear in the file are not necessarily excluded from coverage if they meet Part D eligibility requirements.
MGEC	Policy	Cautions the MGEC on the negative implications of including FKDTs with only one medication as they serve as a mandate that a drug plan add the medication to its formulary. In such situations, P&T Committees do not have flexibility to make the most appropriate decisions based on safety and effectiveness. Moreover, the inclusion of one medication eliminates the ability of a plan sponsor to negotiate and this thwarts CMS's intent of administering a cost-effective program.	USP revises the Model Guidelines in an attempt to balance beneficiary access with the Part D sponsors' ability to manage the plan based upon scientific evidence and the clinical and practice-based expertise of our expert committees.

Summary of Public Comments on Model Guidelines Version 4.0

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
MGEC	Policy	Preserve the scientific integrity of the MGs by maintaining single-drug classes. USP should maintain the original intent of the MMA and the MGs to create a classification system sensitive enough to account for differences in "general" and "more refined pharmacologic effect" among the many drugs available to patients. As such, USP should maintain pharmacologic classes for innovative, first-in-class drugs.	USP revises the Model Guidelines in an attempt to balance beneficiary access with the Part D sponsors' ability to manage the plan based upon scientific evidence and the clinical and practice-based expertise of our expert committees.
MGEC	Policy	USP should continue to establish single-drug classes in the MGs for first-in-class drugs and biologicals. Based on elimination of a number of single-drug classes in MG V3.0 and minutes of MGEC meetings, it appears that USP has adopted a new policy that discourages creation and/or continued existence of drug classes with only one drug. This policy should be reconsidered. Continued implementation may facilitate creation of Part D formularies that discriminate against patients that could benefit from new, unique, first-in-class drugs and biologicals. The Part D Final Rule expressly acknowledges that a category or class may contain only one drug. Therefore, there is no reason to eliminate these categories or classes. CMS's policy change to use FKDTs as an "outlier" test makes it even more critical that the MGs reflect the most accurate and specific classifications to ensure adequate beneficiary access to needed therapies.	The MGEC creates categories and classes of drugs as stipulated in the MMA. Coverage of individual drugs is determined by CMS. The MGEC appreciates the concern and strives to balance beneficiary access with the Part D sponsors' ability to manage the benefit. It is CMS policy that determines FKDT utilization in the formulary review process.
MGEC	Policy	Concerned with actions and apparent policies that would inhibit or effectively eliminate the creation of pharmacologic classes populated by only one drug. Adoption of this new policy is problematic for several reasons: 1) It facilitates creation of Part D formularies that discriminate against beneficiaries that could benefit from or rely on new, unique, first-in-class agents; 2) USP has not established a clinical or other basis for the policy and may be overextending the reach of the organization into the balance between health plans and/or manufacturers in the competitive Part D marketplace; and 3) by instituting a policy that new, first-in-class drugs should not be included in updated versions of the MGs, USP appears to be misinterpreting its role under the MMA.	USP revises the Model Guidelines in an attempt to balance beneficiary access with the Part D sponsors' ability to manage the plan based upon scientific evidence and the clinical and practice-based expertise of our expert committees.
MGEC	Policy	Include notations in the MGs at the product level to identify drugs that have the potential for coverage under Part B vs. Part D. Because beneficiary access to critical therapies may be jeopardized by the current poor level of understanding of differences between Part B and Part D coverage, it is recommended that USP help provide accuracy and precision on this issue by including notations in the MGs for products that are most likely to experience B vs. D coverage confusion.	USP's role under the MMA is to develop a system for classification of Part D drugs. It is not under the purview of USP to determine the circumstances governing the part of the benefit (B or D) under which a drug is eligible for coverage.

Summary of Public Comments on Model Guidelines Version 4.0

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
MGEC	Policy	Increase the frequency with which the MGs are updated. Under the current annual revision system, a new drug could be delayed for inclusion for almost two full years after approval. Given that CMS has no enforcement mechanism to ensure that Part D plan P&T Committees review new drugs within the required 90/180 days after approval, beneficiary access to new drugs may be less than optimal. Recommend the quarterly submission process be utilized to update the MGs. Alternatively, create placeholder classifications for drugs anticipating FDA approval and update the status of the placeholder classification upon approval.	USP has established a process in which suggestions for revisions to the Model Guidelines, FKDTs, and drug list table may be submitted quarterly for review by the MGEC and USP Information Expert Committees. In addition, USP drug information specialists continually review the medical literature for new drug approvals, discontinuations, and changes to therapeutic uses of drugs. However, the cooperative agreement with CMS limits revision of the Model Guidelines and FKDTs to once a year.
