Clinician Quarterly

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Responding to the H1N1 Pandemic

From Paul Mendis, MD, Chief Medical Officer of Neighborhood Health Plan

Paul Mendis, M.D.

As this column goes to print, H1N1 influenza is sweeping across the nation and Massachusetts is experiencing its first school closing. Levels of influenza-like-illness are much higher than last year at this time, although not yet as high as last spring.

Unfortunately, the supply of H1N1 vaccine continues to lag and is not yet available in sufficient quantities to immunize more than the highest risk groups. NHP's Customer Care Center has been linking our members to information about local vaccine availability, provided by the Massachusetts Department of Public Health (DPH). We have supported the Commonwealth's efforts to authorize non-traditional providers to administer vaccine; thereby ensuring rapid immunization of our membership once adequate supplies of vaccine arrive.

NHP has also sent educational brochures to households of all NHP members. Available in multiple languages, these pamphlets were written by DPH for a low literacy audience. Emphasis is placed on prevention measures, including immunization, and advice about what to do if one becomes ill. To preserve clinical access for those most in need, specific reference is made to the indications for primary care or emergency department assessment. These and other helpful tips are also available through links on our website, www.nhp.org.

We have used multiple vehicles to publicize the availability of our 24/7 nurse advice line for those with health-related questions. Those more inclined to access such advice online can also utilize our HealthWise database which includes an interactive "symptom checker."

These measures—expanded channels for vaccine administration, direct written member education, and interactive telephonic or online clinical resources—have been implemented to offer our members as much protection as possible and provide your practices with some additional support during what promises to be a most challenging flu season. ▪

Clinician Quarterly

FEATURED TOPICS

- **"Healthy Neighborhoods" May Cut Diabetes Risk** | John Gever, Senior Editor, *MedPage Today*
- **The Use of Medication to Treat Adolescent Depression** | Girlaine Rosier-Santos, LICSW, Elaine Sherwood, LICSW, Rebecca Cioffi, LICSW, Beacon
- **Hidden Danger of Combination Pain Medication: Acetaminophen Toxicity** | Catherine Pappas, Pharm.D., R.Ph., Director of Pharmacy, NHP

"Healthy Neighborhoods" May Cut Diabetes Risk

By John Gever, Senior Editor, MedPage Today
Published: October 12, 2009
Reviewed by Zalman S. Agus, MD; Emeritus Professor, University of Pennsylvania School of Medicine and Dorothy Caputo, MA, RN, BC-ADM, CDE, Nurse Planner

Neighborhoods that provide easy opportunities for exercise and healthy eating are associated with reduced residents' risk of developing type 2 diabetes, researchers said. People living in "healthy neighborhoods" were less likely to be diagnosed with type 2 diabetes in a five-year cohort study, after controlling for such factors as age, income, race, and education (hazard ratio 0.62, 95% CI 0.43 to 0.88), reported Amy Auchincloss, PhD, MPH, of Drexel University in Philadelphia, and colleagues.

"The strength of the association was considerable and equivalent to a reduction in type 2 diabetes incidence associated with a BMI of 5 [points] lower in this sample," they wrote in the Oct. 12 Archives of Internal Medicine.

Acknowledging no easy fix for the obesity epidemic and rise in incidence of type 2 diabetes, the researchers said that "altering our environments so that healthier behaviors and lifestyles can be easily chosen may be one of the key steps in arresting and reversing these epidemics."

In an accompanying editorial, Mitchell Katz, MD, of the San Francisco Department of Public Health, pointed out that people already inclined to pursue healthy lifestyles may choose to live in neighborhoods with the necessary resources.

He said Auchincloss and colleagues made a good effort at controlling for factors that might predict such choices. Nevertheless, Katz wrote, "it is impossible to adjust for the motivation to live in a healthier place."

