Alabama Medicaid Pharmacist

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PDL Update

Effective January 1, 2020, 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 Deletions
Zontivity—Platelet Aggregation Inhibitors

Inside This Issue

Health Information Designs (HID)

Medicaid Pharmacy Administrative Services

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Auburn, AL 36832-3210

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.

Summary of 2019 ACC/AHA Guidelines for Primary Prevention of Cardiovascular Disease

The American College of Cardiology/American Heart Association (ACC/AHA) adheres to the atherosclerotic cardiovascular disease (ASCVD) Risk Estimator to determine patients' need for lifestyle modifications and pharmacotherapy such as statins. The ASCVD Risk Estimator is calculated based on age, sex, race, smoking status, diabetes, blood pressure, total cholesterol, HDL cholesterol levels, and LDL cholesterol levels. The ASCVD Risk Estimator is used for patients age 40 to 79 years and is divided into categories based on the patient's risk score: low (< 5%), borderline (5%-7.5%), intermediate (≥7.5%), and high (≥20%). In addition to the ASCVD risk, ASCVD risk enhancers should be evaluated; risk enhancers, as indicated in the chart below, include family history of premature ASCVD, LDL ≥ 160 mg/dL, chronic kidney disease, metabolic syndrome, inflammatory diseases, ethnicity factors, and conditions specific to women such as preeclampsia and premature menopause.

Risk-Enhancing Factors for Clinician-Patient Risk Discussion

- **Family history of premature ASCVD** (males, age <55 y; females, age <65 y)
- **Primary hypercholesterolemia** (LDL-C, 160–189 mg/dL [4.1–4.8 mmol/L]; non–HDL-C 190–219 mg/dL [4.9–5.6 mmol/L])*
- **Metabolic syndrome** (increased waist circumference [by ethnically appropriate cutpoints], elevated triglycerides [>150 mg/dL, nonfasting], elevated blood pressure, elevated glucose, and low HDL-C [<40 mg/dL in men; <50 mg/dL in women] are factors; a tally of 3 makes the diagnosis)
- **Chronic kidney disease** (eGFR 15–59 mL/min/1.73 m2 with or without albuminuria; not treated with dialysis or kidney transplantation)
- **Chronic inflammatory conditions**, such as psoriasis, RA, lupus, or HIV/AIDS
- **History of premature menopause (before age 40 y) and history of pregnancy-associated conditions that increase later ASCVD risk, such as preeclampsia**
- **High-risk race/ethnicity** (e.g., South Asian ancestry)
- **Lipids/biomarkers**: associated with increased ASCVD risk
  - Persistently elevated,* primary hypertriglyceridemia (≥175 mg/dL, nonfasting)
  - If measured:
    - **Elevated high-sensitivity C-reactive protein** (≥2.0 mg/L)
    - **Elevated Lp(a)**: A relative indication for its measurement is family history of premature ASCVD. An Lp(a) ≥50 mg/dL or ≥125 nmol/L constitutes a risk-enhancing factor, especially at higher levels of Lp(a).
    - **Elevated apoB** (≥130 mg/dL): A relative indication for its measurement would be triglyceride ≥200 mg/dL. A level ≥130 mg/dL corresponds to an LDL-C >160 mg/dL and constitutes a risk-enhancing factor
    - **ABI** (<0.9)

Grundy SM, Stone NJ, Bailey AL, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol, Journal of the American College of Cardiology (2018), doi: https://doi.org/10.1016/j.jacc.2018.11.003.

