



# ALABAMA MEDICAID PHARMACIST

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A Service of Alabama Medicaid

## PDL Update

Effective April 1, 2015, 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*
Aerospan—Respiratory Agents/ Orally Inhaled Corticosteroids	Glyset—Anti-diabetic Agents/ Alpha-Glucosidase Inhibitors
Levemir—Anti-diabetic Agents/ Insulins	
Tradjenta- Anti-diabetic Agents/Dipeptidyl Peptidase-4 Inhibitors	

\*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.

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## Understanding Allergic Rhinitis

Allergic rhinitis is the sixth most prevalent chronic illness in the United States with the possibility of association or predisposal to other chronic medical conditions, including asthma, nasal polyps, respiratory infections, otitis media, sinusitis, and orthodontic malocclusions. The annual costs of allergic rhinitis are close to five billion dollars and increasing as newer, more expensive treatment options become available. Allergic rhinitis is characterized by the inflammation of nasal mucosal membranes in response to exposure and sensitization to specific allergenic material via inhalation. There are two different types of allergic rhinitis (seasonal rhinitis or perennial rhinitis), with a third type identified as those patients who have mixed allergic rhinitis (patient suffers from both seasonal and perennial). Seasonal rhinitis occurs in response to specific antigens present only during specific times of the year (i.e. fall or spring) and results in acute symptoms; this type is also referred to as hay fever. Oppositely, perennial rhinitis occurs year-round in response to nonseasonal allergens and produces chronic, subtler symptoms.

Predisposing factors of allergic rhinitis include one or both parents who suffer from allergic rhinitis, atopic dermatitis, or asthma. For this reason, many patients have the underlying genetic factors for the development of rhinitis; however, if one never comes into contact with the specific allergens, the disease never becomes “active.” The allergic triad is the predisposal of patients with asthma, allergic rhinitis, or atopic dermatitis to subsequently develop the other two later in the disease process.

Allergic rhinitis begins when a patient is exposed to an allergen (via inhalation) and the allergen is processed by lymphocytes; at this point, patients who are genetically predisposed will produce IgE antibodies against the allergen (or antigen). Upon re-exposure to the allergen, IgE on the surface of histamine producing mast cells bind the antigen leading to degranulation of the mast cell. Degranulation of this cell leads to an immediate reaction with the release of inflammatory mediators, such as histamines, leukotrienes, prostaglandins, kinins, and tryptase. These mediators act to vasodilate the capillary bed of the nasal capillary, increase vascular permeability, as well as to increase the production of nasal secretions. This acute reaction produces bothersome symptoms, including itching, sneezing, rhinorrhea, and obstruction. A late phase reaction typically occurs some four to eight hours after the acute reaction; at this point mast cells further degranulate to release lymphocytes and cytokines. These mediators produce nasal congestion.

While all allergens produce the same allergic reaction and symptoms in patients with allergic rhinitis, not all patients have reactions to the same allergens. Some patients may experience flares during only the spring or some only in late summer to early fall. Some individuals may experience symptoms every day. In general, seasonal allergens include the pollens produced by grasses, trees, and weeds, while perennial allergens include things such as mold spores, dust mites, dust mite droppings, cockroaches, and pets.

It is very important that patients with seasonal allergies understand which allergens cause their symptoms as well as the times of the year these allergens may be encountered. Tree allergens are produced during the spring; grasses tend to pollinate from late spring through summer, while weeds produce the most pollen from late summer to early fall. Patients with seasonal allergies do not require continuous treatment throughout the year, but should begin therapy several weeks prior to the peak season for their allergen and continue through the entire season of allergen production.

