A Service of Alabama Medicaid

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PDL Update

Effective July 1, 2022, 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
Dexmethylphenidate ER (generic)—Cerebral Stimulants/Agents Used for ADHD (Long-Acting)
PDL Deletions
Adhansia XR—Cerebral Stimulants/Agents Used for ADHD (Long-Acting)
Focalin XR—Cebebral Stimulants/Agents Used for ADHD (Long-Acting)

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Kepro

Medicaid Pharmacy Administrative Services

PO Box 3570

Auburn, AL 36831

Please fax all prior authorization and override requests *directly* to Kepro at 800-748-0116. If you have questions, please call 800-748-0130 to speak with a call center representative.

COVID-19 Public Health Emergency Expiration Date Extended

All previously published expiration dates related to the Coronavirus (COVID-19) public health emergency are once again extended by the Alabama Medicaid Agency (Medicaid). **The new expiration date is the earlier of August 31, 2022, the conclusion of the COVID-19 National emergency, or any expiration date noticed by the Alabama Medicaid Agency through a subsequent ALERT.**

A listing of previous Provider ALERT and notices related to the health emergency is available by selecting the Agency's COVID-19 page in the link below:

https://medicaid.alabama.gov/news_detail.aspx?ID=13729.

During the COVID-19 emergency, it is important to file claims as quickly as possible to ensure payment from Medicaid is made to Medicaid providers close to the date of service. The Centers for Medicare and Medicaid Services has increased the federal matching percentage for the emergency time frame, but states can only receive the increased match on claims that are paid during the emergency. Providers should include appropriate COVID-19 diagnosis code(s) on claims submitted to help with tracking of COVID-19.

Preparing for the COVID-19 PHE Unwinding

The Department of Health and Human Services (HHS) Secretary extended the national COVID-19 Public Health Emergency (PHE) effective July 15, and it remains in effect for 90 days unless the secretary determines the PHE no longer exists.

The Alabama Medicaid Agency is preparing now for the end of the PHE. Medicaid partners can assist in relaying a consistent and simple message to the Medicaid recipients they regularly interact with by sharing the message in newsletters, social media posts, and other means of communication.

- PHE Unwinding Partner Toolkit
- Partner Communications for the COVID-19 Unwinding

Social Media Posts to Share

- Social Media: Did you Move?
- Social Media: New Job?
- Social Media: Text Notifications?
- Social Media: Pregnant?

The Medicaid Partner Communications Toolkit for the COVID-19 PHE Unwinding is now available for download! Visit www.Medicaid.Alabama.gov, select the "Providers" tab, and then select, "COVID-19 Information for Providers".

The Agency started the "Yellow Postcard" campaign in May by distributing yellow postcards with recipient messaging on how to update their addresses with the Agency.

Postcards are delivered to provider offices and pharmacies through Academic Detailers starting in May 2022. If you would like to download and print your postcard for your office now, please select the files below and print them on yellow paper.

- English Yellow Postcard
- Spanish Yellow Postcard

Providers, pharmacies, and other providers can assist by posting the yellow postcard in their check-in windows or at their check-in or checkout counters. Medicaid recipients can scan the QR code to take the information with them.

Postcards are posted in Medicaid district offices, outstation worker offices, FQHCs, RHCs, and public health departments. ACHN care coordinators, waiver case managers, and caseworkers with partner agencies have also received these postcards to display in their workstations.

The Alabama Medicaid Agency (Medicaid) regularly receives questions about changes during the COVID-19 public health emergency (PHE). There are several ALERTS posted outlining changes implemented to better serve recipients and to assist providers in our state. The following Provider ALERTs outline changes implemented to better serve recipients and to assist providers in our state.

To stay up to date with Agency efforts, visit Medicaid's COVID-19 Information for Providers page regularly.

Guidelines of Care for the Management of Atopic Dermatitis

Atopic dermatitis (AD) is a chronic, pruritic inflammatory skin disease that occurs most frequently in children, but also affects adults. It follows a relapsing and remitting course. AD is associated with elevated serum immunoglobulin IgE levels and a personal or family history of type 1 allergies, allergic rhinitis, and asthma. It is immune mediated, manifested and propagated by the disruption of the epidermal barrier function and T-helper 2 activation. Approximately 31.6 million people in the U.S. have some form of AD and 9.6 million are under the age of 18. Eighty percent of affected individuals have onset prior to 6 years of age, and 80% will outgrow their AD by adolescence/adulthood.

