Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
John E. Baldacci, Governor Brenda M. Harvey, Commissioner

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PHARMACY BENEFIT UPDATE

Fall / Winter 2009 Issue

Preferred Drug List (PDL) News

A. MAJOR PDL CHANGES EFFECTIVE JANUARY 1, 2010

The State of Maine has recently completed the annual review of all PDL categories and the drugs within those categories. The following is a list of the major changes to the PDL for 2010. For a complete list of the Preferred Drug List please refer to www.mainecarepdl.org

Preferred	Notes
Apriso	*Provides a low pill burden mesalamine alternative*
Combigan	*Additional preferred carbonic anhydrase inhibitor alternative*
Kadian	*Kadian 80mg & 200mg are non-preferred.*
Letairis	*Clinical PA is required to establish diagnosis and medical necessity.*
Lexapro Tabs	*See Lexapro splitting table*
Omnitrope	*Clinical PA is required to establish diagnosis and medical necessity.*
Savella	*Savella available w/o PA for fibromyalgia if first line generic in profile: TCA, Cyclobenzaprine or Gabapentin.*
Trileptal Susp	*No generic alternative*
Venlafaxine ER Tabs	*Replaces Effexor XR, available in 225mg tablet to consolidate doses.*

Non-preferred	Notes/PA Criteria
Actoplus Met Avandaryl Avandamet Tabs	*Requires use of Actos, Metformin, or other preferred anti-diabetics.*
Actos 30mg Tabs Actos 45mg Tabs	*Actos 30mg or 45mg - please use multiple 15mg tabs.*
Altabax	*Dosing limits apply.*
Avandia	*Current users of Avandia who have tried Actos will be able to continue use of Avandia.*
Augmentin XR TB12	*Use preferred generic amoxicillin/clavulanic acid alternatives*
Duetact	*Use Actos 15mgs with generic glimepiride*

Non-preferred	Notes/PA Criteria
Emend	*Clinical PA is required for members on highly emetic anti-neoplastic agents.*
Enbrel 50mg	*Please use multiples of 25mg or other preferred TNFs (Humira, Cimzia)*
Exelon	*Must fail all preferred products before moving to non-preferred.*
Firmagon	*PA required to confirm FDA approved indication.*
Fosamax Tab and Plus D	*Please use Alendronate and Vitamin D.*
Fuzeon Intelence Isentress Selzentry	*Prescribers with >= 10 ART scripts per quarter and 75% ART PDL compliance will be exempt from PA for these products.*
Granisetron	*All preferred medications must be tried.*
Lialda Tabs	*Current Lialda users grandfathered (1.1.10)*
Lyrica	*Lyrica- Second line therapy for Diabetic Peripheral Neuropathy and Post Herpetic Neuralgia. With Fibromyalgia diagnosis, Lyrica will not require PA if previous 4 week trials of the following are seen in drug profile at full therapeutic doses: TCA or cyclobenzaprine, gabapentin, and Savella.*
Nateglinide	*Please use preferred brand Starlix*
Onglyza	*Will re-evaluate at January DUR meeting*
Peg-Intron Kit	*Current users are grandfathered. Pegasys preferred.*
Pentasa 500mg	*Use multiple Pentasa 250mg*
Pulmicort Flexhaler	*Use preferred inhaled steroids*
Relpax	*Current users must switch to other preferred alternatives*
Synagis	*MaineCare will approve Synagis PA's for start date of November 23rd for infants who meet the guidelines. PA will be approved for max of 5 doses. Maximum 1 dose/30 days.*
Treximet	*Use preferred Sumatriptan and Naproxen separately.*
Veramyst	*Please use preferred nasal steroid (fluticasone or Nasonex)*

B. MAINECARE INITIAL 15 DAY SUPPLY

Late in the summer of 2009 MaineCare began a policy for a 15 day supply limit on initial prescriptions for certain medications. The medications chosen reflect those that have low compliance rates for the first 30 days. The purpose of this policy is to decrease the quantity of medications that are wasted during their initial use (first prescription) by patients. This will result in cost savings, less diversion, and a reduction in the negative environmental impact. The actual procedure for this requires NO change (with the exception of schedule 2 medications) from prescribers. Specifically, prescribers write a usual 30 day initial prescription. At the pharmacy, the patient receives the first 15 days. They then return to the pharmacy two weeks later for either the second half of the prescription refill or a full 30 day refill. Moving forward, a 30 day supply is dispensed. The 15 day supply only involves initial prescriptions and does NOT involve subsequent dose increases. For schedule 2 medications, the prescriber must write out an initial 15 day prescription as well as a second prescription, noting the date to be filled on the latter. As of late November, there have not been any notable problems or adverse consequences stemming from this new policy.

