Best Practices for Medication Management for Children & Adolescents in Foster Care

July 2020

North Carolina Pediatric Society
State Chapter of the American Academy of Pediatrics

Introduction

There are typically over 11,000 children/youth in foster care in North Carolina on any given day. These children have special health care needs. Often because of the circumstances that led them to be placed into foster care, their physical, developmental, mental/social-emotional and oral health care has been inconsistent and sometimes impacted by crisis or injury.

According to national data, children in foster care are more likely to have a behavioral health (BH) diagnosis than other children, with one study reporting 63% of kids age 14 to 17 in foster care met criteria for at least one BH diagnosis at some point in their lifetime [1]. With more BH diagnoses come more psychotropic medications that kids in foster care are receiving. A 2008 study of children in foster care taking psychotropic medication found 21.3% were receiving mono- therapy (one class of psychotropic medication), 41.3% were taking three or more classes of psychotropic medications, 15.4% were taking medication from four or more classes, and 2.1% were taking five or more classes of psychotropic drugs [2]. Though children often have complex symptoms and multiple conditions, there is little evidence of the effectiveness of treatment with multiple medications. Furthermore, taking multiple meds increases the likelihood of drug interactions and other adverse effects.

This document was originally developed by Community Care of North Carolina with the assistance of the Medication Management Sub-Group of the Fostering Health NC initiative, a project of the North Carolina Pediatric Society focused on building and strengthening medical homes for infants, children, adolescents and young adults in foster care through integrated communications and coordination of care through a unique partnership among local Departments of Social Services, CCNC, the pediatric care team, the child and the child's family. This document was revised and updated by Fostering Health NC's Medication Workgroup.

Comments or questions about this document may be directed to:

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Psychotropic Medications Key Information

Purpose: This document is designed for readers with any background and provides foundational information about psychotropic medications.

Definition of Psychotropic Medication:
Capable of affecting the mind, emotions, and behavior; denoting drugs used in the treatment of mental illnesses [3].

Common Classes of Psychotropic Medications:

- Antipsychotics
- ADHD medications
- Anti-depressants
- Mood stabilizers
- Anxiety medications

Educational Resources for Psychotropic Medications Used for Children [4-7]:

1. *Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care, March 2016.*
    - Psychotropic medication tables with information including clinical indications for use, drug name, initial and maximum dosage, dose schedule, monitoring, black box warning, and precautions/warnings:
    - https://www.dfps.state.tx.us/Child_Protection/Medical_Services/documents/reports/2016-03_Psychotropic_Medication_Utilization_Parameters_for_Foster_Children.pdf

2. *Recommendations about the Use of Psychotropic Medications for Children and Adolescents Involved in Child-Serving Systems, 2015*
    - Recommendations for clinical practice, psychotropic medication monitoring and oversight.
    - https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/AACAP_Psychotropic_Medication_Recommendations_2015_FINAL.pdf
3. *Los Angeles County Department of Mental Health – Parameters 3.8 for Use of Psychotropic Medication in Children and Adolescents, December 2014.*
    - Psychotropic medication tables with information including drug name and drug class, clinical indications for use, drug interactions, complications/side effects, cautions/contraindications, medical work-up, medical follow-up, dosage, dose schedule, adverse effects, and special considerations:
    - http://file.lacounty.gov/dmh/cms1_191102.pdf

4. *John's Hopkins Guide to Psychopharmacology for Pediatricians*
    - Conceptual framework and selection criteria for psychiatric medications that are appropriate for prescribing in primary care:
    - http://web.jhu.edu/pedmentalhealth/Psychopharmacolog%20use.html

5. *Appropriate Use of Psychotropic Drugs in Children and Adolescents: A Clinical Monograph. Magellan Health Services, 2013.*
    - Psychotropic medication tables with information including drug name, FDA Approval Age/Indication, pediatric dosage, black box warning, precautions/warnings, drug class
    - typical side effects, pregnancy information, and monitoring/monitoring frequency:
    - https://www.openminds.com/wp-content/uploads/indres/magellan-psychotropicdrugs-020314.pdf?status=free

"High Alert" Medication Review Guidelines - for Children & Adolescents in Foster Care

Purpose: To assist DSS staff with a child transitioning into foster care, or changing placements, to make sure the child has needed medication in a timely fashion to prevent adverse events as a result of being without or not taking the medication.

Medications listed are separated into three categories:

- Medications that can cause withdrawal symptoms if stopped abruptly (benzodiazepines, antidepressants, stimulants, Atomoxetine, opioids, baclofen, phenobarbital)
- Medications that would be risky to stop due to potential disease re-occurrence (diabetic agents, antiepileptic's, maintenance asthma inhalers, Pancrelipase, airway clearance therapies, antibiotics, hydroxyurea, endocrine agents, antipsychotics, oral contraceptives)
- Medications that might be needed in an emergency (rescue asthma inhalers, Epi-pen®,triptans)

DSS staff should use this sheet in combination with the any available medication history information when a child first comes into DSS custody or is moved to a different placement. If the child appears to be taking any of these classes of medications consistently within the past 60 days, DSS staff should contact the medical home as soon as possible to get these medications filled in order to prevent adverse effects.

