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THE PRESCRIBER e-LETTER

MassHealth PHARMACY PROGRAM

Getting Ready for RSV Season

The recommended palivizumab **(Synagis) dosing regimen** is 15 mg/kg body weight, given once a month during the respiratory syncytial virus (RSV) season. The MassHealth Drug Utilization Review Program calculates the amount of drug needed for the season at the time of the initial approval for the medication. If the child's growth is significant, the provider will need to submit documentation of the new weight so that the total number of approved vials may be reviewed for appropriateness.

In Massachusetts, **five monthly doses** will typically provide protection for infants and children when the risk of RSV hospitalization is greatest. Generally, use is confined to the RSV season (**October 29, 2007, to March 31, 2008**). MassHealth DUR monitors RSV activity in the state and considers extra doses on a case-by-case basis secondary to reports of increased RSV activity.

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The American Academy of Pediatrics Recommend RSV Prophylaxis in the Following Situations:

- Bronchopulmonary dysplasia (BPD) or chronic lung disease (CLD) (excluding asthma or reactive airway disease): Age < 24 months at start of RSV season ***plus*** required medication or oxygen supplementation for CLD or BPD within last 6 months
- Congenital heart disease (CHD): Age ≤24 months at the start of RSV season ***plus*** hemodynamically significant CHD
- Gestational age < 28 weeks and current age < 12 months at the start of RSV season
- Gestational age = 29-32 weeks and current age < six months at the start of RSV season.
- Gestational age = 32-35 weeks and current age < six months at the start of RSV season ***plus*** ≥ two risk factors (daycare attendance, school-aged siblings, exposure to environmental air pollutants, congenital airway abnormalities, and/or severe neuromuscular disease)

Methods to Decrease Risk of RSV Infection

- **Avoid passive smoking** due to effects on respiratory health
- **Encourage breastfeeding** due to increased immunity
- **Hand sanitation** to prevent nosocomial spread

What's New with the Flu

Due to widespread **resistance**, amantadine and rimantadine are **no longer recommended** for the treatment or chemo-prophylaxis of influenza A in the United States; instead, neuraminidase inhibitors should be considered.

PA is required for all **neuraminidase inhibitor** requests from **June 1 to September 30. However, from October 1 to May 1 of each year, PA is only** required when quantity limits are exceeded:

- oseltamivir 30 mg capsules > 20 units/month or 40 units/season
- oseltamivir 45 mg or 75 mg capsules >10 units/month or 20 units/season
- oseltamivir suspension > 75 ml/month or 150 ml/season
- zanamivir > 20 inhalations/month or 40 inhalations/season

PA is required for the live, attenuated influenza vaccine (LAIV) **Flumist**. It is now FDA-approved for children as young as **two years old**.

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Selected Updates from the 2007-2008 Influenza Prevention & Control Recommendations:

- Children **six months** to eight years of age should initially receive two doses of trivalent inactivated influenza vaccine (TIV) administered ≥ one month apart
- As an alternative to TIV, LAIV may be administered to children **two** to eight years of age with two doses administered ≥ six weeks apart
- Children receiving only one dose of the influenza vaccine in their first year of vaccination should receive **two doses** in just the immediately following year
- In addition to the A/Wisconsin/67/2005-like (H3N2) and B/Malaysia/2506/2004-like viruses, **A/Solomon Islands/3/2006 (H1N1)** is a new viral strain in the TIV for 2007-2008

The Prescriber e-Letter is an update designed to enhance the transparency and efficiency of the MassHealth drug prior-authorization (PA) process and the MassHealth Drug List. Each issue will **highlight** key clinical **information and updates** to the **MassHealth Drug List**. The Prescriber E-Letter was prepared by the MassHealth Drug Utilization Review Program and the MassHealth Pharmacy Program.

Drug/Drug Class	Addition/Deletion/Change	Rationale for PA Requirement
Antipsychotics	Addition of quantity limits (excluding clozapine); requires PA	There is limited data to support the dosing of atypical antipsychotics at dosing intervals greater than those indicated by the FDA. Therefore, requests for atypical antipsychotics exceeding quantity limits based on FDA-approved dosages will require PA and dosages should be consolidated where appropriate. Strong evidence shows that multiple daily dosing and complex regimens decrease medication adherence.
Brand antibiotics	Addition of doxycycline monohydrate (Monodox) 75 mg capsule; requires PA	Generic doxycycline capsules (i.e., 50 mg, 100 mg) are less-costly alternatives to the branded doxycycline 75 mg capsules. The new strength is not associated with a unique indication.
Protein C concentrate	Addition of Protein C concentrate (Ceprotin); requires PA	Therapy with protein C concentrate is costly. Patients with protein C deficiency requiring life-long anticoagulation may be treated with low-molecular-weight heparin or warfarin.
Cerebral stimulants	Addition of lisdexamfetamine (Vyvanse); requires PA	There is a lack of strong clinical data supporting the place in therapy of lisdexamfetamine. Other long-acting cerebral stimulants (i.e., amphetamines, methylphenidate, dexmethylphenidate) are less-costly and their roles in the treatment of ADHD are better established.
Intranasal corticosteroids	Addition of fluticasone furoate (Veramyst) spray; requires PA	There is no data to support increased therapeutic efficacy of fluticasone furoate over the less-costly generic fluticasone proprionate for allergic rhinitis.
Long-acting beta-2-agonists (LABA)	Addition of budesonide/formoterol (Symbicort) inhaler; requires PA	Due to increased risks of asthma-related deaths, LABAs are not recommended for first-line therapy. Rationale for use of the combination product budesonide/formoterol is required for approval.
Neuraminidase inhibitors	Addition of oseltamivir (Tamiflu) 30 mg and 45 mg capsules; seasonal and quantity restrictions for oseltamivir and zanamivir	Rationale is needed for prescriptions exceeding quantity limits during flu season and for any quantity outside of the flu season. Oseltamivir 45 mg and 75 mg quantity limits will be 10 units /month or 20 units/season. The 30 mg capsule will have quantity limits of 20 units/month or 40 units/season to accommodate dosing for members weighing between 23 and 40 kg.
Ocular anti-allergy agents	Addition of generic OTC ketotifen (Alaway) 0.025% ophthalmic solution; no PA required Change in the reference drug from Zaditor OTC to Alaway	Generic OTC ketotifen (i.e., Alaway) is more cost-effective than branded OTC (i.e., Zaditor OTC) or prescription (i.e., Zaditor) ketotifen. Along with Alaway, other OTC combination antihistamines and vasodilators do not require PA.
Topical antibacterials	Addition of retapamulin (Altabax) 1% ointment; requires PA	Generic mupirocin is more cost-effective than retapamulin for treating impetigo.
Urea-containing products	Addition of urea (Kerol) 50% suspension; requires PA	There is limited data on comparative efficacy between urea products. Kerol suspension costs more than other available urea formulations.

Please send any **suggestions** or **comments** to: PrescriberELetter@state.ma.us