On the other hand, he said, "even if there is self-selection into neighborhoods with particular characteristics, the fact is that it is hard to be active if there are no safe places in the neighborhood to walk, and hard to eat better if the nearby stores sell only highly processed foods."

Katz agreed with the researchers that environmental interventions to promote healthy behaviors were worth pursuing.

The study tracked 2,285 participants at three of the six sites involved in the Multi-Ethnic Study of Atherosclerosis (MESA). All were at least 45 years old and underwent baseline health exams from 2000 to 2002 and additional exams about every 18 months thereafter. A median of five years of follow-up was available.

The exams included fasting blood glucose measurements and other standard physical assessments. Sociodemographic data were also collected, along with participants' descriptions of their diet and exercise routines.

The current analysis covered participants in Baltimore, the Bronx borough of New York City, and the North Carolina county that includes Winston-Salem. Individuals with type 2 diabetes at baseline were excluded.

Auchincloss and colleagues also used data from a companion survey to MESA that collected information on neighborhoods from residents contacted randomly by phone.

Respondents were asked if it was "pleasant" and "easy" to walk, and whether exercise facilities were nearby. Another question was whether it was common to see other residents exercising.

The nine-question survey also asked about the availability of large, high-quality selections of vegetables, fruits, and other low-fat foods.

During the follow-up period, 10% of participants were diagnosed with type 2 diabetes.

The unadjusted incidence rate for the one-third of participants residing in neighborhoods with the highest "healthiness" scores was about half that of those in neighborhoods with the lowest scores (7% versus 13%, *P* not reported).

Auchincloss and colleagues found that opportunities for physical activity and availability of healthy foods contributed equally to the difference.

To control for other factors potentially related to diabetes incidence, the researchers calculated adjusted hazard ratios that accounted for different combinations of sex, age, family history of diabetes, income, assets, educational attainment, race and ethnicity, high alcohol intake, smoking status, baseline physical activity, baseline diet, and body mass index.

The hazard ratios corresponded to a difference between the 90th and 10th percentiles in neighborhood resources related to exercise and healthy foods.

In an interview, Auchincloss explained that the researchers' primary model of interest omitted baseline activity and diet and BMI because they mainly wanted to control for those factors that might correlate with neighborhood choice—age, wealth, and race/ethnicity—as well as smoking and heavy drinking.

For that model, the hazard ratio was 0.62 (95% CI 0.43 to 0.88).

As it turned out, omitting drinking and smoking made almost no difference (HR 0.62, 95% CI 0.44 to 0.89). Adding BMI and baseline exercise and diet choices also had little impact (HR 0.64, 95% CI 0.44 to 0.95).

Auchincloss acknowledged that there has been relatively little evidence so far that changing the neighborhood environment leads to improved health

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"Healthy Neighborhoods"

behaviors, but suggested there may be solid answers soon.

"The next step is to look at changes in physical activity with neighborhood changes over time," she said. Another group at Drexel has begun such research, she said, which will also examine changes in diet.

She added that a number of deliberate neighborhood improvement initiatives were now under way in Philadelphia and other cities that could provide fodder for interventional studies.

These include efforts to put farmers' markets and full-size supermarkets in low income neighborhoods where access to fresh fruits and vegetables is now limited or nonexistent.

Many cities are also working to develop bike lanes and other relatively low-cost projects to encourage exercise.

In his editorial, Katz argued that the developed world has stripped away first the necessity and then the opportunity for exercise and low-fat eating.

"Fifty years ago, few people had cars," he wrote. "People had little choice but to walk or take public transportation, which required walking to the transit stops...Lawn mowers were pushed, groceries were carried up steps."

In contrast, Katz suggested, developed nations today appear organized to prevent exercise and healthy eating.

"While causality cannot be proven, the increase in obesity and type 2 diabetes in developed countries tracks with these environmental changes," he wrote.

Echoing Auchincloss, Katz called for such interventions as widening sidewalks, promoting mixed-use development that encourages walking, establishing community gardens, and opening farmers' markets.

