

SPECIAL EDITION

Cost Containment Tips

The DoD Pharmacoeconomic Center offers these cost-saving ideas to help MTFs deal with their tight FY04 pharmacy budgets while continuing to provide clinically effective patient care. We highlight drugs that will meet the clinical needs of most patients at significantly lower cost than other drugs in the therapeutic class. We also provide tips for purchasing drugs at lower prices. Please note that prices may vary depending on formulary status at your facility.

Purchasing / Logistics Tips

Prescribing the most cost-effective agent is only half the battle—your facility has to buy the correct product to actually realize the savings.

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Statins

Nearly 70% of MTF atorvastatin (Lipitor) use is with the lower strengths (10-20 mg). Equivalent LDL-lowering can be achieved with 20-40 mg of **simvastatin (Zocor)** at a much lower cost (contract prices).

- Prescribe simvastatin 20 mg instead of atorvastatin 10 mg and save 59% per dose.
- Prescribe simvastatin 40 mg instead of atorvastatin 20 mg and save 64% per dose.

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Second-Generation Antihistamines

Use **loratadine (Claritin or generics)** instead of fexofenadine (Allegra), cetirizine (Zyrtec), or desloratadine (Clarinex) and save up to 87%. Loratadine costs from \$0.12 to \$0.38/tab compared to \$0.85/tab for Allegra, \$0.96/tab for Zyrtec, and \$0.89/tab for Clarinex.

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Proton Pump Inhibitors

Rabeprazole (Aciphex) and **lansoprazole (Prevacid)** cost only \$0.65/dose-75% less than either esomeprazole (Nexium) at \$2.55/dose or the Prilosec brand of omeprazole at \$2.64/dose.

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Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Use **traditional NSAIDs** (e.g., ibuprofen, naproxen, diclofenac) instead of COX-2 inhibitors — celecoxib (Celebrex), rofecoxib (Vioxx), or valdecoxib (Bextra)—for patients at low risk for NSAID-related GI adverse effects. COX-2 inhibitors cost ten times more per day than traditional NSAIDs.

Consider **meloxicam (Mobic)** for patients at increased risk. Meloxicam is on the Basic Core Formulary (BCF) and the weighted average cost per day is 43% less than COX-2 inhibitors.

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Selective Serotonin Reuptake Inhibitors (SSRIs)

Generic fluoxetine costs only \$0.035 per dose (contract price). Other SSRIs cost at least 25 times more.

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[Bisphosphonates](#)

Alendronate (Fosamax) is on the Basic Core Formulary (BCF) and costs 30% less than risedronate (Actonel). [Page 19](#)

[Triptans](#)

Start new triptan patients on **zolmitriptan** (Zomig). Zolmitriptan at \$3.20 per tablet (contract price) costs at least 20% less than any other triptan. Sumatriptan (Imitrex) costs 40% more per tablet than zolmitriptan. [Page 20](#)

[Thiazolidinediones](#)

Rosiglitazone (Avandia) is on the BCF and costs about 20% less than pioglitazone (Actos) at equivalent doses. [Page 21 - 22](#)

[ACE Inhibitors vs. Angiotensin Receptor Blockers \(ARBs\)](#)

Use **ACE inhibitors** rather than ARBs for patients with hypertension, unless the patient is unable to tolerate an ACE inhibitor. ACE inhibitors are also preferred for heart failure and reduction of renal disease progression in type 2 diabetic patients due to conclusive evidence of morbidity and mortality benefits. ACE inhibitors cost \$0.11 to \$0.29/dose-about 1/3 the cost of ARBs at \$0.48 to \$0.90/dose. [Page 23 - 24](#)

[Calcium Channel Blockers](#)

Don't use amlodipine (Norvasc) or felodipine (Plendil) for uncomplicated hypertension with no other medical problems. Follow JNC VII guidelines by initiating treatment with **thiazide diuretics** or **beta blockers**. Hydrochlorothiazide (\$0.008 / 25-mg tab) and beta blockers (\$0.02-0.04/tab for atenolol and metoprolol) are much less expensive than amlodipine (\$0.81 to \$0.89/tab) or felodipine (\$0.65 to \$1.11). [Page 25 - 27](#)