The mainstay of treatment for AD includes nonpharmacologic interventions (emollient use), topical therapies, and environmental and occupational modifications. For the majority of patients with AD, these therapies can help them achieve clinical improvement and disease control. Topical therapies include corticosteroids; calcineurin inhibitors; and phosphodiesterase inhibitors. At the time of this guideline publication, topical phosphodiesterase inhibitors were only available in clinical trials and no recommendation for use was given. Topical antimicrobials have not been shown to be clinically helpful in AD and their use is generally recommended when there are clinical signs of secondary bacterial infection. Topical antihistamines have shown little efficacy in AD and their use is not recommended.

Phototherapy is a second-line treatment used after the failure of topical agents. For those with AD who are not adequately controlled on optimized topical regimens and/or phototherapy, or when quality of life is substantially impacted, systemic immunomodulating medications are recommended. Additionally, systemic agents may be used for patients who are greatly affected medically, physically, or psychologically.

The chart below lists pharmacologic treatments for AD discussed in the guidelines.

Drug	Mechanism of Action	Recommendations
Topical Corticosteroids	Act on multiple immune cells to interfere with antigen processing and suppressing the release of proinflammatory cytokines.	Recommended for patients who have failed to respond to regular use of emollients or skincare modifications.
Topical Calcineurin Inhibitors	Inhibit calcineurin-dependent T-cell activation blocking the production of proinflammatory cytokines and mediators of the AD inflammatory reaction.	Recommended for acute and chronic treatment and maintenance treatment in children and adults. Recommended in situations when a topical corticosteroid should be avoided, such as sensitive areas; steroid-induced atrophy; etc.
Cyclosporine	Might be related to the inhibition of production and release of IL-2.	Effective in severe AD.
Azathioprine	Purine analog that inhibits DNA production.	Recommended in severe AD. Improves quality of life and signs and symptoms of disease.
Methotrexate	Inhibits dihydrofolate reductase to interfere with DNA, RNA, and purine synthesis, repair, and cellular replication.	Safe, well-tolerated and effective for controlling severe AD. Folate supplementation is recommended.

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Guidelines of Care for the Management of Atopic Dermatitis (continued)

Drug	Mechanism of Action	Recommendations
Mycophenolate mofetil	Prodrug that blocks the inosine monophosphate dehydrogenase (IMPDH) portion of the purine biosynthesis pathway. This pathway is critical for B and T-cell proliferation.	Alternative therapy for refractory AD. Inconsistent efficacy.
Interferon gamma	Thought to participate in immunoregulation by enhancing oxidative metabolism of macrophages, as well as antibody dependent cellular cytotoxicity, activating NK cells and is active in the expression of Fc receptors and major histocompatibility antigens.	Alternative for refractory AD for patients who do not respond to other systemic therapies or phototherapy.
Systemic steroids	Used to regulate the immune system and stress response.	Recommended for short term transition only. Rebound flares and increased disease severity seen with prolonged use.
Omalizumab	Binds free IgE and lowers free IgE levels.	Limited data; one study did not prove efficacy.
Oral Calcineurin Inhibitors	Suppresses cellular immunity (inhibits T-lymphocyte activation) by binding to an intracellular protein, FKBP-12, and complexes with calcineurin dependent proteins to inhibit calcineurin phosphatase activity.	Insufficient data for systemic use. Topical use has proven efficacy.
Antimicrobials	Protect patients from infections due to being predisposed from AD.	Systemic therapy is warranted in overtly-infected patients.
Antihistamines	Inhibit binding of histamine to receptors to prevent pruritus and itching.	Should not be substituted with a topical agent. Use is limited for sedation to aid sleep.

Pediatric Considerations

Atopic dermatitis is most frequently seen in the pediatric population. Therefore, the guidelines assessed the date for the use of systemic therapies in pediatrics. Cyclosporine and azathioprine are considered to be effective in children. Limited data exists to support the use of methotrexate in children, but data has shown its use to be safe and effective in children with psoriasis. Mycophenolate mofetil is considered relatively safe in pediatrics. Interferon gamma and antimicrobials have no unique recommendations. Use of sedating antihistamines should be monitored to ensure no effects on school performance. Systemic steroids are not recommended in children unless they are needed to manage other comorbid conditions.

