Alabama Medicaid Pharmacist

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A Service of Alabama Medicaid

PDL Update

Effective April 2, 2007, the Alabama Medicaid Agency updated 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

Pataday—EENT/Antiallergic Agents
Phisohex—Skin and Mucous Membrane Agents
Relpax—Triptans
Coreg CR—Antihypertensive Agents

PDL Deletions*

Advicor—Antihyperlipidemics
Axert—Triptans
Brethine—Respiratory Agents
Capitrol Shampoo—Skin and Mucous Membrane Agents
Generic Lindane—Skin and Mucous Membrane Agents
Prudoxin—Skin and Mucous Membrane Agents
SSD/SSD AF—Skin and Mucous Membrane Agents
Zaditor—EENT/Antiallergic Agents
Zmax—Anti-infective Agents

**denotes that these products will no longer be preferred but are still covered by Alabama Medicaid and will need Prior Authorization (PA).*

In addition to the above drug changes, the Agency updated its criteria for the following classes: Selective Serotonin Agonists (Triptans) and Skin and Mucous Membrane agents. Prior therapies must include prescribed and PDL preferred agents for these classes.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically, can be found on the Agency website (www.medicaid.alabama.gov).

Hard copy PA requests may be faxed or mailed to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
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Auburn, AL 36832-3210
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Inside This Issue

CMS e-Prescribing

The Centers for Medicare and Medicaid Services (CMS) released a report to Congress in April 2007 detailing the results of the pilot testing of information standards for e-prescribing.

The Medicare Modernization Act of 2003 (MMA) requires Part D plans to support an e-prescribing program, should any of their providers choose to e-prescribe. This program is complex and multi-layered and requires rigorous testing to ensure that there are uniform standards in place that are compatible with existing standards (most especially with the Health Insurance Portability and Accountability Act [HIPAA]). Final e-prescribing standards are due by April 2008, with implementation up to a year later.

Acetaminophen

Acetaminophen is the nation's most popular over-the-counter medication, with 45 million people (roughly 1/5 of US adults) taking a dose in any given week. According to the 2005 annual report from the American Association of Poison Control Centers Toxic Exposure Surveillance System, there were 416 fatalities from analgesic agents, approximately half of which were caused by acetaminophen or acetaminophen-containing combinations. Acetaminophen was the cause of more than 138,000 calls to poison control centers and is now the leading cause of acute liver failure in the United States.

Most patients see acetaminophen as a safe, reliable, and relatively harmless drug, and when used within proper dosing guidelines, it is. Unfortunately, the patients most at risk for acetaminophen toxicity (elderly patients, chronic pain patients, patients with hepatitis, or those with renal failure) are those same patients that are most likely seeing multiple physicians and taking multiple medications. Accidental acetaminophen overdose is very common – roughly half of acetaminophen overdosages are accidental.

What constitutes an overdose? An acute overdose may occur when a patient takes a single dose that exceeds 150mg/kg (generally between 7.5 and 10 grams in adults). A chronic overdose may occur when a patient regularly takes more than 4 grams/day.

What are the signs/symptoms of an overdose? The first symptoms of a single acute overdose do not occur until 12 hours after ingestion, and may remain mild for the first 48 hours.

Stages of Acetaminophen Poisoning

Stage 1 (0 to 24 hours post ingestion) – Anorexia, nausea, and vomiting.

Stage 2 (24 to 72 hours post ingestion) – Abdominal pain; AST and ALT elevation.

Stage 3 (72 to 96 hours post ingestion) – Vomiting and symptoms of hepatic failure; AST and ALT peak; sometimes renal failure and pancreatitis.

Stage 4 (> 5 days) – Resolution of hepatotoxicity OR progression to multiple organ failure (sometimes fatal).

In a chronic overdose situation, symptoms may be absent or may include any of those seen with an acute overdose.

Can acetaminophen overdose be treated? Yes. Acetaminophen toxicity is treated with activated charcoal (if it is suspected that there is still drug in the GI tract) and N-acetylcysteine. For acute poisoning, N-acetylcysteine is most effective if given within the first eight hours of ingestion. For chronic overdose, N-acetylcysteine is given for the first 24 hours if hepatotoxicity is suspected and continued until the AST and ALT levels return to normal.

