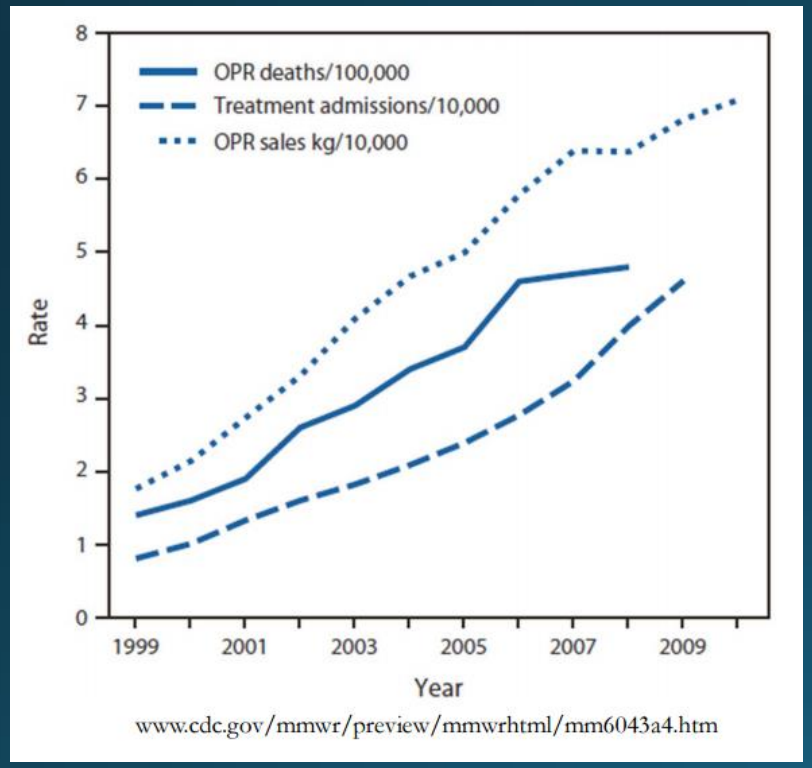
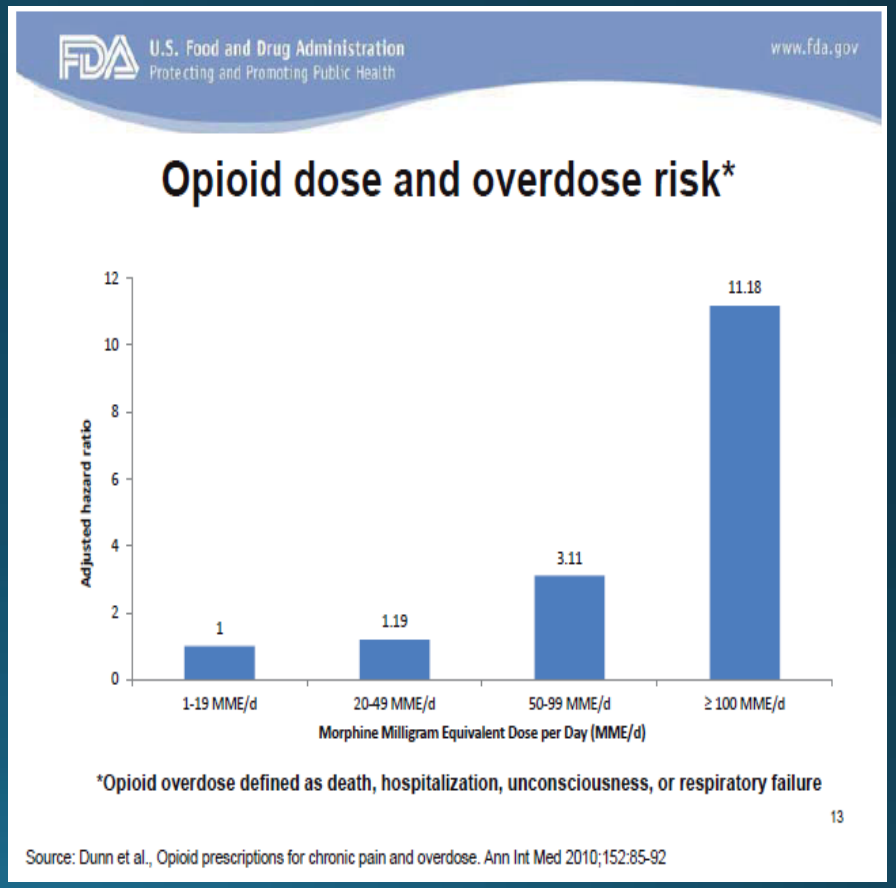
May 2016

