Alabama Medicaid Pharmacist

Published Quarterly by Health Information Designs, Inc., Winter 2007

A Service of Alabama Medicaid

Pharmacy Brand Limitation

Effective January 1, 2008, Alabama Medicaid will increase the current four (4) brand limit policy to five (5) brand name prescriptions per month per recipient. There will not be a limit on the number of covered generic or over-the-counter prescriptions a recipient may receive. This limitation does not apply to children under the age of 21 and recipients living in nursing facilities.

In certain drug classes, allowances are made in the event of an adverse or allergic reaction, or failure to respond. Medicaid will also continue to allow for prescriptions to exceed the five (5) brand limit for antipsychotic and antiretroviral medications; however, there will be no instance where the limit may exceed ten (10) brand name drugs per month per recipient.

PDL Update

Effective January 1, 2008, 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

Vyvanse – Cerebral Stimulants/ADHD-Long Acting

PDL Deletions*

Omnicef – Anti-infective Agents

Proventil – Respiratory Agents

QVAR - Respiratory Agents

Sular – Antihypertensive Agents

Sinequan - Antidepressant Agents

Surmontil - Antidepressant Agents

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

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
PO Box 3210
Auburn, AL 36832-3210
Fax 800-748-0116
Phone 800-748-0130

Inside This Issue:

Monitoring Metabolic Effects of Antipsychotic Therapy: A Public Health Concern

The second-generation antipsychotics (SGAs) have emerged as the mainstay of treatment for psychotic illnesses over the last decade. Compared with their first-generation counterparts, the SGAs are more effective at treating the negative, cognitive, and affective symptoms of psychotic illnesses with fewer or no extrapyramidal side effects at clinically effective doses.[1,2] Despite the potential benefits of SGA therapy, their use has been associated with metabolic side effects, including weight gain, hyperglycemia and diabetes (even diabetic ketoacidosis), and dyslipidemia.[1,3] There is increasing public health concern regarding the differential impact of these therapies on the cardiovascular risk and overall health of patients with serious mental illness.

Patients with psychiatric illness have increased rates of medical morbidity and mortality compared with the general population.[4,5] Among all causes of death, cardiovascular disease (CVD) is responsible for as much as 50% of the excess mortality associated with the diagnosis of schizophrenia.[5] The risk of CVD mortality is two to three times greater in patients with serious mental illness than in the general population.[3] A recent analysis of 689 patients who participated in the Clinical Trials of Antipsychotic Treatment Effectiveness (CATIE) schizophrenia trial demonstrated that the calculated ten-year risk for coronary heart disease was significantly elevated in schizophrenia patients (34% higher in men and 50% higher in women) compared to matched controls.[4] Additionally, studies suggest that the prevalence of both diabetes and obesity is 1.5 to 2.0 times higher in patients with psychiatric disorders than in the general population.[1] The relative contributions to metabolic disturbance and CVD risk of specific antipsychotic agents, lifestyle (lack of exercise, poor diet, smoking), access to general medical care, and the psychiatric illness itself are not clear.[1,4]

ADA-APA Consensus Statement

The potential for SGA therapy to further increase metabolic and CVD risk in patients with serious mental illness has emerged as a major clinical concern. The American Diabetes Association (ADA), the American Psychiatric Association (APA), the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity published a consensus statement in February 2004 examining the relationship between the use of antipsychotic drugs and metabolic side effects.[1] The conclusions of the consensus panel have been confirmed by several recent comprehensive reviews of the psychiatric literature.[3,6]

Treatment with SGAs can cause rapid weight gain in the first few months of therapy that can continue beyond the first year of treatment.[1,2] The mechanism(s) responsible for SGA-associated weight gain are not clear, however the binding affinities of these drugs for receptors implicated in the control of body weight, including dopamine, serotonin, norepinephrine, and histamine-H1 receptors, have been cited.[2] The weight gain liability varies significantly across the different second-generation agents (Table 1).[1,3]

