

## **Opioid and Opioid-Related Innovative Practices**

### **Colorado**

#### **Addressing the Risk Factors for Opiate-Induced Overdose**

The use of opioid analgesics has grown nation-wide as well as within the state of Colorado. With their increasing use, there has been growing concern about the risk of opioid abuse, misuse, and diversion. Obtaining opioid prescriptions from multiple prescribers, as known as doctor shopping, is one way in which opioids may be abused and their use diverted. Several studies have used various metrics to determine doctor shopping of opioid analgesics. Cepeda et al have defined doctor shopping as subjects who had opioid prescriptions written by > 1 prescribers with >1 day of overlap filled at > 3 pharmacies. In their analysis of 112,821 subjects exposed to oxycodone and 42,940 to tapentadol, the investigators found that doctor shopping behavior was seen in 0.8% of those in the oxycodone group and 0.2% in the tapentadol group (adjusted odds ratio of 3.5, 95% CI: 2.8-4.4). These same investigators have found that when using the variable of number of pharmacies, use of three or more pharmacies differentiates opioids from other medication classes.

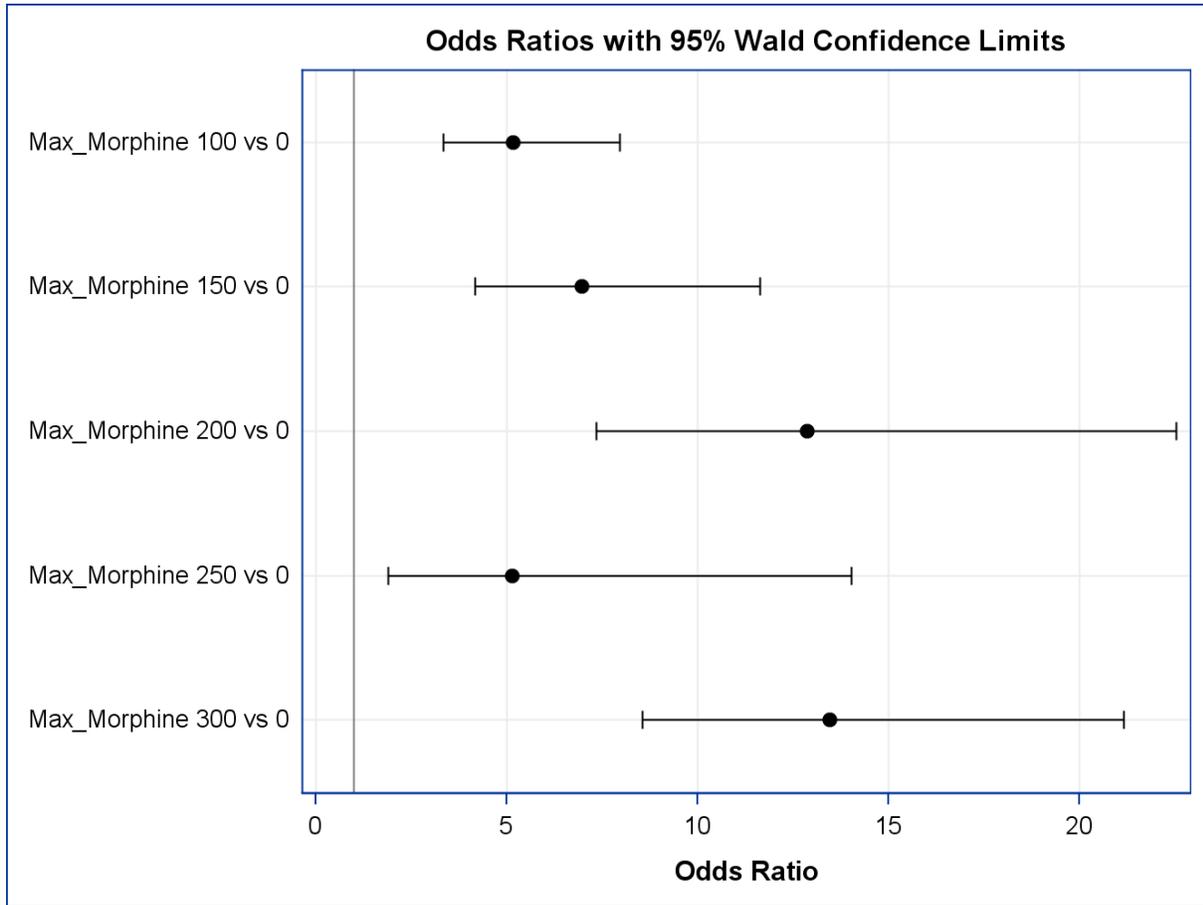
Outside of abuse, the issue of safety is also a major concern as it relates to opioid deaths and overdoses. In an analysis of data generated from the Veterans Health Administration from 2004-2008, Bohnert et al found that risk of opioid overdose death for patients receiving 100 mg morphine equivalents per day to be 7.18 (95% CI: 4.85-10.65), 11.99 (95% CI: 4.42-32.56), 6.64(95% CI: 3.31-13.31)-fold for patients with chronic pain, cancer, and acute pain, respectively.

