



**SUMMER
2024**

**Montana Healthcare Pharmacy
Programs Link**

(Current Montana Healthcare Programs
Preferred Drug List,
Provider Notices, DUR Board/Meeting
Information, Resources)
<http://medicaidprovider.mt.gov/19>

For current drug
prior authorization criteria:
[https://www.mpqhf.org/corporate/
montanans-with-medicaid/pharmacy/](https://www.mpqhf.org/corporate/montanans-with-medicaid/pharmacy/)

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 Healthcare Programs members.

Montana Healthcare Programs
Drug Prior Authorization Unit
1-800-395-7961



**Mountain Pacific
DUR PROGRAM NEWS**

The Changing Face of the Opioid Epidemic

Between 1999 and 2021 almost 645,000 people died from poisoning involving an opioid. This alarming number of deaths includes prescription opioids, heroin and various synthetic opioids including fentanyl and fentanyl analogs.¹ However, the increase in cause of death from opioids over this 22-year period has not included equivalent increases in all classes of opioids. The only consistency is the ongoing rise of death from the general class, opioids.

The Centers for Disease Control and Prevention (CDC) has characterized the changes in opioid overdose death as coming in waves. The first wave began in the 1990s with the dramatic increase in prescription opioids and subsequent overdose deaths. Prescription opioids continued as the leading cause of poisoning death until about 2010. Starting in 2010, we moved into the second wave with the rise in heroin overdose deaths rapidly outpacing those of prescription opioids until 2013 when fentanyl and fentanyl analogs moved into the illicit drug marketplace.

Many of the newly popular fentanyl analogs were repurposed from human or veterinary anesthetics. Others produced were brand new substances manufactured from fentanyl precursors. Some of these new substances had not been seen before and were not listed as scheduled drugs. The Drug Enforcement Agency (DEA) actively pursued and accomplished making these and the other new fentanyl analogs illegal. Unfortunately, the banning of these substances has not stopped the flow of fentanyl analogs into

Continued on p. 2

This information is brought to you by:
Mountain Pacific
P.O. Box 5119 | Helena, MT 59604
www.mpqhf.org

The Changing Face of the Opioid Epidemic (cont.)

the United States. According to the DEA, China remains the primary source of fentanyl and fentanyl-related substances trafficked through international mail and other sources of smuggling, as well as the main source for all fentanyl-related substances trafficked into the United States. Some of the fentanyl precursors are shipped to the drug cartels in Mexico which then complete the manufacture of the drugs and move them into the U.S.

Fentanyl and its analogs continue to be a major threat due to their potency, but new data shows another threat, stimulant medications, are exacerbating an already perilous situation. An article published in the journal *Addiction*, by researchers at the University of California, contends that the combination of Fentanyl with stimulants constitutes the fourth wave of the opioid epidemic.²

