PRIOR AUTHORIZATION PROPOSAL FOR OPIOID PRESCRIPTIONS

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Opioid Prescriptions: the Worst Man-Made Epidemic in Modern Medical History

- Over 200,000 deaths in the U.S.
- Many more hundreds of thousands of overdose admissions.
- Millions addicted and/or dependent.
  - DSM-5 opioid use disorder = 29.4% (Degenhardt et al., 2015)
- Spillover effect to heroin and to SSDI.

Limitations of Long-term (>3 Months) Opioid Therapy

- There are no studies – ZERO – that show that long term opioids improve pain or function.
- 100% of patients on opioids chronically develop dependence.
- 60% of patients on opioids for 3 months will still be on opioids 5 years later (Martin et al., 2011).
- 47% of patients on opioids for 30 days in the first year of use will be on opioids 3 years later (Express Scripts study).

Recent data from this year show increasing mortality in middle aged whites

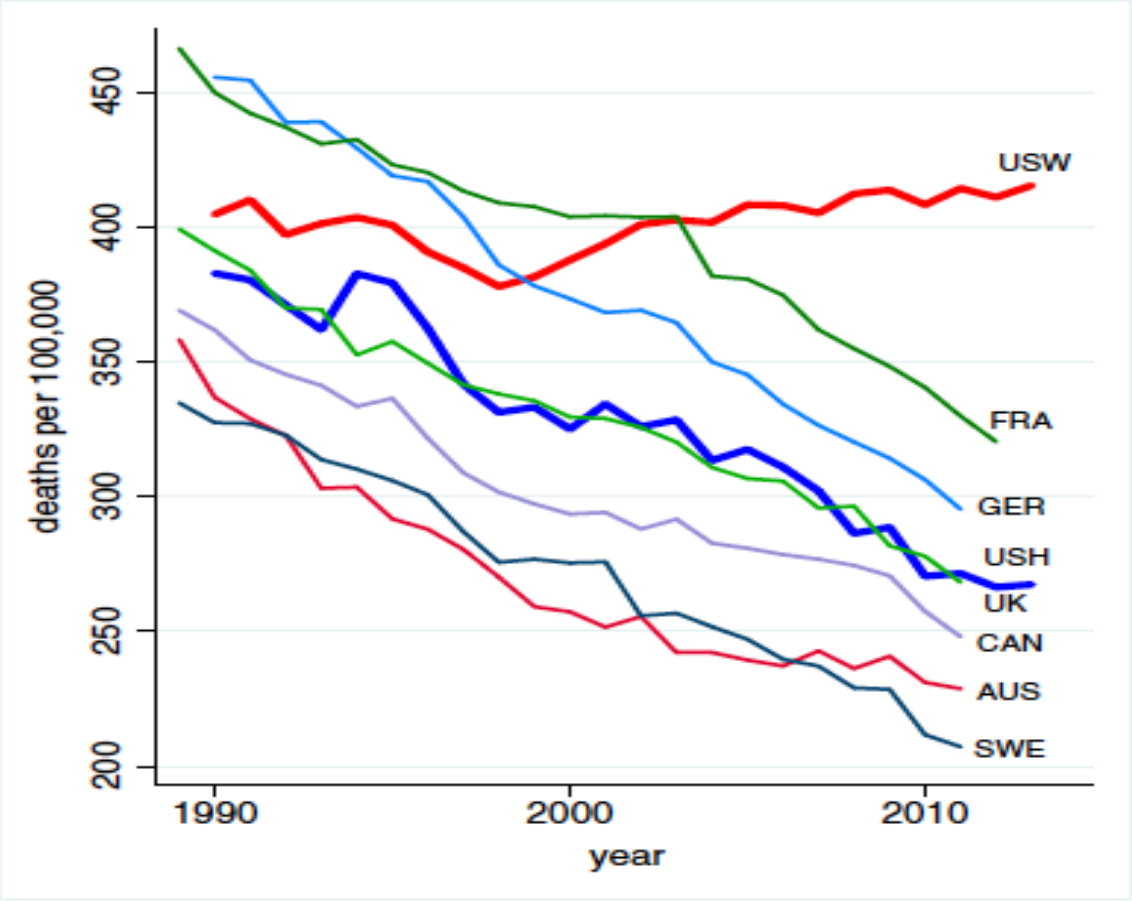

Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

Case and Deaton, 2015

Mortality by Cause

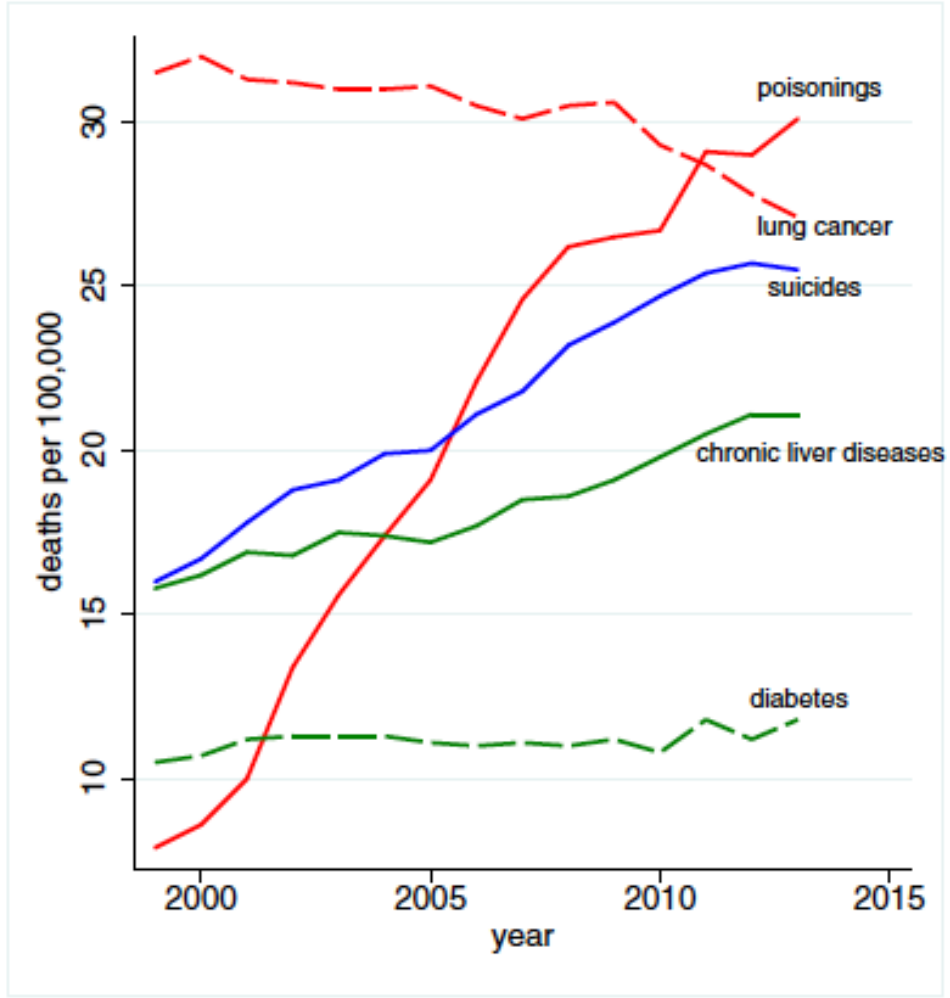

Fig. 2. Mortality by cause, white non-Hispanics ages 45–54.

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- A belief among prescribers that long term narcotics were a safe and effective way to treat pain.
- A federal mandate to call pain the “fifth vital sign” with accompanying pressure on prescribers to reduce pain to zero.
- New pharmaceutical products (such as OxyContin) effectively marketed as safer than older narcotics.

I do not think we will make much improvement in this problem until we change physician prescribing habits.

When physicians do change their prescribing habits, what is it that makes them change their habits?

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One very common answer is prior authorization requirements by insurers.

Proposed Statute

- Insurers will require prior authorizations before paying for opioid prescriptions that do not follow the guidelines.

CDC Guidelines

- **Opioids are not first-line therapy for chronic pain.** Physicians should prescribe long term opioids only if expected benefits outweigh risks to the patient and if other options have been tried. If opioids are used, they should ideally be paired with non-opioid pharmacologic therapy.
- **Establish goals for pain and function.** Before starting opioid therapy, physicians should establish treatment goals with patients, and establish a timeline for opioid discontinuance if no improvements are seen.
