Iowa Medicaid Drug Utilization Review Commission
Meeting Minutes August 6, 2014

Attendees:

Commission Members
Mark Graber, M.D., FACEP; Laurie Pestel, Pharm.D.; Gregory Barclay, M.D.; Kellen Ludvigson, Pharm.D.; Larry Ambroson, R.Ph.; Brett Faine, Pharm.D.; Brian Couse, M.D.; and Susan Parker, Pharm.D.

Staff
Pam Smith, R.Ph.

Guests
Jason Kessler, M.D., IME; Erin Halverson, R.Ph., IME; Megan Smith, Pharm.D., IME; and Melissa Biddle, IME.

Welcome & Introductions

Mark Graber, M.D. called the meeting to order at 9:32 a.m. at the Learning Resource Center in West Des Moines. The minutes from the June 4, 2014 meeting were reviewed. Gregory Barclay, M.D. motioned to accept them, and Brian Couse, M.D. and Brett Faine, Pharm.D. seconded simultaneously. All members were in favor. Annual conflict of interest disclosures were collected in closed session. Brett Faine, Pharm.D. nominated Mark Graber, M.D. to remain Chairperson. Laurie Pestel, Pharm.D. seconded, and all members were in favor. Kellen Ludvigson, Pharm.D. then nominated Laurie Pestel, Pharm.D. to remain Vice-Chairperson, which was seconded by Larry Ambroson, R.Ph. and agreed upon by all members. The recommendation letter sent to DHS after the June 2014 meeting, in addition to an article about the variation among states in the prescribing of opioids and benzodiazepines, were also reviewed.

IME Updates

Medicaid Director Jennifer Vermeer will be leaving Iowa Medicaid for a position at the University of Iowa effective August 21, 2014. Julie Lovelady will be interim director while a national search is conducted. Over 100,000 members are now enrolled in the Iowa Health and Wellness Plan (IHAWP). A new DHS website was launched in June, along with a new website featuring the latest information on IHAWP: http://www.iahealthlink.gov. A recent informational letter notified providers of a change to the dispensing fee effective August 1, 2014, increasing it to $11.73 once CMS approves the State Plan Amendment. Claims will be adjusted retroactively once approval is obtained.

Prevalence Report Summary

Statistics from May though June 2014 were discussed, including: cost per user ($287.06), number of total prescriptions dispensed (an increase of 1.2% compared to the previous reporting period), average cost per prescription ($59.02), and generic

utilization (83.8%). The total paid amount increased by 1.6% from the previous reporting period. There were 180,950 unique users, which is 1.5% less than the total for March and April. Lists of the top 20 therapeutic classes were provided. SSRIs had the highest prescription count, and Anticonvulsants came in second. The top 100 drugs were also reviewed. The ten most expensive medications were: *Abilify, Vyvanse*, methylphenidate hcl er, *Advate, Lantus, Focalin XR, Cymbalta, Adderall, Advair Diskus*, and *Strattera*.

Case Studies

Pam Smith, R.Ph. presented 4 case studies. Recommendations by Commissioners from these four examples resulted in annualized total savings of $3,191.10 pre-rebate (state and federal).

Public Comment

Name	Representing	Drug/Topic
Nancy Bell	Pfizer	Chronic Pain Syndromes PA Criteria and Lyrica
Amy Shertzer	Kaleo	Evzio
Neetha Molakala	Primary Health Care	Prior Authorization Issues (Inhalers and Insulin Pens)
Lorraine Dansie	Vanda Pharma	Hetlioz
Teresa Wakefield	Vanda Pharma (Ambassador)	Hetlioz

Focus Studies

Emergency Contraception: This was a follow-up discussion. One-hundred thirty-two (132) of the 227 members identified changed therapy, for an annualized cost savings of $461.58 (state and federal, pre-rebate) as a result of the 587 surveys sent out to prescribers and pharmacies. Responses were received for 239 (40.72%) of those surveys.

