North Dakota Medicaid Pharmacy Program Quarterly News

Published Quarterly by Health Information Designs, LLC

Welcome to the "North Dakota Medicaid Pharmacy Program Quarterly News," a pharmacy newsletter presented by the North Dakota Department of Human Services and published by Health Information Designs, LLC (HID). This newsletter is published as part of a continuing effort to keep the Medicaid provider community informed of important changes in the North Dakota Medicaid Pharmacy Program.

The North Dakota Department of Human Services has contracted with HID to review and process prior authorizations (PAs) for medications. For a current list of medications requiring a PA, as well as the necessary forms and criteria, visit www.hidesigns.com/ndmedicaid, or call HID at (866) 773-0695 to have this information faxed. An important feature on this website is the NDC Drug Lookup, which allows you to determine if a specific NDC is covered (effective date), reimbursement amount, MAC pricing, copay information, and any limitations (prior authorization or quantity limits).

This newsletter provides information regarding an overview of benzodiazepine receptor agonist use in insomnia and a recently published guideline regarding discontinuing these agents, updates regarding claims processing edits diabetic testing supplies, and updates to the Preferred Drug List.

The North Dakota Medicaid Pharmacy Program team appreciates your comments and suggestions regarding this newsletter. To suggest topics for inclusion, please contact HID at (334) 502-3262, call toll free at 1-800-225-6998, or e-mail us at info@hidinc.com.

north dakota department of human services

Helpful Numbers

PA Help Desk	866-773-0695
To fax PAs	855-207-0250
To report adverse reactions	800-FDA-1088

Inside this issue:

Visit HID's North Dakota Department of Human Services Prior Authorization Webpage, *www.hidesigns.com/ndmedicaid.*

Overview of Authorized Generic Products

An authorized generic is a pharmaceutical product that was originally marketed and sold by a brand company but is relabeled and marketed under a generic product name. An authorized generic may be marketed by the brand company or through a subsidiary, or the brand company may license the product to another company for marketing in return for royalties. Brand companies may launch an authorized generic for several reasons:

1. Settle patent litigation with a generic company by partnering with it.
2. Participation in generic market once generic competition starts.
3. Maintain manufacturing capacity for the drug substance.

In 1984, Congress enacted Hatch-Waxman with the intent to open up the market for products that were previously patent protected. Hatch-Waxman allowed generic manufacturers to file an Abbreviated New Drug Application (ANDA). The ANDA requires the generic company to demonstrate that its product is bioequivalent to a referenced NDA's brand name product. Because the proof of bioequivalence for a drug is much easier to establish than the requirements for a New Drug Application (NDA), the ANDA is a far less expensive process than filing a NDA.

The Medicare Act of 2003 amended Hatch-Waxman in an effort to reduce the barriers to more generics entering the marketplace. The first generic company that files an ANDA obtains a period of 180 days during which it can exclude any other prospective generic product from entering the market, thus establishing a greater market share after exclusivity ends. The position of the FDA is that authorized generics *do not* have to abide by the 180-day market exclusivity to the first generic because the FDA lacks the authority to regulate changes in approved products that do not potentially affect the safety or the effectiveness of the product. Since authorized generics are manufactured under the original, approved NDA submitted for the brand-name drug, the FDA considers authorized generics to be identical to the brand.

Authorized Generics and North Dakota Medicaid

Because authorized generics are considered 'identical' to the brand by the FDA, North Dakota Medicaid requires that prescriptions written for a brand product, available as an authorized generic, be filled with the authorized generic. The FDA listing of authorized generics is available at www.fda.gov/downloads/AboutFDA/CentersOffices/CDER/UCM183605.pdf.

References:

1. FDA Listing of Authorized Generics. Available at www.fda.gov. Accessed March 28, 2019. Authorized Generics: Antitrust Issues and the Hatch-Waxman Act. Available at www.fenwick.com. Accessed March 28, 2019.

Antipsychotic Utilization – A Review of the Evidence

The most common prescribed atypical antipsychotics in ND Medicaid are risperidone (34%), aripiprazole (29%), quetiapine (20%), and olanzapine (6%). Antipsychotics are commonly used off-label, either due to good clinical evidence or because it is common clinical practice. As antipsychotics differ in safety, tolerability and efficacy and are not interchangeable, clinical decisions should be made in a way that favors medications with the most evidence for potential benefit to the patient. [1]

When are antipsychotics used?

