Mountain-Pacific Quality Health
DUR PROGRAM NEWS

WINTER
2021-2022

Tony King, RPh, PharmD
Pharmacy Manager
MT DUR Coodinator
406-457-5843

Mountain-Pacific
Quality Health
P.O. Box 5119
Helena, MT 59604
www.mpqhf.org

The Drug Utilization Review (DUR) Program, administered by Mountain-Pacific through a contract with the Allied Health Services Bureau of the Montana Department of Public Health and Human Services, is the quality assurance body seeking to assure the quality of pharmaceutical care and to help provide rational, cost-effective medication therapy for Montana Healthcare Programs members.

Montana Healthcare Programs
Drug Prior Authorization Unit
1-800-395-7961

Montana Healthcare Programs Team Care

The Montana Healthcare Programs Team Care Program established by the Department of Public Health and Human Services (DPHHS) is designed for Montana Healthcare Programs members who use more services than the average member and may need additional assistance in utilizing the variety of services appropriately. Members identified for Team Care are "locked in" to specific providers to monitor services received and reduce unnecessary or inappropriate utilization. The Team Care Program is intended to prevent members from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

Montana Healthcare Programs members are identified for the Team Care Program through referrals from providers, the Mountain-Pacific Quality Health Pharmacy Case Management Team or the Drug Utilization Review (DUR) Board.

If a member's records indicate that member's utilization is excessive or inappropriate with reference to medical need, DPHHS will designate a primary care provider (PCP) and pharmacy for exclusive service to

- protect the individual's health and safety;
- provide continuity of medical care;
- avoid duplication of service by providers;
- avoid inappropriate or unnecessary utilization of Montana Healthcare Programs as defined by community practices and standards;
- avoid excessive utilization of prescription medications.

Members enrolled in Team Care are generally allowed to select a PCP and pharmacy of their choice. However, the member may be assigned a provider and/or pharmacy, depending on a treatment plan discussed by DPHHS and the provider or Mountain-Pacific Quality Health. If a member does not choose a primary care provider and/or pharmacy, they will be assigned one.

Members may change their Team Care PCP or pharmacy for reasonable cause by notifying the Team Care Program by calling 1-800-362-8312 to discuss any issues/requests for changes.

The Team Care Program components include the PCP, pharmacy and DPHHS Team Care staff that help to establish new lines of collaboration, communication and cooperation to better serve the member's needs.

Continued on p. 2

Montana Healthcare Pharmacy Programs Link
(Current Montana Healthcare Programs Preferred Drug List, Provider Notices, DUR Board/Meeting Information, Resources)
http://medicaidprovider.mt.gov/19

Montana Healthcare Programs Team Care (cont.)

1. PCP – Doctor, nurse practitioner, physician assistant or medical clinic that works closely with other members of Team Care and the member to manage a member's care plan

The PCP is responsible for most of the member's medical care needs. The PCP is delegated the responsibility of overseeing the health care needs of the Team Care member and providing all medically necessary care for which the member is eligible. The provider should be knowledgeable about the member's health care problems and aware of the care and services the member is receiving.

Should members need to utilize a provider who is not their assigned PCP, they may need a referral from their PCP for those services to be covered. Additionally, the assigned PCP receives a small, monthly reimbursement for members who are assigned to their care. Should a member receive services from a provider who is not their assigned PCP without a referral, Montana Healthcare Programs will not pay for those services.

2. Pharmacy – An outpatient retail pharmacy assigned to process and bill medications for the member

The Team Care Pharmacy monitors the drug utilization of the assigned member and exercises sound professional judgment when dispensing drugs in order to prevent inappropriate drug utilization. When the pharmacist reasonably believes the member is attempting to obtain excessive drugs through duplicate prescriptions or other inappropriate means, the pharmacist contacts the providing physician to verify the authenticity and accuracy of the prescription presented.

Should a member use a pharmacy not assigned to them, their medication claim may not be covered. However, if there is reasonable cause for the member to receive medication from another pharmacy (e.g., the assigned Team Care pharmacy does not have the prescribed medication), either the pharmacy or the member may call 1-800-362-8312 to request a temporary authorization at a different pharmacy.

3. DPHHS Team Care Staff – The member and Team Care providers/pharmacies work closely with DPHHS Team Care staff to ensure the member receives the care they need and to ensure progress through the program (at least 12 months).

If, after review of the member's Montana Healthcare Programs claims, including drug-usage profile, it is determined by the DPHHS Team Care Program that restriction of the member to the primary pharmacy is no longer appropriate, the restriction will be removed. Such review will not take place prior to 12 months from the date of enrollment.

For more information about the Team Care Program, call 1-800-362-8312.

