



ALABAMA MEDICAID PHARMACIST

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A Service of Alabama Medicaid

PDL Update

Effective April 2, 2012, 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*
Pegintron —Anti-infective Agent/ Interferon	Avalide —Angiotensin II Receptor Antagonists
	Avapro —Angiotensin II Receptor Antagonists
	Benicar —Angiotensin II Receptor Antagonists
	Benicar HCT —Angiotensin II Receptor Antagonists
	Cleocin —Anti-infective Agent/ Miscellaneous Antibacterials
	Focalin —ADD/ADHD- Short and Intermediate Acting Agents
	Pegasys —Anti-infective Agents/ Miscellaneous Antibacterials

*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 from 10am to 2pm. If you need a form, wish to review criteria, or have other questions, please access our website at www.hidinc.com/almedicaid 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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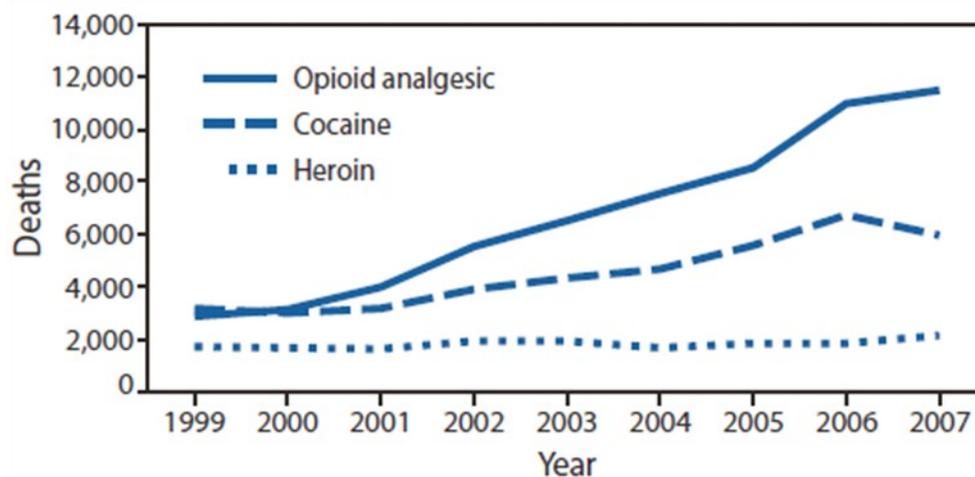


Prescription Drug Abuse and Overdose

Prescription drug abuse is the nation's fastest-growing drug problem. Prescription drugs are the second most-abused category of drugs after marijuana. Data from the National Survey on Drug Use and Health (NSDUH) demonstrate that nearly one-third of people aged 12 and over who abused drugs for the first time in 2009 began by using a prescription drug for non-medical reasons. The survey also showed that over 70 percent of people who abused prescription pain medications got them from relatives or friends. According to the NSDUH 2009 data, more than 5 million Americans misused opioid painkillers in the past month.

There has been a dramatic increase in the number of prescriptions filled for opioid pain relievers over the past decade. From 1997 to 2007, the milligram per person use of prescription opioids in the United States increased from 74 milligrams to 369 milligrams. In 2000, retail pharmacies dispensed 174 million prescriptions for opioids. By 2009, there were 257 million opioid prescriptions dispensed, which was an increase of 48 percent from the year 2000.

In the past, most overdoses of opiates were most likely due to heroin use; however, prescription drugs are now involved in more overdose deaths than heroin and cocaine combined. More than 40 people die daily in the United States from overdoses involving prescription opioid pain relievers. The death toll from prescription painkillers has more than tripled in the past decade. The CDC states that rates of opioid misuse and death are highest among men, persons aged 20 to 64 years, non-Hispanic whites, and poor and rural populations. The two main populations in the United States at the greatest risk for prescription drug overdose are the 9 million persons who report long-term medical opioid use and the 5 million persons who report nonmedical opioid use in the past month. The CDC found that among persons who died of opioid overdoses, a large proportion did not have a prescription in their records for the opioid that killed them. The following figure represents the number of unintentional drug overdose deaths involving opioid analgesics, cocaine, and heroin in the United States from 1999 to 2007.



