



ALABAMA MEDICAID PHARMACIST

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PDL Update

Effective April 1, 2011, the Alabama Medicaid Agency will update the Preferred Drug List (PDL) to reflect the recent Pharmacy and Therapeutics (P&T) Committee recommendations as well as quarterly updates. The updates are listed below:

PDL Additions	PDL Deletions*
Dulera —Inhaled Corticosteroids/Combination Agents	Patanol —EENT Antiallergic Agents
Ritalin-SR —ADD/ADHD—Short and Intermediate Acting Agents	Pataday —EENT Antiallergic Agents
	Patanase —EENT Antiallergic Agents
	Daytrana —ADD/ADHD-Long Acting Agents
	Dexedrine —ADD/ADHD-Short and Intermediate Acting Agents

*Denotes that these brands will no longer be preferred but are still covered by Alabama Medicaid and will require prior authorization (PA) for payment. Available covered generic equivalents (unless otherwise specified) will remain preferred.

The HID Help Desk is open Monday–Friday from 8am to 7pm and on Saturdays 10am to 2pm. If you need a form, wish to review criteria or have other questions, please access our website at hidmedicaid.hidinc.com or the Agency website at medicaid.alabama.gov.

Please fax all prior authorization and override requests

directly to Health Information Designs at

800-748-0116. If you have questions, please call 800-748-0130 to

Speak with a call center representative.

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ADHD Drug Holiday

With summertime approaching, many parents may be considering whether to give their children a break from ADHD medications. This 'break' may also be known as a drug holiday or drug vacation.

A drug holiday is a short period of time when a chronically administered medication is intentionally discontinued with the intention of reinitiating in the future. For ADHD, there is no clear recommendation regarding the appropriateness of drug holidays. Many professionals feel that ADHD should be treated chronically since it is a chronic condition. Other practitioners, however, feel that drug holidays are not only acceptable, but recommended. Proponents of drug holidays point out that most ADHD medications are stimulants and, as such, can be taken on an 'as needed' basis.

With summertime approaching, should parents consider giving their child a break from ADHD medications?

Whether to partake in a drug holiday should be based on the individual patient. Certain patients may tolerate and benefit from a drug holiday while others may not. For example, a patient with academic difficulty but no difficulty with personal relationships or aggression may be an ideal candidate for a brief discontinuation of ADHD medication. A patient with year-round social problems, however, may be negatively impacted by a drug holiday. Since every patient is different, it is very important to take baseline functioning, social interaction, and side effects into consideration when considering a drug holiday.

Advantages of Taking a Drug Holiday:

- Physicians may take this opportunity to reassess ADHD symptoms and the need for medication.
- May reduce medication tolerance.
- May help to reduce the occurrence of side effects associated with many ADHD medications, such as poor appetite and insomnia.

Disadvantages of Taking a Drug Holiday:

- Some patients may experience difficulty readjusting to medication upon re-initiation.

Unmedicated patients often have more traffic accidents (applicable to adolescents and adults), more social difficulties, and decreased quality of life.

Points to Consider:

- A drug holiday should usually only be considered for those taking stimulant medications. Non-stimulant medications, such as Strattera, should be taken on an ongoing basis. If Strattera is discontinued during a child's summer vacation, then it should be re-initiated 3-4 weeks prior to restarting school.
- Every patient is different. The decision about whether a drug holiday is appropriate should be made by the patient, their physician, and their caregiver.
- If a drug holiday is initiated, there should be a plan in place regarding when to restart medication therapy.
- Do not attempt a drug holiday at times of high stress or demand (i.e., the beginning of a new school year).

References:

1. Manos MJ. Opinions on Drug Holidays in Pediatric ADHD, in *Medscape Psychiatry and Mental Health* (vol. 10, no. 2). New York, NY: 2005, Accessed 2011 Jan 20. Available from: <http://www.medscape.org/viewarticle/519331>.
2. Wysong P, Adler L. Long-Term Treatment of ADHS, in *Medscape Psychiatry and Mental Health*. New York, NY: 2003, Accessed 2011 Jan 20. Available from: <http://www.medscape.org/viewarticle/457174>.
3. Martins S, Tramontina S, Polanczyk G, Eizirik M, Swanson JM, Rohde LA. Weekend Holidays During Methylphenidate Use in ADHD Children: A Randomized Clinical Trial. *J Child Adolesc Psychopharmacol*. 2004;14(2):195-206.
4. Pliszka S, AACAP Work Group on Quality Issues: Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder. *J Am Acad Child Adolesc Psychiatry*. 2007;46(7):894-921.

Changes for Acetaminophen-Containing Products

In June 2009, the safety of acetaminophen was discussed at a Joint Meeting of the Food and Drug Administration (FDA) Drug Safety and Risk Management Advisory Committee, Nonprescription Drugs Advisory Committee, and Anesthetic and Life Support Drugs Advisory Committee.