Albuterol MDI Over-Utilization: This was a follow-up discussion. Two-hundred (200) of the 522 members identified changed therapy, for an annualized cost savings of $52,346.55 (state and federal, pre-rebate) as a result of the 1,980 surveys sent out to prescribers and pharmacies. Responses were received for 734 (37.07%) of those surveys.

Albuterol MDI Over-Utilization without Inhaled Corticosteroid: This was a follow-up discussion. Twenty-five (25) of the 257 members identified changed therapy, increasing annual costs by $6,566.32 (state and federal, pre-rebate) as a result of the 783 surveys sent out to prescribers and pharmacies. Responses were received for 297 (37.93%) of those surveys.

Long Term Use of Short-Acting Opioids: The Commission wants to lower the existing quantity limits to a quantity of 120 per 30 days, or 4 per day. Kellen Ludvigson, Pharm.D. suggested using morphine equivalents to allow for titration without additional prior authorization. Erin Halverson will get more information about programming an accumulator in POS for the category, and if a “max 4 per day”

reject message could be added to rejected claims for the convenience of the pharmacies. Susan Parker, Pharm.D. suggested doing this in stages, with soft POS edits notifying providers of the changes prior to implementation of the quantity limits. Providers could be forewarned via letter before the limits are put into place. This will be brought back to the next meeting.

Prasugrel Contraindications: Letters will be sent to the prescribers of the six members identified as having a contraindication for use of prasugrel, and this topic will be revisited in 6 months to see if the numbers increase.

Duplicate Antipsychotics: Pam Smith, R.Ph. will rerun the numbers to include Typical Antipsychotics as well. This will be brought back to the next meeting.

Eszopiclone Dose: Letters will be sent to the providers of the members identified as taking eszopiclone 3mg to inquire if a dose reduction could be attempted based on the new FDA warning, and if not, if the patient has been warned of the risk of next-day impairment and was instructed not to drive or engage in other activities that require complete mental alertness the day after use.

Public Comment

Name	Representing	Drug/Topic
John Strezewski	Bristol-Myers Squibb	Eliquis
Lisa Willshaw	MedImmune	Synagis
Rachel Anhorn	Boehringer-Ingelheim	Pradaxa
Christina Reimers	Merck	Zontivity
Paul James	Genentech	Xolair

Prior Authorization

Chronic Pain Syndromes: The Commission reviewed the prior authorization criteria as follows:

A prior authorization is required for duloxetine (Cymbalta®), pregabalin (Lyrica®), and milnacipran (Savella™). For patients with a chronic pain diagnosis who are currently taking opioids, as seen in pharmacy claims, a plan to decrease and/or discontinue the opioid(s) must be provided with the initial request. Initial authorization will be given for three (3) months. There must be a significant decrease in opioid use or discontinuation of opioid(s) after the initial three (3) month authorization for further consideration. Additional prior authorizations will be considered with documentation of a continued decrease in opioid utilization. Payment will be considered under the following conditions:

1. *A diagnosis of **fibromyalgia** (Cymbalta®, Lyrica®, and Savella™)*
    a. *A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, SSRI, or SNRI, **WITH***

b. *Documented non-pharmacologic therapies (cognitive behavior therapies, exercise, etc.),* ***AND***

c. *Documentation of a previous trial and therapy failure at a therapeutic dose with Savella™ when Cymbalta® and Lyrica® are requested.*

2. *A diagnosis of* ***post-herpetic neuralgia*** *(Lyrica®)*

   A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant, topical lidocaine, valproate, or carbamazepine.

3. *A diagnosis of* ***diabetic peripheral neuropathy*** *(Cymbalta® and Lyrica®)*

   A trial and therapy failure at a therapeutic dose with gabapentin plus one of the following: tricyclic antidepressant or topical lidocaine.

