the DBL report

Issue #19, April 2001

An Official Accompaniment to the Alberta Health and Wellness Drug Benefit List (AHWDBL)

The Expert Committee on Drug Evaluation and Therapeutics (ECDET)

produced by Alberta Blue Cross

In this issue:

Highlights of New Products Added

■ **LIPIDIL SUPRA** (fenofibrate, microcoated formulation) (AOO) will provide an improved formulation of fenofibrate at no extra cost compared to the currently listed products. Fibrates have been confirmed to be the most appropriate therapy for certain dyslipidemic patients and their use is endorsed in the recently published "New Canadian Recommendations for the Management and Treatment of Dyslipidemia".

■ **OXY-IR** (oxycodone hydrochloride) (PFR) has been added to the AHWDBL to provide a 20 mg strength immediate-release (IR) formulation and a less expensive 10 mg IR tablet of oxycodone.

■ **PREMPLUS** (conjugated estrogen/medroxyprogesterone acetate) (WAY) provides one tablet of conjugated estrogen and one tablet of medroxyprogesterone in one package and is expected to impact on compliance and convenience for post-menopausal women on continuous estogen-progestin therapy.

Changes in Special Authorization (SA)

■ **ACTONEL** (risendronate) (PGA)—the SA criteria have been expanded to include coverage: "For the treatment of osteoporosis in patients who have documented hip, vertebral or other fractures. SA is granted to a maximum of 12 months. The patient would go on to etidronate/calcium at the beginning of the second year."

■ **ARAVA** (leflunomide) (AVE)—coverage by SA will now be considered when requested by specialists in Internal Medicine in addition to specialists in Rheumatology. This change was prompted by the fact that some patients in remote geographic areas experience difficulties in gaining access to a rheumatologist.

■ **NEUPOGEN** (filgrastim) (AMG)—the SA criteria for this product have been expanded to include coverage: "For the reduction in the duration of neutropenia, fever, antibiotic use and hospitalization following induction and consolidation treatment for acute myeloid leukemia (AML)." This drug must be prescribed by the Directors of Alberta Cancer Board Centres (or their designates). Data have shown that the original theoretical concern that NEUPOGEN would act as a growth factor for AML is unfounded.

■ **SOTALOL** 80 mg tablets—all brands of sotalol 80 mg tablets previously available by SA will now be listed as unrestricted benefits. As a result, SA will not be required effective April 1, 2001.

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Highlights of Products Not Added

■ **MOBICOX** (meloxicam) (BOE) has not been added as it does not offer therapeutic advantage vis-à-vis other products currently listed. The clincial trial data demonstrated that, at lower doses, a larger number of patients discontinued treatment due to lack of efficacy and when the dose was increased, there were significantly greater GI adverse events reported.

■ **TEVETEN** (eprosartan mesylate) (SLO) has not been added due to its lack of therapeutic advantage. It appears that there would be little incentive for patients to be switched to this new angiotensin II receptor antagonist (ARB). Data supporting its efficacy appear unremarkable and data comparing eprosartan with other ARBs are not available.

Suggest a Topic

Requests for topics or information on reviewed drug products to appear in The DBL Report are welcome and can be forwarded to:

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Expert Committee Profiles: Dr. Norman R. C. Campbell

Dr. Norman R. C. Campbell joined the Expert Committee in July 2000. He obtained his B. Med. Sc. and M.D. from Memorial University of Newfoundland (NF) and received his M.D. from the same university. Dr. Campbell completed his residency in Clinical Pharmacology and Internal Medicine at the Mayo Foundation and the Memorial University of NF, respectively. Dr. Campbell is a diplomat of the American Board in Internal Medicine and a specialist in Clinical Hypertension (The American Society of Hypertension). He has served on numerous scientific advisory committees and has been President of the Canadian Hypertension Society and the Canadian Coalition for High Blood Pressure Prevention and Control. He is currently chairing the Steering Committee for the Canadian Hypertension Recommendations and the Research Committee of the Canadian Society for Internal Medicine. Dr. Campbell is a full professor in the Departments of Medicine and of Pharmacology and Therapeutics at the University of Calgary, and his research interests include studies of drug interactions, assessment of cardiovascular risk factors and evaluation of antihypertensive drugs. His clinical interests are in the fields of general medicine, hypertension, clinical pharmacology and the application of evidence-based knowledge into practice.

Dr. Campbell's vision of the Alberta government-sponsored drug programs is that they should provide new therapies that have been proven effective thus assisting physicians with a more systematic approach to pharmacotherapy.

Changes in SA Renewal Policy for Selected Products

■ In the April 1, 2001 AHWDBL you will note that SA approvals will be extended to 24 months for selected products where approval has been based on a failure to respond or intolerance to other standard therapy (or where other standard therapy is contraindicated). Products affected are:

ACCOLATE	DETROL	IMITREX
ACTONEL	DOSTINEX	MAXALT
ACTOS	DURAGESIC patches	MIACALCIN
AMATINE	EFFEXOR tablets	NEORAL
AMERGE	EVISTA	PLAVIX
ARAVA	FENTANYL injection	SINGULAIR
AVANDIA	FLOVENT 50 mcg	ZANAFLEX
CARDIZEM SR	FOSAMAX	ZOMIG
COUMADIN injection		

Please consult the SA section of the April 1, 2001 AHWDBL for additional details.

■ SA approvals of **BEROTEC U.D.V.**, **ATROVENT U.D.V.** (and generics), **DUOVENT U.D.V.** and **VENTOLIN Nebules P.F.** 2 mg/mL (and generics) will also be extended to 24 months for patients who cannot prepare a dose using the multidose nebulizer solution. Similarly, **SINGULAIR** and **ACCOLATE** renewals will be extended to 24 months also for patients who cannot operate inhalers.

■ **PROSCAR** approvals will be provided until the patient turns 65 years of age, in cases where the patient is considered a poor surgical risk.

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