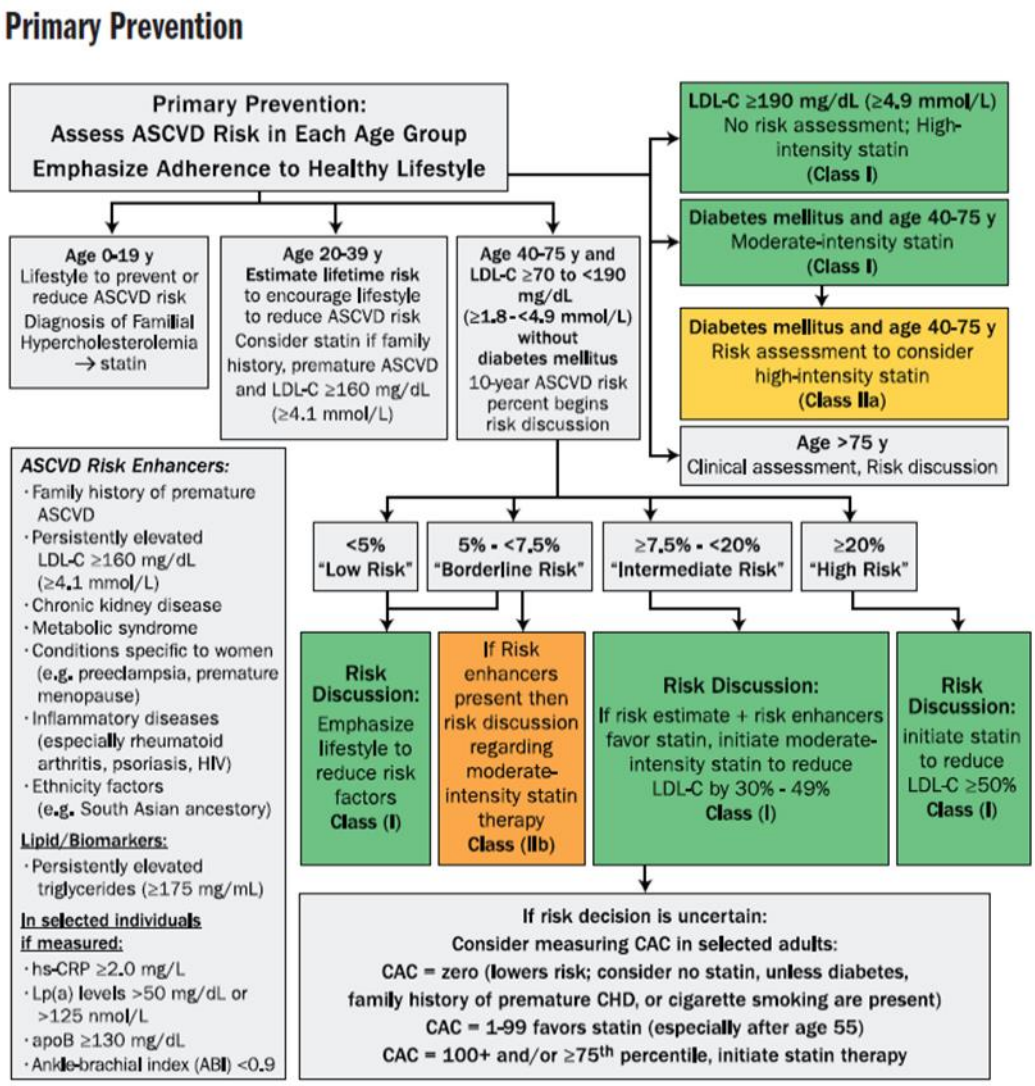
**Optimally, 3 determinations.*

The Primary Prevention diagram on the following page is helpful in assessing ASCVD risk in each age group. If the patient's risk is ≥7.5% with risk enhancers, therapy with a moderate intensity statin should be initiated to reduce the LDL by 30%-49%, and if the risk is ≥20%, therapy with a high intensity statin should be initiated. For patients ages 20-39, risk factors such as hypertension, tobacco use, LDL >160 mg/dL, and family history can be used to evaluate the need for lifestyle modifications or statin therapy, or an estimation of lifetime or 30-year risk for ASCVD can be used with this age group as well as 40 -59 years with ASCVD risk <7.5%.

The guidelines also recommend patients with LDL levels >190 mg/dL with no risk assessment be placed on high intensity statin therapy, and that patients with diabetes mellitus and ages 40-75 years be placed on a moderate intensity statin therapy.

Summary of 2019 ACC/AHA Guidelines for Primary Prevention of Cardiovascular Disease

