**Professional Practice Advisory on Opioid Therapy Management**

## Opioids as Therapy for Pain and Associated Risks

Acute and chronic pain affects large numbers of Americans, with approximately 100 million U.S. adults burdened by chronic pain alone. For many patients, treatment of pain is inadequate not just because of uncertain diagnoses and societal stigma, but also because of shortcomings in the availability of effective treatments and inadequate patient and clinician knowledge about the best ways to manage pain. Pain can be mild and easily handled with over-the-counter medications; it can be acute and recede with treatment; it can be recurrent over months or years; or it can be chronic and debilitating, requiring almost constant attention and accommodation. When opioids are used as prescribed and appropriately monitored, they can be safe and effective, especially for acute, postoperative, and procedural pain, as well as for patients near the end of life, such as those with cancer who require more pain relief.[1]

Even though opioids have been used to treat pain for thousands of years, opioid therapy for chronic non-cancer pain is controversial due to concerns regarding lack of scientific evidence of the long-term effectiveness and safety, particularly with the risk of tolerance, dependence, or abuse. Opioid pain relievers are popular among drug abusers because of the euphoria they can induce.[2] Unlike addiction to heroin and other drugs that have no accepted medical use, addiction to some controlled substances can be unknowingly financed by insurance companies and public programs, such as Medicare Part D and Medicaid.[3]

Prescription drug abuse is found throughout all aspects of our population. Physicians and other health professionals are entrusted with the authority to recommend medications in the treatment of their patients and therefore have an important role to play in helping to ensure safe and effective use of this treatment option and the deterrence of its abuse.[4]

## Defining the Opioid Prescription Abuse Epidemic

Prescription drug abuse has become a major health epidemic in the United States. Overdose deaths involving prescription painkillers have quadrupled since 1999 and now outnumber those from heroin and cocaine combined. According to a 2010 study by the National Institute of Drug Abuse, approximately 7 million Americans reported using a prescription drug for nonmedical reasons in the past month. Of those, opioids alone accounted for 5.1 million. Additionally, the total number of opioid prescriptions dispensed by U.S. retail pharmacies increased from 76 million in 1991 to 201 million in 2010.[5,6]

The increasing use of opioid analgesics for treating chronic noncancer pain, and the introduction of high-dose, extended release oral tablet formulations of opioids with good bioavailability, has increased opportunities for the illicit use of prescription opioids.[6]

Individuals with chronic pain and co-occurring substance use disorders and/or mental health disorders, are at a higher risk for misuse of prescribed opioids. The abuse and misuse of opioids may occur for a variety of reasons, including self medication, use for reward, compulsive use because of addiction, and diversion for profit.[6,7]

## Strategies Utilized by Managed Care Organization to Manage Opioid Therapy

Much of the financial cost of prescription opioid abuse, addiction, and associated health consequences is paid by private and public health insurers.[8] Private and public healthcare payers should consider internal and external procedures and policies, to improve patient safety and lower corporate financial risks associated with prescription drug abuse.

### *Use of Evidence-Based Guidelines*

Guidelines for managing risk in opioid prescribing are available from various medical societies. Managed care organizations can develop evidence-based guidelines and promote and support use of these guidelines among healthcare providers in their systems.

Best practices for preventing errors and adverse outcomes when prescribing opioids include the following: appropriate diagnosis, determination of medical necessity, establishment of treatment goals, informed consent, adherence monitoring, and addressing adverse effects, followed by continuation or discontinuation of opioids after initial treatment of 8 to 12 weeks.

### *Formulary and Utilization Management*

Formulary controls (e.g., prior authorization, quantity limits) that limit reimbursement can help ensure that higher-risk opioids are not prescribed unless the benefits outweigh the risks, and that appropriate monitoring is implemented.

### *Retrospective Claims Review/Drug Utilization Review*

Prescription claims data review can be designed to identify and investigate potentially inappropriate prescriptions, including use of multiple prescribers, multiple pharmacies, and/or early refills. Drug utilization reviews can identify over-utilization, drug-drug interaction, or therapeutic duplication. Some health plans have instituted procedures for matching prescription, medical, behavioral, and substance abuse claims that can identify patterns or “red flags” suggestive of abuse or fraud. Once potential abuse or fraud is identified, each case should be carefully researched, the member and the healthcare provider involved are contacted if appropriate. Interventions can range from provider and patient education, to addiction treatment services, to involvement of law enforcement if necessary.

### *Interventions*

Patients who inappropriately visit multiple physicians and pharmacies, also known as "Dr. Shoppers" can be "locked in" to the use of a single pharmacy and/or single prescriber to minimize inappropriate or fraudulent prescriptions.

Managed care organizations should also screen prescribers and pharmacies against the federal debarment list. Some managed care organizations have implemented prescriber or pharmacy exclusion programs to prevent prescribing or dispensing by providers who have been identified as aberrant by internal review procedures or law enforcement action.

