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**Louisiana Medicaid  
Preferred Drug List (PDL) Program  
Overview and Results  
February 14, 2011**

**Provider Synergies, LLC  
an affiliate of Magellan Medicaid Administration**

## Overview of LDHH Preferred Drug List (PDL) Program Results

The Louisiana Department of Health and Hospitals (LDHH) preferred drug list (PDL) program has been in operation since 2002.

Louisiana is entering the fifth year as one of eight states participating in the multi-state purchasing program, The Optimal PDL Solution (TOP\$). Louisiana was one of three states that initially participated in the multi-state purchasing pool, TOP\$, in 2005. The eight states now participating in the multistate purchasing program (TOP\$) are Louisiana, Maryland, Delaware, Idaho, Pennsylvania, Wisconsin, Nebraska, and Connecticut. In 2010, Connecticut joined TOP\$.

This review is intended to clarify the methodology for financial recommendations and give a detailed review of the estimated results of the program for fiscal year 2010.

### **Major Developments in FY 2010-2011**

In March 2010, President Obama signed the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010, together known as the Affordable Care Act (ACA), into law. While many of the details relating to the enactment of the ACA are in draft form or unknown, it is clear that stipulations in this law will have a significant impact on both Federal and Supplemental Medicaid drug rebates.

### **Background**

- Provider Synergies' clients use a wholesale average cost (WAC)-based Guaranteed Net Unit Price (GNUP) formula for the calculation of supplemental rebates  
$$\text{WAC} - \text{Federal Rebate} - \text{GNUP} = \text{Supplemental Rebate}$$
- In this formula, there is an inverse relationship between the Federal and supplemental rebates.
  - As the Federal rebate rates increase, the Supplemental rebate rates decrease by an equal but opposite amount.
  - If the increase was subject to the current Medicaid program rules, the proposed rebate increase would have no adverse financial impact to the States because the total rebate (Federal + supplemental) amount remains constant.
  - Currently, all rebate dollars, both Federal and Supplemental, are shared between the Federal government and the States in accordance with the Federal Medical Assistance Percentages (FMAP) criteria.
- Our model focuses on the net/net cost of drugs (net of both Federal and Supplemental rebates) in order to provide the most cost-effective Preferred Drug List (PDL) to our clients.
  - Our supplemental rebate contracts afford price protection to States against manufacturer's price increases over time via the guaranteed net unit price (GNUP) contract.
  - Fluctuations in drug prices then only affect how the total rebate is divided between the Federal and State governments.

The following changes mandated by the ACA are effective retroactive to January 1, 2010:<sup>1</sup>

- The minimum Federal Rebate for single source and innovator multiple source drugs increases from 15.1 to 23.1 percent.

- The Federal Rebate for generic drugs increases from 11 to 13 percent.
- The minimum Federal Rebate for clotting factors and outpatient drugs approved exclusively for pediatric indications increases to 17.1%.<sup>2,3</sup>
- The Federal Rebate for line extensions of oral solid dosage forms (such as extended release versions) will now be set at the highest Federal Rebate of any strength of the original dosage form.
- The Federal Rebate is now capped at 100% of AMP (average manufacturer's price).

### Analysis

Due to the increase in the CMS base rebate, we project that Supplemental Rebates will decline by an average of 33% across all states with the range of the projected decline of 25% to 45%. For Louisiana, we project that supplemental rebates will decrease by an estimated 27.3%. This decline in Supplemental Rebates is due to the inverse relationship between Federal and Supplemental Rebates in our Guaranteed Net Unit Price (GNUP) contracts.

Even though CMS rebates are increasing, we project that states, due to the reduction in Supplemental Rebates and the offset of Federal Rebates, will experience an estimated total reduction in rebates of approximately 4.8% with a range in our states of between 3.0% and 6.8%. For Louisiana, we project that the total rebates will decrease by an estimated 5.6%.

### Limitations and Assumptions

CMS has provided limited information in the form of letters to State Medicaid Directors, as well as through conference calls that CMS has held with the states.<sup>4,5</sup> Information received in conference calls only serves as guidance until the official CMS rules are published.

