

Minutes of Meeting

Alabama Medicaid Agency Pharmacy and Therapeutics Committee

February 8, 2012

Members Present: Dr. Lucy Culpepper - Vice Chairman, Ms. Janet Allen, Dr. Julia Boothe, Dr. Gerard Ferris, Dr. Kelli Littlejohn, Mr. Ben Main, Dr. Robert Moon, Dr. Melinda Rowe, and Dr. James Yates

Members Absent: Ms. LaTonya Porter, Dr. Chivers Woodruff

Patient Care Networks of Alabama (PCNA) Staff Present: Mr. Chris Barwick, Dr. Cara Leos, and Dr. Amanda Sparkman

Presenter: Dr. Tina Hisel

Presenters Present via Teleconference: Dr. Laureen Biczak

1. OPENING REMARKS

Vice Chairman Culpepper called the Pharmacy and Therapeutics (P&T) Committee Meeting to order at 9:00 a.m.

2. APPROVAL OF MINUTES

Dr. Culpepper asked if there were any corrections to the minutes from the November 9, 2011 P&T Committee Meeting.

There were no objections. Dr. Yates made a motion to approve the minutes as presented and Dr. Ferris seconded to approve the minutes. The minutes were unanimously approved.

3. PHARMACY PROGRAM UPDATE

Dr. Littlejohn noted that today is the first full day of the legislative session, and Medicaid will work with the legislature as well as the Governor's office and Finance Director's office related to the budget and any other issues.

On January 1, 2012, NCPDP D.0 was implemented.

The Patient Care Networks of Alabama (PCNA) implementation has been very successful. Network Pharmacists, Mr. Chris Barwick and Dr. Amanda Sparkman, were in attendance via phone and Dr. Cara Leos attended the meeting.

Chairman Porter was unable to attend the meeting; therefore, Vice Chairman Culpepper will be leading the meeting.

Dr. Littlejohn introduced Dr. Melinda Rowe. She is an Assistant Medical Director with the Agency and will assume responsibility for the P&T Committee beginning with the May 9, 2012 meeting.

4. ORAL PRESENTATIONS BY MANUFACTURERS/MANUFACTURERS' REPRESENTATIVES

One five-minute verbal presentation was made on behalf of a pharmaceutical manufacturer. The process and timing system for the manufacturer's oral presentation was explained. The drug and corresponding manufacturer is listed below with the appropriate therapeutic class.

5. PHARMACOTHERAPY CLASS RE-REVIEWS (Please refer to the website for full text reviews.)

The pharmacotherapy class reviews began at approximately 9:07 a.m. There were a total of 11 re-reviews. The classes were previously reviewed in August 2009.

Anthelmintics: American Hospital Formulary Service (AHFS) 080800

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the anthelmintics that are included in this review are listed in Table 1. Mebendazole is available in a generic formulation and pyrantel pamoate is available over-the-counter.

The anthelmintics are approved for the treatment of cestode, nematode and trematode infections. There have been no major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Albendazole, ivermectin, and praziquantel are considered first-line therapy for some parasitic diseases that are not commonly seen in the U.S. Therefore, patients with a diagnosis of one of these uncommon helminthic infections should be allowed approval for a brand anthelmintic through the medical justification portion of the prior authorization process.

Therefore, all brand anthelmintics within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand anthelmintic is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Ferris asked for clarification regarding which anthelmintics were available in a generic formulation. Dr. Hisel stated that mebendazole is the only product available in a generic formulation. Dr. Littlejohn clarified that pyrantel pamoate (Reese[®]) is also available over-the-counter and does not require prior authorization.

Dr. Ferris asked if there were any new recommendations regarding the treatment of ascariasis and pinworms. He further asked if the use of a paralytic is clinically appropriate prior to the administration of an anthelmintic. Dr. Biczak stated that there is not a lot of new data to support the use of a paralytic; she noted that ivermectin does paralyze the parasite. She stated that the recommendations for mebendazole and albendazole have not changed.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Aminoglycosides: AHFS 081202

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the aminoglycosides that are included in this review are listed in Table 1. All of the aminoglycosides are available in a generic formulation, with the exception of tobramycin inhalation solution.

The parenteral aminoglycosides are often used empirically as monotherapy or in combination with other antibacterial agents to treat serious infections. They are also recommended as specific therapy for the treatment of susceptible pathogens. The chronic use of tobramycin inhalation solution is recommended for patients \geq years of age with cystic fibrosis colonized with *P. aeruginosa*, regardless of the severity of lung disease. Treatment with tobramycin has been associated with improvements in pulmonary function and quality of life, as well as a decrease in hospitalization rates and requirement for intravenous anti-pseudomonal antibiotics. There have been no major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Therefore, all brand aminoglycosides within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use. Tobramycin inhalation solution has been shown to improve lung function and reduce exacerbations in cystic fibrosis patients colonized with *P. aeruginosa*. Therefore, these patients should be allowed approval for tobramycin inhalation solution through the medical justification portion of the prior authorization process.