There are several reports made available to patients to show which types and how much allergens are being produced throughout the season. Below are some of the most commonly reported allergens:

- Trees: ash, beech, birch, cedar, hickory, maple, oak, poplar, and sycamore
- Grasses: fescue, Kentucky bluegrass, orchard, redtop, and Timothy
- Weeds: ragweed



## Understanding Allergic Rhinitis

Patients with allergic rhinitis often present with generalized symptoms of clear rhinorrhea, sneezing, nasal congestion, and postnasal drip. Patients may also complain of itching ears, eyes, and noses. Those suffering from allergies may be observed breathing through their mouths instead of their noses, have swelling around the eyes, and complain of a loss of taste and/or smell. These individuals may also have a loss of concentration, experience poor sleep, and suffer from symptoms of chronic fatigue. Also of note, patients commonly have what is referred to as ‘allergic shiners,’ or darkening/bruising under the eyes, in addition to nasal creases, or loss of pigmentation on the bridge of the nose due to chronic upward wiping of the nose.

Not all causes of rhinitis are due to allergies. For instance, other possible causes of acute rhinitis may include certain drugs, viral, bacterial, or fungal infections, or changes in hormones (i.e. pregnancy or menstruation). Causes of chronic rhinitis aside from allergies may include anatomic malformations (i.e. tumors, polyps, etc.) or idiopathic origins. Because there are several different causes of rhinitis, diagnosis of allergic rhinitis requires carefully obtaining a thorough medical history and interpretation of findings on the physical exam in addition to other diagnostic measures. Questions asked in obtaining the patient’s medical history should adequately access the frequency and severity of symptoms, times of the year when symptoms become worse, times of the year when symptoms become better, environmental exposure (both indoor and outdoor), and previous medication therapies the patient has attempted to control symptoms. Additionally, the family history of the patient is very important due to the genetic predisposing factors associated with allergic rhinitis. Such history should not only include gathering information about diagnoses of allergic rhinitis in the family, but also asthma, atopic dermatitis, and food allergies.

Two diagnostic tests are helpful in determining whether patients may be suffering from allergic rhinitis. The first is nasal scraping. In this procedure, cells are scraped from the patient’s nostrils and evaluated to determine which cells are infiltrating the nasal mucosa. Typical findings in a patient with allergic rhinitis would reveal an increasing number of eosinophils; these cells are white blood cells that are heavily involved in the mechanisms associated with allergy and asthma. The second is allergy testing. This test is helpful in determining which allergen or combinations of allergens are causing a patient’s symptoms. Allergy testing may be accomplished via skin scratches or blood draws.

Among pharmacological therapies, non-pharmacological interventions may provide alleviation of the symptoms associated with allergic rhinitis. Allergen avoidance is the most effective therapy identified in treating allergic rhinitis, but is also the most difficult for a patient to manage and results in poor adherence rates. For instance, patients suffering from seasonal allergies should limit their time outdoors during the trigger season and wear masks when they are outdoors. Additional measures include keeping windows and doors closed, avoiding inward draws of outdoor air, and showering promptly after outdoor activities.

In summary, allergic rhinitis is a common disease that results in annoying symptoms with the possibility of leading to more complicated disease processes later. Patients suffering from allergic rhinitis are best treated by a combination of non-pharmacological and pharmacological therapies.

### References:

May JR and Smith PH. Allergic rhinitis. In: DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey LM, editors. *Pharmacotherapy: A pathophysiologic approach*. 8th ed. New York: McGraw-Hill Medical; c2011. Chapter 104.

Brock TP and Williams DM. Acute and chronic rhinitis. In: Alldredge BK, Corelli RL, Ernst ME, Guglielmo BJ, Jacobson PA, Kradjan WA, Williams BR, editors. *Koda-Kimble & Young’s applied therapeutics: The clinical use of drugs*. 10th ed. Philadelphia: Lippincott Williams & Wilkins - Wolters Kluwer; c2013. Chapter 25.

## Health Home Expansion

More than 250,000 Medicaid recipients with chronic health conditions will soon have access to enhanced care coordination and other services to improve their overall health when the Alabama Medicaid Agency expands its Health Home program on April 1, 2015.