- **Discuss risks and benefits.** Physicians should discuss the known risks and realistic benefits of opioid therapy.
- **Use immediate-release opioids when starting.**

CDC Guidelines Continued

- **Use the lowest effective dose.** Doses should nearly always be below 50 morphine milligram equivalents (MME) per day unless there is clear justification.
- **Prescribe short durations for acute pain.** Physicians should prescribe no greater quantity than needed for the expected duration of severe pain. Three days or less is recommended, and almost never more than seven.
- **Evaluate benefits and harms frequently.** Physicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy, and then at least every 3 months subsequently.

CDC Guidelines Continued

- **Use strategies to mitigate risk.** Physicians should use management plan strategies to mitigate risk, including considering offering naloxone with patients who are at higher risk for overdosing.
- **Review PDMP data.** Physicians should review patients' histories of opioid prescriptions using the prescription drug monitoring program (PDMP) when beginning opioid therapy, and at least every 3 months subsequently.
- **Use urine drug testing.** Physicians should use urine drug testing before starting opioid therapy, and at least annually thereafter.
- **Avoid concurrent opioid and benzodiazepine prescribing.**
- **Offer treatment for opioid use disorder.**

Insurers

- Insurers will require prior authorizations before paying for opioid prescriptions that do not follow the guidelines.
- May develop own protocol for granting prior authorization, in accordance with administrative rule.

Safeguards for Prescribers & Patients

- The prior authorization process must be set up so that it still allows for physicians to prescribe something that is not in accordance with the guidelines when it is medically necessary.

- With respect to this statute, the determination of what constitutes “medical necessity” is ultimately up to the physician, not the insurer.

Potential Issues

Guidelines	Which guidelines should be used (CDC, Department of Health, others)?
Rules	Should rulemaking be required? If so, who should be consulted in the rulemaking process(Department of Health, Insurance Department, DOPL)?
Affordable Care Act	Restrictions?
Application	Commercial insurers (not self-insured plans), PEHP, Medicaid, Workers' Compensation = 42% of Utahns