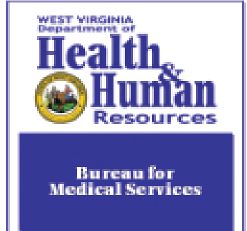

Sept 2009

DUR Capsules

News and Information for West Virginia Providers from the West Virginia Bureau for Medical Services (WVBMS)

Clinical Guidelines for Treatment of H1N1 Flu

Statistics—As of August 6, 2009, a total of 102,905 confirmed cases of H1N1 have been reported in all 35 countries in the Americas Region. A total of 1,274 deaths have been detected among the confirmed cases. In the United States, 353 deaths have been reported, 51 of those since July 31.

Transmission—Transmission of H1N1 virus is still being investigated, but data indicates that it is likely spread by coughing/sneezing, contact with contaminated surfaces, and via airborne transmission. Adults may be contagious from one day prior to 7 days after becoming symptomatic. Children, especially younger children, may be contagious for a longer period of time.

High Risk Groups—Laboratory-confirmed cases of infection with the H1N1 virus have occurred mostly in children and young adults, however, high risk groups currently remain the same as for seasonal influenza. These groups include:

- Children less than 5 years old. (The risk for severe complications is highest for children less than 2 years old.
- Adults 65 years of age and older.
- Patients with the following conditions: chronic pulmonary, cardiovascular, renal, hepatic, hematological, neurologic, neuromuscular, or metabolic disorders (such as diabetes); immunosuppressed patients; pregnant women; patients younger than 19 receiving long-term aspirin therapy; residents of nursing homes/chronic-care facilities.
- Patients who are morbidly obese (body mass index equal to or greater than 40) and perhaps patients who are obese (body mass index 30 to 39).

Resistance—H1N1 virus is susceptible to the antiviral medications, zanamivir and oseltamivir, but is resistant to amantadine and rimantadine.

Management Recommendations

Treatment for uncomplicated febrile illness – Generally, these patients do not require treatment unless they are at high risk for complications (see above for list of high risk patients). Supportive care includes acetaminophen for fever/pain and fluid rehydration, as well as rest and home isolation.

Treatment for high risk patients – The Centers for Disease Control (CDC) recommends treatment for all hospitalized patients and all high risk patients. Recommended duration of therapy is five days, with treatment initiated as soon as possible after onset of symptoms. Evidence shows that the benefit from treatment is strongest when treatment is started within 48 hours of onset, but patients see reductions in mortality and/or duration of hospitalization even when started later.

Chemoprophylaxis **–** Duration of antiviral therapy for prophylaxis post-exposure is 10 days after last known exposure. Prophylaxis should be considered for the following circumstances: Close contacts of cases (confirmed, probable, or suspected) who are at high-risk for complications of influenza, and health care personnel, public health workers, or first responders who have had a recognized, unprotected close contact exposure to a person with H1N1 virus infection during that person's infectious period.

Vaccinations—For the 2009-10 season, patients will have to take a seasonal influenza vaccine and an H1N1 vaccine.

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Clinical Guidelines for Treatment of H1N1 Flu, continued

Relevant Web Addresses

Current epidemiology information and tools for H1N1 (Swine) Influenza in West Virginia (including investigation protocol, hospital reporting forms, outbreak toolkit, etc.): http://www.wvidep.org, click on "A to Z Infectious Diseases" and " H1N1 (Swine) Flu".

General Public and Provider H1N1 Flu Information (Health Alerts, Facts Sheets, H1N1 Vaccine Provider Pre-Registration, Communication messages, etc.): http://www.wvdhr.org, "Follow Swine Flu Updates.

Hospitals, laboratories, providers and health departments are encouraged to monitor influenza surveillance data during the coming season. Updated reports of WV Influenza Surveillance Data (including influenza-like illness and laboratory confirmed influenza by type and subtype will be posted weekly: [see http://www.wvidep.org, click on "A to Z Index of Infectious Disease", "Influenza", and link und "Surveillance Data"].

