Alabama Medicaid Pharmacist

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PDL Update

Effective January 4, 2010, 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	PDL Deletions*
Azasite—EENT Antibacterials	Crestor—HMG CoA Reductase Inhibitors
Bactroban Nasal—EENT Antibacterials	Simcor—HMG CoA Reductase Inhibitors/Combos
Blephamide/Blephamide SOP—EENT Antibacterials	
Bleph-10—EENT Antibacterials	
Neosporin—EENT Antibacterials	
Poly-Pred—EENT Antibacterials	
Tobrex—EENT Antibacterials	
Vigamox—EENT Antibacterials	

**denotes that these products will no longer be preferred but are still covered by Alabama Medicaid and will require Prior Authorization (PA). Available covered generic equivalents (unless otherwise specified) will remain preferred.*

In addition to the above changes, the Agency will be adding two new drug classes to the Preferred Drug Program (PDP):

1. Eye, Ear, Nose and Throat (EENT) Preparations: Antibacterials
2. Multivitamin Preparations: Prenatal Vitamins

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Reminder

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.

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
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HID Help Desk

Monday—Friday

8am—7pm

Saturday

10am– 2pm

Reimbursement for Administration of Seasonal Influenza and H1N1 Vaccines

Alabama Medicaid is reimbursing Medicaid-enrolled pharmacy providers for the administration of the influenza and H1N1 vaccines for eligible recipients age 19 and older. Alabama Medicaid will also continue to reimburse pharmacies for the seasonal influenza vaccine but will not reimburse pharmacies for the H1N1 vaccine because the H1N1 vaccine is being supplied by the Alabama Department of Public Health at no charge to the provider.

Alabama Medicaid is reimbursing pharmacy providers for administration of the influenza and H1N1 vaccines.

Pharmacy providers may bill the following NDC numbers on a pharmacy claim for reimbursement of vaccine administration:

- NDC 99999-9999-10 for seasonal influenza vaccine administration
- NDC 99999-9991-11 for H1N1 vaccine administration

Reimbursement is $5 per administration with no dispensing fee or co-pay applied.

Claims should be submitted with a dispense quantity of 1 for vaccine administration. There will be a maximum quantity of 1 injection allowed per recipient per year for each vaccine.

To facilitate coordination of care, pharmacy providers are instructed to inform (via phone, fax, e-mail, mail) each recipient's Primary Medical Provider (PMP) upon administration of the vaccine(s). Documentation must be kept on file at the pharmacy of the notification to the PMP. If the PMP is unknown, the pharmacy may call the Alabama Medicaid Automated Voice Response System (AVRS) at 1-800-727-7848 to obtain the PMP information. A suggested Immunization Provider Notification Letter, which can be used to notify the PMP, can be found on the Agency website at:

http://www.medicaid.alabama.gov/programs/pharmacy_svcs/pharmacy_services.aspx.

Alabama State Board of Pharmacy law and regulation should be followed regarding dispensing and administration of legend drugs/vaccines.

FDA Develops Fraudulent 2009 H1N1 Influenza Products List

The Food and Drug Administration (FDA) has developed a fraudulent H1N1 products list which is currently available on their website (www.fda.gov). The list is intended to alert consumers and providers about websites that are or were illegally marketing unapproved, uncleared, or unauthorized products in relation to the 2009 H1N1 flu virus.

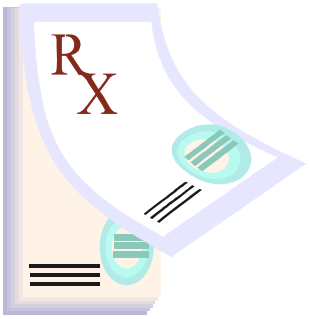
Considerations about the Products List:

- The list does not include every website that is marketing products related to the 2009 H1N1 flu virus without FDA approval, clearance, or authorization, only those websites to which the FDA has issued a warning letter.
- Even if a website is not included in this list, patients should be warned to exercise caution before purchasing any product purporting to diagnose, mitigate, prevent, treat, or cure the 2009 H1N1 flu virus.
- Some products listed may be approved or cleared by the FDA for other medical uses. The fact that a product is listed on the Products List indicates ONLY that the products are not cleared, approved, or authorized for the diagnosis, mitigation, prevention, treatment, or cure of the 2009 H1N1 flu virus.

Once identified, all websites and products will be placed on the fraudulent products list. After the FDA has verified that the products or the objectionable claims related to the 2009 H1N1 flu virus have been rectified, this information will be added to the FDA website.

The information is current as of the date indicated. The FDA is regularly updating and maintaining the Products List.