- Evidence for use in antipsychotics is strongest for schizophrenia [1, 5]
- Substantial evidence exists for use of antipsychotics in bipolar disorder, psychotic depression, severe aggression, and Tourette's syndrome [5]
- There are severe or refractory circumstances where antipsychotics may be used for obsessive compulsive disorder (OCD) or self-injurious behaviors [5]
- Antipsychotics do not have evidence supporting use for ADHD, eating disorders, or insomnia [2, 5]

Antipsychotics: The Evidence for Common Indications

Pervasive developmental disorders (PDD) including autism

- Risperidone: has the most evidence and consistently has shown improvement in aggression, irritability, self-injurious behavior, temper tantrums, & quickly changing moods (FDA approved) [1,3]
- Aripiprazole: shows significantly improved irritability in patients aged 6-17 (FDA approved) [1,3]
- Olanzapine: may provide benefit in disruptive behaviors[1,3]
- Quetiapine: has demonstrated suboptimal effectiveness in patients with PDD [1,3]

Dementia and severe geriatric agitation

Warning: Cerebrovascular adverse events (stroke, transient ischemic attack) including fatalities have occurred in elderly individuals who received treatment of dementia-related psychosis with antipsychotics. Antipsychotics with a high binding affinity of alpha 2 and M1 receptors may be associated with a greater risk of stroke.

- Risperidone: has the most evidence and is effective and well tolerated. It has moderate affinity for alpha 2-adrenergic receptors [1, 2]
- Aripiprazole: has favorable evidence and does not have affinity for alpha-2 adrenergic or M1 muscarinic receptors [2]
- Olanzapine: some trials show safe and superior efficacy to placebo, but data is inconsistent. Olanzapine has a high affinity for M1 muscarinic receptors [2]
- Quetiapine: has not shown statistically significant improvement in agitation [2]

Disruptive Behavior Disorders (DBDs)/Aggression

- Risperidone: There is substantial evidence for disruptive behaviors in children with sub-average intelligence and impulsive aggression in conduct disorder and disruptive behavior disorders. [1]
- Aripiprazole: There is good evidence for aggression in conduct disorders. [1]
- Olanzapine: has demonstrated effectiveness in disruptive behaviors. [1]
- Quetiapine: There is low quality evidence showing evidence for aggression in conduct disorders.[1]

Antipsychotic use in children under age 6:

- Use of antipsychotic medications should only be considered in extraordinary circumstances, such as disruptive aggression in autism. Only risperidone and aripiprazole have evidence for use [5]

Assessing risk-benefit ratio of continuing medications:

Start with medications:[5]

1. Without indication, or if it is unclear what symptoms are being targeted
2. With the least evidence of efficacy for treatment of targeted symptoms or indication or are being used outside of guidelines recommending their use
3. That were ineffective for targeted symptoms or symptoms have resolved
4. Without benefit to justify harms, or have the greatest risk of adverse effects
5. That are part of a prescribing cascade, treating side effects that have been misdiagnosed as another disorder or to counter side effects of another drug

References

1. Findling RL, Drury SS, Jensen PS, Rapoport JL, AACAP Committee on Quality Issues. (2011). Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents. American Academy of Child and Adolescent Psychiatry. Washington, D.C. www.aacap.org (Accessed on January 23, 2019)
2. Maher AR, Maglione M, Bagley S, et al. Efficacy and Comparative Effectiveness of Atypical Antipsychotic Medications for Off-Label Uses in Adults. (2011). *JAMA (12)*306: 1359-1369 doi:10.1001/jama.2011.1360
3. Weissman L, Bridgemohan C. Autism spectrum disorder in children and adolescents: Pharmacologic Interventions. UpToDate. Waltham, MA: UpToDate Inc. https://www.uptodate.com (Accessed on January 18, 2019.)
4. Nutt AE, Keating D. (March 2018). One of America's most popular drugs – first aimed at schizophrenia – reveals the issues of 'off-label' use. [Electronic Version]. *Washington Post*.
5. 2018-2019 Florida Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents (2019). The University of South Florida, Florida Medicaid Drug Therapy Management Program sponsored by the Florida Agency for Health Care Administration (AHCA).