Such programs, Katz noted, "[change] the environment in a way that makes it easier for people to be healthy without individuals enrolling or even knowing they are participating in an intervention."

But, her group noted that outcomes were no better with corticosteroids versus placebo for infants born within seven days of repeated study drug administration.

The lack of benefit and potential harm with repeat dosing in several studies reinforces the importance of studying outcomes meticulously, she said.

Even with what seems a simple intervention, "we need to appreciate that any of our interventions have the potential for long-term benefits but also long-term harm," she concluded. ▪

The study was funded by the National Heart, Lung, and Blood Institute.

Study authors reported no potential conflicts of interest. Katz reported serving as a paid independent consultant for Health Management Associates.

Primary source: Archives of Internal Medicine
Source reference:
Auchincloss A, et al "Neighborhood resources for physical activity and healthy foods and incidence of type 2 diabetes mellitus: the Multi-Ethnic Study of Atherosclerosis" Arch Intern Med 2009; 169: 1698-1704.

Additional source: Archives of Internal Medicine
Source reference:
Katz M "Quality of residential neighborhood: a modifiable risk factor for type 2 diabetes?" Arch Intern Med 2009; 169: 1653-54.

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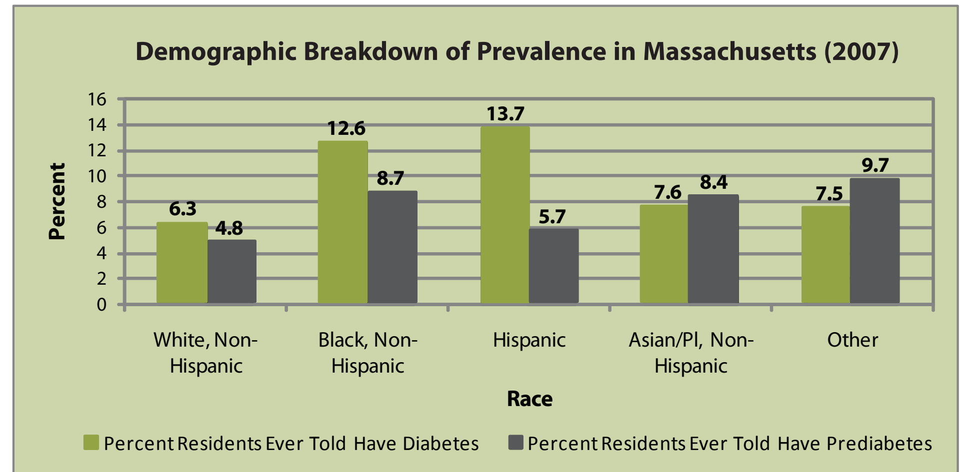
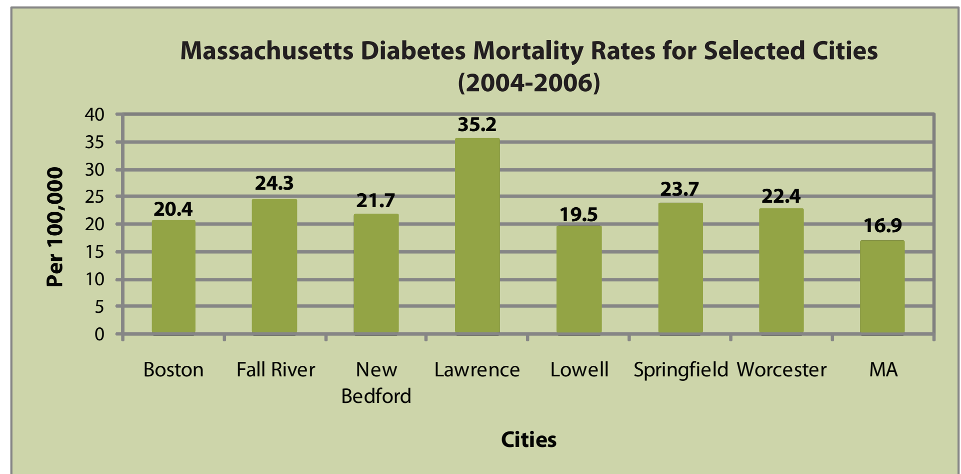
Diabetes in Massachusetts

From the Massachusetts Department of Public Health.



