MAGELLAN MEDICAID ADMINISTRATION

Kentucky UNBRIDLED SPIRIT

Pharmacy Quarterly

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The Numbers Listed Below Are For Fee-For Service Support

Pharmacy Support Center

1-800-432-7005

24 hours per day/7 days per week
For claim assistance, early refill overrides, and lock-in overrides

Clinical Support Center

1-800-477-3071

24 hours per day/7 days per week

Diabetic Supply Questions

Prior Authorization

1-800-477-3071

Claim Inquiry

1-800-432-7005

Please Note: Questions regarding claims prior to October 5, 2010, should be directed to 1-800-807-1232.

Provider Services

1-877-838-5085

M–F, 10:30 a.m.–4:30 p.m. (ET)

Providers should contact Provider Services for inquiries regarding enrollment and changes.

Member Services

1-800-635-2570

M–F, 8:00 a.m.–5:00 p.m. (ET)

Recipients should contact Member Services for medication replacement requests and benefit information.

Web Sites

Kentucky Department for Medicaid Services
http://chfs.ky.gov/dms/Pharmacy.htm

Magellan Medicaid Administration
https://kentucky.magellanmedicaid.com/

Onsite Provider Education

For onsite education presentations, please contact Kasie Purvis at 1-314-387-4792, M–F 8:30 a.m.–5:00 p.m. This education is free of charge.

Getting to Know Kentucky Medicaid Providers

In April, Fred's Stores of Tennessee, Inc. launched a new program to help benefit the community. Fred's smartcard™ Rewards Program allows its customers to purchase Fred's brand items to accumulate points that convert to Fred's smartbucks™. The smartbucks™ are loaded to the Fred's smartcard™ quarterly and can be used for future purchases at Fred's Super Dollar stores. This includes paying for your prescriptions. The rewards program is free and available to everyone. If you would like more information on this program, please go to http://fredsrewards.loyaltylane.com/fredsshopper/Home.mvc/Faq.

If you would like to see your pharmacy highlighted, please contact Kasie Purvis at KLPurvis@magellanhealth.com.

Upcoming Changes

Preferred Drug List (PDL) Changes Effective June 6, 2012

New Drugs to Market: Hepatitis C: Oral Protease Inhibitors, Hepatitis C: Interferons, Hepatitis C: Ribavirins, and Topical Retinoids

PDL Changes Effective June 13, 2012

Beta Agonists: Short-Acting, Beta Agonists: Long-Acting, Corticosteroids: Inhaled, Beta Agonists: Combination Products, Leukotriene Modifiers, COPD Agents, Corticosteroids: Intranasal, Antihistamines: Intranasal, Antihistamines: Non-Sedating, Anticholinergics: Intranasal, Antibiotics: Inhaled, and Self-Injectable Epinephrine

These changes can be viewed at https://kentucky.magellanmedicaid.com/Providers/Bulletins.asp, in the Fee-For-Service Pharmacy Provider Notice #146 – March 15, 2012 PTAC PDL Changes – effective beginning June 6, 2012.

Did You Know...?

The Most Common Deficiencies in a Pharmacy are

- Invalid prescriptions
  - Prescriptions not signed by the prescriber, prescriptions without issue dates, cut faxes, prescriptions that do not contain federal and state required information, and prescriptions not written on temper-resistant prescription pads
- Missing prescriptions from the pharmacy files
- Prescriptions without clear, calculable directions (e.g., "Use As Directed")
- Days' supply and quantity violations
- Wrong prescribers billed

Clinical News[1]

American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD)

The ADA and the EASD simultaneously published a joint position statement on management of hyperglycemia in type 2 diabetes. The new guidelines recommend a patient-centric approach that takes patient preferences, needs, and values into consideration, rather than a uniform approach. Lifestyle interventions in the form of physical activity and food intake are crucial. Metformin remains first-line for type 2 diabetes. After metformin, there is a lack of comparative effectiveness data to guide drug selection. Benefits versus risks of other agents should guide individual treatment choices. For example, the main advantage of the incretin-based class, glucagon-like peptide 1 (GLP-1) receptor agonists, is weight loss. Whereas, gastrointestinal adverse effects (e.g., nausea and vomiting), particularly earlier in the treatment course, are limiting. Conversely, the dipeptidyl peptidase (DPP)-4 inhibitors are weight neutral. Neither of the incretin-based classes causes hypoglycemia by itself. Their potential increased risk of pancreatitis remains unresolved. The guidelines outline the risks and benefits of various therapeutic classes. The glucose-lowering effectiveness of non-insulin agents are considered high for metformin, sulfonylureas, thiazolidinedione (TZDs) and GLP-1 agonists: hemoglobin A1c (HbA1c) reduction of approximately 1.0–1.5% is expected. Typically, HbA1c reduction is lower for meglitinides, DPP-4 inhibitors, alpha glucosidase inhibitors, colesevelam, and bromocriptine (approximately 0.5–1.0%). However, older drugs have mostly been studied in clinical trial patients with higher baseline HbA1c, which is associated with greater treatment emergent glycemic reductions, regardless of therapy type. The guidelines recognize that most patients will need two to three agents to be controlled and will likely need insulin. A color-coded chart depicts strict versus less stringent management based on a number of factors, including risk of hypoglycemia, patient motivation, life expectancy, disease duration, comorbidities, and established vascular complications. Based on cardiovascular trials, these guidelines suggest that not all patients benefit from aggressive glucose management. Therefore, HbA1c targets should also be individualized.

