



ALABAMA MEDICAID PHARMACIST

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A Service of Alabama Medicaid

PDL Update

Effective April 1, 2016, 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*
Nexium—Proton-Pump Inhibitors	
Relpax—Selective Serotonin Agonists	

**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.*



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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CMS Strategies for Preventing Opioid-Related Harms

On January 28, 2016, the Centers for Medicare and Medicaid Services (CMS) released an Informational Bulletin emphasizing emerging Medicaid strategies to prevent opioid-related harms. Millions of Americans are affected by the epidemic of opioid overdose, misuse, and addiction. The bulletin specifically mentions the disproportionate share of opioid-related overdose deaths linked to the use of methadone as a pain-relieving agent. From 2002-2008, methadone was indicated in 1/3 of opioid-related deaths, but represented less than 5% of opioid prescriptions. Methadone overdoses have been found to be twice as fatal as compared to other opioid prescription overdoses.

The Centers for Disease Control and Prevention (CDC) reports that 37% of the entire drug overdose deaths in 2013 were related to prescription opioid analgesics and that deaths related to opioid overdose have quadrupled from 1999-2011. This increase was in part due to an increased number of opioid prescriptions with higher doses, longer durations, and concomitant use with benzodiazepines. An increase in medical costs from complications such as nonfatal overdoses, falls and fractures, drug-drug interactions, and neonatal conditions are also linked to inappropriate opioid prescribing.

The CDC reports that from 1999 to 2013, the amount of prescription opioids dispensed in the United States nearly quadrupled. Medicaid recipients are prescribed painkillers at twice the rate of non-Medicaid patients and are at three-to-six times the risk of prescription painkiller overdose.

The Informational Bulletin lists several strategies to minimize the risks of opioid dependency, addiction, and overdose. Provider education strategies are of utmost importance and should begin with training health care professionals on current opioid prescribing guidelines and protocols for safer methadone prescribing. A complete patient assessment should be performed before opioid medications are prescribed. Patients should be screened for risk factors for substance abuse disorders or mental health conditions that may lead to an increased likelihood of opioid-related harm. Patients would need to be a part of ongoing monitoring efforts by their healthcare provider.

Pharmacy and Therapeutics (P & T) Committees or Drug Utilization Review (DUR) Boards select preferred or non-preferred medications for state Medicaid agencies. CMS recommends that state Medicaid agencies remove methadone from their preferred drug lists (PDL). CMS agrees with the CDC recommendation that methadone should not be considered a drug of first choice for chronic non-cancer pain due to its disproportionate contribution to overdose and death. States that provide prescription drug benefits will still make methadone available to patients who need it, but may subject the medication to prior authorization.

The bulletin describes how clinical criteria can be used at the point-of-sale (POS) to ensure appropriate utilization of methadone if the drug were to remain preferred. When methadone claims are processed, an automated review of the patient's prescription claims and diagnosis history could reveal any potential drug-drug interactions or any chronic pain diagnosis. If clinical criteria are not met, payment would not be authorized at the POS. Claims could then be subject to prior authorization processes to assure appropriate prior use or diagnoses. CMS recommends criteria that reflect evidence-based standards for managing chronic, nonmalignant pain.

Another method CMS recommends as a means to manage methadone utilization is the use of quantity limits. By adding quantity limits to methadone, safe and appropriate use of the medication would be encouraged.

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Retrospective drug utilization review (RDUR) is another tool that can be helpful in managing methadone utilization. RDUR can be used to identify inappropriate prescribing, high doses, drug-drug interactions, and multiple prescribers and/or pharmacies.

State Prescription Drug Monitoring Programs (PDMP) collect controlled substance prescription data that can help identify inappropriate prescribing of controlled substances. CMS recommends that State Medicaid Agencies have access to the PDMP database. CMS also recommends that prescribers access the PDMP database to obtain patient history prior to prescribing controlled substances. In 2013, New York required prescribers to check the state's PDMP database before prescribing opioid pain medications. Since that time, the state reported a 75 percent drop in the number of patients who used multiple prescribers and pharmacies for controlled prescription drugs.