Condition	"High Alert" Medication (Note: List is Not all-inclusive)		
	Medications that cause withdrawal symptoms if stopped abruptly	***Medications risky to stop due to potential disease re-occurrence***	***Medications that might be needed in an emergency***
Diabetes (Type I and II)		Insulin (Humalog, Novolog, Apidra, Lantus, Levemir, Humulin, Novolin) Glyburide Glipizide Metformin	Glucagon
Seizure Disorder	Phenobarbital	Divalproex (Depakote®) Lamotrigine (Lamictal®) Oxcarbazepine (Trileptal®) Levetiracetam (Keppra®)	Diazepam rectal (Diastat®)
Asthma Inhalers (Acute/rescue)			Albuterol (ProAir®, Proventil®, Ventolin®) Levalbuterol (Xopenex®)
Asthma Inhalers (maintenance)		Beclomethasone (QVAR®) Budesonide (Pulmicort®) Fluticasone (Flovent®)	
Asthma oral medications		Montelukast (Singulair®)	
Schizophrenia/Bipolar Disorder/Autism Spectrum Disorders – antipsychotics		Risperidone (Risperdal®) Aripiprazole (Abilify®) Quetiapine (Seroquel®) Olanzapine (Zyprexa®)	
Allergy requiring treatment of anaphylaxis (i.e., bee sting)			Epinephrine (Epi-pen® , Symjepi™)

Condition	"High Alert" Medication (Note: List is Not all-inclusive)		
Anxiety/Depression (treated with medication)	***Antidepressants*** ○ Escitalopram (Lexapro®) ○ Sertraline (Zoloft®) ○ Fluoxetine (Prozac®) ○ Trazodone ○ Duloxetine (Cymbalta®) ○ Venlafaxine (Effexor®) ***Benzodiazepines*** ○ Alprazolam (Xanax®) ○ Lorazepam ○ Clonazepam ○ Diazepam		
Endocrine		Levothyroxine (Synthroid®) Methimazole Propylthiouracil Hydrocortisone Desmopressin	
Infection – Antibiotics		Amoxicillin Azithromycin Cefdinir Amoxicillin/clavulanate (Augmentin®) Trimethoprim/ sulfamethoxazole (Bactrim®) Clindamycin	
ADHD	**Stimulants** Methylphenidate (Aptensio® XR) ○ Ritalin®, Concerta®, Quillichew®, Quillivant®) ○ Dexmethylphenidate (Focalin®) ○ Lisdexamfetamine (Vyvanse®) ○ Amphetamine mixed salts (Adderall®) **Others** ○ Atomoxetine (Strattera®) ○ guanfacine (Intuniv®) ○ clonidine ER (Kapvay®)		
Sickle Cell Disease/Pain	**Opioids** ○ Oxycodone/APAP (Percocet®, Roxicet®) ○ Hydrocodone (Vicodin®, Lortab®)	**Maintenance** Hydroxyurea (+ folic acid) Penicillin (up to age 5)	Naloxone (Narcan®, Evzio®, Vivitrol®)

Migraine Headaches – Triptans			Sumatriptan (Imitrex®) Rizatriptan (Maxalt®) Zolmitriptan (Zomig®)
Cerebral Palsy	Baclofen		
Pancreatic Insufficiency		**Pancrelipase** ○ Pertzye® ○ Ultresa® ○ Creon® ○ Pancreaze® ○ Zenpep®	
Cystic Fibrosis		**Airway Clearance Therapies** ○ Albuterol ○ HyperSal® ○ Pulmozyme® **Aerosolized Antibiotics** ○ Cayston® ○ TOBI®	
Oral Contraceptives		Ortho Tri-Cyclen® TriNessa® Tri-Sprintec® Activella® Loestrin® Junel®	

Disclaimer – It is important that a child continue to take all prescribed medications as directed; however, this list indicates some medications that could be potentially problematic if stopped abruptly.

Please Note: This is NOT an all-inclusive list.

"High Alert" Medication Review Quick Guide - for Children & Adolescents in Foster Care

Purpose: To assist DSS staff with a child transitioning into foster care, or changing placements, to make sure the child has needed medication in a timely fashion to prevent adverse events as a result of being without or not taking the medication.

Medications listed are separated into three categories:

1. Medications that can cause withdrawal symptoms if stopped abruptly (benzodiazepines, antidepressants, stimulants, atomoxetine, opioids, baclofen, phenobarbital)

2. Medications that would be risky to stop due to potential disease re-occurrence (diabetic agents, antiepileptic's, maintenance asthma inhalers, Pancrelipase, airway clearance therapies, antibiotics, hydroxyurea, endocrine agents, antipsychotics, oral contraceptives)

3. Medications that might be needed in an emergency (rescue asthma inhalers, Epi-pen®, triptans)

DSS staff should use this sheet in combination with any available medication history information when a child first comes into DSS custody or is moved to a different placement. If the child appears to be taking any of these classes of medications consistently within the past 60 days, DSS staff should contact the medical home as soon as possible to get these medications filled in order to prevent adverse effects

Disclaimer – It is important that a child continue to take all prescribed medications as directed; however, this list indicates some medications that could be potentially problematic if stopped abruptly.
Please Note: This is NOT an all-inclusive list.