4. *A diagnosis of* ***partial onset seizures****, as adjunct therapy (Lyrica®)*

5. *A diagnosis of* ***major depressive disorder*** *or* ***generalized anxiety disorder*** *(Cymbalta®)*

6. *A diagnosis of* ***chronic musculoskeletal pain*** *(Cymbalta®)*

   A trial and therapy failure at a therapeutic dose with at least three drugs from three distinct therapeutic classes from the following: NSAIDs, opioids, tramadol, or tricyclic antidepressants.

Requests for concomitant use of these agents for an indicated chronic pain diagnosis may only be considered once each agent has been tried at maximum tolerated dose separately. Duplicate use of drugs from the same therapeutic category will not be considered. Requests for doses above the manufacturer recommended dose will not be considered.

Brett Faine, Pharm.D. motioned to accept the criteria, and Brian Couse, M.D. seconded. All members were in favor. The criteria will be sent out for public comment and brought back to the next meeting for further discussion.

Naloxone (Evzio): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for naloxone auto-injector (Evzio). Payment will be considered for patients when the following criteria are met:

1. *Patient is currently being treated with a long-acting opioid for a chronic pain condition; and*
2. *Evidence of use of a long-acting opioid is found in the patients current pharmacy claims history (must be billed to and paid for by Iowa Medicaid); and*
3. *Documentation patient has a caregiver that will be able to administer Evzio should the patient be found unresponsive and an opioid overdose is suspected; and*
4. *Patient has a contraindication to use of intranasal naloxone; and*
5. *The prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program website at*

https://pmp.iowa.gov/IAPMPWebCenter/Login.aspx?ReturnUrl=%2fIAPMPWebCenter%2fdefault.aspx prior to requesting prior authorization.

6. *Lost, stolen, or destroyed medication replacement requests will not be authorized.*
7. *The 72-hour emergency supply rule does not apply to naloxone auto-injector products.*

The commission determined the delivery system used for administration of naloxone was a convenience for the patient or patient's caregiver. Additionally, the commission determined that the use of intranasal naloxone would be the least costly service which would reasonably meet the medical need of the patient. Since the DUR determined Evzio is a convenience item and there are other cost-effective alternatives to Evzio, the DUR recommends not covering this product. Kellen Ludvigson, Pharm.D. made the motion to refer this recommendation to the P&T Committee, and Brian Couse, M.D. seconded. All members were in favor. The P&T Committee will discuss this at their November meeting.

Oral Immunotherapy: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for sublingual allergen immunotherapy. Payment will be considered under the following conditions:

1. *Medication is prescribed by an allergist; and*
2. *Patient is diagnosed with pollen-induced allergic rhinitis with or without conjunctivitis; and*
3. *Patient has documented trials and therapy failures with allergen avoidance and pharmacotherapy (intranasal corticosteroids and antihistamines); and*
4. *Patient has a documented intolerance to immunotherapy injections; and*
5. *The first dose has been administered under the supervision of a health care provider to observe for allergic reactions (date of administration and response required prior to consideration).*
6. *If patient receives other immunotherapy by subcutaneous allergen immunotherapy (SCIT), treatment of allergic rhinitis with sublingual allergen immunotherapy (SLIT) will not be approved.*

Short Ragweed Pollen (Ragwitek®) In addition to the above criteria being met:

- *Patient is 18 through 65 years of age; and*
- *Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to short ragweed pollen.*
- *If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of ragweed pollen season and continued throughout the season.*

Grass Pollen (Grastek® and Oralair®) In addition to the above criteria being met:

Grastek®

- *Patient is 10 through 65 years of age (Oralair®); and*

- *Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to sweet vernal, orchard/cocksfoot, perennial rye, timothy, and Kentucky blue/June grass.*
- *If criteria for coverage are met, authorization will be considered at least 4 months prior to the expected onset of each grass pollen season and continued throughout the grass pollen season; or*

Oralair®

- *Patient is 5 through 65 year of age (Grastek®); and*
- *Patient has a positive skin test or in vitro testing (pollen-specific IgE antibodies) to timothy grass (or cross reactive grasses such as sweet vernal, orchard/cocksfoot, perennial rye, Kentucky blue/June, meadow fescue, and redtop).*
- *If criteria for coverage are met, authorization will be considered at least 12 weeks before the expected onset of each grass pollen season.*

Brian Couse, M.D. motioned to accept the criteria as amended, and Larry Ambroson, R.Ph. seconded. All members were in favor. The criteria will be sent out for public comment and brought back to the next meeting for further discussion.