A patient that presents with hepatic failure is treated with supportive care. These patients may require a liver transplant.

What can be done? In December 2006, the FDA proposed a labeling change in over-the-counter products containing acetaminophen. These new warnings would emphasize the potential for liver toxicity, especially when using acetaminophen in high doses, using multiple products containing acetaminophen, and when taking acetaminophen with alcohol. They would also require the manufacturers to prominently identify acetaminophen as an ingredient.

It is important that pharmacists and physicians remind their patients to be mindful of their prescription acetaminophen ingestion and to look for acetaminophen in over-the-counter products.

Encourage patients to take action if they suspect an acetaminophen overdose. The National Poison Control Center can be reached 24 hours a day at 1-800-222-1222. The Alabama Poison Control Center can also be reached 24 hours a day at 1-800-462-0800.

References

Medline Plus – Acetaminophen Overdose. Available at www.nlm.nih.gov. Accessed April 2007.

FDA News – FDA Proposes Labeling Changes to Over-the-Counter Pain Relievers. Available at www.fda.gov. Accessed April 2007.

Dart RC, Erdman AR, Olson KR, et al. Acetaminophen Poisoning: an Evidence-Based Consensus Guideline for Out-of-Hospital Management. Clinical Toxicology, 44:1-18, 2006.

Merck Manual Professional – Acetaminophen Poisoning. Available at www.merck.com. Revised November 2005. Accessed April 2007.

Larson AM, Polson J, Fontana, RJ, et al. Acetaminophen-Induced Acute Liver Failure: Results of a United States Multicenter, Prospective Study. Hepatology; December 2005.

Lai MW, Klein-Schwartz W, Rodgers GC, et al. 2005 Annual Report of the American Association of Poison Control Centers' National Poisoning and Exposure Database. Clinical Toxicology, 44:803-932, 2006.

Asthma

Asthma is a serious health problem, affecting approximately 20 million (1 in 15) Americans, including 6 million children. The prevalence of asthma has been increasing since the early 1980s across all age, sex, and racial groups. According to data collected by the American Lung Association (*Trends in Asthma Morbidity and Mortality* published July 2006), in a 2005 study, 11.2% of adults in Alabama have been told by a healthcare professional that they have asthma.

Asthma is characterized by inflammation in the air passages resulting in the temporary narrowing of the airways that transport air from the nose and mouth to the lungs. The major cause of constriction is the contraction of bronchial smooth muscles triggered by histamine, prostaglandins, and leukotrienes. This contraction is worsened by thickening of the airway due to edema, cellular infiltration, and mucous. Typically, patients with asthma have airway hyperresponsiveness. The airways of these patients narrow easily and respond disproportionately to certain triggers. Common triggers are pollen, dust mites, molds, tobacco smoke, cold air, and exercise. Patients may experience wheezing, breathlessness, chest tightness, and cough as the airways grow narrower.

Overall goals for the treatment of asthma are to eliminate or minimize symptoms and exacerbations (avoiding ER visits and hospitalizations), maintain normal or near normal pulmonary function, minimize interference with daily activities, and maximize use of medications (while minimizing use of short-acting beta-agonists and adverse reactions). The key to controlling the disease is controlling the inflammation.

The National Asthma Education and Prevention Program (NAEPP - 2002) and the Global Initiative for Asthma (GINA - 2006) have helped to establish standardized treatment plans.

1. Mild Intermittent Asthma – No daily medication needed. Severe exacerbations may occur, separated by long periods of normal lung function and no symptoms. A course of systemic corticosteroids is recommended as needed.

2. Mild Persistent Asthma – Preferred treatment is low-dose corticosteroids. Alternative treatments (listed alphabetically): cromolyn, leukotriene modifier, nedocromil, OR sustained-release theophylline titrated to therapeutic blood concentrations.