- ☐ Abilify® (2)
- ☐ Activella® (2)
- ☐ Adderall® (1)
- ☐ Albuterol (2)
- ☐ Alprazolam (1)
- ☐ Amoxicillin (2)
- ☐ Amphetamine mixed salts (1)
- ☐ Aripiprazole (2)
- ☐ Atomoxetine (1)
- ☐ Augmentin® (2)
- ☐ Azithromycin (2)
- ☐ Baclofen (1)
- ☐ Bactrim® (2)
- ☐ Beclomethasone (2)
- ☐ Budesonide (2)
- ☐ Cayston® (2)
- ☐ Cefdinir (2)
- ☐ Clavulanate (2)
- ☐ Clindamycin (2)
- ☐ Clonazepam (1)
- ☐ Concerta® (1)
- ☐ Creon® (2)
- ☐ Depakote® (2)
- ☐ Desmopressin (2)
- ☐ Dexmethylphenidate (1)
- ☐ Diazepam (1)
- ☐ Divalproex (2)
- ☐ Epi-pen® (3)
- ☐ Epi-pen JR® (3)
- ☐ Escitalopram (1)
- ☐ Fluoxetine (1)
- ☐ Focalin® (1)
- ☐ Glipizide (2)
- ☐ Glyburide (2)
- ☐ Hydrocodone (1)
- ☐ Hydrocortisone (2)
- ☐ Hydroxyurea+folic acid (2)
- ☐ HyperSal® (2)
- ☐ Imitrex® (3)
- ☐ Insulin (2)
- ☐ Junel® (2)
- ☐ Keppra® (2)
- ☐ Lamictal® (2)
- ☐ Lamotrigine (2)
- ☐ Levetiracetam (2)
- ☐ Levothyroxine (2)
- ☐ Lexapro® (1)
- ☐ Lisdexamfetamine (1)
- ☐ Loestrin® (2)
- ☐ Lorazepam (1)
- ☐ Lortab® (1)
- ☐ Metformin (2)
- ☐ Methimazole (2)
- ☐ Methylphenidate (1)
- ☐ Montelukast (2)
- ☐ Olanzapine (2)
- ☐ Ortho Tri-Cyclen® (2)
- ☐ Oxcarbazepine (2)
- ☐ Oxycodone/APAP (1)
- ☐ Pancreaze® (2)
- ☐ Penicillin (2)
- ☐ Percocet® (1)
- ☐ Pertzye® (2)
- ☐ Phenobarbital (1)
- ☐ ProAir® (3)
- ☐ Propylthiouracil (2)
- ☐ Proventil® (3)
- ☐ Prozac® (1)
- ☐ Pulmicort® (2)
- ☐ Pulmozyme® (2)
- ☐ Quetiapine (2)
- ☐ QVAR® (2)
- ☐ Risperdal® (2)
- ☐ Risperidone (2)
- ☐ Ritalin® (1)
- ☐ Roxicet® (1)
- ☐ Seroquel® (2)
- ☐ Sertraline (1)
- ☐ Singulair® (2)
- ☐ Strattera® (1)
- ☐ Sumatriptan (3)
- ☐ Synthroid® (2)
- ☐ TOBI® (2)
- ☐ Trazodone (1)
- ☐ Trileptal® (2)
- ☐ Trimethoprim/ sulfamethoxazole (2)
- ☐ TriNessa® (2)
- ☐ Tri-Sprintec® (2)
- ☐ Ultresa® (2)
- ☐ Ventolin® (3)
- ☐ Vicodin® (1)
- ☐ Vyvanse® (1)
- ☐ Xanax® (1)
- ☐ Zenpep® (2)
- ☐ Zolmitriptan (3)
- ☐ Zoloft® (1)
- ☐ Zomig® (3)
- ☐ Zyprexa® (2)

Red Flag" Medication Review Guidelines for Children & Adolescents in Foster Care

Purpose: To assist Prescribers, Pharmacists, and DSS Staff **(in consultation with pharmacist or prescriber)** with the identification of "Red Flag" criteria which may be potentially harmful to the child/adolescent while reviewing their medications.

"Red Flag" criteria indicate a need to review the child/adolescent's clinical status in order to verify the medication regimen is accurate and appropriate. These parameters do not necessarily indicate that treatment is inappropriate, but they do indicate a need for further review. **Page 13 and 14 (Medication Management Protocols)** explain how Providers, Pharmacists, and DSS Staff can use these "Red Flag" criteria.