No brand aminoglycoside is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Cephalosporins: AHFS 081206

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the cephalosporins that are included in this review are listed in Table 1. Ceftaroline (Teflaro[®]) is an injectable product that was approved by the FDA since this class was last reviewed. The majority of the cephalosporins are available in a generic formulation. There is at least one oral and one injectable agent available in a generic formulation within each cephalosporin generation, with the exception of cefepime and ceftaroline.

The cephalosporins are approved to treat a variety of infections, including central nervous system, dermatologic, genitourinary, respiratory, as well as several miscellaneous infections. Ceftaroline is approved for the treatment of skin and skin-structure infections, including those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), and for the treatment of community-acquired pneumonia. Two studies compared ceftaroline to the combination of vancomycin and aztreonam in patients with complicated skin and skin-structure infections. Clinical cure rates were similar among the treatment groups in the clinically evaluable and modified intent-to-treat populations, as well as in patients infected with MRSA. Two studies compared ceftaroline to ceftriaxone in patients with community-acquired pneumonia. Ceftaroline was found to be non-inferior to ceftriaxone in the clinically evaluable population. There have been no other major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

There is insufficient evidence to support that one brand cephalosporin is safer or more efficacious than another. Formulations without a generic alternative should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand cephalosporins within the class reviewed are comparable to each other and to the generics, within each cephalosporin generation, and OTC products (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand cephalosporin is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Yates stated that ceftazidime is frequently used for the inpatient treatment of *P. aeruginosa*. Dr. Culpepper asked if there would be more generations of cephalosporins made available. Dr. Biczak stated that there is a lot of interest in finding alternative treatments for MRSA. She stated that ceftaroline is the first effort in developing further treatment alternatives to vancomycin.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Miscellaneous β -Lactam Antibiotics: AHFS 081207

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the miscellaneous β -lactam antibiotics that are included in this review are listed in Table 1. Aztreonam inhalation solution (Cayston[®]) was approved by the FDA since this class was last reviewed. All of the injectable products are available in a generic formulation, with the exception of doripenem and ertapenem. Aztreonam inhalation solution is not available in a generic formulation.

The miscellaneous β -lactam antibiotics are approved to treat a variety of infections, including central nervous system, dermatologic, genitourinary, respiratory, as well as several miscellaneous infections. Aztreonam inhalation solution is approved to improve respiratory symptoms in cystic fibrosis patients colonized with *Pseudomonas aeruginosa*. Treatment with aztreonam has been associated with improvements in pulmonary function, improved quality of life, and decreased requirement for inhaled or intravenous anti-pseudomonal antibiotics compared to placebo. An open-label study following patients for 18 months demonstrated continued benefit over time. There have been no other major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

There is insufficient evidence to support that one brand miscellaneous β -lactam is safer or more efficacious than another within its given indication. With the exception of aztreonam inhalation solution, the miscellaneous β -lactam antibiotics are only available in an injectable formulation and are primarily administered in the inpatient setting. Since these agents are not indicated as first-line therapy for the management of common infectious diseases that would be seen in general use and due to concerns for the development of resistance, these agents should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand miscellaneous β -lactam antibiotics within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use. Aztreonam inhalation solution has been shown to improve lung function and reduce exacerbations in cystic fibrosis patients colonized with *P. aeruginosa*. Therefore, these patients should be allowed approval for aztreonam inhalation solution through the medical justification portion of the prior authorization process.

No brand miscellaneous β -lactam antibiotic is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Yates stated that meropenem and amikacin are the drugs of choice for the treatment of service members returning from desert areas.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Chloramphenicol: AHFS 081208

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that chloramphenicol is approved for the treatment of serious infections caused by susceptible microorganisms, acute infections caused by *Salmonella typhi*, and as part of a cystic fibrosis regimen. However, it should only be used when less potentially dangerous drugs are ineffective or contraindicated. It is available in a generic formulation. There have been no major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Therefore, all brand chloramphenicol products within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand chloramphenicol product is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Culpepper stated that chloramphenicol was historically the drug of choice for the treatment of *Hemophilus influenzae*; however, the use of this agent is no longer necessary for the treatment of *H. influenzae* due to availability of vaccines.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Macrolides: AHFS 081212

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the macrolides that are included in this review are listed in Table 1. Fidaxomicin (Dificid[®]) was approved by the FDA since this class was last reviewed. Several of the macrolides are available in a generic formulation, with the exception of erythromycin lactobionate, erythromycin stearate, fidaxomicin and telithromycin.