Source: Massachusetts Behavioral Risk Factor Surveillance System (1994-2007).



Source: MDPH Registry of Vital Records and Statistics (2004-2006). Note: Data are age-adjusted to the 2000 U.S. standard population and comparability modified. Major cities were selected to represent data at the local level.

The Use of Medication to Treat Adolescent Depression

Girlaine Rosier-Santos, LICSW, Elaine Sherwood, LICSW, Rebecca Cioffi, LICSW, Beacon Health Strategies
Neighborhood Health Plan's Behavioral Health Partner

Adolescent depression is one of the most common chronic illnesses of childhood and is associated with an increased risk of suicide. The American Academy of Child and Adolescent Psychiatry (AACAP) reports that Major Depressive Disorder (MDD) is prevalent in 4-8% of adolescents, with a male/female ratio of 1:2 during adolescence.[1] The risk for depression increases after puberty by a factor of 2:4, particularly in females.[2] MDD may affect the development of a child's emotional, cognitive and social skills, interfere with family relationships considerably, as well as increase the risk of suicidal thinking, suicide attempts, and completed suicides, if left untreated.[3] "Suicide is the third leading cause of death for adolescents 15-19 years old."[4]

As in adults, research has shown that depression in children and adolescents is treatable. Selective Serotonin Reuptake Inhibitors (SSRIs), a type of antidepressant medication, can be beneficial to children and adolescents with MDD. The SSRIs include fluoxetine (Prozac), the only medication approved by the FDA for use in treating depression in children ages 8 and older [5], sertraline (Zoloft), paroxetine (Paxil), citalopram (Celexa), escitalopram (Lexapro) and fluvoxamine (Luvox). SSRI medications are known to have fewer side effects than older antidepressant mediations and are less likely to be harmful if taken in an overdose.[6] There has been concern that the use of antidepressant medications may induce suicidal behavior in youths. In 2004, the Food and Drug Administration (FDA) conducted a comprehensive review of all available (23) published and unpublished controlled clinical trials of antidepressants in children and adolescents. The FDA review found that, although no completed suicides occurred among nearly 4,000 children treated with SSRI medications, about 4 percent of those taking the medications experienced (spontaneous) suicidal thinking and behavior, including actual suicide attempts, at twice the rate of those taking the placebo. In October 2004, the FDA issued a public "black box" warning about an increased risk of suicidal thoughts and behavior in children and adolescents treated with SSRI antidepressant medications. The FDA extended the warning to include young adults up to age 25 in 2006. The warning calls for close monitoring of children and adolescents, especially during the initial months of treatment and any time the dose changes, for worsening depression, emergence of suicidal thinking or behavior, or unusual changes in behavior.[7] It is important to remember that "suicidal thoughts or attempts to not equal suicide."[8]

Despite the "black box" warning, the effectiveness of medications in relieving symptoms of depression has been demonstrated in a definitive study funded by the National Institute of Mental Health (NIMH). The Treatment of Adolescent Depression Study (TADS) is a 36-week, multi-site clinical research study that examined the antidepressant medication and psychotherapy alone and in combination for treating depression in 439 adolescents ages 12-17.[9,10] Participants were randomly assigned to one of four treatment groups: fluoxetine (Prozac) alone; placebo alone with clinical management; cognitive-behavioral therapy (CBT) alone or a combination of fluoxetine and CBT. After the first 12 weeks, TADS showed that a combination of fluoxetine (Prozac) and CBT led to significant clinical improvement in 71% of moderately to severely depressed adolescent patients. Improvement rates for other treatment groups were as follows: 61% for fluoxetine alone, 43% for CBT alone and 35% for placebo. "By 36 weeks, the response rate to combination therapy still remained the highest, 68 percent… The results suggest that combination treatment is the safest most effective treatment overall for adolescents with depression…Adding CBT appears to lessen the risk of suicidal thinking and behavior in patients given fluoxetine, and helps them develop new skills to contend with difficult, negative emotions."[11] An important message from this research is that medication can be an important treatment for depression in children and adolescents.