Prescription Drug Abuse and Overdose

In April of 2011, the White House announced a national plan to fight prescription drug abuse. The Prescription Drug Abuse Prevention Plan focuses on four key areas to reduce prescription drug abuse:

- Education must be provided to parents, youth, patients, and healthcare providers to increase awareness about the dangers of prescription drug abuse. Education must also include the proper ways to dispense, store, and dispose of controlled substance medications.
- There must be enhancements to and increased utilization of prescription drug monitoring programs (PDMPs). Currently, there are 37 states (including Alabama) with operational PDMPs that have the ability to receive and distribute controlled substance prescription information to authorized users. PDMPs have the ability to identify “doctor shoppers” and detect therapeutic duplication and drug-drug interactions.
- There must be development of consumer-friendly and environmentally-responsible prescription drug disposal programs to help limit the diversion of drugs. A proper plan must be in place to include the proper disposal of unneeded, unused, or expired medications. Prescription drugs should be disposed of in sealed plastic bags with filler such as kitty litter or coffee grounds.
- Law enforcement agencies should be provided with support and the tools they need to expand efforts to shut down “pill mills” and to halt “doctor shopping”. There should be aggressive enforcement action against prescribers who are not prescribing within the usual course of practice and not for legitimate medical purposes.

The Prescription Drug Abuse Prevention Plan has several goals. Some of those goals are:

- A 15% reduction in non-medical use of prescription-type psychotherapeutic drugs in the past year among people 12 years of age and older
- Approve and implement a Risk Evaluation and Mitigation Strategy for long-acting and extended-release opioids within 12 months
- Write and distribute a Model Pain Clinic Regulation Law within 12 months
- Work along with Federal agencies to develop and implement a national public education campaign on prescription drug abuse and safe and proper medication disposal within 24 months
- Complete rule-making and implement regulations for medication disposal within 24 months
- A guidance document will be issued by the FDA on developing abuse deterrent drug formulations and on post-market assessment of their performance within 24 months
- Legislation in all 50 states will be in place establishing PDMPs within 36 months
- Decrease the number of unintentional overdose deaths related to opioids by 15% within 60 months

Reference:

Epidemic: Responding to America's Prescription Drug Abuse Crisis. Executive Office of the President of the United States. Available from: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf [Accessed February 11, 2012]

Schedule Change for Carisoprodol

Effective January 11, 2012, carisoprodol (Soma®) was changed to a Schedule IV controlled substance in all states under the federal Controlled Substances Act (CSA). The U.S. Drug Enforcement Agency (DEA) enforces the CSA. The CSA, along with state laws, dictates the details of the manufacturing, prescribing, and dispensing of controlled substances. State laws may be more restrictive than federal laws and the stricter law always prevails. Carisoprodol has been classified as a Schedule IV controlled substance in Alabama since January 1998.

The CSA assigns five different schedules of controlled substances. The drug's abuse potential, history of abuse and current pattern of abuse, significance of abuse, and whether the substance is a precursor of another substance that is already scheduled are considered when determining the schedule of a drug.

Schedule I controlled substances have a high potential for abuse, lack data on safe use in humans, and have no currently accepted medical use in the United States. Schedules II through V are commonly prescribed and dispensed drugs. These drugs do have an accepted medical use in the United States. Schedule II drugs have the highest potential for psychological dependence or addiction and abuse. Schedule V drugs have the lowest potential for abuse and addiction.

Carisoprodol abuse has increased in the last decade. Carisoprodol is FDA approved for the relief of discomfort associated with acute, painful musculoskeletal conditions. Carisoprodol metabolizes to meprobamate, a Schedule IV controlled substance. The FDA calculated that carisoprodol is being abused at a rate similar to diazepam which is a Schedule IV benzodiazepine. The FDA found that patients who are abusing carisoprodol are typically abusing opioids, benzodiazepines, cocaine, and marijuana. In 2009, the National Survey on Drug Use and Health (NSDUH) data suggested that more than 100,000 12 to 17 year olds reported using carisoprodol for non-medical reasons and that almost one million 18-25 year olds reported using carisoprodol for non-medical reasons.

The DEA reports that carisoprodol is one of the most commonly diverted drugs. Doctor shopping and prescription forgery are very common diversion methods for carisoprodol. As of March 2011, street prices for carisoprodol ranged from \$1 to \$5 per tablet.