Methotrexate Injection: The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for non-preferred methotrexate injection. Payment will be considered under the following conditions:

1. *Diagnosis of severe, active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) and ALL of the following:*
   a. *Prescribed by a rheumatologist; and*
   b. *Patient has a documented trial and intolerance with oral methotrexate; and*
   c. *Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, minocycline or sulfasalazine); and*
   d. *Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and*
   e. *Patient does not reside in a long-term care facility.*
2. *Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following:*
   a. *Patient is 18 years of age or older; and*
   b. *Prescribed by a dermatologist; and*
   c. *Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy).*
   d. *Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance; and*
   e. *Patient does not reside in a long-term care facility.*

   The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Kellen Ludvigson, Pharm.D. motioned to accept the criteria, and Brett Faine, Pharm.D. seconded. All members were in favor. The criteria will be sent out for public comment and brought back to the next meeting for further discussion.

Tasimelteon (Helitoz): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for tasimelteon (Hetlioz) Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered under the following conditions:

1. *Patient has a diagnosis of Non-24-Hour Sleep-Wake Disorder (Non-24) as confirmed by a sleep specialist; and*
2. *Patient is 18 years of age or older; and*
3. *Documentation the patient is totally blind with no perception of light is provided; and*
4. *Patient has a documented trial and therapy failure with at least one preferred sedative/hypnotic – non-benzodiazepine agent; and*
5. *Patient has a documented trial and therapy failure with ramelteon (Rozerem).*

If criteria for coverage are met, initial requests will be given for 3 months. Requests for continuation of therapy will be considered when the patient has received 3 months of continuous therapy and patient has achieved adequate results with tasimelteon (Hetlioz), such as entrainment, significant increases in nighttime sleep, and/or significant decreases in daytime sleep.

Brett Faine, Pharm.D. motioned to accept the criteria as amended, and Larry Ambroson, R.Ph. seconded. All members were in favor. The criteria will be sent out for public comment and brought back to the next meeting for further discussion.

Apremilast (Otezla): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for apremilast (Otezla®). Payment will be considered under the following conditions:

1. *Patient is 18 years of age or older; and*
2. *Patient has a diagnosis of active psoriatic arthritis (≥ 3 swollen joints and ≥ 3 tender joints); and*
3. *Prescribed by a rheumatologist or a dermatologist; and*
4. *Patient does not have severe renal impairment (CrCl < 30 mL/min); and*
5. *Patient has documentation of a trial and inadequate response to therapy with the preferred oral DMARD, methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated); and*
6. *Patient has documentation of trials and therapy failures with two preferred biological agents used for psoriatic arthritis.*

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Larry Ambroson, R.Ph. motioned to accept the criteria, and Gregory Barclay, M.D. seconded. All members were in favor. The criteria will be sent out for public comment and brought back to the next meeting for further discussion.

Palivizumab (Synagis): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for therapy with palivizumab. Prior authorizations will be approved for administration during the RSV season for a maximum of five doses per patient. No allowances will be made for a sixth dose. Patients, who experience a breakthrough RSV hospitalization, should have their monthly prophylaxis discontinued, as there is an extremely low likelihood of a second RSV hospitalization in the same season. Payment for palivizumab will be considered for patients who meet one of the following criteria:

Chronic Lung Disease (CLD) of Prematurity

- *Patient is less than 12 months of age at start of therapy and develops CLD of prematurity (defined as gestational age less than 32 weeks and required greater than 21% oxygen for at least the first 28 days after birth.*
- *Requests for patients during their second year of life (12 months to < 24 months) will be considered for patients meeting the CLD of prematurity definition above and continue to require medical support (chronic corticosteroid therapy, diuretic therapy, or supplemental oxygen) during the 6-month period before the start of the second RSV season.*