The Advisory Committee recommended, and the FDA is requesting, that drug manufacturers limit the amount of acetaminophen in prescription drug products to 325mg per tablet, capsule, or other dosage unit. It is expected that the higher-dose formulations will be phased out by 2014. In addition, a boxed warning detailing the potential for severe liver injury and a warning highlighting the potential for allergic reactions will be added to the label. OTC medications containing acetaminophen will not be affected by this action.

A number of studies have detailed the incidence of liver toxicity in patients using acetaminophen and clearly indicate reason for concern. A 2007 Centers for Disease Control and Prevention (CDC) report estimates that of 1600 cases of acute liver failure (ALF) each year, acetaminophen was the most common cause. This same study found that most of the cases of acetaminophen-related ALF were caused by unintentional overdose, where a patient accidentally took too much acetaminophen. It is the hope that by limiting the maximum amount of acetaminophen in prescription products, patients will be less likely to overdose.

Information for providers:

- Advise patients not to exceed the acetaminophen maximum total daily dose (4 grams/day)
- Severe liver injury, including cases of acute liver failure resulting in liver transplant and death, has been reported with the use of acetaminophen
- Advise patients not to drink alcohol while taking acetaminophen
- Remind patients of the importance of reading all prescription and OTC labels to ensure they are not taking multiple acetaminophen-containing products
- Rare cases of anaphylaxis and other hypersensitivity reactions have occurred with the use of acetaminophen
- Patients should seek medical attention immediately if they have taken too much acetaminophen or if they experience symptoms of hypersensitivity

References:

1. Changes for acetaminophen-containing prescription products. Pharmacist's Letter/Prescriber's Letter 2011;27(2):270203.
2. Bower WA, Johns M, Margolis HS, et al. Population-based surveillance for acute liver failure. *Am J Gastroenterol* 2007;102:2459-63.
3. Food and Drug Administration drug safety communication concerning changes to prescription acetaminophen-containing products. January 13, 2011. www.fda.gov/Drugs/DrugSafety/ucm239821. Accessed February 2011.

Medication Safety

- In 2006, 27,531 people in the United States died from unintentional medication poisoning.
- 96% of unintentional poisoning deaths are a result of drug poisoning – with more than half due to prescription drugs.
- An estimated 71,000 children (18 and younger) are seen in emergency departments each year because of medication poisonings (excluding recreational drug use). Over 80% were because an unsupervised child found and consumed medication.
- Most at risk are young children (under the age of 5) and older adults (65 years of age and older).

It is important to make sure that parents keep ALL medications out of the reach of children; however, certain medications are especially dangerous.

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- Benzonatate – indicated for patients aged 10 and older, these cough suppressants look a lot like candy, however, just one or two benzonatate capsules can be toxic to children under the age of 2. Symptoms (seen 15 to 20 minutes after ingestion) of benzonatate poisoning include seizures, cardiac arrest, and coma.
- Drugs that lower blood pressure, such as calcium channel blockers and clonidine are very dangerous for young children – just one or two adult doses can be fatal.
- Opioids can cause sedation and slow breathing in toddlers, which can be fatal. Oral doses of methadone 20mg, morphine 200mg, and codeine 100mg can be enough to cause death in a small child.
- OTC medications can be dangerous for children as well. Iron supplements (even those in multivitamin products), acetaminophen, diphenhydramine, and even topical medications such as methyl salicylate (oil of wintergreen), which is found in topical muscle rubs, and camphor (found in Vicks VapoRub and Campho-Phenique) can be dangerous to children if accidentally ingested.

What can be done to reduce the risk of medication poisonings in children?

- Encourage parents to take all medications seriously and never refer to it as candy.
- Make sure prescriptions are dispensed with child safety caps.
- Provide an accurate measuring device to parents when appropriate – household spoons should not be used for measuring doses of liquid medications.
- Remind parents to store ALL medications securely, including OTC medications and vitamins.
- Encourage parents to get rid of medications that are no longer needed or being used, and remind them about proper disposal of medications.
- Remind patients of the poison center phone number. It is 800-222-1222 in the United States. This is a national number, and will dial the poison center nearest the person calling.

Also at risk are elderly patients. Older patients are twice as likely as others to come to emergency departments for adverse drug events and nearly seven times more likely to be hospitalized after that visit.

- Older patients are generally taking more medications, and seeing more providers, than younger patients.
- Older patients are more commonly on drugs that require careful monitoring (e.g. warfarin, digoxin, insulin, etc.)

Encourage patients to talk with their providers before taking additional medications, including OTC/naturopathic medications and vitamins.

References:

1. Centers for Disease Control and Prevention (CDC): Medicine safety: who's at risk and what you can do. Accessed February 2011 at www.cdc.gov/Features/MedicineSafety.
2. Centers for Disease Control and Prevention (CDC): Poison prevention. Accessed February 2011 at www.cdc.gov/Features/PoisonPrevention.
3. Keeping kids safe from medications. Pharmacist's Letter/ Pharmacy Technician's Letter 2011;27(2):270210.