Guidelines of Care for the Management of Atopic Dermatitis (continued)

Dosing and Lab Monitoring

There is insufficient data to firmly recommend optimal dosing, duration of therapy, and precise monitoring protocols for any systemic immunomodulating medication. All agents should be adjusted to the minimal effective dose once response is attained and sustained. Adjunctive therapies should be continued to use the lowest dose and duration of systemic agent possible. Treatment decisions should be based on each individual patient's AD status (current and historical), co-morbidities, and preferences.

Phototherapy

Phototherapy is the use of broadband or narrowband ultraviolet B. Phototherapy has been used since the 1980s for treatment of dermatological conditions such as AD and psoriasis. It is second-line in the treatment of AD after failure of first-line options and can be used for maintenance in patients with chronic AD. Phototherapy is typically performed in an office setting three to five times a week based on skin type. It is shown to be safe and effective in the pediatric population with no long-term side effects.

Since the guidelines were published, several new agents have been approved for the treatment of AD.

Drug	Mechanism of Action	Indication
Tralokinumab-ldrm (Adbry™) injection	IL-13 antagonist	Treatment of moderate-to-severe AD in adult patients not adequately controlled with topical prescription therapies.
Abrocitinib (Cibinqo™) tablets	Janus kinase (JAK) inhibitor	Treatment of adult patients with refractory, moderate-to-severe AD not adequately controlled with other systemic drug products, including biologics.
Dupilumab (Dupixent®) injection	IL-4 receptor alpha antagonist	Treatment of moderate-to-severe AD in adult and pediatric patients, aged 6 months and older, not adequately controlled with topical prescription therapies.
Upadacitinib (Rinvoq®) extended-release tablets	Janus kinase (JAK) inhibitor	Treatment of moderate-to-severe AD in adult and pediatric patients, 12 years of age and older, not adequately controlled with topical prescription therapies.
Ruxolitinib(Opzelura™) cream	Janus kinase (JAK) inhibitor	Topical short-term and non-continuous chronic treatment of mild to moderate AD in non-immunocompromised patients, 12 years of age and older, not adequately controlled with topical prescription therapies.
Crisaborole (Eucrisa®) cream	Phosphodiesterase 4 inhibitor	Treatment of mild to moderate AD in pediatric patients, 3 months of age and older.

References:

Eichenfield, LF et al. Guidelines of Care for the Management of Atopic Dermatitis. *Journal of the American Academy of Dermatology.* 2014; 70: 338-351. Guidelines of care for the management of atopic dermatitis - Journal of the American Academy of Dermatology (jaad.org).

Adbry. Package Insert. LEO Pharma Inc; 2022.

Cibinqo. Package Insert. Pfizer Labs; 2022.

Dupixent. Package Insert. Regeneron Pharmaceuticals Inc; 2022.

Rinvoq. Package Insert. AbbVie Inc; 2022.

Opzelura. Package Insert. Incyte Corporation; 2022.

Eucrisa. Package Insert. Pfizer Labs; 2020.

July 1st Pharmacy Changes

Effective July 1, 2022, the Alabama Medicaid Agency will:

1. **Remove prior authorization (PA) from dexmethylphenidate ER (generic Focalin XR). Brand Focalin XR will now require PA.**
2. **Update the PDL to reflect the quarterly updates listed below:**

PDL Additions
Dexmethylphenidate ER (generic)—Cerebral Stimulants/Agents Used for ADHD (Long-Acting)
PDL Deletions
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For additional PDL and coverage information, visit our drug look-up site at https://www.medicaid.alabamaservices.org/ALPortal/NDC%20Look%20Up/tabId/39/Default.aspx.

The Prior Authorization (PA) request form and criteria booklet should be utilized by the prescriber or the dispensing pharmacy when requesting a PA. The PA request form can be completed and submitted electronically on the Agency's website at https://medicaid.alabama.gov/content/9.0_Resources/9.4_Forms_Library/9.4.13_Pharmacy_Forms.aspx.
Policy questions concerning provider notice should be directed to the Pharmacy Program at (334) 242-5050. Providers requesting PAs by mail or fax should send requests to:1-800-748-0130.

Kepro
Medicaid Pharmacy Administrative Services
P.O.Box 3570
Auburn, AL 36831
Fax: 1-800-748-0116
Phone: 1-800-748-0130

Incomplete PA requests or those failing to meet Medicaid criteria will be denied. If the prescriber believes medical justification should be considered, the prescriber must document this on the form or submit a written letter of medical justification along with the PA form to HID. Additional information may be requested. Staff physicians will review this information.