## Craib, Patrick MTIC:EX

**Subject:** Pfizer files
**Location:** T/C#: s.15 Moderator: Tijana

**Start:** Tue 2010-11-30 1:00 PM
**End:** Tue 2010-11-30 2:00 PM
**Show Time As:** Tentative

**Recurrence:** (none)

**Meeting Status:** Not yet responded

**Organizer:** Fazlagic, Tijana HLTH:EX

Hi Everyone teleconference code shared is incorrect, please dial s.15 participant ID s.15

**Craib, Patrick MTIC:EX**

**From:** Lun, Eric HLTH:EX
**Sent:** Wednesday, February 11, 2015 2:19 PM
**To:** Zimmerman, Janine M HLTH:EX
**Subject:** FW: Pfizer Canada - Business Review - Celebrex
**Attachments:** Algo AINS EN.doc; celebrex reimbursement criteria.doc

**From:** Smith, Christopher C s.22
**Sent:** Friday, November 12, 2010 8:31 AM
**To:** Lun, Eric HLTH:EX
**Subject:** Pfizer Canada - Business Review - Celebrex

Eric,

First, let me say it was a real pleasure meeting with you and the PSD team last Friday. I feel the *'business review"* setting is a positive and productive environment to discuss files.

Further to our meeting on Nov. 5th, I am working closely with my colleagues in Pfizer to provide you with the information we agreed upon, related to each specific file.

Regarding Celebrex, we had a discussion surrounding the current Special Authority criteria in BC and PSD's willingness to review it. As mentioned in our meeting, attached is a document, which outlines the reimbursement criteria for each province. In addition, I have had had our head office translate the decision-making Algorithm for Quebec, which I have also attached.

Please don't hesitate to contact me if you require any further information.

Sincerely,

Chris

**Chris Smith I Manager, British Columbia -- Government, Patient Access, Health Policy**

**Pfizer Canada Inc.**
17300 Trans Canada, Kirkland, Qc, H9J 2M5 s.22

**pfizer.ca**

# Algorithm for Use of Non-steroidal Anti-inflammatories (NSAIDs)

**Publisher**
Conseil du médicament
www.cdm.gouv.qc.ca

**Coordination**
Anne Fortin, Pharmacist

**Development**
Conseil du médicament
Fédération des médecins omnipraticiens du Québec (FMOQ)
Fédération des médecins spécialistes du Québec (FMSQ)

**Scientific review**
FMOQ and FMSQ experts' committee: Dr. Louis Bessette, Dr. Marc Bradette, Dr. Denis Boucher, Dr. Réjean Cloutier, Dr. Daniel D'Amours, Dr. Jean-Guy Fontaine, Dr. Paul René de Cotret, Dr. Michel Turgeon and Hélène Gilbert, Pharmacist

Comité scientifique du suivi et de l'usage optimal du Conseil du médicament

**Collaboration**
Dr. James Brophy, Dr. Michel Cauchon, Dr. Gilles Hudon (FMSQ), Dr. Pierre Raîche (FMOQ) and Carole Chamberland, Pharmacist

**Language review**
Les Publications du Québec

**Design and electronic publishing**
Charles Lessard and the Conseil du médicament

A complete reference list is available from the Conseil du médicament.

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ISBN 978-2-550-58395-0 (PDF version)


This initiative was financed with funds deriving from a partnership agreement on optimal use of COX-2 selective inhibitors (coxibs).

The purpose of the Conseil du médicament is to assist Quebec's Minister of Health and Social Services in updating the list of drugs reimbursed under the basic prescription drug insurance plan and to promote optimal use of drugs. "Optimal use" means use that maximizes the clinical benefits of a drug and minimizes the risks for the people of Quebec. Optimal use is determined by looking at existing therapeutic options, the costs of the different treatments and the resources available as well as patient values and social values.

To promote optimal use of drugs, the Conseil may conduct or support reviews of the use of a particular drug, suggest implementation of training, information and awareness strategies for professionals and the public, or contribute to such strategic measures. The Conseil may also evaluate problems associated with use of a drug and take necessary measures to prevent them. It was thus that the Conseil turned to the expertise of the Fédération des médecins omnipraticiens du Québec and the Fédération des médecins spécialistes du Québec to develop in partnership with these two federations this *Algorithm for the use of non-steroidal anti-inflammatories (NSAIDs)*.

This algorithm is meant to serve as a tool for the clinician and cannot replace the clinician's judgment.