Taking each of each of these variables into consideration, we evaluated potential variables which could impact both doctor shopping as well the potential for opioid overdose. After preliminary analysis, we found that within Medicaid beneficiaries taking opioids the following variables were predictive of overdose:

- At least one opioid prescription in the last year where morphine daily dose equivalence is > 300 mg
- At least 3 unique pharmacies that were used within the last year to fill opioid prescriptions
- At least 300 days supplied of opioid prescriptions within the last year

In order to address this concern with Colorado Medicaid members, the CO-evidenced Based DUR Program working with the DUR Board and the Department determined the odds of opioid overdose. The figures below summarize our findings.

Figure 1. Odds of Opioid Overdose Stratified by Maximum Morphine Equivalents per Year.\*



\* The comparator group of “0 morphine equivalents” for all odds ratios accounts for 1-99 mg of morphine daily-dose equivalent as a patient’s maximum. Those in the “100” category had their highest morphine daily-dose equivalent somewhere between 100 and 149.99mg. Similarly, those in the “150” category had their highest somewhere between 150 and 199.99mg per day... “300” included all those who had at least one prescription with a 300mg or more morphine daily dose equivalent

Figure 2. Odds of Opioid Overdose Stratified by Maximum Morphine Equivalents per Year.

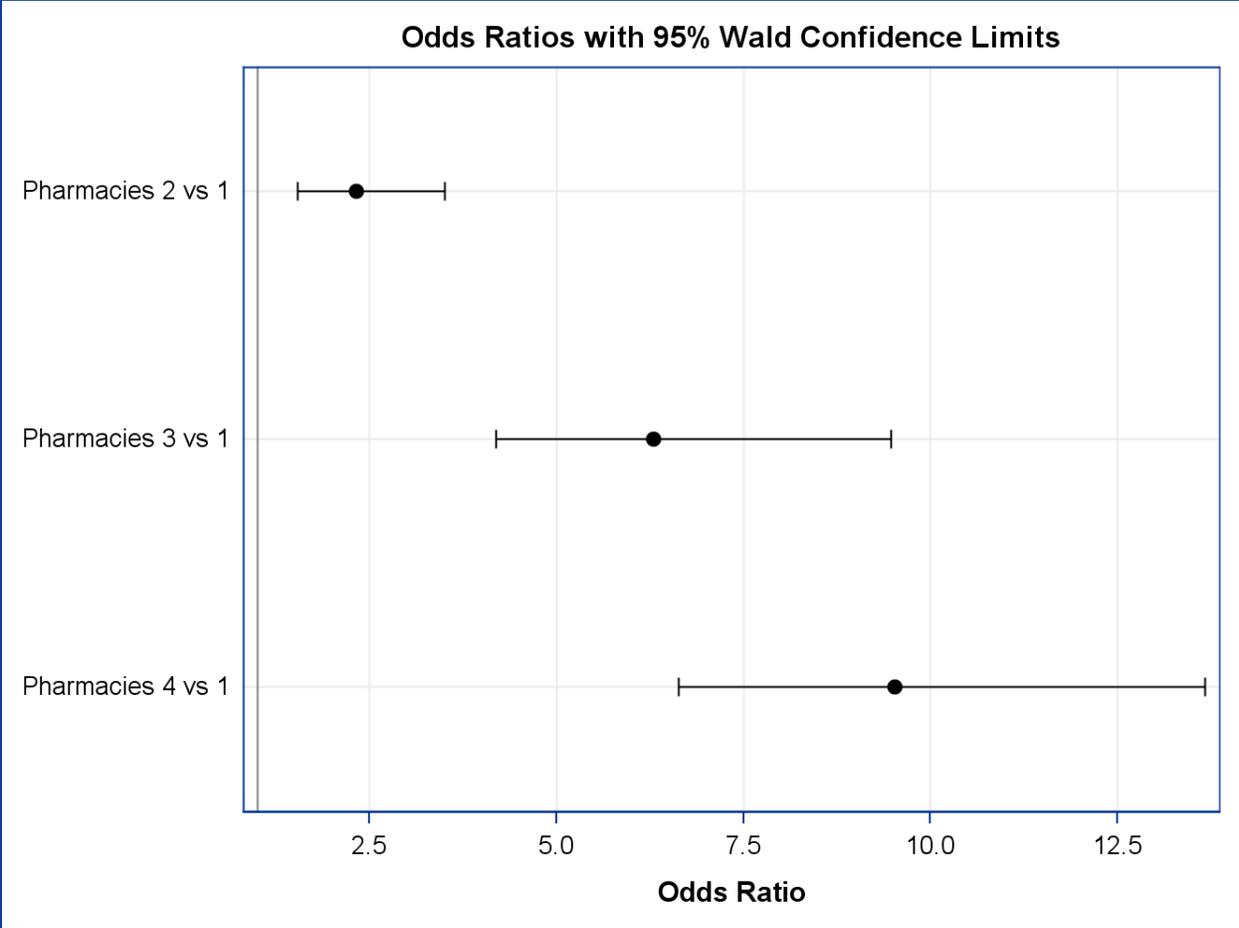
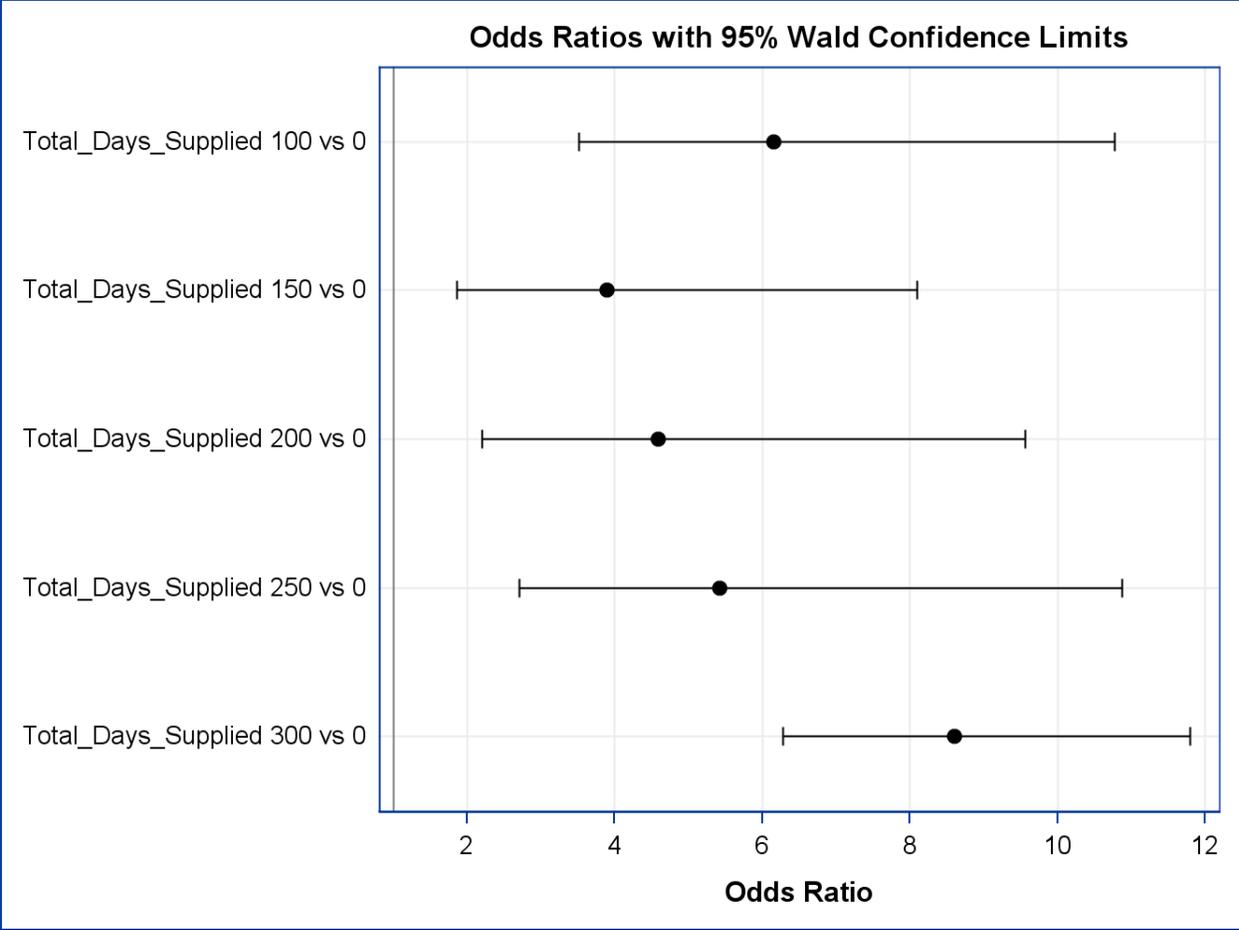