MGEC	Policy	Recommends that USP and CMS develop a mechanism whereby new classes would be defined and added to the existing classification system during the year and the MGs could be updated on a continuous basis.	USP has established a process in which suggestions for revisions to the Model Guidelines, FKDTs, and drug list table may be submitted quarterly for review by the MGEC and USP Information Expert Committees. In addition, USP drug information specialists continually review the medical literature for new drug approvals, discontinuations, and changes to therapeutic uses of drugs. However, the cooperative agreement with CMS limits revision of the Model Guidelines and FKDTs to once a year.
MGEC	Policy	Provide transparency into the MGs decision process and CMS's FKDT review and enforcement for FKDTs. CMS has done little to communicate details about the automated system it employs to review formularies. USP should request information from CMS on the manner in which the CMS outlier policy is being applied and how it is being enforced. An understanding of how CMS has actually implemented this process is critical for both USP and other stakeholders to accurately assess the value of the MGs in context.	USP provides transparency in the Model Guidelines revision process by way of public outreach activities. These activities include the request for and review of comments from any interested parties throughout the year as well as a formal request for comments on the draft version of the Model Guidelines. USP also seeks input from stakeholders through collaboration with four Advisory Forums representing pharmaceutical manufacturers, healthcare providers, beneficiaries, and managed care plans. In addition, USP posts the notes from all MGEC meetings on the USP website. However, USP is not involved in CMS policy.
MGEC	Policy	Provide additional transparency into the quarterly review process by releasing an agenda and publicizing the comments submitted and the decisions made by the expert committees.	The notes from all MGEC meetings, which include discussion of requests received via the quarterly review process, are posted on USP's website.
MGEC	Policy	USP should improve the process for updating the MGs to incorporate new therapies and indications throughout the year. Requests that USP publish materials explaining what information has been examined and considered in reviewing new drugs and biologicals and rationale for determining a new treatment's category, class, or not including a therapy at all.	The MGEC and appropriate Information Expert Committee(s) review medical literature related to new FDA-approved, Part D-eligible drugs throughout the year. Staff-prepared drug reviews and proposed revisions to the Model Guidelines are based upon objective, evidenced-based data and clinical and practice-based experience of our experts, as well as public comments and other information provided by stakeholders via the quarterly review process.
MGEC	Policy	The MGs should serve their intended purpose of ensuring that beneficiaries have access to needed therapies. USP's focus should be to ensure that the categories and classes will prevent a plan from discouraging enrollment of certain types of beneficiaries. Seeks clarity around the MGEC's decision-making process for drugs and biologicals that could be covered under either Part B or Part D, depending on specific circumstances.	CMS determines Part B and Part D coverage requirements. The Model Guidelines are mandated to include only those therapeutic categories and pharmacologic classes of drugs eligible for coverage under Part D. The Information Expert Committees and MGEC use publicly available documentation for determination of Part B versus Part D coverage.

Summary of Public Comments on Model Guidelines Version 4.0

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
MGEC	Policy	Requests including in the drug listing any combination drug, which is the only FDA-approved treatment for a given condition, as this meets the exclusive clinical benefit test as stated in the Summary of USP Approach and Methodology to the MG V3.0.	No change to the Model Guidelines. The MGEC believes that combination products are eligible for coverage under the Part D benefit when at least one component of the combination is a Part D-eligible drug and the product as a whole is not excluded from coverage. To avoid creation of extraneous categories, classes, and FKDTs, combination products are considered in the Model Guidelines only when an exclusive clinical benefit has been established such as when the individual components of the product are not commercially available or when they combine to form a unique chemical entity.
MGEC	Policy	Concerned by excessive granularity in the specification of pharmacologic classes and FKDTs. High granularity and inclusion of newly approved drugs influences plans to include drugs in their formularies that have limited clinical experience and minimal real-world safety track records, particularly with elderly patients with co-morbidities; may not be accepted in general practice; and have little evidence of conferring clinical benefit when compared to alternatives. Continues to urge elimination of FKDTs that do not make a significant clinical contribution to their therapeutic categories.	USP appreciates the comment and will take it under advisement.