Numerous reports have also documented changes in glucose regulation, including hyperglycemia, new-onset diabetes, exacerbation of existing diabetes, and diabetic ketoacidosis, following the initiation of therapy with certain antipsychotic medications.[1,3] These events may occur within a few weeks of initiating drug treatment. Data have demonstrated an increased risk for diabetes in patients treated with clozapine and olanzapine compared with no antipsychotic therapy, conventional antipsychotic therapy, and therapy with other select SGAs.[1,3,6] Evidence regarding the risk for diabetes in patients taking risperidone and quetiapine is inconsistent, and a generally smaller effect has been seen in studies where an effect was reported.[1,3] Evidence from clinical trials with aripiprazole and ziprasidone suggest that these agents are not associated with an increase in the risk for diabetes, however long-term epidemiologic data are limited.[1,3] Changes in serum lipids (increased LDL cholesterol and triglycerides, decreased HDL cholesterol) associated with SGA therapy appear to be concordant with changes in body weight.[1]

Weight gain and changes in body composition appear to underlie much of the increased risk for metabolic complications of SGA therapy (insulin resistance, diabetes, dyslipidemia), however case reports suggest that some patients may experience treatment-associated glucose dysregulation without substantial weight gain or obesity.[1,3] Further studies are necessary to determine if specific SGAs have a direct effect on insulin sensitivity or secretion.

Monitoring

Given the serious health risks, the consensus panel recommends appropriate baseline screening and follow-up monitoring in patients receiving therapy with SGAs (Table 2).[1] Baseline screening measures should include personal or family history of obesity, diabetes, dyslipidemia, hypertension, or CVD, weight and height (for body mass index calculation), waist circumference, blood pressure, fasting plasma glucose, and a fasting lipid profile. These assessments can be used to identify overweight (body mass index = 25.0-29.9) or obesity (body mass index $\geq$30), pre-diabetes (fasting plasma glucose = 100-125 mg/dL) and diabetes (fasting plasma glucose $\geq$126 mg/dL), hypertension, or dyslipidemia. Weight should be reassessed at 4, 8, and 12 weeks after initiating or changing SGA therapy (Table 2). Fasting plasma glucose, lipid levels, and blood pressure should be reassessed three months after initiation of antipsychotic medications. Thereafter, blood pressure and fasting plasma glucose should be obtained annually or more frequently in patients with a higher baseline risk for developing diabetes or hypertension. The consensus panel recommends repeat lipid profile testing at five-year intervals in those with a normal baseline lipid profile, however others have suggested an annual evaluation of the lipid profile, given the high rate of untreated dyslipidemia in this population.[7]

The available data suggest that there is considerable variability in the risk for metabolic abnormalities among the class of second-generation antipsychotics.[1,3] According to the consensus statement, the results of baseline and follow-up monitoring should influence antipsychotic choice and the decision to switch SGA therapy.

Monitoring Metabolic Effects of Antipsychotic Therapy: A Public Health Concern, cont'd

Consider metabolic risks when selecting antipsychotic therapy.[1]

Initial treatment with an SGA with a lower risk for weight gain and glucose intolerance may be preferable in patients with, or at higher risk for, diabetes. Potential for weight gain should also be considered in the choice of psychiatric and nonpsychiatric medications.[1]

Consider switching to an SGA that has not been associated with significant weight gain or diabetes in the event of:

Worsening glycemia or dyslipidemia[1]
Significant weight gain (≥5% of the initial weight) [1]

In summary, there has been a growing body of literature focused on improving the general medical health of patients with schizophrenia and other forms of serious mental illness. One impetus for this increased awareness arises from concern over the metabolic effects of atypical antipsychotic therapy. The choice of antipsychotic therapy for a specific patient depends on many factors. The likelihood of developing severe metabolic disease should also be an important consideration. [1] Baseline screening and follow-up monitoring is essential to the care of patients with psychiatric illness.

