Mountain-Pacific Quality Health

DUR PROGRAM NEWS

SUMMER 2016

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The Drug Utilization Review (DUR) Program, administered by Mountain-Pacific through a contract with the Allied Health Services Bureau of the Montana Department of Public Health and Human Services, is the quality assurance body seeking to assure the quality of pharmaceutical care and to help provide rational, cost-effective medication therapy for Montana's Medicaid recipients.

CDC Releases Opioid Prescribing Guideline for Chronic Pain

Drug overdose is the leading cause of accidental death in the United States. In 2014, there were nearly 19,000 overdose deaths attributable to prescription pain relievers, with nearly 11,000 related to heroin. As a result of increased national awareness regarding the opioid overdose epidemic, the U.S. Department of Public Health and Human Services has developed a national action plan to reduce opioid abuse, dependence and overdose. One initiative of the multifaceted approach was the development of the "CDC Guideline for Prescribing Opioids for Chronic Pain,"which was released in March 2016. The majority of existing prescribing guidelines do not reflect recent literature, therefore the CDC completed a systematic review of the most recent clinical evidence. This was accomplished in order to determine the effectiveness, benefits, and harms of the long-term use of opioids in the treatment of chronic pain. Federal partner comments, expert and stakeholder opinions were also taken into consideration.

It is important to note that this guideline does not apply to the treatment of active cancer pain, palliative, or end-of-life care.

Recommendations for primary care providers who intend to treat chronic pain (lasting >3 months) have been grouped into three categories which are briefly summarized below:

- ***Initiation and continuation of opioids for chronic pain.***
  - » Nonpharmacologic (i.e., physical therapy, interventional procedures, exercise) and non-opioid (i.e., acetaminophen, NSAIDS, specific antidepressants) therapies are considered first-line treatments for chronic pain.
  - » Consider initiating opioids only if the potential benefits for function and pain are expected to outweigh the risks. Combine opioids with non-pharmacologic and non-opioid therapies as appropriate.
  - » Discuss known risks and realistic benefits with patients prior to initiation, including patient and provider responsibilities.
  - » Establish treatment goals with patients including setting realistic goals for pain and function, and a plan for discontinuation if goals are not met. *Continue opioid therapy only if there is clinically meaningful improvement in pain/function (generally 30% improvement from baseline)* which outweighs potential harms.

Continued ›

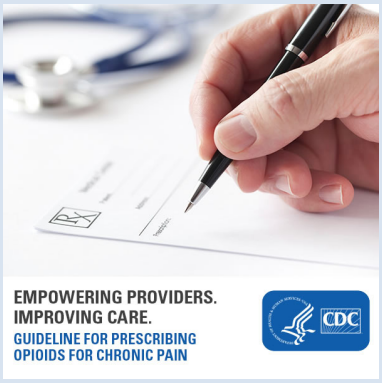
For drug-specific prior authorization information, please contact the Medicaid Drug Prior Authorization Unit @ Mountain-Pacific 1-800-395-7961

- ***Initial choice of opioid formulation, dosage and duration, follow-up and discontinuation.***
  - » **Selection:** In new-start patients, initiate treatment with immediate-release (IR) opioids. Clinical evidence supports less risk of overdose with IR formulations compared to ER/LA products.
  - » **Dosage:** Utilize the lowest-effective dose and assess the benefits/risks of increasing dosage to >50 morphine milligram equivalents (MME)/day. Avoid increasing to >90 MME/day unless clinical decision is justified. Clinical evidence supports a higher risk of motor vehicle accidents, opioid use disorder, and overdose at higher doses.
  - » **Duration:** Acute pain severe enough to require opioids should not typically require >3 days and rarely >7 days of therapy. Acute opioid use is associated with an increased risk of long-term use.
  - » **Follow-up:** Evaluate patients within 1-4 weeks for benefits/risks if opioids are initiated for chronic pain or following dose escalation, and then every 3 months thereafter. (Continuation of opioid therapy for 3 months substantially increases the risk of opioid use disorder.) Consider dose taper or drug discontinuation if benefits do not outweigh risks. (Patients not experiencing pain relief at 1 month are unlikely to experience pain relief at 6 months).

- ***Assessment of the risk and harms of opioid use.***
  - » Evaluate risk factors for opioid-related harms prior to initiation and during opioid therapy. Incorporate strategies to reduce risk, such as offering naloxone and education on overdose prevention if patients are at increased risk for overdose (i.e., history of overdose, history of substance use disorder, opioid dosages >50 MME/day, or concurrent benzodiazepine use).
  - » Review the state Prescription Drug Monitoring Program (PDMP) for a patient's controlled substance history upon opioid initiation and throughout the course of therapy (from every prescription (ideal) to a minimum of every 3 months).
  - » Use urine drug testing before starting therapy and consider testing at least annually for the presence of prescribed and non-prescribed substances. Specific clinical situations will require more frequent testing.
  - » Avoid concurrent prescribing of benzodiazepines and opioids. Clinical evidence supports a greater risk for potentially fatal overdose when these medications are used in combination.
  - » Refer patients for assessment for opioid-use disorder if patient behavior, PDMP monitoring, or urine drug testing findings suggest concern. Treatment typically consists of medication-assisted treatment (MAT) in combination with psychosocial therapies.