The macrolides are approved to treat a variety of infections, including dermatologic, gastrointestinal, genitourinary, respiratory, as well as a variety of miscellaneous infections. Fidaxomicin is a newer macrolide that is approved to treat *Clostridium difficile*-associated diarrhea (CDAD). It is minimally absorbed after oral administration and has little or no activity against organisms other than clostridia. Guidelines recommend oral metronidazole or oral vancomycin for the treatment of CDAD. Metronidazole is recommended for patients with mild to moderate disease, while vancomycin is recommended for patients with severe disease. First recurrences are generally treated like the initial episode; however, only vancomycin is used to treat the second or later recurrence of CDAD. Metronidazole should not be used beyond the first recurrence of CDAD, or for long-term chronic therapy, due to the potential for neurotoxicity. Fidaxomicin was approved by the FDA in May 2011; therefore, there were no recommendations regarding this

product in the guidelines. Louie et al. compared fidaxomicin and vancomycin in patients with CDAD. Overall, clinical cure rates were similar among the treatment groups, and fidaxomicin was found to be non-inferior to vancomycin. Recurrence was reported in 15.4% of patients treated with fidaxomicin compared to 25.3% of patients treated with vancomycin, which was statistically significant. The lower rate of recurrence was seen in patients infected with the non-NAP1/BI/027 strains. However, recurrence rates were similar among patients infected with the NAP1/BI/027 strain.

Safety concerns with telithromycin have led to changes in the prescribing information, including stronger warnings regarding hepatotoxicity, visual disturbances and loss of consciousness. This agent is only indicated for the treatment of community-acquired pneumonia and there is a lack of data demonstrating clinical advantages over other macrolides. There have been no other major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Therefore, all brand macrolides within the class reviewed, with the exception of telithromycin, are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use. Telithromycin possesses an extensive adverse effect profile compared to the other brands, generics and OTC products in the class (if applicable) and should be managed through the existing medical justification portion of the prior authorization process.

No brand macrolide is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

No brand telithromycin product is recommended for preferred status, regardless of cost.

Ms. Allen asked if the studies evaluating the efficacy and safety of fidaxomicin included an analysis of geriatric patients. Dr. Biczak stated that she was not aware of a subgroup analysis in this patient population. She noted that studies generally report the severity of the illness rather than the age of the patients. She stated that the patient population most commonly affected with CDAD is the very young and the elderly.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Penicillins: AHFS 081216

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the penicillins that are included in this review are listed in Table 1. The majority of the penicillins are available in a generic formulation. They are classified into five subgroups based on their spectrum of activity. There is at least one oral and one injectable agent available in a generic formulation within each subgroup, with the exception of ticarcillin/clavulanate.

The penicillins are approved to treat a variety of infections, including central nervous system, dermatologic, gastrointestinal, genitourinary, respiratory, as well as several miscellaneous infections. There have been no major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Therefore, all brand penicillins within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand penicillin is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Ferris asked about the incidence of allergic reactions to cephalosporins in those who are allergic to penicillin. Dr. Biczak stated that the incidence from more recent reviews is 1% to 3%. In general, if an allergic reaction was mild with a penicillin, the reaction with a cephalosporin will also be mild. The same is true for life-threatening reactions. If a patient has a history of a mild reaction to a penicillin, it is routine in the hospital setting to administer a cephalosporin if that is the drug of choice. Cephalosporins are avoided if the patient has a history of a severe reaction to a penicillin. It is not as well quantified what the rate of cross-reactivity is if a patient has a cephalosporin allergy and needs a penicillin; however, it is likely 10% to 20%. Also poorly characterized is the cross-reactivity between penicillins and cephalosporins and the miscellaneous beta-lactams; however, it is likely 10% to 20% as well.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Quinolones: AHFS 081218

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the quinolones that are included in this review are listed in Table 1. This review encompasses all dosage forms and strengths. Ciprofloxacin, levofloxacin and ofloxacin are available in a generic formulation.

The quinolones are approved to treat a variety of infections, including dermatologic, gastrointestinal, genitourinary, respiratory, as well as several miscellaneous infections. There have been no other major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Therefore, all brand quinolones within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand quinolone is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Yates asked if you should avoid using ciprofloxacin for infections above the diaphragm. Dr. Biczak stated that ciprofloxacin does not provide anaerobic coverage. Some of the newer respiratory fluoroquinolones have some coverage; however, they don't cover all of the oral anaerobes. If the diagnosis is aspiration pneumonia, it is recommended to add an agent with anaerobic activity to the quinolone.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Sulfonamides: AHFS 081220

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the sulfonamides that are included in this review are listed in Table 1. All of the products are available in a generic formulation.