Opioid PA Criteria Proposal

The Opioid Epidemic





*2007 National Opioid Abuse Related Costs: $25 Billion
*2012 National Hospitals Opioid Abuse Related Costs: $15 Billion

Morphine Equivalents

MME: Morphine Milligram Equivalent
MED: Morphine Equivalent Dose

Medication	~MME Factor	~MME Dose
Morphine	1	30mg
Codeine	0.15	200mg
Hydrocodone	1	30mg
Hydromorphone	4	7.5mg
Oxycodone	1.5	20mg
Oxymorphone	3	10mg
Methadone	3	10mg
Tapentadol	0.4	75mg
Tramadol	0.1	300mg (Max IR Daily Dose)
Meperidine	0.1	300mg
Pentazocine	0.37	~100mg
Opium	1	30mg
Buprenorphine 15mcg/hr Patch	12.6 (1.8 Daily)	~30mg
Buprenorphine Tablet/Film	10	3mg
Fentanyl 12.5mg/hr Patch	7.2 (2.4 Daily)	30mg

www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf

Changing Opioid Selection: Total Current Opioid Dose divided in half converted to new opioid plus IR PRN

CDC Chronic Pain Opioid Guidelines (Summary)

1. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2. Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5. When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

6. Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7. Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

9. Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10. When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12. Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Opioid Use Decision

1. Non-Pharm, Non-Opioid, then Opioid
2. Treatment Goals
3. Risk Assessments & Side Effects

Type/Amount/Time of Opioid

4. IR not ER.
5. MME >/= 50/day: Use caution
   MME >/= 90 avoid unless justified
4. Acute pain: Short duration
5. Re-evaluate 1 month, then every 3 months.

Risk/Harms of Opioid Use

8. Higher risk → naloxone
9. PDMP initially + every 1-3 months
10. UDT initially + annually
11. Avoid combining opioids & benzos
12. Opioid Use Disorder: Offer MAT

West Virginia
Expert Pain Management Panel

Panel Member
Mark Garofoli, PharmD, MBA (Coordinator)
Timothy Deer, MD (Chairperson)
Richard Vaglienti, MD (Vice Chairperson)
Rahul Gupta, MD
Ahmet Ozturk, MD
Denzil Hawkinberry, MD
Bradley Hall, MD
Matt Cupp, MD
Michael Mills, DO
Jimmy Adams, DO
Richard Gross, PhD
Jason Roush, DDS
Stacey Wyatt, RN
Vicki Cunningham, RPh
Felice Joseph, RPh
Stephen Small, RPh, MS
Patty Johnston, RPh
Charles Ponte, PharmD, CPE
James Jeffries
Michael Goff

WV SEMP Guidelines

West Virginia
Safe & Effective Management of Pain
Guidelines

West Virginia (WV) has the highest national state-by-state drug overdose death rate of 35 per 100,000 (Age Adjusted), with a large margin over the next closest state of New Mexico having a rate of 27, while the national average is 14. To address this statewide and national opportunity, a geographically and professionally diverse expert panel of West Virginia professionals with intentions of building upon the CDC Chronic Pain Opioid Guidelines of 2016 to develop pain management guidelines paving the way to safely and effectively improving a patient's daily function and reducing pain. The guidance, included herein, aims to first provide a risk reduction strategy for the appropriate use of all pain treatments, and secondly, to develop clinical pain management algorithms based on best practices, clinical experience, and evidence-based literature.

Risk Reduction Strategy

A major concern of healthcare professionals and patients alike is the question of what is the "gold standard" approach to managing pain, particularly chronic pain. Previously, pain management strategies have been largely based upon subjective evaluation methods versus more objective assessments. The risk reduction strategy contained herein, aims to minimize patient risk and reduce healthcare professional anxiety in the overall management of chronic pain, which is paramount for ensuring the safest and most effective management of pain.

