Alabama Medicaid Pharmacist

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PDL Update

Effective April 1, 2018, 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	
Alvesco	Orally Inhaled Corticosteroids
Asmanex HFA	Orally Inhaled Corticosteroids
Citranatal Bloom	Prenatal Vitamins
Ezetemibe (generic Zetia)	Cholesterol Absorption Inhibitors
Flovent Diskus	Orally Inhaled Corticosteroids
Flovent HFA	Orally Inhaled Corticosteroids
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Tudorza	Inhaled Antimuscarinics
Xopenex HFA	Respiratory Beta Agonists
Zetonna	Intranasal Corticosteroids
Zyflo CR	Leukotriene Modifiers
PDL Deletions	
Levalbuterol HFA (generic Xopenex HFA)	Respiratory Beta Agonists
Qnasl/Qnasl Children	Intranasal Corticosteroids
Qvar	Orally Inhaled Corticosteroids
Zetia	Cholesterol Absorption Inhibitors
Zileuton ER (generic Zyflo CR)	Leukotriene Modifiers

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

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2017 Pediatric Hypertension Guidelines

The American Academy of Pediatrics (AAP) updated the pediatric hypertension (HTN) guidelines in September 2017. The update applies to all children between the ages of 1 and 18 years of age. The new guidelines created blood pressure (BP) categories that are based on the normative distribution of blood pressure in healthy children. The child's sex, age, and height should be taken into consideration to ensure proper classification of blood pressure. The new categories recognize elevated blood pressure and set lower goals in hopes to recognize hypertension in children and adolescents to prevent progression of disease and further complications.

Risk Factors:

- Pre-term birth
- Positive family history
- Obesity
- High-sodium diet
- Sedentary lifestyle

Pharmacologic Agents Associated With Elevated BP:

OTC Products:

- Decongestants
- Caffeine
- NSAIDS

Prescription Drugs:

- Stimulants for ADHD/hyperactivity disorder
- Steroids
- Tricyclic antidepressants

Blood Pressure Categories and Stages:

Children 1—13 Years	Children ≥ 13 Years
Normal: < 90th percentile	**Normal:** <120 / <80 mmHg
Elevated: ≥90th percentile to <95th percentile **or** 120/80 mmHg to <95th percentile (whichever is lower)	**Elevated:** 120/<80 to 129/<80 mmHg
Stage 1 HTN: ≥95th percentile to <95th percentile + 12 mmHg **or** 130/80 to 139/89 mmHg (whichever is lower)	**Stage 1 HTN:** 130/80 to 139/89 mmHg
Stage 2 HTN: ≥95th percentile + 12 mmHg **or** ≥140/90 mmHg (whichever is lower)	**Stage 2 HTN:** ≥140 / ≥90 mmHg

Screening:

- BP should be measured annually in children and adolescents ≥ 3 years of age.
- Children younger than 3 years should have BP measured if they are at increased risk for developing HTN.

2017 Pediatric Hypertension Guidelines, continued

History of prematurity <32 week's gestation or small for gestational age, very low birth weight, other neonatal complications requiring intensive care, umbilical artery line
Congenital heart disease (repaired or unrepaired)
Recurrent urinary tract infections, hematuria, or proteinuria
Known renal disease or urologic malformations
Family history of congenital renal disease
Solid-organ transplant
Malignancy or bone marrow transplant
Treatment with drugs known to raise BP
Other systemic illnesses associated with HTN
Evidence of elevated intracranial pressure

Non-pharmacologic Options: Lifestyle modification is recommended prior to initiating treatment.

- **Exercise:** At the time of diagnosis of elevated BP or HTN in a child or adolescent, 30-60-minute sessions of moderate to vigorous physical activity at least 3-5 days per week is recommended. Any type of exercise (aerobic, resistance, or combined) is beneficial in both helping reduce blood pressure and preventing further complications.
- **Diet:** At the time of diagnosis of elevated BP or HTN in a child or adolescent, the DASH diet is recommended. Reduction in sodium intake results in lower BP and CV mortality. The combination of diet and physical activity has shown to have a beneficial effect on SBP as well as CV risk.

DASH DIET: high in fruits, vegetables, whole grains, and low-fat dairy, with decreased amount of foods high in saturated fat or sugar

Pharmacologic Treatment: Children who fail to reach BP goal after trial of lifestyle modification or who have symptomatic HTN, stage 2 HTN without a modifiable factor, or any stage of HTN with CKD or DM should be initiated on a single antihypertensive medication.

First line options include ACE inhibitors, Angiotensin Receptor Blockers (ARBs), Calcium Channel Blockers (CCBs), or thiazide diuretics. The dose can be increased every 2 to 4 weeks based on home BP measurements. The patient should be seen every 4 to 6 weeks until BP goal has been reached.

If child is unable to reach goal on one medication, the addition of a second medication with another mechanism is appropriate. Because of the water and salt retention that occurs with many antihypertensive medications, a thiazide diuretic is often the preferred second agent.

