North Dakota Medicaid Pharmacy Program Quarterly News

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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

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

Utilization and Recommendations Regarding the Use of Benzodiazepine Receptor Agonists for the Treatment of Insomnia

It is estimated that 10-15% of American adults have a diagnosis of insomnia, and use of prescription medications to manage insomnia has increased by greater than 7-fold since 1993, including a 30-fold increase in non-benzodiazepine sedative hypnotics. Of those patients receiving prescription medications to treat insomnia, ~55% take benzodiazepine receptors agonists (BZRAs), including benzodiazepines, zaleplon, eszopiclone, and zolpidem.

While evidence has shown that short-term use (up to 6 weeks) of BZRAs for insomnia can result in improvements in sleep onset latency of 4 minutes and an additional hour of sleep duration, use of these agents may result in multiple adverse events including falls, psychomotor impairment, behavioral changes, and motor vehicle accidents, all of which occur at a much higher rate in elderly (>65 years of age) patients. Furthermore, prolonged use of these agents also carries the risk of physical and psychological dependence.

Despite the high prevalence of utilization of these agents, recent evidence suggests that the efficacy of these agents wanes after approximately 4 weeks of treatment, while the adverse effects of these medications might persist. Because of the potential limited efficacy and continued safety concerns, the College of Family Physicians of Canada has released guidelines with specific recommendations for deprescribing BZRAs.

These overall recommendation of the guidelines is that providers should make an effort to slowly taper BZRAs with elderly patients and patients who have used these drugs for > 4 weeks, except in patients with other sleeping disorders, unmanaged anxiety or depression, or other physical or mental health conditions that might cause or aggravate insomnia. Specific recommendations include the following:

- Patients who have a higher risk for relapse, including those with a history of psychological distress or long-term BZRA use should have their BZRA reduced at a slower rate (potentially over several months)
- Clinicians should monitor patients every 1 to 2 weeks for expected benefits (including improvements in cognition, alertness, daytime sedation, and the incidence of falls) and withdrawal symptoms (including insomnia, anxiety, irritability, sweating, and gastrointestinal symptoms)
- Providers should consider using behavior management strategies to help patients with insomnia
- Recommended strategies for deprescribing include the following:
    - Abruptly stopping the BZRA (abrupt discontinuation)
    - Gradually reducing the dose until complete cessation of the BZRA
        - Using a lower BZRA dose
        - Using BZRAs only when needed
    - Recommending a cognitive behavioral therapy program for insomnia with the aim of stopping or reducing BZRA use in the process
    - Combining tapering and CBT
    - Replacing BZRAs with an alternative agent [e.g. melatonin] either abruptly or by cross-tapering

It should be noted that the current American Academy of Sleep Medicine guidelines for management of insomnia do not carry these same recommendations for discontinuing BZRAs, but do recommend that hypnotic treatment be used at the lowest effective maintenance dosage and be supplemented with behavioral and cognitive therapies when possible. They also recommend that patients receiving pharmacological treatment should be followed on a regular basis to assess for effectiveness, possible side effects, and the need for ongoing medication.

References:

1. Bertisch SM, Herzig SJ, Winkelman JW, Buettner C. National Use of Prescription Medications for Insomnia: NHANES 1999–2010. Sleep. 2014;37(2):343–349. doi: 10.5665/sleep.3410.
2. Pottie K, Thompson W, Davies S, et al. Deprescribing benzodiazepine receptor agonists: Evidence-based clinical practice guideline. *Can Fam Physician.* 2018 May;64(5):339-351.
3. Kapur VK, Auckley DH, et al. Clinical practice guideline for diagnostic testing for adult obstructive sleep apnea: an American Academy of Sleep Medicine clinical practice guideline. Journal of Clinical Sleep Medicine. 2017 Mar 15;13(03):479-504.
4. Vinkers CH, Olivier B. Mechanisms underlying tolerance after long-term benzodiazepine use: a future for subtype-selective GABA receptor modulators? Adv Pharmacol Sci 2012;2012:416864.

Diabetic Testing Supplies Claims Processing Update

In line with current ADA guidelines, ND Medicaid will be changing coverage parameters for blood glucose testing for type 2 diabetes patients who are not taking insulin or sulfonylureas.

The 2018 ADA guidelines point out the lack of clinical utility and cost-effectiveness of routine Self-Monitoring of Blood Glucose (SMBG) in non-insulin treated patients. Both the Society of General Internal Medicine and the Endocrine Society recommend against routine SMBG for type 2 diabetes patients not on insulin or agents that cause hypoglycemia. Several studies have found that these practices lead to waste and possibly worse outcomes for depression and quality of life. Long term SMBG has not been proven to be beneficial, as the minimal benefit of SMBG at 6 months is no longer shown at 12 months.

Given this body of evidence, ND Medicaid is requiring prior authorization for blood glucose testing for type 2 diabetes patients who are not taking insulin or sulfonylureas. Overrides for a period of 6 months will be considered for patients that are newly diagnosed, acutely ill, or have a significant change in health status for medically necessary purposes. To obtain an override, please fax a letter of medical necessity to (701) 328-1544 explaining why your patient would benefit from self-monitoring of blood glucose.

For a link to this initial communication and for a full list of references, please go to the the North Dakota Department of Human Services Prior Authorization website (http://www.hidesigns.com/ndmedicaid) and use the "Pharmacy E-Mail Archive Link" to view the 06/20/2018 e-mail containing referenced for this change.

Updates from the Most Recent Preferred Drug List

PDL Category Revisions:

- Criteria updates and/or revisions for the following PDL classes: Constipation – Irritable Bowel Syndrome/Opioid Induced, COPD – Long Acting Anticholinergics, Cytokine Modulators, Diabetes – DPP4 Inhibitors, Diabetes – DPP4 Inhibitors/SGLT2 Inhibitor Combinations, Diabetes – Insulin, Diabetes – Insulin/GLP1 Agonists, Digestive Enzymes, and Opioid Partial Agonists – Opioid Dependence.

Moved to Non-Preferred (Requires PA):

- Methylphenidate 72 mg
- Onglyza (saxagliptin) & Kombiglyze XR (saxagliptin/metformin)
- Auvi-Q (epinephrine)
- Enablex (darifenacin)

Moved to Preferred:

- Relistor Vial (methylnaltrexone)
- Lonhala Magnair (glycopyrrolate) & Tudorza Pressair (aclidinium)
- Nix (permethrin) 1% crème rinse liquid, permethrin 5% cream, & permethrin 1% liquid
- Buprenorphine/naloxone tablets
- Ofloxacin drops
- Renvela (sevelamer carbonate) tablet
- Aggrenox (aspirin/dipyridamole) & Prasugrel
- Adcirca (tadalafil)
- Revatio (sildenafil) suspension
- Advair HFA (fluticasone/salmeterol)
- Flovent Diskus (fluticasone)

Removed From PDL:

- Dermacinrx Lexitral (diclofenac/capsicum), Vopac MDS (diclofenac), & Xrylix (diclofenac)
- Olysio (simepravir)
- Aerospan (flunisolide)
- QVAR (beclomethasone

Please visit http://www.hidesigns.com/ndmedicaid for information on prior authorization. Helpful links include PA Forms, PA Criteria, and NDC Drug Lookup.