Alabama Medicaid Pharmacist

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PDL Update

Effective July 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*
Daytrana—Cerebral Stimulants/ Agents for ADD/ADHD-Long Acting	**Astelin**—EENT preparations/ Antiallergic Agents
	Symbicort—Respiratory/ Corticosteroids
	Besivance—EENT preparations/ Antibacterials
	Protopic—Misc Skin and Mucous Membrane Agents
	Elidel—Misc Skin and Mucous Membrane Agents
	Levemir—Insulins
	Luvox CR—Antidepressants
	Aciphex—Proton Pump Inhibitors

**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.*

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

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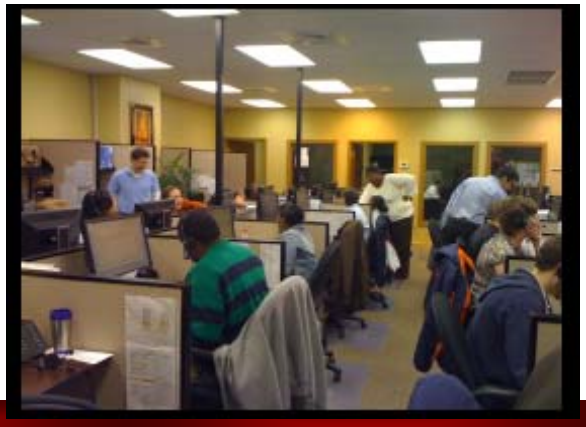

Providers recognized for compliance with Preferred Drug List

Physicians who help the state of Alabama save money by using Medicaid's Preferred Drug List (PDL) are now being recognized by a new program that exempts them from many of the Agency's prior authorization (PA) requirements.

The Gold Standard program was launched April 1, 2011 to recognize prescribers whose compliance rate with the Agency's PDL is in the top 3 percent or higher, according to Pharmacy Services Director Kelli Littlejohn, PharmD. To qualify as a Gold Standard prescriber, physicians must have three or fewer non-preferred drug claims and more than 220 prescriptions for preferred or over-the-counter (OTC) drugs written during the previous quarter. Based on fourth quarter 2010 data, 345 prescribers were designated as 'gold standard' providers for the second quarter of 2011 (April-June).

New Gold Standard Program recognizes prescribers with a high PDL compliance rate.

Gold Standard providers are exempt from certain prior authorization requirements for a specified time. During that time period, most non-preferred prescriptions written by the provider will be approved at the pharmacy and a written PA request form will not be required. Certain drugs are excluded from the exemption and still require a PA, including monoclonal antibodies, PDE inhibitors, weight loss agents, growth hormones and biological injectable agents.

Providers are re-evaluated each quarter, and once a provider has been on the Gold Standard list for 3 of 4 quarters, the exemption stretches to one year. Providers who do not meet the 'gold standard' will continue to use the usual request process when prescribing a drug that requires prior authorization.

In Fiscal Year 2010, more than 8.6 million prescriptions were dispensed at a cost of more than $514 million. The Agency's Preferred Drug List (PDL) was started in 2003 to manage health care costs by encouraging use of preferred, generic and over-the-counter drugs.

"A 2010 study found that implementation of a mandatory PDL saved the state more than $275 million between November 2003 and December 2009," Dr. Littlejohn said. "This validates our experience that the PDL results in cost savings while supporting quality health care."

Patient Care Networks

Since the late 1990s, Alabama Medicaid's Patient 1st program has made it possible for thousands of Alabama Medicaid recipients to have a primary care physician close to home. Now, the Agency is poised to expand and strengthen this doctor-patient relationship by pilot testing care networks in three areas of the state starting August 1, 2011.

Interest in the care network concept is growing, according to Robert Moon, MD, Medicaid Medical Director and Deputy Commissioner, Health Systems.

MedNet West, Inc., Care Network of East Alabama, Inc., and North Alabama Community Care, Inc. have been selected to pilot test a six-county network in West Alabama, pending approval of the new program by the Centers for Medicare and Medicaid Services. Proposals for a four-county area in east Alabama and two counties in north Alabama were received March 4 and were recently approved. Together, the three pilot areas will cover approximately 80,000 Medicaid recipients.

