



ALABAMA MEDICAID PHARMACIST

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A Service of Alabama Medicaid

PDL Update

Effective July 1, 2013, 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*
Lansoprazole—Gastrointestinal Agents/Proton-Pump Inhibitors	Pegasys—Anti-infective Agents/ Interferons
Astelin—EENT Preparations/ Antiallergic Agents	Astepro—EENT Preparations/ Antiallergic Agents
	Azelastine HCL—EENT Preparations/Antiallergic Agents
	Maxair Autohaler—Respiratory/ Beta-adrenergic 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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Acute Otitis Media Treatment Guidelines

An inflammation of the middle ear space, known as Otitis Media (OM), is typically caused by an infection from bacteria (the three most common: *S. pneumonia*, *H. influenza*, *M. catarrhalis*) or viruses that travel from the nose, sinuses and throat area up the eustachian tube into the middle ear. Bacterial- or viral-infected OM is typically referred to as Acute Otitis Media (AOM). More than 80% of patients seen for AOM receive a prescription, as it remains the most common condition for antibacterial agents for children in the United States. The direct and indirect costs associated with managing it add up to almost \$3 billion annually, although clinician visits have decreased over the years.

Previous guidelines by the American Academy of Pediatrics (AAP) in 2004 defined the diagnostic criteria for uncomplicated AOM as meeting the following three clinical signs:

- Acute onset
- Middle ear inflammation
- Middle ear effusion (MEE, also known as bulging of the tympanic membrane)

The 2004 AAP guidelines and updates state if the patient did not meet all three criteria, then the diagnosis is classified as uncertain. The new 2013 guideline has more stringently addressed this issue by saying that MEE is a requirement for the diagnosis of AOM, and without MEE, it cannot be diagnosed as AOM.

There is no gold standard for the diagnosis of AOM because it has a spectrum of signs as the disease develops. Diagnosis is essentially based on signs, symptoms, history, and an examination that includes a pneumatic otoscope to look into the ear.

Treatment goals include pain management, a decision to initiate antibiotics, and preventative care measures.

Acetaminophen and ibuprofen remain the mainstays of pain management for AOM and fever symptoms. They are both effective analgesics for mild to moderate pain.

The following charts detail the current guideline recommendations in terms of antibiotic management.

Recommendations for Initial Management for Uncomplicated AOM (with Certain Diagnosis)				
Age	Otorrhea <u>with</u> AOM	Unilateral or Bilateral AOM <u>With Severe Symptoms</u> *	Bilateral AOM <u>Without</u> Otorrhea	Unilateral AOM <u>Without</u> Otorrhea
6 mo–2 yrs	Antibiotic therapy recommended	Antibiotic therapy recommended	Antibiotic therapy	Antibiotic therapy OR <i>additional observation</i> **
2 yrs and greater			Antibiotic therapy OR <i>additional observation</i> **	
<p>* <i>Severe symptoms</i>: a toxic-appearing child, persistent otalgia more than 48 hrs, temperature 39°C (102.2°F) in the past 48 hrs, or if there is uncertain access to follow up after the visit.</p> <p>** <i>Additional observation</i>: a strategy in initial management that provides an opportunity for shared decision-making with the child’s family for those categories appropriate for additional observation. If observation is offered, a mechanism must be in place to ensure follow up and begin antibiotics if the child worsens or fails to improve within 48 to 72 hrs of AOM onset. Many AOM infections may resolve on their own without antibiotics.</p>				

Acute Otitis Media Treatment Guidelines, continued

Recommendation for Antibiotics for (Initial or Delayed) Treatment	
First-Line Treatment	Alternative Treatment (If Penicillin Allergy)
High dose Amoxicillin (80-90 mg/kg/ day in 2 divided doses)	Cefdinir (14mg/kg/day in 1 or 2 doses)
OR Amoxicillin-Clavulanate (90 mg/kg/day of amoxicillin, with 6.4 mg/kg/day (14:1 ratio) in 2 divided doses) if the patient had received amoxicillin within the previous 30 days or has otitis-conjunctivitis syndrome.	Cefuroxime (30mg/kg/day in 2 divided doses)
	Cefpodoxime (10mg/kg/day in 2 divided doses)
	Ceftriaxone (50mg IM or IV per day for 1-3 days) if unable to tolerate oral formulations

Treatment failure is considered if symptoms worsen or treatment fails to show improvement after 48-72 hours of initiation of therapy. This situation warrants switching to an alternative therapy.

Recommendation for Change in Therapy After 48-72 Hrs of Antibiotic Treatment Failure	
First-Line Treatment	Alternative Treatment
Amoxicillin-Clavulanate (90 mg/kg/day of amoxicillin, with 6.4 mg/kg/day (14:1 ratio) in 2 divided doses)	Ceftriaxone 3 day course (50mg/kg/day IV or IM injection) Clindamycin (30-40mg/kg/day in 3 divided doses) with or without an antibiotic that covers <i>H. influenzae</i> and <i>M. catarrhalis</i> , such as cefpodoxime, or third-generation cephalosporins: Cefdinir or Cefixime.
OR Ceftriaxone (50mg IM or IV per day for 1-3 days) if unable to tolerate oral formulations	Tympanocentesis Perform tympanocentesis/drainage if skilled in procedure or consult a specialist. If drainage reveals multidrug resistant bacteria, seek an infectious disease specialist.
<u>Agents no longer recommended for AOM due to growing resistance:</u> 2 nd generation cephalosporins, Bactrim, erythromycin-sulfisoxazole	

The duration of therapy was defined by controlled trials that showed optimal efficacy based upon age and severity, as summarized below.