Lifestyle modifications should continue to be encouraged even after starting pharmacologic treatment.

2017 Pediatric Hypertension Guidelines, continued

Dosing Recommendations:

Drug	Age	Initial Dose	Max Dose	Dosing Interval
ACE Inhibitors				
Benazepril	≥6 y ears	0.2mg/kg per day (up to 10 mg per day)	0.6mg/kg per day (up to 40 mg per day)	Daily
Captopril	Infants Children	0.05mg/kg per day 0.5mg/kg per day	6mg/kg per day 6 mg/kg per day	Daily to QID TID
Enalapril	≥1 month	0.08mg/kg per day (up to 5 mg per day)	0.6mg/kg per day (up to 40mg per day)	Daily to BID
Fosinopril	≥6 years & <50kg ≥6 years & ≥50kg	0.1mg/kg per day (up to 5 mg per day) 5mg per day	40mg per day 40mg per day	Daily Daily
Lisinopril	≥6 years	0.07mg/kg per day (up to 5 mg per day)	0.6mg/kg per day (up to 40 mg per day)	Daily
ARBs				
Candesartan	1-5 years ≥6 years & <50kg ≥6 years & ≥50kg	0.2mg/kg per day (up to 4mg per day) 4mg per day 8mg per day	0.4mg/kg per day (up to 16mg per day) 16mg per day 32mg per day	Daily to BID
Irbesartan	6-12 years ≥13 years	75mg per day 150mg per day	150mg per day 300mg per day	Daily
Losartan	≥6 years	0.7mg/kg (up to 50mg)	1.4mg/kg (up to 100mg)	Daily
Olmesartan	≥6 years & <35kg ≥6 years & ≥35kg	10mg 20mg	20mg 40mg	Daily
Valsartan	≥6 years	1.3mg/kg (up to 40mg)	2.7mg/kg (up to 160mg)	Daily
Thiazide Diuretics				
Chlorthalidone	Child	0.3mg/kg	2mg/kg per day (50mg)	Daily
Chlorothiazide	Child	10mg/kg per day	20mg/kg per day (up to 375 mg per day)	Daily to BID
HCTZ	Child	1mg/kg per day	2mg/kg per day (up to 37.5mg per day)	Daily to BID

2017 Pediatric Hypertension Guidelines, continued

Calcium Channel Blockers				
Amlodipine	1-5 years ≥6 years	0.1mg/kg 2.5mg	0.6mg/kg (up to 5mg per day) 10mg	Daily
Felodipine	≥6 years	2.5mg	10mg	Daily
Isradipine	Child	0.05-0.1mg/kg	0.6mg/kg (up to 10mg per day)	BID to TID
Nifedipine XR	Child	0.2-0.5mg/kg per day	3mg/kg per day (up to 120mg per day)	Daily to BID

Flynn JT, Kaelber DC, Baker-Smith CM, et al. Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents. *Pediatrics*. 2017;140(3).

Recipient Signature Requirements

Rule No. 560-X-1-.18 Provider and Recipient Signature Requirements

As a reminder, all providers must obtain a signature from the recipient and this signature must be kept on file as verification that the recipient was present on the date of service for which the provider seeks payment (e.g., release forms or sign-in sheets). Unless otherwise specified, the signature requirements may be satisfied by a handwritten, electronic, or digital signature.

As stated in the Administrative Code for Alabama Medicaid under Rule No. **560-X-1-.18(3)(a)(2):**

> "Recipient signatures are required for all pharmacy, Durable Medical Equipment ("DME"), supply, appliance and Prosthetics, Orthotics and Pedorthics ("POP") claims to validate the billed and reimbursed service was rendered to the recipient and for pharmacy claims to ensure the recipient was offered appropriate counseling (if applicable). For pharmacy, DME, supply, appliance and POP items that have been delivered, the provider must ensure that the delivery service obtains the recipient's signature or the signature of the recipient's Designee."

Please note it is important for providers to follow these procedures. Failure of providers to follow the signature requirements will result in recoupment as stated in Rule No. **560-X-1-.18(3)(c):**

> "When payment has been made on claims for which a signature is not available and one of the above exceptions is not applicable, the funds paid to the provider covering this claim will be recouped."

For further guidance and additional information on signature requirements, as well as a description of exceptions to the listed signature requirements, providers are encouraged to refer to **Rule No. 560-X-1-.18 located in** Chapter 1 of the Administrative Code for Alabama Medicaid Agency, which can be found on pages 13 through 17 of the following link: http://www.medicaid.alabama.gov/documents/9.0_Resources/9.2_Administrative_Code/9.2_Adm_Code_Chap_1_General_10-24-16.pdf.

April 1st Pharmacy Changes

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1. **Update the PDL to reflect quarterly updates.** The updates are listed below:

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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.

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