Maryland Pharmacy Program
PDL P&T Meeting

Minutes from May 5, 2016

UMBC Research and Technology Park

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Attendees:

<u>P&T Committee</u>

Zakiya Chambers (Chairperson); Jenel Steele Wyatt (Vice Chairperson); Esther Alabi; Sharon Baucom; Kim Leah Bright; Damean Freas; Amol Joshi; Evelyn White Lloyd; Marie Mackowick; Devang Patel; Emily Pherson; Karen Vleck

<u>Department of Health and Mental Hygiene (DHMH)</u>

Athos Alexandrou (Maryland Pharmacy Program Director); Dixit Shah (Maryland Pharmacy Program Deputy Director); Shannon McMahon (Deputy Secretary, Health Care Financing); Lisa Burgess (Chief Medical Officer); Nicole Clark, (Esquire, Attorney General's Office); Paul Holly (Consultant Pharmacist to Maryland Pharmacy Program); Dennis Klein (Maryland Pharmacy Program Pharmacist); Shawn Singh (Maryland Pharmacy Program Supervisor)

<u>Xerox</u>

John LaFranchise, Sr., RPh

<u>Magellan Health/Medicaid Administration (MH/MMA)</u>

Nina Bandali, PharmD

Anju Harpalani, PharmD, MBA, BCACP

Proceedings:

The public meeting of the PDL P&T Committee was called to order by the Chairperson, Dr. Chambers, at 9:00 a.m. The meeting began with brief introductions of all the representatives including the P&T Committee members, DHMH, and MH/MMA staff. The Committee then approved the minutes from the previous P&T Committee meeting held on November 5, 2015.

Dr. Chambers then called upon Mr. Alexandrou to provide a status update on the Medicaid Pharmacy Program. Mr. Alexandrou stated that there were five new members on the Committee who are replacing the following former P&T Committee members: Dr. Boronow, Dr. Lann, Dr. Miller, Dr. Pinto and Dr. Schor. He acknowledged the former members for their time and dedication to the Committee and extended a welcome to all of

the five new members. He further stated that Certificates of Appreciation, signed both by him and Secretary Mitchell have been sent to all the former members.

Mr. Alexandrou reminded everyone that at the last P&T meeting in November he had indicated that Matt Lennertz, the Maryland Account Manager from Magellan Health had resigned. He further announced that Magellan had now recruited a new Clinical Account Manager, Dr. Anju Harpalani, and welcomed her to the team on behalf of the department.

Mr. Alexandrou stated that this meeting marked the beginning of the thirteenth year of Maryland's Preferred Drug List (PDL). Over these years, the Medicaid Program has saved tens of millions of dollars in its expenditures for prescription drugs due to the PDL. These savings have allowed the State of Maryland to manage costs without reducing covered services for Medicaid members. He reminded everyone that the Program's goal is to provide safe clinically sound and cost effective medications to the Maryland Medicaid members.

Mr. Alexandrou further stated that the State of Maryland is currently experiencing an opioid addiction and overdose epidemic. Between 2008 and 2014, age-adjusted prescription opioid-related hospital emergency department admission rates more than doubled, while heroin-related admission rates nearly quadrupled. Drug and alcohol-related emergency department visits cost $14.4 million in 2014 and were mostly paid for by Medicaid. Between 2008 and 2013, heroin-related admissions to publicly-funded substance use disorder treatment programs increased from 31% to 38% of all admissions reported to the State, while prescription opioid-related admissions increased from 13% to 20%. In 2014, 86% of the 1,039 unintentional overdose deaths in Maryland involved opioids alone or in combination with other substances. Prescription opioids were involved in 32% of all overdose deaths, often in combination with heroin, benzodiazepines and/or alcohol. Between 2010 and 2014, the total number of overdose deaths increased 60%, driven by a 143% rise in heroin-related deaths. In 2015, just over 9 million controlled dangerous substance prescriptions were dispensed in Maryland, written by 73,941 prescribers. Mr. Alexandrou explained that, of the eligible prescribers, 19% are registered with the Prescription Drug Monitoring Program (PDMP), and of those practitioners, 60% actively check the PDMP. Although the final numbers for 2015 are not yet available, deaths have increased at least 21% since 2014. The local police department in Wicomico County on Maryland's Eastern Shore reported responding to 100 overdoses in 2015 and already surpassing that number in the first quarter of 2016. The Anne Arundel County Police Department has also reported increases in overdose calls within the same timeframe.