For a child/adolescent being prescribed a psychotropic medication, any of the following suggests the need for additional review of a patient's clinical status:

#1: Absence of a thorough assessment for the DSM-5 diagnosis (es) in the child/adolescent's medical record.	☐ YES ☐ NO
#2: Four (4) or more psychotropic medications prescribed at the same time (medications being prescribed to deal with the side effects of the primary medication are not included in this count (i.e., benztropine, diphenhydramine, trihexyphenidyl)).	☐ YES ☐ NO
#3: Prescribing of: • Two (2) or more concomitant stimulants *[1], or • Two (2) or more concomitant alpha agonists [2], or • Two (2) or more concomitant antidepressants [3], or • Two (2) or more concomitant antipsychotics [4], or • Three (3) or more concomitant mood stabilizers [5] * The prescription of a long-acting stimulant and an immediate-release stimulant of the same chemical entity (e.g., methylphenidate) does not constitute concomitant prescribing. ***Note*:** When switching psychotropic medications, medication overlaps (where one medication overlaps with another medication for a period) and cross taper (slowly decreasing the dose of one medication while slowly increasing the dose of another medication) should occur in a timely fashion, generally within 4 weeks.	☐ YES ☐ NO
#4: Psychotropic medications are prescribed for children of very young age, including children receiving the following medications with an age of: • Stimulants [1]: Less than three (3) years of age • Alpha Agonists [2]: Less than four (4) years of age • Antidepressants [3]: Less than four (4) years of age • Antipsychotics [4]: Less than four (4) years of age • Mood Stabilizers [5]: Less than four (4) years of age	☐ YES ☐ NO

#5: The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder** or with documented target symptoms usually associated with a therapeutic response to the medication prescribed (i.e. medication isn't usually used to treat diagnosed mental disorder or symptoms). **** **See page 4** for resources that include information about clinical indications for use.	☐ YES ☐ NO
#6: Psychotropic polypharmacy (2 or more medications) for a given mental disorder is prescribed before utilizing psychotropic monotherapy (single medication).	☐ YES ☐ NO
#7: The psychotropic medication dose exceeds usual recommended doses*** (FDA and/or literature based maximum dosages). ***** **See page 4** for resources that include information about maximum dosages.	☐ YES ☐ NO
#8: Prescribing by a primary care provider who has not documented previous specialty training for a diagnosis other than the following (unless recommended by a psychiatrist consultant): • Attention Deficit Hyperactive Disorder (ADHD) • Uncomplicated Anxiety Disorders • Uncomplicated Depression	☐ YES ☐ NO
#9: Antipsychotic medication(s) prescribed continuously without appropriate monitoring of glucose and lipids at least every 6 months.	☐ YES ☐ NO
#10: Psychotropic medication therapy for longer than 6 months without re-evaluation of the need for the medication.	☐ YES ☐ NO
#11: Psychotropic medication(s) prescribed without co-occurring counseling or psychotherapy.	☐ YES ☐ NO

[1] Examples of **stimulants** include methylphenidate, (Ritalin®, Concerta®), dexmethylphenidate (Focalin®), lisdexamfetamine (Vyvanse®), and amphetamine mixed salts (Adderall®).
[2] Examples of **alpha agonists** include Guanfacine ER (Intuniv®) and clonidine ER (Kapvay®).
[3] Examples of **antidepressants** include Escitalopram (Lexapro®), Sertraline (Zoloft®), fluoxetine (Prozac®), and Trazodone.
[4] Examples of **antipsychotics** include Risperidone (Risperdal®), olanzapine (Zyprexa®), Aripiprazole (Abilify®), and Quetiapine (Seroquel®).
[5] Examples of **mood stabilizers** include Divalproex (Depakote®), lithium, Lamotrigine (Lamictal®), and carbamazepine (Tegretol®, Equetro®).

This resource was adapted from the Psychotropic Medication Utilization Parameters for Children and Youth in Foster Care (March 2016) that was developed by the Texas Department of Family and Protective Services and The University of Texas at Austin College of Pharmacy. Any changes, and additional criteria were decided upon by the Medication Management Subgroup of the Fostering Health NC Initiative, a project of the North Carolina Pediatric Society. This project is focused on building and strengthening medical homes for infants, children, adolescents, and young adults in foster care through integrated communications and coordination of care through a unique partnership among local Department of Social Services, Community Care of North Carolina Networks, the pediatric care team, the child, and the child's family.

"High Alert" Medication Review for a Child/Adolescent Transitioning into Foster Care or Changing Foster Care Placement
Review to be completed by – Prescribers/Pharmacists

Purpose: To assist Prescribers and Pharmacists with a child transitioning into foster care, or changing placements, to make sure the child has needed medication in a timely fashion to prevent adverse events as a result of being without or not taking the medication. This form should be used in combination with any available medication history information and filled out by a Prescriber or Pharmacist. Once completed, it should be given to the DSS staff member who is caring for the child for them to assist the child in obtaining any needed medication.

Note: If this form is filled out by a prescriber, it would be helpful to the DSS staff member who is caring for the child to also include prescriptions for any needed medications.