MGEC	Policy	USP continues to rely on a rationale of "clinical non-distinction" as justification for many of its decisions in assigning critical pharmacologic treatments to particular categories or classes, as well as revising the classification system itself. At no time does USP define this term or describe its analysis in application to the revisions made in each section.	Clinical distinction or non-distinction refers to a consensus opinion of the MGEC, taking into consideration clinically relevant therapeutic differences, pharmacology, and medical practice.
MGEC	Policy	The MGs cite "clinical non-distinction" as justification for some of its decisions in assigning critical pharmacologic treatments to particular categories or classes, as well as revising the MGs. This terminology has not been defined and its analysis in application to each section has not been described. USP appears to be inconsistent in its application of criteria by confusing therapeutic effect and pharmacologic effect in the collapse of categories and classes within specific illness categories. As a consequence, treatment options for individuals with severe chronic diseases and disabilities are restricted and inadequate. This is particularly notable with respect to severe mental illnesses.	Clinical distinction or non-distinction refers to a consensus opinion of the MGEC, taking into consideration clinically relevant therapeutic differences, pharmacology, and medical practice.
MGEC	Policy	Appreciative of USP's actions to maintain the total overall number of categories and classes for the 2009 MGs. In addition, encouraged by and support decisions to increase category and class options in the areas of hypertension and breast cancer.	USP thanks those whose comments were written in support of the draft.
MGEC	Policy	Suggests that first reviewing the range of illnesses affecting seniors and people with disabilities and then analyzing effective treatment options would provide a more rational approach to determining therapy options than the current practice of reviewing the range of medications and assigning these to disease categories.	In building the framework for Model Guidelines Version 1.0, the MGEC began with disease and diagnosis, utilizing the ICD-9 classification system, and linked the diagnosis to treatment. This foundation formed the structure of the Model Guidelines that remains in place.

Summary of Public Comments on Model Guidelines Version 4.0

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
MGEC	Policy	Principles for a model therapeutic class system: 1) Reasonably cover all common conditions in the Medicare population and provide choice to address individual variations; 2) give attention to the high incidence of co-morbidities and potential for adverse pharmaceutical interactions in the Medicare population; 3) utilize clinical practice guidelines based on scientific knowledge of geriatric medicine and chronic disease management to guide development; 4) account for the variability in response to certain medications among distinct subpopulations and consider the importance of medication adherence and decreased risk of ADRs with combination therapy; 5) must be reviewed, updated, and, if necessary, augmented on a regular and timely basis; and 6) must be designed to ensure that all seniors and people with disabilities have access to medications that clinical practice guidelines or standards of care indicate are appropriate.	Observational comment. No specific change to the Model Guidelines requested.
MGEC	Policy	Urges reclassification of the pharmacologic classes and FKDTs as therapeutic categories to help ensure that drug plans offer broad coverage of medications on their formularies that is adequate to meet the complex treatment needs of the Medicare population.	The MGEC appreciates the concern and strives to balance beneficiary access with the Part D sponsors' ability to manage the benefit.
MGEC	Policy	Requests USP work with CMS in a proactive manner to identify and differentiate the FKDTs that truly make sense from those with questionable validity that may potentially hinder formulary approval. To base what plans are required to put on their formulary based on outliers (meaning what the majority of plans are doing or not doing) detracts from the plan's recognition of their P&T Committee decisions who weigh the evidence and value of these medications.	The MGEC strives to balance beneficiary access with the Part D sponsors' ability to manage the benefit. Individual coverage under the benefit is determined by CMS. Individual drug coverage within each plan is determined by P&T committees.
MGEC	Policy	Requests a meeting with the MGEC to provide greater clarification regarding concerns and present additional clinical details not provided in the comment letter.	It is not possible for the MGEC to meet with individual stakeholders. USP's public outreach activities include the request for and review of comments from any interested parties throughout the year as well as a formal request for comments on the draft version of the Model Guidelines. USP also seeks input from stakeholders through collaboration with four Advisory Forums representing pharmaceutical manufacturers, healthcare providers, beneficiaries, and managed care plans.