[LHRH Agonists for Prostate Cancer](#)

Use the contract agent, **goserelin acetate (Zoladex)**, instead of leuprolide acetate (Lupron Depot). Zoladex costs \$90 per month-40% less than Lupron at \$147-154 per month (based on strengths used for prostate cancer). [Page 28 - 29](#)

[Oral Fluoroquinolones](#)

- Whenever clinically appropriate, use **gatifloxacin (Tequin)** instead of levofloxacin (Levaquin). Gatifloxacin 400 mg is on the BCF and costs only \$1.35, compared to \$5.06 for levofloxacin 500 mg.
- Levofloxacin 500 mg costs nearly four times more than gatifloxacin for a 10-day course of therapy (\$13.50 vs. \$50.60). The 5-day course of therapy for CAP with levofloxacin 750 mg costs almost twice as much as a 10-day course of gatifloxacin (\$13.50/10-day course)

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[Putting the Tips to Work: Communicating with Providers](#)

Some commonsense suggestions about communicating cost containment information to your providers: work with your P&T committee, incorporate cost containment information into existing educational functions, and use CHCS to remind providers about preferred agents at the point of prescribing. [Page 32](#)

[Ted's Soapbox: Blood Glucose Test Strips & Betaseron](#)

The correct NDCs for ordering Precision QID & Xtra (don't pay extra!) and an incentive agreement for interferon beta-1b (Betaseron). [Page 33](#)

Editor's Notes: This issue, it's all about the money. Our regular columns will return next issue.

For some additional reading material in the meantime, check out the presentations from the 2004 DoD Pharmacoeconomics and Pharmacy Benefit Conference, which are now posted on the PEC website at www.pec.ha.osd.mil/2004_PEC_Conference/PEC_conference_2004.htm (the link to the presentations is on the right under the title). Presentations include briefs on the DoD pharmacy benefit, the TRICARE Mail Order Pharmacy (TMOP), the new TRICARE retail pharmacy (TRRx), plus multiple presentations focusing on the conference theme—improving the effectiveness of your Pharmacy & Therapeutics Committee.

A technical note: if you want to download one of these Powerpoint presentations, try right-clicking on the link to the presentation and selecting "save target as..." (in Microsoft Explorer) or "save link as..." (in Netscape). This may also help if you have a slower connection—some of the files are quite large.



Also, remember that the PEC's web forum for health care providers, [RxNet](#), is open for discussions of any or all of these cost containment tips. Come browse the forum or post a question and find out what other facilities are doing.

Our Disclaimer

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Submitting Articles

Do you have an article you'd like to see published in the *PEC Update*? Just send Shana Trice an e-mail, or call the PEC at DSN 421-1271, Commercial (210) 295-1271. Of course, this has never actually happened. (sigh).

Publication Schedule

The *PEC Update* is, in theory, published 10 times per year (monthly except July and December). This may change soon as we investigate format changes. We'll keep you informed.

Mark your Calendars...

For the 2005 DoD Pharmacoeconomics & Pharmacy Benefit Conference, 9-12 Jan 2005, San Antonio, TX. For more information, see www.pec.ha.osd.mil/2005_PEC_Conference/PEC_conference_2005.htm