Prescribing Information Update: Proton Pump Inhibitors



- *Proton-pump inhibitors (PPIs) are the most potent inhibitors of gastric secretion available. All PPIs are indicated for the treatment of GERD and pathological hypersecretory conditions.*

- *Aciphex®, Prilosec OTC®, omeprazole, Prevacid OTC®, and lansoprazole are preferred agents for Alabama Medicaid recipients.*

- *Studies show no clinically significant difference in available PPIs for treating gastric ulcers, NSAID-induced ulcers, duodenal ulcers, or H. Pylori.*

- *Studies also show no clinically significant difference in the available PPIs for esophagitis healing, symptom relief, or prevention of GERD relapse in*

Proton-Pump Inhibitors (PPIs)

Preferred Brands	*Preferred OTCs/Generics*	*Non-preferred Brands/PA Generics*
Aciphex®	Omeprazole	Kapidex®
	Prilosec OTC®	Nexium®
	Prevacid OTC®/lansoprazole	Pantoprazole (generic)
		Prevacid®
		Protonix®

Information from the Alabama Medicaid Preferred Drug List.

Proton-pump inhibitors (PPIs) are considered to be the most potent acid suppressants currently available. PPIs work to suppress gastric acid secretion by inhibiting the proton pumps in the parietal cells in the gastric mucosa. Generally, after a meal, only 70-80% of the proton pumps are active, so maximal acid suppression occurs in 3 to 4 days.

The American Gastroenterological Association, in its Medical Position Statement (on dyspepsia and the management of gastroesophageal reflux disease) does not recommend any one PPI over the other, and multiple randomized controlled studies show that no PPI is clinically more effective than another for treating gastric ulcers, NSAID-induced ulcers, duodenal ulcers, or *H. Pylori*.

Criteria for Approval of Non-preferred Proton-Pump Inhibitors

- The patient must have an appropriate diagnosis supported by documentation in the patient record.

- The patient must have failed 30-day treatment trials with at least 2 prescribed and preferred PPIs in this class within the last 6 months.

- Approval may be given for children age 18 years and under who have documented stable therapy on the requested medication for 60 consecutive days or greater.

- Medical justification may be submitted for consideration of approval if the above criteria has not been met.

References:

- Comparison of proton pump inhibitors. Pharmacist's Letter/Prescriber's Letter 2009;25(3):250304.
- The American Gastroenterological Association Institute Medical Position Panel. American Gastroenterological Association Technical Review on the Management of Gastroesophageal Reflux Disease. Gastroenterology 2008;135:1392-1413.
- The American Gastroenterological Association Medical Position Statement: Evaluation of Dyspepsia. Gastroenterology 2005;129:1753-1755.
- Weaver K. Proton pump inhibitors. Oregon Health Resources Commission. April 2004.

Breast Cancer Awareness and Prevention

According to the World Health Organization (WHO), breast cancer is the top cancer in women in both the developed and the developing world. The incidence of breast cancer is increasing in developing countries due to increases in life expectancy, urbanization, and adoption of western lifestyles. Still, breast cancer survival rates vary greatly worldwide, ranging from 80% in North America, Sweden, and Japan to around 60% in middle-income countries and below 40% in low-income countries.

In the United States, breast cancer incidence is estimated to be 1 in 8 (13%) but since 2001 incidence rates and death rates have been on the decline. These decreases are thought to be the result of treatment advances, earlier detection through screening, and increased awareness.

Breast Cancer Risk Factors

Controllable Risk Factors:

- Obesity
- Diet – Studies have yet to conclusively determine which foods increase risk, so a low-fat diet rich in fruits and vegetables is generally recommended.
- Exercise – exercising 4 or more hours a week may help decrease the risk of breast cancer.
- Alcohol consumption – the level of risk increases as consumption increases.
- Exposure to estrogen – it has been shown that estrogen stimulates breast cell growth and exposure to estrogen over long periods of time, without any breaks, can increase the risk of breast cancer (i.e. taking combined hormone replacement therapy [HRT] for several years or taking estrogen alone for more than 10 years).

Non-controllable Risk Factors:

- Gender – while men can get breast cancer, women are at much higher risk.
- Age – as patients age, the risk increases.
- Family history of breast cancer – if a patient has a first-degree relative who has had breast cancer, or has had multiple relatives affected by breast or ovarian cancer (especially if these cancers were developed before the age of 50), the risk of developing breast cancer increases.
- Personal history of breast cancer
- Race – Caucasian women are slightly more likely to develop breast cancer. Asian, Hispanic, and Native American women have a lower risk of developing and dying from breast cancer.
- Pregnancy and breastfeeding – this appears to reduce future breast cancer risk, so women who have never had a full-term pregnancy or had their first full-term pregnancy after age 30 may have an increased risk of breast cancer.
- DES exposure – women who took a medication called diethylstilbestrol (DES) or women whose mothers took DES during pregnancy may have a slightly higher risk of breast cancer.

