BACKGROUND

DOM’s Drug Utilization Review (DUR Board) recommended several quality improvement initiatives addressing the use of antipsychotic medications in children. During the past year, the Centers for Medicare and Medicaid (CMS) added a quality measure addressing the use of multiple antipsychotic (AP) medications in children to the Core Set of measures used to evaluate quality of care in Medicaid programs. Effective October 1, 2016, DOM implemented a new prior authorization (PA) requirement for long-term treatment of children less than 18 years of age prescribed more than one antipsychotic medication.

MAILING

The HEDIS Multiple Antipsychotics in Children quality measure was computed the period July 1, 2015 – June 30, 2016 using all prescription claims data (FFS and CCOs). Although the current quality measure only covers children, a similar measure is being considered for adults. All beneficiaries (adult and children) meeting the quality measure criteria for multiple APs were detected and the prescribers associated with these prescriptions were identified. 140 different prescribers were identified. Each prescriber was mailed the attached letter and PA form.
September 9, 2016

IMPORTANT INFORMATION ABOUT CHANGE IN PRIOR AUTHORIZATION REQUIREMENTS
FOR USE OF MULTIPLE ANTIPSYCHOTICS IN CHILDREN

Dear Medicaid Provider:

The Mississippi Division of Medicaid (DOM) is committed to improving the quality of care provided to Mississippi Medicaid beneficiaries. DOM’s Drug Utilization Review (DUR Board), comprised of twelve Medicaid providers, including physicians, nurse practitioners and pharmacists statewide, has recommended several quality improvement initiatives addressing the use of antipsychotic medications in children. During the past year, the Centers for Medicare and Medicaid (CMS) added a quality measure addressing the use of multiple antipsychotic medications in children to the Core Set of measures used to evaluate quality of care in Medicaid programs. Effective October 1, 2016, DOM will be implementing a new prior authorization (PA) requirement for long-term treatment of children less than 18 years of age prescribed more than one antipsychotic medication.

You have been identified as a provider who, during the last year, prescribed multiple antipsychotics for a Medicaid beneficiary. We wanted to inform you about a new clinical edit that is being implemented so that you can plan appropriately for uninterrupted care of your patients.

USE OF MULTIPLE ANTIPSYCHOTICS IN CHILDREN EDIT: Beginning October 1, 2016 the prescription claims processing system will have a new edit in place to detect long-term use of multiple antipsychotics for this age group of beneficiaries. The prescription edit allows up to 90 days of overlap in therapy in order to accommodate cross tapering when changing medications. When treatment with multiple antipsychotics is needed for longer than 90 days, claims will deny and a manual PA will be required.

A copy of the manual PA form, “Multiple Antipsychotics for Patients Less Than Age 18 Years (Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications),” is attached so that you can be familiar with the information that will be requested. This form can also be found on DOM’s Pharmacy Prior Authorization website at:

https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/

Sincerely

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**Manual Prior Authorization**

Multiple Antipsychotics for Patients Less Than Age 18 Years (Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications)

**Beneficiary ID:** __________________ 
**Beneficiary Full Name:** __________________

**Gender:** ☐ Male ☐ Female  
**Age:**

**Beneficiary under State Care/Custody:** ☐ Yes  ☐ No  ☐ Unknown

**Medication Request:** ☐ New ☐ Continuation

**Diagnosis:** (check all that apply)

☐ ADHD  ☐ Disruptive Behavior Disorder  ☐ Mood Dysregulation Disorder  ☐ Tourette’s

☐ Schizoaffective Disorder  ☐ Autism Spectrum

☐ Bipolar Disorder

**Other:** __________________

**Height:** ___________ in.  ___________ cm.  **Weight:** ___________ lb.  **BMI:** ______

**Target Symptoms:** (check all that apply)  ☐ Aggression  ☐ Impulsivity  ☐ Irritability

☐ Mood Instability  ☐ Depressed  ☐ Manic  ☐ Psychosis  ☐ Self-Injurious Behavior  ☐ Other: __________________

**Overall Target Symptoms Severity:** ☐ 1-Mild  ☐ 2-Moderate  ☐ 3-Severe

**Functional Impairment:** ☐ 1-Mild  ☐ 2-Moderate  ☐ 3-Severe

**List All Current Medications:** __________________

<table>
<thead>
<tr>
<th>Antipsychotic Requested</th>
<th>Strength</th>
<th>Directions</th>
<th>Quantity</th>
</tr>
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☐ Yes  ☐ No  ☐ NA  If prescribing more than one (1) antipsychotic, is the plan to cross taper, with antipsychotic dual/mootherapy resumed within the next ninety (90) days? (if applicable)

    ☐ YES: Which of the medication(s) listed above will be discontinued? __________________

    ☐ NO: What is the rationale for continuing treatment with two (2) or more antipsychotics? __________________

☐ Yes  ☐ No  Beneficiary has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies, such as, but not limited to, evidence based behavioral, cognitive, and family based therapies.

☐ Yes  ☐ No  Beneficiary is currently receiving non-pharmacologic/psychosocial services.

☐ Yes  ☐ No  For a beneficiary not currently receiving non-pharmacologic/psychosocial services, a referral has been made and an appointment is pending. If there is no pending appointment, provide explanation below:

Has an assessment for Extrapyramidal Symptoms, including Tardive Dyskinesia (TD) been done in the last 26 weeks (6 months)? AIMS: ☐ Yes ☐ No  DISCUS: ☐ Yes ☐ No  AIMS/DISCUS Forms

☐ Yes  ☐ No  Medical record documentation of metabolic monitoring: weight or BMI, blood pressure, fasting glucose, and a fasting lipid panel within the last 12 months.

**Next appointment date:** __________________

I certify that the benefits of antipsychotic treatment outweigh the risks of treatment.

**Prescriber’s Signature:** __________________  **Specialty:** __________________