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Indiana Medicaid DUR Board
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Indianapolis, Indiana 46204

Indiana Medicaid Drug Utilization Review Board Newsletter

Indiana Rational Drug Program, Phase II

On January 18, 2002, the Indiana Medicaid DUR Board approved the Phase II implementation of the Indiana Rational Drug Program (IRDP). The IRDP, originally launched January 7, 2002, places certain drugs and drug classes on prior authorization (PA) and is intended to promote quality drug therapy while controlling costs. Phase II of the IRDP is a continuation of this concept and was implemented on April 15, 2002, with the intent to manage the drug therapies of fee-for-service, Primary Care Case Management (PCCM), and Package C members in the Indiana Health Coverage Programs (IHCP). The PA Department of Health Care Excel (HCE) manages the program and renders decision on authorization requests submitted by prescribing physicians.

The remainder of this article will highlight the aspect of Phase II of the IRDP. Specifically, the Phase II program adds PA requirements under certain circumstances when topical tretinoin products (e.g., Retin-A[®]), oral azithromycin products (e.g., Zithromax[®]), controlled-release oxycodone (Oxycontin[®]), lactulose, Synagis[®] and Respigam[®], are prescribed.

Topical Tretinoin Products (Retin-A[®])

Topical tretinoin products are authorized only for the treatment of acne. Prescribing of these products for other indications is not approved. Therapy is permitted for patients under 21 years of age. However, PA will be required for acne patients 21 years of age or older.

Oral Azithromycin Products (Zithromax[®])

Physicians are able to prescribe a standard five-day course of oral azithromycin therapy to their patients without PA. However, PA will be required if azithromycin therapy is repeated within 10 days of the original prescription. Repeating azithromycin therapy within that time would be approved if culture and sensitivity and a specific disease state indicate that azithromycin is the drug of choice.

Patients who are receiving greater than five days of therapy as follow-up to intravenous azithromycin treatment for community-acquired pneumonia, and patients with immune deficiency secondary to Human Immunodeficiency Virus (HIV) will be approved for their prescribed durations of therapy following a request by the ordering physician. PA for patients with HIV will be granted on an annual basis.

All decisions for dosage approval will be based on guidelines found in the [Sandford Guide to Antibiotic Therapy](#).

Controlled-Release Oxycodone (Oxycontin[®])

The goal of the IRDP is to support pain management therapy that provides effective pain relief while preventing abuse and overutilization of these drug products by patients and prescribers. To accomplish its goal, the IRDP approves the use of controlled-release oxycodone only in the management of chronic, intractable pain. Short term or acute use of this dosage form will not be approved. Patients may receive up to 120 tablets of any strength of controlled-release oxycodone within a 30-day period without requiring PA. This allows prescribers to treat their

pain patients, using a single tablet strength, or combinations of two tablet strengths, every twelve hours, without a need for an authorization request. The claims system monitors the patient's IHCP claims history to verify that no more than 120 tablets have been dispensed within the previous 30-day period. Patients who exceed the 30-day limit will have their prescription claim denied for PA.

Prior authorization is also required when the patient's prescription supply is greater than a four tablet per day average. Prescribing physicians are required to personally submit the PA request for therapies that exceed the limitation. Requests from other health care personnel will not be accepted. In submitting the PA request, the prescribing physician should have the following information available:

- Diagnosis and cause of the patient's chronic, intractable pain.
- A list of previously prescribed opioids must be documented, since controlled-release Oxycodone is considered a second-line drug of choice for chronic pain.
- Verification of whether or not a Patient and Physician Pain Management Agreement has been signed by the patient and kept on file.

Prior authorization must be renewed every six months for controlled-release oxycodone therapy, or whenever the dosage changes.

Lactulose

Prior authorization is required for all circumstances in which lactulose is prescribed. The goal of the IRDP is to encourage prescribers to select less expensive alternatives, such as sorbitol, when treating constipation. Diabetic patients who are transitioned to sorbitol should be monitored for any changes in blood sugar.

Authorization for lactulose will be granted to prescribers who indicate that their patients are being treated for hepatic encephalopathy.