Table 1. Second Generation Antipsychotics and Metabolic Abnormalities

	Weight Gain	Risk for Diabetes	Worsening Lipid Profile
Clozapine	**+++**	**+**	**+**
Olanzapine	**+++**	**+**	**+**
Risperidone	**++**	**D**	**D**
Quetiapine	**++**	**D**	**D**
Aripiprazole*	**+/-**	**-**	**-**
Ziprasidone*	**+/-**	**-**	**-**
Paliperidone	**+**	**-**	**-**

+ increase effect; - no effect; D discrepant results; * Newer drugs with limited long-term data

Table 2. Monitoring Protocol for Patients on Second Generation Antipsychotics *

	Baseline	4 Weeks	8 Weeks	12 Weeks	Quarterly	Annually	Every 5 Years
Personal/Family History	X					X	
Weight (BMI)	X	X	X	X	X		
Waist Circumference	X					X	
Blood Pressure	X			X		X	
Fasting Plasma Glucose	X			X		X	
Fasting Lipid Profile	X			X			X

* More frequent assessments may be warranted based on clinical status and baseline risk. See text for details.

References

American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. J Clin Psychiatry. 2004;65:267-272.

Tardieu S, Micallef J, Gentile S, Blin O. Weight gain profiles of new anti-psychotics: public health consequences. Obesity Reviews. 2003;4:129-138.

Newcomer JW. Second-generation (atypical) antipsychotics and metabolic effects: a comprehensive review of the literature. CNS Drugs. 2005;19 suppl1:1-93.

Goff DC, Sullivan LM, McEvoy JP, et al. A comparison of ten-year cardiac risk estimates in schizophrenia patients from the CATIE study and matched controls. Schizophrenia Research. 2005;80:45-53.

McEvoy JP, Meyer JM, Goff DC, et al. Prevalence of the metabolic syndrome in patients with schizophrenia: baseline results from the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) schizophrenia trial and comparison with national estimates from NHANES III. Schizophrenia Research. 2005;80:19-32.

Newcomer JW, Haupt DW. The metabolic effects of antipsychotic medications. Can J Psychiatry. 2006;51:480-491.

Cohn TA, Sernyak MJ. Metabolic monitoring for patients treated with antipsychotic medications. Can J Psychiatry. 2006;51:492-501.

Over-the-Counter (OTC) Pediatric Cough and Cold Products

On October 19, 2007, the Food and Drug Administration (FDA) Nonprescription Drugs Advisory Committee and the Pediatric Advisory Committee recommended that all OTC cough and cold medications should be avoided in children under 6 years of age. The medications involved include: antitussives (dextromethorphan), nasal decongestants (pseudoephedrine, phenylephrine), antihistamines (diphenhydramine, chlorpheniramine, brompheniramine), and combination cough/cold products. It should be noted that single-agent pain/fever relievers like acetaminophen and ibuprofen will still be available.

The recommendation was made for multiple reasons. First, there is limited information on the efficacy of these medications in the pediatric population; most information is extrapolated from the adult and adolescent population. This is not always the best assumption to make, as the respiratory anatomy of children (chest wall structure, immunologic responses, etc) is different than that of adults. Second is the issue of safety. When used appropriately, these ingredients are safe for most children, but these products are often unintentionally misused and serious harm, even death, can occur.

Healthcare professionals are not required to inform the FDA of adverse events associated with OTC products. However, during 2004-2005, an estimated 1,519 children less than 2 years of age were treated in U.S. emergency rooms for adverse events and overdose associated with the use of OTC cough and cold medications. In 2005, the National Association of Medical Examiners (NAME) identified 3 children aged 6 months and younger whose deaths were determined to be caused by a cough or cold medication. Unfortunately, these numbers may significantly underestimate the incidence of death and provides no information on the rate of serious adverse events.

Cough and cold medications are accidentally misused for a number of reasons. Most often, parents are using combination products that may contain the same ingredients, and are unaware of potential ingredient duplication. Second, there are no FDA approved dosing guidelines for children under the age of 2, and many OTC cough and cold products recommend that parents “consult the physician”. Parents may simply calculate a dose based on what would be given to an older child, which is not always appropriate for an infant. Another reason for potential overdose is dosing inaccuracies. The typical household teaspoon can contain anywhere from 2mL to 10mL, leading to significant over- or under-dosing. Finally, some parents believe that OTC drugs are ‘safe’ and don’t follow dosing instructions carefully.

Recommendations for Parents:

- Do not give any cough/cold medicine to children under 6 years of age without first talking to your healthcare provider.
- When giving a child medicine, use a calibrated dosing cup, dropper, or dosing syringe. Do not use a spoon from the kitchen.