Purchasing / Logistics Tips

- Be careful about NDCs for **loratadine**—prices range from as low as \$0.12 per 10-mg tablet to as high as \$1.73.
- If you are willing to deal with packaging issues, the over-the-counter version of **omeprazole** (Prilosec OTC) costs only \$0.52/dose
- The contracted price for lisinopril 20 mg is \$0.11, but MTFs are paying an average of \$0.26/dose for lisinopril due to non-availability of the contract drug. **Ramipril** (Altace) is readily available at \$0.12 /dose. If you are unable to obtain lisinopril at the contract price, encourage prescribers to use ramipril instead.
- Stop buying brand name Tiazac (no longer on contract). The FSS price for the **Inwood brand of diltiazem extended release** (Forest Labs' AB-rated generic) is \$0.26 per capsule for all strengths.
- Despite the recent introduction of generics (not yet available in all strengths), **Adalat CC** remains the lowest price **nifedipine extended release** at \$0.30 for all strengths.
- **Stop buying brand name drugs when less expensive generic equivalents are available.** Although this may sometimes be necessary when a less costly generic version is unavailable, some MTFs appear to be purchasing brand name drugs with multiple generic equivalents and no known supply issues. Examples include doxycycline (\$2.17 for Vibra-Tabs vs. \$0.035 for generic doxycycline 100 mg) and enalapril (\$0.71 for Vasotec vs. \$0.05 for generic enalapril 10 mg).
- **Buy contract drugs** rather than more expensive equivalents that are not under contract. Even a small difference in the price of a commonly used agent adds up. An example is glyburide—\$0.02 at contract prices vs. \$0.07 for non-contract versions. In some cases, the price range is extreme. For example, MTFs have purchased cyclobenzaprine at up to \$2.48 per tablet—the contract price is \$0.03. Monitor contract compliance.
- **Ask your Prime Vendor for a “backorder report/substitution list”** that is faxed to you daily after your order has been transmitted. **Identify contracted NDCs that are on backorder** and substitute another contracted NDC, if one exists, or make a note to continue checking for availability. **Spot-check your shelves** routinely to see if contracted products are still being ordered. Schedule regular meetings and in-services with updates on improving or declining contract compliance.
- **Helpful Websites**
 - For the DSCP National Contract List and Incentive Agreement Chart: <http://dmmonline.dscp.dla.mil/pharm/contractlist.asp>
 - For DSCP incentive agreements: <http://dmmonline.dscp.dla.mil/pharm/incentives.asp>
 - For VA incentive agreements, many of which apply to the DoD as well: www.vapbm.org/prices/incentives.pdf
 - For national pharmaceutical contract guidance: www.pec.ha.osd.mil/national_contracts.htm
 - For Basic Core Formulary listings: www.pec.ha.osd.mil/ac01001.htm
- During the 1st quarter of FY 04, MTFs bought contract drugs about 77% of the time. For the first quarter of FY 2004, cost avoidance from national pharmaceutical contracts was \$34 million out of a possible \$44 million. **If MTFs could increase contract compliance to 85%, they would save an additional \$12 million per year.**

Contact Defense Supply Center Philadelphia (DSCP) if you have difficulties obtaining contract drugs. NDC numbers and other information can be accessed on the DSCP website at <http://dmmonline.dscp.dla.mil/pharm/contractlist.asp>. A link to the DSCP page is also available on the PEC National Pharmaceutical Contracts page (www.pec.ha.osd.mil/national_contracts.htm).

