When different strengths of agents are parity priced by manufacturers, that is the per unit cost is the same regardless of the strength, tablet splitting can be a means of reducing program costs while not limiting access. The Mississippi Division of Medicaid (MDOM) identified aripiprazole as a good candidate for a tablet splitting policy. The MDOM consulted with psychiatrists to assess the feasibility and to identify potential difficulties with a tablet splitting policy for aripiprazole. Potential issues identified that made programming for electronic prior authorization (EPA) difficult included labeling indicates QD dosing but BID dosing is sometimes used for tolerability reasons, and the daily dose computed from quantity dispensed and days supply on claims does not always result in a reasonable daily dose. MDOM implemented the aripiprazole tablet splitting criteria through EPA at the end of February 2013.

The goal of a tablet splitting criteria is to reduce total program costs without restricting beneficiary access to treatment options. The research objectives were to evaluate the impact of a tablet splitting policy for aripiprazole on access to care and pharmacy costs.

A retrospective analysis was conducted of the MDOM prescription claims for February 2013 – April 2014. All aripiprazole prescriptions were extracted and daily consumption (DACON) was computed by dividing the number of tablets dispensed by the days supply. Tablet splitting rates and the number of beneficiaries taking aripiprazole were computed for each month. Saving were computed based on the average cost of goods paid for each tablet strength and the number of tablets that would have been dispensed without tablet splitting for the period January – June 2014.

Feedback from practitioners has indicated little, if any, problems with the tablet splitting criteria. As noted in the Provider Summary Sheet, MDOM added coverage for a tablet splitter each year. As shown in Figure 1, dispensing of Abilify® with a daily dosing of 0.5 tablets/day significantly increased after implementation. Due to grandfathering of patients on stable doses, the percentage of Abilify® prescriptions that could be shifted to daily doses of 0.5 tablets/day did not peak for each strength for 6-9 months. During the first six months of 2014, 65% of prescriptions were for split dosing. This ranged from 7% for 2mg tablets to 83% for 10mg tablets. The percentages are not ever expected to be 100% due to manual PAs being approved for BID dosing and whole tablet dosing when special patient needs exist.

A base-line of rate of dispensing at 0.5 tabs/day or each strength was derived as the average during the 6 months prior to policy implementation. The average for the first 6 months in 2014 was used as an estimate of what will be achieved from this criteria. The increase in dispensing at 0.5 tabs/day for each strength was then used to estimate the savings in the amount reimbursed to pharmacies for Abilify®. During the first half of 2014, this policy resulted in a reduction of $253,995 paid for Abilify® per month. This was a reduction of $265.13 per bene on Abilify® per month.

When medications are not priced on a linear per milligram basis, tablet splitting can result in significant savings without reducing access to needed doses.

CONCLUSIONS

The work reported was conducted by the MS-DUR program in the Center for Pharmaceutical Marketing and Management as part of the retrospective drug use analysis activities conducted under contract with the Mississippi Division of Medicaid. The views expressed are those of the authors and do not necessarily reflect those of Mississippi Division of Medicaid or the University of Mississippi.

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