Savings from Implementing a Tablet Splitting Criteria for Aripiprazole in a State Medicaid Program

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BACKGROUND

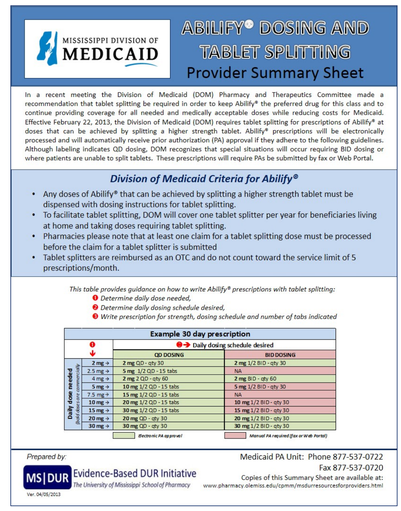
When different strengths of agents are parity priced by manufacturers, that is the per unit cost is the same regardless of the strength, tablet splitting can be a means of reducing program costs while not limiting access. The Mississippi Division of Medicaid (MDOM) identified aripiprazole as a good candidate 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.

OBJECTIVES AND PURPOSE

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.

METHODS

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.



MISSISSIPPI DIVISION OF MEDICAID

ABILIFY® DOSING AND TABLET SPLITTING
Provider Summary Sheet

In a recent meeting the Division of Medicaid (DOM) Pharmacy and Therapeutics Committee made a recommendation that tablet splitting be required in order to keep Abilify® the preferred drug for this class and to continue providing coverage for all needed and medically acceptable doses while reducing costs for Medicaid. Effective February 22, 2013, the Division of Medicaid (DOM) requires tablet splitting for prescriptions of Abilify® at doses that can be achieved by splitting a higher strength tablet. Abilify® prescriptions will be electronically processed and will automatically receive prior authorization (PA) approval if they adhere to the following guidelines. Although labeling indicates QD dosing, DOM recognizes that special situations will occur requiring BID dosing or where patients are unable to split tablets. These prescriptions will require PAs be submitted by fax or Web Portal.

Division of Medicaid Criteria for Abilify®

- Any doses of Abilify® that can be achieved by splitting a higher strength tablet must be dispensed with dosing instructions for tablet splitting.
- To facilitate tablet splitting, DOM will cover one tablet splitter per year for beneficiaries living at home and taking doses requiring tablet splitting.
- Pharmacies please note that at least one claim for a tablet splitting dose must be processed before the claim for a tablet splitter is submitted
- Tablet splitters are reimbursed as an OTC and do not count toward the service limit of 5 prescriptions/month.

This table provides guidance on how to write Abilify® prescriptions with tablet splitting:
Determine daily dose needed,
Determine daily dosing schedule desired,
Write prescription for strength, dosing schedule and number of tabs indicated

Example 30 day prescription

Daily dose needed	QD DOSING	BID DOSING
2 mg →	2 mg QD - qty 30	2 mg 1/2 BID - qty 30
2.5 mg →	5 mg 1/2 QD - 15 tabs	NA
4 mg →	2 mg 2 QD - qty 60	2 mg BID - qty 60
5 mg →	10 mg 1/2 QD - 15 tabs	5 mg 1/2 BID - qty 30
7.5 mg →	15 mg 1/2 QD - 15 tabs	NA
10 mg →	20 mg 1/2 QD - 15 tabs	10 mg 1/2 BID - qty 30
15 mg →	30 mg 1/2 QD - 15 tabs	15 mg 1/2 BID - qty 30
20 mg →	20 mg QD - qty 30	20 mg 1/2 BID - qty 30
30 mg →	30 mg QD - qty 30	30 mg 1/2 BID - qty 30

Electronic PA approval | Manual PA required (fax or Web Portal)

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Ver. 04/08/2013

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Copies of this Summary Sheet are available at: www.pharmacy.olemiss.edu/cpmm/msdurresourcesforproviders.html

OUTCOMES

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.

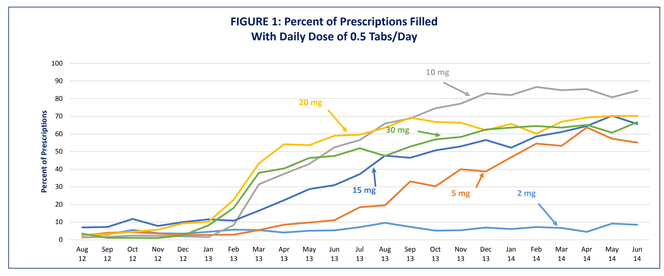
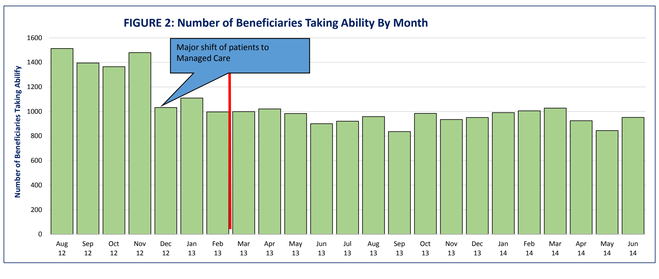


Figure 2 shows the number of beneficiaries filling prescriptions each month for Abilify®. The drop in December of 2012 was due to a major shift of beneficiaries into managed care. After implementation of tablet splitting, the number of beneficiaries on Abilify® has remained relatively stable. This indicates that the new clinical criteria did not reduce access to Abilify® as a treatment option.



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.

CONCLUSIONS

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

ACKNOWLEDMENTS/DISCLOSURES

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.