Alabama Medicaid's care networks are set up to function as "medical neighborhoods" in which doctors, pharmacists and others work cooperatively to coordinate care for patients, according to Dr. Moon. He explained that care networks are specifically designed to ensure that patients gain access to specialists, tests or services they need, to encourage consumers to have greater involvement in their care, facilitate communication across settings and providers, and ultimately result in patient care that is less fragmented and more holistic.

Using ADHD Stimulant Medications with Decongestants—Is It Safe?

The use of stimulant medication has become more common in the last decade. Approximately 9.5% of children ages 4-17 years of age have been diagnosed with attention-deficit/hyperactivity disorder (ADHD), as of 2007. The rates of patients being diagnosed with ADHD have continued to rise as well, increasing an average of 5.5% per year from 2003 to 2007.

Stimulant medications are listed as first-line therapy in the treatment of attention-deficit/hyperactivity disorder and are commonly used. In 2005, in response to international reports of sudden cardiac death and stroke related to the use of stimulant medications, the FDA conducted a review of the sudden/cardiac death or stroke rate in children. The FDA concluded that the sudden death rate for children on stimulants did not exceed the base rate for the general population. Stimulants CAN increase blood pressure and heart rate, but these effects are not clinically significant in patients without pre-existing cardiac conditions.

Because there is still concern with increased blood pressure and heart rate in patients taking stimulants, the American Heart Association (AHA) recommends routine electrocardiograms (ECGs) for children starting stimulant medication. However, the American Academy of Pediatrics (AAP) does NOT currently recommend pre-treatment ECGs unless there is a family history or high risk of cardiovascular disease.

Pseudoephedrine is an oral decongestant and is structurally related to the stimulant agents. This being the case, is it safe to give children taking stimulants an oral decongestant?

Current labeling of methylphenidate and

amphetamine products do not caution against concomitant use of oral decongestants, some sources advise caution with such combinations. Since monotherapy with either a stimulant or a decongestant has been associated with adverse cardiovascular events, then theoretically, concomitant use can potentiate these effects.

Alternatives for oral decongestants can be recommended to ADHD patients with nasal congestion. Saline nasal irrigation, nasal strips, and/or a humidifier may be useful in cases of nasal congestion. In patients with chronic rhinitis, antihistamines and nasal steroids may also be helpful.

References:

1. CDC. Attention-Deficit/Hyperactivity Disorder (ADHD). www.cdc.gov. [Accessed 5/18/2011].
2. Perrin JM, Friedman RA, Knilans TK, et al. AAP Policy Statement. Cardiovascular Monitoring and Stimulant Drugs for Attention-Deficit/Hyperactivity Disorder. Pediatr Vol 122 No. 2 August 2008 p 451-3.
3. PL Detail-Document, Safety of using ADHD stimulant meds with decongestants. Pharmacist's Letter/Prescriber's Letter. April, 2011.

Treatment of Nocturnal Enuresis

Nocturnal enuresis is defined as repeated, spontaneous voiding of urine during sleep in a child five years or older. It affects around 15-20% of five year olds, and up to 2% of young adults.

Primary nocturnal enuresis occurs when the nocturnal urine production is more than the bladder's capacity and the child fails to awaken in response to a full bladder. Enuresis can also be secondary to a medical, psychological, or behavioral problem, although this is less common.

There are several treatment options; including behavioral therapies, enuresis alarms, and pharmacological interventions.

According to the International Children's Continence Society, which published a standardization document in the Journal of Urology in 2010, there are currently two valid first line therapies: desmopressin and enuresis alarms. Alarm therapy results in dryness in about two-thirds of children (grade Ia evidence), and should be considered for children with primary nocturnal enuresis without polyuria. Patients generally require a trial of two to three months. If positive results have not been noted at the end of this time, the alarm therapy should be discontinued.

Approximately 15-20% of five year olds and up to 2% of young adults are affected by nocturnal enuresis.

Desmopressin works best for children with nocturnal polyuria and normal bladder reservoir function and for families in whom alarm treatment has failed. Approximately 30% of children with enuresis are full responders and 40% have a partial response (grade Ia evidence).

