



ALABAMA MEDICAID PHARMACIST

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A Service of Alabama Medicaid

PDL Update

Effective July 2, 2012, 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*
Pegasys—Anti-infective Agents/ Interferons	Foradil—Respiratory Agents/ Beta-Adrenergic Agonists
	Ventolin HFA—Respiratory Agents/ Beta-Adrenergic Agonists
	Daytrana—ADD/ADHD-Long Acting Agents
	Concerta—ADD/ADHD-Long Acting Agents

*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.

The HID Help Desk is open Monday–Friday from 8am to 7pm and on Saturdays 10am to 2pm. If you need a form, wish to review criteria or have other questions, please access our website at hidmedicaid.hidinc.com or the Agency website at medicaid.alabama.gov.

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.

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ISDA Issues New Guidelines for Bacterial Rhinosinusitis

Rhinosinusitis is defined as symptomatic inflammation of the mucosal lining of the nasal passage and paranasal sinuses. In 2008, a national health study found nearly 1 in 7 adults were diagnosed with rhinosinusitis within the previous 12 months. Adults between the ages of 45 and 74 years are most commonly affected and incidence rates are higher for women than men.

Acute rhinosinusitis can be caused by allergens, environmental irritants, and viral, bacterial, or fungal infections. Most cases begin when a viral infection extends into the paranasal sinuses. Acute rhinosinusitis typically lasts up to four weeks. The major symptoms of rhinosinusitis are: postnasal discharge, nasal congestion, facial pain/pressure, hyposmia (reduced sense of smell) or anosmia (loss of the sense of smell), and possible fever. Minor symptoms of rhinosinusitis include headache, ear pain/pressure, halitosis, tooth pain, cough, and fatigue.

The prevalence of a bacterial infection during acute rhinosinusitis is estimated to be 2%-10%, whereas viral causes account for 90%-98%. A recent national survey of antibiotic prescriptions for upper respiratory infections in the outpatient setting found that antibiotics were prescribed for 81% of adults with acute rhinosinusitis, despite the fact that most cases are due to a viral infection. A viral infection may sometimes be followed by a bacterial infection. The most common organisms identified in patients with acute rhinosinusitis are *Streptococcus pneumoniae* and *Haemophilus influenzae*. *Moraxella catarrhalis*, Group A streptococcus, *Staphylococcus aureus*, and anaerobic organisms are less commonly associated with acute rhinosinusitis. Bacterial infections are more likely when signs and symptoms are present for at least ten days or when signs and symptoms worsen within ten days after an initial improvement.

Overprescribing of antibiotics is a major concern in the management of acute rhinosinusitis. The primary goal of the ISDA guidelines is to improve the appropriate use of first-line antibiotics for patients with a presumptive diagnosis of acute bacterial rhinosinusitis. The ISDA guidelines are also intended to reduce excessive or inappropriate utilization of antimicrobial agents and to deter the emergence of antibiotic resistance among respiratory pathogens.

The 2012 ISDA Guidelines recommend using antibiotics in the following situations where viral involvement can be ruled out:

- Persistent signs or symptoms lasting ten or more days without clinical improvement; or
- Severe signs or symptoms of high fever (102°F or higher) and purulent nasal discharge or facial pain lasting at least 3-4 consecutive days at the beginning of illness; or
- Worsening signs or symptoms characterized by new onset of fever, headache, or an increase in nasal discharge after a typical viral upper respiratory tract infection that lasted 5-6 days that was initially improving

When antimicrobial therapy is indicated, the ISDA recommends the following options in **adults** (recommended duration of treatment 5-7 days):

Initial empiric therapy	Amoxicillin-clavulanate 500 mg/125 mg orally three times a day or 875 mg/125 mg orally twice daily
Penicillin-allergic patients	Doxycycline 100 mg orally twice daily or 200 mg orally once daily; or Levofloxacin 500 mg orally once daily; or Moxifloxacin 400 mg orally once daily
Risk for antibiotic resistance or failed initial therapy	Amoxicillin-clavulanate 2000 mg/125 mg clavulanate orally twice daily; or Levofloxacin 500 mg orally once daily; or Moxifloxacin 400 mg orally once daily

