North Dakota Medicaid Pharmacy Program Quarterly News

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Welcome to the Winter 2008 edition of 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, Inc. 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 Health Information Designs, Inc. (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, go to www.hidndmedicaid.com, or call HID at (866) 773-0695 to have this information faxed. An important feature on this website is the NDC Drug Lookup. This will allow you to determine if an NDC is covered (effective date), price allowed and MAC pricing, copay information, and any limitations (prior authorization or quantity limits).

The Winter 2008 newsletter contains treatment guidelines for hyperlipidemia. This includes important information on cost-saving measures that providers can utilize with the statin class of medications.

The North Dakota Pharmacy Program team appreciates your comments and suggestions regarding this newsletter. To suggest topics for inclusion, or to make comments, please contact Health Information Designs, Inc. at (334) 502-3262 or toll free at 1-800-225-6998, or email us at info@hidinc.com.

north dakota department of human services

Helpful Numbers

PA Help Desk	866-773-0695
To fax PAs	866-254-0761
To report adverse reactions (via Med Watch)	800-FDA-1088

Inside this issue:

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

Current Treatment Guidelines for Hyperlipidemia

The decision to treat hyperlipidemia generally follows the treatment guidelines of the Third Report of the National Cholesterol Education Program (NCEP) Adult Treatment Panel (ATP) III, published in 2002 and updated in 2004. The report stresses that the intensity of treatment should be directed by the degree of cardiovascular risk. Because LDL-C is the major atherogenic lipid component, NCEP-ATP III focuses primarily on achieving target LDL-C levels. For most patients who are prescribed a statin, the target is <130 mg/dL or <100 mg/dL. In ATP-III, patients who have type 2 diabetes without CHD; peripheral or carotid vascular disease; and patients who have multiple risk factors and a 10-year risk of CHD > 20% are said to have 'CHD equivalents.' This means that the criteria for using drug therapy and the LDL-C target is the same for patients who have a history of CHD.

The 2006 update of the American Heart Association/American College of Cardiology consensus statement on secondary prevention states that an LDL-C goal of <70 mg/dL for high risk patients is a therapeutic option. Factors that place patients in the category of very high risk are the presence of established CVD plus 1) multiple major risk factors (especially diabetes), 2) severe and poorly controlled risk factors (especially continued smoking), 3) multiple risk factors of the metabolic syndrome (especially high triglycerides >200 mg/dL plus non-HDL-C >130 mg/dL with low HDL-C <40 mg/dL, and 4) patients with acute coronary syndromes. If it is not possible to attain LDL-C <70 mg/dL because of a high baseline LDL-C, it generally is possible to achieve LDL-C reductions of >50% with either statins or LDL-C lowering drug combinations. The optional goal of <70 mg/dL does not apply to individuals who are not at high risk.

Table 2. NCEP Treatment Guidelines: LDL-C Goals and Cutpoints for TLC and Pharmacotherapy

Risk Category	LDL Goal	LDL Level to Initiate TLC	LDL Level at Which to Consider Drug Therapy
CHD or CHD Risk Equivalent (10-year risk > 20%)	< 100 mg/dL	≥ 100 mg/dL	≥ 130 mg/dL (100-129 mg/dL, drug optional)*
2 or more Risk Factors (10-year risk ≤ 20%)	< 130 mg/dL	≥130 mg/dL	≥ 130 mg/dL (for 10-year risk 10-20%) > 160 mg/dL (for 10-year risk < 10%)
0-1 Risk Factors	< 160 mg/dL	≥ 160 mg/dL	≥ 190 mg/dL (160-189 mg/dL, drug optional)**

*Some authorities recommend use of LDL-C lowering drugs in this category if an LDL-C < 100 mg/dL cannot be achieved by TLC. Clinical judgment may also call for deferring drug therapy in this category.

**Factors that favor drug therapy after 3 months of TLC include a severe single risk factor (heavy smoking, poorly controlled hypertension, strong family history of premature CHD, or very low HDL-C), multiple life-habit risk factors and emerging risk factors, or 10-year risk approaching 10%.

The American College of Cardiology recommends achieving targets for levels of LDL and HDL cholesterol (or of the ratio of total cholesterol to HDL cholesterol) with the use of statins plus drugs that have shown clinical benefits when added to statins (e.g., nicotinic acid, fibrates, and bile acid sequestrants), as tolerated. Efforts should also be made at dietary control and regular exercise. The ACC also notes that conclusions regarding the ENHANCE trial (Vytorin vs Simvastatin) can not be made until clinical-outcome trials are presented within the next two to three years.

Statin Utilization - 01/01/07 to 12/31/07		
Generic Name	**Qty Dispensed**	**Total Reimb Amt**
Amlodipine/Atorvastatin	2433	$10,034.68
Atorvastatin	82732	$262,305.53
Ezetimibe/Simvastatin	15717	$45,617.59
Fluvastatin	625	$1,903.23
Lovastatin	5850	$4,783.53
Pravastatin	5259	$5,219.38
Rosuvastatin	26645	$80,748.06
Simvastatin	35935	$24,883.85
TOTAL 926 Recipients	175196	$435,495.85

Statins are one of the most widely prescribed medications in the United States. North Dakota Medicaid spends nearly half a million dollars on this class of medications, annually. Three statins are now available as lower-cost generics. Lovastatin has been a generic since 2001. Pravastatin and simvastatin both became available generically in 2006. Generic simvastatin is the most potent statin to become available as a generic.

North Dakota Medicaid suggests that physicians starting patients on statin medications remember that simvastatin is now available generically. Recipients receiving a prescription for a generic statin will save money through the generic cost incentive program. Lower statin copayments are associated with higher levels of statin adherence, which is very important with this class of medication. Cost effective choices allow North Dakota Medicaid to continue providing drug benefits to recipients.

Tablet splitting is another cost saving measure that can be used. The biggest savings comes from splitting flat-priced tablets (costs of different dosage strengths are equal/similar). For those patients that are physically capable, tablet splitting of atorvastatin may be an option. Atorvastatin (Lipitor) has an estimated acquisition cost of 4.09 per pill for the 20mg, 40mg, and 80mg. Splitting these tablets could save up to 50% per prescription.

The following conditions should be considered when tablets are split:

1. Pharmacist instruction on proper technique.
2. Patients should be comfortable with splitting their own tablets.
3. Patients should be free from physical impairments that might impair accurate pill splitting.
4. Patients should split only a two day supply at a time to maintain product integrity.

Summary of Evidence

- For patients who require LDL-C reductions of up to 35% to meet their goal, any of the statins are effective.
- In patients requiring an LDL-C reduction of 35% to 50% to meet the NCEP goal, atorvastatin 20mg or more, lovastatin 80mg, rosuvastatin 10mg or more, and simvastatin 20mg or more daily are likely to meet the goal.

References
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For 30 years, HID has worked to improve the quality and cost effectiveness of health care through clinically rational use of prescription medication. Our clients include public and private health care plans throughout the U.S. with a combined total of over 11 million covered lives.

Health Information Designs, Inc. was founded in 1976 and is incorporated as a C Corporation in the State of Delaware. HID's initial mission was to market drug utilization review (DUR) services nationally and since its founding, has provided DUR services for clients in approximately two-thirds of the United States. HID is headquartered in Auburn, Alabama, with regional offices in Arkansas, Maryland, and Mississippi.

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391 Industry Drive
Auburn, AL 36832
Tel: 800-748-0130
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