Due to the confidentiality of Federal Rebate data, it is not possible to definitively quantify the net impact of the ACA on Federal and Supplemental Rebates. Since Federal rebate information is largely protected by confidentiality between CMS and the pharmaceutical manufacturers ("best price"), neither the States nor any PBM have all of the information needed to perform a more precise analysis. We have attempted, however, to project the impact on states' accrual of rebates based on the information that is available with the following caveats:

- 1) Unless indicated otherwise, we used 4Q2009 state utilization data and ran two identical analyses, the first using pre-ACA rebate percentages and the second using post-ACA rebate percentages.
- 2) We have not accounted for manufacturer price increases (which are likely) or changes in utilization. The purpose of the analysis is to benchmark the direction and magnitude that the ACA will have on accrual of Federal and Supplemental Rebates by our states by using fixed set of assumptions.
- 3) We assumed that about 20% of single source brand products have their Federal Rebate obligation determined by Best Price. While these drugs will not be affected by the 8% increase in base rebate, CMS has indicated that they intend to offset 8% of the Federal Rebate, thus reducing the state share of the Federal Rebate, for these drugs. For drugs with the Federal Rebate calculated based on BP, we project that Supplemental Rebates will remain at their current levels.
- 4) We assume that there will be a slight reduction in Federal Rebates for the 1% to 2% of brand drugs that currently have a Federal Rebate greater than the new cap of 100% of AMP. For these drugs, the direct impact to the states is not only the loss of the 8%

difference between 15.1% and 23.1%, but also the loss of all Federal Rebates above 100% of AMP.<sup>6</sup>

5) We have not accounted for changes in CMS rates on drugs subject to “line extension” pricing. At this time, it is not clear how CMS will define or determine the drugs subject to “line extension” pricing, hence our exclusion from the analysis.

#### Additional Observations

The ACA will certainly have a significant and immediate impact on states’ shares of rebates. Over time, we believe that this impact will largely be negated as competition in the pharmaceutical marketplace and expanded Medicaid enrollment drive manufacturers to offer Supplemental Rebates to ensure the positioning of their drug products on Medicaid PDLs.

This legislation will have little financial impact on drugs for which there are no supplemental rebate agreements (oncology, HIV, etc.). For these drugs, the Federal government will collect the full amount of the increased rebate, and States will continue to get their share of the current Federal rebate.

CMS has not published the Federal Rebate amounts under ACA at this time. Manufacturers are performing their own estimated calculations and submitting estimated payments for Federal and Supplemental rebate amounts. It is unknown when CMS will publish Federal Rebate amounts under ACA stipulations.

#### I. Savings Methodology

There are two ways that Louisiana derives savings from the Preferred Drug List: (1) Supplemental Rebates and (2) Market Shift savings. These are reflected in our quarterly savings report that is sent to LDHH.

##### a. **Supplemental Rebates = Sum (Supplemental Rebate Per Unit x Number of units dispensed)**

Supplemental Rebate per Unit is calculated in accordance with the supplemental rebates offered for products (identified by 11 digit NDC) that are included on the PDL.

The predominant calculation type that manufacturers may use is called a “Guaranteed Net Unit Price” or “GNUP.” GNUP calculations differ from total percent offers by protecting the state from price increases by providing a price guarantee from the manufacturer. If the manufacturer increases its price, it makes up the price increase penny for penny in additional rebates. For example, if the manufacturer offered a GNUP of \$0.60 per unit, its federal rebate was \$0.15 and the AWP of the product was \$1.00, the manufacturer would pay a \$0.25 supplemental rebate. Should the manufacturer then increase its price to \$1.10, the rebate liability would also increase, from \$0.40 to \$0.50 (i.e. \$1.10 - \$0.60).

##### b. **Market Shift Savings = Total Savings – Supplemental Rebates**

“Market Shift Savings” occur when a patient on a product not included on the PDL changes therapy to a preferred medication that is less expensive. Essentially, this is a measure of cost avoidance for the Medicaid program.