Non-pharmacologic ways to keep a sick child comfortable:

- Make sure the child drinks plenty of fluids so they don’t become dehydrated.
- Use single-ingredient pain/fever relievers when necessary.
- When a child is congested, keep the child upright, use gentle nasal suctioning, saline nose drops, and/or a cool room humidifier.

Again, this is only a *recommendation* to the FDA. The final decision will be made sometime in 2008.

References:

Centers for Disease Control and Prevention. Infant Deaths Associated with Cough and Cold Medications – Two States, 2005. MMWR. January 2007:56(01);1-4.

Foxhall K. Cough and cold recommendations may impact other products: two Food and Drug Administration advisory committees voted 13 to 9 to recommend that cough and cold over-the-counter medications not be used for children who are more than two and less than six years old. Drug Topics. November 19, 2007.

Concerns about OTC cough and cold products in children. Pharmacist’s Letter/Prescriber’s Letter 2007;23(11):231106.

Flu Myths

The flu isn't a serious disease.

Each year, about 200,000 people in the United States are hospitalized and 36,000 die because of the flu. Most who die are 65 years and older, but children under the age of 2 are as likely as those over 65 to be hospitalized due to the flu virus.

Flu vaccine CAUSES the flu.

The **injectable** vaccine is inactive (dead) so it cannot cause the flu. People who get the flu within 2 weeks after vaccination had been exposed to the virus *before* they could develop immunity.

The **nasal** vaccination does contain live attenuated virus and could cause a patient to come down with the flu, but this is only a risk in SEVERELY immunocompromised patients.

The flu shot doesn't work.

The flu shot is 70-90% effective when there is a good match between circulating viruses and those in the vaccine.

The side effects of the vaccine are worse than the flu!

The injectable flu vaccine will occasionally cause arm soreness or tenderness, but the risk of a severe allergic reaction is less than 1 in 4 million. The nasal mist flu vaccine might cause temporary nasal congestion, runny nose, sore throat, or cough.

The flu shot is only necessary for elderly patients.

Not so. The more people that are vaccinated, the less the virus spreads. It is especially important that patients under 5 and over 50, health care workers, and any patient with asthma, diabetes, heart disease, kidney disease, or other chronic disease get vaccinated.

You can't get vaccinated if you are sick.

It is okay to get the flu vaccine with a minor illness, but postpone if the illness is moderate or severe.

Asthma patients can't get a flu shot.

Asthma patients can, and should, get an injectable flu shot. These patients should avoid using the nasal mist vaccine.

There isn't enough vaccine to go around.

There were years when the vaccine was in short supply, but there is a plentiful supply of vaccine this flu season.

Flu vaccine causes autism.

The preservative, thimerosal, is what scientists are studying to see if there is a link to autism. Single-dose flu shots and the nasal mist have very little or no themerosal.

It's too late in the season to get the vaccine.

October or November is the best time to be vaccinated, but flu season often peaks in February – so it is not too late to be vaccinated.

I got vaccinated last year.

Because the influenza virus changes every year, so does the flu vaccine. Also, the protective effects of the vaccine wear off with time. For best protection, patients should be vaccinated every year.

Herbal products such as vitamin C and Echinacea will keep me healthy.

Vitamin C and Echinacea will not prevent the flu. Echinacea *might* help the symptoms of the flu, but only after you are already sick.

For more information:

Centers for Disease Control and Prevention Influenza Homepage: www.cdc.gov/flu
US Food and Drug Administration Flu Information Homepage: www.fda.gov/oc/opacom/hottopics/flu.html

References:

Myths about influenza and influenza vaccination. Pharmacist's Letter/Prescriber's Letter 2007;23(11):231101.

Flu Vaccine Facts and Myths. Centers for Disease Control and Prevention. Accessed at www.cdc.gov/flu.

HID Help Desk Holiday Hours

Christmas Eve 8am-7pm CST

Christmas Day—Closed

New Years Eve 8am-7pm CST

New Years Day—Closed

1-800-748-0130

Fax 1-800-748-0116

Happy Holidays!

Health Information Designs, Inc.
391 Industry Drive
Auburn, AL 36832
Ph 800-748-0130
Fax 800-748-0116