2015
Vol. 28, No. 1

DUR DIGEST

The Bulletin of Medicaid Drug Utilization Review in Iowa

Commission Welcomes New Member

The DUR Commission welcomes the addition of Daniel Gillette, M.D.

Dr. Gillette completed his undergraduate work at Yankton College, where he graduated Magna Cum Laude as valedictorian in 1985. He then attended medical school at the University of Nebraska, followed by a residency at the University of Kansas, and a fellowship at the University of New Mexico. He is board certified in General Psychiatry, as well as Child and Adolescent Psychiatry, and also has a Master's degree in Health Care Management from the Harvard School of Public Health. During his 10 years at the Cherokee Mental Health Institute he served in several roles, including Clinical Director and Superintendent. While there, he reduced pharmacy costs by 20% in a single month, and then maintained that reduction over more than two years. Currently, in addition to offering direct clinical psychiatric care at Dean and Associates and Opportunities Unlimited, he is Senior Physician Leader of Behavioral Health for UnityPoint Health - St. Luke's in Sioux City, past president of the Iowa Psychiatric Society, and provides clinical consultation for Wellmark Blue Cross Blue Shield of Iowa and South Dakota. Dr. Gillette was appointed to the DUR Commission in 2015; his first term will expire in June 2019.

Updated Drug Prior Authorization Criteria

CNS Stimulants and Atomoxetine (formerly known as ADD/ADHD/Narcolepsy Agents)

Prior Authorization (PA) is required for CNS stimulants and atomoxetine for patients 21 years of age or older. Prior to requesting PA for any covered diagnosis, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at https://pmp.iowa.gov/IAPMPWebCenter/. Payment for CNS stimulants and atomoxetine will be considered under the following conditions:

1. Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) meeting the DSM-5 criteria and confirmed by a standardized rating scale (such as Conners, Vanderbilt, Brown, Snap-IV). Symptoms must have been present before twelve (12) years of age and there must be clear evidence of clinically significant impairment in two or more current environments (social, academic, or occupational). Documentation of a recent clinical visit that confirms the patient continues to require medication to treat the symptoms of ADD/ADHD will be required for renewals or patients newly eligible that are established on medication to treat ADD/ADHD.
2. Narcolepsy with diagnosis confirmed with a recent sleep study (ESS, MSLT, PSG).
3. Excessive sleepiness from obstructive sleep apnea/hypopnea syndrome (OSAHS) with documentation of non-pharmacological therapies tried (weight loss, position therapy, CPAP at maximum titration, BiPAP at maximum titration or surgery) and results from a recent sleep study (ESS, MSLT, PSG) with the diagnosis confirmed by a sleep specialist.

Payment for a non-preferred agent will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. * If a non-preferred long-acting medication is requested, a trial with the preferred immediate release and extended release product of the same chemical entity (methylphenidate class) or chemically related agent (amphetamine class) is required. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Requests for Vyvanse for Binge Eating Disorder must be submitted on the Binge Eating Disorder Agents PA form.

Binge Eating Disorder Agents

Prior authorization (PA) is required for Vyvanse for the treatment of Binge Eating Disorder (BED). Prior to requesting PA, the prescriber must review the patient's use of controlled substances on the Iowa Prescription Monitoring Program (PMP) website at https://pmp.iowa.gov/IAPMPWebCenter/. Payment will be considered under the following conditions:

1. Patient is 18 to 55 years of age;
2. Patient meets the DSM-5 criteria for BED;
3. Patient has documentation of moderate to severe BED, as defined by the number of binge eating episodes per week (number must be reported);
4. Patient has documentation of non-pharmacologic therapies tried, such as cognitive-behavioral therapy or interpersonal therapy, for a recent 3 month period, that did not significantly reduce the number of binge eating episodes;
5. Patient has documentation of an adequate trial and therapy failure at a therapeutic dose with topiramate and fluvoxamine;
6. Prescription is written by a psychiatrist or psychiatric nurse practitioner;
7. Patient has a BMI of 25 to 45;
8. Patient does not have a personal history of cardiovascular disease;
9. Patient has no history of substance abuse;
10. Is not being prescribed for the treatment of obesity or weight loss; and
11. Doses above 70mg per day will not be considered.