Date:		**DSS County:**	
Attn: DSS Child Welfare Worker		**DSS Email:**	
DSS Telephone:		**DSS Fax No:**	
Name Child/Adolescent		**D.O.B**	

Dear _____ (DSS Child Welfare Worker/Supervisor),
I am a Prescriber/Pharmacist with _____, a practice/pharmacy/CCNC in _____ County. I have reviewed the medication profile of _____, DOB/MID: _____ and have the following recommendation(s) regarding acuity of medication needs and follow up with his/her Primary Care Provider.
This patient is prescribed medications for one or more of the following conditions:

Foster Child's Medical Condition	Foster Child's Medication(s)
☐ Diabetes (Type I and II)	
☐ Seizure Disorder (anticonvulsants)	
☐ Asthma (acute/rescue, maintenance)	
☐ Anxiety/Depression (treated with medication)	
☐ Allergy requiring treatment of anaphylaxis (i.e., bee sting)	
☐ Pancreatic Insufficiency (pancreatic enzyme supplements)	
☐ Cystic Fibrosis	
☐ Infection (antibiotics)	
☐ ADHD (stimulants, atomoxetine)	
☐ Sickle Cell Disease/Pain (opioids, hydroxyurea, etc.)	
☐ Migraine Headaches (triptans)	
☐ Cerebral Palsy (baclofen)	
☐ Endocrine (levothyroxine, hydrocortisone, etc.)	
☐ Schizophrenia/Bipolar Disorder/Autism Spectrum Disorders (antipsychotics, mood stabilizers)	
☐ Oral Contraceptives	

☐ Other (specify): _____	

Recommended to obtain medications noted above:

- ☐ Urgently / As soon as possible (ASAP) _____
- ☐ Within 48-72 hours (2-3 days) _____
- ☐ Within 1 week _____
- ☐ Not needed until next scheduled visit _____

According to the AAP Standards of Care:

1. The **"Initial Visit",** to address acute care needs, should occur **within 72 hours of placement** into foster care (NC Division of Social Services policy directs that this visit be completed within **7 days** of entry into care).
2. A 30-day **"Comprehensive Visit"** should occur within 30 days of placement into foster care, unless medically necessary to see the child sooner.

I may also include a **Patient Care Team and Medication Report** for this child/Adolescent, which includes pharmacy information for the medications noted above. Please contact me if you have any further questions.

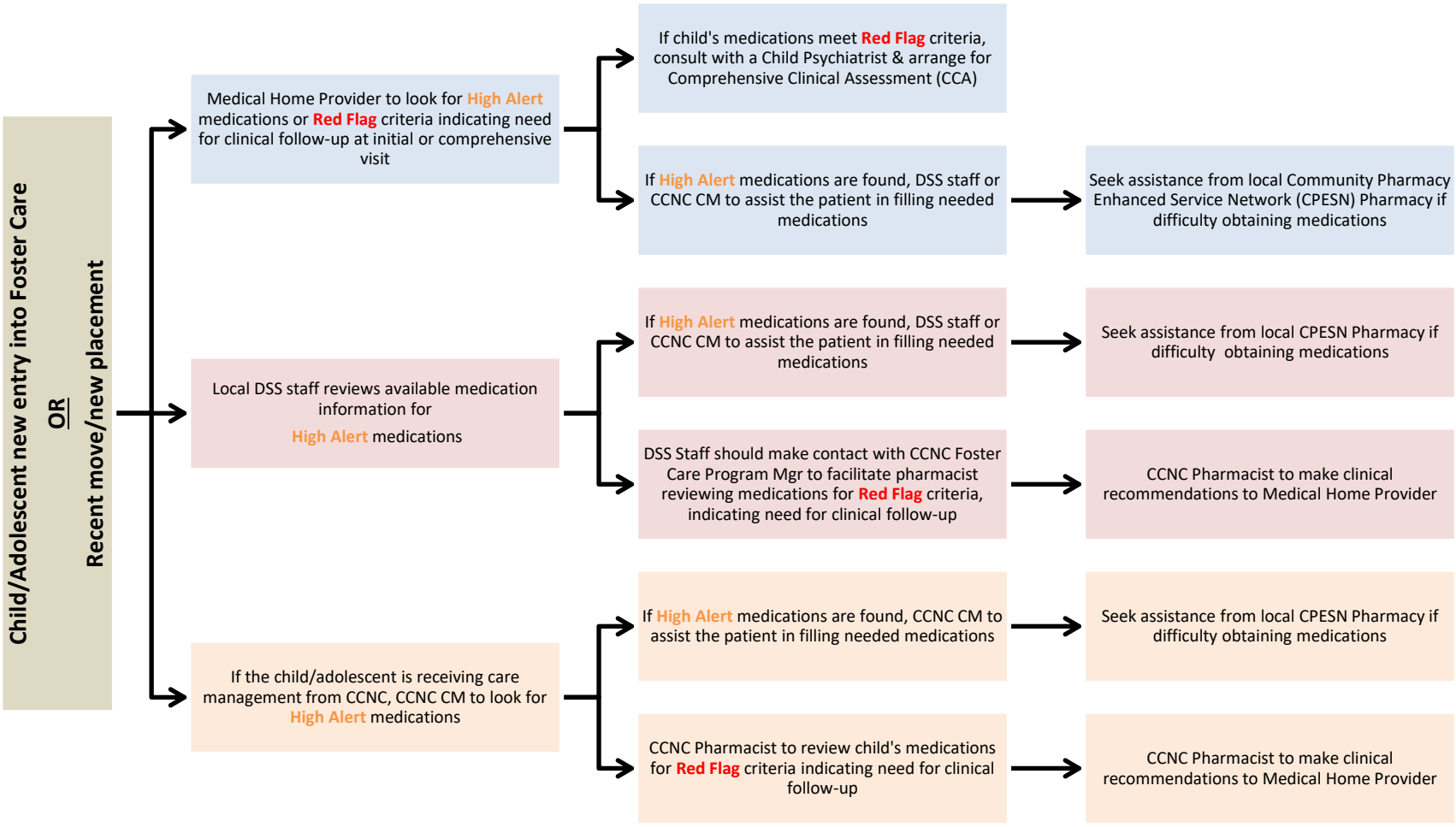
Recommendations & Review done by:

