PHARMACY PRACTICE NEWS

Clinical

AUGUST 11, 2017

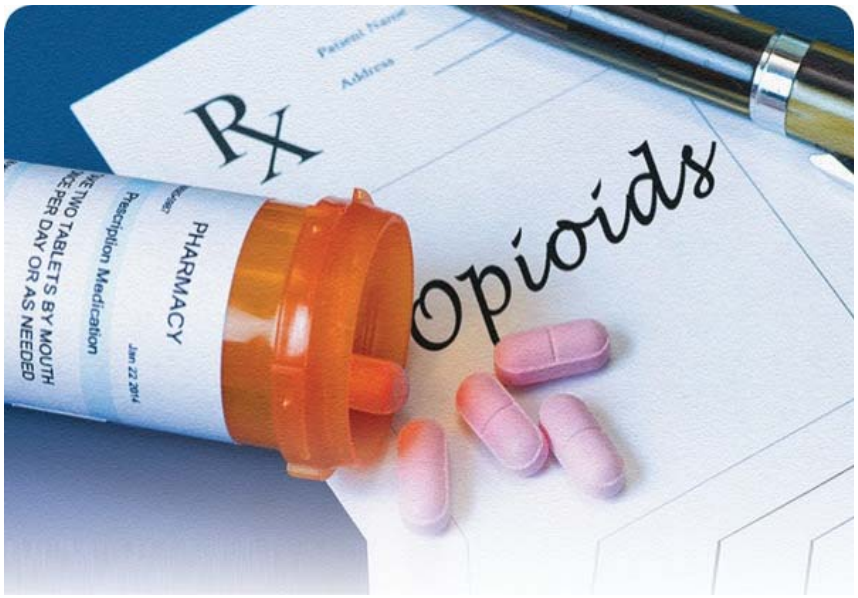
# Managed Care Pushes for Safer Opioid Oversight

High-risk pain Rx eyed

Denver—Health systems haven't escaped the nation's ongoing opioid crisis, as evidenced by surging ER visits for patients suffering the ill effects of misuse or abuse. Fortunately, hospitals have a new partner in this fight: managed care plans.

The plans are employing several tools for promoting more rational use of opioids by members, experts said during the Academy of Managed Care Pharmacy Managed Care & Specialty Pharmacy 2017 annual meeting.

Strategies include restrictions on short- and long-acting medications, dose or quantity limits, and restrictions on short-fill or initial-fill prescriptions. Another approach is to create controlled substance abuse management lock-in programs, where a member who meets a threshold is locked into a particular prescriber or pharmacy, said Kimberly Lenz, PharmD, the clinical pharmacy manager for MassHealth, the Massachusetts Medicaid program. "What's becoming more common is payors looking at dangerous combinations of medications—such as opioids with benzodiazepines—where they feel the member is at risk for overdose or respiratory depression," said Dr. Lenz, who also is an assistant professor at the University of Massachusetts Medical School, in Worcester.






"Our health system is looking for ways we can manage this class while striking a balance of appropriate access," Dr. Lenz added. Nearly every organization that touches pain has come out with a position paper or guidelines, but they are not universal, she noted. Pharmacy benefits managers and payors need to create strategies that allow for case-by-case determinations, because those who suffer from pain or substance use disorder often have comorbid diagnoses, making them more challenging to manage.

Overall, she said, about 100 million patients every year are in pain, many of whom have used an opioid at some point in their treatment plan.

The CDC and the Washington State Agency Medical Directors' Group have helpful guidelines for managing opioids, she said. Their suggestions include using nonpharmacologic therapy when appropriate and, if initiating opioids, to use the lowest dose and minimum duration necessary. Clear treatment plans should be created, Dr. Lenz said, including goals that can be documented, regular screening and monitoring, and strategies to mitigate risk, such as offering naloxone.



## Eyeing Prescriptions

MassHealth has implemented several steps to better manage opioid utilization among its members, including the aforementioned placement of restrictions on the use of duplicate short- and long-acting opioids. Under the program, patients are allowed 60 days of overlap within an opioid class if a patient is slowly cross-titrating to a different agent, explained Tyson Thompson, PharmD, a clinical consultant pharmacist with the program and the University of Massachusetts Medical School . The program also placed quantity limits on all long-acting opioids to ensure the proper frequency of administration, set daily morphine equivalent dosage limits at 120 mg, and instituted a prior authorization for methadone at any dose as a safety issue.

“Methadone is unique in that it [accounts for] a relatively small amount of prescriptions, but it’s responsible for a high amount of overdoses,” Dr. Thompson said.