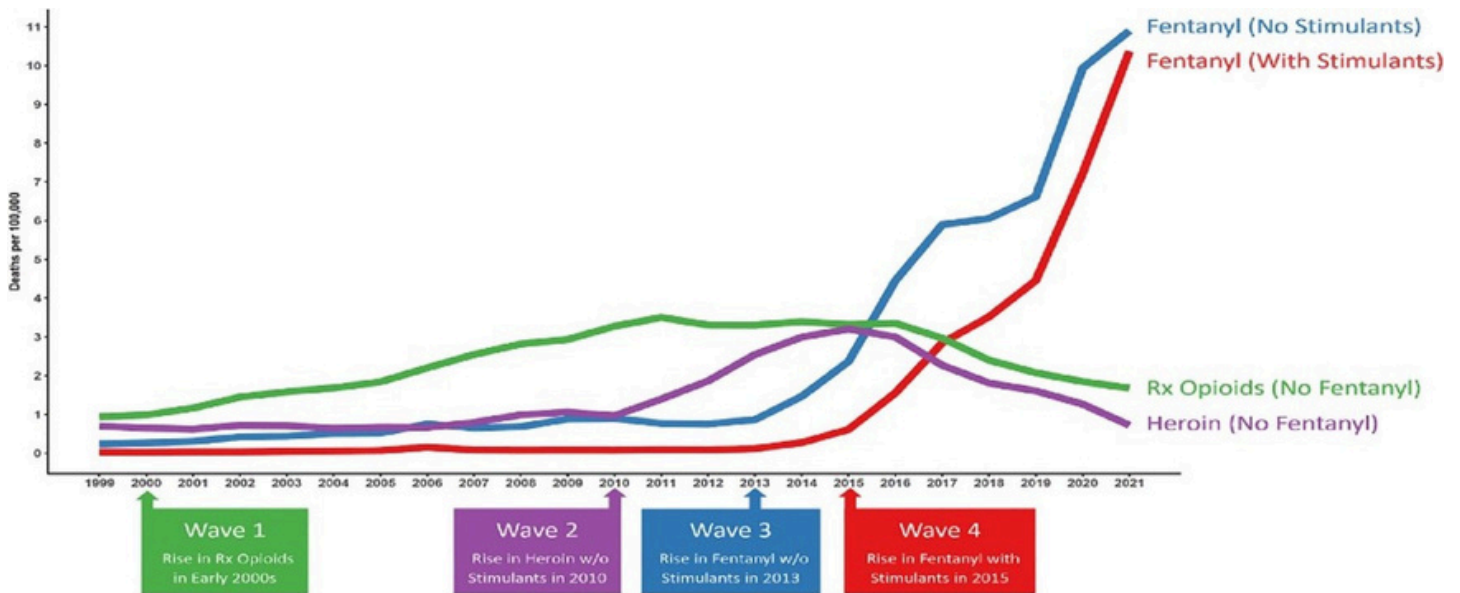


Figure 1: Four waves of overdose mortality: a simplified schema of the four waves of the United States overdose mortality crisis Waves 1 and 2 are represented by deaths involving commonly prescribed opioids and heroin, respectively, but excluding fentanyl co-involved deaths. Fentanyl-co-involved deaths are excluded for illustrative purposes here, because the precipitous rise of fentanyl-involved deaths starting in 2013 has had the effect of raising deaths rates for a whole host of other substances used together with fentanyl, despite fentanyl representing the key driving factor in wave 3 and 4. Here, we can observe that prescription opioid- and heroin-driven waves reach inflection points and begin to decline in 2010 and 2015 respectively, after removing the inflating effects from fentanyl co-involvement. Wave 3 and wave 4 are separated by showing fentanyl deaths not involving and involving stimulants respectively as distinct trends, revealing the short ~2-year lag between the two waves.

Data obtained from CDC Wide-Ranging Online Database for Epidemiologic Research.

CDC National Center for Health Statistics data from 2021 to 2022 shows drug overdose death rates increased when involving synthetic opioids, psychostimulants and cocaine. Between 2015 and 2022 the poisoning death rate from psychostimulants, mostly methamphetamine increased from 5,716 to 34,265. Cocaine-related deaths have also increased every year since 2015.³ Stimulants have never lost

Continued on p. 3



Mountain Pacific
INNOVATING BETTER HEALTH

The Changing Face of the Opioid Epidemic (cont.)

popularity, but the recent dramatic increase in their involvement in poisoning deaths has occurred due to the change in how the drug cartels are now presenting stimulants and cocaine mixed with fentanyl. Many of these combination products are pressed into tablet form that are counterfeit prescription drugs. Some drugs being mimicked are oxycodone, Adderall®, Xanax®, Percocet® and Vicodin®, right down to the size, color and markings. This method of introducing drugs to persons expecting either the legitimate prescription product or something similar has resulted in increased danger. Fentanyl is much more potent than either oxycodone or hydrocodone and methamphetamine is much more unpredictable than other amphetamines. Illicit counterfeit tablets have also changed the way these substances are being abused. Prior to 2021, most poisoning deaths were the result of injected illicit drugs. As the graphic below shows, smoking has surpassed injection in the mechanism of use in overdose deaths. The positive news from this change is reduction in the transmission of blood-borne infectious disease, but the health implications of smoking these substances and the chemicals involved in their production are yet to be completely determined.