Hemodynamically Significant Congenital Heart Disease (CHD)

- *Patient is less than 12 months of age at start of therapy and has hemodynamically significant CHD further defined by any of the following:*
  - *Patient with acyanotic heart disease who is receiving medication to control congestive heart failure and will require cardiac surgical procedures or*
  - *Patient with moderate to severe pulmonary hypertension.*
  - *Requests for patients with cyanotic heart defects will be considered with documentation of consultation with a pediatric cardiologist that recommends patient receive palivizumab prophylaxis.*

Premature Infants (without CLD of Prematurity or CHD)

- *Patient is less than 12 months of age at start of therapy with a gestational age of less than 29 weeks.*

Children with Anatomic Pulmonary Abnormalities or Neuromuscular Disorder

- *Patient is 12 months of age or younger at the start of therapy and has either severe neuromuscular disease or congenital anomaly that impairs the ability to clear secretions from the upper airway due to an ineffective cough.*

Immunocompromised Children

- *Patient is less than 24 months of age at start of therapy and is profoundly immunocopromised during the RSV season (e.g., severe combined immunodeficiency, advanced acquired immunodeficiency syndrome, receiving chemotherapy).*

Larry Ambroson, R.Ph. motioned to accept the criteria as amended, and Brian Couse, M.D. seconded. All members were in favor. The criteria will be sent out for public comment and brought back to the next meeting for further discussion.

Vorapaxar (Zontivity): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for vorapaxar (Zontivity™). Payment will be considered under the following conditions:

1. *Patient has a history of myocardial infarction (MI) or peripheral artery disease; and*
2. *Patient does not have a history of stroke, transient ischemic attack (TIA), intracranial bleeding, or active peptic ulcer; and*
3. *Patient has documentation of an adequate trial and therapy failure with clopidogrel; and*
4. *Patient will use concurrently with aspirin and/or clopidogrel.*

The required trial may be overridden when documented evidence is provided that the use of this agent would be medically contraindicated.

The Commission wondered if a trial and therapy failure on aspirin should be added. This will be revised and brought back to the next meeting.

Omalizumab (Xolair): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for Xolair®. Payment for Xolair® will be authorized when the following criteria are met:

Moderate to Severe Persistent Asthma

1. *Patient has a diagnosis of moderate to severe persistent asthma for at least one year; and*
2. *Patient is 12 years of age or older; and*
3. *Pretreatment IgE level is between 30 IU/mL and 700 IU/mL; and*
4. *Patient's weight is between 30 kg and 150 kg; and*
5. *History of positive skin or RAST test to a perennial aeroallergen; and*
6. *Prescriber is an allergist, immunologist, or pulmonologist; and*
7. *Patient is currently using a high dose inhaled corticosteroid AND long-acting beta-agonist, is compliant with therapy and asthma symptoms are not adequately controlled after at least three (3) months of therapy.*
8. *Patient must have access to an EpiPen to treat allergic reactions that may occur after administration of Xolair®.*

If the criteria for coverage are met, the initial authorization will be given for 16 weeks to assess the need for continued therapy. Requests for continuation of therapy will not be granted for patients who have not shown adequate response to Xolair® therapy and for patients who do not continue concurrent use with a high dose corticosteroid and long-acting beta-agonist.

Chronic Idiopathic Urticaria

1. *Patient has a diagnosis of moderate to severe chronic idiopathic urticaria; and*
2. *Patient is 12 years of age or older; and*
3. *Patient has documentation of a trial and therapy failure with at least one second-generation antihistamine, one of which must be cetirizine at a dose up to 20 mg per day; and*
4. *Patient has documentation of a trial and therapy failure with at least one first-generation antihistamine; and*
5. *Patient has documentation of a trial and therapy failure with at least one potent H1 receptor antagonist (hydroxyzine and/or doxepin); and*
6. *Patient has documentation of a trial and therapy failure with a preferred leukotriene receptor antagonist in combination with a first or second-generation antihistamine.*

If criteria for coverage are met, the initial authorization will be given for 12 weeks to assess the need for continued therapy.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

As this was the second review of these criteria, no motion was necessary. The recommendation will be forwarded to the Department for consideration.