ISDA Guidelines, continued

When antimicrobial therapy is indicated, the ISDA recommends the following options in **children** (recommended duration of treatment 10-14 days):

Initial empiric therapy	Amoxicillin-clavulanate 45 mg/kg/day orally twice daily
Penicillin-allergic patients	Levofloxacin 10-20 mg/kg/day orally every 12-24 hours; or Clindamycin 30-40 mg/kg/day orally three times a day plus cefixime 8 mg/kg/day orally twice a day or cefpodoxime 10 mg/kg/day orally twice a day
Risk for antibiotic resistance or failed initial therapy	Amoxicillin-clavulanate 90 mg/kg/day orally twice daily; or Clindamycin 30-40 mg/kg/day orally three times a day plus cefixime 8 mg/kg/day orally twice a day or cefpodoxime 10 mg/kg/day orally twice a day; or Levofloxacin 10-20 mg/kg/day orally every 12-24 hours

If symptoms worsen after 48-72 hours of initial antimicrobial therapy, or if there is no improvement within three to five days, an alternative treatment strategy is recommended. If antimicrobial therapy is to be continued, coverage should be broadened or a different antimicrobial class should be considered.

High-dose amoxicillin-clavulanate (2000 mg amoxicillin/125 mg clavulanate twice daily) is recommended in geographic areas that have a $\geq 10\%$ rate of penicillin-non-susceptible *S. pneumonia*. High-dose amoxicillin-clavulanate should also be used in patients who: attend daycare, are less than two years of age or > 65 years, have been recently hospitalized, have used antimicrobials within the past month, or are immunocompromised. High-dose amoxicillin-clavulanate should also be used in patients who have severe infection with a fever of 102°F or higher.

Pain relief is important in the treatment of acute rhinosinusitis. Acetaminophen and NSAIDs can be used to treat mild to moderate pain. Intranasal corticosteroids are recommended as adjunctive treatment to antibiotics and may provide symptomatic relief due to their anti-inflammatory effect on the nasal mucosa. The ISDA does not recommend topical or oral antihistamines or decongestants as adjunctive treatment because there is not enough evidence to validate their use.

Reference:

Chow AW, Benninger MS, Brook I, et al. ISDA Clinical Practice Guideline for Acute and Bacterial Rhinosinusitis in Children and Adults. Clin Infect Dis 2012; 54: e72-e112. Available from: http://www.idsociety.org/uploadedFiles/ISDA/Guidelines-Patient_Care/PDF_Library/ISDA%20Clinical%20Practice%20Guideline%20for%20Acute%20Bacterial%20Rhinosinusitis%20in%20Children%20and%20Adults.pdf. Accessed 05/18/2012.

FDA Issues Safety Alert Regarding Fentanyl Patch

Fentanyl (Duragesic®) transdermal system is a potent opioid pain reliever that is used to treat moderate to severe chronic pain. The transdermal system releases the medicine over a course of three days. The FDA has issued a safety alert regarding the dangers of accidental exposure to and improper storage and disposal of the fentanyl patch. Since 1997, there have been 26 cases of accidental exposure to fentanyl in children less than two years, resulting in 10 cases of death and 12 hospitalizations. Sixteen of the 26 cases occurred in children two years of age or younger.

The FDA is recommending that physicians and pharmacists talk to their patients about the correct storage, usage, and disposal of fentanyl. To reduce the risk of a child being exposed to fentanyl, the FDA recommends that fentanyl patch users take these precautions:

- Keep fentanyl patches in a secure location out of a child's sight and reach. The patch may be mistaken for a sticker, bandage, or tattoo.
- Cover the patch with an adhesive film to make sure it does not accidentally become removed from the body.
- Verify that the patch remains in its proper placement by simply touching or looking at the application area.