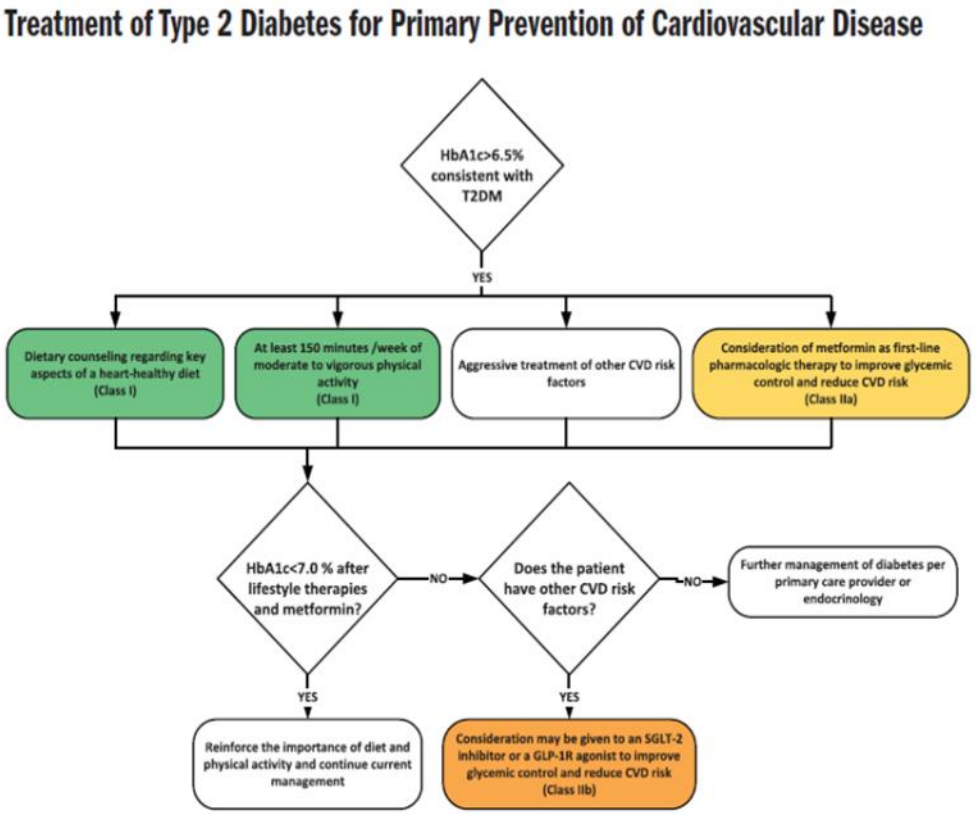
The guidelines also recommend that patients ages 40-75 years with diabetes mellitus as well as risk assessment be considered for high-intensity statin therapy, and that patients > 75 years be clinically assessed. Patients 0-19 years should also be evaluated for familial hypercholesteremia, and statin and lifestyle modifications should be considered.



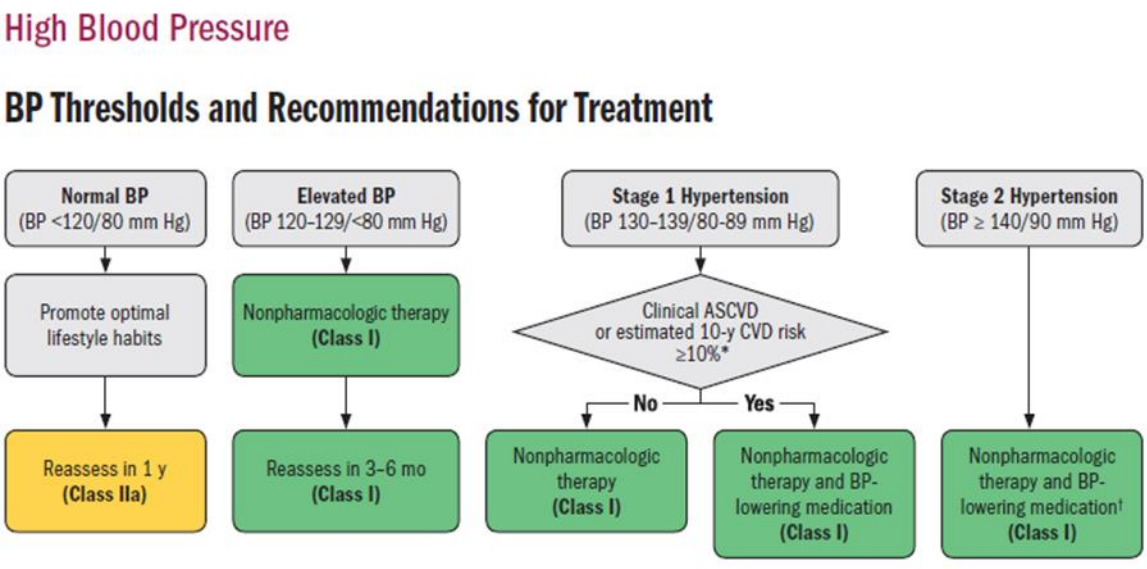
The guidelines outline the preventive measures and emphasize that the most important way to prevent cardiovascular disease is through a healthy lifestyle. The healthy lifestyle includes exercise and a well-balanced diet. It is recommended specifically that adults perform 150 minutes of moderate intensity or 75 minutes of vigorous intensity exercises per week. Examples of moderate intensity exercise include yoga and swimming, and examples of vigorous intensity exercise include jogging and basketball. Along with exercise, it is recommended that adults eat a heart healthy diet which includes vegetables, fruits, whole grains, lean meats or vegetables, and fish, and it is recommended that they decrease the amount of trans fats, red meat, and processed meats as well as carbohydrates in their diet. Obese or overweight patients should be given counseling on weight loss. In addition to diet and exercise, smoking cessation is recommended in the prevention of cardiovascular disease, and patients' smoking status should be evaluated by their provider at each visit.