Provider's Name: _____ **Date:** _____/_____/_____

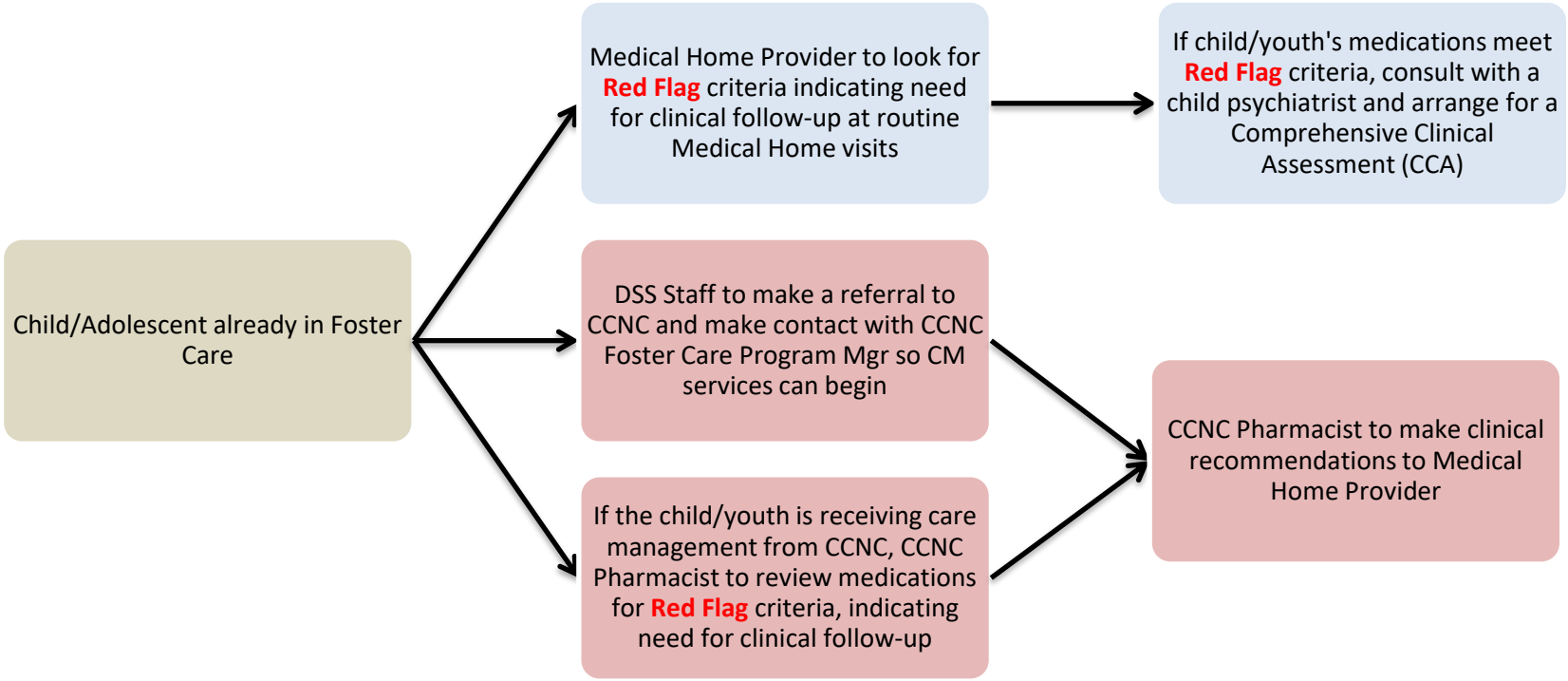
Provider's Tel No.: _____ **Fax No.:** _____

Provider's E-mail Address: _____

Protocol for a Child/Adolescent who is New to Foster Care or has recently Changed Placements (i.e, gone to a new foster home, group home, returned home)



Protocol to follow for Child/Adolescent Already in Foster Care



Community Pharmacy Enhanced Services Network

Integrating pharmacy services, medical services, and behavioral health

CPESN® North Carolina pharmacies see their complex patients on average 35 times per year. These same patients see their primary care physician only about 3.5 times per year. Every one of these interactions is an opportunity to get more value from medications and alert physicians when new issues arise that could lead to readmission or a worsening of the patient's condition.