The group also instituted a restriction for high-dose, short-acting opioids as monotherapy to encourage reservation of short-acting opioids for breakthrough pain once pain has become chronic, Dr. Lenz explained. This approach is partially driven by an in-house analysis showing that more than half of members who were using opioids, such as 30 mg of oxycodone immediate release (IR), had a history of or current substance use disorder. Members prescribed opioids at the high-dose limits need drug-specific prior authorization, if applicable, and medical records demonstrating a treatment plan noting why the patient is on a high dose, as well as a pain specialist consult that supports the requested regimen. In addition, the program implemented a requirement for a patient–prescriber agreement



## A Team Approach

The University of Massachusetts Medical School-Clinical Pharmacy Services created a therapeutic class management team to help develop and implement the program. The team included the division’s medical director; MassHealth; a clinical pharmacy manager (Dr. Lenz); a board-certified psychopharmacology pharmacist; two clinical consultant pharmacists (including Dr. Thompson); and an operations supervisor pharmacist. The team developed an 80-plus–page guideline using evidence-based medicine and current best practices. Consultant pharmacists now

evaluate prior authorizations for high-dose or duplicate therapy requests, which are then emailed with a brief write-up to the workgroup, which reviews and prioritizes cases needing tailored plans. Often such plans include outreach to the prescribers or referrals to care management. Outcomes and fraud unit referrals are tracked.

From 2010 to 2016, the program reviewed 304 cases, 147 of which required interventions by prescribers. Some required other interventions such as referral to the fraud unit or behavioral health services.

The most frequent interventions were made due to high-dose medications or duplicate therapy, Dr. Thompson said, although the group has intervened in other cases involving controlled substances, including that of a pediatric member who was prescribed ketamine.

Overall, Dr. Thompson said, 78% of the interventions were successful—that is, when prescribers accepted their recommendations or provided more information establishing medical necessity. In about 19% of interventions, none of the recommendations were implemented, most frequently due to prescribers not returning phone calls. These prior authorizations remain denied or only provisionally approved.

After instituting these protocols, the average daily dose of oxycodone IR and morphine sulfate extended-release (ER) decreased by 10% and 9%, respectively. Other highly used products—oxycodone ER and morphine IR—saw decreases of 13% and 15%, respectively (*P* values not calculated). (See Table for specific dosage reductions.)

Table. Opioid Dosage Adjustments

| Opioid | Pre-Reduction Dose (mg/d)[a] | Post-Reduction Dose (mg/d)[a] |
|---|---|---|
| Oxycodone immediate release | 36.7 | 33.1 |
| Morphine sulfate extended release | 79 | 72.1 |
| Oxycodone extended release | 95.5 | 83.5 |
| Morphine sulfate immediate release | 94.1 | 80.5 |

[a] These figures are specifically due to the reduction in the high-dose threshold, which occurred on 3/7/2016. The pre- and post- periods are six-month samples before 3/7/16 and after 3/7/16. The six-month time samples do not include March (as a buffer period when the change occurred).

A common challenge has been managing patients being treated for opioid dependence by one provider and being prescribed opioids by another provider, Dr. Thompson noted. When he and his colleagues contact an opioid prescriber, they can't disclose the patient's treatment for opioid dependence for privacy reasons, so they are limited to recommending that physicians check the prescription drug monitoring program.

In 2015, the AMCP established its Addiction Treatment Advisory Group to help managed care organizations improve access to medications for the treatment of substance use disorders, Dr. Lenz said. The group has three main recommendations: Review your plan's policies and step therapy guidelines to ensure members have access to medication-assisted therapies as needed; ensure your plan or accountable care organization has continuity of care for patients who suffer from substance use disorder, including a comprehensive arrangement between the medical and pharmacy benefits and behavioral health services; and improve patient awareness of and access to substance use disorder treatments. For more information, see www.amcp.org/?atag.

**Roadblocks Remain**

Patients who are denied access to opioids may buy them on the street or take meds prescribed to friends or family.

(/aimages/2017/ppn0817_014b_18849_150.jpg)

Some may pay cash for drugs to avoid a paper trail, while others may hop to a different benefits plan to avoid participating in lock-in programs.

Management of specific formulations or dosages of some opioids may drive patients to increased units of other drugs with higher abuse potential, such as 10 mg of oxycodone immediate release instead of 30 mg.

Although state PDMPs are extremely useful for detecting potential "doctor shopping" and other red flags for opioid abuse, some payors do not have access to the databases.

**PDMPs,** prescription drug monitoring programs

**Source:** Kimberly Lenz, PharmD.

*—Karen Blum*

*Drs. Lenz and Thompson reported no relevant financial relationships.*