Synagis® and Respigam®

Synagis® and Respigam® are approved for the prevention of serious lower respiratory tract disease cause by the respiratory syncytial virus (RSV) in pediatric patients. Treatment can be authorized only during the RSV season from October 15 through April 30, annually. A maximum of six doses will be approved within each season. Administration of Synagis® is permitted in any setting where intra-muscular (IM) injections are appropriate. Because administration is by infusion, the IRDP will not permit Respigam® to be administered at home. Administration of Respigam® should be performed in a clinic, physician's office, or hospital setting.

In order for approval, patients must be considered at risk for RSV and meet at least one of the following criteria:

- Patient is less than 24 months of age at the start of therapy and has chronic lung disease, especially if on oxygen chronically or if off oxygen less than three to six months.
- Patient is less than one year of age at the start of therapy with a gestational age of less than 28 weeks, or less than one year and has a history of concomitant medical problems (e.g., caffeine administration for respiratory stimulation with the last year).
- Patient is less than six months of age at the start of therapy with a gestational age of 28-32 weeks.
- Patient is less than three months of

How to Contact Health Care Excel
Health Care Excel
Prior Authorization Department
Attention: Indiana Rational Drug Program
2629 Waterfront Parkway East Drive,
Suite 200
Indianapolis, Indiana 46214
Telephone: (317) 347-4511
Fax: (317) 347-3593
Toll Free: (800) 457-4518

age at the start of therapy with gestational age of 32-36 weeks and concomitant medical problems.

Patients who have received immunoglobulin infusions will not have their prescriptions approved for Synagis® or Respigam® as immunity to RSV should be acquired through the immunoglobulin infusions.

Questions About the IRDP

Providers who wish to know more about the IRDP are encouraged to refer to IHCP bulletins *BT200148*, dated November 28, 2001, and *BT200210*, dated March 1, 2002. Copies of the bulletins are available on the IHCP Web site at www.indianamedicaid.com. Copies of all PA forms under the IRDP are also available on the Web site and can be downloaded onto a personal computer and used for faxing authorization requests to Health Care Excel.

Questions about the bulletins or the IRDP are to be directed to the Health Care Excel Medical Policy Department at (317) 347-4500. Providers who wish to submit PA requests, or inquire about PA may contact Health Care Excel PA Department.

New Members Added to the DUR Board

Three new members have joined the DUR Board this year, bringing the Board's membership to twelve and filling all open seats.

Ms. Vicki Perry was presented as a new Board member at the February 15, 2002, DUR Board meeting. Ms. Perry is the president and CEO of Advantage Health Plan, Inc., a health maintenance organization licensed to do business in Indiana. She will occupy the Board position of an individual who is employed by an HMO that has a pharmacy benefit and has expertise in formulary development and pharmacy benefit administration.

Dr. Philip N. Eskew, Jr. and Dr. Marko A. Mychaskiw were presented as new

Board members at the March 15, 2002, DUR Board meeting. Dr. Eskew is the medical director of the Women and Infants Family Life Center of St. Vincent Hospital in Indianapolis. He will occupy the Board position of a physician.

Marko A. Mychaskiw, R.Ph., Ph.D., is an Assistant Professor for the Department of Pharmacy Practice at Purdue University in West Lafayette. He will occupy the Board position of a health economist.

Members of the Indiana Medicaid DUR Board for 2002 are as follows:

Patricia Treadwell, M.D.
Chairperson, Physician

Terry Lindstrom, Ph.D.
Vice Chairperson, Pharmacologist

Marc Shirley, R.Ph.
OMPP Representative-Ex Officio

Neil Irick, M.D.
Physician

John J. Wernert, M.D.
Physician

Phillip N. Eskew, Jr., M.D.
Physician

G. Thomas Wilson, B.S. Pharm., J.D.
Pharmacist

Thomas A. Smith, P.D., M.S.
Pharmacist

Paula J. Ceh, Pharm.D.
Pharmacist

Brian Musial, R.Ph.
Pharmacist

Marko Mychaskiw, R.Ph., Ph.D.
Health Economist

Vicki Perry
HMO Representative

DUR Board meetings are usually scheduled at 9:30 a.m. on the third Friday of each month. Dates, locations, and agendas for upcoming meetings are published on the DUR Board Web site. The Web site also allows readers to submit comments to the Board via e-mail. To access the DUR Board Web site, go to the IHCP Web site at www.IndianaMedicaid.com. Move the mouse to the Pharmacy Services button, found on the top bar of the IHCP's homepage, to highlight menu selections. Readers can access information pertaining to bulletins and the latest news involving the IHCP pharmacy

benefit, as well as DUR Board information, by clicking the appropriate button.