For example, suppose that a non-preferred medication costs the Louisiana Medicaid program \$40.00 per prescription (after all rebates are applied), and the physician changes a recipient's drug regimen to replace that medication with one on the PDL that costs \$30.00 per prescription (again, after application of all rebates). As a result of the change, the Medicaid program saves \$10 each time the recipient receives the new prescription versus the program spend had the patient not changed drugs.

In some cases, products are placed on the PDL and generate savings even without offering a supplemental rebate. This situation occurs either because the product is less expensive or because it has a large federal rebate that renders the net price paid by LDHH lower than the cost of competing therapies.

Market Shift Savings for each class are calculated for each drug name in the class, and then summed for the class total. Total Savings is the sum of Market Shift Savings and Supplemental Rebate Savings.

#### **c. PDL Performance report (cost avoidance) for the LDHH PDL Program**

Starting with FY 2009, Provider Synergies began a new methodology of reporting cost avoidance or PDL performance for the Preferred Drug List (PDL) Program. This change enabled us to provide reporting capability in reconciling cost avoidance projections made in our bi-annual Pharmaceutical and Therapeutics committee PDL review process.

The cost sheets are developed for the scheduled therapeutic categories prior to each Pharmaceutical and Therapeutics (P&T) meeting. Each therapeutic category is reviewed annually at one of two meetings. Cost sheets incorporate actual utilization of prescriptions, total cost paid by state, federal rebate amounts, maximum allowable cost (MAC) pricing, Federal Upper Limit (FUL) pricing, and offers for supplemental rebates. Estimation of market share shifts and the impact of drugs being ON the PDL or requiring prior authorization are included in the analysis.

The PDL Performance report derives cost avoidance from calculating the projected spend without the PDL for each therapeutic category (from the cost sheet) minus the sum of cost avoidance from market shifts and savings from supplemental rebates. The difference between the projected spend without the PDL and the projected spend with the PDL results in Total Savings with Recommendations; this is calculated for each therapeutic category. The Total Savings with Recommendations represents the projected cost avoidance from both the market share shifts and the supplemental rebates.

The PDL Performance report has the ability to compare projected cost avoidance side-by-side with actual cost avoidance experience. Variances between the projected savings on the cost sheets and the actual savings may include changes in volume, differences in market share shifts than expected, changes in manufacturer pricing not guaranteed by contract and adjustments to maximum allowable cost (MAC) program, clinical issues that develop with one or more products within a class, and launch of new branded or generic products, or removal of drugs from the market. New drugs, both branded and generic products, are incorporated into the report as utilization occurs, because they can have considerable impact on market share.

In summary, savings from the PDL program are generated through supplemental rebates and the movement of market share from higher cost products to lower cost, preferred products.

## II. Review of major Therapeutic Classes

The following is a summary of the major therapeutic classes that generate a significant amount of savings for the PDL program. Hepatitis C Agents are included also.

### Antipsychotics

The year 2005 marked the first time that LDHH selected preferred drugs within the atypical antipsychotic medications. This class represents the largest single class of expenditures within the Medicaid drug budget. The majority of the cost avoidance for this class is generated by the market share shift to the lower cost preferred agents.

On the PDL published April 2008, the preferred antipsychotics included clozapine, Invega<sup>®</sup>, Seroquel<sup>®</sup>, Seroquel<sup>®</sup> XR, Risperdal<sup>®</sup>, and Geodon<sup>®</sup>. The November 2008 PDL included the following preferred agents among the Atypical Antipsychotics: clozapine, Seroquel<sup>®</sup>, Risperdal<sup>®</sup>, and Geodon<sup>®</sup>. Risperidone, the generic for Risperdal<sup>®</sup>, was launched in August 2008. In the first six months after the generic launch, the generic product was priced at a significant premium to the branded Risperdal<sup>®</sup> product. At the P&T meeting in August 2009, the first generation antipsychotics and the injectable antipsychotics were reviewed within the PDL program for the first time. The preferred agents for the PDL published October 1, 2009 were the generic first generation antipsychotics, Fazaclor<sup>®</sup>, Seroquel<sup>®</sup>, Seroquel<sup>®</sup> XR, risperidone, oral Geodon<sup>®</sup> and injectable Geodon<sup>®</sup>. Overall utilization is increasing for this category due to the expanding FDA-approved indications and populations eligible for treatment with the Antipsychotics.