Statins

- Based on all available projections and population models, we expect that 5-8% of patients needing statin therapy would require a statin with a greater degree of LDL reduction than simvastatin 80 mg. The statins that could be used in this situation are atorvastatin 80 mg and rosuvastatin 40 mg and possibly atorvastatin 40 mg and rosuvastatin 20 mg. The latter two examples only reduce LDL marginally more than simvastatin 80 mg, yet all of these come at a significantly higher price.
- Since our overall utilization was in line with population estimates, we didn't expect much opportunity to save costs until we examined the dose distribution. We found that nearly 70% of our atorvastatin and rosuvastatin use was with the lower strengths—atorvastatin 10 mg & 20 mg and rosuvastatin 5 mg & 10 mg—use that can clearly be covered with moderate doses of simvastatin at a much lower cost.
- There is little logical or clinical reasoning why the use of these strengths is prominent at MTFs. Likewise, there is little evidence supporting the need for dose titration for statins, in fact, the current labeling for atorvastatin now includes a 40 mg starting dose for individuals requiring significant LDL reductions, although the risk of adverse events increase for all statins as doses are raised.
- As a reminder, we have included below the contract prices and the NDCs for ordering simvastatin. Be aware that other NDCs exist for simvastatin that are NOT available at contract prices and are substantially more costly than the contracted NDCs. Please make sure you are buying simvastatin from this NDC list.
- Please note that there have not been any published trials comparing two or more statins at **equipotent dosages** showing superior clinical outcomes for any particular statin.
- Also below, we included our statin dosing equivalency chart for your reference. The chart is intended to allow clinicians to more easily select the statin dose based on the patient's requirement for LDL reduction. It is based on the average LDL reductions in published clinical trials; individual patient response will vary. An additional chart that predicts what statin dose will be required, based on LDL goal, may be found using the link below.
- For more information about the statin contract:
www.pec.ha.osd.mil/Contracts/Statin_Contract_Guidance.htm

PEC Points of Contact for Statins: Dave Bretzke, RPh, Clinical Pharmacy Analyst, PEC; LtCol Barb Roach, MD, Air Force Physician Representative, PEC

For Contract or Pricing Questions: Contact Maureen Gallagher, DSCP Pricing Team Leader via e-mail at paa3073@dscp.dla.mil or by phone at (215) 737-7893; or contact CDR Ted Briski (ted.briski@amedd.army.mil) or Mr. Dave Bretzke (david.bretzke@amedd.army.mil) at the PEC, (210) 295-1271.

Simvastatin (Zocor) Product Information

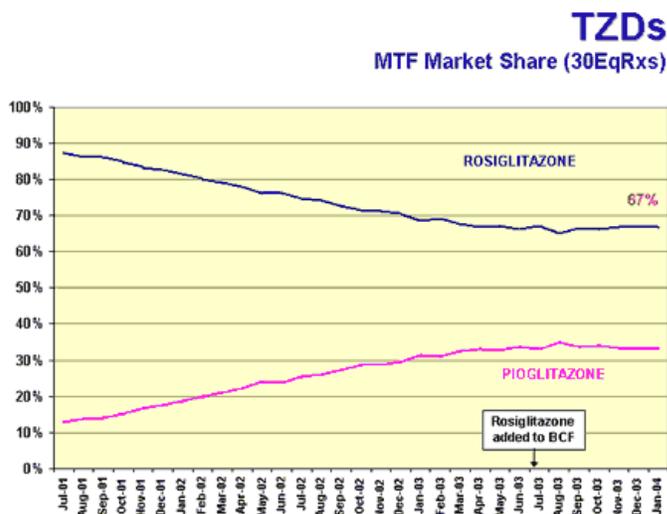
Strength	Dosage Form	NDC	Bottle Size	Price per Bottle	Price per Tablet
5 mg	Tablet	00006-0726-31	30	\$6.00	\$0.20
		00006-0726-54	90	\$18.00	
		00006-0726-28	100	\$20.00	
		00006-0726-82	1,000	\$200.00	
10 mg	Tablet	00006-0735-31	30	\$7.80	\$0.26
		00006-0735-54	90	\$23.40	
		00006-0735-28	100	\$26.00	
		00006-0735-82	1,000	\$260.00	
		00006-0735-87	10,000	\$2,600.00	
20 mg	Tablet	00006-0740-31	30	\$13.20	\$0.44
		00006-0740-54	90	\$39.60	
		00006-0740-28	100	\$44.00	
		00006-0740-82	1,000	\$440.00	
		00006-0740-87	10,000	\$4,400.00	
40 mg	Tablet	00006-0749-31	30	\$19.80	\$0.66
		00006-0749-54	90	\$59.40	
		00006-0749-28	100	\$66.00	
		00006-0749-82	1,000	\$660.00	
80 mg	Tablet	00006-0543-31	30	\$26.70	\$0.89
		00006-0543-54	90	\$80.10	
		00006-0543-28	100	\$89.00	
		00006-0543-82	1,000	\$890.00	