DUR Board Meeting Dates:

- **June 21, 2002**
- **July 19, 2002**
- **August 16, 2002**
- **September 20, 2002**
- **October 18, 2002**
- **November 15, 2002**
- **December 20, 2002**

Annual Summary of ProDUR Alert Activity

On May 15, 2002, the Indiana Medicaid DUR Board was presented a summary report of ProDUR alert activity occurring in the IHCP prescription drug benefit during Federal Fiscal Year 2001, from October 2000 to September 2001. The following information was contained in the report:

For the year, 821,409 ProDUR alerts were issued on pharmacy claims submitted via Point-of-Sale. Pharmacists submitted overrides for 694,932 of those alerts (84.6 percent). Among the alert overrides, the prescribers of these claims were consulted 34 percent of the time, and changes to the prescriptions were made on 63,522 claims, resulting in a different drug, dose, direction, or prescription quantity. Close to one out of six alerts resulted in cancellations of the prescription claims by pharmacists.

Warfarin products, beta-adrenergic agents, and potassium replacement products were among the drug classes that posted the highest number of drug-drug alerts against other prescription medications contained on patients' profiles. Nearly six percent of the drug-drug alerts for warfarin resulted in cancellations of the prescription claims.

Sucralfate prescriptions had the highest percentage for posting high dose alerts at 42 percent of the time. A high dose alert for a sucralfate claim occurs whenever the prescribed dosage is greater than four grams per day average. Prescription claims for Fiorinal #3, and generic equivalents, posted high dose

alerts 34 percent of the time (>six tablets per day); claims for hydrocodone / acetaminophen combination products posted high dose alerts 27 percent of the time (> three grams APAP per day); and claims for naproxen sodium posted high dose alerts 15 percent of the time (>1500mg per day).

A review of the late refill alert activity for the year revealed that drug classes prescribed for the treatment of chronic disease states had the highest incidence of late refill alerts (i.e., non-compliance). Prescription refills for xanthines posted late refill alerts 26 percent of the time, while refills for anticonvulsants, oral hypoglycemics, and ACE-blocking type hypotensives posted late refill alerts 25 percent, 21 percent and 19 percent of the time, respectively. The Board identified the opportunity and duty the pharmacist has in helping to reduce these occurrences. Over the past three years, the incidences of late refill alerts for these drug classes have risen. Pharmacist should identify their patients whose prescription claims post late refill alerts and inquire as to the reasons for the non-compliance, emphasizing to the patient the importance of compliance to their drug therapy regimens.

Changes to the IHCP Reimbursement for Covered Legend Drugs

Effective May 30, 2002, reimbursement to pharmacy providers for covered legend drugs dispensed to IHCP members will be calculated at the lowest of the following:

- The estimated acquisition cost (EAC) of the drug as of the date of dispensing, plus any applicable IHCP dispensing fee.
- The federal upper limit (FUL) as determined by the Centers for Medicare and Medicaid Services (CMS) as of the date of dispensing, plus any applicable IHCP dispensing fee.

- The state maximum allowable cost (MAC) of the drug as determined by the Office of Medicaid Policy and Planning as of the date of dispensing, plus any applicable IHCP dispensing fee.
- The pharmacy provider’s usual and customary charge as of the date of dispensing.

The IHCP EAC for covered legend drugs will be 86.5 percent of the average wholesale price (AWP) rate if the drug is a brand name product, and 80 percent of the AWP if the drug is a generic drug product.

The maximum IHCP dispensing fee for covered legend drugs will be \$4.90. Pharmacy providers providing services to nursing facility residents are reminded that a maximum of one dispensing fee per month is allowed per member per drug order for covered legend drug products.