CMS also recommends that Medicaid Programs implement Patient Review and Restriction programs if they have not done so already. These programs identify patients who may be overusing controlled substance prescriptions or who may be using multiple physicians or pharmacies for controlled substance prescriptions. These programs may restrict a patient to a particular physician and/or pharmacy for their controlled substance prescriptions. States may only impose these programs if they give patients notice and an opportunity for a hearing, ensure restricted patients access to Medicaid services, and exclude emergency services from the restriction.

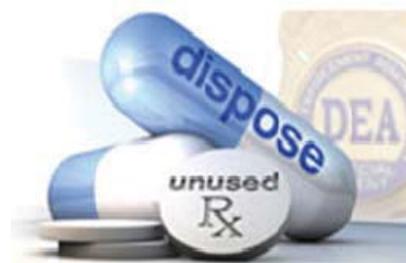
Reference:

Wachino V. Best practices for addressing prescription opioid overdoses, misuse, and addiction. Centers for Medicare & Medicaid Services. 2016 Jan 28 [cited 2016 Mar 24]. Available from: <https://www.medicaid.gov/search.html?q=best%20practices%20for%20addressing%20prescription%20opioid%20overdoses>

DEA Drug Take-Back Day

The DEA has scheduled the National Prescription Drug Take-Back Day for Saturday, April 30, 2016, from 10:00 am to 2:00 pm. This is an opportunity for unused, unwanted prescription medications to be disposed of in a safe manner. The DEA has held previous Take-Back events in conjunction with state, local, and tribal law enforcement partners. Over 5,000,000 pounds of prescription medications have been removed from the public.

Please visit http://www.deadiversion.usdoj.gov/drug_disposal/takeback/ for more information and to locate a collection site in your area.



CDC Recommendations for Prescribing Opioids for Chronic Pain

The Centers for Disease Control and Prevention (CDC) released updated recommendations for the prescribing of opioids to patients 18 years of age or older for chronic pain outside of active cancer, palliative, and end-of-life care by primary care clinicians. Chronic pain is defined as “pain conditions that typically last > 3 months or past the time of normal tissue healing.” The guidelines also address the use of opioid pain medications in special populations, such as pregnant women, older adults, and those with a history of substance use disorder.

The recommendations are grouped into three areas of consideration:

1. Determining When to Initiate or Continue Opioids for Chronic Pain

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy.
- Before patients are started on opioid therapy, clinicians should establish realistic treatment goals. Clinicians should also establish a discontinuation plan if benefits of opioid therapy do not outweigh risks.
- Before starting and during opioid therapy, clinicians should discuss known risks and benefits of opioid therapy.

2. Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

- Immediate-release opioids should be initiated first for chronic pain.
- Clinicians should prescribe the lowest effective dosage when beginning opioid therapy. Clinicians should reassess individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day.
- If opioids are being prescribed for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids for the shortest amount of time (typically < 7 days).
- Clinicians should assess benefits and harms with patients within 1 to 4 weeks of opioid therapy initiation. Patients on continued opioid therapy should be evaluated at least every 3 months. If continued therapy is found to increase harm, clinicians should optimize other therapies and taper opioids to lower dosages or taper and discontinue opioids.

3. Assessing Risk and Addressing Harms of Opioid Use

- Clinicians should consider offering naloxone when patients are at an increased risk for opioid overdose. Factors that increase the risk of overdose are: history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use.
- State Prescription Drug Monitoring Program (PDMP) database should be reviewed when initiating opioid therapy and periodically during opioid therapy.
- Urine drug testing should be performed when initiating opioid therapy and at least annually during opioid treatment.
- Clinicians should avoid prescribing benzodiazepines and opioid medications concurrently.
- Clinicians should offer medication-assisted treatment to patients with opioid use disorder. This could include treatment with buprenorphine or methadone in combination with behavioral therapies.

Reference:

Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. MMWR Recomm Rep 2016;65:1–49. Available from: <http://dx.doi.org/10.15585/mmwr.rr6501e1>.

CMS Buprenorphine Guidance

The Centers for Medicaid and Medicare Services (CMS) released an educational toolkit related to buprenorphine regulatory requirements, prescribing, dispensing, and safety recommendations. Buprenorphine also holds abuse potential and physicians and pharmacists should take precautions to prevent buprenorphine diversion.