SAVINGS: In FY 2009, supplemental rebates generated significantly exceeded projections at \$920,000; however, overall cost avoidance is lower than projected due to the launch of the high cost risperidone generic for Risperdal<sup>®</sup>. The market share moved from the branded Risperdal<sup>®</sup> product to risperidone generic quickly. During FY 2009, the net cost of risperidone was slowly decreasing from a peak of more than 50% higher than the branded product price. The average net price for this class in FY 2009 was \$213 per prescription. In FY 2010, the net price of risperidone generic fell significantly and was the lowest cost atypical antipsychotic in the class. The estimated average cost per prescription has been trending downward steadily to \$150 per prescription in the last quarter of FY 2010. Estimated supplemental rebates were \$612,000 for FY 2010.

### Stimulants and Related Agents

Stimulants and Related Agents are used for the treatment Attention Deficit/Hyperactivity Disorders and Narcolepsy. In FY 2009, new entries to the class included the generic for Adderall<sup>®</sup> XR (amphetamine salt combo extended release) and a new liquid formulation of dextroamphetamine (Procentra<sup>™</sup>). The generic for Adderall<sup>®</sup> XR was launched at a significant premium price to the branded product and has remained at a premium into FY 2010. In FY 2010, new entries to the market included Nuvigil<sup>®</sup> (armodafinil) and Intuniv<sup>®</sup> (guanfacine ER).

SAVINGS: In FY 2009, savings generated by this class totaled \$9,950,000 with the majority of savings generated by supplemental rebates. Estimated supplemental rebates for FY 2010 are \$13,255,000.

## Glucocorticoids, Inhaled

Glucocorticoids, Inhaled, also called Inhaled Corticosteroids, are generally used in the management of asthma and chronic obstructive pulmonary disease. The class included only branded agents until the sporadic release of the generic for Pulmicort<sup>®</sup> Respules.

Over the last two years, Pulmicort<sup>®</sup> Respules, a product exclusively for children ages 1 to 8 years, had a generic product enter and leave the US market. Pulmicort<sup>®</sup> Respules are available to children 8 years and younger without prior authorization. Pulmicort<sup>®</sup> Respules or the generic equivalent require prior authorization for patients ages 9 years and older. The shifting of market share from brand to generic resulted in increased costs; most recently, the utilization is mostly the brand Pulmicort<sup>®</sup> Respules rather than the generic product. The preferred agents in November 2008 included Qvar<sup>®</sup>, Pulmicort<sup>®</sup> Flexhaler, Symbicort<sup>®</sup>, Aerobid<sup>®</sup> and Aerobid<sup>®</sup> M, Flovent<sup>®</sup> and Flovent<sup>®</sup> HFA, Advair<sup>®</sup> Diskus and HFA, and Azmacort<sup>®</sup>. Non-preferred agent was Asmanex<sup>™</sup>. For the PDL published for October 2009, the preferred agents were Qvar<sup>®</sup>, Symbicort<sup>®</sup>, Aerobid<sup>®</sup> and Aerobid<sup>®</sup> M, Flovent<sup>®</sup> and Flovent<sup>®</sup> HFA, Advair<sup>®</sup> Diskus and HFA, and Azmacort<sup>®</sup>. Non-preferred agents were Asmanex<sup>™</sup> and Alvesco<sup>®</sup>, a new market entry.

SAVINGS: In FY 2009, the Glucocorticoids, Inhaled accrued savings of \$1.3 million in supplemental rebates and market shift savings. In FY 2010, estimated savings for the Glucocorticoids, Inhaled were \$1.5 million.