Statin Dose Equivalency Chart

% LDL-C Reduction	HMG-CoA Reductase Inhibitor				
	Pravastatin	Fluvastatin	Lovastatin	Simvastatin	Atorvastatin
18	10 mg	20 mg	10 mg	5 mg	10 mg
19					
20					
21	20 mg	40 mg	20 mg	10 mg	
22					
23					
24					
25					
26					
27	40 mg	80 mg	40 mg	20 mg	
28					
29					
30	80 mg		80 mg	40 mg	
31					
32					
33					
34					
35					
36					
37					
38				80 mg	
39					
40					
41					
42					
43					
44					
45					
46					
47					
48				80 mg	
49					
50					
51					
52					
53					
54					
55					
56					
57					
58					

Thiazolidinediones (TZDs)

- The primary clinical difference between rosiglitazone and pioglitazone relates to changes in lipid profiles – rosiglitazone may adversely affect lipid levels more so than pioglitazone. No randomized, controlled, head-to-head trials have been published that directly compare TZD effects on lipid levels as a primary outcome; available evidence comes from measurement of lipids performed as part of clinical efficacy studies with these agents. No morbidity/mortality studies are available. Diabetes itself is a risk factor for cardiovascular disease, thus the true clinical impact of a difference between the lipid effects of rosiglitazone and pioglitazone has yet to be determined.
- A table containing lipid results from TZD clinical trials and further discussion regarding the TZDs are available in the August 2002 DoD P&T Executive Council minutes (click [here](#) to download the minutes in pdf format).
- It is important to remember that metformin and the sulfonylureas still remain the first line choices for treating type 2 diabetics. TZDs are reserved for second or third line use in combination with the either sulfonylureas or metformin; neither rosiglitazone nor pioglitazone are indicated for triple therapy (TZD + metformin + sulfonylurea). Both TZDS are also indicated for use with insulin; both carry warnings for fluid retention when used with insulin. Patients with New York Heart Association (NYHA) class III/IV heart failure should not receive TZDs, due to the risk of fluid retention and symptom exacerbation.
- **Rosiglitazone is expected to meet the clinical needs of at least 90% of MTF patients.** Consider pioglitazone in a diabetic patient who has experienced adverse lipid changes with rosiglitazone, or in other special situations where the lipid profile is of utmost concern.
- Rosiglitazone (Avandia) is on the BCF, with discounted pricing based on market share under a national incentive agreement. When equivalent doses are considered, rosiglitazone costs about 20% less than pioglitazone (Actos). The higher the market share, the lower the cost of rosiglitazone. The current market basket for the TZD class shows rosiglitazone has 67% of MTF TZD prescriptions. You might see a local incentive agreement for pioglitazone, which requires local MTF formulary addition.
- If you need details regarding the incentive agreements and what the effective price for these products would be at your MTF, please contact DSCP or CDR Ted Briski or Mr. Dave Bretzke at the PEC (1-210-295-1271).
- The following graph shows the change in percent utilization of the TZDs ("market share") associated with addition of rosiglitazone to the BCF in July 2003. [Rosiglitazone/metformin (Avandamet) was also added to the BCF in July 2003; click [here](#) for meeting minutes in pdf format]



Source: PDTS

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PEC Points of Contact for TZDs: Angela Allerman, Pharm.D, Clinical Pharmacy Specialist, PEC; LtCol Barb Roach, MD; MC, USAF; Air Force Physician Representative, PEC