Summary of 2019 ACC/AHA Guidelines for Primary Prevention of Cardiovascular Disease

In addition to cholesterol, the guidelines address diabetes mellitus, and recommend metformin and lifestyle modifications to manage the disease. The guidelines also recommend the addition of a sodium glucose cotransporter-2 or a glucagon like peptide-1 receptor agonist. The diagram below details treatment for patients with Type 2 diabetes.



In addition to cholesterol and diabetes mellitus, hypertension is addressed in the guidelines, and the goal blood pressure is recommended to be < 130/80 mmHg. Lifestyle modifications should be implemented before pharmacotherapy, but pharmacotherapy is recommended if the patient has clinical ASCVD or 10-year CVD risk of ≥10% and BP of 130-139/80-89 mmHg or if the patient has BP ≥ 140/90. Lifestyle modifications include low salt intake, exercise, and weight loss. The diagram below details blood pressure thresholds and treatment recommendations.



Summary of 2019 ACC/AHA Guidelines for Primary Prevention of Cardiovascular Disease

The guidelines also addressed the use of aspirin, and low dose aspirin is only recommended for patients 40 -70 years with higher ASCVD risk and no increased bleeding risk.

References:

Arnett DK, Blumenthal RS, Albert MA, et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *J Am Coll* Cardiol 2019; March 17. Available from: https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2019/03/07/16/00/2019-acc-aha-guideline-on-primary-prevention-gl-prevention

Opioid Cumulative Daily MME Limit Decrease

Effective December 2, 2019, Alabama Medicaid will implement hard edits on cumulative daily MME claims exceeding 200 morphine milligram equivalents (MME)/day. A phase-in period for claims exceeding 150 MME/day, but less than 200 MME/day, will also be implemented.

Higher doses of opioids are associated with higher risk of overdose and death—even relatively low dosages (20—50 MME per day) may increase risk.[1] Therefore, Alabama Medicaid will limit the amount of cumulative MME allowed per day on opioid claims. The edit began at 250 cumulative MME per day and is gradually being decreased over time. The final cumulative MME target is scheduled to be 90 MME per day.

Hard Edit Implementation (Greater than 200 MME):
Effective December 2, 2019, opioid claims that exceed a cumulative MME of 200 MME/day will be denied. **The universal PA 0009996322 will no longer be valid to bypass the 200 MME edit.** Pharmacy override requests for quantities exceeding the MME limit may be submitted to Health Information Designs (HID) and will be reviewed for medical necessity. See the link below for an override form.

Phase-In Period (150 MME—200 MME):
Effective December 2, 2019, claims that exceed the cumulative daily MME limit of 150 MME/day will be denied. The dispensing pharmacist will be provided a universal prior authorization (PA) number on the rejection screen and may enter this universal PA number on the claim to allow it to be paid. **Pharmacists are urged to notify the affected patient/prescriber to develop a plan to decrease the patient's total daily MME.**

Edit Details:

- The universal PA number to override the 150 MME (but less than 200 MME) edit will be 0009996323.
- The universal PA number will be provided on each cumulative MME rejection screen for the pharmacist's convenience.
- Additional edits, such as therapeutic duplication, maximum quantity limitations, early refill, non-preferred edits, etc., will still apply.
- Claims prescribed by oncologists will bypass the edit.
- Long term care and hospice recipients are excluded.
- Children are included in the edit.
- A Recipient Information Sheet for prescribers and pharmacists to provide to recipients can be found at: https://medicaid.alabama.gov/content/4.0_Programs/4.3_Pharmacy-DME.aspx

[1] https://www.cdc.gov/drugoverdose/prescribing/guideline.html

January 1st Pharmacy Changes

To: Pharmacies, Physicians, Physicians Assistants, Nurse Practitioners, Oral Surgeons, Optometrists, Dentists, FQHCs, RHCs, Mental Health Service Providers and Nursing Homes

Effective January 1, 2020, the Alabama Medicaid Agency will:

1. **Remove methotrexate tablets from the mandatory three-month supply program.**
2. **Update the PDL to reflect the quarterly updates. The updates are listed below:**

PDL Additions
None
PDL Deletions
Zontivity—Platelet Aggregation Inhibitors

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. Providers requesting Pas by mail or fax should send requests to:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P.O.Box 3210
Auburn, AL 36832-3210
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.

Policy questions concerning provider notice should be directed to the Pharmacy Program at (334) 242-5050. Questions regarding PA procedures should be directed to the HID help desk at 1-800-748-0130.