



# ALABAMA MEDICAID PHARMACIST

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A Service of Alabama Medicaid

## PDL Update

Effective April 1, 2014, 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*
Tobi (ampules only) –Anti-infective Agents/ Aminoglycosides	Tobramycin (generic Tobi-ampules only)–Anti-infective Agents/ Aminoglycosides
	Levemir–Diabetic Agents/Insulins
	Levemir Flexpen–Diabetic Agents/Insulins
	Xopenex HFA–Respiratory/Beta-Adrenergic 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.*

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](http://hidmedicaid.hidinc.com) or the Agency website at [medicaid.alabama.gov](http://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.

### Inside This Issue

<b>PDL Update</b>	<b>Page 1</b>
<b>JNC-8</b>	<b>Page 2</b>
<b>JNC-8 continued</b>	<b>Page 3</b>
<b>Preferred Antihypertensives</b>	<b>Page 4</b>
<b>Pharmacy Auto-Refills</b>	<b>Page 5</b>
<b>Quantity Limitations</b>	<b>Page 5</b>
<b>Medicaid Updates</b>	<b>Page 6</b>

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## JNC 8 Hypertension Guidelines

The Joint National Committee (JNC-8) guidelines were published in the *Journal of American Medical Association* on December 18, 2013. JNC 8 guidelines advise higher blood pressure goals and less use of several types of antihypertensives. Evidence was gathered from randomized controlled trials. Evidence quality and recommendations were graded based on their effect on important outcomes.

JNC 8 guidelines also recommend lifestyle modifications as an important part of therapy. Some of the modifications include using the Dietary Approaches to Stop Hypertension (DASH) eating plan, weight loss, reduced sodium intake, and at least 30 minutes of aerobic activity most days of the week.

The following recommendations summarize the JNC 8 Guidelines and are based on systemic evidence review:

### Recommendation 1

- In the general population  $\geq 60$  years, initiate pharmacologic treatment when blood pressure (BP) is  $\geq 150/90$ mmHg
  - Goal:  $< 150/90$ mmHg (Strong Recommendation – Grade A)
  - If pharmacologic treatment for high BP results in low systolic blood pressure (SBP) (eg,  $< 140$ mmHg) and treatment is well tolerated and without adverse effects on health or quality of life, treatment does not need to be adjusted. (Expert Opinion – Grade E)

### Recommendation 2

- In the general population  $< 60$  years, initiate pharmacologic treatment when diastolic blood pressure (DBP)  $\geq 90$ mmHg and treat to a goal DBP  $< 90$ mmHg.
  - For ages 30-59 years: Strong Recommendation – Grade A
  - For ages 18-29 years: Expert Opinion – Grade E

### Recommendation 3

- In the general population  $< 60$  years, initiate pharmacologic treatment when SBP  $\geq 140$ mmHg and treat to a goal SBP  $< 140$ mmHg. (Expert Opinion – Grade E)

### Recommendation 4

- In the population aged  $\geq 18$  years with **chronic kidney disease (CKD)**, initiate pharmacologic treatment when BP  $\geq 140/90$ mmHg and treat to goal BP  $< 140/90$ mmHg. (Expert Opinion – Grade E)

### Recommendation 5

- In the population aged  $\geq 18$  years **with diabetes**, initiate pharmacologic treatment when BP  $\geq 140/90$ mmHg and treat to goal BP  $< 140/90$ mmHg. (Expert Opinion – Grade E)

### Recommendation 6

- In the general **nonblack** population, including those **with diabetes**, initial antihypertensive treatment should include a thiazide-type diuretic, calcium channel blocker (CCB), angiotensin-converting enzyme inhibitor (ACEI), or angiotensin receptor blocker (ARB). (Moderate Recommendation – Grade B)

### Recommendation 7

- In the general **black** population, including those **with diabetes**, initial antihypertensive treatment should include a thiazide-type diuretic or CCB.
  - For general black population: Moderate Recommendation – Grade B
  - For black patients with diabetes: Weak Recommendation – Grade C

### Recommendation 8

- In the population aged  $\geq 18$  years **with CKD** regardless of race or diabetes status, initial (or add-on) antihypertensive treatment should include an ACEI or ARB to improve kidney outcomes. (Moderate Recommendation – Grade B)

## JNC 8 Hypertension Guidelines

### Recommendation 9

- If goal BP is not reached within a month of treatment, increase the dose of the initial drug or add a second drug from one of the classes in recommendation 6 (thiazide-type diuretic, CCB, ACEI, or ARB). The clinician should continue to assess BP and adjust the treatment regimen until goal BP is reached.
- If goal BP cannot be reached with 2 drugs, add and titrate a third drug from the list provided. Do not use an ACEI and an ARB together in the same patient.
- If goal BP cannot be reached using only the drugs in recommendation 6 because of a contraindication or the need to use more than 3 drugs to reach goal BP, antihypertensive drugs from other classes can be used.
  - Referral to a hypertension specialist may be indicated for patients in whom goal BP cannot be attained using the above strategy or for the management of complicated patients for whom additional clinical consultation is needed. (Expert Opinion – Grade E)

