Mountain Pacific DUR PROGRAM NEWS

FALL 2023

Montana Healthcare Pharmacy Programs Link
(Current Montana Healthcare Programs Preferred Drug List, Provider Notices, DUR Board/Meeting Information, Resources)
http://medicaidprovider.mt.gov/19

For current drug prior authorization criteria:
https://www.mpqhf.org/corporate/montanans-with-medicaid/pharmacy/

The Drug Utilization Review (DUR) Program, administered by Mountain Pacific through a contract with the Allied Health Services Bureau of the Montana Department of Public Health and Human Services, is the quality assurance body seeking to assure the quality of pharmaceutical care and to help provide rational, cost-effective medication therapy for Montana Healthcare Programs members.

Montana Healthcare Programs
Drug Prior Authorization Unit
1-800-395-7961

Drug Shortages: An Ongoing Problem

"Drug shortages continue to inflict widespread harm to patients who may not receive appropriate care in every circumstance," said Jesse Ehrenfeld, MD, President of the American Medical Association (AMA) on the association's website as he encouraged member physicians to join together to improve the current plight facing providers as they attempt to navigate the current drug shortage crisis.[1] The AMA is not the only group looking for some solutions to a very complex problem. The Drug Shortage Prevention Act of 2023, a bipartisan bill, passed the Senate in August with the support of the AMA and the American Hospital Association.

According to the University of Utah Drug Information Service, at the end of the second quarter of 2023 drug shortages had hit a 10 year high of 309. Further complicating the issue is the problem with which medications are in short supply. Many in high demand are in short supply or not currently available, according to the U.S. Food and Drug Administration (FDA) Drug Shortage Database. These include antibiotics, chemotherapy agents, injectable corticosteroids, benzodiazepines, stimulants and opioids. The FDA Drug Shortage database "focuses on shortages that have the greatest impact on public health. Shortages that are expected to be resolved quickly or which involve only a particular strength or package size, which has a substitute strength(s) and package size(s), are not usually the focus of the Drug Shortage web page."

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Drug Shortages: An Ongoing Problem (continued)

What is causing the short supply of many medications? There are differing opinions on this, but most will agree the supply chain of raw materials and generic drugs has been a major factor impacting suppliers, manufacturers, wholesalers and purchasing organizations. Also called out are manufacturing quality issues, the decrease of domestic production and quotas placed by the Drug Enforcement Administration (DEA). Every year, the DEA administrator determines, in advance, the total quantity to be manufactured of each basic class of controlled substances listed in Schedule I or II necessary for all estimated medical, scientific, research and industrial needs in the U.S., including lawful exports and reserve stocks. This unfortunately does not accommodate unexpected demand, as what happened with opioids during COVID-19 or is currently happening with attention-deficit/hyperactivity disorder (ADHD) medications.

If a critical medication is unavailable, it can be very difficult to navigate. Additional stress is placed all the way up the chain to the manufacturer and down the chain to the prescriber and patient. The unavailability increases the cost to facilities and patients. Providers and pharmacists are required to develop alternative treatment plans, and patients may need to be educated on the change. While we cannot point the finger in one direction for the cause of the problem, we are all aware that a solution must be found.

Additional information:

- American Medical Association. *Reforms needed to alleviate persistent drug shortages*. https://www.ama-assn.org/about/leadership/reforms-needed-alleviate-persistent-drug-shortages
- American Society of Health System Pharmacists® (ASHP). *Drug Shortage Statistics*. https://www.ashp.org/drug-shortages/shortage-resources/drug-shortages-statistics
- U.S. Food & Drug Administration (FDA). *Drug Shortages*. https://www.fda.gov/drugs/drug-safety-and-availability/drug-shortages
- American Hospital Administration. *AHA Responds to Request for Information on Drug Shortages*.
- Code of Federal Regulations. *Title 21/Chapter II/Part 1303/Aggregate Production and Procurement Quotas*. https://www.ecfr.gov/current/title-21/chapter-II/part-1303/subject-group-ECFR2b8c25396f0c33e/section-1303.11

Using Direct-acting Oral Anticoagulants

The Clinical Background

Direct-acting oral anticoagulants (DOACs) (e.g., Eliquis® [apixaban], Pradaxa® [dabigatran], Savaysa® [edoxaban], Xarelto® [rivaroxaban]) are lifesaving medications used for various conditions, including non-valvular atrial fibrillation and venous thromboembolism (VTE). VTE includes deep vein thrombosis (DVT) or pulmonary embolism (PE).