The evidence supporting the long-term use of opioids in the treatment of chronic pain is limited. The long-term benefits of opioid therapy vs. no opioids also lacks evidence, and it is important to note that the literature supports the risk for harm to be dose dependent.

Incorporation of evidence based, best-practice opioid prescribing guidelines into daily clinical practice may improve patient safety and reduce medication misuse trends which have escalated the opioid overdose epidemic. **The CDC has developed a checklist for providers (enclosed) which highlights the important prescribing considerations discussed herein.**



Important Web Sites

Complete CDC Guideline for Prescribing Opioids in Chronic Pain
http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

CDC Clinical Tools for Prescribing Opioids for Chronic Pain
http://www.cdc.gov/drugoverdose/prescribing/resources.html

Montana Prescription Drug Registry
http://boards.bsd.dli.mt.gov/pha/pha-mpdr

Sources

http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm. Accessed 5/24/16.
https://www.healthcarelawtoday.com/2016/03/29/four-distinct-federal-and-state-policies-addressing-prescription-opioid-abuse/. Accessed 5/24/16.
http://www.cdc.gov/nchs/data/factsheets/factsheet_drug_poisoning.pdf. Accessed 6/1/2016.

Long-Acting Narcotic Analgesics

- **Methadone** has been removed from the Medicaid Preferred Drug List and will require prior authorization for the treatment of non-cancer pain as recommended by the Drug Utilization Review Board (DURB). Patients currently stable on methadone therapy prior to this date will be allowed continuation therapy. Specific clinical criteria for initiation of therapy in new patients will be discussed at a future DURB meeting. The unique pharmacokinetic and pharmacodynamic profile of methadone requires significant appropriate patient selection and significant experience in use. The clinical evidence suggests methadone contributes disproportionately to opioid overdose and deaths compared to other, safer therapeutic opioid alternatives. The CDC has recommended methadone should not be considered first-line for chronic, non-cancer pain treatment.

Oral Anti-Allergans

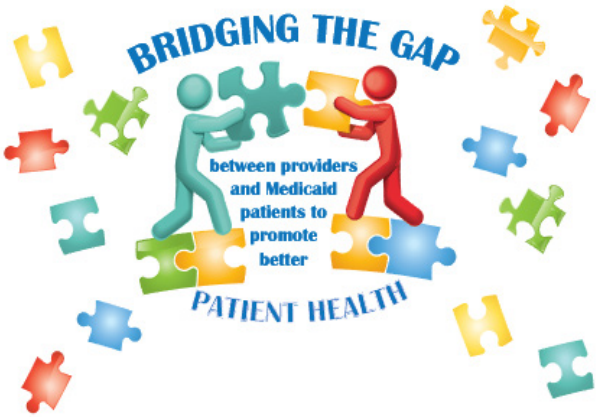
- Prior authorization criteria has been implemented for the oral sublingual immunotherapy tablets, **Grastek®**, **Oralair®**, and **Ragwitek®**. The following prior authorization criteria apply:
  - » The patient must have received an allergist consult to confirm the specific allergen being treated AND
  - » Treatment with both a preferred oral antihistamine and nasal steroid has been ineffective, contraindicated or not tolerated
  - » Approval will be limited to 1 tablet per day

Opioid Reversal Agents

- **Narcan® (naloxone) nasal spray** has been moved to preferred status on the Montana Medicaid Preferred Drug List following a recommendation from the Drug Utilization Review Board/Formulary Committee. **Naloxone syringe** and **naloxone vial** are also both available without prior authorization.

Medicaid Clinical Pharmacy Case Management Services Administered by Mountain-Pacific Quality Health

The Medicaid Pharmacy Case Management clinicians are available to exchange information with providers about drug therapy and patient-specific drug usage. This may help to improve clinical outcomes and reduce patient risk by



- Providing medication and drug diagnosis history to facilitate continuity of care (i.e., Medicaid foster care recipients)
- Identifying medication noncompliance
- Preventing medication duplication
- Identifying drug-drug or drug-disease state issues
- Identifying multiple pharmacies or providers
- Providing unbiased, evidence-based disease management interventions

How we do it: This is accomplished by our access to all of the medical and pharmacy services your patients receive through Medicaid.

