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OTC PAYABLES

Due to Federal statutes, OTC medications are only payable if the manufacturer participates with rebate agreements. Many manufacturers of OTC products will not be payable because they are NOT participating manufacturers. The OTC manufacturers list is posted at www.iowamedicaidpdl.com or please call the IME POS (Iowa Medicaid Point of Service) helpdesk at 1-877-463-7671 or 515-725-1107 (local calls)

**Hours of Operation PHARMACY POS HELP DESK
8:00AM – 6:00PM (after-hours on-call available)**

DUAL ELIGIBLES AND MEDICARE PART D

Dual eligibles are patient beneficiaries who qualify for full Medicaid and Medicare benefits. Effective January 1, 2006, dual eligibles will receive medication benefits through Medicare Part D. Once the PDPs (prescription drug plans) are announced in mid-October, Center for Medicare and Medicaid Services (CMS) will automatically enroll all dual eligibles, on a random basis, into a PDP plan with a premium at or below the low-income subsidy amount in their region. Medicare will notify current dual eligible beneficiaries of the upcoming transition in coverage and the specific prescription drug plan in which they will be automatically enrolled.

Dual eligible beneficiaries may select a different prescription drug plan during the open enrollment between November 15, 2005 and December 31, 2005. Once the PDPs are announced, each plan's formulary will be available so dual eligibles can determine if their auto-assigned PDP will cover their current medications. If members choose a more extensive plan with higher premiums, the member will be responsible for the increased cost. Those patients who do not select a different plan will be automatically enrolled in the previously assigned prescription drug plan. After January 1, 2006 dual eligibles will be able to change plans if desired on up to a monthly basis.

Dual eligible beneficiaries will not pay an annual premium or deductible unless they enroll in a more extensive coverage plan. Dual eligibles will pay a \$1 - \$3 copay for medication costs up to \$5,100. There will be no copays for medications after \$5,100. Catastrophic coverage for medication costs over \$5,100 will be 100% covered. The \$2,850 donut hole gap in coverage will not apply to dual eligibles.

The final Part D regulation does not provide "grandfathering" of medications. So, if a medication is not covered by the plan, there is no guarantee the plan will authorize payment even if they are currently stabilized on the therapy. PDP plans can change their formularies at anytime, but are required to provide beneficiaries 60 days notice of any formulary changes. Just because a medication is on the formulary does not mean the plan is required to provide unrestricted access to it. The plan may require prior authorization or a step therapy trial before the medication is available to patients.

Medications or classes are currently being excluded under Medicare Part D include: (1) agents used for anorexia, weight loss, or weight gain; (2) agents used to promote fertility; (3) agents used for cosmetic purposes or hair growth; (4) agents used for the symptomatic relief of cough and colds; (5) prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; (6) nonprescription drugs; (7) outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale; (8) barbiturates; and (9) benzodiazepines. These classes of drugs may be covered by the state Medicaid programs. The definition of a Part D drug also excludes any drug for which payment would be available under Parts A or B of Medicare for that individual.

For additional information on the Medicare prescription drug benefit visit: www.cms.hhs.gov/medicarereform

TREATMENT GUIDELINES FOR CHF

The American College of Cardiology and the American Heart Association first published guidelines for the evaluation and management of HF in 1995. The groups revisited these and approved the following updated guidelines in 2001 to reflect current standards for both pharmacological and nonpharmacological approaches to treatment of CHF¹. ACC & AHA designed the guidelines to emphasize both the evolution and progression of the disease and in doing so defined 4 stages of HF¹. ACC & AHA designed the classification system to complement the New York Heart Association (NYHA) functional classification system. Their approach assumes patients would only be expected to advance from one stage to the next, unless progression of the disease was slowed or stopped by treatment.¹ The stages are described by ACC & AHA as:¹