The State has taken a comprehensive approach to combating the heroin epidemic. The State's activities can largely be grouped into five major categories. These are prevention, treatment and recovery, harm reduction, law enforcement, and lastly, data performance and measurement.

Mr. Alexandrou provided an update on a number of activities that Medicaid has undertaken. These include instituting a corrective managed care program; carving out naloxone; which has had the impact of greatly improving access to claims; asking the

federal government in our waiver application to allow the State to provide presumptive eligibility for Medicaid-eligible individuals leaving jails and prisons in the State as well as to cover residential treatment for individuals with substance use disorders; circulating a draft proposal to rebundle the Medicaid rate for methadone treatment; and lastly, working with the Health Home Advisory Committee to determine the real and perceived barriers for opioid treatment programs to become health homes.

Mr. Alexandrou further remarked that over the last two years, the Department has been working on changing a pharmacy reimbursement methodology to utilize National Average Drug Acquisition Cost, commonly referred to as NADAC. The NADAC was developed by Centers for Medicare & Medicaid Services (CMS) and was designed to create a national benchmark that relates to the prices paid by the retail community pharmacies to acquire prescription and some over-the-counter outpatient medications. In 2014, a fiscal impact analysis was completed and its results revealed that utilizing actual acquisition costs with an enhanced professional dispensing fee would be overall cost neutral to the State. In March of last year, a pharmacy stakeholders' meeting was held to share the proposed reimbursement methodology and the results of the cost feasibility analysis. On January 21st of this year, CMS published in the Federal Register, the final rule which implements provisions of the Affordable Care Act, pertaining to Medicare reimbursement for covered outpatient drugs. State Medicaid agencies must ensure that the reimbursement methodologies, as they relate to ingredient costs and professional dispensing fees, are aligned with CMS' final ruling. The Maryland Medicaid Pharmacy Program (MMPP) team is currently reviewing the rule to determine how it affects their proposed reimbursement methodology which was shared with pharmacy stakeholders in March of last year. With the exception of the implementation of the Affordable Care Act, Federal Upper Limits (FUL) for generic drugs, which was implemented last month, all other provisions of the rule must be implemented by April 2017. Additional information will be provided at the next P&T committee meeting in November 2016.

Mr. Alexandrou reminded everyone that the Maryland Medicaid prior authorization process is quick, simple and significantly less cumbersome than many other prior authorization processes. Additionally, when compared to other states as well as the private sector, the Maryland Preferred Drug List stands out in the fact that many more options of preferred drugs are provided. Last quarter, prescribers achieved over a 94.6% compliance rate with the Maryland Medicaid Preferred Drug List.

He also noted that the Preferred Drug List remains accessible on the Maryland Medicaid Pharmacy Program's website and through Epocrates. In addition, the Pharmacy Hotline remains active, answering over 2,200 calls each month and approximately 4% of these calls pertain to the Preferred Drug List.

Mr. Alexandrou expressed his sincere gratitude to all of the P&T Committee members for dedicating their time to participate on this Committee.

Dr. Chambers' next called upon Ms. Shannon McMahon, the Deputy Secretary of Healthcare Financing of DHMH to provide an update of Maryland Medicaid Program. Ms. McMahon thanked everyone on behalf of Secretary Mitchell, for their service on the P&T Committee and emphasized how it is often hard to get volunteers especially those who are "on the ground" and active practitioners treating Medicaid patients. She expressed that the Committee's clinical expertise was extremely valuable and their input is critical to the decision making process for the Maryland Medicaid Preferred Drug List.

Ms. McMahon said that she underscored all that was presented by Mr. Alexandrou and pointed to the fact that the opioid crisis is a huge priority of Governor Hogan and Lieutenant Governor Rutherford and is being addressed from a multifaceted perspective. She further pointed to the fact that from a social determinant perspective and the Medicaid population that is served, the P&T Committee is well represented by members that are very aware of these issues and their input would be much appreciated during the review of the opioid drug class.

Ms. McMahon also called attention to the Medicaid Managed Care Organizations (MMCO's), of which there are eight, and that they function to serve the vast majority of the Medicaid population. A work group will be convened by Dr. Burgess with all the Chief Medical Officers there to look closely at drug utilization activities and review their opioid prescribing guidelines for the purpose of sharing best practices and informing mutually agreed upon standards of care for the Medicaid population.