Risk assessment

# Optimal Use of NSAIDs

Risk Assessment

Gastrointestinal Risk  Cardiovascular Risk  Renal Risk

**ALL THREE OF THESE RISKS MUST BE CONSIDERED IN SELECTING A TREATMENT**

**General considerations**

- Before prescribing an NSAID in the treatment of osteoarthritis, it is important to make sure that the patient has not obtained relief with the required dose of acetaminophen.
- Coxibs are as effective in treating acute and chronic pain as non-selective NSAIDs.
- In patients with chronic pain, the indication of NSAID therapy must be reevaluated on a regular basis.
- With non-selective NSAIDs and coxibs, the lowest effective dose must be used for the shortest period of time, as the gastrointestinal risk is proportional to the NSAID dose.
- Combination of two NSAIDs should be avoided at all times.

**Other considerations**

- Recent research indicates that certain NSAIDs (ibuprofen in particular) can inhibit ASA's antiplatelet effect if taken before ASA.
- Vigilance is required in elderly patients, given the frequency of comorbidities, the large number of drugs taken and the risks of possible drug interactions.
- Pharmacoeconomically, coxibs may not be cost effective enough for the population as a whole. In other words, the clinical benefits obtained may not justify the cost.

Gastrointestinal

## Gastrointestinal Risk

| No identifiable risk factors | One or more risk factors |
|---|---|
| Non-selective NSAID | YES |
| MODERATE RISK*<br>1. > 65 years of age but < 75 years of age<br>2. History of uncomplicated upper GI ulcer<br>3. Comorbidity**<br>4. Concomitant drugs (clopidogrel, oral steroids, SSRI)<br>5. More than one NSAID | HIGH RISK<br>1. ≥ 75 years of age<br>2. History of complicated ulcer (GI hemorrhage or perforation)<br>3. Taking warfarin: monitor INR**** |
| Non-selective NSAID + gastroprotection***<br>or COXIB | COXIB + gastroprotection*** |

**Considerations with respect to gastrointestinal risk**

- There is a risk of lower GI tract complications with NSAIDs that gastroprotection (PPI, misoprostol) cannot prevent. There seems to be less of a risk of this type of complication with coxibs.
- Concomitant administration of ASA and a coxib considerably reduces the benefits of the coxib in terms of GI protection.
- Even though the pharmacoeconomic data are ambiguous, prescription of a coxib in patients with a risk of GI complications may be a more cost-effective strategy than using a conventional NSAID and a PPI.

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* The risk of GI complications increases with the number of risk factors. The clinician's judgment is used to determine the number of risk factors warranting addition of gastroprotection.

** Comorbidity is a serious medical condition that predisposes to exacerbation of the patient's clinical condition following administration of an NSAID.

*** Gastroprotection: PPI once a day or misoprostol at a minimum daily dose of 800 mcg.

**** International normalized ratio (INR).

Cardiovascular

Cardiovascular

# Cardiovascular Risk

| Thromboembolic risk (coronary, cerebral and peripheral vascular disease) | | Heart failure risk | |
|---|---|---|---|
| YES | | YES | |
| ASA* + GI risk factors | ASA* but no other GI risk factors | **LOW-TO-MODERATE RISK** NYHA Classes I and II | **HIGH RISK** NYHA Classes III and IV or ejection fraction < 30% |
| See GI algorithm | Non-selective NSAID** (mainly naproxen) + gastroprotection*** or COXIB | Non-selective NSAID** or COXIB with caution (depending on GI risk) | NO NSAID |
| | | Instructions: monitor weight, edema, dyspnea, orthopnea; if taking warfarin, monitor INR**** | |

**Considerations with respect to cardiovascular risk**

- The risk of cardiovascular complications is the same with non-selective NSAIDs as with coxibs.
- The same precautions are required with a coxib as with a non-selective NSAID.
- Non-selective NSAIDs and coxibs are not a substitute for ASA in the prevention of stroke. Low-dose ASA must be continued in patients at risk for cardiovascular disease even if it increases coxib GI toxicity.

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* Antiplatelet dose of ASA (325 mg/day or less).

** Caution: cardiovascular risk has been demonstrated for coxibs. However, no randomized studies controlled with a placebo or another medication have assessed the cardiovascular risks of non-selective NSAIDs. At present, there are observational studies that attribute to non-selective NSAIDs (with the exception of naproxen) a risk similar to that with coxibs, though not with the same degree of certainty.