Multiple Sclerosis and Fingolimod (Gilenya™)

In December 2011, a patient with multiple sclerosis (MS) in the United States died within 24 hours of taking the first dose of the oral MS agent fingolimod (Gilenya). Although the cause of death remains unexplained, the drug label has been strengthened. The product, which did not originally carry any contraindications, now carries four new contraindications. Fingolimod is now contraindicated in patients with a history or occurrence of certain cardiovascular conditions, including myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure requiring hospitalization, or Class III/IV heart failure within the last six months. It is also contraindicated in second degree or third degree atrioventricular (AV) block or sick sinus syndrome, unless patient has a pacemaker, in other serious cardiac rhythm disturbances, and in treatment with select anti-arrhythmic drugs. Prior to the label change, it was recommended that all patients be observed for six hours post first dose for signs and symptoms of bradycardia. The current label provides specific guidance to health care professionals for first-dose monitoring in a medical setting. The label now recommends observing all patients for signs and symptoms of bradycardia for at least

six hours after first dose with hourly pulse and blood pressure measurement. An electrocardiogram (ECG) must be obtained prior to initial dosing and at the end of the observation period. In the following situations, additional observation should be started until the finding has resolved: the heart rate six hours post-dose is <45 bpm; the heart rate six hours post-dose is at the lowest value post-dose (suggesting that the maximum pharmacodynamic effect on the heart may not have occurred); the ECG six hours post-dose shows new onset second degree or higher AV block. In patients experiencing post-dose symptomatic bradycardia, continuous ECG monitoring is recommended until the symptoms have resolved. If pharmacological intervention is required to treat bradycardia, continuous ECG monitoring should continue overnight in a medical facility, and first-dose monitoring strategy should be repeated for the second dose. The new label also provides guidance for re-initiation of fingolimod. In an unrelated event, an MS patient who had been treated with natalizumab (Tysabri®) for approximately three and a half years prior to initiating fingolimod was recently hospitalized. The patient is positive for JCV and has confirmed progressive multifocal leukoencephalopathy (PML). There were about six weeks between natalizumab and fingolimod treatments.

Drospirenone-Containing Oral Contraceptives Venous Thromboembolism (VTE) Risk

The Food and Drug Administration (FDA) has completed its safety review of some epidemiologic studies of drospirenone-containing oral contraceptives, which have shown up to a three-fold increase in risk of VTEs compared to birth control pills containing levonorgestrel or some other progestins. The labels of nine contraceptives (Beyaz®, Gianvi, Loryna, Ocella, Safyral®, Syeda™, Yasmin®, Yaz®, and Zarah) and two generics have been updated. It should be noted that the risk of clotting while using these contraceptives is lower than thrombosis risk during pregnancy and in the immediate postpartum period.

Drug Information[1]

FDA

FDA has revised the boceprevir (Victrelis™) label to state that co-administration of boceprevir with ritonavir-boosted atazanavir (Reyataz®), ritonavir-boosted darunavir (Prezista®), or lopinavir/ritonavir (Kaletra®) to patients infected with both chronic HCV and HIV is not recommended.

Finasteride (Proscar®, Propecia®)

Finasteride (Proscar®, Propecia®) labels have been updated to expand the list of sexual adverse events that may continue even after the drug is discontinued. Decreased libido was added for Proscar. Libido, ejaculation, and orgasm disorders were added for Propecia. Male infertility and/or poor semen quality that normalized or improved after discontinuation was added for both.

Aliskiren-Containing Drugs

The labels of aliskiren-containing drugs (Tekturna®, Tekturna HCT®, Tekamlo™, and Amturnide™) have been updated as a result of the FDA ALTITUDE trial analysis. Aliskiren is now contraindicated in diabetic patients on concomitant ARBs or ACEIs. A new warning against use of aliskiren-containing drugs has been added for moderate-severe renal impairment (GFR <60 mL/min) who are on ARBs or ACEIs. Novartis will voluntarily cease marketing of Valturna®, combination of aliskiren and the ARB valsartan. Valturna will be available until July 20, 2012, to allow patients to transition to alternate therapy.

[1] Magellan Medicaid Administration, Inc. Clinical Alert. May 2012. Available at www.MagellanMedicaid.com/news/ClinicalAlerts.asp.