## Cephalosporins and Related Agents

The Cephalosporins and Related Agents treat a number of common infections, and selection of a particular agent to treat a specific infection is often empirical and without the availability of microbiology culture and sensitivity data of the pathogen. The cephalosporins class consists of mostly generic products with a few branded exceptions – Suprax<sup>®</sup>, Augmentin<sup>®</sup> XR, Spectracef<sup>®</sup>, and Cedax<sup>®</sup>. In FY 2009, the generic cephalosporins were generally preferred; non-preferred agents included Raniclor<sup>®</sup> (chewable cefaclor tablets), Spectracef<sup>®</sup> (cefditoren pivoxil), and cefpodoxime. Branded preferred agents included Augmentin<sup>®</sup> XR (extended release high-dose product exclusively for adults), Suprax<sup>®</sup> (cefixime), and Cedax<sup>®</sup> (ceftibuten). Cefdinir (generic for Omnicel<sup>®</sup>), a frequently utilized broad spectrum cephalosporin, was preferred in FY 2009. In FY 2010, all branded products [Augmentin<sup>®</sup> XR, Spectracef<sup>®</sup>, Suprax<sup>®</sup>, and Cedax<sup>®</sup>] were listed as preferred; non-preferred agents included two very high cost generics, cefdinir and cefpodoxime.

SAVINGS: Savings for the Cephalosporins and Related Agents class consist of both market share movement to lower cost generic preferred agents and from the accrual of supplemental rebates. In FY 2009, market shift savings did not meet expectations due to the continued high cost of recently released generics such as cefdinir. Total supplemental rebate savings for FY 2009 were \$1.4 million. In FY 2010, market shift savings and supplemental rebates totaled an estimated \$6.8 million for the Cephalosporins and Related Agents. Majority of market shift savings were derived from movement of market share from cefdinir to lower cost agents in the class.

## Proton Pump Inhibitors (PPI)

The proton pump inhibitor class has generated the most savings to date of any of the classes reviewed. At the start of FY 2009, Nexium<sup>®</sup> and Prevacid<sup>®</sup> were the two preferred PPIs. In FY 2009, the generic for Prevacid<sup>®</sup> (lansoprazole) entered the market in November 2009. The cost

of the new Prevacid<sup>®</sup> generic, lansoprazole, was much higher than the other products in the class and was recommended as non-preferred at the February 2010 P&T meeting. In FY 2010, omeprazole, the generic for Prilosec<sup>®</sup>, was added to the preferred drug list at the February 2010 meeting. Omeprazole generic historically had a high cost, but pricing has significantly improved for the State in the last year. Nexium<sup>®</sup> remained a preferred agent in FY 2010.

SAVINGS: For FY 2009, the savings for the PPI category were \$8 million. In FY 2010, the savings for the PPI category totaled an estimated \$4.7 million. Prevacid<sup>®</sup> became available as a generic in November 2009; savings were negatively impacted in the third and fourth quarter of FY 2010 because of the arrival of the higher cost generic, lansoprazole, for Prevacid<sup>®</sup>. Additionally, the market share shifted to higher cost generic lansoprazole which negatively impacted savings from market share shifting.

### Analgesics, Narcotics

Narcotic Analgesics category consists of agents which are long-acting for chronic pain management and short-acting analgesics which are typically used for acute pain. At the February 2009 meeting, the preferred agents for the class include Duragesic<sup>®</sup> transdermal (brand only preferred), Kadian<sup>®</sup>, and morphine ER. Fentanyl transdermal generic was at a significant premium to the branded Duragesic<sup>®</sup> product and therefore, required prior authorization. At the February 2010 meeting, fentanyl transdermal (generic) was recommended as preferred; Duragesic<sup>®</sup> branded product was recommended as non-preferred. A new entry to the market was Embeda<sup>®</sup>, a morphine ER product with features to reduce abuse; however, Embeda<sup>®</sup> has not been proven to reduce abuse. Embeda<sup>®</sup> was recommended as non-preferred. Ryzolt<sup>™</sup>, a new long acting form of tramadol, was recommended as non-preferred. Despite the large number of preferred products, PDL compliance rates for the long-acting narcotic analgesics remain relatively low compared to many other PDL classes. Oxycontin<sup>®</sup> continues to maintain significant market share despite the non-preferred status. For the February 2010 review of the short-acting Narcotic Analgesics, all generic agents are recommended as preferred with the exception of fentanyl buccal (for Actiq<sup>®</sup>). Branded short-acting narcotic analgesics continue to be recommended as non-preferred with the exception of Reprexain<sup>™</sup>.