WHO: Clinical management of human infection with new influenza A (H1N1) virus: initial guidance. Accessed 08/17/09 at: http://www.who.int/csr/resources/publications/swineflu/clinical_managementH1N1_21_May_2009.pdf

CDC: Interim guidance on antiviral recommendations for patients with novel influenza A (H1N1) virus infection and their close contacts. Accessed 08/17/09 at: http://www.pharmacistsletter.com/(S(jzieuf55rlawmi45v1154h55))/pl/detaildocuments/250809-1638.pdf?rn=4&cs=&s=PL

Prior Authorization for Seroquel® 25mg

The use of 25mg tablets of quetiapine (Seroquel®) may require prior authorization. The prior authorization has been implemented to reduce the off-label use of quetiapine (Seroquel) for the treatment of insomnia.

Claims for quetiapine (Seroquel) 25mg will be denied for patients without a diagnosis of schizophrenia or bipolar disorder. Claims for the 25 mg tablet will also be denied if used alone and not in combination with other strengths of quetiapine (Seroquel) to achieve the total daily dose required for the patient.

Please refer to the Bureau for Medical Services' website http://www.wvdhhr.org/bms/sPharmacy/PDL/bms_PDList_PageRV.asp for a list of the preferred sedative-hypnotic agents currently covered by West Virginia Medicaid. Should a prior authorization be required, please contact the Rational Drug Therapy Program (RDTP) and submit supporting documentation. RDTP can be reached by phone (1-800-847-3859) or fax (1-800-531-7787).

PDL Update

As of October 1, 2009, Kapidex® will replace Prevacid® as a preferred PPI on the West Virginia Medicaid Preferred Drug List (PDL). Prevacid will be moving to non-preferred status. Effective October 1, 2009, new starts on a PPI agent will be required to use either Kapidex or Nexium® (our two preferred agents). The generic formulation of Prevacid (lansoperazole) will be non-preferred. Patients on Prevacid can continue using it until January 1, 2010, but will need to be on a preferred agent after that date.

Medicaid programs receive a federal rebate on the drugs they provide for their members. These rebates, on both brand name and generic drugs, are significant and often make drugs that have a higher Average Wholesale Price (AWP) a better buy for Medicaid. In addition, West Virginia Medicaid was given the authority in 2002 to establish a PDL and to negotiate for supplemental rebates. So, if you sometimes wonder why seemingly very expensive drugs are listed as preferred for Medicaid members (as opposed to ones that would seem to be less expensive alternatives), it is because of rebates that are either required by Federal law or negotiated by the Medicaid Pharmacy Program.

How Can Pharmacists Help Improve Medication Adherence?

Kristen M. Cook, PharmD
Published: 08/05/2009

Relationships Between Beliefs About Medications and Adherence

Gatti ME, Jacobson KL, Gazmararian JA, Schmotzer B, Kripalani S *Am J Health Syst Pharm.* 2009;66:657-664

Study Summary

Adherence rates for medications vary greatly across different disease states, clinical settings, and populations. In general, adherence is not as high as healthcare professionals would prefer. This study looked at the relationships between health literacy and beliefs about medications, and how these factors affect medication adherence.

The investigators screened patients who were picking up prescriptions at three pharmacies in a single healthcare system. Participants were at least 18 years of age, were picking up prescriptions for themselves, were comfortable with English, had been in the healthcare system longer than 6 months, had no visual impairment, and passed a screening test for cognitive impairment. Participants were then given a 50-minute interview that used several different questionnaires to address health literacy, adherence, and medication beliefs.

The participants who completed the study were primarily black (86.2%), women (73.1%), and had an annual income of less than $10,000 (63.7%). Health literacy was defined as the ability to read at a high school level, which applied to 40.3% of the participants. Low adherence to medications was found in 53% of the sample.

Investigators found that the following factors were significant predictors of low medication adherence: age < 65 years ($P = .02$), low self-efficacy scores ($P < .001$), and negative beliefs about medications ($P = .006$). Health literacy was not a significant predictor of medication adherence in this population.