References:

Schedules of Controlled Substances: Placement of Carisoprodol Into Schedule IV. Federal Register 76 (2011 Dec 12): 77330-77359. Available from: <http://www.gpo.gov/fdsys/pkg/FR-2011-12-12/pdf/2011-31542.pdf>. [Accessed February 10, 2012]

Drug Enforcement Administration. Carisoprodol. January 2012. Available from: http://www.dea diversion.usdoj.gov/drugs_concern/carisoprodol/carisoprodol.pdf. [Accessed February 10, 2012]

AAP Updates ADHD Guidelines

The American Academy of Pediatrics (AAP) recently updated guidelines to help in the diagnosis and treatment of attention-deficit/hyperactivity disorder (ADHD) in children and adolescents. The AAP first published clinical recommendations for the diagnosis and evaluation of ADHD in children in 2000. Recommendations for treatment followed in 2001.

After a thorough literature review evaluating new evidence, the new guidelines were developed to replace the previous guidelines and recommendations published in 2000 and 2001. The previous guidelines addressed diagnosis and treatment for children six through 12 years of age. The new guidelines expand the age range and include children four through 18 years of age.

Recommendations for evaluation and diagnosis:

- The primary care clinician should evaluate any child four through 18 years of age who displays academic or behavioral problems and symptoms of inattention, hyperactivity, or impulsivity.
- The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria must be met to make a diagnosis of ADHD. Information should primarily be obtained from parents or guardians, teachers, and other school and mental health clinicians involved in the child's care.
- The primary care clinician should assess the child for other conditions that may coexist with ADHD, including emotional or behavioral, developmental, and physical conditions.
- The primary care clinician should recognize ADHD as a chronic condition and consider children with ADHD as having special healthcare needs. These children should be managed according to the principles of the chronic care model and the medical home.

Recommendations for treatment:

- For children ages 4 to 5 years, first-line treatment should be evidence-based parent- or teacher-administered behavior therapy. If behavioral interventions do not provide significant improvement, methylphenidate may be prescribed.
- For children ages 6 to 11 years, the primary care clinician should prescribe FDA-approved ADHD medications and/or evidence-based parent- and/or teacher-administered behavior therapy. The evidence is particularly strong for stimulant medications. Evidence is sufficient, but less strong for atomoxetine, extended-release guanfacine, and extended-release clonidine.
- For adolescents ages 12 to 18 years, the primary care clinician should prescribe FDA-approved ADHD medications with the agreement of the adolescent and may also prescribe behavior therapy. It is preferred that the clinician prescribe both.
- Doses of the ADHD medication should be titrated to achieve maximum benefit with minimum adverse effects.

Reference:

ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity/Disorder in Children and Adolescents. Subcommittee on Attention-Deficit/Hyperactivity Disorders, Steering Committee on Quality Improvement and Management. Pediatrics. 2011;128(5): 1007-1022.

Alabama Medicaid Updates

Dr. Melinda Rowe Named Alabama Medicaid Assistant Medical Director

Melinda G. Rowe, MD, MBA, MPH, has been appointed Assistant Medical Director of Health Systems for the Alabama Medicaid Agency. In this capacity, Dr. Rowe will coordinate and work with Agency staff on a number of issues including long term care, radiology/lab programs and quality initiatives, and will serve as the Agency's contact person for the Alabama Chapter of the Academy of Pediatrics, along with other duties. She will also assist Medicaid Chief Medical Officer Robert Moon, MD.

Board certified in Pediatrics and Preventive Medicine, Dr. Rowe is a graduate of the University of Alabama, the University of Alabama, School of Medicine, and the University of Alabama at Birmingham where she earned Master's degrees in Business Administration and Public Health. Her career includes a variety of public health leadership positions in Kentucky, Georgia and Alabama, including more than six years as the Director of Health for the Louisville/Jefferson County Health Department in Louisville, Ky., where she was responsible for the public health of a community of more than 1 million people.

Dr. Rowe comes to the Agency with more than 25 years of high-level experience in public health management. Prior to joining Medicaid, Dr. Rowe was in private practice, served as regional medical director at Qualis Health in Birmingham, and was a medical consultant to the State of Alabama's Disability Determination Service.

Dr. Rowe has a strong professional interest in rural health care, health education/prevention, and evidence-based medicine leading to increased quality of care. She hails from north Alabama and operates a cattle farm with her husband in Chilton County.