SAVINGS: Total annual drug spend for the Long-Acting Narcotic Analgesics has been rising due to the high cost of the generic transdermal fentanyl (for Duragesic<sup>®</sup> transdermal) and oxycodone ER (for Oxycontin<sup>®</sup>). Despite changing prices and availability between branded and generic products for Oxycontin<sup>®</sup> and Duragesic<sup>®</sup> transdermal in the Long-Acting Narcotics class, the average net cost per prescription has remained relatively stable. Market share shift savings provide a majority of savings for the Narcotics class. For FY 2009, the average net cost per prescription was \$198 for the Long-Acting Narcotics. For the first two quarters of fiscal year 2010, the average net cost per prescription is approximately \$195 for the Long-Acting Narcotics. The estimated savings generated for FY 2010 are \$466,000.

While switching among brand and generic forms of a drug moves market share, the goal and result is to maintain costs as low as feasible for similar products. Very little has changed in the PDL recommendations for the Short Acting Narcotics since most products are generic. Market shift savings are minimal. The PDL has effectively limited the growth in market share of the expensive brand products for the last two years. For the Short-Acting Narcotic Analgesics, the average net cost per prescription was \$22 for both Fiscal Years 2009 and 2010.

## Leukotriene Modifiers

The National Asthma Education and Prevention Program (NAEPP) and Global Initiative for Asthma (GINA) guidelines recommend inhaled glucocorticoids or corticosteroids as the cornerstone for the treatment of asthma while leukotriene modifiers are included as potential alternatives or add-on therapy in patients with mild persistent asthma and in some patients with aspirin-sensitive asthma.<sup>7,8</sup> Leukotriene Modifiers are also used as add-on therapy in patients receiving inhaled corticosteroids to reduce the dose of the inhaled corticosteroids in patients with moderate to severe asthma and to potentially improve asthma control in patients whose asthma is not controlled with low or high doses of inhaled corticosteroids. In the NAEPP and GINA guidelines, leukotriene modifiers may be used as controller treatment in asthma, particularly in children ages zero to four years.<sup>9,10</sup> However, in adults and adolescents over 12 years of age and children ages five to 11 years, leukotriene modifiers are not the preferred adjunctive therapy to inhaled corticosteroids compared to the addition of long-acting inhaled beta<sub>2</sub>-agonists according to NAEPP. Three oral agents consist of the Leukotriene Modifiers – Singulair<sup>®</sup>, Accolate<sup>®</sup>, and Zflo<sup>®</sup> CR. Preferred agents for the past several years are Singulair<sup>®</sup> and Accolate<sup>®</sup>. Zflo<sup>®</sup> CR is non-preferred. Despite the Leukotriene Modifiers being second or third line in the management of asthma, utilization has risen over the last two years.

SAVINGS: With little change in preferred agents, savings for this class are mostly derived from supplemental rebates. In FY 2009, savings for the Leukotriene Modifiers totaled \$1.3 million. In FY 2010, due to changes in the balance between federal rebates and supplemental rebates, estimated savings were \$447,000.

## Beta Agonist Bronchodilators

The Beta Agonist Bronchodilators manage asthma symptoms and exacerbations. On December 31, 2008, all chlorofluorocarbon (CFC)-containing albuterol generic products were removed from the market. The PDL implemented on November 1, 2008 listed numerous therapeutic alternatives to the generic albuterol CFC inhalers to minimize any supply issues. In August 2009, the preferred agents included Proair<sup>®</sup> HFA, Ventolin<sup>®</sup> HFA, albuterol nebulizer, Foradil<sup>®</sup>, Xopenex<sup>®</sup> inhalation, and Serevent<sup>®</sup>. With fewer preferred agents, greater market share shift savings were observed by driving market share to the lower cost agents.

