Strategies to Address Prescription Drug Abuse

To complement this robust PMP legislation, shared strategies will be implemented across Medicaid Fee-For-Service **(DMAS, Department of Medical Assistance Services)** *(link to: http://www.dmas.virginia.gov/default.aspx)* and Medicaid MCOs.

These strategies include:

- Integrating CDC Guidelines for Prescribing Opioids for Chronic Pain into the DMAS FFS Preferred Drug List (PDL) and into the MCO formularies,
- Implementing an innovative Lock-In program to identify members with or at risk of prescription drug abuse and opioid use disorder and refer them to Substance Use Disorder (SUD) treatment, and introducing claims edits for concurrent opioid and benzodiazepine prescriptions.

Integrating CDC Opioid Prescribing Guidelines into DMAS FFS PDL and MCO Formularies

In accordance with changes approved by the DMAS Pharmaceuticals and Therapeutics (P&T) Committee in April 2016, the MCOs and Magellan will implement requirements for prescribing short and long-acting narcotics to align Medicaid prescription drug coverage with the CDC Guidelines for Prescribing Opioids for Chronic Pain. These requirements are discussed below.

Strategies to Address Opioid Use Disorder

DMAS, MCOs and Virginia Department of Behavioral Health and Developmental Services (DBHDS), with support from the U.S. Department of Health and Human Services, is promoting opioid prescribing practices, expanding use and distribution of naloxone, and expanding Medication-Assisted Therapy (MAT) to reduce opioid use disorders and overdose. DMAS and the MCOs are exploring implementing the following specific strategies:

1. Promoting the CDC Guidelines for Prescribing Opioids for Chronic Pain to providers across the Commonwealth;

2. Encouraging providers to co-prescribe naloxone with opioids and widely disseminating naloxone through Project REVIVE;

3. Increasing MAT coverage and promoting evidence-based best practices through standardized Prior Authorization Forms;

4. Implementing a robust benefit package to incentivize providers to offer MAT for opioid addiction;

5. Delivering a Comprehensive MAT Provider Education and Training Campaign statewide; and

6. Partnering with the Board of Medicine to develop guidelines for buprenorphine/naloxone (Suboxone®) providers.

Short and Long Acting Narcotics

- Prescriber must calculate the morphine milligram equivalents (MME) for prescribed drug:
  - If MME is 51-90 per day – prescriber must offer naloxone and overdose prevention education.
  - If MME is > 90 per day – prescriber must give member a prescription for naloxone, provider overdose prevention education and consider a consultation with a pain specialist.
  - A link to a MME calculator and to Virginia's PMP will be included.

- Prescriber must document what other non-pharmacological alternatives the patient has tried including physical therapy, weight loss, aerobic exercises, aquatic exercises, resistance exercises, arthrocentesis, intraarticular glucocorticoid injection, subacromial corticosteroid injection, and psychological therapies such as cognitive behavioral therapy.

- Prescriber must document what other non-opioid pharmacological therapies have been tried including NSAIDs, muscle relaxants, anti-convulsants, Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs).

- Prescriber must attest that the PMP has been checked for all new prescriptions and they have discussed with the patient any findings and the risks of using other central nervous depressants such as benzodiazepines, alcohol, other sedatives, illicit drugs such as heroin, or other opioids.

- The service authorization form asks "Does this patient exhibit signs of opioid use disorder?" and requires the prescriber to indicate if the patient has a history of addiction to the requested drug, frequent request for odd quantities, requests for short-term or PRN use of long-acting narcotics, frequent requests for early refills, and frequent reports of lost or stolen tablets. The service authorization form requires the physician to attest that a realistic treatment plan with goals to address the benefits and harm of opioid therapy has been established with the patient. The prescriber must address all five CDC recommendations for this treatment plan:
  - Established expected outcome and improvement in pain relief and function or just pain relief as well as limitations (i.e., function may improve yet pain persist OR pain may never be totally eliminated).
  - Established goals for monitoring progress toward patient-centered functional goals e.g., walking the dog or walking around the block, returning to part-time work, attending family sports or recreational activities, etc.
  - Goals for pain and function, how opioid therapy will be evaluated for effectiveness & the potential need to discontinue if not effective.
  - Emphasize Serious Adverse Effects of Opioids (including fatal respiratory depression & opioid use disorder, OR alter the ability to safely operate a vehicle).
  - Emphasize Serious Common Side Effects of Opioids (constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, withdrawal)

- Prescriber agrees to evaluate and reassess the benefits and harm of continued opioid therapy with the patient every 3 months or more frequently if dose changes.