Breast Cancer Prevention

Although great advances have been made in diagnosing and treating this disease, it is important to remember that patients should perform a self-exam monthly and patients age 50 to 74 should have regular biennial mammograms.

References:

1. Breast Cancer. National Cancer Institute/U.S. National Institutes of Health. www.cancer.gov. Accessed November 23, 2009.

2. Breast Cancer: Prevention and Control. World Health Organization. www.who.int. Accessed November 23, 2009.

3. Breast Cancer. www.breastcancer.org. Accessed November 23, 2009.

4. Breast Cancer. Centers for Disease Control (CDC). www.cdc.gov. Accessed November 23, 2009.

5. Screening for Breast Cancer: Recommendation Statement. U.S. Preventive Services Task Force (USPSTF). www.ahrq.gov. Accessed December 15, 2009.

Community Acquired MRSA Infections

Data suggests that the incidence of community acquired MRSA (methicillin-resistant *Staphylococcus aureus*) is on the rise. Community acquired MRSA manifests as a skin and soft tissue infection, usually a boil or an abscess. Symptoms associated with an MRSA infection include redness, pus, and sometimes fever. A patient might present with the complaint that they have a 'spider bite'. It is important to encourage these patients to be seen by a physician as MRSA skin infections can progress to more serious infections if left untreated.

Primary Treatment Options

Incision and drainage is the primary therapy for these skin infections, but empiric antibiotic therapy is often indicated. Because community acquired MRSA infections are resistant to currently available beta-lactam antibiotics, including penicillins (penicillin, amoxicillin), methicillin, and cephalosporins, they are generally treated with fluoroquinolones or sulfamethoxazole/trimethoprim.

Patient Education

Patients should be encouraged to follow their doctor's instructions and finish any antibiotics that are prescribed. To avoid spreading an MRSA infection while being treated, patients should:

1. **Cover the wound.** Keep wounds that are draining or have pus covered with clean, dry bandages until healed. Pus from infected wounds can contain staph, including MRSA, so keeping the infection covered will help prevent the spread to others. Bandages and tape can be discarded with the regular trash.

2. **Keep hands clean.** The patient, his/her family, and others in close contact should wash their hands frequently with soap and water or use an alcohol-based hand sanitizer, especially after changing the bandage or touching the infected wound.

3. **Do not share personal items.** Personal items, such as towels, washcloths, razors, clothing, or uniforms that may have had contact with the infected wound or bandage should not be shared. Wash sheets, towels, and clothes that become soiled with water and laundry detergent. Use a dryer to dry clothes completely.

4. **Talk to the doctor.** Tell any healthcare providers who treat you that you have or had a staph or MRSA skin infection.

How to Prevent the Spread of MRSA

Factors that have been associated with the spread of MRSA skin infections include: close skin-to-skin contact, openings in the skin such as cuts or abrasions, contaminated items and surfaces, crowded living conditions, and poor hygiene. To prevent the spread of MRSA:

1. Keep hands clean by washing thoroughly with soap and water or using an alcohol-based hand sanitizer.

2. Keep cuts and scrapes clean and covered with a bandage until healed.

3. Avoid contact with other people's wounds or bandages.

4. Avoid sharing personal items such as towels or razors.

References:

Community Acquired MRSA: Information for Healthcare Professionals. Centers for Disease Control and Prevention (CDC). www.cdc.gov. Accessed November 23, 2009.

Food and Drug Administration

Safe Use Initiative

In November 2009, the Food and Drug Administration (FDA) unveiled the Safe Use Initiative, a program aimed at reducing the likelihood of preventable harm from medication use.

Millions of people are harmed every year from inappropriate medication use. Some of these injuries occur as a result of incomplete access to information about a drug, a patient, or a patient's condition. Other preventable sources of harm include unintentional misuse of medications, medication abuse, and attempts at self harm.

The FDA intends to collaborate with health care professionals to identify those drugs and drug classes that are linked to preventable harm. In addition, the FDA will take other risk-reduction programs, such as those that evaluate consumer medication information and those that communicate the risk of inadvertent overexposure to acetaminophen, and collaborate with the Safe Use program.

The FDA also made public new guidance for companies that manufacture, market, or distribute over-the-counter liquid medications packages with dosage delivery devices such as calibrated cups, droppers, syringes and spoons.

The ultimate goal of the Safe Use Initiative is to avoid unnecessary injuries from medication misuse and errors.

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