SAVINGS: For FY 2009, the class savings were \$3.6 million; the average prescription net-net cost was approximately \$33. For FY 2010, the estimated savings totaled \$4.9 million with an average estimated prescription net-net cost of \$29.

## Antidepressants, Others and Selective Serotonin Reuptake Inhibitors (SSRIs)

Antidepressants includes two major subclasses – the Selective Serotonin Reuptake Inhibitors (SSRIs) and the Other Antidepressants.

The majority of the SSRIs are now available as generics. Approximately half of the Other Antidepressants are branded products. In August 2008, the preferred agents for the SSRIs included fluoxetine, sertraline, paroxetine, fluvoxamine, Pexeva<sup>™</sup>, and Lexapro<sup>®</sup>. Non-preferred SSRIs effective November 1, 2008 included paroxetine CR (for Paxil<sup>®</sup> CR), Luvox<sup>®</sup> CR, and Prozac<sup>®</sup> Weekly. Preferred agents selected at the August 2009 review included Lexapro and all generics except paroxetine CR (for Paxil<sup>®</sup> CR).

For the Other Antidepressants in FY 2009, the preferred agents included bupropion immediate-release (IR) and sustained-release (SR), mirtazapine, trazodone, and Effexor<sup>®</sup> XR. Non-preferred antidepressants included bupropion XL (newly released generic for Wellbutrin<sup>®</sup> XL), Pristiq<sup>®</sup>, Cymbalta<sup>®</sup>, nefazodone, Emsam<sup>®</sup>, and venlafaxine IR. In FY 2010, preferred other Antidepressants included bupropion IR and SR, mirtazapine, trazodone, and venlafaxine ER tablets. Non-preferred agents included Aplenzin<sup>®</sup>, bupropion XL, Pristiq<sup>®</sup>, Cymbalta<sup>®</sup>, nefazodone, Emsam<sup>®</sup>, venlafaxine IR, and Effexor<sup>®</sup> XR. PDL Compliance averages approximately 50 percent for the Other Antidepressants category.

SAVINGS: The cost avoidance savings for FY 2009 were \$2 million for the Antidepressants. For FY 2010, the cost avoidance for Antidepressants classes is estimated to be approximately \$1.5 million. Average cost per prescription has been steadily dropping for both classes of Antidepressants with decrease of approximately 23% for the Other Antidepressants and a reduction of approximately one-third for the SSRIs.

### Hepatitis C Agents

In August 2005, the P&T committee first reviewed this class. In general, hepatitis C treatment requires combination therapy of a peginterferon and ribavirin for 24 to 48 weeks. Preferred agents since February 2007 have included PEG-Intron<sup>®</sup>, PEG-Intron<sup>®</sup> Redipen, Pegasys<sup>®</sup>, and ribavirin (generic). In February 2010, the preferred agents recommended were Pegasys<sup>®</sup>, which has the largest market share of the peginterferons, and ribavirin (generic). PEG-Intron<sup>®</sup> and PEG-Intron<sup>®</sup> Redipen began to require prior authorization on April 1, 2010.

SAVINGS: The cost of Hepatitis C agents have been increasing steadily for many years. As the newer pegylated interferon products have gained market share, the cost per prescription has risen dramatically. The majority of cost avoidance for this class has been from supplemental rebates. For FY 2009, the cost avoidance totaled \$387,000 for the Hepatitis C agents. For FY 2010, the estimated cost avoidance is \$377,000.

### Number of Therapeutic Classes Reviewed

The Pharmaceutical and Therapeutics (P&T) Committee reviewed a total of 57 classes in FY 2008. In FY 2009 and FY 2010, the number of classes reviewed by the P&T committee was 68 classes each year. While the number has remained constant, two new classes were the Antihyperuricemics and the Tetracyclines, Oral in 2009.

