MARYLAND PHARMACY PROGRAM

Medicaid - Pharmacy Assistance – Pharmacy Discount

No. 14 Revised
Friday, March 4, 2005

ADVISORY

*In an effort to give timely notice to the pharmacy community concerning important pharmacy topics, the Department of Health and Mental Hygiene's (DHMH) **Maryland Pharmacy Program** (MPP) has developed the **Maryland Pharmacy Program Advisory**. To expedite information timely to the pharmacy and prescriber communities, an email network has been established which incorporates the email lists of the Maryland Pharmacists Association, EPIC, CARE, Long Term Care Consultants, headquarters of all chain drugstores and prescriber associations and organizations. It is our hope that the information is disseminated to all interested parties. If you have not received this email through any of the previously noted parties or via DHMH, please contact the MPP representative at 410-767-5395.*

Further Clarification for Dose Optimization: Quantity Limits for Atypical Antipsychotic Agents

The Appropriate Use of Palladone™ (long-acting hydromorphone [Dilaudid®])

Grandfathering Non-Preferred Mental Health Drugs

Dose Optimization: Quantity Limits for Atypical Antipsychotic Agents

The following is to clarify the dose optimization quantity limitations for tablet and capsule forms of atypical antipsychotic agents. Reimbursement costs for the atypical antipsychotic agents account for approximately one fifth of the entire Maryland Pharmacy Program budget. The manufacturers' prices for some of these drugs vary based on the tablet or capsule strength. For example, the price of two 5mg tablets of Zyprexa® or Abilify® exceed the price of one 10mg tablet. Both of these agents are labeled for once daily administration. Using one 10mg tablet is more cost effective than using two 5mg tablets.

In an effort to promote the most cost effective use of the Program's resources, dose optimization criteria were established for ***selected strengths*** of these agents (see table on the next page listing reimbursement costs per dosage unit and dose optimization limits).

We are asking prescribers to consider substituting the tablet strength prescribed (when appropriate) with the more cost effective one to help maximize the cost savings of these highly expensive medications. ***If a patient requires 10mg of Zyprexa® or Abilify®, prescribing one 10mg tablet is more cost effective than prescribing two 5mg tablets or 1 tablet twice a day.*** There is no cost savings for dispensing either two 10mg Zyprexa® or one 20mg tablet, therefore there are no dose optimization criteria limits for the 10mg tablet strength of this agent. The following table lists some examples of recommended changes to dosage regimens.

DRUG NAME AND REGIMEN	***RECOMMENDED CHANGE TO REGIMEN***
Abilify® 5mg: Take 2 tablets daily	***Abilify® 10mg: Take 1 tablet daily***
Abilify® 5mg: Take 1 tablet twice daily	***Abilify® 10mg: Take 1 tablet daily***
Geodon®20mg: Take 2 capsules twice daily	***Geodon® 40mg: Take 1 capsule twice daily***
Zyprexa® 5mg: Take 2 tablets daily	***Zyprexa® 10mg: Take 1 tablet daily***
Zyprexa® 5mg: Take 1 tablet twice daily	***Zyprexa® 10mg: Take 1 tablet daily***

Average Reimbursement Costs for Atypical Antipsychotic Agents
Dose Optimization Limits for Atypical Antipsychotic Agents for Adults 18 Years of Age and Older

DRUG NAME AND STRENGTH	Average Reimbursement Cost/Unit	Daily Dose Optimization Limits
ABILIFY® 5MG TABLET	$9.82	1 tablet
ABILIFY® 10MG TABLET	$9.73	1 tablet
ABILIFY® 15MG TABLET	$9.79	1 tablet
ABILIFY® 20MG TABLET	$13.80	N/A
ABILIFY® 30MG TABLET	$13.85	N/A
CLOZAPINE 100MG TABLET	$1.74	N/A
CLOZAPINE 25MG TABLET	$0.65	N/A
CLOZARIL® 100MG TABLET	$3.55	N/A
CLOZARIL® 25MG TABLET	$1.24	N/A
FAZACLO® 100MG TAB RAPDIS	$3.08	N/A
FAZACLO® 25MG TAB RAPDIS	$0.95	N/A
GEODON® 20MG CAPSULE	$4.15	2 tablets
GEODON® 40MG CAPSULE	$4.14	2 tablets
GEODON® 60MG CAPSULE	$4.45	N/A
GEODON® 80MG CAPSULE	$4.50	N/A
RISPERDAL® 0.25MG TABLET	$2.80	2 tablets
RISPERDAL® 0.5MG TABLET	$2.97	2 tablets
RISPERDAL® 1MG TABLET	$3.16	2 tablets
RISPERDAL® 2MG TABLET	$4.92	2 tablets
RISPERDAL® 3MG TABLET	$6.02	N/A
RISPERDAL® 4MG TABLET	$8.03	N/A
RISPERDAL® 0.5MG TAB RAPDIS	$3.24	2 tablets
RISPERDAL® 1MG TAB RAPDIS	$3.80	2 tablets
RISPERDAL® 2MG TAB RAPDIS	$6.04	2 tablets