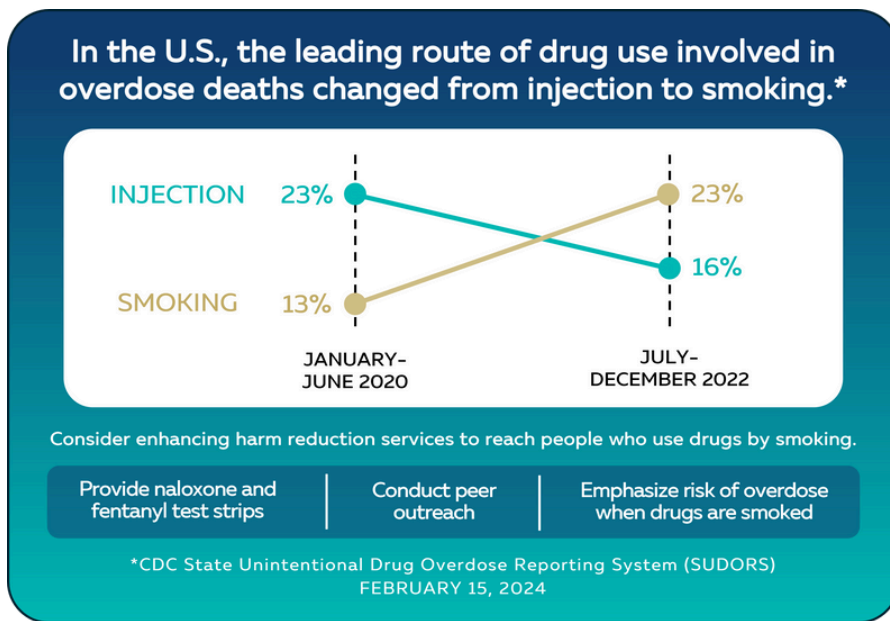


Figure 2: Leading Route of Drug Use Involved in Overdose Deaths

Tanz LJ, Gladden RM, Dinwiddie AT, et al. Routes of Drug Use Among Drug Overdose Deaths—United States, 2020–2022. MMWR Morb Mortal Wkly Rep 2024;73:124–130. DOI: <http://dx.doi.org/10.15585/mmwr.mm7306a2>

To address the opioid epidemic, the U.S. Department of Health and Human Services has developed an Overdose Prevention Strategy.

It consists of four pillars of action:⁴

- 1 Primary Prevention:** This strategy promotes tiered, multidisciplinary prevention activities, ranging from population-level strategies to target interventions aimed at high-risk individuals.

Continued on p. 4



**Mountain
Pacific**
INNOVATING BETTER HEALTH

The Changing Face of the Opioid Epidemic (cont.)

These activities engage health and human services providers directly to facilitate cross-sector collaboration on prevention.

- 2 **Harm Reduction:** Individuals inherently deserve services that promote health, regardless of whether they use drugs. Evidence-based harm reduction strategies minimize negative consequences of drug use. These activities further expand access to harm reduction interventions and better integrate harm reduction into general medical care.
- 3 **Evidence-Based Treatment:** Evidence-based treatments for substance use disorder can reduce substance use, related health harms and overdose deaths. High-quality treatment can also increase social functioning. The strategy, therefore, focuses on reducing barriers to accessing the most effective treatments, using motivational and cultural enhancements to encourage those who might be reluctant, advancing strategies to improve engagement and retention and continuing to develop new therapeutic approaches.
- 4 **Recovery Support:** The strategy recognizes treatment alone may not be enough to support long-term recovery. Despite the demonstrated benefits of recovery support services -- such as peer support, employment and housing services -- various challenges impede their availability and uptake. Enhancing coverage and integration of recovery support services is critical to promoting access to and use of these services. Strengthening the recovery support services workforce is also essential to promoting access and quality.