Migraine Prevalence, Diagnosis and Treatment in Adults

Migraine headaches affect roughly 16% of the adult population, with 21% of women and approximately 11% of men affected.[1] Overall, it is estimated migraines account for more than four million emergency department visits (5th most common reason for an ED visit), 4.3 million office visits and have an estimated associated cost

Continued on p. 3

Migraine Prevalence, Diagnosis and Treatment in Adults (cont.)

of at least $27 billion in the U.S. While the prevalence of migraines peaks at a fairly young age (25-55), it is the second most common neurological condition when looking at years lost to disability and can be associated with an increased risk for common health conditions such as depression, asthma, anxiety, epilepsy and stroke.[2,3] Due to the condition affecting a person's abilities at work, school and home, many of those suffering from migraines have trouble maintaining employment and obtaining medical insurance. It is estimated nearly 40% of U.S. adults with migraines are unemployed, and one in five has no health insurance.

Migraines are defined by their frequent attacks and can usually be tracked through four phases, although not everyone can identify each stage before, during or after an attack, and the duration of each stage can vary.

1. **Prodrome** – Seventy-seven percent of migraine sufferers progress through prodromal symptoms, including euphoria, depression, constipation, neck stiffness and irritability. These symptoms usually appear 24 to 48 hours prior to a migraine attack.

2. **Aura** – Roughly 25% of people suffering from migraines report symptoms consistent with a migraine aura. This may include changes in vision; changes in feelings in the body, including tingling or numbness (sensory aura); difficulty with normal language patterns (language aura) and weakness in the limbs or face on one side of the body (motor aura). Generally, the aura of a migraine develops gradually over five or more minutes.

3. **Migraine** – Often the migraine headache itself affects one side of the body and is generally signaled with a throbbing or pulsing. As the severity increases, patients can also experience nausea and vomiting and be very sensitive to light and/or sound. Generally, a migraine can affect a patient for several hours and up to a couple of days and can sometimes resolve itself during periods of sleep.

4. **Postdrome** – After most of the migraine symptoms resolve, patients can still have periods of pain at the location of the migraine, generally associated with sudden head movement. Additionally, patients report feeling run down but also a feeling of elation or euphoria.

While not all patients could identify a trigger for their migraine attacks, approximately 75% of patients in one study of nearly 2,000 individuals believed they could associate their migraines with some cause, with the most common being stress (80%), hormone changes in women (65%), lack of eating (57%), weather changes (53%), changes in sleep patterns (50%), a specific odor (44%), neck pain (38%), lights (38%) and alcohol (38%).[3]

Continued on p. 4

[1] https://pubmed.ncbi.nlm.nih.gov/33349955/
[2] https://headachejournal.onlinelibrary.wiley.com/doi/10.1111/head.14153
[3] https://www.uptodate.com/contents/pathophysiology-clinical-manifestations-and-diagnosis-of-migraine-in-adults?search=migraine&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#H203275744

Migraine Prevalence, Diagnosis and Treatment in Adults (cont.)

Migraine without aura

A. At least five attacks fulfilling criteria B through D
B. Headache attacks lasting 4 to 72 hours (untreated or unsuccessfully treated)
C. Headache has two of the following characteristics:
    - Unilateral location
    - Pulsating quality
    - Moderate or severe pain intensity
    - Aggravation by or causing avoidance of routine physical activity (e.g., walking or climbing stairs)
D. During headache, at least one of the following:
    - Nausea, vomiting or both
    - Photophobia or phonophobia
E. Not better accounted for by another ICHD-3 diagnosis

Migraine with aura

A. At least two attacks fulfilling criteria B and C
B. One or more of the following fully reversible aura symptoms:
    - Visual
    - Sensory
    - Speech and/or language
    - Motor
    - Brainstem
    - Retinal
C. At least three of the following six characteristics:
    - At least one aura symptom spreads gradually over ≥5 minutes
    - Two or more symptoms occur in succession
    - Each individual aura symptom lasts 5 to 60 minutes
    - At least one aura symptom is unilateral
    - At least one aura symptom is positive (Scintillations and pins and needles are examples of positive symptoms.)
    - The aura is accompanied or followed within 60 minutes by headache
D. Not better accounted for by another ICHD-3 diagnosis

Features of migraine in children and adolescents

- Attacks may last 2 to 72 hours (The evidence for untreated durations of less than 2 hours in children has not been substantiated.)
- Headache is more often bilateral than in adults; an adult pattern of unilateral pain usually emerges in late adolescence or early adult hood
- Photophobia and phonophobia may be inferred by behavior in young children

When developing a treatment plan, emphasis should be placed on patient education and lifestyle modification specifically targeting nutrition, exercise, hydration, sleep hygiene, mitigating stress and tracking of migraines and triggers.