*** Gastroprotection: PPI once a day or at least 800 mcg misoprostol daily.

**** International normalized ratio (INR).

Renal

**Renal**

# Renal Risk

| Presence of One or More Risk Factors | |
|---|---|
| 1. Prostagandin-dependent renal function:<br>- Patients with kidney failure<br>- Elderly patients<br>- Hypovolemia<br>2. Hyperkalemia (> 5 mmol/L) | 3. HBP<br>4. Certain drugs:<br>- Diuretics<br>- ACE inhibitor-ARB<br>- Lithium<br>- Aminoglycosides, cyclosporin |

YES

| | MODERATE RISK | HIGH RISK |
|---|---|---|
| • Check creatinine and $K_+$ at 1 week and 1 month | • Creatinine clearance* 30-60 mL/min | • Creatinine clearance* < 30 mL/min<br>• $K_+$ > 5.5 mmol/L<br>• Poorly controlled HBP |
| • Weigh *i.d.*<br>• Check $K_+$ at 3-5 days | • $K_+$ = 5.0-5.5 mmol/L | |
| • Check BP regularly | • Controlled HBP | **NO NSAIDs** |

## Considerations regarding renal risk

- Non-selective NSAIDs and coxibs present a comparable risk of renal complications.
- The onset of electrolytic complications and kidney failure can be rapid after non-selective NSAIDs or coxibs are introduced.
- Before prescribing an NSAID (non-selective or coxib), make sure the patient is not taking over-the-counter NSAIDs.
- Serum creatinine alone is not adequate for assessing kidney function. Creatinine clearance is determined using the Cockcroft-Gault equation, which takes into consideration weight, age and sex.
- Dosage and efficacy of all drugs eliminated by the kidneys must be monitored. Among other things, lithium levels must absolutely be checked in patients taking lithium before starting NSAIDs, when modifying NSAID therapy and when discontinuing it.

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* Cockroft-Gault creatinine clearance calculator:

| **Creatinine clearance (mL/min) in women:** | **Creatinine clearance (mL/min) in men:** |
|---|---|
| $\frac{(140 - \text{age}) \times \text{body mass (kg)}}{\text{Serum creatinine (µmol/L)}}$ | $\frac{(140 - \text{age}) \times \text{body mass (kg)} \times 1.2}{\text{Serum creatinine (µmol/L)}}$ |

**Notes**

**NOTES**

## Celebrex reimbursement Criteria:

### British Columbia:

1. Diagnosis of osteoarthritis
**PLUS**
trial of acetaminophen
**PLUS**
treatment failure or intolerance to at least one of the following: ASA-enteric, ibuprofen or naproxen
**PLUS**
treatment failure or intolerance to at least three of the following: diclofenac, diflunisal, fenoprofen, indomethacin, ketoprofen, salsalate, nabumetone, piroxicam, sulindac, tenoxicam, tiaprofenic, tolmetin or meloxicam.

OR

2. Diagnosis of rheumatoid arthritis or other inflammatory conditions
PLUS
treatment failure or intolerance to at least one of the following: ASA-enteric, ibuprofen, naproxen
PLUS
treatment failure or intolerance to at least three of the following: diclofenac, diflunisal, fenoprofen, flurbiprofen, indomethacin, ketoprofen, salsalate, nabumetone, piroxicam, sulindac, tenoxicam, tiaprofenic, tolmetin or meloxicam.

### Alberta :

1)For patients who are at high risk of upper gastrointestinal (GI) complications due to a proven history of prior complicated GI events (e.g. GI perforation, obstruction or major bleeding)
or
2) For patients who have a documented history of ulcers proven radiographically and/or endoscopically.
Special authorization for both criteria may be granted for 6 months."
All requests for celecoxib must be completed using the Celebrex Special Authorization Request Form (ABC 31140).

### Saskatchewan :

For treatment of:
(a) Patients age 65 and over (approved automatically through the online computer system).
(b) Rheumatoid arthritis and osteoarthritis in patients who have one of the following factors:
• past history of ulcers;
• concurrent prednisone therapy;
• concurrent warfarin therapy.
(c) Patients intolerant to other NSAIDs listed in the Formulary.

