Alabama Medicaid Pharmacist

Published Quarterly by Health Information Designs, Inc., Fall 2010 — A Service of Alabama Medicaid

PDL Update

Effective October 1, 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
Aricept ODT—Alzheimer's Agents	Norpace/Norpace CR—Antiarrhythmics
Teveten/Teveten HCT—ARBs/Combos	Lescol/Lescol XL—HMG CoA Reductase Inhibitors
Oxytrol—Genitourinary Agents	Niaspan—Miscellaneous Antilipemic Agents
	Veramyst—Intranasal Corticosteroids
	Diovan HCT—ARBs/Combos
	Cozaar—ARBs
	Hyzaar—ARBs/Combos
	Maxalt—Selective Serotonin Agonists
	Treximet—Selective Serotonin Agonists
	Azor—CCBs/Combos
	Exforge—CCBs/Combos
	DynaCirc CR—CCBs

Also effective October 1, the Alabama Medicaid Agency will add the Genitourinary Smooth Muscle Relaxants (over-active bladder agents) to the Preferred Drug List (PDL). Non-preferred brands in this class require prior authorization (PA) for payment. The Preferred Drug List (PDL) will be updated to reflect these changes.

In addition, prior authorization for payment of generic lansoprazole and omeprazole-sodium bicarbonate will be required. Preferred brands as well as OTC versions of Proton Pump Inhibitors will continue to be available with no PA. Preferred PPIs include: Aciphex, Prevacid OTC, Prilosec OTC, Zegerid OTC, and omprazole.

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Palivizumab and Respiratory Syncytial Virus (RSV)

Palivizumab (Synagis®) is FDA approved for the prevention of RSV in selected infants and children. Palivizumab requires prior authorization (PA) for reimbursement through the Alabama Medicaid Agency. Prior Authorization criteria are based on manufacturer labeling and current American Academy of Pediatrics (AAP) recommendations. Criteria are reviewed and evaluated annually. Health Information Designs (HID) is contracted with the Agency to manage the PA helpdesk and process, including palivizumab PAs.

Synagis® season starts October 1, 2010 and is effective through March 31, 2011.

The Centers for Disease Control and Prevention (CDC) has a laboratory-based system, called the National Respiratory and Enteric Virus Surveillance System (NREVSS), which monitors patterns associated with different viruses, including respiratory syncytial virus. Different parts of the country experience high activity with RSV at different times during the year. According to the NREVSS website, RSV activity in Alabama peaked in early January 2010. In addition, the state saw significant numbers of positive antigen detection tests between October 2009 and March 2010. For this reason, the palivizumab approval timeframe will begin October 1, 2010 and be effective through March 31, 2011.

Highlights of the prior authorization criteria for palivizumab:

- Up to five doses will be allowed per recipient in this timeframe. Some recipients may only receive a maximum of 3 doses, depending on the gestational and chronological age.
- There are no circumstances that will result in the approval of a sixth dose.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.
- For approval of requests, the recipient must meet gestational and chronological age requirements. In order to meet chronological age requirements, the recipient must not exceed the specified age at the start of the RSV season.
- Prescribers, not the pharmacy, manufacturer or any other third party entity, are to submit requests for palivizumab on a separate prior authorization form (Form 351) directly to Health Information Designs and completed forms will be accepted beginning September 1, 2010 (for an October 1 effective date).
- A copy of the hospital discharge summary from birth or documentation of the first office visit with pertinent information (gestational age, diagnosis, etc.) is required on all palivizumab PA requests.
- If approved, each subsequent monthly dose will require submission of the recipient's current weight and last injection date and may be faxed to HID by the prescribing physician or dispensing pharmacy utilizing the original PA approval letter.

Letters will be faxed to both the prescriber and the dispensing pharmacy notating approval or denial.

The palivizumab form and complete updated criteria are available on the Agency's website at www.medicaid.alabama.gov under Programs: Pharmacy Services. Additional questions can be directed to HID at 800-748-0130.

Prescribing Information Update: Rosiglitazone

In 2007, the FDA reviewed information about rosiglitazone and cardiovascular risk ultimately deciding that rosiglitazone could remain on the market with a black box warning about cardiovascular risk in the approved labeling. On July 13 and 14, 2010, an FDA advisory committee met once again to decide the fate of rosiglitazone, based on newer information regarding the cardiovascular safety of the drug. Prior to the meeting in 2010, two articles regarding the safety of rosiglitazone were published. The first article concluded that the most current literature demonstrates an increased risk for myocardial infarction, although not for cardiovascular or all-cause mortality resulting in an unfavorable benefit to risk ratio for rosiglitazone. The second article concluded that compared with pioglitazone, rosiglitazone was associated with an increased risk of stroke, heart failure, and all-cause mortality and an increased risk of the composite of acute myocardial infarction, stroke, heart failure, or all-cause mortality in patients 65 years or older.

