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## WHAT'S INSIDE!

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**The last Pharmacy and Therapeutics (P&T) Committee Meeting held by Idaho Medicaid was February 15, 2008. Recommendations from the meeting can be found on the Medicaid website at: [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov) Follow the Medical link to Prescription Drugs and then P&T Committee.**

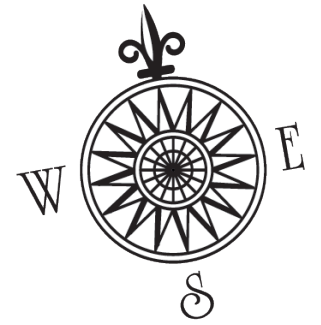
**The next P&T Meeting will be held on July 18, 2008, at Idaho Medicaid, 3232 Elder Street, Boise, ID 83705**

Table: ACEI, ARB, and Statin Drugs

ACEIs	ARBs	Statins
Benazepril (Lotensin) Captopril (Capoten) Enalapril (Vasotec) Fosinopril (Monopril) Lisinopril (Prinivil, Zestril) Moexipril (Univasc) Perindopril (Aceon) Quinapril (Accupril) Ramipril (Altace) Trandolapril (Mavik)	Candesartan (Atacand) Eprosartan (Tevetan) Irbesartan (Avapro) Losartan (Cozaar) Telmisartan (Mycardis) Valsartan (Diovan)	Atorvastatin (Lipitor) Fluvastatin (Lescol) Lovastatin (Mevacor) Pravastatin (Pravachol) Rosuvastatin (Crestor) Simvastatin (Zocor)

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# The DUR Discovery



Exploring ways to improve pharmacotherapy

## Navigating the Prior Authorization Process

By *Chris Owens, PharmD, BCPS*  
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The prior authorization (PA) process can be a frustrating and time consuming part of dealing with third-party payers, including Medicaid programs. While most will agree in principle with the need for assuring clinically appropriate and cost-effective drug therapy (which are reasons often cited for the PA process), the day-to-day headaches that seem to accompany its implementation are very real.

The purpose of this article is to familiarize providers and pharmacists with some of the tools that are available from Idaho Medicaid to navigate and facilitate the PA process. Such tools include the Medicaid pharmacy website which contains the regularly updated preferred drug list (PDL), telephone contact information which can assist in answering PA-related questions, and policies such as the emergency 72-hour rule, which can allow for providing small quantities of prescribed drugs for patients in critical situations.

The Department of Health and Welfare's website, available at [www.healthandwelfare.idaho.gov](http://www.healthandwelfare.idaho.gov), contains links to several pages that may be helpful to providers and pharmacists. A short cut to access prior authorization forms can be found at [www.medicaidpharmacy.idaho.gov](http://www.medicaidpharmacy.idaho.gov). Just scroll down to resources and click on prior authorization forms. The PA forms link contain a list of drug classes with links to printable forms which indicate preferred agents and outline any therapeutic and/or prior authorization criteria. On this page you will also see a link to the entire Preferred Drug List (PDL), which is a comprehensive listing of preferred agents and prior authorization criteria and is regularly updated.

It is important to note that some preferred drugs listed on the PDL also require that specific clinical criteria be met prior to dispensing. For example: even if a patient requiring a PPI is prescribed an agent from the preferred list (Prilosec OTC, Prevacid, or Nexium), there are additional

clinical criteria that must be met (i.e. a diagnosis of an approved indication such as GERD or PUD). If a diagnosis is on file and a preferred agent is requested, it will be approved.

A pharmacy call center is also available to answer questions and assist pharmacists and providers with the PA process. The call center can be reached by dialing 208-364-1829 or 866-827-9967 and may be accessed on weekdays during normal operating hours (8 AM to 5 PM) for specific PA-related questions. A helpful hint for pharmacists is that they may call the call center to expedite asthma and ADHD claims if they have the diagnosis code. In addition, if a PA is required for a change in dosage, a pharmacist can call the call center and get it approved without filling out additional paperwork for the same medication. The Medicaid Automated Voice Information Service (MAVIS) is available 24-hours a day and can be utilized to help determine maximum allowable dispense quantities for most drugs.

The 72-hour rule is a policy established to promote timely drug therapy for patients in emergency situations or for those whose therapy is otherwise time-sensitive. According to this policy, a 72-hour supply of virtually any medication (regardless of PA status) may be dispensed if deemed necessary in the clinical judgment of the provider or pharmacist. To utilize this rule, a patient must be Medicaid eligible on the date of service, the prescription must be new to the pharmacy, and the quantity may not exceed a 3-day supply. The following override codes will need to be inputted in the proper DUR conflict, intervention, and outcome fields: TP, MR, and 1F.

