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Improving Treatment of Opioid Addiction and Preventing Abuse

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The drug abuse epidemic in the US has placed attention on opioids. There are an estimated 110 million people in the US suffering from chronic pain, who take opioid pain medications, but approximately 5 million Americans used pain relievers for non-medical reasons in 2010.

During a session at the AMCP Managed Care & Specialty Pharmacy Annual Meeting 2016, panelists discussed the current state of treatment for opioid addiction and future changes that may be on the way.

There is a slippery slope to addiction using opioids, said Kelly J. Clark, MD, MBA, president elect of the American Society of Addiction Medicine. There has been a 183% increase in opioid use in the last 7 years and 1 in 20 people use opioids for non-medical use.

“About 80% of people … using heroin started with a prescribed pill,” Dr Clark said. “So we’re very clear that the use pills is leading to heroin.”

It is important to understand that addiction is a chronic brain disease, she explained, and that people can become addicted by taking medication exactly as prescribed. Being addicted to opioids means a person loses control of their drug use and then their lives. In contrast, someone can be physically dependent on opioids without becoming addicted.

Although opioid addiction is a chronic brain disease, it is not treated or managed the same as other chronic diseases. Similarly, there is no magic bullet or way to miraculously fix the disease.

“We manage chronic diseases,” Dr Clark said. “It’s about a psychosocial approach that we use.”

Historically, treatment for opioid addiction was spiritual (12 steps) or payment-based (rehab program). Currently, there are only 3 FDA-approved medications to treat opioid addiction: methadone, naltrexone, and buprenorphine. There is extremely strong evidence for the effectiveness and cost effectiveness of methadone and buprenorphine, but there are challenges.

Methadone is only available in licensed clinics and patients have to come daily to receive a dose. However, there are access issues, particularly for patients in rural areas. In addition, few payers cover these services. Naltrexone is approved for use in alcohol use disorder, and there is no abuse risk, because it blocks people from getting high. However, because it has been on the market for opioid addiction for less time, there is less evidence for long term utility.

Lastly, there is buprenorphine can be prescribed in a doctor's office, but the physician can only treat up to 30 patients in year 1 and then just 100 patients per year after. There are a number of non-clinical coverage issues for this treatment, such as lifetime limits on coverage, forced taper on the medication, and requiring that the patient refrains from all drugs of abuse.

The main takeaway from Dr Clark's talk was that the restrictions involved in treatment for opioid addiction are not done in other chronic conditions. If a patient with diabetes has cake at a party, they don't have their insulin taken away, she explained.

Gary M. Henschen, MD, chief medical officer-behavioral health at Magellan Health, explained solutions for substance use, primarily: medication-assisted treatment, office-based opioid treatment, ambulatory detoxification, identifying and treating co-occurring disorders, and screening tools and processes.

Magellan developed an initiative to find out if medication-assisted treatment worked. At the time of discharge, a care manager would ask if the attending physician had considered medication-assisted treatment. If they hadn't, they would receive educational materials to explain the efficacy of medication-assisted treatment. The initiative also wanted to intervene early and identify patients at risk and get them into treatment early.

Identifying patients who are at risk for opioid abuse means the use of an algorithm that is based on the number of prescriptions filled in the last 90 days, and morphine equivalent dose.

Finally, Reginia Grayson Benjamin, JD, BS, director of legislative affairs at AMCP, ran through the latest federal legislative efforts. Notably, there is a bill called the Comprehensive Addiction and Recovery Act (CARA), which has passed the Senate and is now in the House. The bill is designed to be a comprehensive approach to prevention, education, treatment recovery, and law enforcement efforts to address opioid and heroin addiction.

However, there are 5 other bills pending related to substance abuse, such as the Recovery Enhancement for Addiction Treatment Act, which would increase the number of patients a

prescribing doctor can prescribe buprenorphine for opioid addiction.

In addition to the federal legislation pending, there have been state actions in response to increased opioid use. Nearly all states (45) have laws that provide immunity to people who administer naloxone, plus there are laws to promote training and education on recognizing and preventing overdoses.

On top of these efforts, CDC released on March 15, 2016, a new guideline for prescribing opioids for chronic pain.

“There is action basically on every front on opioids,” Benjamin said. “It seems everyone agrees, and finally admits, there is a problem.”