The duration and dosage for VTE treatment are dependent on the condition for which the DOAC is being used and are also dependent on individual patient risk factors, including whether the DVT/PE was provoked or unprovoked.[1-5] Unprovoked is a clot that occurs without identifiable risk factors.[5] A provoked clot is a clot caused by a known event or risk factors.[5]

Phases of VTE Treatment

- Initial treatment phase (5–21 days): The initial provision of anticoagulants following VTE diagnosis.[1]
- Treatment phase (three months): The period after initiation that completes treatment for the acute VTE event.[1]
- Extended treatment phase (longer than three months with no planned stop date): The period of anticoagulant use at full or reduced dose for the goal of secondary prevention. Patients selected to receive extended phase therapy, with apixaban or rivaroxaban, may be considered for a reduced dose, depending on individual patient risk factors.[1]

The 2021 American College of Chest Physicians (CHEST) Guideline Update

- **VTE provoked by a major transient risk factor** (present within three months of VTE diagnosis). Examples include being confined to bed for at least three days in a hospital, major trauma, cesarean section and recent surgery with general anesthesia for more than 30 minutes. **Extended treatment phase is not recommended**.[1]
- **VTE provoked by a minor transient risk factor** (present within two months before VTE diagnosis). Examples include prolonged car or air travel, leg injury with decreased mobility for at least three days, surgery with anesthesia for less than 30 minutes, admission to hospital for less than three days with an acute illness and estrogen therapy. Extended treatment phase is not recommended.[1]
- **VTE provoked by a persistent (irreversible) risk factor or unprovoked DVT. Extended phase anticoagulation with a DOAC is recommended**.[1]

For the most up-to-date information and updates to the CHEST guidelines, please visit https://journal.chestnet.org/ and search for "antithrombotic therapy for VTE disease."

Risks and Concerns

The 2021 CHEST guideline update recommends assessing the benefits versus risks of using extended anticoagulation medication after the treatment phase of three months. A decision should be made by

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weighing the benefits of extended phase anticoagulation versus the risks of bleeding after looking at patient risk factors for recurring VTE.[1]

- Factors associated with increased bleeding risk include concurrent aspirin use, dual antiplatelet therapy (DAPT), increased fall risk, chronic kidney disease, liver disease, active peptic ulcer disease, thrombocytopenia, alcohol abuse, previous stroke, hypertension, history of a bleed within the past three months, active cancer and rheumatologic disease.[5-7]
- Health issues that can affect the kinetics of certain DOACs include a history of gastric bypass surgery, renal impairment and hepatic impairment concerns.[9-12]
- Ensuring the patient is adherent to the DOAC medication regimen is important due to the short elimination half-lives of the DOACs and their mechanism of action, which differs from warfarin.[8-12]

Practice Implication

Guidelines recommend assessing benefits versus risks of extended anticoagulation after the treatment phase of three months. A decision to continue extended phase anticoagulation therapy should be balanced by evaluating the risk of recurrent VTE versus bleeding.

[1] Stevens S.M., Woller S.C., Kreuziger L.B., Bounameaux H., Doerschug K., Geersing G.J., Huisman M.V., Kearon C., King C.S., Knighton A.J., Lake E., Murin S., Vintch J.R.E., Wells P.S., Moores L.K. Antithrombotic Therapy for VTE Disease: Second Update of the CHEST Guideline and Expert Panel Report. Chest. 2021 Dec;160(6):e545-e608. doi: 10.1016/j.chest.2021.07.055.

[2] Kearon C., Akl E.A., Ornelas J., Blaivas A., Jimenez D., Bounameaux H., Huisman M., King C.S., Morris T.A., Sood N., Stevens S.M., Vintch J.R.E, Wells P., Woller S.C., Moores L. Antithrombotic Therapy for VTE Disease: CHEST Guideline and Expert Panel Report. Chest. 2016 Feb;149(2):315-352. doi: 10.1016/j.chest.2015

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[4] Kearon C., Ageno W., Cannegieter S.C., et al. Categorization of patients as having provoked or unprovoked venous thromboembolism: guidance from the SSC of ISTH. J Thromb Haemost. 2016; 14: 1480-1483

[5] Lip, G.Y., Hull, R.D. Overview of the treatment of proximal and distal lower extremity deep vein thrombosis (DVT). In: UpToDate, post, TW (Ed), UpToDate, Waltham, MA, 2023.

[6] Lip, G.Y. Implications of the CHA2DS2-VASc and HAS-BLED Scores for thromboprophylaxis in atrial fibrillation. Am J Med 2011; 124:111.

[7] Decousus, H., Tapson, V.F., Bergmann, J.F., et al. Factors at admission associated with bleeding risk in medical patients: findings from the IMPROVE investigators. Chest 2011; 139:69.

[8] Lexicomp. (n.d.). Warfarin: Drug information. UpToDate. Retrieved May 5, 2023, from https://www.uptodate.com/contents/warfarin-drug-information.

[9] Lexicomp. (n.d.). Apixaban: Drug information. UpToDate. Retrieved May 5, 2023, from https://www.uptodate.com/contents/apixaban-drug-information.

[10] Lexicomp. (n.d.). Dabigatran: Drug information. UpToDate. Retrieved May 5, 2023, from https://www.uptodate.com/contents/dabigatran-drug-information.