Sulfadiazine and sulfamethoxazole/trimethoprim are approved to treat a variety of infections, including central nervous system, dermatological, gastrointestinal, genitourinary, respiratory, as well as several miscellaneous infections. Sulfasalazine is approved for the treatment of ulcerative colitis and rheumatoid arthritis. There have been no major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Therefore, all brand sulfonamides within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand sulfonamide is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Ferris asked if there was a consensus about the dosing schedule with sulfamethoxazole/trimethoprim for the treatment of MRSA. Dr. Biczak stated most infectious disease physicians will dose the agent based on renal function and the site of the infection, rather than the specific organism. For mild skin or soft tissue infections, physicians frequently use a twice daily dosing regimen. She stated that if higher doses are required, she uses a weight-based calculation.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Tetracyclines: AHFS 081224

Manufacturer comments on behalf of these products:

None

Dr. Hisel commented that the tetracyclines that are included in this review are listed in Table 1. Demeclocycline, doxycycline, minocycline and tetracycline are available in a generic formulation.

The tetracyclines are approved to treat a variety of infections, including central nervous system, dermatologic, gastrointestinal, genitourinary, respiratory, as well as numerous miscellaneous infections. There have been no major changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

Therefore, all brand tetracyclines within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand tetracycline is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

Antibacterials, Miscellaneous: AHFS 081228

Manufacturer comments on behalf of these products:

Xifaxan[®] – Salix Pharmaceuticals

Dr. Hisel commented that the miscellaneous antibacterials that are included in this review are listed in Table 1. Telavancin (Vibativ[®]) was approved by the FDA since this class was last reviewed. Rifaximin was previously reviewed by this committee in May 2011 due to the availability of a new tablet strength and FDA-approved indication. Bacitracin, clindamycin, colistimethate, polymyxin B sulfate and vancomycin are available in a generic formulation.

The miscellaneous antibacterials are a diverse group of products that are used to treat many different types of infections. The FDA-approved indications vary depending on the particular agent and antimicrobial properties. Telavancin is approved for the treatment of complicated skin and skin-structure infections (SSTIs) caused by susceptible gram-positive bacteria (including MRSA). For hospitalized patients with complicated SSTIs, empirical therapy for MRSA should be considered. Treatment options include telavancin, vancomycin, linezolid, daptomycin, and clindamycin. Two studies compared telavancin to standard therapy (penicillinase-resistant penicillin or vancomycin) in patients with complicated SSTIs caused by gram-positive organisms. Cure rates were similar among the treatment groups, including in patients with MRSA at baseline. Telavancin was also compared to vancomycin in patients with hospital-acquired pneumonia due to gram-positive organisms. Cure rates were similar among the treatment groups, including in patients with MRSA at baseline. Increases in serum creatinine have occurred more frequently in patients receiving telavancin compared to patients receiving vancomycin. There have been no other major

changes in the prescribing information, treatment guidelines or clinical studies since this class was last reviewed.

There is insufficient evidence to support that one brand miscellaneous antibacterial is safer or more efficacious than another within its given indication. Since the majority of these agents are not indicated as first-line therapy for the management of common infectious diseases that would be seen in general use and due to concerns for the development of resistance, these agents should be managed through the medical justification portion of the prior authorization process.

Therefore, all brand miscellaneous antibacterials within the class reviewed are comparable to each other and to the generics and OTC products in the class (if applicable) and offer no significant clinical advantage over other alternatives in general use.

No brand miscellaneous antibacterial is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Dr. Yates stated that the use of Helidac[®] is the only treatment option for individuals with a penicillin allergy. Dr. Hisel noted that each ingredient is also available in a generic formulation.

There were no further discussions on the agents in this class. Dr. Culpepper asked the P&T Committee Members to mark their ballots.

6. RESULTS OF VOTING ANNOUNCED

The results of voting for each of the therapeutic classes were announced; all classes were approved as recommended. Results of voting are described in the Appendix to the minutes.

7. NEW BUSINESS

There was no new business.

8. NEXT MEETING DATE

The next P&T Committee Meeting is scheduled for 9:00 a.m. on May 9, 2012 at the Medicaid Building in the Commissioner's Board Room. Additional meetings will be held on August 8, 2012 and November 14, 2012.