Lastly, Ms. McMahon reiterated that there have been recent updates on opioid prescribing practices from the Center of Disease Control (CDC) and also CMS and thanked everyone on the Committee for all the input they provide to Medicaid.

Dr, Chambers thanked Ms. McMahon and announced that the next presentation on the agenda was by Dr. Renee Hilliard, Lead Pharmacist, CMS Drug Utilization Review and a subject matter expert on a number of areas such as opioids, opiate abuse, antipsychotics, alternate benefit plans and pediatric exclusivity for the Division of Pharmacy at CMS.

Dr. Hilliard presented the CDC guidelines on prescribing opioids which encourage primary care providers to implement best practices for responsible prescribing, specifically, by promoting the use of non-opioid and non-pharmacologic therapies whenever possible. Additionally, the guidelines recommend starting with the lowest possible dose of opioids and titrating up slowly, combined with routine follow-up and monitoring of patients to ensure that opioids are improving pain and function without causing harm.

Dr. Hilliard further stated that the Department of Health and Human Services (DHHS) has three important goals, which are, to improve opioid prescribing practices; increase awareness and education on opioid overdose prevention; and finally to expand access to substance use disorder treatment, including medication-assisted treatment for opioid use disorders.

Finally, Dr. Hilliard spoke about CMS initiatives and the various measures that are being undertaken to combat the opioid epidemic, including an overview of Medicaid best practices for addressing prescription opioid overdose, misuse, and addiction.

Dr. Chambers thanked Dr. Hilliard for her update and acknowledged that it was time for the public presentation period to begin. As customary, pre-selected speakers have 5 minutes and there is no question and answer period or demonstrations.

Name	Affiliation	Class/Drug of Interest
Angela Traynor	Consumer	Opiate Dependence Treatment Agents
Paul Katz, DO, FASAM, FACA	Orexo	Opiate Dependence Treatment Agents
Kristin Loehr, BA	TAGI Pharma	Alendronate Sodium Oral Solution
Elizabeth Stanley, MPH	Boehringer-Ingelheim Pharmaceuticals	Pradaxa, Jardiance
Janet Gripshover, MSN	Consumer	Hepatitis C Agents
Jerod Downing, PharmD	Purdue Pharma, LP	Butrans, Hysingla ER
Lilla Horvath MD	Sanofi Genzyme	Aubagio
Jodi Jensen, PharmD	Biogen	Tecfidera
Ali Toumadj, PharmD	Gilead Sciences	Harvoni
Paul Hueseman, PharmD	AstraZeneca, LP	Brilinta, Movantik
Mark Veerman, PharmD	Janssen Scientific Affairs, LLC	Xarelto, Invokana
Melanie Shadoan, Ph.D.	United Therapeutics	Orenitram, Tyvaso
Timothy Birner, PharmD, MBA	Alkermes	Aristada

Following the presentation by 13 speakers, Mr. John LaFranchise from Xerox, the claims processor, was called upon to present the prior authorization (PA) report. He stated that in the first quarter of 2016, there were 2,643 new PDL PA approvals. The number one requested PA class was the opiate dependence treatments and this was also the number one requested PA class in the fourth quarter of 2015, with about half as many requests. The number of PAs for this class alone in the first quarter of 2016 was equal to the average total top ten PDL PAs in recent quarters. The drugs Evzio and Vivitrol each had more requests than any of the other nine classes in the top 10 classes of the first quarter of 2016.

Mr. LaFranchise stated that the most likely drivers are increased awareness of opioid addiction and overdose and the Maryland Overdose Response Program. The remaining classes in the top ten were anticonvulsants; antidepressants; antipsychotics; sedative hypnotics; stimulants and related agents; analgesics, narcotics; glucocorticoids orally inhaled; anticoagulants, and beta agonist bronchodilators. The top ten were 86% of all PDL PAs for the first quarter of 2016. Dr. Alabi then asked what the typical turnaround time was for PAs and Mr. Lafranchise responded that it was 24 hours.

Dr. Chambers stated that the classes of drugs scheduled for review today have been posted on the MMPP website and are listed on the meeting agenda.The classes to be reviewed first are the three opioid-related classes followed by classes with unchanged recommendations, classes with new recommendations and finally single-drug reviews. Dr. Nina Bandali from Magellan Health reviewed these three opioid-related classes.