The American Academy of Family Physicians (AAFP) published recommendations for the treatment of enuresis in 2008. Their guidelines state that there are 2 first-line therapies, enuresis alarms and desmopressin.

The AAFP states that an enuresis alarm is effective in children with monosymptomatic nocturnal enuresis (evidence grade A) and that desmopressin is most effective in children who have enuresis with nocturnal polyuria and normal bladder capacity (evidence grade A). The article indicates that about two-thirds of children have success with the enuresis alarm and nearly one-half of children remain dry after discontinuation. There is a 60-70% response rate with desmopressin although about 80% of children relapse after discontinuing therapy.

A Cochrane Literature Review of 56 studies involving 3257 children provides much the same evidence. Alarms take longer than desmopressin to reduce bedwetting, but the effects continue even after discontinuation of the alarm.

References:

1. Neveus T, Eggert P, Evans J, et al. Evaluation of and Treatment for Monosymptomatic Enuresis: A Standardization Document From the International Children's Continence Society. J Urol 2010; 183:441-447.

2. Ramakrishnan, K. Evaluation and Treatment of Enuresis. Am Fam Physician 2008; 78(4): 489-496, 498.

3. Glazener CMA, Evans JHC, Peto RE. Alarm interventions for nocturnal enuresis in children. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD002911. DOI: 10. 1002/14651858. CD002911.pub2.

Attention: Family Physicians, Pediatricians, and Urologists

Effective May 1, 2011, Alabama Medicaid will cover enuresis alarms through the Durable Medical Equipment (DME) program for recipients age 5 years up to age 21. Providers may submit procedure code S8270 for coverage of the alarm and should bill Medicaid their usual and customary charge for reimbursement.

In 2008, the American Academy of Family Physicians (AAFP) published recommendations for the treatment of enuresis stating there are 2 first line therapies, enuresis alarms and desmopressin. Alarms have been shown to have a two-thirds success rate for recipients with monosymptomatic nocturnal enuresis. Providers are encouraged to prescribe the enuresis alarm as a first line and cost effective therapy.

Safe Prescribing Tips for Opioids

Opioids are an important class of medication used in the treatment of acute and chronic pain. While these drugs provide much relief to patients they also have many unwanted and often dangerous side effects.

It is important to recognize that opioids are effective for some patients but are ineffective or potentially harmful to others. Opioids need to be used as safely as possible.

There are several things prescribers can do to increase the safety of opioid use. Below are a few guidelines to help ensure the safe prescribing and use of opioids.

Individualize treatment. Keep in mind that opioids are a class of medications and may not be the only treatment option for patients. For some patients, opioids will not be effective alone or well tolerated; the treatment plan for each patient should account for variability in patient responses.

Consider long-acting preparations. It cannot be said that long-acting opioids provide superior pain relief compared with shorter-acting opioids, but longer-acting opioids may require fewer pills. They also may provide the potential benefit of more stable blood levels of the medication rather than highs and lows produced with short-acting opioids. As a result, they tend not to reinforce potentially addictive behaviors.

Use multimodal therapy. Opioids are a class of medications that may be useful in many patients with moderate to severe pain, but not for all. When opioids are used to treat chronic pain they should be considered one portion of a multimodal treatment plan.

The treatment plan should acknowledge that the patient is likely to benefit from a range of therapies, both pharmacologic and non-pharmacologic. In patients with chronic pain, opioid therapy should be considered after the patient has tried and failed non-opioid therapy as well as non-pharmacologic pain therapy.

Educate patients and get a written treatment agreement. Patients must be educated regarding their therapy, especially when opioids are a part of their treatment plan. Some patients may be afraid that the use of opioids will cause more harm than good, while others may think of opioids as a cure-all. Patients should be informed that total pain relief with opioids is rare.

Patients should be well informed of the goals of therapy as well as the prescribers' expectation of them as a patient. There should be a treatment agreement signed by the patient and prescriber, which can be used as a tool for educating the patient about the opioid treatment plan and to document the patient's agreement to participate.

