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Featured *Health Business Daily* Story, Nov. 9, 2016

Claims, Costs for Long-Acting Opioids Are Rising; Bills Could Give Huge Cost Boost

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By Angela Maas, Managing Editor - October 21, 2016 - Volume 17 Issue 20

As the abuse and misuse of opioids became a national health problem, some state legislators began taking steps to curb this, passing legislation to require insurers to cover FDA-validated abuse-deterrent opioids, as well as put limits on their cost-sharing approaches for members. And while such legislation seems to be having an impact on prescribing, these drugs come at a much higher cost than do opioids without FDA validation, but their abuse-deterrent properties are not 100% foolproof, according to a recent poster presented at the Academy of Managed Care Pharmacy Nexus 2016, held Oct. 3-6. Although only a handful of states actually have passed such legislation, about 20 more have proposed it. If passed, these bills could result in a huge increase in costs for these drugs.

Prime Therapeutics LLC analyzed pharmacy claims between Jan. 1, 2014, and March 31, 2016, for about 15 million commercially insured members. The opioids were placed in four categories:

(1) Non-abuse-deterrent short-acting opioids.

(2) Non-abuse-deterrent long-acting opioids.

(3) Long-acting FDA-validated abuse-deterrent opioids.

(4) Long-acting opioids that have abuse-deterrent properties but that have not received FDA validation of that.

From 2014 to 2015, claims for short-acting opioids decreased 4.5%, from 563 claims per 1,000 members to 537. However, claims rose in the other three categories:

- ***Claims for long-acting opioids without abuse-deterrent properties increased 2.0%,*** from 30.9 claims per 1,000 members to 31.5.
- ***Claims for long-acting FDA-validated abuse deterrent opioids increased 3.2%,*** or 12.2 claims to 12.6 claims per 1,000 members.
- ***Claims rose 26% for long-acting opioids with abuse-deterrent properties but without FDA validation,*** from 3.5 claims per 1,000 members to 4.4.

Most of the opioid claims — 92.0% — from Jan. 1, 2014, through March 31 of this year were for the short-acting products. However, among the more than $900 million paid for the class during that time, short-acting opioids represented only 51.4% of the entire class, according to Pat Gleason, Pharm.D., director of health outcomes at Prime, and Cathy Starner, Pharm.D., principal health outcomes researcher at Prime, who were co-authors of the poster.

On a per-claim basis, the long-acting opioids are $475 to $560, compared with about $25 per claim for the short-acting opioids, says Starner. The long-acting opioids are all brand medications, while the short-acting ones have generic options, she tells *DBN*.

In 2014, Massachusetts became the first state to pass a law requiring that insurers cover FDA-validated abuse-deterrent opioids and that they implement limited cost-sharing approaches on the medications. The following year, Maine and Maryland passed

similar legislation, and this year, Florida and West Virginia followed suit. According to the poster, about 30 bills in 20 states have been introduced in the 2016 session.

These bills were part of the reason behind Prime's research, says Starner. "It's probably safe to say that, yes, costs will rise" for the class if more states pass similar legislation. "However, if and when a short-acting [abuse-deterrent] product is approved by the FDA, this will have a significant impact."

Gleason explains that although many of the long-acting opioids have abuse-deterrent properties, "that doesn't mean there isn't a way to abuse it," which is "part of the difficulty" with these drugs.

Start With Short-Acting Opioids

"If you're going to use an opioid for pain, you should start with a short-acting product," says Starner. The long-acting products mainly are used in chronic cancer patients and others with chronic pain, but even these people should be started on a short-acting opioid so physicians can "understand how people are responding…after a few days" on the medications, Gleason says. He points to CDC guidelines released this past spring that say that "three days or less will often be sufficient; more than seven days will rarely be needed" to treat acute pain. There is a recognition that many providers have been prescribing much more than this, he says. For example, giving someone 30 Vicodin after a dental extraction "is not unheard of," nor is prescribing the same amount to someone who presents to the emergency room with back pain.

When it comes to payer coverage of this class, "the short-acting products are going to be covered because they're largely generic," says Starner. Many payers have "programs in place for the long-acting products to ensure appropriate use.…A lot of times there are quantity limits in place." In addition, some of these products are similar, so preferencing one over others is a possibility. For example, says Gleason, a payer might have at least one abuse-deterrent opioid on its formulary, and then "after that, it is all about cost-effectiveness" when it comes to pharmacy and therapeutics committee evaluations.