Apixaban (Eliquis): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for apixaban (Eliquis®). Payment will be considered under the following conditions:

1. *Patient does not have a mechanical prosthetic heart valve; and*
2. *Patient does not have active pathological bleeding; and*
3. *Patient has a diagnosis of non-valvular atrial fibrillation; with*
4. *Documentation of a previous trial and therapy failure with warfarin (TIA, stroke, or inability to maintain a therapeutic INR with a minimum 6 month trial); and*
5. *Presence of at least one additional risk factor for stroke, with a CHADS2 score ≥ 1; OR*
6. *For patients requiring deep vein thrombosis (DVT) prophylaxis undergoing hip or knee replacement. Requests will be considered when the patient has contraindications to use of the preferred agent(s). If patient meets criteria for coverage, requests will be approved for the following doses:*
    - *Hip replacement: 2.5 mg twice daily for up to 35 days following hip replacement; or*
    - *Knee replacement: 2.5 mg twice daily for up to 12 days following knee replacement.*

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

As this was the second review of these criteria, no motion was necessary. The recommendation will be forwarded to the Department for consideration.

Dabigatran (Pradaxa): The Commission reviewed the prior authorization criteria as follows:

Prior authorization is required for dabigatran (Pradaxa®). Payment will be considered for patients under the following conditions:

1. *Patient does not have a mechanical prosthetic heart valve; and*
2. *Patient does not have active pathological bleeding; and*
3. *Patient has documentation of a previous trial and therapy failure with warfarin (TIA, stroke, recurrence of DVT/PE, or inability to maintain a therapeutic INR with a minimum 6 month trial).*

Non-valvular atrial fibrillation (in addition to the above)

- *Patient has the presence of at least one additional risk factor for stroke, with a $CHADS_2$ score ≥ 1; and*
- *Patient does not have severe renal impairment (CrCl < 15mL/min) or is not on dialysis.*

Treatment and prevention of DVT or PE (in addition to the above)

- *Patient does not have a CrCl < 30mL/min or is not on dialysis.*
- *For patients with current DVT/PE, patient must have documentation of 5 to 10 days of parenteral anticoagulation prior to initiation of dabigatran.*

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

As this was the second review of these criteria, no motion was necessary. The recommendation will be forwarded to the Department for consideration.

Neuraminidase Inhibitor Utilization

The Commission is interested in developing prior authorization criteria, as studies have shown these only reduce symptoms by half a day. Additionally, to be effective, these have to be used within a very limited time frame that would be further reduced by a prior authorization process. Brett Faine, Pharm.D. and Mark Graber, M.D. offered to create some criteria. Pam Smith, R.Ph. will work with them and bring this to the next meeting. Erin Halverson, R.Ph. also suggested the three day emergency override option be removed for this drug class. Susan Parker, Pharm.D. said that was a possibility, as DHS has the right to determine what constitutes an emergency.

Miscellaneous

DUR Digest: The Commission members reviewed the draft for DUR Digest Volume 27, Number 1. Mark Graber, M.D. requested the wording for the first bullet on page 1 be updated. This was the first review and will be brought back to the next meeting for a second and final review.

MedWatch: The Commission members received FDA announcements concerning new Black Box Warnings.

A unanimous roll call vote was made at 12:38 to adjourn the meeting and move to closed session (motion by Larry Ambroson, R.Ph., second by Brian Couse, M.D. and Kellen Ludvigson, Pharm.D.).

The next meeting will be held at 9:30 a.m. on Wednesday, October 1, 2014, at the Learning Resource Center in West Des Moines.