The number of products reviewed within classes is growing as Provider Synergies is broadening the scope of drugs included in many classes. As an example, the Atypical Antipsychotics class was changed to the Antipsychotics class so that the first generation antipsychotics and the injectable products could be included in the PDL review process. In August 2009, the Ophthalmics, NSAIDs class was expanded and renamed the Ophthalmics, Anti-inflammatories; the corticosteroid products were added to provide a more comprehensive review of the anti-inflammatory agents for ophthalmic use.

### PDL Compliance

PDL Compliance is the percentage of the number of dispensed prescriptions that are preferred divided by the total number of dispensed prescriptions that are subject to the PDL. In FY 2008, the PDL compliance was 91.5 percent. In FY 2009, the PDL compliance rate was 92.3 percent. For FY 2010, the PDL compliance rate was 91.2 percent.

### III. Projected Savings FY 2010 – FY 2011

#### Factors affecting the program in FY 2010 – FY 2011

##### a. United States Health Care Reform

As noted in Section I (Major Developments in FY 2010-2011) on the first page, the 8% increase in the Federal rebate on the majority of single source brand drugs and 2% on generics, an increase that is exempted from State FMAP (Federal Medical Assistance Percentage) regulations, will effectively reduce State Medicaid supplemental rebate dollars in the near term for those drugs under contract.

##### b. Savings History and Projections

In FY 2009, cost avoidance generated by the PDL program totaled \$37.3 million. For the first three quarters of FY 2010, the savings are \$38.6 million with the estimated year end savings of \$46.4 million.

It is not possible to finalize the savings report for CY1Q10 (last quarter for FY 2010) since CMS has yet to publish the Federal Rebate amounts. Once CMS finalizes the Federal Rebate amounts, PDL performance reports will be re-analyzed. It is unknown when CMS will publish the Federal Rebate amounts.

It is not possible at this time to project savings for FY 2011 as the CMS Federal Rebate amounts have not been published under the stipulations of ACA. Calculations of supplemental rebate amounts are dependent on the Federal Rebate amounts.

**Table 1: Estimated Savings by Quarter FY 2010**

Savings Projections FY 2010				
Calendar Qtr	LA Fiscal Qtr	Quarterly Savings	Jan 2009 Revised Budget Estimate per Quarter	Comment
2Q09	Q110	\$ 12,408,971	\$ 9,656,426	Actual 2Q2009
3Q09	Q210	\$ 12,345,714	\$ 9,656,426	Actual 3Q2009
4Q09	Q310	\$ 13,893,704	\$ 9,656,426	Actual 4Q2009
1Q10	Q410	ESTIMATED \$ 7,747,517	\$ 9,656,426	Estimated 1Q2010 following use of mfg submitted estimated federal rebate amounts. Impact of ACA implementation on Federal Rebate rules.
Totals		<b>ESTIMATED \$ 46,395,906</b>	<b>\$ 38,625,704</b>	

#### IV. Features of the Louisiana Medicaid PDL that Impact Savings

**Weakness:** The feature of Louisiana's program that possibly affects savings to the greatest extent is the statutorily mandated continuity of care process. Under continuity of care program, a patient whose prescription medication is non-preferred may continue to take the non-preferred medication for up to six months or five refills. While this approach has minimized the initial impact of the PDL on patients, usage has not shifted as quickly to preferred medications, and savings have not been realized as quickly as would otherwise have been possible.

**Strengths:** Louisiana participates in the multi-state purchasing pool and benefits from volume purchasing but maintains autonomy in PDL decisions. States receive in some cases better offers for supplemental rebates as a part of the TOP\$ program compared to other single states soliciting for supplemental rebates.

#### Conclusion

The LDHH PDL program continues to be extremely successful. Savings for FY 2009 were \$37.3 million. For the first three quarters of FY 2010, the savings are \$38.6 million with the estimated year end savings of \$46.4 million. It is not possible to finalize the savings report for CY1Q10 since CMS has yet to publish Federal Rebate amounts.

Similar to other states with competitive selection based PDL models, prices have continued to drop or at worst stabilize in each subsequent review of each class. Louisiana's leadership in establishing the TOP\$<sup>SM</sup> multi-state program accelerated this trend.

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