May 2014 Volume 4, Number 1

IDAHO MEDICAID PHARMACY DEPARTMENT

1-208-364-1829

MAGELLAN MEDICAID ADMINISTRATION PHARMACY SUPPORT CENTER

1-800-922-3987

24 hours/day/7 days per week

- Claims processing assistance
- Drug coverage and payment information
- Eligibility
- Plan limitations
- Coordination of benefits
- Prior authorization status

IDAHO MEDICAID PHARMACY CALL CENTER

1-866-827-9967

1-208-364-1829

8:00 a.m. – 5:00 p.m. MT

Monday – Friday

Closed federal and state holidays

- Initiate prior authorizations

PRIOR AUTHORIZATION FAX

1-800-327-5541

WEBSITES

http://healthandwelfare.idaho.gov/Default.aspx?TabId=119

- Preferred Drug List
- PA forms
- P&T information

https://Idaho.fhsc.com

MYERS AND STAUFFER LC

Website: http://www.mslc.com/Idaho/

Phone: 1-800-591-1183

Fax: 1-317-571-8481

E-mail: pharmacy@mslc.com

- Establishing and maintaining the Average Actual Acquisition Cost for drugs

DUR BOARD MEETINGS

- January 16, 2014
- April 17, 2014
- July 17, 2014
- October 16, 2014

P&T COMMITTEE MEETINGS

- April 18, 2014
- May 23, 2014
- October 17, 2014
- November 14, 2014

CHOOSING WISELY

Choosing Wisely is an initiative of the American Board of Internal Medicine (ABIM) Foundation. Their goal is to promote conversations between physicians and patients by helping patients choose care that is supported by evidence, not duplicative of other tests or procedures already received, free from harm, and truly necessary. National organizations of medical specialists have identified five tests or procedures common in their field whose necessity should be questioned and discussed. Currently there are more than 50 organizations involved. These are considered to be guidelines and should not be used to establish coverage decisions or exclusions. The ABIM has partnered with Consumer Reports to help educate patients. The Idaho Medicaid Pharmacy Unit reviewed the list of those guidelines that included medications and came up with 41 different recommendations that included medications. These are a few that we would like to bring to your attention. The full list and more information can be found at http://www.choosingwisely.org/.

1. Do not prescribe oral antifungal therapy for suspected nail fungus without confirmation of fungal infection. Approximately half of nails with suspected fungus do not have a fungal infection. As other nail conditions, such as nail dystrophies, may look similar in appearance, it is important to ensure accurate diagnosis of nail disease before beginning treatment. By confirming a fungal infection, patients are not inappropriately at risk for the side effects of antifungal therapy, and nail disease is correctly treated. *American Academy of Dermatology.*
2. Do not use opioid or butalbital treatment for a migraine except as a last resort. Opioid and butalbital treatment for migraine headaches should be avoided because more effective, migraine-specific treatments are available. Frequent use of opioid and butalbital treatment can worsen headaches. Opioids should be reserved for people with medical conditions precluding the use of migraine-specific treatments or for those who fail these treatments. *American Academy of Neurology.*
3. Do not prescribe biologics for rheumatoid arthritis (RA) before a trial of methotrexate (or other conventional non-biologic DMARDS). High quality evidence suggests that methotrexate and other conventional non-biologic disease modifying antirheumatic drugs (DMARD) are effective in many patients with RA. Initial therapy for RA should be conventional non-biologic DMARDs, unless these are contraindicated. If a patient has an inadequate response to methotrexate with or without other non-biologic DMARDs during an initial three-month trial, then biologic therapy can be considered. Exceptions include patients with high disease activity and poor prognostic features (e.g., functional limitations, disease outside the joints, seropositivity, or bony damage), where biologic therapy may be appropriate first-line treatment. *American College of Rheumatology.*
4. For pharmacological treatment of patients with gastroesophageal reflux disease (GERD), long-term acid suppression therapy (proton pump inhibitors or histamine 2 receptor antagonists) should be titrated to the lowest effective dose needed to achieve therapeutic goals. The main identifiable risk associated with reducing or discontinuing acid suppression therapy is an increased symptom burden. It follows that the decision regarding the need for (and dosage of) maintenance therapy is driven by the impact of those residual symptoms on the patient's quality of life rather than as a disease control measure. *American Gastroenterological Association.*

PROTON PUMP INHIBITORS

Proton Pump Inhibitors (PPIs) are one of the most widely used classes of drugs on the market today. They are consistently in the top 10 most prescribed classes of medications on a monthly basis in the State of Idaho's Medicaid population. PPIs are proven to be safe, effective, and well-tolerated and patients benefit from their use; however, they are often used longer than indicated and in higher doses than what is Food and Drug Administration (FDA)-approved, leading to serious safety concerns.