3. Moderate Persistent Asthma – Preferred treatment is low-to-medium dose inhaled corticosteroids and long-acting inhaled $beta_2$-agonists. Alternative treatments: increase inhaled steroids within medium-dose range OR low-to-medium dose inhaled corticosteroids and either leukotriene modifier or theophylline.

4. Severe Persistent Asthma – High-dose inhaled corticosteroids and long-acting inhaled $beta_2$-agonists. If needed, oral corticosteroids may be added – making attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.

In November 2005, the FDA issued a Public Health Advisory requesting the manufacturers of Advair Diskus (fluticasone and salmeterol), Foradil Aerolizer (formoterol) and Serevent Diskus (salmeterol) to update their existing product labels with new warnings and a Medication Guide for patients to alert health care professionals and patients that these medicines may increase the chance of severe asthma episodes, and death when those episodes occur. All of these products contain medicines belonging to the class known as "long-acting $beta_2$-agonists" (LABA).

In part, the FDA wanted to remind health care professionals that LABAs should not be the first medicine used to treat asthma. LABAs should be added to the asthma treatment plan only if other medications do not control the asthma, including the use of low-or-medium dose corticosteroids. The advisory was also issued to make sure that patients are aware that LABAs do not relieve sudden wheezing or treat wheezing that is getting worse – patients should always have a short-acting bronchodilator available for these circumstances.

References

American Lung Association Epidemiology & Statistics Unit Research and Program Services. Trends in Asthma Morbidity and Mortality. July 2006.

Asthma and Allergy Foundation of America. Asthma Facts and Figures. Available at www.aafa.org. Accessed September 2006.

National Institutes of Health/National Heart, Lung, and Blood Institute. NAEPP Expert Panel Report Guidelines for the Diagnosis and Management of Asthma – Update on Selected Topics 2002. NIH Publication No. 02-5075. Originally printed June 2002.

Global Strategy for Asthma Management and Prevention. NIH Publication No. 02-3659. Issued January 1995 (updated 2006). GINA reports available at www.ginasthma.org.

Asthma Facts. Environmental Protection Agency – Indoor Environments Division/Office of Air and Radiation. EPA 402-F-04-019. Updated May 2006.

Prevalence Data – Asthma 2005. CDC. Updated June 2006. Available at apps.nccd.cdc.gov. Accessed September 2006.

Smoot LC. Asthma – Help to promote a breath of fresh air. Drug Topics. 2005 September. Available at www.drugtopics.com. Accessed September 2006.

Global Strategy for Asthma Management and Prevention[1]

Management Approach Based on Control

For Children Older Than 5 Years, Adolescents and Adults

Reduce

Level of Control	Treatment Action
Controlled	Find and maintain lowest controlling step
Partly Controlled	Consider stepping up to gain control
Uncontrolled	Step up until controlled
Exacerbation	Treat as exacerbation

Increase

Reduce ← **Treatment Steps** → Increase

Step **1**	Step **2**	Step **3**	Step **4**	Step **5**
Asthma education Environmental control				
As needed rapid-acting B_2-agonist	As needed rapid-acting B_2-agonist			
Controller options	Select one	Select one	Add one or more	Add one or both
	Low-dose inhaled ICS*	Low-dose ICS plus long-acting B_2-agonist	Medium- or high-dose ICS plus long-acting B_2-agonist	Oral glucocorticosteroid (lowest dose)
	Leukotriene modifier **	Medium- or high-dose ICS	Leukotriene modifier	Anti-IgE treatment
		Low-dose ICS plus leukotriene modifier	Sustained release theophylline	
		Low-dose ICS plus sustained release theophylline		

*ICS=inhaled glucocorticosteroids
**=Receptor antagonist or synthesis inhibitors

Alternative reliever treatments include inhaled anticholinergics, short-acting oral B_2-agonists, some long-acting B_2-agonists, and short-acting theophylline. Regular dosing with short and long-acting B_2-agonist is not advised unless accompanied by regular use of an inhaled glucocorticosteroid.