### *Interdisciplinary Care Teams*

The increased use of opioid analgesics and concomitant rise in abuse and addiction underlie another issue that may be amenable to case management. In particular, offering support to primary care physicians and specialists may help reduce clinical dependence on opioid use for persistent pain. Programs including medication review and promotion of nonpharmacologic therapies (e.g., biofeedback, acupuncture, massage, health/wellness classes) may shift the focus away from simply prescribing opioids as a means of pain relief.

## Strategies Utilized by Local and Federal Government Agencies to Manage Opioid Therapy

### *Prescription Drug Monitoring Programs*

A Prescription Drug Monitoring Program (PDMP) is a statewide electronic database that collects designated data on specified prescription drugs dispensed in the state. A PDMP is a tool used to combat prescription drug diversion and abuse. As of October 2012, 42 states have operational PDMPs, and 7 states and one territory (Guam) have enacted legislation to establish PDMPs.[8] PDMPs serve multiple functions:

- Support access to legitimate medical use of controlled substances
- Identify drug-seeking behaviors or "doctor shopping"
- Identify clinicians with patterns of inappropriate prescribing and dispensing
- Facilitate the identification, intervention with and treatment of persons addicted to prescription drugs
- Inform public health initiatives through outlining of use and abuse trends
- Educate individuals about PDMPs and prescription drug abuse

Each state determines which agency houses the PDMP, which controlled substances must be reported, which types of dispensers are required to submit data (e.g., pharmacies), how often data is collected, and who may access the information. Data is made available to individuals authorized under state law and can include prescribers, law enforcement, and licensing boards. Each state also varies in terms of allowing the data to be shared with other states but there is ongoing effort to facilitate interstate information sharing in order to better monitor individuals' prescription drug history across states. The National Association of Boards of Pharmacy (NABP) developed InterConnect, a technology platform to facilitate interstate sharing of PDMP data. Currently, NABP InterConnect allows users of PDMPs in 15 states to

securely exchange prescription data. Research shows states with PDMPs tend to have slower increase in opioid abuse than states without PDMPs.[9]

***State Laws***

States have broad authority to regulate the prescribing and dispensing of prescription drugs and do so in a variety of ways. States laws addressing inappropriate use of opioids include the following:

- Requiring a physical examination before prescribing
- Requiring tamper-resistant prescription forms
- Regulation of pain clinics
- Setting prescription drug limits
- Prohibiting "doctor shopping"
- Requiring Patient Identification before Dispensing
- Providing Immunity from Prosecution/Mitigation at Sentencing for Individuals Seeking Assistance During an Overdose

For further information on each of these state laws, refer to the following link:

http://www.cdc.gov/homeandrecreationalsafety/Poisoning/laws/laws.html

***DEA Drug Take-back day***

On September 25th 2010, DEA initiated the first National Prescription Drug Take-Back campaign in an effort to collect expired, unused, unwanted, or potentially dangerous medications that were stored in home cabinets. Studies show that a majority of abused prescription drugs are obtained from family and friends, making home medicine cabinets a susceptible site of drug diversion. Expired medications stored in homes are safety concerns, as patients can accidentally ingest them. Due to the popularity of the program, DEA now holds two Drug Take-Back campaigns a year, once in the spring and once in the fall. The public can take their unwanted medications to more than 5,829 collection sites manned by state and local law enforcement agencies that partner with the DEA. As of (October 2013, more than 3.4 million pounds f medications have been collected.[10] Practitioners are encouraged to educate patients about the various national drug take-back programs as well as appropriate ways to dispose unused medication.

***Opioid Overdose Prevention Toolkit***

The Substance Abuse Mental Health Services Administration has released the Opioid Overdose Prevention Toolkit. The toolkit is the first federal resource promoting safety and prevention information for persons at risk for overdose, such as how to recognize and respond appropriately to overdose, specific drug-use behaviors to avoid, and the role of naloxone in preventing fatal overdose. The toolkit equips communities and local governments with material to develop policies and practices to help prevent and respond

appropriately to opioid-related overdose. Prescribers will find evidence-based guidance for safe prescribing practices, identifying patients at risk for overdose, engaging them in prevention and risk-reduction efforts, and accessing opioid-dependence treatment[11]. The toolkit is available at

http://store.samhsa.gov/product/opioid-overdose-prevention-toolkit/all-new-products/sma13-4742

***CMS Opioid Drug Utilization Review Programs***

CMS requires Part D plans to perform retrospective drug utilization review (DUR) analysis to identify prior inappropriate or unnecessary medication use and provide education, such as alert letters, to the prescribers involved. By analyzing historical prescription claims data, the drug plans can identify individuals who are likely obtaining excessive amounts of highly abused drugs or potentially seeking such drugs from multiple medical practitioners.[12]

In 2013, Medicare introduced new DUR requirements for Part D plans to inaugurate Level 3 retrospective DUR systems, policies, and procedures designed to ensure ongoing periodic examination of claims data and other records. For the future, drug plan sponsors who have identified a bona fide safety concern about a beneficiary's use of opioid analgesics can move forward with a protocol for overutilization of these agents if the sponsor has made reasonable efforts to contact the prescriber. If a beneficiary's prescription drug claims for an opioid cannot be established as medically necessary, the sponsor may implement edits for the beneficiary level at the point-of-sale for all network pharmacies. This will result in the rejection of claims or in the rejection of quantities in excess of a beneficiary's plan's established limits for opioids.

