
Oklahoma Health Care Authority

DUR Newsletter

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Drug Utilization Review for Oklahoma Medicaid

Prior Authorization of Strattera

Effective 7/29/03, Strattera was added to the Product Based Prior Authorization class of ADHD medications requiring prior authorization. Strattera will be covered for clients that meet ALL of the following criteria:

1. A diagnosis of ADHD.
2. Have failed a stimulant medication or have a contraindication to stimulant use.
3. Are not using stimulants concurrently (except that Strattera will be covered simultaneously with stimulants for a maximum of a 2 month titration period, in order to taper off the stimulant).
4. Strattera dosing does not exceed 100 mg per day.

Length of approval for Strattera petitions: Clients aged 0-20 years: 6 months. Clients aged 21 years and older: 1 year.

Strattera (atomoxetine) is indicated for the treatment of ADHD and is available in 10, 18, 25, 40, 60 mg capsules. Strattera is dosed QD – BID. Dosing is weight-based. The maximum FDA approved dose is 100 mg. There are no data to support increased effectiveness at higher doses. The adverse effect profile of Strattera is similar to that of the older stimulants, including anorexia and weight loss, increased blood pressure and heart rate, head-



ache, irritability, mood swings, and sleep disturbance. The comparative efficacy between Strattera and older ADHD treatments is unknown, as is the safety and efficacy of using Strattera and stimulants concomitantly.

OTC Loratadine Covered for Adult Clients with Prior Authorization

Effective 7/29/03, OTC loratadine became a covered benefit for clients over 21 years of age with PA. OTC loratadine for these clients requires a failed trial with a traditional OTC antihistamine (e.g. chlorpheniramine, diphenhydramine, etc.). Clients under 21 years of age do not require prior authorization for OTC loratadine products. For all OTC loratadine claims, a prescription from the client's physician is required. Petitions will be approved for 3 months per authorization unless the prescriber documents any additional conditions or complications such as asthma.

Prior Authorization of Ranitidine Capsules and Effervescent Tablets

Effective 8/25/03, ranitidine capsules and effervescent tablets will require prior authorization. Please include on the petition information explaining why the client is unable to take the tablet or liquid dose form. Ranitidine tablets will be unaffected and should not require prior

authorization. Approved petitions will be valid for 12 months of therapy.

Summary of the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-VII)

Hypertension currently affects approximately 50 million people in the United States and will continue to rise unless effective preventive measures are initiated. In response to this growing trend and a need for updated, clear, and concise guidelines, the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of Hypertension have developed the seventh report for hypertension prevention and management. The new guidelines state that the risk of cardiovascular disease begins at 115/75 for individuals aged 40-70 and this risk doubles with each incremental increase of 20 mmHg in systolic BP and 10 mmHg in diastolic BP.

The new classification system has four categories and is based on the proper measurement of the average of >2 , seated BP readings on 2 or more office visits. The new classifications follow:

- Normal – blood pressure $<120/80$. This category was previously termed “optimal”.
- Prehypertension – systolic blood pressure 120-139; diastolic blood pressure 80-89. This is a new category, encompassing both the previous sections of “normal” and “high-normal” that was introduced to increase awareness of cardiovascular disease and prevent the progression to hypertension. This level signals the health care provider to increase education and initiate lifestyle modifications in order to decrease blood pressure levels in the general population.
- Stage 1 hypertension – systolic blood pressure 140-159; diastolic blood pressure 90-99. Lifestyle modifications and

single drug therapy should be initiated.

- Stage 2 hypertension – blood pressure $\geq 160/100$. Because the treatment is the same, the prior stages 2 and 3 were combined in a step to simplify the classification. Lifestyle modifications and two drug combination therapy should be initiated.

There are three objectives when evaluating patients with hypertension: (1) Assess lifestyle and identify other cardiovascular risk factors and concomitant disorders that may affect prognosis and treatment; (2) Reveal identifiable causes of high blood pressure; and (3) Assess the presence or absence of target organ damage and cardiovascular disease. Lowering blood pressure has been associated in clinical trials with reductions in stroke incidence of 35-40%; MI, 20-25%; and heart failure, $>50\%$. Current control rates of patients at goal blood pressure (defined as $<140/90$), determined by the National Health and Nutrition Examination Survey, are at 34%. Inadequate control may be a result of unutilized lifestyle modifications, inadequate drug doses and/or combinations, or lack of patients understanding on their disease state and therapy.

Goal blood pressure levels are $<140/90$ for most patients with hypertension or $<130/80$ in patients with concomitant diabetes or renal disease. Lifestyle modifications are essential to control and manage blood pressure levels. A single modification can have effects similar to single drug therapy with combinations of two or more lifestyle modifications having an even greater effect. Identified effective measures include: weight reduction in the overweight population, adoption of the Dietary Approaches to Stop Hypertension (DASH) eating plan (rich in fruits, vegetables, and low fat dairy), reduced dietary sodium consumption to <100 mmol per day (2.4 g sodium or 6 g sodium chloride), regular physical activity, and moderation of alcohol consumption.