CPESN core services include medication fill synchronization, adherence monitoring, adherence coaching, compliance packaging, home delivery, comprehensive medication review, care plan development and reinforcement and clear communication back to the provider. Many CPESN pharmacies offer broader services as well, including the additional services listed below**.**

In addition to these services, CPESN pharmacies offer creative solutions to complex problems faced by special populations.

Optional Enhanced Services Provided by CPESN Pharmacies

- 24-hour Emergency Service/On Call – Dispensing and Non-Dispensing
- Adherence Packaging
- Collection of Vital Signs or Standardized Assessments (PHQ, etc.)
- Comprehensive Medication Review
- Home Delivery
- Medication Synchronization Program
- Medication Dispensing for Patients with Presumptive Medicaid Eligibility
- Smoking Cessation Program
- DME Billing – Medicare and Medicaid
- Home Visits
- Care Plan Development/Reinforcement
- Point of Care Testing
- Immunizations – Non-Medicaid
- In Depth Counseling/Coaching
- Long-Acting Injections
- Multi-Lingual Staff
- Naloxone Dispensing
- Nutritional Counseling
- Printout of Patient's Personal Medication Record
- Pre-filling Syringes for Oral Administration
- Specialty Pharmacy Dispensing
- Disease State Management Programs
- Compounding, Sterile and/or Non-Sterile

How do I find the CPESN pharmacies in my area of North Carolina?

Access the Pharmacy Finder on the CPESN website: https://collaboration.cpesn.com/finder.

For more information about this program and what participation can mean for you and your patients, contact Kristin Lundeen via phone at 919-516-8118 or email klundeen@communitycarenc.org

Community Pharmacy Enhanced Services Network

Integrating pharmacy services, medical services, and behavioral health

CPESN Success Story

A CCNC Pharmacist received a call from the Foster Care Program Care Manager about an adolescent in foster care being discharged from a behavioral health (BH) facility in Columbia, SC. The DSS Case Worker who had traveled down to pick her up was not able to fill her discharge medications since the facility's Prescriber was not enrolled with NC Medicaid. The BH facility was unable to send her home with any medications to bridge her therapy until she could be linked to a Primary Care Physician so the child and DSS Case Worker were waiting at the facility until medication access could be obtained.

CCNC Pharmacist reached out to one of their CPESN pharmacy partners to explain the situation and request they use the organizational NPI of the facility to run the claims. The Foster Program Care Manager called the facility to request their NPI and have the prescriptions faxed to the CPESN Pharmacy.

The CPESN Pharmacy was even willing to run a test claim to ensure the patient's prescriptions were successfully covered before receiving the faxed prescriptions. The CCNC Pharmacist explained to the DSS Case Worker that she could bring the patient home and her prescriptions would be ready when they arrived. The willingness of the CPESN Pharmacy to go above and beyond resulted in no disruption of medication management for this complex patient transitioning back into the community.

Antipsychotics – Keeping it Documented for Safety (A+KIDS)

A+KIDS Project Re-launched June 5, 2015

Prior authorization is required for antipsychotics for NC Medicaid and NC Health Choice beneficiaries.

Objectives of the A+KIDS prior authorization includes improving the use of evidence-based safety monitoring for patients for whom an antipsychotic agent is prescribed, reduction of antipsychotic polypharmacy, and reduction of cases in which the FDA maximum dose is exceeded. It is a safety monitoring program designed to make sure that children enrolled in NC Medicaid and Health Choice who are prescribed an antipsychotic medication are monitored according to generally accepted guidelines.

The questions that providers are expected to document in the NCTracks portal are listed on the worksheet on the next page.

Q & A for Providers

What will I need to do if I prescribe an antipsychotic for a child enrolled in the Medicaid program?

Prescribers will need to go online and enter some basic information about the patient, medication, dose, diagnosis, etc. into the NCTracks provider portal. Data elements collected within the NCTracks portal reflect a generally accepted monitoring profile for the safety and efficacy of antipsychotic therapy, are typically collected as part of a routine exam, and should take no longer than 5 minutes to enter. The requirement of safety monitoring documentation in the NCTracks portal by the prescriber occurs when an antipsychotic agent is prescribed for any Medicaid or Health Choice beneficiary under age 18. Once the data is entered into the NCTracks portal, the pharmacy will have authorization to process the claim.

How do I enter the data online or by phone?

In order to have access to the NCTracks Provider portal, each Provider (NPI) must first complete the NCTracks Currently Enrolled Provider (CEP) Registration.