References

- ¹ Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2021. Available at <http://wonder.cdc.gov>.
- ² Addiction, Volume: 118, Issue: 12, Pages: 2477-2485, First published: 13 September 2023, DOI: (10.1111/add.16318)
- ³ Drug Enforcement Administration 2024 National Drug Threat Assessment; https://www.dea.gov/sites/default/files/2024-05/NDTA_2024.pdf
- ⁴ U. S. Department of Health & Human Services; Opioid Prevention Strategy. <https://www.hhs.gov/overdose-prevention/>



**Mountain
Pacific**

INNOVATING BETTER HEALTH

Benzodiazepines: From Breakthrough to Crisis

Benzodiazepines (BZDs), once hailed as a breakthrough in anxiety and insomnia treatment, have also been associated with an increasing number of overdoses and deaths. This is not only related to prescribed BZDs but also an ongoing surge of synthetic BZDs into the illicit drug market.

Data from the CDC revealed alarming trends in nonfatal and fatal overdoses involving BZDs across 38 states and the District of Columbia from 2019 to 2020.¹ In an article by Stephen Liu et al., a 23.7% increase in BZD overdose-related emergency department (ED) visits per 100,000 ED visits was noted during this time period. Data was also compared from April-June 2019 to April-June 2020, where overall BZD deaths increased 42.9%, and prescription BZD deaths increased 21.8%. It was observed most BZD deaths also involved opioids, primarily synthetic fentanyl, which highlighted the growing co-occurrence of illicit BZDs with opioids.

In August 2023, the Drug Enforcement Agency (DEA) published an article titled "Benzodiazepines (Street Names: Benzos, Downers, Nerve Pill, Tranks)".² It discusses illicit uses of both prescription and "novel designer" BZDs. Examples include:

- Using diazepam (Valium®) and alprazolam (Xanax®) concurrently with methadone to potentiate its euphoric effects.
- BZDs with alcohol to augment effects and modulate alcohol withdrawal states.
- Higher than prescribed doses of BZDs to facilitate sexual assaults.

The DEA describes how individuals abusing BZDs obtain them by getting prescriptions from multiple providers, forging prescriptions or buying already diverted BZDs from the illicit drug market. Short-acting BZDs have the highest abuse potential and the DEA states that alprazolam, a short-acting prescription BZD, is one of the top three of all diverted prescription medications.

Despite growing awareness of their potential for dependence and misuse, BZDs are widely prescribed drugs, and in 2021 there were "34.6 million alprazolam, 21.3 million lorazepam, 23.7 million clonazepam, 9.1 million diazepam and 4.7 million temazepam prescriptions dispensed."²

Benzodiazepines clearly have an effective and beneficial role in therapy for acute anxiety, panic disorders, alcohol withdrawal, seizure disorders and more. However, they are only safe for short durations as dependence can develop in 50% of individuals who continue BZD therapy beyond one month.^{3,4} Furthermore, once dependence has developed, discontinuation of BZDs must be done very slowly, and withdrawal symptoms during this process may continue for months. This makes discontinuation of BZD therapy extremely difficult and uncomfortable, and many individuals struggle to be successful.



**Mountain
Pacific**

INNOVATING BETTER HEALTH

Benzodiazepines: From Breakthrough to Crisis (cont.)

It is imperative prescribers are aware of the risks versus benefits when prescribing BZDs and prescribe in short durations of two to four weeks whenever possible.³ Providers should also counsel patients on the process and symptoms they may experience when tapering off BZDs such as anxiety, insomnia, irritability, sweating and muscle spasm should they become dependent. Fortunately, there are resources available to assist in providing patient education as well as tapering or “deprescribing” guidelines to improve success rates. One such resource is <https://deprescribing.org/resources/deprescribing-guidelines-algorithms/>.⁵

There is currently no prescription medication that is approved for treating benzodiazepine use disorder. Combining non-pharmacological approaches while tapering may be extremely beneficial. These approaches may include cognitive behavioral therapy (CBT), family therapy, sleep hygiene, stimulus control, and relaxation techniques. Finally, it is imperative to ensure any co-existing psychiatric disorders are being appropriately addressed and treated during this process.^{3,4}

A local analysis of Montana Medicaid claims indicates Montana providers may already be changing practices due to awareness of the risks of BZDs.⁶ The top prescribed and dispensed BZD to Montana Medicaid enrollees is clonazepam, which is a long-acting BZD with lower abuse potential than its short-acting relatives.