**Table 4. Evidence-Based Dosing for Antihypertensive Drugs**

Antihypertensive Medication	Initial Daily Dose, mg	Target Dose in RCTs Reviewed, mg	No. of Doses per Day
<b>ACE inhibitors</b>			
Captopril	50	150-200	2
Enalapril	5	20	1-2
Lisinopril	10	40	1
<b>Angiotensin receptor blockers</b>			
Eprosartan	400	600-800	1-2
Candesartan	4	12-32	1
Losartan	50	100	1-2
Valsartan	40-80	160-320	1
Irbesartan	75	300	1
<b>β-Blockers</b>			
Atenolol	25-50	100	1
Metoprolol	50	100-200	1-2
<b>Calcium channel blockers</b>			
Amlodipine	2.5	10	1
Diltiazem extended release	120-180	360	1
Nitrendipine	10	20	1-2
<b>Thiazide-type diuretics</b>			
Bendroflumethiazide	5	10	1
Chlorthalidone	12.5	12.5-25	1
Hydrochlorothiazide	12.5-25	25-100 <sup>a</sup>	1-2
Indapamide	1.25	1.25-2.5	1

### References:

James PA, Oparil S, Carter BL, Cushman WC, Dennison-Himmelfarb C, Handler J, Lackland DT, LeFevre ML, MacKenzie TD, Ogedegbe O, Smith SC, Svetkey LP, Taler SJ, Townsend RR, Wright JT, Narva AS, Ortiz E. 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report from the Panel members Appointed to the Eight Joint National Committee (JNC 8). Dec 18. JAMA. doi:10.1001/jama.2013.284427

## Alabama Medicaid Preferred Antihypertensive Drugs

<b>ACE Inhibitors</b>	<b>Angiotensin II Receptor Antagonists (ARBs)</b>
quinapril	candesartan
ramipril	irbesartan
benazepril	losartan
trandolapril	eprosartan
lisinopril	
moexepiril	<b>Beta-Adrenergic Blocking Agents</b>
enalapril	sotalol
captopril	carvedilol
fosinopril	nadolol
perindopril	propranolol
	betaxolol
<b>Calcium Channel Blockers</b>	metoprolol
nifedipine	acebutolol
verapamil	atenolol
diltiazem	labetalol
amlodipine	bisoprolol
nisoldipine	pindolol
felodipine	propranolol
isradipine	timolol
nicardipine	
nimodipine	<b>Diuretics—Thiazide Type</b>
nisoldipine	chlorthalidone
	hydrochlorothiazide (HCTZ)
	indapamide
	metolazone
	chlorthiazide
	methylclothiazide

## Pharmacy ‘Auto-Refills’

The use of automatic refills by pharmacies is not allowed by the Medicaid Agency. Prescriptions that have been filled but not picked up by the patient or patient’s authorized representative should be credited back to pharmacy stock and Medicaid through claims reversal within 60 days. Violations of these policies may result in unauthorized charges. The pharmacy may be held liable or Medicaid may cancel the pharmacy vendor agreement.

## Policy Reminder—Quantity Limitations

If a prescription to be paid by Medicaid exceeds the drug’s maximum unit limit allowed per month, the prescriber or pharmacist must request an override for the prescribed quantity. If the override is denied, then the excess quantity above the maximum unit limit is non-covered and the recipient can be charged as a cash recipient for that amount in excess of the maximum unit limit. In other words, for a prescription to be “split billed” (the maximum unit allowed paid by Medicaid and the remainder paid by the patient), a maximum unit override must be requested by the provider and denied.

A prescriber **should not** write separate prescriptions, one to be paid by Medicaid and one to be paid as cash, to circumvent the override process. Note: A provider’s failure or unwillingness to go through the process of obtaining an override does not constitute a non-covered service. For more information, this policy can be found in the Alabama Medicaid Provider Billing Manual, Chapter 27.



## April 1st Pharmacy Changes

Effective April 1, 2014, the Alabama Medicaid Agency will:

1. **Require prior authorization for payment of tobramycin inhalation solution (generic Tobi inhalation solution). Brand Tobi inhalation solution will be preferred with no PA.**
  - Use Dispense as Written (DAW) Code of 9 for brand Tobi inhalation solution. DAW Code of 9 indicates the following: Substitution Allowed by Prescriber but Plan Requests Brand - Patient's Plan Requested Brand Product to be Dispensed.
2. **Include preferred Proton Pump Inhibitors 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.
3. **Update the Preferred Drug List (PDL) to reflect the quarterly updates.** The updates are listed below:

PDL Additions	
Tobi Inhalation Solution	Anti-infective Agents/Aminoglycosides
PDL Deletions	
Levemir	Diabetic Agents/Insulins
Levemir Flexpen	Diabetic Agents/Insulins
Tobramycin Inhalation Solution (Generic Tobi Inhalation Solution)	Anti-infective Agents/Aminoglycosides
Xopenex HFA	Respiratory/Beta-Adrenergic 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](http://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 (HID)**  
**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.