Figure 3. Odds of Opioid Overdose Stratified by Days Supplied of Opioid Prescriptions within the Last Year.\*



\* The comparator group of “0 days supply” accounts for 1-99 days supplied for all odds ratios. “100” includes all patients with an annual total days supplied of opioid medications of 100 through 149 days, “150” includes 150 through 199, ... “300” includes those with 300 or more total days supplied of opioid medications.

Based on these findings, we are using these data to develop criteria in order to identify high risk opiate users as well develop PA criteria to enhance safe use of opiates and possible criteria for intranasal naloxone. Currently, we have contracted with a pain specialist to assist in reviewing high risk opiate users.

## **Delaware**

Delaware Medicaid & Medical Assistance Program (DMMA) continued to provide appropriate cost effective healthcare, while devising innovative practices and policies to ensure best practices. We regularly review evidence based medicine, journal articles, guidelines, and presentations to look for innovative practices. We continually review and fine tune policies on pressing nationwide issues such as preventing prescription misuse, abuse, and diversion in high risk pharmaceutical categories. In addition to strengthening drug criteria, in 2014 Delaware also utilized alternative opportunities to improve healthcare practices through drug pricing, additional informed consent forms, and provider education.

Over the past several years, the program has implemented drug benefit policy to reduce the opioid epidemic. These changes in policy address the economic burden of drug abuse and diversion and overuse. Changes in 2010 focused on opioids and placed a yearly quantity limit on short acting opioids for 720 tablets per year or 60 units monthly. Prior authorizations are needed for potent opioids doses greater than 120 milligram equivalents of morphine daily. Two benzodiazepine policies were implemented during the last 12 months. First, therapeutic duplication of benzodiazepines is no longer covered without documented clinical necessity. Secondly, because of the number of overdose deaths related to benzodiazepines and opioids, any narcotic that already requires authorization will not be approved if the client is concomitantly using a benzodiazepine. Prior authorizations were reviewed on a case by case basis and conditions like seizures were taken into consideration. Studies show that overdose deaths with benzodiazepines are second only to that of narcotics. Most deaths attributed to benzodiazepine overdose in the United States are in patients who are also taking narcotics. There is no evidence that the use of benzodiazepines improves analgesic effects or makes a difference in the treatment of pain.