After lifestyle changes have failed, thiazide-type diuretics, alone or in combination, should be used as initial therapy for most patients unless special considerations indicate other-

wise. Not only are thiazide diuretics effective in reducing blood pressure but they also enhance the efficacy of other antihypertensive therapy and are more affordable. Certain high risk conditions are “compelling indications” for initiating therapy with a different class such as ACEI, ARB, BB, and CCB. These conditions include heart failure, post myocardial infarction, high CVD risk, diabetes, chronic kidney disease, and recurrent stroke prevention. Most hypertensive patients will require 2 or more medications to reach their goal blood pressure level. When single drug therapy is dosed at therapeutic levels and patient has still failed to reach goal, a second agent from a different class should be initiated. If blood pressure is >20/10 mmHg above goal, therapy can be initiated with two agents although particular caution should be paid to those at risk for orthostatic hypotension such as the elderly, diabetics, and patients with autonomic dysfunction.

Follow-up and medication adjustments for most patients should start at monthly intervals and can increase to 3-6 month intervals once blood pressure goal is achieved. Those with Stage 2 hypertension or co-morbid conditions will require more frequent monitoring. Other cardiovascular risk factors should also be identified and treated appropriately. Low-dose aspirin therapy should only be considered once blood pressure is stabilized to avoid the risk of hemorrhagic stroke in patients with uncontrolled hypertension.

The guidelines are available online at www.nhlbi.nih.gov/guidelines/index.htm.

Third Party Billing Update

For many years, Oklahoma Medicaid regulations have allowed pharmacists to bill Medicaid as the first payer for clients with Medicare or other public or private medical coverage. A recent revision to the regulations will now require pharmacists to first bill the other payer and then bill the remainder to Medicaid. This change assures that Medicaid is the payer of last resort. The change will apply only to adult clients who do not reside in a long term care

facility. Children and nursing home residents will be exempt from this requirement.

This change will be implemented in two steps. The first step is for those patients with private third party coverage or Medicare HMO coverage for prescriptions. The second step will include patients with Medicare Part B coverage if the drug submitted is one of the drugs covered by Medicare. The first step will be activated September 15, 2003.

When you send a claim for a patient with private third party Medicare HMO coverage, you will receive NCPDP reject code 41 along with the name, address, and telephone number of the third party to be billed.

After you submit the claim to the appropriate third party, you may submit the remainder of the claim to Oklahoma Medicaid. For claims that are partially paid, i.e. less than the Medicaid allowable, enter the amount paid by the other payer in the “Other Payer Amount Paid” field. You may need to contact your software vendor to verify the location of this field and other software-specific details. Partially paid claims include claims that result in full payment minus a co-payment amount.

For claims that are denied, enter at least one of the NCPDP reject code numbers received from the other payer in the “Reject Code” field and resubmit the claim to Oklahoma Medicaid.

If your pharmacy software does not support Coordination of Benefits (COB), you may submit the claim through the OHCA website. If you have not set up your internet account, please contact the OHCA Help Desk at 405-522-6205 or toll-free statewide at 800-522-0114. Do not call the Pharmacy Help Desk as their staff does not have access to the website.

If you do not have access to the internet, you may submit a paper claim. The Pharmacy Help Desk can fax or mail a paper claim form to you.

If the client has coverage through a closed network HMO of which you are not a member, please direct the patient to seek services from a participating network provider. Retrospective claims reviews will be performed to assess compliance with this requirement.

Billing Procedure for Cost Avoidance

1. Pharmacy sends claim to EDS and it is rejected with OHCA edit 2508 and NCPDP Reject Code 41. Reject Code 41 says "Submit Bill to Other Processor or Primary Payer". In the text of the rejection message, the pharmacy also receives the Third Party payer information including name, address, and telephone number.
2. Pharmacy sends claim to Third Party listed in the rejection message from OHCA.
 - a. Third Party Payer pays 100% of the Medicaid allowable – claim may be resubmitted but no payment will result.
 - b. Third Party Payer pays less than 100% of the Medicaid allowable – Claim should be resubmitted to EDS
 - Enter the paid amount in the "TPL AMOUNT PAID" field of your software. The same step is used for the internet claims screen.
 - Send claim to EDS.
 - Resulting payment will be Medicaid allowable minus TPL Amount Paid.
 - c. Third Party Payer REJECTS or DENIES the claim.
 - Enter up to 9 reject codes in the TPL Reject Reason Code field of your software. Do not use spaces or commas to separate the codes. Or Enter "Yes" in the Insurance Denied Field on the Internet claims screen.
 - Send the claim to EDS.

- Claim will pay Medicaid Allowable.

Helpful Hints for Running Claims

- Make certain you have the prescriber's correct Prescriber Number and not the NABP number on each pharmacy claim.
- Prescriber Numbers can now be found on the OHCA Secured Website at www.ohca.state.ok.us. This site requires a log on ID and is password protected. OHCA Customer Service can assist those needing passwords.
- The Medicaid system does not have a "dummy" prescriber number (i.e. 1111111 or 5555555) that will allow a claim to run without using the correct physician prescriber number.

Medicaid Pharmacy Help Desk Contact Numbers

Pharmacies Call

State Wide (Toll Free) 1-800-831-8921
 OKC Metro 271-6349

Physicians Call

State Wide (Toll Free) 1-877-269-2728
 OKC Metro 271-9048

Email address: mcau@ouhsc.edu

OHCA Website
www.ohca.state.ok.us

University of Oklahoma College of Pharmacy
 Pharmacy Management Consultants
 ORI-W4403
 PO Box 26901
 Oklahoma City, OK 73190

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