9. ADJOURN

There being no further business, Mr. Main moved to adjourn and Dr. Boothe seconded. The meeting was adjourned at 9:54 a.m.

Appendix

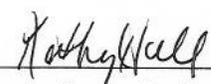
RESULTS OF THE BALLOTING
Alabama Medicaid Agency
Pharmacy and Therapeutics Committee
February 8, 2012

- A. **Recommendation:** No brand anthelmintic is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

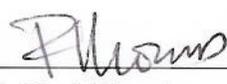
 Approve Approve as amended Disapprove No action
Deputy Commissioner

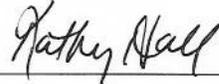
 Approve Approve as amended Disapprove No action
Commissioner

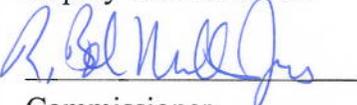
- B. **Recommendation:** No brand aminoglycoside is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

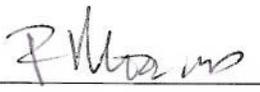
 Approve Approve as amended Disapprove No action
Deputy Commissioner

 Approve Approve as amended Disapprove No action
Commissioner

C. Recommendation: No brand cephalosporin is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

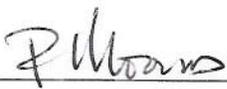
 Approve Approve as amended Disapprove No action
Deputy Commissioner

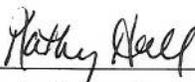
 Approve Approve as amended Disapprove No action
Commissioner

D. Recommendation: No brand miscellaneous β -lactam antibiotic is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

 Approve Approve as amended Disapprove No action
Deputy Commissioner

 Approve Approve as amended Disapprove No action
Commissioner

E. Recommendation: No brand chloramphenicol is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

[Signature] Approve Approve as amended Disapprove No action
Medical Director

[Signature] Approve Approve as amended Disapprove No action
Deputy Commissioner

[Signature] Approve Approve as amended Disapprove No action
Commissioner

F. Recommendation: No brand macrolide is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

No brand telithromycin product is recommended for preferred status, regardless of cost.

Amendment: None

Vote: Unanimous to approve as recommended

[Signature] Approve Approve as amended Disapprove No action
Medical Director

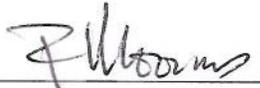
[Signature] Approve Approve as amended Disapprove No action
Deputy Commissioner

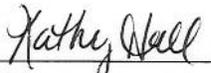
[Signature] Approve Approve as amended Disapprove No action
Commissioner

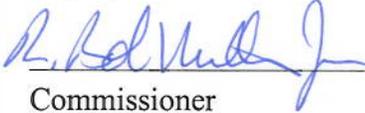
G. Recommendation: No brand penicillin is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

 Approve Approve as amended Disapprove No action
Deputy Commissioner

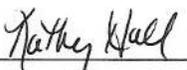
 Approve Approve as amended Disapprove No action
Commissioner

H. Recommendation: No brand quinolone is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

 Approve Approve as amended Disapprove No action
Deputy Commissioner

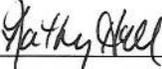
 Approve Approve as amended Disapprove No action
Commissioner

I. **Recommendation:** No brand sulfonamide is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

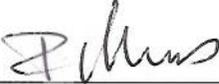
 Approve Approve as amended Disapprove No action
Deputy Commissioner

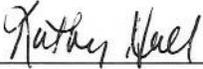
 Approve Approve as amended Disapprove No action
Commissioner

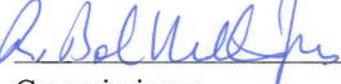
J. **Recommendation:** No brand tetracycline is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

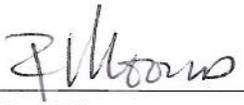
 Approve Approve as amended Disapprove No action
Deputy Commissioner

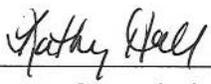
 Approve Approve as amended Disapprove No action
Commissioner

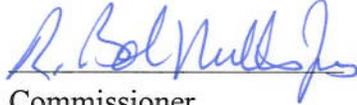
K. Recommendation: No brand miscellaneous antibacterial is recommended for preferred status. Alabama Medicaid should accept cost proposals from manufacturers to determine the most cost effective products and possibly designate one or more preferred brands.

Amendment: None

Vote: Unanimous to approve as recommended

 Approve Approve as amended Disapprove No action
Medical Director

 Approve Approve as amended Disapprove No action
Deputy Commissioner

 Approve Approve as amended Disapprove No action
Commissioner

Respectfully submitted,



February 8, 2012

Tina Hisel, Pharm.D., BCPS