DMMA has been working with sister agencies to allow as many options as possible to treat opioid dependence. Delaware began reimbursing for the administration of buprenorphine in medication assisted outpatient facilities (MAOTPs). By providing reimbursement through daily clinic visits, providers are given other treatment options for clients where more frequent monitoring is needed or where relapses in the traditional outpatient buprenorphine setting occurred. Access through the MA-OTP allowed certified physicians to treat more clients given the limits on prescribing.

## California

The Medi-Cal DUR Program plays an integral role in the Department of Health Care Services' Strategy for Quality Improvement in Healthcare initiative. The following areas aimed to improve patient safety are directly linked to the activities of the DUR Program:

**Reduce opiate overdose:** Both independently and in collaboration with the Audits & Investigations Branch, the DUR Board has evaluated opioid pharmacy claims data in order to characterize the nature and magnitude of opiate use in the Medi-Cal fee-for-service population, in order to develop effective policies and programs to reduce the adverse impact of opiates. For example, the DUR Board reviewed data looking at the policy impact of maximum duration and quantity limits on 50 mg tramadol tablets and approved a plan to send out letters to the top prescribers of tramadol in the Medi-Cal fee-for-service population, in order to advise them of the change in scheduling of tramadol to a schedule IV controlled substance.

The Medi-Cal DUR Program also continues to collaborate with the California State Board of Pharmacy (BOP) and their Prescription Abuse Subcommittee in their mission to:

- promote the prevention and treatment of prescription drug abuse, particularly the abuse of controlled substances
- provide education to practitioners and the public regarding prescription drug misuse
- optimize the widespread use of tools such as Controlled Substance Utilization Review and Evaluation System (CURES)

One of the emerging QI focus areas is to reduce opiate-related morbidity and mortality. DHCS took steps to improve access to naloxone by adding naloxone injection (0.4 mg/ml and 1 mg/ml) to the Medi-Cal List of Contract Drugs in July 2013, and throughout FFY 2014 they promoted the new policies and sent informational letters to all Medi-Cal providers, encouraging them to prescribe take-home naloxone to prevent accidental deaths from opioid overdose. To further help with this effort, the DUR Program has reached out to other state agencies (California Medical Board, California Board of Pharmacy, and California Division of Workers Compensation) with a goal to coordinate recommendations and educate providers on Morphine Equivalent Daily Dose.

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## **Illinois**

Illinois Medicaid continues to focus on controlling Medicaid drug spending while ensuring Medicaid recipients have access to the most cost-effective, clinically appropriate therapies. Illinois Medicaid routinely reviews processes to improve the care of Medicaid patients, maximize cost containment, and streamline operations. The following innovative practices were started or continued in FFY14.

**Benzodiazepine use.** Provider outreach continues to prescribers of chronic use of benzodiazepine medications for the management of anxiety in the absence of first-line therapies, such as selective serotonin re-uptake inhibitors (SSRIs). In an effort to improve anxiety management and decrease inappropriate benzodiazepine use, providers of clients receiving a benzodiazepine for longer than 2-3 months are sent a fax outlining issues related to inappropriateness of long-term benzodiazepine use in their patient. During FF13, at least 2,431 faxes regarding benzodiazepine therapy were sent to providers. In FFY 14, at least 7,884 faxes were sent. In addition after retrospective DUR and assessment of other states' practices, quantity limits were decreased for benzodiazepines.

**Opioid pain management.** The pain management program, launched in January 2013, continues to ensure appropriate pain management with opioids. Providers of clients who have been taking an opiate medication for pain for three or more months are contacted via a faxed pain management program request. Providers provide history of the client's pain management and a plan for managing chronic pain for the next 3 months. A copy of a signed client/patient-provider pain management contract is required. Providers are encouraged to check the Illinois Prescription Monitoring Program (IPMP) database prior to writing prescriptions. Justification is required with renewal requests.