For more information on the changes, refer to the IHCP bulletin, *BT200218*, May 6, 2002

**Table 1: TOP 25 Prescription Drugs (All Strengths)
Ranked by Claims Paid
For First Quarter 2002**

Rank	Drug Name	Paid Claims	Paid Units	Amount Paid
1	Hydrocodone/APAP	92,279	5,157,652	\$1,244,548
2	Furosemide	60,846	2,657,100	\$434,890
3	Albuterol	60,645	4,680,341	\$1,390,255
4	Zithromax	45,544	597,976	\$1,715,879
5	Amoxicillin	41,682	3,808,377	\$379,320
6	Risperdal	37,630	1,776,135	\$5,685,125
7	Propoxyphen/APAP	36,577	1,729,126	\$544,801
8	Alprazolam	36,332	2,328,642	\$334,646
9	Prevacid	35,418	1,209,839	\$4,680,126
10	Zyprexa	33,598	1,250,216	\$9,375,347
11	Depakote	29,721	2,676,318	\$2,983,631
12	Claritin	27,443	1,084,465	\$1,899,497
13	Lipitor	26,686	870,872	\$2,144,008
14	Augmentin	26,322	2,007,141	\$1,784,031
15	Paxil	25,751	886,532	\$2,143,615
16	Potassium Chloride Products	25,342	2,802,777	\$465,285
17	Ibuprofen	24,280	2,065,598	\$226,455
18	Lorazepam	24,176	1,169,246	\$689,052
19	Neurontin	22,850	2,150,351	\$2,494,665
20	Cephalexin	22,633	1,353,758	\$327,673
21	Fluoxetine	22,496	943,503	\$2,276,090
22	Norvasc	21,954	727,951	\$1,150,913
23	Ranitidine	21,609	991,103	\$827,555
24	Prilosec	20,444	781,763	\$3,105,804
25	Celexa	19,904	690,600	\$1,384,731

Top 25 Drugs for 1Q2002

Hydrocodone with acetaminophen was the most frequently prescribed prescription drug service dispensed to non-risk based IHCP members from January-March 2002. Table 1 lists the drug products in order of the highest paid claim volumes.

Zyprexa® prescription products accounted for the highest dollar amount paid by the IHCP in services for the same period. Zyprexa® claims totaled \$9,375,347 for January-March 2002, a 16.5 percent increase over the past six months. Other prescription drug products that contributed to the highest IHCP expenditures include:

1. Zyprexa® \$9,375,347
2. Risperdal® \$5,685,125
3. Prevacid® \$4,680,126
4. Prilosec® \$3,105,804
5. Depakote® \$2,983,631
6. Neurontin® \$2,494,665
7. Fluoxetine® \$2,276,090
8. Lipitor® \$2,244,008

9. Paxil® \$2,143,615
10. Claritin® \$1,899,497

Changes to the IHCP ProDUR System

On July 1, 2002, the IHCP’s online ProDUR system will be modified to screen prescription claims in the following manner:

Early Refill Alerts

Claims that post an early refill alert at the POS will be denied. An early refill alert will occur when a request for a refill is at a time when the patient is expected to still possess at least a five day supply of the previous prescription fill. The pharmacist will not be allowed to override the alert unless prior authorization (PA) is obtained. Pharmacists will be granted PA only when an extenuating circumstance exists to substantiate the need for an early refill of the drug product.

High Dose

Claims that post a high dose alert at the POS will be denied. Pharmacists will

not be permitted to override the alert unless PA is obtained. Prescribers will be granted PA only when extenuating circumstances exist to substantiate the need for high doses of any drug product.

Therapeutic Duplication

Claims that post a therapeutic duplication alert will be denied. Prescribers will be granted PA only when extenuating circumstances exist to substantiate the need for multiple products of the same therapeutic class, or where one of the drugs has been discontinued.

Drug-Drug Interaction

Claims that post a severity level 1 drug-drug interaction will be denied. Prescribers must substantiate the need to dispense the products that are contraindicated for simultaneous use before PA will be granted.

For more information about the changes, please refer to the IHCP bulletin, *BT200221*, May 15, 2002.