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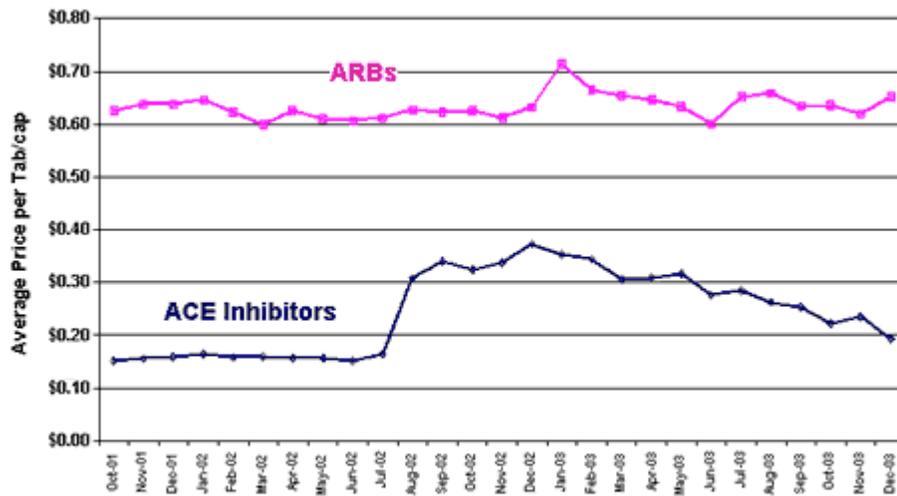
ACE Inhibitors vs. Angiotensin Receptor Blockers

- Angiotensin Converting Enzyme (ACE) inhibitors and Angiotensin Receptor Blockers (ARBs) show similar efficacy for hypertension. Because of the cost differential—ACE inhibitors are available for as low as \$0.11 per tab/cap, compared to \$0.48 to \$0.90 for ARBs—ACE inhibitors should be used for patients with hypertension unless the patient is unable to tolerate an ACE inhibitor.
- ACE inhibitors have proven mortality benefits in several conditions (e.g., heart failure post-myocardial infarction, congestive heart failure). Long term morbidity and mortality benefits with ARBs are still under investigation. It is likely premature to conclude that all ARBs will share the same clinical benefits ("class effect"), based on the different results reported in individual ARB trials (e.g., ValHeFT vs. CHARM; VALIANT vs. OPTIMAAL). Clinical experience and cost still support the use of ACE inhibitors instead of ARBs, particularly for chronic heart failure and in high risk patients post MI.
- Patients experiencing cough with one individual ACE inhibitor can sometimes find relief when switched to another ACE inhibitor, rather than starting an ARB. Use caution with patients who have experienced angioedema with an ACE inhibitor, since they can also experience angioedema with an ARB. So when would you use an ARB? When patients can't tolerate ACE inhibitors.
- Ensure that other causes of cough (e.g. upper respiratory infection) are ruled out before a patient is labeled as having an ACE cough. One VA study found success when switching patients from one ACE to another when cough occurred, before starting an ARB (Petropoulos 2002).
- The issue of when to use dual therapy with both an ACE inhibitor and an ARB (for CHF or diabetic renal disease) is not resolved.
- Although lisinopril is the most commonly used ACE in DoD, **ramipril** (Altace) is also a good choice due to its well-established morbidity and mortality benefits (HOPE trial), BCF status, and low price (\$0.12 for all doses). **Lisinopril** is available under a mandatory source contract at prices ranging from \$0.04-\$0.18/tab, depending on strength, but supply issues have been problematic. The average price paid by MTFs for lisinopril is \$0.26 per tab/cap (please see the chart and graph below for comparisons).

**Weighted average cost per tab/cap
for Lisinopril & Ramipril vs. ARBs**

Lisinopril	\$0.26
Ramipril	\$0.12
Candesartan	\$0.82
Eprosartan	\$0.77
Losartan	\$0.65
Valsartan	\$0.63
Irbesartan	\$0.59
Telmisartan	\$0.48
Olmesartan	\$0.48

ARB vs ACE average cost per unit, MTFs, based on prime vendor data



Source: Prime Vendor Data

Bottom-line

Use ACE inhibitors rather than ARBs for patients with hypertension, unless the patient is unable to tolerate an ACE inhibitor. ACE inhibitors are also preferred for heart failure and reduction of renal disease progression in type 2 diabetic patients due to conclusive evidence of morbidity and mortality benefits.