**Manitoba :**

For the long-term treatment of osteoarthritis or rheumatoid arthritis in patients who have one or more of the following risk factors:

- ▫ Previous peptic ulcer, gastrointestinal bleeding, gastric outlet obstruction (endoscopy or radiographic evidence);
- ▫ Elderly (more than 65 years of age);
- ▫ Concurrent warfarin therapies;
- ▫ Bleeding disorders;
- ▫ Concurrent prednisone therapy at doses greater than 5 mg/day for more than 2 weeks; OR
- ▫ Where at least 3 NSAID's have been tried and failed or were not tolerated.

Also may approve for ankylosing spondilitis, gout, pseudo-gout, lupus or psoriatic arthritis.

**NOTE:** *If a patient is receiving a proton pump inhibitor (PPI) for reflux disease, COX II inhibitors are not warranted for additional protection.*

**Ontario:**

Osteoarthritis Code 316 For patients who have failed an adequate trial of acetaminophen (e.g. acetaminophen 1g QID for several weeks) and have had:
History of a documented, clinically significant ulcer or GI bleed; or
Failure or intolerance to at least three listed NSAIDS.
**NOTE:** The maximum daily dose of celecoxib which will be reimbursed for the treatment of osteoarthritis is 200mg. LU Authorization Period: 1 year.

Rheumatoid arthritis code 317
For patients who have had: History of a documented, clinically significant ulcer or GI bleed; or
Failure or intolerance to at least three listed NSAIDS. **NOTE:** The maximum daily dose of celecoxib which will be reimbursed for the treatment of rheumatoid arthritis is 400mg. LU Authorization Period: 1 year.

**Quebec:**

Full Listing

**New Brunswick:**

For the treatment of osteoarthritis and rheumatoid arthritis in patients who have at least one of the following risk factors:

- Past history of ulcers
- Concurrent warfarin therapy
- Concurrent prednisone therapy
- Failure or intolerance to at least two other NSAIDs (e.g. ibuprofen, diclofenac, naproxen)

Recommended maximum daily doses: 200mg for osteoarthritis
400mg for rheumatoid arthritis

**Nova Scotia:**

Full Listing

## Newfoundland:

for the treatment of osteoarthritis* in patients who have one or more of the following factors:
a) 65 years of age or older
b) concurrent oral steroids
c) documented history of PUD
d) concurrent warfarin therapy
e) persistent dyspeptic symptoms despite trials of at least 3 nsaids, including an enteric coated formulation
* maximum daily dose approved in OA is 200mg

- For the treatment of rheumatoid arthritis** in patients who have one or more of the following factors:
a) 65 years of age or older
b) concurrent oral steroids
c) documented history of PUD
d) concurrent warfarin therapy
e) persistent dyspeptic symptoms despite trials of at least 3 nsaids, including an enteric coated formulation
** maximum daily dose approved is 400mg

**PEI**:

Not Listed

## Craib, Patrick MTIC:EX

**From:** Dawson, Bob s.22
**Sent:** Thursday, November 25, 2010 9:45 AM
**To:** Lun, Eric HLTH:EX; Smith, Christopher C
**Cc:** Mochrie, Paul HLTH:EX; Fazlagic, Tijana HLTH:EX; Shin, Sophia HLTH:EX; Marchetti, Donna
**Subject:** RE: Pfizer files

**Follow Up Flag:** Follow up
**Flag Status:** Completed

Eric - thank you for your email. Although it is disappointing to close a file that does not end up in a positive decision, we recognize and support PSD's effort to address the back log. Hopefully we will be able to bring an added value proposition on Lyrica for PSD to review in the New Year.

Yesterday's Multi-Stakeholder Session organized by PSD was excellent.
As I mentioned to you briefly at the session, Pfizer has no medicines in the new review process so all of our files would be defined as part of the back log. I thought it would be useful to align on the files that we have in queue for decision. Below is our record of our submission files. Please let us know if there are any discrepancies.
Many thanks,
Bob

---

Product Date submission received in BC

Fragmin (for CAT) November 15, 2005 (pre CDR)

Lyrica July 21, 2005

Caduet May 17, 2006

RevatioNov 3, 2006

Champix May 4, 2007

InspraMay 7, 2009

-----Original Message-----
From: Lun, Eric HLTH:EX [mailto:Eric.Lun@gov.bc.ca]
Sent: Saturday, November 13, 2010 10:45 AM
To: Dawson, Bob; Smith, Christopher C
Cc: Mochrie, Paul HLTH:EX; Fazlagic, Tijana HLTH:EX; Shin, Sophia HLTH:EX
Subject: Pregabalin

Hi Bob and Chris,

Sorry, meant to call you about this rather than email but ran out of time s.22

We've discussed internally and would prefer to close the submission.
However, we would be happy to reopen once your value proposition is ready. We expect to send you official confirmation sometime next week.