Initial requests will be approved for 12 weeks when criteria for coverage are met. Requests for renewal must include documentation of a change from baseline at week 12 in the number of binge days per week.

Preferred Dosing of Orally Administered Liquid Medications

Emergency department visits for unintentional medication overdoses account for more than 70,000 children visits each year. Volumetric dosing errors and use of incorrect dosing delivery devices are two frequent sources of these overdoses.

In April 2015, the American Academy of Pediatrics (AAP) released a policy statement titled *Metric Units and the Preferred Dosing of Orally Administered Liquid Medications,* recommending the exclusive use of milliliter-based dosing when prescribing and administering liquid medications. Several other organizations (including the Institute for Safe Medication Practices, the Academic Pediatric Association, the American Academy of Family Physicians, the American Medical Association, and the National Council for Prescription Drug Programs, and the FDA) have issued similar statements in support of metric dosing.

Syringes achieve a more precise dosing than dosing cups or dosing spoons, as demonstrated by recent studies. It is recommended that prescribers stop prescribing liquid medications to children that use teaspoon or tablespoon volumes to decrease the likelihood of use of household spoons to administer liquid medications.

Below are some of the recommendations from the AAP. A complete list of the recommendations can be found at http://pediatrics.aappublications.org/content/135/4/784.

1. Orally administered liquid medications should be dosed exclusively by using metric-based dosing with milliliters to avoid confusion and dosing errors with common kitchen spoons.
    a. Medications should be dosed to the nearest 0.1, 0.5, or 1 mL, as appropriate based on the margin for safe and effective dosing; dosing to the hundredth of a milliliter should be avoided.
    b. The appropriate abbreviation for milliliter is “mL” and use of alternatives (e.g., ml, ML, cc) should be avoided.
    c. Milliliter-based dosing should include leading zeros preceding decimals for doses less than 1 mL to avoid 10-fold dosing errors.
    d. Trailing zeros after decimals should not be included when dosing in whole number units to avoid 10-fold dosing errors.
2. The concentration of all orally administered liquid medications (e.g., mg/mL) should be clearly noted on prescriptions to allow accurate calculation of the medication dose administered.
3. The frequency of administration of orally administered liquid medications should be clearly noted, avoiding abbreviations that could lead to dosing errors (e.g., use of “daily” is preferred over “qd”, which could be misinterpreted as “qid”).
4. Pharmacies, hospitals, and health centers should dispense orally administered liquid medications with metric dosing on the label.
    a. Pharmacies, hospitals, and health centers should distribute appropriate-volume milliliter-based dosing devices with all orally administered liquid medications. Syringes are the preferred dosing device. Cups and spoons calibrated and marked in milliliters are acceptable alternatives.

Medicaid Statistics for Prescription Claims

from January 1, 2015 to March 31, 2015*

Number of claims paid: 1,679,151

Total dollars paid: $108,773,767

Percent generic prescriptions: 85%

Average amount paid per claim: $64.78

Average amount paid per claim, brand: $315.78

Average Amount paid per claim, generic: $20.99

Top Drugs by Number of Prescriptions	Top Drugs by Dollars Spent	Top Therapeutic Class by Dollars Spent
Hydrocodone/APAP 5-325mg $14.70/RX	*Lantus* Injection 100/ml $2,578,967 $379.26/RX	Antipsychotics – Atypicals $9.4 million
Ventolin HFA $54.46/RX	*Abilify* 20mg $1,801,943 $676.91/RX	Anticonvulsants $6.0 million
Tramadol 50mg $11.76/RX	Methylphenidate ER 36mg $1,556,405 $233.59/RX	Stimulants – Amphetamines – Long Acting $5.4 million
Amoxicillin 400mg/5ml $12.09/RX	*Synagis 100mg/ml* $1,481,437 $3,023.34/RX	Diabetic – Insulin $5.1 million
Loratadine 10mg $8.87/RX	*Spiriva* $1,382,602 $291.44/RX	Stimulants – Methylphenidate – Long Acting $4.5 million

*All dollars reported are pre-rebate