When treating a child or adolescent with depression, the physician, in consultation with the parents/guardians, and as appropriate the child, should develop a comprehensive treatment plan and should include a combination of medication and psychotherapy, as well as work with the child's family and/or school.[12] Children and adolescents prescribed antidepressant medication should

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Hidden Danger of Combination Pain Medication: Acetaminophen Toxicity

by Catherine Pappas, Pharm.D., R.Ph., Director of Pharmacy, Neighborhood Health Plan

In the 2007 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 25th Annual Report published in December 2008, nearly one third (348) of the poisoning fatalities involved acetaminophen. Over 200 of these involved acetaminophen in combination with another substance. This same report indicates that 50% of the acetaminophen poisonings are unintentional and 80% of the exposures involved combinations with other substances.

At the beginning of the summer of 2009, an FDA advisory committee recommended new restriction on medications that contain acetaminophen. The FDA advisory committee recommendation was a "black-box" warning for products that include acetaminophen in combination with other medications.

Note the amount of acetaminophen contained in the prescription medications listed in Table 1, then consider that your patient might also be taking an over-the-counter medication (Table 2). To stay within the maximum adult daily dose of 4.0 grams of acetaminophen, when you prescribe a medication that also contains acetaminophen, consider these precautions:

1. Use caution if your patient has any liver disease.
2. Ask about alcohol use.
3. Caution your patient about over-the-counter medications that might contain Tylenol, acetaminophen or "non-aspirin" pain relievers. Suggest aspirin, or ibuprofen as alternatives if necessary. ■

Medication	Combination	Strength per Tablet	If the directions are:	Maximum Dose of Acetaminophen	Alternatives
Percocet 5/325 or Roxicet	Oxycodone-Acetaminophen	5mg 325mg	1-2 tablets every 4 to 6 hours when needed	3.9 grams	Percocet 10mg/325mg Oxycodone plain Oxycodone with Aspirin
Vicodin or Lortab 5	Hydrocodone-Acetaminophen	5mg 500mg	1-2 tablets every 4 to 6 hours when needed	6.0 grams	Hydrocodone 7.5mg with Ibuprofen 200mg
Vicodin ES	Hydrocodone-Acetaminophen	7.5mg 750mg	1 tablets every 4 to 6 hours when needed	4.5 grams	Hydrocodone 7.5mg with Ibuprofen 200mg
Darvocet N-100	Propoxyphene-Acetaminophen	100mg 650mg	1-2 tablets every 4 to 6 hours when needed	7.8 grams	Propoxyphene 65mg plain

Table 1

Medication	Combination	Dose per Unit of Acetaminophen	Adult Package Directions	Maximum Dose of Acetaminophen
Extra Strength Tylenol		500mg	2 tablets, caplets, gelcaps or tablespoons every 4 to 6 hours. Do not take more than 8 tablets, caplets, gelcaps or tablespoons in 24 hours.	6 grams
Nyquil Liquicaps	Acetaminophen Dextromethorphan Doxylamine	325mg	2 LiquiCaps with water every 6 hours- Maximum of 4 doses per day	2.6 grams
Nyquil Liquid	Acetaminophen Dextromethorphan Doxylamine	500mg/15ml	2 TBSP (30 ml) every 6 hours	4.0 grams
Excedrin Sinus Headache	Phenylepherine Acetaminophen	325mg	take 2 caplets every 4 hours	3.9 grams
Extra Strength Excedrin	Acetaminophen Aspirin Caffeine	250mg	2 every 6 hours; not more than 8 in 24 hours	2.0 grams
Excedrin Tension Headache	Acetaminophen Caffeine	500mg	12 years and over: take 2 caplets every 6 hours; not more than 8 caplets in 24 hours	4.0 grams