NCTracks enrolled providers may then enter the requested information by visiting the NCTracks Web Portal using your NCID and password (log in at https://www.nctracks.nc.gov/ncmmisPortal/login).

The prior authorization (PA) may also be authorized by phone by calling CSC-NCTracks at 1-866-246-8505. Providers must be enrolled in Medicaid and have an NPI number in order to access the NCTracks phone option.

Use of Point of Sale (POS) Overrides

Point of sale (POS) overrides are available for pharmacies to use when the prescriber has not provided NCTracks portal documentation either electronically or by phone for the recipient. Use of overrides to successfully process a claim for an antipsychotic medication for NC Medicaid and Health Choice patients is restricted to 2 overrides per beneficiary per rolling calendar year. Pharmacists are encouraged to ensure that all providers are informed when the override option is utilized for their patient. Each override will apply to all claims for antipsychotic medication(s) on the same date of service.

Information Gathering Resource Tool for A+KIDS

Purpose: This tool will assist Providers in collecting the necessary information to complete the required documentation for NCTracks Provider Portal when prescribing an antipsychotic for a child less than 18 years of age.

The NCTracks Provider Portal will request the following information to complete the Prior Authorization request for a child less than 18 years of age:

- Drug name, strength, quantity per 30 days, length of therapy, dosing instructions
- Primary psychiatric diagnosis (indication)
- Primary target symptoms
- Height, weight
- Labs: Lipids, glucose
- Clinical improvements
- Adverse effects

NC Medicaid and Health Choice Preferred Drug List (PDL)

Summary

Periodically, North Carolina Medicaid publishes updates to its Preferred Drug List (PDL). The agents listed as preferred do not require prior authorization unless clinical criteria apply. The agents that are non-preferred will require a non-preferred drug request (prior authorization).

Non-Preferred Drug Requests

In order to request a non-preferred drug for a NC Medicaid or Health Choice Beneficiary, the patient must have tried and failed 2 preferred agents, or have a contraindication to preferred agents, or have other clinically compelling rationale to remain on the non-preferred agent, unless otherwise stated on the PDL.

Non-Preferred Drug requests require prior authorization and may be submitted via phone or through the NCTracks Web Portal using your NCID and password (log in via https://www.nctracks.nc.gov/ncmmisPortal/login).

NCTracks Pharmacy Page

Find information about which drugs require prior authorization, criteria for approval and fax forms.

https://nctracks.nc.gov/content/public/providers/pharmacy.html

NCTracks Pharmacy Call Center

Phone: 1-866-246-8505
Fax: 1-855-710-1969
Hours of operation: Monday - Friday: 7:00 AM to 11:00 PM & Saturday and Sunday: 7:00 AM to 6:00 PM

72- Hour Emergency Supply

Pharmacies may dispense an emergency 72-hour supply if a beneficiary is awaiting prior authorization (PA).

Please Note: If the 72-hour supply is for a C-II (such as stimulants for ADHD) medication, the pharmacy will have to obtain a new prescription after the PA is approved, or they can reverse the 72-hour supply claim and bill for the entire prescription quantity for the original prescription.

Questions DSS Child Welfare Workers and/or Resource Parents Can Ask of Treatment Providers Who Prescribe Psychotropic Medications [5]

1. Are there behavioral interventions that might be tried before medication, or used along with medication at a lower dose?

2. Does research support using this medication for a child that is my child's age and with similar needs?

3. How does medication fit within the overall treatment plan and how will we coordinate with other treatment, such as therapy, school behavior plans, and more?

4. Is the prescribed medication more, less, or equally effective as other non-drug interventions?

5. What kind of changes in behavior and symptoms should we be looking for, and whom should we contact with questions about these changes and the medication?

6. How long will it take before we should start seeing behavioral changes? Will those potential changes be significant or minor?

7. What are the potential risks and benefits of the medication and other treatment options, and what are the potential side effects?

8. If a medication dose is missed or stopped abruptly, are there potential adverse effects? What might those be and what should I do if I observe them?

9. How will our family, our child, and the treating provider monitor progress, behavior changes, symptoms, and safety concerns? (Close monitoring is critical with all medications at all times; however, it is especially important when medication is started and when dosages are changed.)

10. How will we know when it is time to talk about stopping medication treatment and what steps need to be taken before the medication is stopped?

11. How can we best develop a clear communication plan between our family and the treating providers (therapist and psychiatrist) to ensure open lines of communication?

12. What if my child has a crisis and is hospitalized? Who can we contact in your office, especially if someone wants to change medications?

Adapted from NAMI, "Choosing the Right Treatment: What Families Need to Know about Evidence-Based Practices, 2007."

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Updates to the Document:

1. July 2015: Document completed and released
2. October 2015: Pages 19-22 updated to reflect NC Medicaid PDL changes effective Nov. 1, 2015
3. July 2020: Document reviewed and revised

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(Original 2015 version: Collaboration between Theodore Pikoulas, PharmD, BCPP - Associate Director of Behavioral Health Pharmacy Programs Community Care of North Carolina and Fostering Health NC Medication workgroup)