1. Global Strategy for Asthma Management and Prevention, *Global Initiative for Asthma (GINA) 2006. Available from: http://www.ginasthma.org.*

Global Strategy for Asthma Management and Prevention[1]

Classification of Asthma Severity by Clinical Features Before Treatment
Intermittent
Symptoms less than once a week Brief exacerbations Nocturnal symptoms not more than twice a month FEV_1 or PEF ≥ 80% predicted PEF or FEV_1 variability < 20%
Mild Persistent
Symptoms more than once a week but less than once a day Exacerbations may affect activity and sleep Nocturnal symptoms more than twice a month FEV_1 or PEF ≥ 80% predicted PEF or FEV_1 variability < 20 – 30%
Moderate Persistent
Symptoms daily Exacerbations may affect activity and sleep Nocturnal symptoms more than once a week Daily use of inhaled short-acting B_2-agonist FEV_1 or PEF 60-80% predicted PEF or FEV_1 variability > 30%
Severe Persistent
Symptoms daily Frequent exacerbations Frequent nocturnal asthma symptoms Limitation of physical activities FEV_1 or PEF ≤ 60% predicted PEF or FEV_1 variability > 30%

Levels of Asthma Control			
Characteristic	**Controlled (All of the Following)**	**Partly Controlled (Any measure present in any week)**	**Uncontrolled**
Daytime symptoms	None (twice or less/week)	More than twice/week	**Three or more features of partly controlled asthma present in any week**
Limitations of activities	None	Any	
Nocturnal symptoms/awakening	None	Any	
Need for reliever/ rescue treatment	None (twice or less/week)	More than twice/week	
Lung function (PEF or FEV_1)	Normal	< 80% predicted or personal best (if known)	
Exacerbations	None	One or more/year*	One in any week†

* Any exacerbation should prompt review of maintenance treatment to ensure that it is adequate.
† By definition, an exacerbation in any week makes that an uncontrolled asthma week.

1. Global Strategy for Asthma Management and Prevention, *Global Initiative for Asthma (GINA) 2006. Available from: http://www.ginasthma.org.*

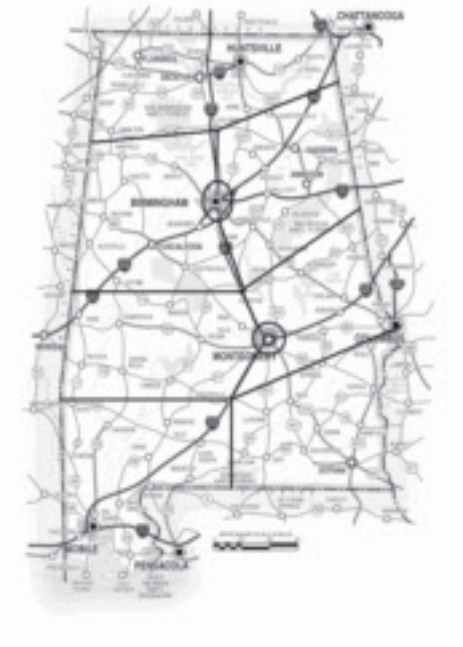
Academic Detailing Program

The Alabama Medicaid Agency contracts with Health Information Designs (HID) for the Academic Detailing Program (ADP). The purpose of the ADP is to promote and educate Medicaid providers regarding generic utilization, the Preferred Drug List (PDL), the Prior Authorization (PA) program, and other priority issues determined by the Alabama Medicaid Agency.

In order to try to visit as many providers as possible, the state is divided up into seven geographic regions – each including at least one major city. Each region has a full time Medicaid Pharmacy Specialist (MPS) that lives in and travels throughout the area, making prescheduled visits to physicians and pharmacies.

Geographic Regions

Huntsville and North Alabama
Birmingham and West Alabama
Birmingham and East Alabama
Montgomery and West Alabama
Montgomery and East Alabama
Mobile and SW Alabama
Dothan and SE Alabama



The Specialists have received extensive training on the Preferred Drug List (PDL), the Prior Authorization (PA) program, and other Medicaid programs.

The ADP home office is located in Auburn, Alabama and employs two schedulers and a nurse manager.

To set up an appointment with a Medicaid Pharmacy Specialist, please call 334-466-3055 or 334-466-3056.

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