Clinical Treatment Algorithms

Nociceptive Pain

Pain arising from noxious stimuli affecting thermal, mechanical, or chemical receptors (nociceptors) in normal tissues.

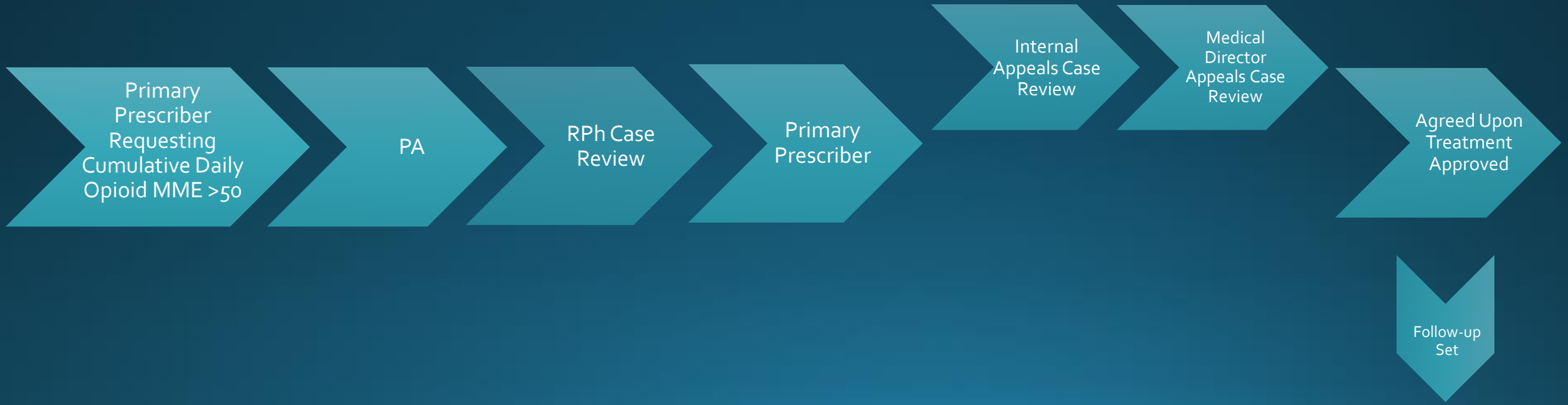
Neuropathic Pain

Abnormal processing of sensory input by the Central and/or Peripheral Nervous Systems (CNS/PNS)

Mixed Pain

Combination of both Nociceptive & Neuropathic Pains

Prior Authorization (PA) Process Flow



Prior Authorization (PA) Phases

Phase 1
PCP
(Primary Care Provider)
	• Chronic Pain Non-Cancer Patients
	• Acute Care (<90 Days): No MME Restrictions
	  • Extended-Release (ER) Formulation Opioids require previous (>/= 30 days) Immediate-Release (IR) Use
	• Chronic Care (>90 Days): Limited Restrictions (PAs)
	  • Abuse-Deterrent Formulation (ADF) ER Opioid formulations preferred if utilizing ER formulations

Phase 2 **PCP & PA Case Review**	• 90 Day Cumulative Daily Morphine Milligram Equivalent (MME) > 50 per day • Patient LOCKED IN for PA Case Review • Opioid Risk Assessment, Pain Management Treatment History, PDMP/CSMP, Urine Screenings, Patient/Provider(s) Agreements, Physical Exam, Lab Values, & Radiology Reviewed • Approvals/Denials must be communicated to PCP • Original appeals (at least one) must be handled within the program

Phase 3
PCP, PA Case Review, & Further Appeals
	Appeals:
	• Referral to Payer Medical Director for appeal
	  • New medication approved in payer system
	  • SEMPP communicates updates to PCP
	• Referral to local pain management specialist, if needed
	  • New agreement needs to be signed
	  • New medication approved in payer system
	  • SEMPP communicates updates to PCP

Academic Detailing

(Healthcare Professional Education)

Individualized Telephonic Approach

- Sending Guidelines with *every* case review
- Systematically reaching out to those prescribers *repeatedly requesting* higher risk opioids

Broad Approach

- Professional Conference Presentations
- Online/Live CE Programs
  - Prescribers
  - Dispensers

"Insanity is doing the same thing over and over again while expecting different results"

~Albert Einstein