New Guidelines for Treatment of Methicillin-resistant *S. aureus* (MRSA)

The Infectious Diseases Society of America (IDSA) has published new treatment guidelines for MRSA. This will change how community-acquired skin infections are treated.

Skin infections WITH pus are generally due to staph and those WITHOUT pus are usually due to strep. Currently, most purulent skin infections are due to community-acquired MRSA and resistant to beta-lactam antibiotics (such as amoxicillin, cephalexin, etc.)

Simple, small abscesses can be treated with incision and drainage. However, antibiotics are usually required when there are multiple abscesses, rapid progression, and/or systemic symptoms.

For adults:

Clindamycin 300-450mg TID

OR

TMP/SMX DS 1 or 2 tabs BID

OR

Doxycycline 100mg BID

OR

Minocycline 200mg X1, then 100mg BID

OR

Linezolid 600mg BID

Duration of therapy should be 5 to 10 days.

For children:

Providers can use mupirocin 2% ointment for minor skin infections. If oral antibiotics are needed, see recommended agents and dosing below:

Clindamycin 40mg/kg/day divided Q6-8H

OR

TMP/SMX 4-6mg(TMP)/kg/dose Q12H (for children \geq 2 months old only)

OR

Doxycycline 2mg/kg/dose Q12H (\geq 8 years old only—dose as adult if $>$ 45kg)

OR

Minocycline 4mg/kg X1, then 2mg/kg/dose Q12H (\geq 8 years old only)

OR

Linezolid 10mg/kg/dose Q8H (max = 600mg/dose)

Duration of therapy should be 5 to 10 days.

A beta-lactam antibiotic can be added if coverage for both strep and CA-MRSA is needed.

For patients that have recurrent skin and soft tissue infections, consider nasal decolonization with mupirocin BID for 5 to 10 days and/or topical body decolonization with chlorhexidine for 5 to 14 days or dilute bleach baths twice weekly for 3 months. It is important to emphasize personal hygiene, covering wounds, and cleaning high-touch surfaces.



References:

1. Liu C, Bayer A, Cosgrove SE, et al. Clinical practice guidelines by the Infectious Diseases Society of America for the treatment of methicillin-resistant *Staphylococcus aureus* infections in adults and children. Clin Infect Dis 2011;52:e18-55.
2. Pharmacist's Letter/Prescriber's Letter 2011;27 (2):270202.

Dr. R. Bob Mullins, Jr. appointed Medicaid Commissioner

Longtime family physician R. Bob Mullins, Jr., MD, has been appointed Alabama Medicaid Commissioner by Governor Robert Bentley. He joins the Agency after 37 years in private practice in the east Alabama city of Valley.

A 1968 graduate of the University of Alabama School of Medicine, Dr. Mullins interned at Lloyd Noland Hospital in Fairfield, AL, served two years in the U.S. Army, and completed a two-year General Practice residency in Columbus, GA, before beginning his private practice in 1973.

“Dr. Mullins is a family doctor of long standing and is eminently qualified to be Medicaid Director,” Governor Bentley said. “He understands the issues our Medicaid Agency faces from the provider side as well as the patient and health care institutions’ perspective. I have every confidence that he is the right man for the job and will work with all those affected by our Medicaid Agency.”

In addition to his practice, Dr. Mullins has been involved in a variety of local and state health care organizations, beginning in 1978 when he volunteered to help start an Impaired Physicians Committee for the Medical Association of the State of Alabama (MASA). He served on its Executive Committee until 1988.

His service to MASA continued in 1989 when he assumed the office of Vice Speaker of the House of Delegates and College of Counselors, a post he held until his election to Speaker of the House in 1995. He held that position through 1997. In addition, he served as Alternate Delegate to the American Medical Association House of Delegates from 1990 to 1999 and as Delegate from 2000-2001. He served as President of MASA for 2004-2005.

In early 1989, Dr. Mullins served as Chairman of MASA’s Ad Hoc Committee on Rural and Indigent Care and later that same year served on both the Manpower and Finance subcommittees of the Alabama Legislative Rural Health Task Force. As a result of the Alabama Legislature’s response to the Task Force’s recommendations, the Alabama Family Practice Rural Health Board was created in 1990 and Dr. Mullins served on its Executive Committee until 2003, the last year as Committee Chairman. He was reappointed to the Board in 2004 and served until 2007. Also in 1990, Dr. Mullins served on the organizing committee of the Physician’s Alabama Opportunity Fair.

Community activities have included Leadership Alabama Class II, the Board of Directors for Chambers County/Bradshaw Library, the Board of Trustees for Lanier Health Services and Chattahoochee Valley Healthcare Foundation, the Steering Committee for the Greater Valley Area Chamber of Commerce’s Project Leadership and the Executive Committee of the National Physician’s Center for Family Resources.