MGEC	Policy	Recommends use of the quarterly review process to consider newly approved drugs and publicly update the MGs accordingly. New technologies are consistently coming to market year-round. Therefore, a quarterly review and update process would ensure that CMS and Part D plans are apprised of the proper classification of newly approved drugs and biologics.	USP has established a process in which suggestions for revisions to the Model Guidelines, FKDTs, and drug list table may be submitted quarterly for review by the MGEC and USP Information Expert Committees. In addition, USP drug information specialists continually review the medical literature for new drug approvals, discontinuations, and changes to therapeutic uses of drugs. However, the cooperative agreement with CMS limits revision of the Model Guidelines and FKDTs to once a year.
MGEC	Policy	Suggests that USP act independently of CMS and make transparent all communications between CMS and USP.	USP strives to balance the independent creation of the Model Guidelines with collaboration with CMS and all other interested stakeholders.

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
MGEC	Policy	Concerned that USP and CMS policies on combination drugs negatively impact patient access. Because combination products are excluded by USP, CMS does not count combination drugs in determining whether Part D plans meet their class and FKDT inclusion quotas. The practice of including certain combination drugs in the MGs but not others further complicates matters. This practice could be perceived as suggesting that non-listed combination drugs are not deserving of coverage under Part D while listed combination drugs are.	The MGEC believes that combination products are eligible for coverage under the Part D benefit when at least one component of the combination is a Part D-eligible drug and the product as a whole is not excluded from coverage. To avoid creation of extraneous categories, classes, and FKDTs, combination products are considered in the Model Guidelines only when an exclusive clinical benefit has been established such as when the individual components of the product are not commercially available or when they combine to form a unique chemical entity.
Nephrology/Urology	Genitourinary Agents	Pleased that the new FDA-approved phosphate binder, sevelamer carbonate, was added to the drug list. Clinical studies comparing sevelamer carbonate to sevelamer hydrochloride have shown that patients were more likely to maintain bicarbonate levels within the recommended ranges and had a lower incidence of GI adverse events with the carbonate formulation.	USP thanks those whose comments were written in support of the draft.
Neurology/ Ophthalmology/ Otorhinolaryngology	Analgesics	Tramadol should be listed as a long-acting opioid analgesic in addition to being listed as a short-acting opioid. It's available in an extended-release, once daily formulation.	Tramadol was added to the drug list as an example of a long-acting opioid analgesic.
Neurology/ Ophthalmology/ Otorhinolaryngology	Analgesics	Recommends that Non-opioid, Non-NSAID Analgesics be considered as a separate category with class distinctions to treat neuropathic pain.	No change to the Model Guidelines. The MGEC recognizes that neuropathic pain is an emerging area for which medications are differentiated from those used for nociceptive pain. However, the currently approved agents (carbamazepine, duloxetine, gabapentin, pregabalin, and local lidocaine) are either in protected therapeutic categories or already accommodated for in the Model Guidelines. Therefore, the MGEC believes that patients should have access to approved therapies. One of the principles of the Model Guidelines is to avoid duplication of drugs when reasonable. If the protected class concept is changed in the future, the potential addition of a new pharmacologic class may be reassessed.
Neurology/ Ophthalmology/ Otorhinolaryngology	Anesthetics	Drugs that are primarily covered as Part B drugs should not be listed on the drug list. Articaine, included under the Local Anesthetics pharmacologic class, is currently only used for dental/periodontal procedures. Since this use would be primarily covered under Part B, recommend removal of the drug from the drug list.	Articaine was removed from the drug list table.
Neurology/ Ophthalmology/ Otorhinolaryngology	Anticonvulsants	Recommends maintaining the five pharmacologic classes as listed in the draft of MG V4.0.	USP thanks those whose comments were written in support of the draft.
Neurology/ Ophthalmology/ Otorhinolaryngology	Anticonvulsants	Establish a new Alpha ₂ -delta Ligand pharmacologic class. Pregabalin is a potent and specific ligand at the α ₂ -δ subunit of voltage-gated calcium channels, and it does not fall into any of the other commonly used classes of drugs.	No change to the Model Guidelines. Pregabalin is accommodated for under the "Anticonvulsants" therapeutic category and "Calcium Channel Modifying Agents" pharmacologic class. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
Neurology/ Ophthalmology/ Otorhinolaryngology	Antidementia Agents	Drugs that are of questionable efficacy or safety should not be included on the drug list. The role of ergoloid mesylates in the treatment of Alzheimer's disease and dementia is controversial. But, rather than including it on the list, which creates an expectation that the drug will be on the formulary, recommend removing the drug from the drug list and allow each plan to decide if its formulary will include this drug.	USP's role under the MMA is to develop a list of categories and classes that may be used by drug plans to develop their formularies. The drug list table is a guide to provide examples of drugs that may be associated with each therapeutic category, pharmacologic class, and FKDT. Any FDA-approved, Part D-eligible drug may be considered for inclusion on the list. It is the role of the P&T committee, not USP, to consider safety and efficacy when making clinical decisions and selecting formulary drugs.
