Magellan Rx MANAGEMENT

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

PRIOR AUTHORIZATIONS

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 co-pay and benefit information.

WEBSITES

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 Magellan Medicaid Administration at kyproviders@magellanhealth.com. This education is free of charge.

Proper Utilization of the Pregnancy Indicator

Pregnant women should not have cost sharing for medications. To override/ waive a co-payment on each prescription, pharmacists should enter the pregnancy indicator, "2", in NCPDP Field # 335-2C each time a prescription is filled.

Pregnant women should be charged $0 co-payment for **no more than 11 months (including 60 days postpartum)**. After 60-days postpartum, the pharmacist should stop entering the pregnancy indicator, "2,"to override co-payment for the fill of current prescriptions. No further action will be required by the pharmacist, and normal co-payment will resume.

Call for Pharmacy & Therapeutics Advisory Committee Members

The Department for Medicaid Services (DMS) Fee for Service (FFS) Pharmacy Program is seeking placement of additional committee members for the Pharmacy and Therapeutics Advisory Committee (P & T). Our committee members provide leadership in advancing the healthcare interests of the Commonwealth's FFS members who are in long term care facilities (LTC) and waiver programs.

The P&T was established via KRS 205.564. The P&T is charged with advising the Department for Medicaid Services on the development and administration of the outpatient drug formulary. The P&T also performs drug reviews and makes recommendations to the Department regarding specific drugs or drug classes regarding prior authorization or other indicated restrictions. In addition, managed care organizational partners review the P&T results and criteria and often align internal criteria for cohesive benefit application.

For scheduling commitment consideration here is some basic information on the P&T meeting criteria:

- The P&T is required to meet six (6) times a calendar year. Typically the meetings are held on odd months (January, March, May, July, September, and November) on the third Thursday of the month
- The meetings are held in Frankfort, and members are reimbursed for mileage expenses. (There will be a travel voucher at each meeting already prepared and ready for your signature.)
- The meetings typically begin at 1:00 p.m. and end by 5:00 p.m.

If you are interested in serving as a member of the P&T Advisory Committee please contact Leeta Williams by phone at (502) 564-6890 ext. 2193 or email at Leetar.Williams@KY.gov.

Centers for Disease Control and Prevention (CDC) Influenza Update

On December 3, 2014, the CDC reported that influenza A (H3N2) viruses have been reported most frequently during the current 2014-2015 influenza season. Historically, a predominance of H3N2 virus has been associated with higher rates of hospitalization and increased mortality, particularly among the elderly, very young children, and those with certain chronic illnesses, as compared to seasons when H1N1 viruses dominated. In addition, surveillance data has identified that 52% of the H3N2 viruses collected and analyzed between October 1 and November 22, 2014 differed antigenically, or drifted, from the H3N2 virus contained in the vaccine. This may lead to decreased vaccine effectiveness. However, the vaccine may provide some protection against drifted viruses and may reduce the likelihood of hospitalization and death. The CDC stresses the importance of drugs such as oseltamivir (Tamiflu®; Genentech) and zanamivir (Relenza®; GlaxoSmithKline) when indicated as adjunct to vaccination for the treatment and prevention of influenza, as these agents have demonstrated benefit in reducing the duration and severity of influenza infection. Individuals experiencing influenza-like symptoms who are at high risk for influenza complications should be promptly evaluated for the need for influenza antiviral treatment. The CDC maintains that all patients six months of age and older should be vaccinated against influenza.

American Heart Association (AHA) Primary Prevention of Stroke Guidelines

The AHA has released new guidelines for the primary prevention of stroke as an update to their 2011 guidance. This updated guidance is consistent with several other current AHA statements regarding cardiovascular (CV) risk assessment and reduction, lifestyle and weight management, and dyslipidemia management and supports an individualized approach to primary prevention.

AHA recommends a Mediterranean diet to lower stroke risk. AHA supports the use of the American College of Cardiology (ACC)/AHA CV risk calculator to identify individuals who could benefit from therapeutic intervention. Guidance on management of dyslipidemia now follows the 2013 ACC/AHA blood cholesterol guidelines, rather than those from the National Cholesterol Education Program (NCEP), in which they recommend statin therapy in patients with a high 10-year risk of a CV event. Hypertension therapy should be individualized and focus on successful reduction of blood pressure rather than the choice of a specific agent. In patients with valvular atrial fibrillation (AF) and at high risk for stroke (CHA2DS2-VAS score ≥ 2) and low risk for bleeding, anticoagulation therapy with warfarin is recommended. For patients with non-valvular AF (NVAF), warfarin, apixaban (Eliquis®), dabigatran (Pradaxa®), and rivaroxaban (Xarelto®) are all acceptable choices. Anticoagulant or antiplatelet therapy is reasonable for patients with heart failure who do not have AF or a previous thrombotic event. These guidelines also offer guidance for the use of anticoagulants for stroke prevention in those with valvular conditions such as mitral stenosis and valvular prosthetics. The use of aspirin for overall CV prophylaxis is reasonable in people at high risk (10-year risk > 10 percent). Aspirin may be considered for primary prevention in people with chronic kidney disease (glomerular filtration rate between 30 and 45 mL/min/1.73 m^2). Cilostazol (Pletal®) may be used in those with peripheral arterial disease.

Benzodiazepine Use and Risk of Alzheimer's Disease

Benzodiazepines are widely used to treat agitation, anxiety and insomnia, all of which may also be early signs of Alzheimer's disease in the elderly population. A recent study sought to examine the total exposure to benzodiazepines and the risk of developing Alzheimer's disease in patients over 66 years of age. The researchers used a case control study design using the large national Quebec health insurance program database, which covers 90% of the elderly population, to access prescription information. They assessed benzodiazepine treatment that was started greater than five years before the diagnosis of Alzheimer's disease and then matched a control group for age and gender.

The results demonstrated that individuals who had taken a benzodiazepine for three months or less had similar risk of developing Alzheimer's disease as those who had never taken a medication from this class. However, an association was found when a benzodiazepine was taken for longer than three months, and those taking a long-acting benzodiazepine were at a greater risk compared to those taking a short-acting agent.

The study showed an association between higher cumulative benzodiazepine doses and a higher risk for developing Alzheimer's disease, but this study does not prove a causal relationship and further research is needed to determine if benzodiazepine use may be a factor in causing dementia or an indication that the disease might already be developing. It is important to keep in mind that benzodiazepines were designed and studied for short-term use and it is necessary to evaluate the risks and benefits for individual patients. Source: BMJ 2014; 349:g5205.

Magellan Medicaid Administration, Inc. Clinical Alert. 2015. Available at: http://www.MagellanMedicaid.com/news/ClinicalAlerts.asp.