Average Reimbursement Costs for Atypical Antipsychotic Agents
Dose Optimization Limits for Atypical Antipsychotic Agents for Adults 18 Years of Age and Older (continued)

DRUG NAME AND STRENGTH	Average Reimbursement Cost/Unit	Daily Dose Optimization Limits
SEROQUEL® 25MG TABLET	$1.56	4 tablets
SEROQUEL® 100MG TABLET	$2.74	N/A
SEROQUEL® 200MG TABLET	$5.23	N/A
SEROQUEL® 300MG TABLET	$6.86	N/A
ZYPREXA® 2.5MG TABLET	$5.14	1 tablet
ZYPREXA® 5MG TABLET	$6.09	1 tablet
ZYPREXA® 7.5MG TABLET	$7.38	1 tablet
ZYPREXA® 10MG TABLET	$9.19	N/A
ZYPREXA® 15MG TABLET	$13.87	N/A
ZYPREXA® 20MG TABLET	$18.47	N/A
ZYPREXA® ZYDIS® 5MG TAB RAPDIS	$7.07	1 tablet
ZYPREXA® ZYDIS® 10MG TAB RAPDIS	$10.32	N/A
ZYPREXA® ZYDIS® 15MG TAB RAPDIS	$14.72	N/A
ZYPREXA® ZYDIS® 20MG TAB RAPDIS	$19.60	N/A

If claims are submitted in excess of the above quantities, pharmacists will receive the denial message "X q*uantity per day exceeded; PA REQ'D, MD call MPP 800-932-3918," where the value of "X" is specific for each drug.* In order to dispense higher quantities than noted above, prescribers should contact First Health Services Corporation for prior authorization at 800-932-3918 or fax the attached form "Atypical Antipsychotic Agent Maximum Quantity Override Request" to First Health Services Corporation at 800-932-3921.

Appropriate Use of Palladone™ (long- acting hydromorphone [Dilaudid®])

A new long-acting once a day formulation of hydromorphone is now available. Palladone™ (hydromorphone HCl extended-release) capsules are available in 12mg, 16mg 24mg and 32mg strengths. Palladone™ is only indicated for the management of persistent, moderate to severe pain in patients requiring continuous, around-the-clock analgesia with a high potency opioid for an extended period of time (weeks to months or longer). Treatment with Palladone™ should only be initiated in patients for whom other opioid therapy has failed and who have demonstrated opioid tolerance, and require a minimum total daily dose of opiate medication equivalent to 12mg of oral hydromorphone.

Palladone™ should be administered only once every 24 hours. Appropriate patients for treatment with Palladone™ include patients who require high doses of potent opioids on an around-the-clock basis for an extended period of time to improve pain control and patients who have difficulty attaining adequate analgesia with immediate-release opioid formulations.

Palladone™ is contraindicated for use on an as needed basis (i.e., prn). Palladone™ should never be used as the first opioid product prescribed for a patient, or in patients who require opioid analgesia for a short period of time. Use of Palladone™ in non-opioid-tolerant patients may lead to fatal respiratory depression.

Palladone™ capsules are to be swallowed whole and are not to be broken, chewed, opened, dissolved or crushed. Taking broken, chewed, dissolved, or crushed Palladone™ capsules or its contents can lead to the rapid release and absorption of a potentially fatal dose of hydromorphone. Due to the high doses of hydromorphone contained in Palladone™ capsules, Palladone™ has a very high potential for misuse and abuse. In order to avoid misuse or abuse of this agent, the Maryland Pharmacy Program has developed prior authorization criteria for the use of the drug. Prior authorization forms are available on the Maryland Pharmacy Program website at: *http://www.dhmh.state.md.us/mma/mpap/forms.htm*. The Palladone™ preauthorization form is attached to this Advisory.