Neurology/ Ophthalmology/ Otorhinolaryngology	Antidementia Agents	Supports decision to maintain Cholinesterase Inhibitors; Glutamate Pathway Modifiers; and Antidementia Agents, Other as three distinct pharmacologic classes. Also commends MGEC for minimizing changes from V3.0, thus providing greater stability from one plan year to the next.	USP thanks those whose comments were written in support of the draft.
Neurology/ Ophthalmology/ Otorhinolaryngology	Antimyasthenic Agents	Drug products that are not listed on the CMS Formulary Reference File cannot be added to Part D Plan formularies without intervention from CMS. Recommend removal of neostigmine from the drug list.	The MGEC believes that the Formulary Reference File is not a coverage list for Part D drugs. It is their understanding that drugs that do not appear in the file are not necessarily excluded from coverage if they meet Part D eligibility requirements.
Neurology/ Ophthalmology/ Otorhinolaryngology	Antiparkinson Agents	Supports the Antiparkinson Agents therapeutic category as proposed in the draft and supports continued separation of dopamine precursors, dopamine agonists (ergot), dopamine agonists (nonergot), and MAOIs, which is consistent with nationally recognized practice guidelines for Parkinson's disease.	USP thanks those whose comments were written in support of the draft.
Neurology/ Ophthalmology/ Otorhinolaryngology	Antiparkinson Agents	Concerned with the decision to downgrade all pharmacologic classes within the Antiparkinson Agents therapeutic category to FKDTs. These concerns are heightened by the announcement by CMS that, beginning in 2008, plans will no longer be required to cover at least one drug in each FKDT. Urges restoration of these FKDTs to the pharmacologic class level. Without such a change, there is risk that certain beneficiaries may not have access to drugs they need to combat this devastating illness.	No change to the Model Guidelines. The MGEC believes that patient access is sufficiently protected by the current structure of the "Antiparkinson Agents" therapeutic category.
Neurology/ Ophthalmology/ Otorhinolaryngology	Antispasticity Agents	Recommends creation of two separate pharmacologic classes for centrally acting muscle relaxants to more closely resemble the current treatment of spasticity in MS: 1) Centrally Acting, Central Nervous System Anti-spasticity; and 2) Skeletal Muscle Relaxant, Other. Centrally acting anti-spasticity drugs relieve spasticity caused by diseases of the CNS, which often result in painful contraction of opposing muscle groups. Locally acting agents, however, relieve muscle spasm caused by local irritation of a nerve and are ineffective as treatment for spasticity due to CNS disease.	No change to the Model Guidelines. "Antispasticity Agents" and "Skeletal Muscle Relaxants" currently exist as separate therapeutic categories.
Neurology/ Ophthalmology/ Otorhinolaryngology	Sedatives/ Hypnotics	Designate a separate class for newer sleep agents that have a shorter duration of effect, fewer side effects, and a higher safety profile in the elderly and people with disabilities because these agents have pharmacologic and clinical distinction.	No change to the Model Guidelines. Sedative/hypnotic agents are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to effectively manage the benefit.

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
Neurology/ Ophthalmology/ Otorhinolaryngology	Skeletal Muscle Relaxants	Concerned about the broad classification of skeletal muscle relaxants. The category is overly broad and does not recognize the important differences between spasticity drugs like baclofen and relaxants like cyclobenzaprine. This could lead to the exclusion of antispasticity drugs (baclofen and tizanidine) that are approved for the treatment of people with MS in favor of less expensive drugs that have not demonstrated as much efficacy in the treatment of spasticity due to MS. Recommends two separate pharmacologic classes: 1) Centrally Acting, Central Nervous System Antispasticity and 2) Skeletal Muscle Relaxant, Other.	No change to the Model Guidelines. "Antispasticity Agents" and "Skeletal Muscle Relaxants" currently exist as separate therapeutic categories.