Goals for acute treatment should also consider patient preference (especially oral vs. non-oral), severity and frequency of “normal” migraines, recovery time, potential adverse events and cost considerations. For mild-to-moderate attacks, nonsteroidal anti-inflammatory drugs (NSAIDS), nonopioid analgesics, acetaminophen or caffeinated combinations are generally recommended. If those treatments do not have a positive clinical response, or if the migraine is moderate or severe, treatments with migraine-specific agents (triptans,

Continued on p. 5

ergotamine derivatives, CGRP or 5-HT 1F receptor agonists) are also available for use. While quick initiation of treatment and overall larger doses tend to have better outcomes than smaller, more frequent doses, many try a newer agent/treatment to obtain adequate relief. Below are the American Headache Society's criteria for initiating acute treatment with CGRP (gepants), 5-HT 1F receptor agonists (ditans) or neuromodulatory devices.

Use is appropriate when ALL the following are met:

A. Prescribed/recommended by a licensed clinician
B. Patient is at least 18 years of age
C. Diagnosis is ICHD-3 migraine with aura, migraine without aura or chronic migraine
D. Either of the following:
    - Contraindications to or inability to tolerate triptans
    - Inadequate response to two or more oral triptans, as determined by EITHER of the following:
        - Validated acute treatment patient-reported outcome questionnaire (mTOQ, Migraine-ACT, PPMQ-R, FIS, PGIC)
        - Clinician attestation

Additionally, if a patient has been diagnosed with chronic migraines, discussion between patient and provider should also include preventative treatment. Typically, a person with a migraine or tension-type headaches for 15 or more days per month for over three months is examined for a chronic migraine diagnosis. Again, below are the American Headache Society's criteria for identifying patients for preventative treatment:

Prevention should be...	Headache days/month	Degree of disability required
Offered	6 or more	None
	4 or more	Some
	3 or more	Severe
Considered	4 or 5	None
	3	Some
	2	Severe

Although there are many new prevention treatments being approved by the U.S. Food and Drug Administration (FDA), guidelines still indicate using evidence-based treatments first (including beta blockers, antidepressants and anti-convulsants), titrating oral medications for maximum clinical benefits (no need to titrate injectable medications), allowing ample time for each trial (2-6 months) and monitoring for overuse of acute treatments. Adding in non-pharmacologic methods (neuromodulation) has also shown helpful. Additionally, as more research is being conducted to diagnose subtypes of a migraine, each treatment method will need to be evaluated for the specific subtype of migraine. While much progress is being made in the knowledge and treatment of migraine headaches, there is still much to be done to ensure patients can live full, migraine-free lives.

For a complete list of medications and the supported evidence in the prevention of migraines from the joint statement from the American Academy of Neurology joined with the American Headache Society from 2012 (last reaffirmed on 2015), please view: https://www.aan.com/Guidelines/home/GuidelineDetail/536.

Level A. The following medications are established as effective and should be offered for migraine prevention:

- Antiepileptic drugs (AEDs): divalproex sodium, sodium valproate, topiramate
- β-Blockers: metoprolol, propranolol, timolol
- Triptans: frovatriptan for short-term MAMs prevention

Continued on p. 6

Migraine Prevalence, Diagnosis and Treatment in Adults (cont.)

Level B. The following medications are probably effective and should be considered for migraine prevention:

- Antidepressants: amitriptyline, venlafaxine
- β-Blockers: atenolol, nadolol
- Triptans: naratriptan, zolmitriptan for short-term MAMs prevention

Level C. The following medications are possibly effective and may be considered for migraine prevention:

- ACE inhibitors: lisinopril
- Angiotensin receptor blockers: candesartan
- α-Agonists: clonidine, guanfacine
- AEDs: carbamazepine
- β-Blockers: nebivolol, pindolol

Level U. Evidence is conflicting or inadequate to support or refute the use of the following medications for migraine prevention:

- AEDs: gabapentin
- Antidepressants
  - Selective serotonin reuptake inhibitor/selective serotonin-norepinephrine reuptake inhibitors: fluoxetine, fluvoxamine
  - Tricyclics: protriptyline
- Antithrombotics: acenocoumarol, Coumadin, picotamide
- β-Blockers: bisoprolol
- Calcium-channel blockers: nicardipine, nifedipine, nimodipine, verapamil
- Acetazolamide
- Cyclandelate

Level A negative. The following medication is established as ineffective and should not be offered for migraine prevention:

- Lamotrigine

Level B negative. The following medication is probably ineffective and should not be considered for migraine prevention:

- Clomipramine