Viewpoint

Each year, a substantial number of hospitalizations result from medication nonadherence, and these hospitalizations cost the healthcare system billions of dollars.[1] Pharmacists should be extensively involved in collaborating with patients and other healthcare professionals to address this problem.

This study, along with previous research, confirms the fact that attitudes and beliefs about medications play a large role in adherence. In my own ambulatory care practice, I encounter many patients who received no information about their medications from prescribers, and often do not know the reason they are taking these medications. This lack of knowledge about prescribed medications often leads to fear of taking the medications. Some patients conclude that the medications are unimportant because their healthcare providers didn't deem it important to explain the rationale for the medications.

The pharmacist is the healthcare provider who encounters the patient each time he or she fills or refills a prescription. The pharmacist should assess medication adherence, patient understanding, and efficacy at each of these encounters. Of course, there are several barriers to providing this type of education, including pharmacist workload and lack of patient interest. However, as pharmacists move further away from the dispensing role, it is increasingly imperative that we establish ourselves as the primary educators about patients' medications.

Educating patients about the potential adverse effects of their medications is another important step in overcoming nonadherence. As identified in this and other research, patient beliefs about adverse outcomes and consequences of long-term use of their medications can impede adherence. Pharmacists need to educate patients about outcomes associated with their medications and provide them with plans that explain what to do if they experience adverse effects, so that appropriate interventions can occur. Pharmacists must partner with other healthcare professionals to identify patient beliefs and misunderstandings about medications, and must educate patients appropriately. Pharmacists can educate providers about the value of pharmacist services and partner with them to establish programs to monitor medication adherence. Teamwork presents a more united front and gives patients multiple opportunities to hear critical messages.

This study reinforces the need to talk to patients about their medications and ascertain their level of understanding. Because this study was conducted in an indigent population, the findings suggest an opportunity to reduce health disparities in similar populations.

References

1. Osterberg L, Blaschke T. Adherence to medication. N Engl J Med. 2005;353:487-497.

Authors and Disclosures

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NPI Submission: Changes in Requirements

The West Virginia Medicaid Pharmacy Program will implement a new edit (#7237) in the Point-of-Sale system during the third quarter of 2009 to increase the accuracy of national prescriber identification (NPI) number submissions. NPIs that do not belong to one of the six groups of eligible prescribers enrolled with the West Virginia Medicaid program will cause the prescription to deny when submitted. The six categories of enrolled prescribers are: physicians, physicians' assistants, nurse practitioners, optometrists, dentists, and podiatrists. Other submitted NPIs (e.g. laboratories, hospitals, clinics, pharmacies, etc.) that do not belong to prescribers will no longer be accepted, causing the claim to deny. If the prescriber NPI is not on the prescription or made available to the pharmacist, it can be obtained by searching the website https://nppes.cms.hhs.gov/NPPES/NPIRegistrySearch.do?subAction=reset&searchType=ind

Edit #7237 will send a warning message for a period of at least 30 days and then be set to deny after that time. A FAX Blast will be sent to pharmacists to inform them when the change in the edit setting occurs. Pharmacists are encouraged to enter prescriber identifier information as accurately as possible, since this information is used to identify prescribing trends and allows for communication with prescribers after retrospective drug utilization reviews.

In addition, prescriptions written by prescribers who are excluded from Medicare and Medicaid participation (identified and published by the DHHS Office of Inspector General) will be denied. Prescriptions written by these excluded providers are not eligible for federal matching funds. If one of your patients presents a prescription that is denied for this reason, you may wish to explain to them that their prescriber is barred from participating in federally-funded healthcare programs. The patient has the option of paying cash for the prescription or finding another treating prescriber to provide their medical care and to write their prescriptions. More information about the OIG list and regulations regarding excluded providers can be found at http://oig.hhs.gov/fraud/exclusions/instructions.asp.

The DUR Capsules is a quarterly newsletter published for West Virginia Medicaid Providers. Information concerning West Virginia Medicaid can be accessed online at www.wvdhhr.org/bms

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