Refer patients to a specialist. Most patients on opioid therapy can be monitored in the primary care setting; however, some patients have complicated medical or social conditions which require integrated care with specialists outside of this setting. These more complicated cases may be treated successfully within primary care by involving specialists as co-managers.

The management of patients with a history of substance abuse may require extra care, monitoring, documentation, and consultation with a behavioral health specialist.

Use opioid monitoring. Random urine drug screening may be important, even before an opioid is prescribed. This can be an important part of the patient history as it can screen for the presence of illegal drugs, unreported prescribed medications, or unreported alcohol use prior to starting therapy. It's important to know who you are prescribing to in order to maximize benefit and safety.

Consider tamper-resistant products. There are many new products available as well as many products in the pipeline to help reduce inappropriate use. These products will not prevent all misuse but they can help prevent patients from crushing the medication for a use other than the medical purpose of an opioid. The tamper-resistant products should be considered in all patients and not just those exhibiting potential abuse behaviors.

<u>References</u>

Chou R, Fanciullo GJ, Fine PG, et al. Clinical guidelines for the use of chronic opioid therapy in chronic noncancer pain. *J Pain*, 2009;10(2):113-130.

The Department of Veterans Affairs and The Department of Defense. Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. Washington, DC. Available at: http://www.healthquality.va.gov/Chronic_Opioid_Therapy_COT.asp

FDA Will Remove Unapproved Cough, Cold and Allergy Drugs

The FDA announced on March 2, 2011, that action will be taken against companies who manufacture, distribute, or market certain unapproved prescription cough, cold and allergy products. This marks the seventeenth action of the FDA's Unapproved Drugs Initiative which began in June 2006. These products will be removed because they have not been evaluated by the FDA for safety, effectiveness and quality. Many of the drug products contain active ingredients that were introduced into the marketplace without prior review for effectiveness. Drug labels do not disclose that these products lack FDA approval.

Companies which listed their products prior to the FDA's action are expected to stop manufacturing their products by June 1, 2011, and stop shipping their products by August 30, 2011. Companies who have not previously listed their products with the FDA are expected to stop manufacturing and shipping their products immediately. For a complete listing of all products being withdrawn, please visit www.fda.gov.

The FDA does not anticipate this initiative to have a negative impact on patient care as there are many approved prescription and over-the-counter products available to treat cough, cold and allergies. Patients should discuss alternative regimens with their health care provider.

References:

1. FDA. FDA prompts removal of unapproved drugs from market. March 2, 2011. http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm245045.htm. [Accessed May 18, 2011].
2. FDA. Unapproved prescription cough, cold and allergy products. April 4, 2011. http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/EnforcementActivitiesbyFDA/SelectedEnforcementActionsonUnapprovedDrugs/ucm245106.htm. [Accessed May 18, 2011].
3. Alternatives to unapproved cough and cold meds. Pharmacist's Letter/Prescriber's Letter 2011;27(4):270407.

Helpful Hints for the Reimbursement of Hospice Related Drugs

In an effort to support the coordination of care between a recipient's hospice provider and pharmacy provider, the Alabama Medicaid Agency has provided information below to assist providers regarding the appropriate billing of hospice services:

- Reimbursement for disease specific drugs related to the recipient's terminal illness is included in the per diem for hospice covered services. These drugs will not be reimbursed through the Medicaid Pharmacy Program.
- Reimbursement for drugs not related to the recipient's terminal illness may be made to the dispensing pharmacy through the Medicaid Pharmacy Program. These drugs will not be reimbursed through the per diem for hospice covered services.
- Retrospective audits of the hospice and pharmacy providers are conducted regularly to ensure appropriate billing has occurred.

For more information regarding which program specific medications should be billed, the Hospice Palliative Drug List shall be used as a guide for drugs that may be associated with the patient's terminal illness and therefore should be billed to hospice services. The HPDL is available on the website using the following link:

http://medicaid.alabama.gov/documents/4.0_Programs/4.5_Pharmacy_Services/4.5.4_Drug_Info/4.5.4_Hospice_Palliative_Care_Drug_List_4-1-11.pdf

Policy questions related to the HPDL should be directed to Hospice Services at (334) 242-5018.