- A link to a prescriber/patient opioid use contract in the event the prescriber does not have a standardized form which he/she currently uses is included on the service authorization form.

- A link to the CDC Guidelines for Prescribing Opioids is included on the service authorization form.

Short Acting Narcotics

- Quantity limits will be placed on all short acting narcotics based on 120 MME/day x 10 day supply. Anything above these quantity limits will trigger a service authorization.
- The exception to 120 MME/day will be any combination narcotic that contains acetaminophen. The quantity limit will be based on the maximum 4 grams/day of acetaminophen.

Long Acting Narcotics

- Requirement of a urine drug test at least annually
- Trial and failure of a short-acting opioid for at least one week

Introducing Claims Edits for Concurrent Opioid and Benzodiazepine Prescriptions

DMAS and the MCOs are exploring implementation of point of service edits for managing opioid and benzodiazepine prescriptions. Point of service edits would require prescriber involvement prior to override or approval. Identified edits will be implemented under the SUD demonstration.

Potential edits include:

1. Initiation of concurrent opioid and benzodiazepine prescriptions; or
2. Any additional oral benzodiazepine prescriptions for patients currently on benzodiazepines and opioids; or
3. Any additional opioid prescriptions for patients currently on benzodiazepines and opioids; or
4. Benzodiazepine prescription for patients currently being treated with an oral buprenorphine containing drug.

Expanding Access to naloxone Statewide

DMAS and the MCOs all cover intranasal naloxone without a Prior Authorization and will encourage providers and pharmacies to carry naloxone. In addition, DMAS and the MCOs will require prescribers to offer naloxone to any patient taking greater than 50 morphine milligram equivalents of a prescription drug per day and require prescribers to give prescriptions for naloxone to any members taking greater than 90 morphine milligram equivalents per day.

REVIVE! is the Opioid Overdose and naloxone Education (ONE) program for the Commonwealth of Virginia. REVIVE! is a statewide program that distributes naloxone kits and provides training across the Commonwealth to health care professionals, law enforcement officers, firefighters, advocates, and others on how to recognize and respond to an opioid overdose emergency with the administration of naloxone. REVIVE! is a collaborative effort led by DBHDS working collaboratively with the Virginia Department of Health, the Virginia Department of Health Professions, recovery community organizations, OneCare of Southwest Virginia, the Substance Abuse and Addiction Recovery Alliance of Virginia (SAARA), and other stakeholders.

Guidelines for Buprenorphine/naloxone (Suboxone®) Providers

The General Assembly during the 2016 session passed legislation that clarified that buprenorphine/naloxone (Suboxone®) and other FDA-approved opioid replacement therapy providers are not subject to the same regulatory environment as methadone providers in Virginia. The Virginia Board of Medicine is convening a workgroup to develop guidance on clinical best practices for buprenorphine/naloxone (Suboxone®) providers.

These guidelines will include evidence-based best practices such as ensuring that counseling and psychosocial supports are offered alongside the buprenorphine/naloxone (Suboxone®) medication and that buprenorphine/naloxone (Suboxone®) providers check the PMP and require random urine drug screens. This workgroup includes representatives from DMAS and the MCOs who will ensure that these best practices are adopted by DMAS, the MCOs, and Magellan and incorporated into the design and implementation of the MAT benefit.

In addition DMAS and MCOs will implement a single Uniform Service Authorization (PA) Request Form for Initiation of Buprenorphine SL or Suboxone® (Buprenorphine/Naloxone) Sublingual Film and a single Uniform Service Authorization (PA) Request Form for Maintenance of Buprenorphine SL or Suboxone® (Buprenorphine/Naloxone) Sublingual Film.