INITIAL IMPLEMENTATION OF TABLET SPLITTING CRITERIA IN ELECTRONIC PRIOR AUTHORIZATION

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BACKGROUND

Medicaid programs struggle to control costs while providing needed products to beneficiaries. When expensive agents are priced such that different strengths cost the same amount or they are not linearly priced, tablet splitting can be a means of reducing program costs. To achieve the full benefit of these potential savings, a clinical edit needs to be used during adjudication and the requirement of tablet splitting needs to be accomplished through electronic prior authorization (EPA) as opposed to manual prior authorizations. As costs continue to rise, tablet splitting will be considered more often as a method of controlling program costs. The Mississippi Division of Medicaid (MDOM) decided to explore the use of tablet splitting in 2013.

OBJECTIVES

The objective of a tablet splitting criteria is to maintain beneficiary access and treatment options while reducing total program costs by taking advantage of the non-linear pricing of an agent.

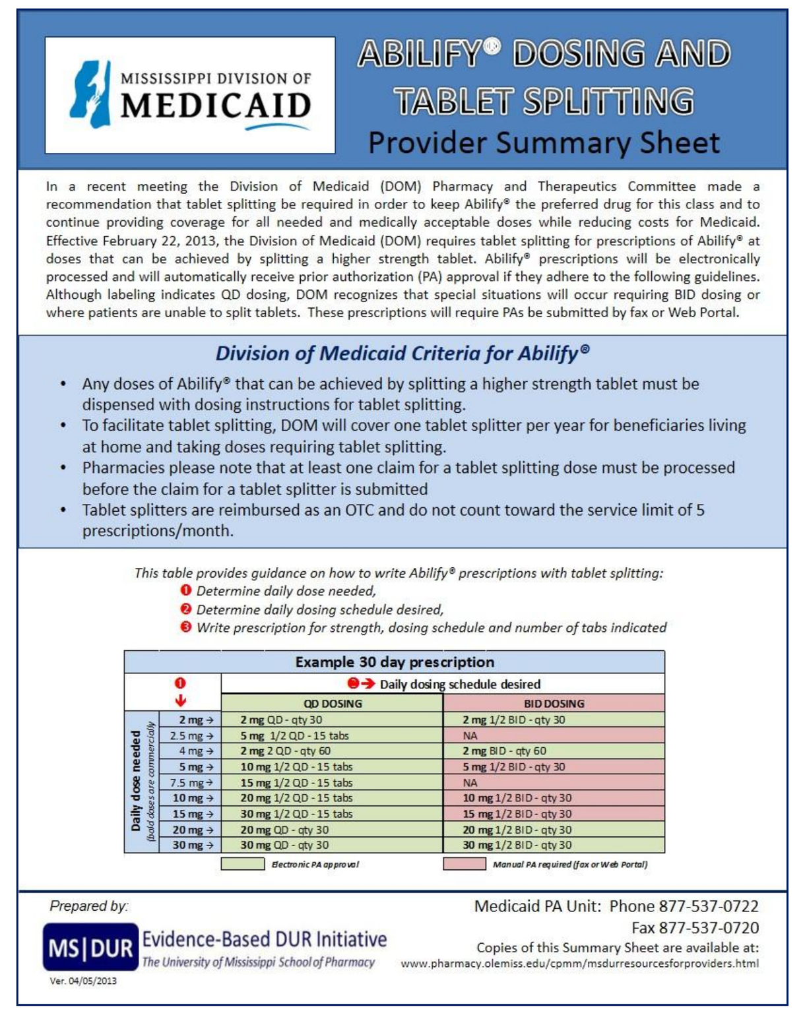
PRACTICE DESCRIPTION

Goold Health Systems (MDOM's PDL clinical vendor) identified Abilify® as a product that would economically justify a tablet splitting criteria. MDOM consulted with practicing psychiatrists regarding feasibility and identifying potential difficulties. An analysis was conducted by MS-DUR to determine current dosing patterns for the product and the potential number of cases where tablet splitting could occur. MDOM allowed grandfathering for patients remaining on prior stable therapy in order to minimize the difficulty of beneficiaries and providers transitioning to the tablet splitting requirement. Tablet splitting was not required until a dosing change occurred.

Potential issues identified that made programming for EPA difficult included:

1. Abilify® labeling indicates QD dosing but BID dosing is sometimes used for tolerability reasons.
2. Some commonly used doses of Abilify® cannot be achieved with tablet splitting so not every prescription would require splitting.
3. The daily dose computed from quantity dispensed and days supply on claims does not always result in a reasonable daily dose.