Table 2

Continued from page 4

The Use of Medication

be monitored very closely by parents, caregivers, and health care professionals for side effects, as well as changes in mood or behavior. "The highest risk of suicidal thinking and behavior occurs during the first few months of treatment with an antidepressant or when the dosage is increased or decreased. Parents and caregivers should closely observe children on a daily basis during these transition periods."[13]

The Food and Drug Administration (FDA) recommends that "ideally" a child see his or her health care professional once a week during the first month of treatment; every two weeks during the second month of treatment; a follow-up visit after 12 weeks of treatment and as recommended after those first 12 weeks and, obviously, more often if problems or questions arise.[14] The American Psychiatric Association (APA) and AACAP "believe that rather than requiring adherence to a prescribed schedule, the frequency and nature of monitoring should be individualized to the needs of the child and family."[15] It is important to note that patients should never abruptly stop taking antidepressant medications because adverse withdrawal effects, which include agitation and increased depression, may occur.[16]

When prescribed responsibly and monitored carefully, medications are both safe and effective for treatment of adolescent depression. While medications have been associated with a small increase in thoughts of suicide, there is no evidence that antidepressants actually increase the risk of suicide.[17] As depression itself is a significant risk factor for suicide, the potential benefits from medication outweigh the theoretical risks.

Neighborhood Health Plan and its Behavioral Health partner, Beacon Health Strategies, concur with the AACAP Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders, as well as the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) written by the American Academy of Pediatrics, that all children, particularly those ages 13-18, should be screened for depressive symptoms. For those children who screen positive for depression, an assessment for the presence of suicidal ideation, plan, intent, and means should immediately follow. Furthermore, and in accordance with the AACAP Practice Parameters, we recommend that treatment for depression includes, but is not limited to, psychoeducation of the child and family about the causes, symptoms, course, risks, and treatment options for depression; individual therapy in the form of CBT; family therapy, or at minimum family involvement and consultation where appropriate; and antidepressant medication, particularly for those adolescents with moderate to severe depression and for which psychotherapy alone has not been effective in alleviating depressive symptoms. GLAD-PC also recommends the establishment of a safety plan should the patient decompensate, become actively suicidal or experience an acute crisis or stressor.[18] ■

1 American Academy of Child and Adolescent Psychiatry (2007). Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders [on-line]. Available: www.aacap.org.

2 American Academy of Child and Adolescent Psychiatry (2007). Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders [on-line]. Available: www.aacap.org.

3 American Academy of Child and Adolescent Psychiatry (2007). Practice Parameter for the Assessment and Treatment of Children and Adolescents with Depressive Disorders [on-line]. Available: www.aacap.org.

4 Shain, B.N., and the Committee on Adolescence. (2007). Suicide and Suicide Attempts in Adolescents. Pediatrics, 120, 669-676.

5 National Institute of Mental Health (2008) Antidepressant Medications for Children and Adolescents: Information for Parents and Caregivers [on-line]. Available: www.nimh.nih.gov.

6 National Institute of Mental Health (2008) Antidepressant Medications for Children and Adolescents: Information for Parents and Caregivers [on-line]. Available: www.nimh.nih.gov.

7 National Institute of Mental Health (2008) Antidepressant Medications for Children and Adolescents: Information for Parents and Caregivers [on-line]. Available: www.nimh.nih.gov.