The Drug Addiction Treatment Act of 2000 (DATA 2000) allows physicians to get a waiver to prescribe buprenorphine for opioid use disorder outside of a Substance Abuse and Mental Health Services Administration (SAMHSA)-certified opioid treatment program (OTP). Physicians may only prescribe buprenorphine to treat addiction. Midlevel providers, such as nurse practitioners or physicians assistants, cannot obtain a DATA 2000 waiver to prescribe buprenorphine for the treatment of opioid use disorder. Physicians who receive a DATA 2000 waiver are assigned an additional DEA registration number that begins with the letter X. This additional DEA number must be included on the written prescription for buprenorphine or must be verbally provided if the prescription is phoned in to the pharmacy.

CMS recommends that buprenorphine and naloxone products should be preferentially prescribed. Buprenorphine-only products should be reserved for pregnant or breast-feeding women or patients who have a true adverse reaction to naloxone. To help prevent diversion, providers should perform toxicology testing on patients who are using buprenorphine and they should require patients to bring in any unused prescription for inventory.

Before treatment is initiated, patients should be screened for any other substance use disorders. Patients should be assessed to determine whether psychiatric symptoms are a result of substance-induced conditions or a primary psychiatric disorder. Treatment plans should be tailored to individual patients and co-occurring medical and/or psychiatric problems should be addressed. Maintenance dosing should be individualized for each patient. The chart below lists approved maintenance dosing ranges for buprenorphine/naloxone products.

Product Name	Dosage Form	Target Dose Buprenorphine/ Naloxone	Maintenance Dosage Range Buprenorphine/ Naloxone
Bunavail [®]	Buccal film	8.4/1.4 mg	2.1/0.3 mg to 12.6/2.1 mg
Suboxone [®]	Sublingual film	16/4 mg	4/1 mg to 24/6 mg
Buprenorphine/ naloxone	Sublingual tablet	16/4 mg	4/1 mg to 24/6 mg
Zubsolv [®]	Sublingual tablet	11.4/2.9 mg	2.8/0.7 mg to 17.1/4.2 mg

Patients may require maintenance therapy for years. Providers should consider patient's stability, life skills, and recovery support when determining the time to taper or discontinue therapy.

For more information, please visit the Medicaid Program Integrity Education page located at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html>.

Reference:

Center for Medicare and Medicaid Services. (2015). Drug Diversion Toolkit Buprenorphine – A Primer for Prescribers and Pharmacists. Retrieved from <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html>.

April 1st Pharmacy Changes

Effective April 1, 2016, the Alabama Medicaid Agency will:

1. **Require prior authorization (PA) for payment of esomeprazole magnesium (generic Nexium). Brand Nexium will be preferred without PA.** Use Dispense as Written (DAW) Code of 9 for brand Nexium. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand. This value is used when the prescriber has indicated, in a manner specified by prevailing law, that generic substitution is permitted, but the Plan requests the brand product to be dispensed.
2. **Include Vitamin D 50,000 unit capsules in the mandatory three-month maintenance supply program.** Prescriptions for three-month maintenance supply medications will not count toward the monthly prescription limit. A maintenance supply prescription will be required after 60 days' stable therapy. Please see the website for a complete listing of maintenance supply medications.
3. **Update the Preferred Drug List (PDL) to reflect quarterly updates.** The updates are listed below:

PDL Additions	
Nexium	Proton-Pump Inhibitors
Relpax	Selective Serotonin Agonists

For additional PDL and coverage information, visit our drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

The PA request form and criteria booklet, as well as a link for a PA request form that can be completed and submitted electronically online, can be found on the Agency's website at www.medicaid.alabama.gov and should be utilized by the prescribing physician or the dispensing pharmacy when requesting a PA. Providers requesting PAs by mail or fax should send requests to:

Health Information Designs
 Medicaid Pharmacy Administrative Services
 P.O. Box 3210
 Auburn, AL 36832-3210
 Fax: 1-800-748-0116
 Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescribing physician believes medical justification should be considered, the physician must document this on the form or submit a written letter of medical justification along with the prior authorization form to HID. Additional information may be requested. Staff physicians will review this information.

Policy questions concerning this provider notice should be directed to the Pharmacy Program at (334) 242-5050. regarding prior authorization procedures should be directed to the HID help desk at 1-800-748-0130.