Following Dr. Bandali's presentation on the opioid classes, Dr. Sharon Baucom, who serves as the Chief Medical Officer for the Department of Corrections made a statement for consideration. She stated that Suboxone film had replaced heroin as the top illicit drug used in correctional facilities across the nation and also in Maryland. She provided many examples on ways that the film was smuggled into the prisons and detention centers making it easy for inmates to access and abuse. She further emphasized the devastation and impact of this on the inmates, their families and the community and urged the Committee to consider other alternatives for inclusion on the preferred drug list (PDL). Additionally, Dr. Baucom made a motion to remove Suboxone film from the PDL and add Zubsolv SL as preferred. The motion was seconded and carried. Voting results for the three classes are summarized below,

Class	Voting Result
Analgesics, Narcotics (Long Acting)	**ADD:** Embeda **REMOVE**: Methadone **Other preferred agents:** generics (fentanyl patch, morphine sulfate SR), Kadian
Analgesics, Narcotics (Short Acting)	**Maintain current preferred agents:** generics (apap/codeine, butalbital/apap/codeine/caffeine, butalbital/asa/codeine/caffeine, codeine tablets, hydrocodone/apap, hydrocodone/ibuprofen, hydromorphone tablets, morphine sulfate tablets, morphine sulfate solution, oxycodone capsules, oxycodone tablets, oxycodone solution, oxycodone/apap, tramadol, tramadol/apap)
Opiate Dependence Treatment	**ADD:** Narcan Nasal Spray, Zubsolv SL Tablets **REMOVE**: Suboxone Film **Other preferred agents:** generics (buprenorphine, naloxone, naltrexone)

Dr Chambers stated that there were 32 classes that had no recommended changes from the existing PDL. Dr. Chambers also stated that Dr. Joshi would recuse himself from voting on the Angiotensin Modulator Combinations; Antiemetic/Antivertigo Agents; Hepatitis B agents; Lipotropics, Other; Lipotropics, Statins; Pulmonary Arterial

Hypertension Agents, Oral and Inhaled; as well as Pancreatic Enzymes classes of drugs. Once again, Dr. Nina Bandali of Magellan Health provided clinical updates on the 32 classes of drugs with no new recommendations.

During the review of the Anticoagulants, Dr. Pherson made a motion to add Xarelto to the Preferred Drug List. Discussion ensued by the Committee members. After the discussion, Dr. Chambers asked if the motion was seconded. Instead, the Committee members voted to wait until they had more information pertaining to cost and clinical/safety data to make a final decision on whether to add Xarelto or another oral anticoagulant to the PDL.

Dr. Chambers then said that since no motions were carried with regards to specific recommendations, the recommendation by Magellan Health (listed below) for no change in the 32 classes were approved with the understanding and expectation that the Anticoagulant class would be reviewed again at the November P&T meeting.

Class	Voting Result
Acne Agents, Topical	**Maintain current preferred agents:** generics (benzoyl peroxide OTC, clindamycin, erythromycin, erythromycin/benzoyl peroxide, tretinoin), Azelex, Differin cream, Differin lotion
Androgenic Agents	**Maintain current preferred agents:** testosterone gel
Angiotensin Modulator Combinations	**Maintain current preferred agents:** generics (amlodipine/benazepril, amlodipine/valsartan, amlodipine/valsartan/HCTZ)
Antibiotics, GI	**Maintain current preferred agents:** generics (metronidazole tablets, neomycin, vancomycin), Alinia
Antibiotics, Topical	**Maintain current preferred agents**: generics (bacitracin OTC, bacitracin/polymyxin OTC, gentamicin, mupirocin ointment, triple antibiotic OTC)
Antibiotics, Vaginal	**Maintain current preferred agents**: generics (clindamycin, metronidazole vaginal), Cleocin ovule
Anticoagulants	**Maintain current preferred agents**: generics (enoxaparin, warfarin), Fragmin