See what we can do for you Mountain-Pacific Quality Health *call 1.800.395.7961*

Mountain-Pacific Quality Health

Montana Medicaid Top 20 Drugs for YTD 2016 by Generic Name*

Drug Name	By Dollars	# of Patients	Drug Name	By Rx Count
Aripiprazole	4,545,532	1,538	Hydrocodone/Acetaminophen	23,739
Methylphenidate	1,948,400	2,981	Albuterol	20,658
Lurasidone	1,533,601	492	Amoxicillin	17,889
Lisdexamphetamine	1,306,092	1,569	Omeprazole	12,905
Dextroamphetamine/amphet	1,239,819	2,172	Gabapentin	12,773
Insulin aspart	1,238,127	828	Methylphenidate	12,026
Atomoxetine	1,235,917	893	Levothyroxine	11,970
Albuterol	1,193,160	10,423	Azithromycin	11,212
Fluticasone/salmeterol	1,185,619	1,362	Fluoxetine	10,509
Insulin glargine	1,130,812	909	Sertraline	10,100
Paliperidone palmitate	1,101,099	141	Lisinopril	9,497
Pregabalin	1,054,186	794	Dextroamphet/amphet	8,498
Dornase alpha	691,211	48	Clonazepam	8,226
Quetiapine	634,831	1,850	Bupropion	8,081
Ombitasvir/paritaprevir/ritonavir/dasabuvir	623,287	22	Quetiapine	7,907
Dexmethylphenidate	619,210	541	Oxycodone	7,679
Oxycodone	607,356	2,129	Lamotrigine	7,555
Fluticasone	536,309	3,360	Montelukast	7,495
Insulin detemir	533,184	415	Trazodone	7,051
Oseltamivir	527,245	2,107	Metformin	7,036

*excludes injectable drugs except insulins (Note: the brand product is preferred in some instances; dollars are pre-rebate).

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Checklist for prescribing opioids for chronic pain

For primary care providers treating adults (18+) with chronic pain ≥3 months, excluding cancer, palliative, and end-of-life care

CHECKLIST

When CONSIDERING long-term opioid therapy

- ☐ Set realistic goals for pain and function based on diagnosis (eg, walk around the block).
- ☐ Check that non-opioid therapies tried and optimized.
- ☐ Discuss benefits and risks (eg, addiction, overdose) with patient.
- ☐ Evaluate risk of harm or misuse.
  - Discuss risk factors with patient.
  - Check prescription drug monitoring program (PDMP) data.
  - Check urine drug screen.
- ☐ Set criteria for stopping or continuing opioids.
- ☐ Assess baseline pain and function (eg, PEG scale).
- ☐ Schedule initial reassessment within 1–4 weeks.
- ☐ Prescribe short-acting opioids using lowest dosage on product labeling; match duration to scheduled reassessment.

If RENEWING without patient visit

- ☐ Check that return visit is scheduled ≤3 months from last visit.

When REASSESSING at return visit

Continue opioids only after confirming clinically meaningful improvements in pain and function without significant risks or harm.

- ☐ Assess pain and function (eg, PEG); compare results to baseline.
- ☐ Evaluate risk of harm or misuse:
  - Observe patient for signs of over-sedation or overdose risk.
    - If yes: Taper dose.
  - Check PDMP.
  - Check for opioid use disorder if indicated (eg, difficulty controlling use).
    - If yes: Refer for treatment.
- ☐ Check that non-opioid therapies optimized.
- ☐ Determine whether to continue, adjust, taper, or stop opioids.
- ☐ Calculate opioid dosage morphine milligram equivalent (MME).
  - If ≥50 MME/day total (≥50 mg hydrocodone; ≥33 mg oxycodone), increase frequency of follow-up; consider offering naloxone.
  - Avoid ≥90 MME/day total (≥90 mg hydrocodone; ≥60 mg oxycodone), or carefully justify; consider specialist referral.
- ☐ Schedule reassessment at regular intervals (≤3 months).

REFERENCE

EVIDENCE ABOUT OPIOID THERAPY

- *Benefits of long-term opioid therapy for chronic pain not well supported by evidence.*
- *Short-term benefits small to moderate for pain; inconsistent for function.*
- *Insufficient evidence for long-term benefits in low back pain, headache, and fibromyalgia.*

NON-OPIOID THERAPIES

Use alone or combined with opioids, as indicated:

- Non-opioid medications (eg, NSAIDs, TCAs, SNRIs, anti-convulsants).
- Physical treatments (eg, exercise therapy, weight loss).
- Behavioral treatment (eg, CBT).
- Procedures (eg, intra-articular corticosteroids).

EVALUATING RISK OF HARM OR MISUSE

Known risk factors include:

- Illegal drug use; prescription drug use for nonmedical reasons.
- History of substance use disorder or overdose.
- Mental health conditions (eg, depression, anxiety).
- Sleep-disordered breathing.
- Concurrent benzodiazepine use.

Urine drug testing: Check to confirm presence of prescribed substances and for undisclosed prescription drug or illicit substance use.

Prescription drug monitoring program (**PDMP**): Check for opioids or benzodiazepines from other sources.

ASSESSING PAIN & FUNCTION USING PEG SCALE

PEG score = average 3 individual question scores
(30% improvement from baseline is clinically meaningful)

Q1: *What number from 0–10 best describes your **pain** in the past week?*
0="no pain", 10="worst you can imagine"

Q2: *What number from 0–10 describes how, during the past week, pain has interfered with your **enjoyment of life**?*
0="not at all", 10="complete interference"

Q3: *What number from 0–10 describes how, during the past week, pain has interfered with your **general activity**?*
0="not at all", 10="complete interference"

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

TO LEARN MORE
www.cdc.gov/drugoverdose/prescribing/guideline.html

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