Thank you to our Montana Medicaid providers for their continued due diligence!

References

- ¹ Liu, S., O'Donnell, J., Gladden, R. M., McGlone, L., & Chowdhury, F. (2021, August 27). Trends in Nonfatal and Fatal Overdoses Involving Benzodiazepines – 38 States and the District of Columbia, 2019–2020. MMWR, 70(34). US Department of Health and Human Services/Centers for Disease Control and Prevention.
- ² U.S. Department of Justice, Drug Enforcement Administration. (n.d.). Benzodiazepines (Street Names: Benzos, Downers, Nerve Pill, Tranks). Retrieved May 15, 2024, from https://www.deadiversion.usdoj.gov/drug_chem_info/benzo.pdf.
- ³ Nauts, D., Sise R. (2024) Benzodiazepines: The Good, The Bad, and The Ugly [PowerPoint slides]. Montana Primary Association Pain and Addiction Conference, Bozeman, MT. <https://www.mtpca.org/document/the-good-the-bad-and-the-ugly-of-benzos/> (Retrieved May 13, 2024).
- ⁴ Titus-Lay, E. (2022). Substance-Related Disorders. CPNP Psychiatric Pharmacotherapy Review.
- ⁵ Deprescribing.org. (n.d.). Deprescribing Guidelines & Algorithms. Retrieved May 15, 2024, from <https://deprescribing.org/resources/deprescribing-guidelines-algorithms/>.
- ⁶ State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data. (n.d.). Retrieved May 15, 2024, from <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-and-chip-program-application-eligibility-determination-and-enrollment-data>



Summertime Is Sunscreen Time

Skin cancer is the most common type of cancer in the United States. As we move into summer, this is a reminder that we need to focus on what can be done to prevent skin cancer. Most skin cancer is caused by too much exposure to ultraviolet (UV) rays, which damage skin cells. UV rays come from the sun, tanning beds and sunlamps.

Tips to reduce exposure to UV rays from the sun include:

- Avoid or limit your time in the sun between the hours of 10 a.m. and 2 p.m. when the sun's rays are most intense. The UV Index also provides information to help plan the safest time of day to be outdoors.
- Shade reduces sun exposure, but most often does not offer complete protection.
- Wear clothing to protect your skin from sun exposure. Hats, long-sleeved shirts and pants can offer protection from UV rays.
- Be careful near water and sand, which can reflect the sun's rays.
- Do not forget your eyes. Hats can help shade the eyes, but sunglasses that provide 99-100% UVA/UVB protection will reduce eye damage from sun exposure.
- Always wear sunscreen that is broad spectrum, protective against UVA and UVB radiation with a sun protection factor (SPF) of 15 or higher.
- Sunscreen should be applied at least 15 minutes before sun exposure. It should cover the entire face and body.
- Do not forget the ears, nose, back of the neck, tops of feet and hands and in the case of thinning hair, the scalp.^{1,2}



DID YOU KNOW

Ultraviolet A (UVA) rays have a longer wavelength than UVB rays, meaning UVA radiation penetrates deeper into a person's skin. UVA rays are associated with skin aging. UVB rays are associated with skin burning. Both damage the skin and can lead to cancer.

All sunscreens are not created equal. Proper use also influences the effectiveness of sunscreen.