[11] Lexicomp. (n.d.). Edoxaban: Drug information. UpToDate. Retrieved May 5, 2023, from https://www.uptodate.com/contents/edoxaban-drug-information.

[12] Lexicomp. (n.d.). Rivaroxaban: Drug information. UpToDate. Retrieved May 5, 2023, from https://www.uptodate.com/contents/rivaroxaban-drug-information.

Morphine Milligram Equivalent Change

On November 4, 2022, the Centers for Disease Control and Prevention (CDC) updated practice guidelines for prescribing opioids for pain. With this update, the CDC replaced the 2016 morphine milligram equivalent (MME) conversion table with an updated version. The primary changes affect the conversion factors for hydromorphone, methadone and tramadol. Based on this update, Montana Medicaid's drug database vendor has updated the MME conversion factor, effective in September of 2023.

MME Doses for Commonly Prescribed Opioids for Pain Management
2022 CDC Guideline Tool

Opioid	Conversion Factor
Codeine	0.15
Fentanyl transdermal (mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	5
Methadone	4.7
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol	0.4
Tramadol	0.2

CDC Clinical Practice Guideline for Prescribing Opioids–United States, 2022, p.203, CDC-2022-0024-0002_content.pdf (squarespace.com)

Update MME conversion factors:
Hydromorphone = 5 (previously 4), methadone = 4.7 (previously a sliding scale of 4 to 12 based on dose) and tramadol = 0.2 (previously 0.1)

Calculating MMEs
2016 CDC Guideline Tool

Opioid	Conversion Factor
Codeine	0.15
Fentanyl transdermal (mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20mg/day 21-40mg/day 41-60mg/day ≥61-80mg/day	4 8 10 12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tramadol	0.1

Opioid Oral Morphine Milligram Equivalent (MME) Conversion Factors; https://www.hhs.gov/guidance/document/opioid-oral-morphine-milligram-equivalent-mme-conversion-factors-0

Because of this update, this will result in patient's medication to deny as their dose(s) exceeds the allowed 90MME per day limitation. If the prescriber's intent is to keep their patient on the current high dose, they will be able to complete a High-Dose Opioid Therapy Provider Attestation Form and fax back for authorization. If the intent is to decrease the dose based on the new practice guidelines, please contact the Drug Prior Authorization Department directly at 1-800-395-7961, so a plan can be discussed. We apologize for the short notice and any frustration this may cause, as we were only recently notified that the database was changing the conversion factors to match the updated guidelines. Please contact us at 1-800-395-7961 with any questions or concerns regarding this update.

Prior Authorization Corner

Prior authorization (PA) criteria updates are available at https://www.mpqhf.org/corporate/montanans-with-medicaid/pharmacy/.

In 2023, the Physician-Administered Drugs (PAD) program has had the following updates:

- Ocrevus® specific PA requirement has been removed.
- Tzield®, a new agent to delay the transition to type I diabetes, has had criteria added.
- Evkeeza® has a change of indication for age.
- Leqembi® is a new Alzheimer's drug that now has criteria for approval, and Aduhelm® has updated criteria.
- Nucala® criteria has been updated with new indications.

Updates to Pharmacy Drug Prior Authorization so far in 2023:

- Criteria updates have been made due to new indication or guideline changes for Doptelet®, Nucala®, Xeljanz®, Kevzara®, Diacomit®, Lucemyra® and medications for Hereditary Angioedema (HAE).
- Lumyrz® now has prior authorization criteria.
- Entresto® prior authorization criteria have been removed.
- The topical calcineurin inhibitor criteria are being removed, and it will be managed by the preferred drug list (PDL) on a preferred or non-preferred basis.

Montana Medicaid Top Drugs for 2022

Rank	RX Count	Drug Generic Name	Percent
1	83,024	ALBUTEROL SULFATE	2.83
2	73,656	GABAPENTIN	2.51
3	57,875	OMEPRAZOLE	1.97
4	54,107	SERTRALINE HCL	1.85
5	53,881	BUPROPION HCL	1.84
6	51,884	DEXTROAMPHETAMINE/AMPHETAMINE	1.77
7	51,263	BUPRENORPHINE HCL/NALOXONE HCL	1.75
8	49,386	FLUOXETINE HCL	1.69
9	48,615	LEVOTHYROXINE SODIUM	1.66
10	47,127	HYDROCODONE/ACETAMINOPHEN	1.61

Rank	RX Count	Drug Generic Name	Percent
11	44,959	LISINOPRIL	1.53
12	41,615	ESCITALOPRAM OXALATE	1.42
13	38,607	TRAZODONE HCL	1.32
14	38,031	ATORVASTATIN CALCIUM	1.30
15	37,097	METFORMIN HCL	1.27
16	34,989	METHYLPHENIDATE HCL	1.19
17	34,286	LAMOTRIGINE	1.17
18	34,142	CLONIDINE HCL	1.17
19	33,986	AMOXICILLIN	1.16
20	33,881	DULOXETINE HCL	1.16