8 Physicians Med Guide: The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians [on-line]. Prepared by the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry. Available: www.parentsmedguide.org/physiciansmedguide.htm.

9 Physicians Med Guide: The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians [on-line]. Prepared by the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry. Available: www.parentsmedguide.org/physiciansmedguide.htm

10 National Institute of Mental Health (2008) Questions and Answers about the NIMH Treatment for Adolescents with Depression Study (TADS) [on-line]. Available: www.nimh.nih.gov.

11 National Institute of Mental Health (2008) Questions and Answers about the NIMH Treatment for Adolescents with Depression Study (TADS) [on-line]. Available: www.nimh.nih.gov.

12 Physicians Med Guide: The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians [on-line]. Prepared by the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry. Available: www.parentsmedguide.org/physiciansmedguide.htm

13 Mayo Clinic. (2008). Antidepressants for children: Explore the pros and cons [on-line]. Available: www.mayoclinic.com/health/antidepressants/MH00059.

14 Mayo Clinic. (2008). Antidepressants for children: Explore the pros and cons [on-line]. Available: www.mayoclinic.com/health/antidepressants/MH00059.

15 Physicians Med Guide: The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians [on-line]. Prepared by the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry. Available: www.parentsmedguide.org/physiciansmedguide.htm

16 Physicians Med Guide: The Use of Medication in Treating Childhood and Adolescent Depression: Information for Physicians [on-line]. Prepared by the American Psychiatric Association and American Academy of Child and Adolescent Psychiatry. Available: www.parentsmedguide.org/physiciansmedguide.htm

17 American Academy of Child and Adolescent Psychiatry (2008). Child and Adolescent Depression Resource Center: FAQs on Child and Adolescent Depression [on-line]. Available: www.aacap.org/cs/child_and_adolescent_depression_resource_center/faqs_on_child_and_adolescent_depression.

18 Zuckerbrot, R.A., Cheung, A.H., Jensen P.S., Stein, R., Laraque, D and the GLAD-PC steering Group, (2007). Guidelines for Adolescent Depression in Primary Cary (GLAD-PC): I. Identification, Assessment and Initial Management. Pediatrics, 120, e1300-e1312.

Pharmacy and Therapeutics Update

The NHP pharmacy benefit strives to provide a high quality benefit while controlling the ever rising cost of a pharmacy benefit. As part of this effort, NHP uses several different programs including medication tiering, mandatory generic substitution, prior authorization, step therapy and quantity limits. All pharmacy programs are reviewed by the NHP P&T committee on an annual basis to assure the programs are clinically-sound and relevant. The NHP P&T committee reviews new to market medications after they have been available for six months. Prior to P&T review, new-to-market medications are blocked and reviewed as a prior authorization.[1]

Preferred Drug List (PDL) Update

The Pharmacy and Therapeutics Committee has reviewed the following medications.

Tier 1 (Generics)

Casodex (bicalutamide)
Catapres TTS (clondine patch)
Ortho Tricyclen Lo (norgestimate-ethnyl estradiol)
Plan B (levonorgestrel 0.75mg)
Prograf (tacrolimus)
Xopenex Nebulizer Solution (levalbuterol)

Tier 3

Kapidex[3] (dexzlansoprazole)
Sancuso[1] (granisetron transdermal patch)
Vectical[1] (calcitriol ointment)

Quantity Limitations[2]

The Pharmacy and Therapeutics Committee has voted to implement a quantity limit[2] on the following:

Kapidex (dexlansoprazole)
30 tablets/30 days

Vectical Ointment[1] (calcitriol)
2 tubes/7 days

Step Therapy Program[3]

The Pharmacy and Therapeutics Committee has voted to add Kapidex to step therapy[3] program for Proton Pump Inhibitors:

1st Line Medications	2nd Line Medications	3rd Line Medications	4th Line Medications
Prilosec OTC	Pantoprazole	Prevacid	Kapidex
	Omeprazole	Nexium	
		Aciphex	
		Zegerid	

The Pharmacy and Therapeutics Committee has voted not to cover:[4] Xylarex Solution (xylitol oral solution).