It is easy to get confused by what the SPF number on the label means. SPF is the level of sunburn protection from UVB rays provided by the sunscreen. It is not related to the amount of time it is safe to stay in the sun, but instead is an indication of how much of the UVB radiation is being blocked. For example, SPF 15 blocks 93% of UVB radiation, SPF 30 blocks 97% and SPF 50 blocks 98%. So thinking SPF 30 is twice as strong as SPF 15 is not accurate.

Continued on p. 8



**Mountain
Pacific**

INNOVATING BETTER HEALTH

Summertime Is Sunscreen Time (cont.)



when the difference of UVB radiation blocked between SPF 30 and SPF 15 is just 4%.

Broad spectrum sunscreen offers additional protection against UVA rays. Not all sunscreens are broad spectrum, so checking the label for this is also important.

Because protection from solar radiation is the role of sunscreen, solar intensity also needs to be taken into consideration. It depends on time of day, distance from the equator and altitude. This means adjustments may need to be made to avoid the most intense solar

radiation. When avoidance is not possible, reapply sunscreen at least every two hours and consider protective clothing and physical barriers for additional protection.

If avoiding painful sunburn, excessive wrinkles, sagging skin and brown spots are not enough incentive to use sunscreen, consider the data collected by The Skin Cancer Foundation. Regular daily use of sunscreen as directed can reduce the risk of squamous cell carcinoma (SCC) by about 40% and reduce melanoma risk by 50%.³

References

¹ U. S. Food and Drug Administration (FDA). "Sunscreen: How to Help Protect Your Skin from the Sun." <https://www.fda.gov/drugs/understanding-over-counter-medicines/sunscreen-how-help-protect-your-skin-sun>. May 17, 2024

² Centers for Disease Control and Prevention (CDC). "Sun Safety Facts." <https://www.cdc.gov/skin-cancer/sun-safety/index.html> May 3, 2024

³ Skin Cancer Foundation. "All About Sunscreen: Why You Need It. How it Works for You." <https://www.skincancer.org/skin-cancer-prevention/sun-protection/sunscreen/> May 3, 2024



**Mountain
Pacific**

INNOVATING BETTER HEALTH



Summer Help Corner

As we head into summer, here are five reminders about the Montana Healthcare Programs:



- 1 Vacation refills:** Vacation overrides for medications are not provided. Prescriptions for non-controlled substances may be refilled after 75% of the estimated therapy days have elapsed. Prescriptions for controlled substances (CII-CV), and gabapentin may be refilled after 90% of the estimated therapy days have elapsed.
- 2 Preferred Drug List updates:** The Montana Healthcare Programs Preferred Drug List (PDL) holds an annual review of the drugs that are preferred and non-preferred on the list. This review is divided by class and held in three public meetings, one each in March, April and May. In these meetings the DUR Board, acting as the Formulary Committee for Montana, makes their clinical recommendations to the Montana Department of Public Health and Human Services (DPHHS) and the PDL contractor. Because these three meetings are held closely together in the spring, the PDL will go through several changes in the subsequent months after the PDL season closes. Be sure to check for a new PDL when looking for a particular preferred drug. The most recent version is from June and is located at <https://medicaidprovider.mt.gov/19>.
- 3 Lost or stolen medications:** The Montana Healthcare Programs do not cover lost or stolen medications.
- 4 Filling prescriptions for an eligible Montana Healthcare member outside of the state of Montana:** Prescriptions for members can be filled in other states, but the pharmacy must be enrolled as a Montana Healthcare provider. The Montana Healthcare Programs does not reimburse members for medications purchased by the member. For coverage of prescription drugs, they must be purchased through an enrolled pharmacy using their Montana Healthcare benefit.
- 5 Phone numbers to save:**
 1. Drug Prior Authorization (PA) requests: 1-800-395-7961
 2. Member eligibility, ID numbers, coordination of benefits: 1-800-624-3958
 3. Point-of sale claim reversals: 1-800-365-4944
 4. Durable Medical Equipment: 406-444-4518
 5. Members calling about medication coverage: 406-444-2738



**Mountain
Pacific**

INNOVATING BETTER HEALTH