Prior to implementation, MS-DUR mailed educational materials to high prescribers. MDOM implemented the Abilify® tablet splitting criteria through EPA in February 2013.



ACKNOWLEDMENTS/DISCLOSURES

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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. During the first few months of implementation, EPA denials were predominately due to pharmacists not reading the denial messages and making appropriate changes to the strength and dosing information submitted (e.g., "Tablet splitting is required. Dispense ½ tab of Abilify® 20mg for 10mg daily dosing. Abilify® 10mg is limited to 16 tabs/month for 5mg daily dosing").

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 can be shifted to daily doses of 0.5 tablets/day has not peaked for many of the strengths. The percentages are not ever expected to be 100% due to manual PAs approved for BID dosing and whole tablet dosing when special patient needs exist.

FIGURE 1: Percent of Prescriptions Filled With Daily Dose of 0.5 Tabs/Day

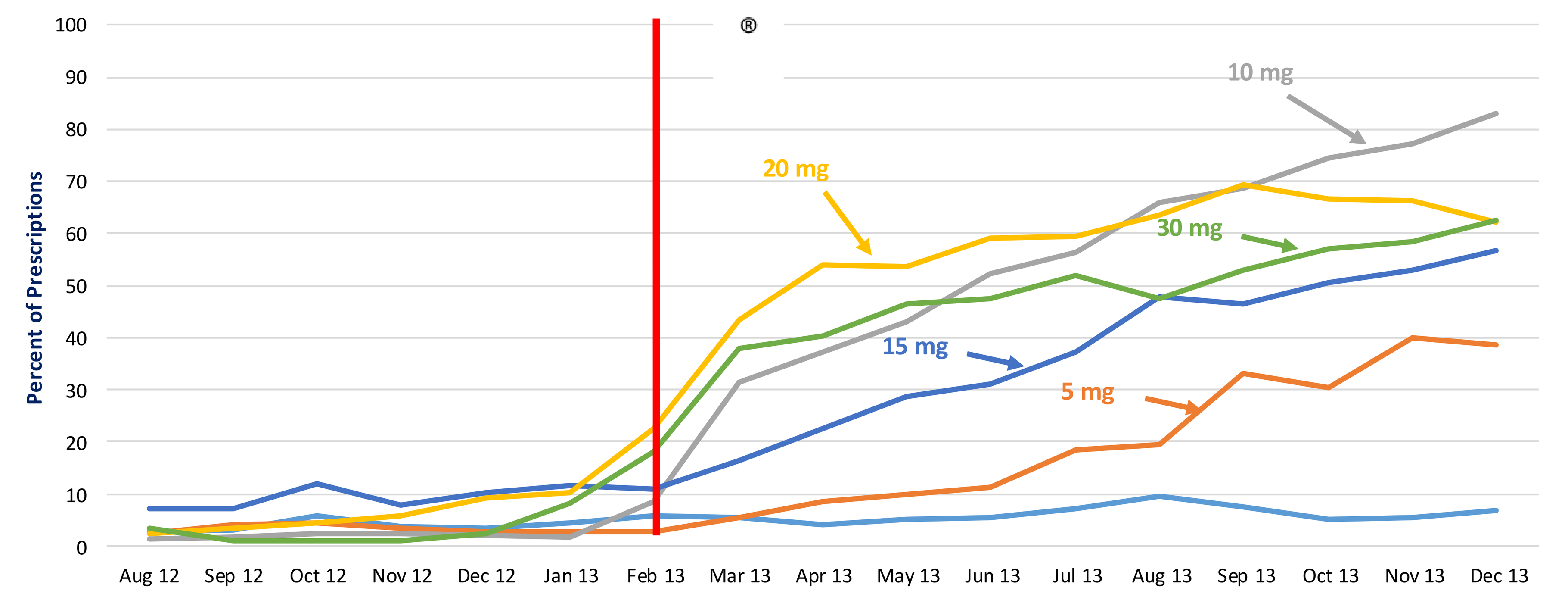

Figure 2 shows the number of beneficiaries filling prescriptions each month for Abilify®. The drop in December of 2012 was due to a major shift of beneficiaries into managed care. After implementation of tablet splitting, the number of beneficiaries on Abilify® has remained relatively stable. This indicates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

Cost savings achieved from tablet splitting are reported in Table 1. A base-line of dispensing at 0.5 tabs/day was derived as the average during the 6 months prior to policy implementation. The average for the last 6 months in 2013 was used as a conservative 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®. As shown in Table 1, MDOM reduced payments for by $176,000/month and by an average of $190/beneficiary on Abilify®/month.