However, if a Part D plan takes that step, CMS wants the plan's P&T committee to document the basis for the opioid overutilization conclusion in every case. The agency also expects the P&T committee to develop an overall program to prevent opioid overutilization. The revised CMS policy will require health plan staff to communicate with physicians and resolve questions about potential overuse of medications before contemplating any changes to a patient's prescription drug coverage.

CMS' concerns about patient "doctor shopping" for controlled substances, verified in a Government Accountability Office (GAO) report in 2011, was the primary motivation for this forced expansion of DUR policies. The CMS expects Level Three controls to be applied to opiates in 2013, but the agency also thinks that PDPs need to expand DURs for all medications.[3]

When a Part D beneficiary changes insurers, CMS requires that the previous plan submit information to that beneficiary's new insurer.

***Medicaid – State Level Strategies***

CMS in close collaboration with States, is providing education resources through its Education Medicaid Integrity Contractor (Education MIC) to promote best practices and will focus on providers that have been identified as having the high potential aberrant prescribing patterns for five targeted therapeutic drug classes that have also been identified as having potentially high outlier payments. Materials will focus on the importance of prescribing drugs

within the dosage guidelines approved by the FDA. Although this collaboration effort is initially being piloted in only 5 States, if the results are promising, plans are in place to expand the education campaign nationally. Also, the Education MIC is developing written materials to help educate providers on areas of drug diversion, including how to identify drug seeking behavior in beneficiaries and appropriate reporting of suspicious fraudulent behavior.[13]

Previous laws enacted to help safeguard against drug diversion include tamper resistant prescription pads. Effective October 1, 2007, Federal law prohibits payments for covered outpatient drugs written on non tamper-resistant pad.

**Strategies Utilized by the Pharmaceutical Industry to Manage Opioid Therapy**

***Tamper-resistant Opioid Technology (TRF)***

There are several new opioid formulations that are resistant to common forms of tampering, including crushing or dissolving the tablet to accelerate release. These formulations are designed to be very difficult to crush or dissolve, and are intended to prevent chewing, snorting, and injecting of the medication. Evidence has shown that the introduction of the reformulated OxyContin demonstrated a 41% reduction in the prevalence of past-30-day abuse. On April 16 2013, FDA determined that the reformulated version of OxyContin has abuse-deterrent properties and approved new labeling that indicates that the product has physical and chemical properties that are expected to make abuse by injection difficult and to reduce abuse via the intranasal route. As a result, any generics of OxyContin that do not contain the tamper-resistant technology will not be approved. Other examples of opioids with TRF include Remoxy and TQ-1017, an ER formation of tramadol.[14]

There has been patient objection to receiving TRF oxycodone CR tablets. Some patients have reported difficulty swallowing the TRF oxycodone because the tablet may swell and gel when exposed to saliva in the mouth. After switching to the new TRF formulation, some patients reported they could not “feel” the new drug working. Clinical trials have demonstrated bioequivalence between the TRF and non-TRF formulations. However, TRF oxycodone has a less rapid early release phase which can result in misperception of the drug’s efficacy. In addition, cost is a major objection as well. The TRF of oxycodone CR is carried on large private insurance formularies as a brand-name drug, rendering it more expensive than a generic opioid. Medicare formularies may or may not include TRF oxycodone CR.[15]

***Long-acting Opioid REMS Training***

In July 2012, FDA approved a Risk Evaluation and Mitigation Strategy (REMS) for extended release (ER) and long-acting (LA) (ER/LA) opioids due to high potential for harm, misuse, and abuse. A central component to the REMS is the availability of voluntary ER/LA opioid REMS-compliant training programs to all licensed prescribers. Health care providers who prescribe ER/LA opioid analgesics must ensure the safe and effective use of these medications. REMS- compliant training programs cover the FDA Blueprint for Prescriber Education for Extended-Release and Long-Acting Opioid Analgesics and include a post-course knowledge assessment.[16] Also included is information on the risks and benefits of opioid therapy, the appropriate choice of therapy for patients, the management of patients on these drugs, and the recognition of opioid misuse, abuse, and addiction. These programs are

funded by opioid product manufacturers and offered by independent providers of continuing medical education, and are of little or no cost to U.S. licensed prescribers.[17]

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**Additional AMCP Reference Documents**

*Where We Stand on the Management of Opioids*. Approved by the AMCP Board of Directors June 2013. http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=16926

*Where We Stand on Fraud, Waste, and Abuse in Prescription Drug Benefits*. Approved by the AMCP Board of Directors October 2011. http://www.amcp.org/Tertiary.aspx?id=14212