Six probationary Regional Care Organizations (RCOs) have signed contracts to operate Health Home programs. The groups include: Region A: Alabama Community Care – Region A and My Care Alabama; Region B: Alabama Care Plan; Region C: Alabama Community Care – Region C; Region D: Care Network of Alabama; and Region E: Gulf Coast Regional Care Organization.

The program, which has operated since 2012 as Patient Care Networks in 21 counties of the state, is expanding statewide as an interim step toward implementation of full-risk Regional Care Organization. RCOs are locally-led managed care systems that will ultimately provide health-care services to Medicaid enrollees at an established cost under the supervision and approval of the Alabama Medicaid Agency.

In contrast, the Health Home program is defined by the federal government as an optional Medicaid program that integrates and coordinates care for patients with certain chronic conditions to achieve improved health outcomes. In Alabama, the Health Home program is set up to add an additional level of support to Patient 1<sup>st</sup> Primary Medical Providers (PMPs) by intensively coordinating the care of patients who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, COPD, HIV, mental health conditions, substance use disorders, transplants, sickle cell, BMI over 25, heart disease and hepatitis C.

Care management, or coordinated care, in the Health Home program is done by connecting patients with needed resources, teaching self-management skills, providing transitional care and bridging medical and behavioral services,

among other efforts.

“This interim step is designed as a building block for probationary RCOs that are working toward full certification by facilitating network development and providing resources while offering the probationary RCOs an opportunity to demonstrate that they have resources to manage patients in their region,” said Dr. Robert Moon, Chief Medical Officer and Deputy Commissioner for Health Systems.



## News You Can Use

### Concerta/Methylphenidate Billing Guidance

The Food and Drug Administration (FDA) recently changed the rating of methylphenidate ER (18, 27, 36 and 54 mg). It is no longer classified as a generic equivalent to the brand name product Concerta. In order for pharmacies to be reimbursed correctly, claims billed for brand named Concerta may be billed using a DAW code of 8 (substitution allowed-generic drug not available in the marketplace). Concerta remains non-preferred and will continue to require prior authorization.

### Dispense as Written (DAW) Code 9 Medication List

In cases of cost-effectiveness, the Alabama Medicaid Agency sometimes allows for reimbursement of certain brand named medications while requiring prior authorization for the generic alternative. In these cases, a Dispense as Written (DAW) code of 9 must be utilized when dispensing the preferred brand named medication. A DAW code of 9 indicates that substitution is allowed by the prescriber but Alabama Medicaid requests the brand product be dispensed. The list is subject to change. For additional PDL and coverage information, visit the drug look-up site at <https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx>.

Preferred Brand	Non-preferred Generic
Accolate	Zafirlukast
Adderall XR	Amphetamine Salts XR
Diastat	Diazepam Rectal Kit
Diastat Accudial	Diazepam Rectal Kit
Focalin (IR only)	Dexmethylphenidate
Intuniv	Guanfacine ER
Lidoderm	Lidocaine Topical Patch
Meproon	Atovaquone
Provigil	Modafinil
Pulmicort Inhalation Solution	Budesonide Inhalation Solution
TOBI	Tobramycin Inhalation Solution
Xopenex Inhalation Solution	Levalbuterol Inhalation Solution

## April 1st Pharmacy Changes

Effective April 1, 2015, the Alabama Medicaid Agency will:

1. **Require prior authorization for payment of extended release guanfacine HCL (generic Intuniv). Brand Intuniv will continue to be preferred with no PA.**
  - Use Dispense as Written (DAW) Code of 9 for brand Intuniv. 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. **Update the Preferred Drug List (PDL) to reflect the quarterly updates.** The updates are listed below:

PDL Additions	
Aerospan	Respiratory Agents/Orally Inhaled Corticosteroids
Levemir	Anti-diabetic Agents/Insulins
Tradjenta	Anti-diabetic Agents/Dipeptidyl Peptidase-4 Inhibitors
PDL Deletions	
Glyset	Anti-diabetic Agents/Alpha-Glucosidase Inhibitors

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.

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