Although navigating the PA process can be difficult, it is hoped that these tools will be helpful to your daily practice as we all strive to deliver the best, most cost-effective patient care possible for Idaho Medicaid patients.

## Use of ACEIs, ARBs, and Statins in Childbearing Age Women

By Christine Lee, PharmD and Brooke Pugmire, PharmD, BCPS

Although undesirable, prescribing medications that may cause birth defects or result in neonatal complications may be necessary for the appropriate medical management of women of childbearing age. Some medical conditions (e.g. bipolar disorder and epilepsy) offer little choice of drug therapy because the medications used in their management are often associated with risks to the developing fetus, but others (e.g. hypertension and hyperlipidemia) offer clinicians more flexibility in drug selection.

Angiotensin converting enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs), and HMG-CoA reductase inhibitors (statins) are medications primarily used to treat patients with a variety of chronic cardiovascular or renal conditions (table page 4). Their use has increased tremendously over the past several years, in part due to the increasing prevalence of these chronic diseases but also as a result of recent evidence-based clinical guidelines strongly encouraging their use in appropriate patients.<sup>1-3</sup> **Use of ACEIs, ARBs, and statins in childbearing age women in Idaho has increased 3-fold in the last decade.**

Although these drugs have important benefits for certain patient populations, they also have been associated with fetal harm. Statins are FDA pregnancy category X and are contraindicated in women who are or may become pregnant. Teratogenic effects of statins include limb abnormalities, visceral malformations, and

central nervous system (CNS) defects. ACEIs and ARBs are category D in the second and third trimesters, and a recent report suggests increased risk in the first trimester as well.<sup>4</sup> ACEIs and ARBs are associated with fetal cardiovascular and CNS defects, as well as Potter's Syndrome if taken during pregnancy. **ACEIs, ARBs, and statins should always be avoided during pregnancy.**

Because more women of childbearing age are being affected by conditions that may require treatment with drugs associated with fetal risk, increased awareness on the part of clinicians is important. **Pharmacologic contraception should be discussed, provided, and documented in women prescribed ACEIs, ARBs, and statins; and agents from these classes should be avoided in women for whom contraception is not desired or feasible.**

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## Treatment of Depression in Pregnancy

By Rebecca Holt, PharmD and Brooke Pugmire, PharmD, BCPS

The lifetime risk for depression in women ranges from 10-25% with the highest prevalence during the childbearing years.<sup>1</sup> Although drug therapy is a mainstay of treatment for depression, pharmacologic treatment beginning in or continuing through pregnancy is controversial. Uncontrolled depression during pregnancy has been associated with significant risks, including substance abuse, poor prenatal care, postpartum depression, and suicide attempts; however, available data indicate a potential for increased risk of rare fetal malformations and neonatal adverse effects with antidepressant use in pregnancy.<sup>2-4</sup>

According to the American College of Obstetrics and Gynecology (ACOG), antidepressant treatment should be individualized, with attention given to factors such as mother's severity of symptoms, past responsiveness to treatments, concern for postpartum symptoms, and the possibility of breast feeding.<sup>3</sup> **Women with a history of severe, recurrent depression, who are being successfully treated with an antidepressant and become pregnant, should continue treatment throughout pregnancy.**<sup>5</sup> Women with milder depression, who are being effectively treated with an antidepressant and become pregnant, should be made aware of the risks associated with recurrent depression and postpartum depression if contemplating discontinuing therapy.<sup>5</sup>

To date, the FDA has not approved specific antidepressant therapy for use in pregnancy; most are pregnancy category C. SSRIs are generally recommended first-line for

moderate-to-severe depression in treatment-naïve pregnant women.<sup>3,5</sup> **While fluoxetine (Prozac) and sertraline (Zoloft) have been studied most during pregnancy, the ACOG recommends that antidepressant treatment be individualized. However, paroxetine (Paxil) should be avoided due to increased risk of congenital cardiac malformations.**<sup>3</sup> Bupropion (Wellbutrin) may be considered as an alternative to SSRIs, especially for patients who have responded to it in the past and/or for patients unable to stop smoking. Although less commonly employed due to adverse effects, tricyclic antidepressants (TCAs) are also a viable option, as they have not been shown to cause harm in pregnancy.<sup>2</sup>

Regardless of medication choice, monitoring depression symptoms is critical during pregnancy as studies have shown that many women with major depressive disorder may be sub-optimally treated. It is common for depression symptoms to increase in the second or third trimester, and increased doses of antidepressant medications may be necessary.<sup>1</sup>

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