Antiemetic/Antivertigo Agents	**Maintain current preferred agents**: generics (dimenhydrinate, dimenhydrinate OTC, meclizine, meclizine OTC, metoclopramide, ondansetron, ondansetron ODT, prochlorperazine, promethazine) Emend capsules, TransDerm Scop
Antifungals, Oral	**Maintain current preferred agents**: generics (clotrimazole troches, fluconazole, griseofulvin suspension, ketoconazole, nystatin suspension and tablets, terbinafine)
Anti-Migraine Agents, Triptans	**Maintain current preferred agents**: generics (rizatriptan, rizatriptan ODT, sumatriptan), Relpax
Antiparasitics, Topical	**Maintain current preferred agents:** generics (permethrin, permethrin OTC, piperonyl/pyrethrins OTC, piperonyl/pyrethrins/permethrin OTC), Ulesfia
Antivirals, Oral	**Maintain current preferred agents**: generics (acyclovir, rimantadine, valacyclovir)
Benign Prostatic Hyperplasia Treatments	**Maintain current preferred agents:** generics (alfuzosin, doxazosin, finasteride, tamsulosin, terazosin)
Bladder Relaxant Preparations	**Maintain current preferred agents:** generics (oxybutynin, oxybutynin ER), Toviaz
Bone Resorption Suppression and Related Agents	**Maintain current preferred agents:** generics (alendronate tablets, calcitonin nasal), Fortical
Cephalosporin and Related Agents	**Maintain current preferred agents:** generics (amoxicillin/clavulanate, cefaclor, cefaclor ER, cefadroxil capsules, cefdinir, cefixime suspension, cefprozil, cefuroxime, cephalexin), Suprax capsules
Fluoroquinolones, Oral	**Maintain current preferred agents**: generics (ciprofloxacin tablets, levofloxacin tablets)
Gastrointestinal Motility, Chronic	**Maintain current preferred agents:** Amitiza, Linzess
Growth Hormones	**Maintain current preferred agents**: Genotropin, Norditropin, Nutropin, Nutropin AQ

Hepatitis B Agents	**Maintain current preferred agents:** Baraclude, Epivir HBV, Hepsera
Hypoglycemics, Incretin Mimetics and Enhancers	**Maintain current preferred agents**: Bydureon, Byetta, Janumet, Janumet XR, Januvia, Jentadueto, Symlin, Tradjenta
Hypoglycemics, Meglitinides	**Maintain current preferred agents**: generics (nateglinide, repaglinide)
Hypoglycemics, SGLT2 inhibitors	**Maintain current preferred agents:** Invokana (Step Therapy), Invokamet (Step Therapy)
Immunosuppressives, Oral	**Maintain current preferred agents**: generics (azathioprine, cyclosporine, cyclosporine modified, mycophenolate mofetil, sirolimus, tacrolimus), Rapamune solution, Sandimmune solution
Lipotropics, Other	**Maintain current preferred agents**: generics (cholestyramine, colestipol, fenofibric acid, fenofibrate tablets, gemfibrozil, niacin ER), Niacor
Lipotropics, Statins	**Maintain current preferred agents:** generics (atorvastatin, lovastatin, pravastatin, simvastatin)
Multiple Sclerosis Agents	**Maintain current preferred agents**: Avonex, Betaseron, Copaxone 20mg, Rebif
Pancreatic Enzymes	**Maintain current preferred agents**: generics (pancrelipase), Creon, Zenpep
Phosphate Binders and Related Agents	**Maintain current preferred agents**: generics (calcium acetate), Calphron OTC
Pulmonary Arterial Hypertension, Oral and Inhaled Agents	**Maintain current preferred agents**: generics (sildenafil), Letairis, Tracleer, Ventavis
Tetracyclines	**Maintain current preferred agents:** generics (doxycycline hyclate, doxycycline monohydrate tablets, doxycycline monohydrate 50mg and 100mg capsules, minocycline capsules, tetracycline)
Ulcerative Colitis Agents	**Maintain current preferred agents:** generics (balsalazide, sulfasalazine, sulfasalazine DR), Apriso, Canasa)

Immediately following were reviews of 13 classes with modified recommendations from the existing PDL and reviews of 6 classes with single drug reviews.

Dr. Chambers indicated that Dr. Joshi will recuse himself from participation in the class reviews due to a potential conflict of interest with the following classes: Angiotensin Modulators; Antibiotics, Inhaled; and Hepatitis C Agents. The following table reflects the voting results for each of the affected therapeutic categories:

Class	Voting Result
Angiotensin Modulators	**ADD:** Entresto **REMOVE:** captopril, fosinopril, fosinopril/HCTZ **Other preferred agents:** generics (benazepril, benazepril/HCTZ, captopril/HCTZ, irbesartan, irbesartan/HCTZ , lisinopril, lisinopril/HCTZ, losartan, losartan/HCTZ, quinapril, quinapril/HCTZ, ramipril, telmisartan, telmisartan/HCTZ, valsartan, valsartan/HCTZ)
Antibiotics, Inhaled	**DO NOT ADD:** tobramycin pak **Other preferred agents:** Bethkis, Kitabis Pak, Tobi Podhaler (Step Therapy)
Antifungals, Topical	**REMOVE:** econazole. Lotrimin AF **Other preferred agents**: generics (clotrimazole, clotrimazole OTC, clotrimazole/betamethasone, , ketoconazole cream, ketoconazole shampoo, miconazole OTC, nystatin, nystatin/triamcinolone, terbinafine OTC, tolnaftate OTC)
Antivirals, Topical	**ADD:** Zovirax cream **REMOVE:** acyclovir ointment **Other preferred agents:** Abreva OTC, Denavir
Beta Blockers	**REMOVE:** nadolol **Other preferred agents:** generics (atenolol, atenolol/chlorthalidone, bisoprolol/hctz, carvedilol, labetalol, metoprolol tartrate, metoprolol succinate XL, pindolol, propranolol, propranolol/HCTZ, propranolol LA, sotalol, sotalol AF)

Calcium Channel Blockers	**ADD:** diltiazem ER capsules, nifedipine **REMOVE:** diltiazem ER tablets **Other preferred agents:** generics (amlodipine, diltiazem, nicardipine, nifedipine ER, verapamil, verapamil ER),
Hepatitis C Agents	**ADD:** Zepatier **Other preferred agents:** generics (ribavirin) Daklinza, Harvoni, Pegasys, Peg-Intron, Sovaldi, Technivie, Viekira Pak
Hypoglycemics, Insulins and Related Agents	**DO NOT ADD:** Tresiba **REMOVE:** Humulin pen, Humulin 70/30 pen, Novolin **Other preferred agents**: Humalog, Humalog mix, Humulin vial, Lantus, Levemir, Novolog, Novolog mix
Hypoglycemics, TZDs	**REMOVE:** pioglitazone/glimepiride **Other preferred agents**: generics (pioglitazone,)
Macrolides/Ketolides	**REMOVE:** erythromycin base tablets **Other preferred agents**: generics (azithromycin, clarithromycin tablets, erythromycin base capsule DR), E.E.S., EryPed, Ery-Tab, Erythrocin
Platelet Aggregation Inhibitors	**REMOVE: aspirin/dipyridamole** **Other preferred agents**: generics (clopidogrel, dipyridamole, ticlopidine)
Proton Pump Inhibitors	**ADD:** Nexium suspension **Other preferred agents:** generics (lansoprazole, omeprazole, pantoprazole), Prevacid Solutab, Protonix suspension
Skeletal Muscle Relaxants	**REMOVE:** Carisoprodol **Other preferred agents:** generics (baclofen, ,

	chlorzoxazone, cyclobenzaprine, dantrolene, methocarbamol, orphenadrine, tizanidine tablets)
Single Drug Reviews	**Voting Results**
Antihyperuricemics	**DO NOT ADD:** Mitigare
Antipsychotics	**ADD:** Astrada **DO NOT ADD:** Vraylar
COPD Agents	**DO NOT ADD:** Seebri Neohaler, Utibron Neohaler
Cytokine and CAM Antagonists	**DO NOT ADD:** Xeljanz XR
Intranasal Rhinitis Agents	**DO NOT ADD:** Ticanase
Stimulants and Related Agents	**DO NOT ADD:** Dyanavel XR, Quillichew ER

~ The State will continue to monitor the pricing of generic drug products (both new and existing) and continues to maintain autonomy to modify or adjust the PDL status of multi-source brands and/or generic drugs that may become necessary as a result of fluctuations in market conditions (e.g. changes in Federal rebates, supplemental rebates, etc.).

During the review of the Hypoglycemics, Insulins, and Related Agents class, Dr. Wyatt asked if the Humalog Mix pen was also a 70/30 pen. Dr. Chambers replied that it was a 75/25 pen and Dr. Bandali clarified that all of the strengths are rolled up together.

Dr. Chambers informed that the next meeting was scheduled for November 3rd 2016 and asked whether there was any further business to present at this time.

Dr. Mackowick requested clarification on dosage conversion based on the Committee's earlier decision to move from Suboxone film to Zubsolv tablets as preferred for Opiate Dependence Treatment Agents. Specifically, she asked if there would be educational materials provided and appropriate outreach made to inform providers before this change went into effect on July 1st. Dr. Baucom also agreed with this point that was raised. Mr. Alexandrou responded that the State will work closely with the Behavioral Health Administration and appropriate outreach will be made to the prescribers.

With no further business to discuss, the public meeting was adjourned at 12.22 p.m.