Fentanyl patches should be disposed of properly, as well. The FDA recommends folding used patches in half so that the sticky sides meet. The patches should then be flushed down the toilet to completely eliminate any risk of harm to people in the home. The FDA does not recommend placing the used patches in the household trash because children may be able to find them.

Although there are environmental concerns about flushing medications down the toilet, the FDA feels as if the risk associated with accidental exposure outweighs any potential risk associated with flushing the patch. The FDA has included fentanyl patches on a list of medications that should be flushed down the toilet because of the potential of harm or fatality if used by someone other than the intended user. The FDA also recommends disposing of the patches through a drug-take back program if such program is available.

Other medications the FDA recommends for disposal by flushing:

Abstral® (fentanyl sublingual tablets)	Methadone (oral solution & tablets)
Actiq® (fentanyl citrate transmucosal lozenge)	Nucynta® ER (tapentadol ER)
Avinza® (morphine sulfate ER capsules)	Oxycodone (capsules, tablets, & oral solution; IR & ER)
Daytrana® (methylphenidate transdermal patch)	Percocet® (APAP & oxycodone)
Demerol® (meperidine tables & oral solution)	Percodan® (ASA & oxycodone)
Dilaudid® (hydromorphone tables & oral liquid)	Xyrem® (sodium oxybate oral solution)

For a complete list of medications recommended for disposal by flushing, please visit: <http://www.fda.gov/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/EnsuringSafeUseofMedicine/SafeDisposalofMedicines/ucm186187.htm#MEDICINES>

References:

The Food and Drug Administration. Fentanyl Patch Can Be Deadly to Children. April 19, 2012. Available from: <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm300803.htm>. Accessed 05/14/2012.

New Medicaid Enrollment Requirements

Federal law now requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable **only** if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

A new enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section:

http://medicaid.alabama.gov/CONTENT/5.0_Resources/5.4_Forms_Library/5.4.6_Provider_Enrollment_Forms.aspx.

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

HPES Provider Enrollment

P.O. Box 241685

Montgomery, AL 36124

Faxed or emailed copies will not be accepted.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict).

Medicaid will allow a grace period until September 30, 2012 for OPR providers to become enrolled. On October 1, 2012, claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the October 1, 2012 deadline.

Providers should contact one of the following HPES Provider Representatives with any questions:

- Araceli Wright 1-855-523-9170 extension 2334560
- Remona Riley 1-855-523-9170 extension 2334532
- Shamekia Pena 1-855-523-9170 extension 2334588
- Aleetra Adair 1-855-523-9170 extension 2334587

Alabama Medicaid Updates

Changes Effective June 1, 2012

As a result of General Fund proration declared on March 16, 2012, the Alabama Medicaid Agency has been directed to identify and implement cuts to its overall budget. After program impact analysis and multiple provider meetings and communications, the Agency will implement these cuts in three ways:

- Reduction of payments to certain provider groups by 10 percent
 - Physicians
 - Dentists
 - Physician Lab and X-ray
 - Durable Medical Equipment
 - Independent Lab and X-ray
 - Other licensed practitioners
 - Maternity primary contractors (effective for dates of service on or after May 14, 2012)
- Reduction in services to adults (benefits to children remain unchanged)
 - Change coverage of routine eye exams and work-up for refractive error to once every three years (now one eye exam every two years)
 - End coverage of eyeglasses as a benefit (now on pair every two years)
 - Limit drugs to one brand-name drug per month; generics and covered OTCs remain unlimited. Allowances will remain for up to 10 brands per month for antipsychotics, antiretrovirals, and switchovers. (In addition to children, LTC recipients are excluded from this reduction)
- Reduction in cough/cold covered drugs for all recipients: Legend generic cough/cold drugs will no longer be covered (legend brand drugs are currently non-covered). Certain OTC drugs will remain covered.
 - A listing of covered OTC cough and cold products can be found on the Agency's website at www.medicaid.alabama.gov.

Except as specified otherwise above, these reductions will be effective for dates of service on or after June 1, 2012.