Following testimony, 33 voting panelists of the Endocrine and Metabolic Advisory Committee were asked to vote on recommendations for rosiglitazone's future availability in the US. Twelve of the thirty-three panelists voted to withdraw rosiglitazone from the market and 20 of the 33 voted to leave the drug on the market (with some recommending stronger warnings and added restrictions). Although the FDA is not required to follow the advisory committee recommendations, it usually does.

Until the FDA announces its decision, the previous FDA recommendation for healthcare professionals should be followed:

- Follow recommendations in the drug label when prescribing rosiglitazone. This includes a boxed warning stating that:

  1. Use of rosiglitazone in patients with established NYHA Class III or IV heart failure is contraindi cated. Further, rosiglitazone is not recommended in patients with symptomatic heart failure.

  2. Rosiglitazone causes or exacerbates congestive heart failure in some patients. Healthcare profess sionals should monitor for the signs and symptoms of heart failure (including excessive, rapid weight gain, difficulty breathing, and/or swelling) after starting treatment and after dose increases of rosigli tazone. If heart failure signs and symptoms occur, heart failure should be managed appropriately and discontinuation or dose reduction of rosiglitazone must be considered.

- Discuss with patients the risks of rosiglitazone treatment, taking into account the clinical utility of rosiglitazone, the risks/benefits of other antidiabetic medications, and the risks associated with poorly controlled blood glucose.

- Discuss with patients the importance of adhering to their diabetes medication regimen.

- Report any adverse events associated with the use of rosiglitazone to FDA's MedWatch program.

References:

Cardiovascular Safety of Rosiglitazone (Avandaia)-2010 Update. Pharmacist's Letter 2010;26(8):260801.

An Update on Vitamin D Dosing

Information shows that taking vitamin D supplements can help decrease fracture risk in the elderly, but evidence is starting to show that adequate intake can decrease the risk of colon cancer and other cancers. The risk of diabetes, hypertension, cardiovascular disease, and multiple sclerosis may also be linked to low levels of vitamin D. Currently, though, most of the recommendations are based on what we know about the role of vitamin D in bone health.

Vitamin D2, ergocalciferol, comes from ergosterol and yeast. Vitamin D3, cholecalciferol, is synthesized in the skin in response to sun exposure. Vitamin D3 may be more than three times as effective as vitamin D2 in raising and maintaining serum levels. Patients with end stage renal disease have impaired conversion of vitamin D3 to its active from, calcitriol. These patients require supplementation with calcitriol, or other active vitamin D analogues.

Experts recommend 400 IU to 800 IU daily for adults under age 50 and 800 IU to 1000 IU daily for older adults to help decrease risk of falls and fractures.

There are few foods that contain significant amounts of vitamin D. Salmon, canned tuna, and fortified milk are some of the best sources. Of course, the skin produces vitamin D3 with sun exposure, but the American Academy of Dermatology recommends avoiding sunlight and getting vitamin D from food or supplements.

The National Osteoporosis Foundation currently recommends vitamin D 400 IU to 800 IU daily for adults under age 50 and 800 IU to 1,000 IU daily for older adults. Evidence from studies suggests that taking at least 800 IU per day reduces falls by at least 20%.

Adequate vitamin D intake is important for infants and children as well. To prevent rickets and other complications of vitamin D deficiency, the American Academy of Pediatrics (AAP) recommends that children that fall into any of the following categories receive 400 IU of vitamin D daily:

1. Breastfed and partially breastfed infants (begin vitamin D supplementation during the first few days of life)
2. All nonbreastfed infants and older children who are ingesting less than one liter (4 cups) of vitamin D-fortified milk a day
3. Adolescents who do not obtain 400 IU of vitamin D through vitamin D-fortified milk and foods
4. Children who are at increased risk of vitamin D deficiency such as those with fat malabsorption and those taking chronic anticonvulsant medications

Symptoms of vitamin D deficiency include bone pain and muscle weakness. Risk factors include advanced age, being shut-in, living above 35 degrees latitude in winter (e.g., Atlanta, GA), sunscreen use, malabsorption, and anticonvulsant or glucocorticoid use. Treating a vitamin D deficiency is different than recommending supplementation. Higher doses must be used to replenish vitamin D stores that have been depleted. A rule of thumb is that taking 1,000 IU daily increases levels up to about 10 ng/mL over 8 months. For vitamin D deficient adults, 50,000 IU of vitamin D2 or D3 can be given once weekly for six to eight weeks for replenishment. This is a ***weekly*** dose, not a daily dose.