The Pharmacy and Therapeutics Committee has voted to implement **a Prior Authorization**[1] program on: Sancuso (granisetron transdermal patch), Vectical (calcitiol ointment).

For the most up-to-date information regarding the NHP pharmacy programs and the current medical necessity criteria, check the drug look-up and pharmacy section on www.nhp.org by clicking on “Drug Lookup” under “Quick Links.”

[1] Prior Authorization is an individual case review compared to P&T-established guidelines, or NHP New-to-Market policy, before a prescription for the specific medication will be covered.

[2] Quantity Limits promote cost-effective prescribing by limiting the number of units of medication that can be dispensed over a given time. These are established based on strengths available and the recommended doses.

[3] Step Therapy is an automated case review, based on P&T-established guidelines and the individual member’s NHP pharmacy profile. This process occurs with a pharmacy claim submission and does not require provider intervention if prior NHP pharmacy claims indicate use of the first line and/or second line medications.

[4] Requests for a not covered medication are reviewed on a case by case basis.

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Comments or Suggestions?
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Practice Guidelines

NHP endorses: the Massachusetts Health Quality Partners Adult and Pediatric Preventive Care Guidelines and the Prenatal Care Guidelines; the National Heart, Lung, Blood Institute Guidelines for the Diagnosis and Management of Asthma and the Massachusetts Asthma Action Plan; the Institute for Clinical Systems Improvement guideline on the treatment of Major Depression in Adults in Primary Care; the Massachusetts Guidelines for Adult Diabetes Care; and the U.S. Department of Health and Human Services guidelines for HIV/AIDS Treatment Information Service Guidelines. Through Beacon Health Strategies, NHP's Behavioral Health Partner, NHP endorses the American Academy of Child and Adolescent Psychiatry's (AACAP) Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit/Hyperactivity Disorder.

Recent updates have been made in the following Practice Guidelines:

- Diabetes Guidelines
- Prenatal Care Guidelines
- Major Depression in Adults in Primary Care
- HIV-Aids Guidelines including:
  - The Prevention and Treatment of Opportunistic Infections Among HIV-Exposed and HIV-Infected Children
  - Pregnant Women and Novel Influenza A (H1N1): Considerations for Clinicians
  - Interim Guidance—HIV-Infected Adults and Adolescents: Considerations for Clinicians Regarding Novel Influenza A (H1N1) Virus
  - Pregnant Women and Novel Influenza A (H1N1): Considerations for Clinicians
  - Prevention and Treatment of Opportunistic Infections Guidelines
  - Updated Pediatric Treatment Guidelines

To access these guidelines endorsed by NHP, click on Providers, Clinical Resources and then Clinical Practice Guidelines at www.nhp.org.

Paper copies of all guidelines are also available upon request. Contact Catherine Jason, Manager of Clinical Compliance and Education for the Clinical Operations Department, at 617-204-1427 or 1-800-433-5556, extension 1427. ■

Utilization Management Criteria

Neighborhood Health Plan develops medical necessity guidelines and criteria to review medical appropriateness of targeted services based on its member population and service utilization. Guidelines and criteria are objective and based on medical evidence utilizing various professional and government agencies and local health care delivery plans. Utilization management (UM)criteria and procedures for their application are reviewed at least annually and criteria are updated when appropriate. NHP elicits opinions, advice and comments from area practitioners on the development and adoption of UM criteria. NHP applies the criteria based on individual circumstances and needs and takes into account the local delivery system when determining the medical appropriateness of health care services. Criteria used to make UM decisions are available upon request. Please contact Catherine Jason, Manager of Clinical Compliance and Education for the Clinical Operations Department, at 617-204-1427 or 1-800-433-5556, extension 1427. ■

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