Oncology	Antineoplastics	Therapeutic distinctions within the Molecular Target Inhibitors class are diverse enough to warrant multiple pharmacologic classes. While other classes contain FKDTs with essentially the same disease indications, the Molecular Target Inhibitors contain drugs targeting such dissimilar diseases as chronic myelogenous leukemia, gastric stromal tumor, and renal cell carcinoma. A function of targeted inhibition renders some agents effective in only small subsets of cancer types. Identification of FKDTs therefore suggests therapeutic interchangeability that in many cases does not exist.	No change to the Model Guidelines. The MGEC believe that evidence base is not yet firm enough to create additional granularity. The molecular target inhibitors will remain classified based on the dominant pathway for the labeled indication until further clinical evidence is available.
Oncology	Antineoplastics	Commends addition of the Multitargeted Kinase Inhibitors, HER2 Receptor Tyrosine Kinase Inhibitors FKDT. Many future self-administered products are likely to be molecular target inhibitors. These agents have very discreet targets, indications, lines of therapy, tumor types, potential combination uses and biomarker requirements for use. Delineation into FKDTs is appropriate.	USP thanks those whose comments were written in support of the draft.
Oncology	Antineoplastics	Recommends addition of azathioprine to the drug list under the Antimetabolites pharmacologic class and Purine Analogs and Related Inhibitors FKDT.	Based on its FDA-approved use in the treatment of rheumatoid arthritis, azathioprine was added under the "Immunological Agents" therapeutic category, "Immune Suppressants" pharmacologic class, and "Immune Suppressants (Non-TNF Inhibitors)" FKDT.
Oncology	Antineoplastics	Recommends addition of a new FKDT under the Antimetabolites pharmacologic class titled Antimetabolites, Antiproliferative (mycophenolate mofetil and mycophenolate acid).	No change to the Model Guidelines. Mycophenolate's only FDA-approved indication is for prophylaxis of organ rejection. As such an agent, the MGEC believes it may be eligible for coverage under Part B. Alternatively, the MGEC believes it may be eligible for coverage under Part D as one of the six classes of clinical concern.
Psychiatry	Antidepressants	Pleased that the three separate classes for antimentia drugs have been maintained. Concerned that patients with Alzheimer's disease may have less access to medications to treat neuropsychiatric symptoms. Recommend dividing the Antidepressants category into five classes: 1) Monoamine Oxidase Inhibitors, 2) Selective Serotonin Reuptake Inhibitors (SSRIs), 3) Serotonin Norepinephrine Reuptake Inhibitors (SNRIs), 4) Tricyclics, and 5) Other. To combine SSRIs and SNRIs is erroneous because they work differently on different receptors and have different therapeutic effects.	No change to the Model Guidelines. Although the MGEC recognizes there are differences between the mechanisms of action of the SSRIs and SNRIs, they do not believe there is sufficient new evidence that demonstrates a clinically important differential in safety and efficacy between the two types of agents or believe combining them in one pharmacologic class in the Model Guidelines diminishes beneficiary access to the medications.

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
Psychiatry	Antidepressants	Create two separate pharmacological classes for SSRIs and SNRIs in the treatment of depression to better ensure that beneficiaries suffering from depression have access to the treatment most appropriate for them.	No change to the Model Guidelines. Although the MGEC recognizes there are differences between the mechanisms of action of the SSRIs and SNRIs, they do not believe there is sufficient new evidence that demonstrates a clinically important differential in safety and efficacy between the two types of agents or believe combining them in one pharmacologic class in the Model Guidelines diminishes beneficiary access to the medications.
Psychiatry	Antidepressants	Strongly urges recognition of the pharmacologic and clinical distinction of SSRI and SNRI agents. The current classification would provide greater access to older, less effective, and more dangerous medications (tricyclics and MAOIs) and less access to SSRIs and SNRIs that are safer and more effective.	No change to the Model Guidelines. Although the MGEC recognizes there are differences between the mechanisms of action of the SSRIs and SNRIs, they do not believe there is sufficient new evidence that demonstrates a clinically important differential in safety and efficacy between the two types of agents or believe combining them in one pharmacologic class in the Model Guidelines diminishes beneficiary access to the medications.