PEC Points of Contact for ACE inhibitors and ARBs: Angela Allerman, Pharm.D, Clinical Pharmacy Specialist, PEC; LtCol Barb Roach, MD; MC, USAF; Air Force Physician Representative, PEC

For Contract or Pricing Questions: Contact Maureen Gallagher, DSCP Pricing Team Leader via e-mail at paa3073@dscp.dla.mil or by phone at (215) 737-7893; or contact CDR Ted Briski (ted.briski@amedd.army.mil) or Mr. Dave Bretzke (david.bretzke@amedd.army.mil) at the PEC, (210) 295-1271.

Brief References

Mann D, Deswal A. Angiotensin-receptor blockade in acute myocardial infarction – a matter of dose. N Engl J Med 2003;349 (20): 1963-65.

Petropoulos JB. Success of a P&T policy for use of a second ACE inhibitor before switching to an ARB. Formulary 2002;37:97-98, 101.

Calcium Channel Blockers

Calcium channel blockers (CCBs) represent the seventh most expensive drug class in DoD as measured by prime vendor purchases, with \$45 million in annual expenditures in FY 2003. Of the three types of CCBs—diltiazem, verapamil, and the dihydropyridines—the dihydropyridine CCBs account for 81.4% of the dollar expenditures in the class.

Diltiazem

There has recently been a significant development in the extended release diltiazem group. The DoD/VA contract for Tiazac expired in December 2003 and was not renewed due to generic availability. However, Inwood (a subsidiary of Forest Labs) is offering an A-B rated generic to Tiazac at \$0.26 per capsule. **This price is even lower than the price offered for Tiazac under the original contract.** The table below shows NDC numbers, strengths and prices.

Extended Release Diltiazem (Inwood) Available at Reduced Prices

NDC Number	Item Description	Strength	FSS Price/tablet
00258-3687-90	Diltiazem HCL 120 mg Cap, SA	120 mg	\$0.26
00258-3688-90	Diltiazem HCL 180 mg Cap, SA	180 mg	
00258-3689-90	Diltiazem HCL 240 mg Cap, SA	240 mg	
00258-3690-90	Diltiazem HCL 300 mg Cap, SA	300 mg	
00258-3691-90	Diltiazem HCL 360 mg Cap, SA	360 mg	

Verapamil

There is a Joint DoD/VA sole source contract for verapamil extended release tablets. At \$0.07 per tablet for most strengths, **the IVAX generic is the most cost effective generic verapamil extended release that DoD MTFs can purchase.**

Extended Release Verapamil (IVAX) Available at Contract Prices

NDC Number	Item Description	Strength	FSS Price/capsule
00172-4285-60	Verapamil 120 mg Tab, SA 100's	120 mg	\$0.15
00172-4286-60	Verapamil 180 mg Tab, SA 100's	180 mg	\$0.07
00172-4286-70	Verapamil 180 mg Tab, SA 500's	180 mg	\$0.07
00172-4280-60	Verapamil 240 mg Tab, SA 100's	240 mg	\$0.07
00172-4280-70	Verapamil 240 mg Tab, SA 500's	240 mg	\$0.07

Dihydropyridines

Drugs in this class include nifedipine (Procardia, Procardia XL, Adalat, Adalat CC), amlodipine (Norvasc), felodipine (Plendil), isradipine (Dynacirc, Dynacirc CR), nisoldipine (Sular), nimodipine (Nimotop), bepridil (Vascor), and nicardipine (Cardene, Cardene SR). With the exception of nimodipine, all are indicated for hypertension, angina, or both, with the long acting forms (extended release or long half-life) being the more clinically useful agents. Nimodipine is unique among these agents in that its sole indication is for patients with subarachnoid hemorrhage; it is not included in the table below.

The table below compares the long acting DHP calcium blockers by price and indication.