- **Stage A** identifies the patient who is at high risk for developing HF but has no structural disorder of the heart
- **Stage B** refers to a patient with a structural disorder of the heart but who has never developed symptoms of HF
- **Stage C** denotes the patient with past or current symptoms of HF associated with underlying structural heart disease
- **Stage D** designates the patient with end-stage disease who requires specialized treatment strategies such as mechanical circulatory support, continuous inotropic infusions, cardiac transplantation, or hospice care.¹

Table 1- Treatment Guidelines for CHF¹

Stage of CHF	Recommended Therapy
Stage A	<ul style="list-style-type: none"> • Treat hypertension • Encourage smoking cessation • Treat lipid disorders • Encourage regular exercise • Discourage alcohol intake and illicit drug use • Treat thyroid disorders • ACE inhibitors in select patients <ul style="list-style-type: none"> - History of atherosclerotic vascular disease - Diabetes - Hypertension with associated cardiovascular risk factors
Stage B	<ul style="list-style-type: none"> • All measures under Stage A • ACE inhibitors in select patients <ul style="list-style-type: none"> -History of MI -Reduced ejection fraction -As outlined for Stage A patients • Beta-blockers in appropriate patients <ul style="list-style-type: none"> - History of MI - Reduced ejection fraction
Stage C	<ul style="list-style-type: none"> • All measures under Stages A and B • ACE inhibitors and beta-blockers in all patients unless contraindicated • Dietary salt restriction • Daily measurement of weight • Diuretics for fluid retention • Digitalis for treatment of CHF symptoms • Withdrawal of drugs known to adversely affect CHF patients • Spironolactone in appropriate patients
Stage D	<ul style="list-style-type: none"> • All measures under Stages A, B and C • Mechanical assist devices • Heart transplantation if eligible • Continuous IV inotropic infusions for palliation • Hospice Care

Table 2- Target Doses for ACE Inhibitors Used in CHF^{2,3,4,5}

Generic Name	Brand Name	Initial dose	Target maintenance dose	Maximum recommended dose
Benazepril ⁴ <i>not FDA approved for CHF</i>	Lotensin®	10 mg QD	40mg QD	80mg QD
Captopril ⁴	Capoten®	25mg TID	50mg TID	100mg QID
Enalapril ⁴	Vasotec®	5mg BID	10mg BID	20mg BID
Fosinopril ^{5,6}	Monopril®	10mg QD	40mg QD	40mg QD
Lisinopril ⁴	Prinivil®, Zestril®	10mg QD	20mg QD	40mg QD
Quinapril ⁴	Accupril®	10mg BID	20mg BID	40mg BID
Ramipril ⁴	Altace®	5mg QD	10mg QD	20mg QD
Trandolapril ^{2,3,6}	Mavik®	1mg QD	4 mg QD	4mg QD



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Table 3- Target Maintenance Doses for Beta-blockers used in CHF^{2,3}

Beta-blockers	Target Maintenance Dose for CHF
Bisoprolol (Zebeta®) not FDA approved for CHF	5 mg/day
Carvedilol (Coreg™)	Mild to moderate heart failure: <85 kg: 25 mg twice daily >85 kg: 50 mg twice daily Severe heart failure: 25 mg twice daily
Metoprolol (Lopressor®, Toprol XL™) regular release (Lopressor®) not FDA approved for CHF	Extended release: 200 mg once daily Regular release: 100-150 mg daily given in 2-3 divided doses

1. Hunt SA, Baker DW, Chin MH, et al. ACC/AHA guidelines for the evaluation and management of chronic heart failure in the adult: executive summary. *Circulation*. 2001; 104 (24):2996-3007.
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3. Lexi-Comp Online online.lexi.com Accessed 12-9-04.
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5. National Collaborating Centre for Chronic Conditions. Chronic heart failure. National clinical guideline for diagnosis and management in primary and secondary care. London: National Institute for Clinical Excellence (NICE); 2003. <http://www.nice.org.uk/page.aspx?o=89330> Accessed 8-9-5
6. Micromedex www.micrimedex.com Accessed 8/9/5.