On May 25, 2010, the FDA revised the prescription label for the PPI class of medications to include new safety information about a possible increased risk of fractures of the hip, wrist, and spine with the use of these medications. The FDA has also issued a statement warning that PPIs taken for a prolonged period of time (in most cases, longer than one year) may also cause low serum magnesium levels, which could lead to muscle spasm, irregular heartbeat, and convulsions.

~CONTINUED~

There is also information about an increased risk of enteric infections and community-acquired pneumonia from the reduction of acidity. Rebound hypersecretion is observed in 60–90 percent of patients when PPIs are used for at least two to three months and may continue for three or more months. When discontinuing PPIs, tapering the dose and then dosing every other day for a week or longer can help reduce breakthrough symptoms. Either antacids or histamine-2 (H2) blockers can also be used for breakthrough symptoms if needed. The FDA recommends that when healthcare professionals prescribe PPIs, they should utilize the lowest dose and shortest duration of therapy to adequately treat the patient's condition. If PPIs have been used for more than a few months, therapy should be discontinued if there is no clear indication for continuation, remembering that the dose may need to be tapered and not stopped abruptly to lessen the likelihood of breakthrough symptoms. Please refer to the educational handout located on the Idaho Medicaid Pharmacy Program website: https://idaho.fhsc.com/downloads/providers/IDRx_DUR_outreach_PPI_Long_Term_Use_Educational_Sheet.pdf.

NARCOTIC ANALGESIC PRESCRIBING IMPROVEMENT PROJECT

Note: Participants with cancer or other chronic malignant pain syndromes will not be subject to the following action plan.

The Idaho Medicaid Pharmacy and Therapeutics Committee and Drug Utilization Review Board have been concerned over the past several years with the prescribing trends of narcotic analgesics in Medicaid participants diagnosed with chronic non-cancer pain syndromes.

While pain control is an important part of treating patients, narcotic use must be balanced with patient safety, improvement in functionality, and quality of life while minimizing the potential for misuse, abuse, and diversion.

During the next 18 months, Idaho Medicaid will be providing education on appropriate use of narcotic analgesics in chronic, non-cancer pain, as well as implementing some best practice guidelines to limit potentially inappropriate use.

The changes that will be implemented with target implementation dates are below:

JANUARY 2014	**COMBINATION PRODUCTS WITH > 325MG ACETAMINOPHEN PER TABLET OR CAPSULE**
	Prescribers received a letter outlining FDA requirements to remove narcotic analgesic combinations with more than 325 mg of acetaminophen. A list of the prescriber's current patients on these formulations was included.
APRIL 2014	**DISTRIBUTION OF TIMELINE TO PRESCRIBERS**
	Action plan with timeline will be distributed to prescribers.
APRIL 2014	**LIMIT TO ONE LONG-ACTING NARCOTIC ANALGESIC**
	Prescribers will receive a letter with a list of current patients receiving more than one long-acting narcotic analgesic concurrently.
JULY 2014	**HARD EDIT LIMITING TO ONE LONG-ACTING NARCOTIC ANALGESIC**
	A hard edit in the adjudication system will be activated to deny payment when two or more long-acting narcotic analgesics are prescribed concurrently. Prior authorization with adequate documentation of medical necessity will be required for participants to receive more than one long-acting narcotic analgesic within the same time period.
OCTOBER 2014	**LIMIT TO ONE SHORT-ACTING NARCOTIC ANALGESIC**
	Prescribers will receive a letter with a list of current patients receiving more than one short-acting narcotic analgesic concurrently.
JANUARY 2015	**HARD EDIT LIMITING TO ONE SHORT-ACTING NARCOTIC ANALGESIC**
	A hard edit in the adjudication system will be activated to deny payment when two or more short-acting narcotic analgesics are prescribed concurrently. Prior authorization with adequate documentation of medical necessity will be required for participants to receive more than one short-acting narcotic analgesic within the same time period.
APRIL 2015	**LIMIT TO < 300 MG MORPHINE EQUIVALENTS PER DAY**
	Prescribers will receive a letter with a list of patients receiving > 300 mg morphine equivalents per day.
JULY 2015	**LOCK-IN FOR > 300 MG MORPHINE EQUIVALENTS PER DAY AND ADDITIONAL PA REQUIREMENTS**
	Patients receiving > 300 mg morphine equivalents per day will be placed on prescriber and pharmacy lock-in (one prescriber, one pharmacy). All narcotic prescriptions will require prior authorization; prior authorizations will be limited to no more than 90 days at which time an updated progress report will be required for evaluation.