Vitamin D toxicity is rare, but symptoms include nausea, vomiting, anorexia, confusion, constipation, weakness, and weight loss. According to the Institute of Medicine, the tolerable upper limit for vitamin D for people of one year of age is 2,000 IU daily, but in fact, the upper limit may be as much as 10,000 IU daily. Excessive sun exposure does not cause toxicity, presumably due to photodegradation of vitamin D3 in the skin. Generally speaking, patients taking vitamin D supplements can continue with sensible sun exposure, eating vitamin D-containing foods, and taking a multivitamin containing vitamin D; toxicity is doubtful in this scenario.

References:

Vitamin D dosing: an update. Pharmacist's Letter/Prescriber's Letter 2010;26(7):260707.

Alabama Medicaid to Track Health, Cost Impact of BP Oil Spill

While the full impact of the BP oil spill in the Gulf of Mexico remains unknown, the Alabama Medicaid Agency is now using special tracking codes to provide a more accurate picture of the state's health and financial costs associated with the environmental disaster.

Providers were notified July 12, 2010 to begin use of special indicators on claims billed to Alabama Medicaid in order to track claims resulting from an oil spill-related illness or injury. Indicators are to be used on medical, institutional and pharmacy claims submitted to the Agency for payment.

"Based on our past experience, it is essential that we closely track and evaluate health outcomes and costs to accurately assess the full impact of this disaster," said Commissioner Carol H. Steckel.

Information will be used to monitor taxpayer-funded expenses and services that are directly linked to the oil spill and will be used to support any claims filed with BP or other entities, Commissioner Steckel said.

Specific information about the tracking codes is listed below, and is available on the Agency's website at www.medicaid.alabama.gov/news/provider_alerts_2010.aspx.

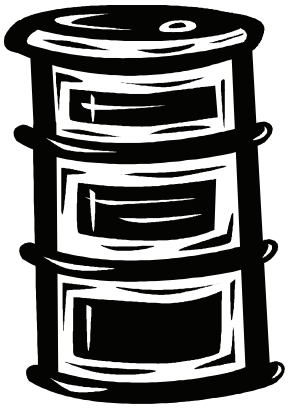
Providers are asked to use the following indicators on applicable claims submitted to Alabama Medicaid:

- Professional Claims (837P, other electronic methods, or CMS-1500) - Enter ***Modifier*** **"U9"** (Disaster-Related Service or Illness) with all appropriate procedure codes. This modifier should follow any other modifiers currently required for claims payment.

- Institutional Claims (8371, other electronic methods, or UB-04) - Enter the ***Condition Code*** **"DR"** (Disaster-Related Service or Illness) as the first condition code with all appropriate services.

- Pharmacy POS Transactions—Enter the NCPDP Field ***Reason for Service Code*** **"RE"** (Suspected Environmental Risk) with all appropriate services. This reason for service code should follow any other reason for service code required for claims payment.

Providers can contact the Provider Assistance Center at 1-800-688-7989 for any related questions.



Flu vaccine reimbursement continues for Medicaid-enrolled providers

As the 2010-11 flu season approaches, the pharmacy flu vaccine program launched by Alabama Medicaid last November is continuing. Under the program, Medicaid-enrolled pharmacy providers will be reimbursed for administration of influenza vaccine to Medicaid-eligible persons ages 19 and older.

"The Agency is working through our academic detailing program and other various educational efforts to increase the utilization of pharmacist vaccination administration," said Medicaid Pharmacy Services Director Kelli D. Littlejohn, RPh, PharmD. "We, as pharmacists, have a prime opportunity to promote public health through professional services such as vaccine administration, while integrating the multi-lateral communication between the prescriber, pharmacist, other health care professionals, and ultimately, the patient." In addition to the administration, pharmacies are also reimbursed for the vaccine. Beginning with the 2010-11 flu season, the available vaccination will protect against seasonal influenza virus and the H1N1 virus. Pharmacists should submit the NDC of 99999-9999-10 on a pharmacy claim for the administration of the vaccine for reimbursement. Pharmacies will be reimbursed $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 required to inform each recipient's Primary Medical Provider (PMP) upon administration of the vaccine. 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. A suggested Immunization Provider Notification Letter, which can be used to notify the PMP, can be found on the Agency website.

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

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