Psychiatry	Antidepressants	Based on actual use patterns and clinical differentiation, SSRIs and SNRIs should be separated out as distinct pharmacologic classes. SNRIs are used as frequently as tricyclics, more frequently than the entire "other" class, and much more frequently than MAOIs.	No change to the Model Guidelines. Although the MGEC recognizes there are differences between the mechanisms of action of the SSRIs and SNRIs, they do not believe there is sufficient new evidence that demonstrates a clinically important differential in safety and efficacy between the two types of agents or believe combining them in one pharmacologic class in the Model Guidelines diminishes beneficiary access to the medications.
Psychiatry	Antipsychotics	Create two new FKDTs within the Atypicals pharmacologic class entitled Serotonin/Dopamine Antagonists (SDAs) and Dopamine Partial Agonists (DPAs). DPAs differ substantially from SDAs and conventional antipsychotics. Aripiprazole, the only DPA to be approved for schizophrenia and manic and mixed episodes associated with bipolar I disorder, differs substantially from the SDAs in its intrinsic activity at the D ₂ receptor, in its impact on prolactin, and in the ratio of binding affinities for the D ₂ and 5-HT _{2A} receptors. And, clinically, its partial D ₂ agonist property results in a low risk for treatment-emergent movement disorders, efficacy in adjunctive treatment of major depression, and reversal of clozapine-induced metabolic abnormalities.	No change to the Model Guidelines. Antipsychotics are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to manage the benefit.
Psychiatry	Antipsychotics	Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) buttress the view that atypical and conventional antipsychotics represent distinct pharmacologic classes. Urges retention of this distinction as part of the MGs.	USP thanks those whose comments were written in support of the draft.
Psychiatry	Bipolar Agents	Recommends retention of the Bipolar Agents therapeutic category and reconsideration of pharmacologic classes. Effective treatment of bipolar disorder requires both acute therapy (to treat manic and depressive episodes) and long-term therapy (maintenance to minimize relapse/recurrence). Classes should be consistent with the nationally recognized practice guideline treatment recommendations, such as the APA practice guideline that recommends a minimum of four types of agents to treat bipolar disorder: antipsychotics, anticonvulsants, antidepressants, and mood stabilizers.	No change to the Model Guidelines. Agents used for the treatment of bipolar disorder are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to manage the benefit.

Responsible Expert Committee or Party	Therapeutic Category Affected or Issue	Proposed Changes/Items for Discussion	MGEC Decision/Rationale
Psychiatry	Bipolar Agents	Subdivide the Bipolar Agents therapeutic category into two separate pharmacologic classes: 1) Mood stabilizers, and 2) Atypical Antipsychotics. There are distinct pharmacologic and clinical differences among the products currently listed as bipolar agents. Mood-stabilizing agents primarily control bipolar illness by "leveling out" or stabilizing mood symptoms, while atypical agents primarily work by decreasing psychotic symptoms. By permitting plans to establish formularies that drastically limit treatment options, the MGs can have the effect of discouraging enrollment by patients with this disorder or restricting access to the most efficacious treatment options.	No change to the Model Guidelines. Agents used for the treatment of bipolar disorder are accommodated for in the existing structure of the Model Guidelines and FKDTs. The MGEC does not believe the information currently available justifies additional granularity and may hinder drug plans' ability to manage the benefit.
Pulmonary Disease and Allergy	Respiratory Tract Agents	Supports the Respiratory Tract Agents therapeutic category as proposed and recommends that the pharmacologic classes, which are consistent with recommendations of evidence-based, nationally accepted practice guidelines for treating asthma and COPD and standard clinical practice, be retained. Also recommends consideration of listing of combination products that have been shown to improve patient adherence.	USP thanks those whose comments were written in support of the draft.
Pulmonary Disease and Allergy	Respiratory Tract Agents	Synthesis Inhibitors FKDT has only one drug, which makes inclusion on Medicare formularies mandatory and eliminates the role of Medicare P&T Committees. Zileuton has no clinical advantage over leukotriene antagonists and has several disadvantages including 4 times daily administration, required monitoring of liver enzymes prior to and during therapy, potential for significant drug interactions with theophylline and warfarin, and paucity of data as compared to leukotriene antagonists.	No change to the Model Guidelines. FKDTs are created as a mechanism to provide CMS with additional information regarding the types of drugs that the MGEC believes should be included on Part D formularies.