FIGURE 2: Number of Beneficiaries Taking Abilify® By Month

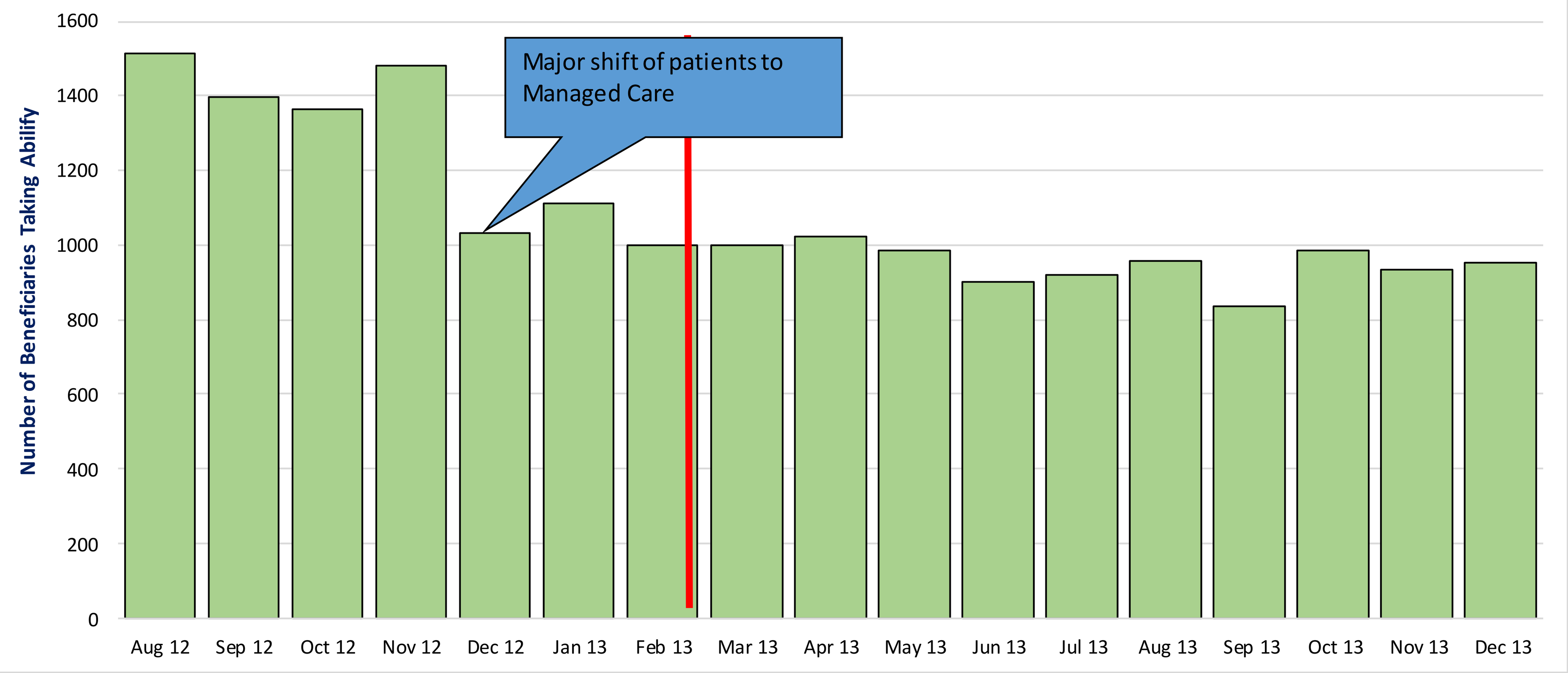

TABLE 1: Savings From Abilify Tablet Splitting

Strength	Increase in % Dispensed 0.5 Daily Dose	Average # RXs/month	Savings/RX in Paid Amount When Splitting	Savings/Month in Paid Amount From Splitting
5 mg	26.7%	130	$355	$12,342
10 mg	69.1%	331	$355	$81,188
15 mg	39.3%	78	$1,065	$32,752
20 mg	58.7%	300	$209	$36,697
30 mg	52.1%	125	$209	$13,539
TOTAL Savings/Month				$176,519
Savings/Bene on Abilify/Month				$189.53

CONCLUSIONS

With proper planning and programming of an EPA edit, tablet splitting can be successfully implemented for products such as Abilify® without affecting access to therapy while significantly reducing pharmacy expenditures.

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