MARYLAND PHARMACY PROGRAM

Medicaid - Pharmacy Assistance – Pharmacy Discount

No. 13
Tuesday, December 7, 2004

ADVISORY

*In an effort to give timely notice to the pharmacy community concerning important pharmacy topics, the Department of Health and Mental Hygiene's (DHMH) **Maryland Pharmacy Program** (MPP) has developed the **Maryland Pharmacy Program Advisory**. To expedite information timely to the pharmacy and prescriber communities, an email network has been established which incorporates the email lists of the Maryland Pharmacists Association, EPIC, CARE, Long Term Care Consultants, headquarters of all chain drugstores and prescriber associations and organizations. It is our hope that the information is disseminated to all interested parties. If you have not received this email through any of the previously noted parties or via DHMH, please contact the MPP representative at 410-767-5395.*

Dose Optimization: Quantity Limits for Atypical Antipsychotic Agents
Effective Date: December 14, 2004

One of the goals of the Maryland Pharmacy Program is to ensure that Medical Assistance recipients receive optimal drug therapy at the lowest reasonable cost.

The Program has evaluated the use of multiple daily doses of selected atypical antipsychotic agents for adults 18 years of age and older. These drugs are widely used and have a high cost. In many cases, the price of dosage units is not proportionate to the increase in strength (e.g. the price of two 5 mg tablets of a selected drug can substantially exceed the price of one 10 mg tablet).

In addition, some of these agents have a relatively long half-life and are indicated for once a day dosing which also increases compliance. Therefore, for a selected drug, one 10 mg tablet taken once a day is preferable to one 5 mg tablet taken twice a day.

In order to maximize the therapeutic benefits of these costly agents, the Program will be implementing the following maximum daily dosing limits for adults 18 years of age and older, effective December 14, 2004 **only for the strengths listed.**

DRUG NAME	STRENGTH	DOSES PER DAY	QUANTITY LIMITATIONS PER MONTH SUPPLY
Risperdal®	0.25mg; 0.5mg; 1mg; 2mg	2 tablets	68 tablets
Abilify®	5mg; 10mg; 15mg	1 tablet	34 tablets
Geodon®	20mg; 40mg	2 capsules	68 capsules
Zyprexa®	2.5mg; 5mg; 7.5mg	1 tablet	34 tablets
Zyprexa® Zydis®	5mg	1 tablet	34 tablets
Seroquel®	25mg	4 tablets	136 tablets

In an effort to educate prescribers, the Maryland Pharmacy Program has sent letters to selected prescribers to alert them of their patients who would be affected by the quantity limitations requirement. Prior authorization will be required to dispense atypical antipsychotic agents in excess of these limits. Prescribers should contact First Health Services Corporation for prior authorization at 800-932-3918 or fax the attached form "Atypical Antipsychotic Agent Maximum Quantity Override Request" to First Health Services Corporation at 800-932-3921.

Full consideration for the recipient continues to be a top priority. Recipients having problems obtaining prescribed medications from the pharmacy may call the Maryland Pharmacy Access Hotline at 1-800-492-5231. Questions concerning this Advisory should be directed to the Division of Pharmacy Services, 410-767-1455.

MARYLAND PHARMACY PROGRAM

Atypical Antipsychotic Agent

Maximum Quantity Override Request

Recipient Name: _____ **I** | | | | | | | | |

Medicaid ID #: | | | | | | | | | | | |

Maximum quantity override request for:

Drug Name _____ Strength_____ Quantity per day _____

Maximum Quantity Limits

Abilify® 5mg; 10mg; 15mg	1 tablet per day/ 34 tablets per 34 days
Geodon® 20mg; 40mg	2 capsules per day/ 68 capsules per 34 days
Risperdal® 0.25mg; 0.5mg; 1mg; 2mg	2 tablets per day/ 68 tablets per 34 days
Seroquel® 25mg	4 tablets per day/ 136 per 34 days
Zyprexa® 2.5mg; 5mg; 7.5mg	1 tablet per day/ 34 per 34 days
Zyprexa® Zydis® 5mg®	1 tablet per day/ 34 per 34 days

Justification for use of quantities greater than the limits noted above:

Diagnosis (Do not use ICD-9 codes)_____

Please check all that apply:

□ Yes □ No 1. Patient cannot tolerate recommended dose due to adverse effect of _____

_____

□ Yes □ No 2. Patient's dose is being tapered and will change within a few weeks

□ Yes □ No 3. Patient has failed recommended regiment and requires more frequent dosing to receive clinical benefits of drug

□ Yes □ No 4. Other reason, please specify _____

_____

I certify that use of high quantities of atypical antipsychotic for this patient is justified and medically necessary.

Prescriber Signature: _____ Date: | | | | | | | | |

Prescriber Name: _____ DEA#: | | | | | | | | | |

Address: _____

Phone#: | | | | | | | | | | Fax #: | | | | | | | | | |

Is prescriber a psychiatrist? Yes____ No____ If no, indicate area of practice (such as Internal Medicine, Family Practice). _____

FAX THIS FORM TO: 800-932-3921

For information on a Prior-Auth request, please call First Health Services at 800-932-3918