We have been asked by many to address our back log so we are doing our best to do so.

Thanks for your understanding.

If you have any questions on this matter, pls contact Paul while I'm away.

Thanks,

Eric

Eric Lun, Pharm.D.
Executive Director, Drug Intelligence
Pharmaceutical Services Division, BC Ministry of Health Services

**Craib, Patrick MTIC:EX**

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**From:** Dawson, Bob s.22
**Sent:** Friday, November 26, 2010 3:29 PM
**To:** Fazlagic, Tijana HLTH:EX
**Subject:** RE: Pfizer files

Thanks Tijana - If Eric is busy it's no problem. The purpose of my note is just to make sure that PSD and Pfizer are working from the same list. Talk to you Monday.
Have a good weekend,
Bob

---

**From:** Fazlagic, Tijana HLTH:EX [mailto:Tijana.Fazlagic@gov.bc.ca]
**Sent:** Friday, November 26, 2010 3:17 PM
**To:** Dawson, Bob
**Cc:** Smith, Christopher C
**Subject:** RE: Pfizer files

Hi Bob,

That was a quick reply. Monday and Tuesday work for me, but I will check Eric's calendar to see if he can join us as well. I probably won't be able to let you know before end of the day, but I let you know Monday for sure.

Tijana

Tijana Fazlagic , B.Sc.(Pharm), MSc
Director
Formulary Management
Pharmaceutical Services
(250) 952-1475
Tijana.Fazlagic@gov.bc.ca

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**From:** Dawson, Bob s.22
**Sent:** Friday, November 26, 2010 3:14 PM
**To:** Fazlagic, Tijana HLTH:EX
**Cc:** Smith, Christopher C
**Subject:** RE: Pfizer files

Hi Tijana - thanks for the note. It's great to hear from you!

I am available next week (Monday, November 29 after 12 p.m. or Tuesday November 30 11:00 am - 3:00 pm) or the following week (December 6 and December 8 pretty well open all day). If none of these dates/times work let me know.

Also, since I sent the email to Eric, Chris Smith did get the Caduet rejection letter so we are up to speed on the status of that file.

Bob

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**From:** Fazlagic, Tijana HLTH:EX [mailto:Tijana.Fazlagic@gov.bc.ca]
**Sent:** Friday, November 26, 2010 1:48 PM
**To:** Lun, Eric HLTH:EX; Dawson, Bob; Smith, Christopher C
**Cc:** Mochrie, Paul HLTH:EX; Shin, Sophia HLTH:EX; Marchetti, Donna; Fowler, Sherrill A HLTH:EX; Zimmerman, Janine HLTH:EX
**Subject:** RE: Pfizer files

Hello Bob,

Hope you are doing well.

I would like to set up a call with you and review all Pfizer files under review by the Ministry. Let me know what dates/times work for you, so we arrange a meeting.

Have a nice weekend.

Tijana

Tijana Fazlagic , B.Sc.(Pharm), MSc
Director
Formulary Management
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Tijana.Fazlagic@gov.bc.ca

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**From:** Lun, Eric HLTH:EX
**Sent:** Thursday, November 25, 2010 10:00 AM
**To:** Dawson, Bob; Smith, Christopher C
**Cc:** Mochrie, Paul HLTH:EX; Fazlagic, Tijana HLTH:EX; Shin, Sophia HLTH:EX; Marchetti, Donna
**Subject:** RE: Pfizer files

Thanks for this and your participation at the session yesterady Bob. We will check our list to ensure that your files are on our list.

Eric Lun, Pharm.D.
Executive Director, Drug Intelligence
Pharmaceutical Services Division, BC Ministry of Health Services

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**From:** Dawson, Bob s.22
**Sent:** Thu 25/11/2010 9:45 AM
**To:** Lun, Eric HLTH:EX; Smith, Christopher C
**Cc:** Mochrie, Paul HLTH:EX; Fazlagic, Tijana HLTH:EX; Shin, Sophia HLTH:EX; Marchetti, Donna
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Eric Lun, Pharm.D.
Executive Director, Drug Intelligence
Pharmaceutical Services Division, BC Ministry of Health Services