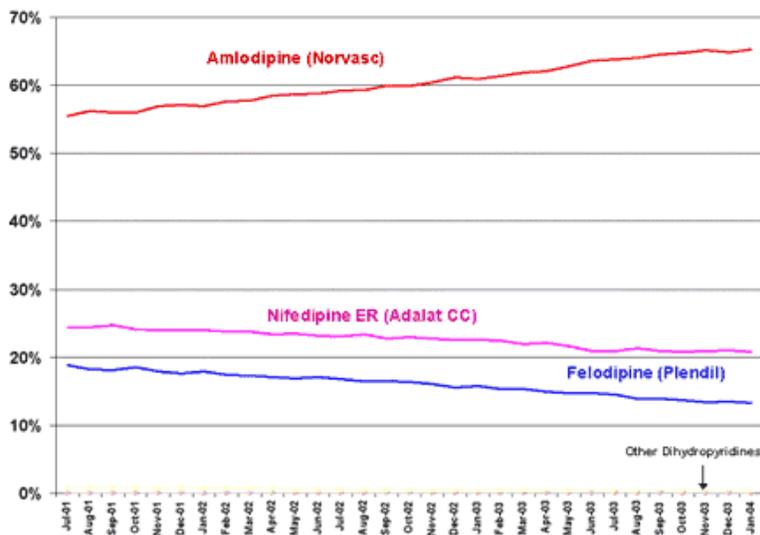
Long-Acting Dihydropyridine Calcium Channel Blockers

Brand Name	FDA Indications	Generic	Strengths	Best DoD Price
Adalat CC	Hypertension Angina (effort and vasospastic)	Nifedipine extended release	30 mg 60 mg 90 mg	\$0.30
Procardia XL (Mylan generic)	Hypertension Angina (effort and vasospastic)	Nifedipine extended release	30 mg 60 mg 90 mg	\$0.265 \$0.445 \$0.641
Procardia XL	Hypertension Angina (effort and vasospastic)	Nifedipine extended release	30 mg 60 mg 90 mg	\$0.864 \$1.493 \$1.773
Norvasc	Hypertension Angina (stable and unstable)	Amlodipine	2.5 mg 5 mg 10 mg	\$0.84 \$0.817 \$0.894
Plendil	Hypertension	Felodipine	2.5 mg 5 mg 10 mg	\$0.646 \$0.659 \$1.111
Dynacirc CR	Hypertension	Isradipine extended release	5 mg 10 mg	\$0.46 \$0.46
Sular	Hypertension	Nisoldipine extended release	10 mg 20 mg 30 mg	\$0.735 \$0.713 \$0.713

Source: DoD/VA FSS Prices, 1 Feb 2004

The market share of amlodipine in DoD MTFs is currently 65% and rising. At approximately 2.8 times the price of Adalat CC, this represents missed opportunity for cost containment. Given that the FDA recently issued a stay of their approval for generic amlodipine maleate, it appears unlikely that the generic form will be available soon. Thus **the best opportunity for cost containment under current conditions is for MTFs to encourage the use of Adalat CC in hypertensive patients requiring a dihydropyridine calcium channel blocker**—keeping in mind the fact that most hypertensive patients do not require calcium channel blockers as initial therapy.

MTF Market Share of Dihydropyridine Calcium Channel Blockers



Bottom-line

For the most cost-effective treatment of hypertension, follow JNC VII guidelines by initiating treatment with **thiazide diuretics** or **beta blockers** in patients with uncomplicated hypertension and no other medical problems. Initiate treatment with other antihypertensive drug classes (e.g., angiotensin converting enzyme inhibitors, angiotensin receptor blockers, or calcium channel blockers) only if there are compelling indications for their use.

PEC Points of Contact for CCBs: Eugene Moore, Pharm.D, Clinical Pharmacy Specialist, PEC; LtCol Barb Roach, MD; MC, USAF; Air Force Physician Representative, PEC

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