C. CHRONIC OPIATE PRESCRIPTION MONITORING

Beginning January 1, 2010 a prior authorization procedure (PA) will begin for any MaineCare "new" chronic opiate using members (defined as having 90 days of opiates in the past 100 days). Patients who have been receiving chronic opiate prescriptions before this time will not be affected by this new process. Additionally, all patients being treated for cancer, AIDS, in hospice, and in long-term care facilities will also be exempt from this policy. The goal of this policy is to promote the widespread adoption of standards of care as they pertain to "new" chronic opiate treated patients. This will be in alignment with Rule 11 of the Boards of Licensure in Medicine and Osteopathy. These goals seek to decrease iatrogenic opiate abuse and dependence and to cut down on diversion of these substances. This PA will focus on the following principles of pain management:

1. Insuring an appropriate indication exists for chronic opiates
2. Reviewing that non-pharmacologic and non-opioid drug treatments have been considered and/or tried
3. Insuring that an opiate/controlled substance contract exists
4. Reviewing a monitoring plan (such as whether Urine Drug Screens and Random Pill counts may be appropriate)
5. Insuring that the Prescription Monitoring Program reports are used routinely

It is likely that only a handful of Chronic Narcotic Prior Authorizations will be required. Once it is clear that appropriate opiate use protocols are being undertaken, PA exemptions will be quickly granted. It is anticipated that each prescriber will not do more than 5 chronic opiate PAs and the total PA volume will be 100 – 130 PAs per month.

Providers who wish to participate in a consultation for chronic pain sponsored by the Maine Medical Association and the Maine Board of Licensure in Medicine. This program offers free, professional consultations. To schedule a visit to your practice contact Noel Genova at noelpac@aol.com or 207-671-9076 or contact Kellie Miller at kmiller@mainemed.com or 622-3372 ext. 229.

D. BENZODIAZEPINE UTILIZATION

State wide utilization of benzodiazepines was presented at a recent conference this past October. Use of this class of medication has increased markedly over a brief period, especially in the 45 to 64 age range. Benzodiazepines are increasingly being associated with deleterious outcomes, particularly in conjunction with other medications such as opiates. Toxic poisonings are becoming increasingly noted in conjunction to benzodiazepine use. It is apparent that long term use of this drug class is the factor most associated with adverse outcomes. There continues to be a lack of understanding relating to this drug class by prescribers. As an example in a recent PA, a prescriber was requesting that extended release Xanax ® (alprazolam) be used in a patient already receiving diazepam, clonazepam, and immediate release alprazolam. This demonstrates a basic lack of understanding that using multiple agents in this drug class does not make for good or safe clinical practice. It is essential that prescribers fully understand the potential benefits and risks of benzodiazepines as a medication class and it is becoming increasingly evident that substantial toxicities exist.

E. ABILIFY DOSE SPLITTING

Abilify was a non-preferred atypical antipsychotic until last winter when it was made preferred contingent upon dose splitting at low dosage strengths. (Abilify remains non-preferred at the higher 20 mg and 30 mg doses). Such dose splitting allows significant cost savings and makes utilization of this medication possible. Other insurers already endorse the splitting of different atypical antipsychotics to achieve cost savings. The MaineCare PDL has required splitting of both Lexapro and Celexa for years and has noted both wide acceptance and excellent results. Since the introduction of splitting Abilify, use has increased and there are no apparent adverse consequences noted to this practice. Currently, an early analysis of potential impact on medication compliance and adherence notes no degradation when comparing dose splitting to non-splitting using baseline data. Ongoing analysis of the potential impact of splitting on compliance measures is continuing. Splitting medication appears to be a potentially powerful method to help control cost and make expensive medications available. One can also write a prescription for a pill splitter for patients selected for splitting.

F. ACADEMIC DETAILING

The State of Maine in conjunction with the Maine Medical Association has launched an innovative pilot program called MiCiS (The Maine Independent Clinical Information Service). This Academic Detailing program is designed to provide physicians and healthcare providers with objective, evidence based information on prescription medications. By providing outreach visits to practitioners with licensed clinicians, the MiCiS program hopes to present education and support with evidence based information about common prescribing choices without the commercial and marketing approach employed by drug manufacturers. While academic detailing is primarily a quality driven endeavor it has also demonstrated an ability to control costs. For further information please see www.mainemed.com

G. PA STATISTICS

For the third quarter of 2009, there were 24,418 unique PA requests, 84% were approved. The top five most frequently requested drugs were: lansoprazole/Prevacid (1,334), pantoprazole/Protonix (1,333), aripiprazole/Abilify (1,193), duloxetine/Cymbalta (1,100), quetiapine/Seroquel (933). The average determination time was 3.16 hours.

H. MAIL ORDER

The Department would like to once again remind providers of the mail-order option that is available to MaineCare members. Prescriptions may be obtained in quantities up to a 90 day supply. Cost savings and conveniences to the MaineCare members are greater when prescriptions are written in 90 day quantities when using mail-order.

MaineCare Mail Order Pharmacies
I-Care Pharmacy: 1-888-422-7319
Wal-Mart Mail Order: 1-800-273-3455

I. NEXT DUR COMMITTEE MEETING

The next DUR meeting will be held January 12, 2010 at OMS (442 Civic Center Drive) in Augusta. Comments on the PDL or any PA's, either proposed or already in effect, may be made at these meetings or by e-mail, letter or phone if more convenient.

For DUR questions you may contact:
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Timothy Clifford, MD at tclifford@ghsinc.com

For PA/PDL questions you may contact:
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