Age Group/Severity	Duration
Children under 2 or has severe symptoms	10 days
Children age 2-5 yrs with mild or moderate symptoms	7 days
Children 6 and older with mild or moderate symptoms	5-7 days

The AAP guidelines also address certain preventative measures to reduce the AOM burden, including pneumococcal conjugate vaccination to all children according to the ACIP guidelines, an annual influenza vaccination for ages 6 months and older, avoidance of tobacco smoke exposure, and the encouragement of breast feeding for at least the first 6 months of life.

For more information regarding the diagnosis and management of AOM, clinicians should consult the current guidelines as well as the available primary literature in order to help reduce the burden and costs of AOM.

References:

American Academy of Pediatrics Subcommittee on Management of Acute Otitis Media. Diagnosis and management of acute otitis media. *Pediatrics*. March 2013;131(3):e964-e990.

Upper Respiratory Tract Infections. In: Dipro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey LM, editors. *Pharmacotherapy: A pathophysiological approach*. 8th ed. New York: McGraw-Hill Medical; c2011.

Lyme Disease in Children, continued

Early Localized Disease		
8 years of age or older	Doxycycline, 4 mg/kg per day divided into 2 doses (maximum 200 mg/day) for 14-21 days.	
Younger than 8 years or unable to tolerate doxycycline	Amoxicillin, 50 mg/kg per day divided into 3 doses (maximum 1.5 g/day) for 14-21 days OR cefuroxime, 30 mg/kg per day in 2 divided doses (maximum 1000 mg/day) or 1000 mg/day for 14-21 days.	Tetracyclines are contraindicated in children < 8 years.
Early Disseminated and Late Disease		
Multiple Erythema Migrans	Same oral regimen as for early localized disease, but for 21 days.	
Isolated Facial Palsy	Same oral regimen as for early localized disease, but for 14-21 days.	Corticosteroids should not be given. Purpose of treatment is to prevent late disease.
Arthritis	Same oral regimen as for early localized disease, but for 28 days.	

*Chart does not reflect complete treatment guidelines.

References:

American Academy of Pediatrics. *Red Book: 2012 Report of the Committee on Infectious Diseases*. Pickering LK, ed. 29th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2012.

Lyme disease [2013 May 6]. *Centers for Disease Control and Prevention*. Retrieved from <http://www.cdc.gov/lyme/>.

DEA Edits Effective Date Extended

The effective date for implementing the DEA Edits has been extended from May 13, 2013, to July 8, 2013.

Effective July 8, 2013, Alabama Medicaid will DENY any claim for a controlled drug written by a prescriber who does not have their Drug Enforcement Administration (DEA) number registered with the Department of Justice (DOJ) **and** on file at Medicaid. These edits are designed to prevent controlled substances from being filled when the prescription is written by an unauthorized prescriber.

Please refer to http://medicaid.alabama.gov/news_detail.aspx?ID=7829 for more information.

Co-Payment Changes for Medicaid Services

Effective for dates of service July 1, 2013, and thereafter, copayments for Medicaid covered services will be based on the federally approved maximum amounts shown below (including Medicare crossovers):

Services with Co-payments	Co-payment Amounts	Based on Medicaid's Allowed Amount for the Services
Office Visits (including visits to physicians, optometrists, nurse practitioners)	\$1.30 to \$3.90 per office visit code	\$50.01 or more - \$3.90 \$25.01 - \$50.00 - \$2.60 \$10.01 - \$25.00 - \$1.30
Federally Qualified Health Centers (FQHC)	\$3.90 per encounter	
Rural Health Clinic (RHC)	\$3.90 per encounter	
Inpatient Hospital	\$50.00 per admission	
Outpatient Hospital	\$3.90 per visit	
Ambulatory Surgical Centers	\$3.90 per visit	
Durable Medical Equipment	\$1.30 to \$3.90 per item	\$50.01 or more - \$3.90 \$25.01 - \$50.00 - \$2.60 \$10.01 - \$25.00 - \$1.30
Medical Supplies and Appliances	\$0.65 to \$3.90 per item	\$50.01 or more - \$3.90 \$25.01 - \$50.00 - \$2.60 \$10.01 - \$25.00 - \$1.30 \$10.00 or less - \$0.65
Prescription Drugs	\$0.65 to \$3.90 per prescription	\$50.01 or more - \$3.90 \$25.01 - \$50.00 - \$2.60 \$10.01 - \$25.00 - \$1.30 \$10.00 or less - \$0.65

Co-payment does **not** apply to services provided to/for:

- Pregnant women
- Nursing facility residents
- Recipients less than 18 years of age
- Native American Indians with an active user letter from Indian Health Services (IHS)
- Emergencies
- Family Planning

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (co-payment) amount imposed.