Grandfathering Non-Preferred Mental Health Drugs

The Maryland Pharmacy Program recognizes the difficulty of stabilizing mental health patients when switching from one chemical entity to another. Therefore, preauthorization is not required to keep recipients on existing mental health drug therapy, even if the drug is non-preferred, when they have a history with that drug. For claims processing purposes, “drug history” is the most recent 90-day period. If a recipient did not receive the drug as an ***outpatient*** within the previous 90 days, such as during hospitalization, even if the recipient were continued on the non-preferred mental health drug while in the hospital, there would be no history in the claims file and preauthorization would be necessary.

Full consideration for the recipient continues to be a top priority. Recipients having problems obtaining prescribed medications from the pharmacy may call the Maryland Pharmacy Access Hotline at 1-800-492-5231. Questions concerning this Advisory should be directed to the Division of Pharmacy Services, 410-767-1455.

MARYLAND PHARMACY PROGRAM

Atypical Antipsychotic Agent

Maximum Quantity Override Request

Recipient Name: _____ **DOB**: | | | | | | | | |

Medicaid ID #: | | | | | | | | | | | |

Maximum quantity override request for:

Drug Name _____ Strength_____ Quantity per day _____

Maximum Quantity Limits

Abilify® 5mg; 10mg; 15mg	1 tablet per day/ 34 tablets per 34 days
Geodon® 20mg; 40mg	2 capsules per day/ 68 capsules per 34 days
Risperdal® 0.25mg; 0.5mg; 1mg; 2mg	2 tablets per day/ 68 tablets per 34 days
Seroquel® 25mg	4 tablets per day/ 136 per 34 days
Zyprexa® 2.5mg; 5mg; 7.5mg	1 tablet per day/ 34 per 34 days
Zyprexa® Zydis® 5mg®	1 tablet per day/ 34 per 34 days

Justification for use of quantities greater than the limits noted above:

Diagnosis (Do not use ICD-9 codes)_____

Please check all that apply:

□ Yes □ No 1. Patient cannot tolerate recommended dose due to adverse effect of _____

_____

□ Yes □ No 2. Patient's dose is being tapered and will change within a few weeks

□ Yes □ No 3. Patient has failed recommended regiment and requires more frequent dosing to receive clinical benefits of drug

□ Yes □ No 4. Other reason, please specify _____

_____

I certify that use of high quantities of atypical antipsychotic for this patient is justified and medically necessary.

Prescriber Signature: _____ Date: | | | | | | | | |

Prescriber Name: _____ DEA#: | | | | | | | | | |

Address: _____

Phone#: | | | | | | | | | | Fax #: | | | | | | | | | |

Is prescriber a psychiatrist? Yes____ No____ If no, indicate area of practice (such as Internal Medicine, Family Practice). _____

FAX THIS FORM TO: 800-932-3921

For information on a Prior-Auth request, please call First Health Services at 800-932-3918

Revised – November 22, 2004

MARYLAND PHARMACY PROGRAM

PRIOR AUTHORIZATION REQUEST

PALLADONE™

Recipient Name: _____ DOB: | | | | | | | | |

Medicaid ID #: | | | | | | | | | | |

Patient Location: ____ Outpatient ____ Nursing Home or Skilled Nursing Facility

Palladone® Prior Authorization Criteria - Patient must meet all four criteria below:

☐ Yes ☐ No 1. Will the patient be taking Palladone™ for chronic pain (duration of pain expected for greater than 3 months)?

☐ Yes ☐ No 2. Has the patient become tolerant to current chronic opiate therapy?*

☐ Yes ☐ No 3. Will PalladoneTM replace currently prescribed chronic long-acting opioid therapy such as OxyContin, Duragesic or Morphine SR?

☐ Yes ☐ No 4. Is Palladone™ being prescribed once daily?

☐ Yes ☐ No 5. Patient does not have any of the following contraindications: hypersensitivity to opiates; severe asthma, respiratory depression or chronic obstructive pulmonary disease; or paralytic ileus.

*Tolerance is defined as receiving 60 mg. oral morphine/day, or at least 30 mg. of oral oxycodone/day, 50 mcg. transdermal fentanyl/hour, or an equianalgesic dose of another opioid for a week or longer.

List all current opioid therapy and duration of use:

Drug	Total daily dose	Duration of therapy
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that use of Palladone™ for this patient is consistent with the FDA approved labeling.

Prescriber Signature:_____ Date: _____

Prescriber Name: _____ DEA#: | | | | | | | | | |

Address: _____

Phone #: | | | | | | | | | | Fax #: | | | | | | | | | |

Is prescriber a Pain Management Specialist or Oncologist? Yes____ No_____ If no indicate area of practice (such as Internal Medicine, Family Practice) _____.

FAX THIS FORM TO: 800-932-3921

For information on a Prior-Authorization request, please call First Health Services at 800-932-3918