

# **Changes in the Florida Medicaid Formulary of Psychotherapeutic Medications- 2005**

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## **WHY THIS CONVERSATION**

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- Recent changes in Medicaid Formulary
- Possibly necessitating changes in an individual's psychotherapeutic medication regimen
- Relationship between mental illness, its effective treatment, and suicidality
- Drug equivalence and variation in Individual responsiveness

## CHANGES IN MEDICAID FORMULARY

- Elimination of exemption of psychotherapeutic medications from Florida Medicaid Preferred Drug List and Step Therapy in 2005 in state statute
- Preferred Drug List has been developed for antidepressants, antipsychotics, mood stabilizers and medications to treat ADHD
- Procedure for step therapy and process for “Prior Authorization” for a non-PDL medication before it will be dispensed by a pharmacy have been developed
- Although implementation was supposed to be from July 11, 2005, a 60-day extension was provided for antidepressant and antipsychotic medications.

# **FLORIDA MEDICAID Preferred Drug List (PDL) for Psychotherapeutic Agents**

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- Antipsychotics: all agents and formulations on PDL
- Antidepressants: most antidepressants; Serzone, Remeron, Cymbalta, and Symbax are NOT on the PDL  
Also Effexor is on PDL, but Effexor XR is NOT
- Mood Stabilizers: Lithium, and FDA-approved anticonvulsant mood stabilizers (Depakote, carbamazepine, and Lamictal) are on the PDL. Some other anticonvulsants (eg., Topamax) are not.
- Anti-ADHD Drugs: Some formulations of methylphenidate are not on PDL (eg., Ritalin, Concerta), but generic substitutes are. Straterra is NOT on the PDL.

# **If Individual is on medication which NOT on PDL**

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## **TWO OPTIONS**

- 1. Switch from non-PDL medication to a corresponding agent on the PDL.**
- 2. Obtain Prior Authorization from Medicaid representative to continue to use medication.**

# Switching From One Agent to Another

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In the present context, switching from a non-PDL agent to a PDL agent in the same class

- Is it safe to switch?
- If I “clearly” must not switch, what must I do?
- If I must switch, which agent to switch to?
- How fast should the switching process occur?
- When I switch, what issues need careful attention?

# Switching From One Agent to Another

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In the present context, switching from a non-PDL agent to a PDL agent in the same class

If “clearly” must not switch, what must happen?

- Doctor needs to obtain “Prior Authorization” from Medicaid for use of the non-PDL medication before my pharmacy will fill it for more than 4 days.
- To do so, doctor will have to provide (fax) a brief written summary of why child must continue on this non-PDL medication and why child must not switch to some PDL medication.

# **Switching Psychotherapeutic Agents: Considerations**

# Switching From One Agent to Another

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In the present context, switching from a non-PDL agent to a PDL agent in the same class

## Four Key Elements as one Switches

- STOP: Stopping the non-PDL medication
- START: Starting the new PDL medication
- COMBINE: Using both the non-PDL and PDL medications concurrently
- CHANGE: The fact that something is changing

# **Switching From One Psychotherapeutic Agent to Another**

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**ALL TREATMENT DECISIONS ARE MADE BY  
THE CLINICIAN AND THE INDIVIDUAL  
RECEIVING TREATMENT**

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# Switching From One Psychotherapeutic Agent to Another

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In the present context, switching from a non-PDL agent to a PDL agent in the same class

- History of previous and current response
- Pharmacological characteristics of non-PDL agent from which and the PDL agent to which the individual is being switched
- Dose equivalence of non-PDL agent from which and the PDL agent to which the individual is being switched
- Be aware of pharmacological carry-over effects, withdrawal effects, and issues of tolerance
- Specific vulnerabilities of individual

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# Switching From One Agent to Another

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In the present context, switching from a non-PDL agent to a PDL agent in the same class

The process of switching always entails some risks, even if the individual ultimately does better on the new agent

- Therefore, the process should be gradual
- Therefore, the process should be carefully monitored

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# **Switching From One Antipsychotic to Another**

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**ALL ANTIPSYCHOTIC MEDICATIONS  
ARE ON THE FLORIDA PDL**

# Switching From One Antidepressant Formulation to Another

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In the present context, what are the considerations with regard to switching from Effexor XR to regular Effexor

- Once a day TO twice a day
- Dose adjustments not necessary, but need monitoring

In the present context, what are the considerations with regard to switching from Cymbalta to ??

- Discontinuation syndrome include dysphoria, dizziness, nausea, headache, irritability, nightmare, anxiety,
- Only other SNRI is Effexor (venlafaxine)
- **Approximate** dose equivalence  
40 mg duloxetine = 150 mg venlafaxine

# Switching From One Antidepressant Formulation to Another

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In the present context, what are the considerations with regard to switching from Weekly Prozac to daily fluoxetine

- Approximately 90 mg once a week weekly prozac capsules  
= 20 mg/day of fluoxetine
- Initiate daily fluoxetine about 1 week after last dose of weekly Prozac
- No good trial data on transition

# Switching From One Anti-ADHD Formulation to Another

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In the present context, what are the considerations with regard to switching from one methylphenidate formulation to another

- Concerta and Ritalin LA to Metadate (ER or CD) and generic long-acting methylphenidate (Methylin ER or Methylphenidate ER)
- Ritalin to generic methylphenidate (Methylin or Methylphenidate)

In the present context, what are the considerations with regard to switching from Straterra to ??

- No documented Discontinuation syndrome
- No other equivalent nonstimulant anti-ADHD agent

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