PROPOSED DUR CRITERIA FOR MANAGING OPIOID USE AND MINIMIZING RISK OF OVERDOSE

BACKGROUND

In March, 2016, the CDC released the final version of their Guidelines for Prescribing Opioids for Chronic Pain.[1] Some important facts about opiate use that were summarized in the guidelines include:

- Opioids are commonly prescribed for pain; with an estimated 20% of patients presenting to physician offices with non-cancer pain symptoms or pain-related diagnoses (including acute and chronic pain) receiving an opioid prescription[2].
- In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills.[3]
- Opioid prescriptions per capita increased 7.3% from 2007 to 2012, with opioid prescribing rates increasing more for family practice, general practice, and internal medicine compared with other specialties.[4]
- From 1999 to 2014, more than 165,000 persons died from an overdose related to opioid pain medication in the United States.[5]
- In the past decade, while the death rates for the top leading causes of death such as heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly.[6]

Opioid abuse and related overdoses deaths have become a major health problem in the United States. In 2015, the Department of Health and Human Services (HHS) published a report on the actions they were taking to address this problem.[7] The Food and Drug Administration (FDA) recently announced an Action Plan to increase actions related to the "growing epidemic of opioid abuse, dependence, and overdose in the United States."[8] In March of 2016, the FDA announced required label changes to add new warnings about the risk of addiction, abuse, overdose, and death for all immediate release (short acting) opioid pain medications.[9]

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[1] CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. http://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf.

[2] Daubresse M, Chang HY, Yu Y, et al. Ambulatory diagnosis and treatment of nonmalignant pain in the United States, 2000–2010. Med Care 2013;51:870–8. http://dx.doi.org/10.1097/MLR.0b013e3182a95d86

[3] Paulozzi LJ, Mack KA, Hockenberry JM. Vital signs: variation among states in prescribing of opioid pain relievers and benzodiazepines—United States, 2012. MMWR Morb Mortal Wkly Rep 2014;63:563–8.

[4] Levy B, Paulozzi L, Mack KA, Jones CM. Trends in opioid analgesic- prescribing rates by specialty, U.S., 2007–2012. Am J Prev Med 2015;49:409–13. http://dx.doi.org/10.1016/j.amepre.2015.02.020

[5] CDC. Multiple cause of death data on CDC WONDER. Atlanta, GA: US Department of Health and Human Services, CDC; 2016. http:// wonder.cdc.gov/mcd.html

[6] CDC, National Center for Health Statistics. Health, United States, 2014: with special feature on adults aged 55–64. Hyattsville, MD: US Department of Health and Human Services, CDC, National Center for Health Statistics; 2015.

[7] ASPE Issue Brief: Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths. https://aspe.hhs.gov/pdf-report/opioid-abuse-us-and-hhs-actions-address-opioid-drug-related-overdoses-and-deaths

[8] Food and Drug Administration. Fact Sheet – FDA Opioids Action Plan. http://www.fda.gov/NewsEvents/Newsroom/FactSheets/ucm484714.htm

[9] Food and Drug Administration. New Safety Measures Announced for Immediate Release (IR) Opioids. http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm491437.htm

The Office of Inspector General of the Department of Health and Human Services (OIG) has strongly recommended that steps must be taken to address opioid misuse and diversion. **The OIG 2016 Work Plan will focus on state actions taken through drug utilization review (DUR) programs to address opioid misuse and abuse in state Medicaid.**[10] Efforts are directed to protect "an expanding Medicaid program from fraud, waste, and abuse."

> ➢ **REVISED** States' actions based on Medicaid drug utilization reviews
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> We will review the education and enforcement actions that States have taken on the basis of information generated by their drug utilization review (DUR) programs related to inappropriate dispensing and potential abuse of prescription drugs, including opiates. We also will review State oversight of and coordination with MCOs' DUR programs and any resulting actions related to inappropriate dispensing of opiates.

With the increasing importance being placed on managing opioid utilization, the MS-DUR reviewed the recommendations in the recently approved CDC guidelines for Prescribing Opioids for Chronic Pain. Identified are those areas where DUR activities could appropriately help minimize risk of abuse and overdose and assure appropriate utilization of opioids in the Mississippi Medicaid program. CDC recommendations that could be addressed through DUR activities are provided along with related excerpts from the CDC backgrounder sections.

Wherever possible, analyses were conducted to provide background data that will help assess the magnitude of the current status of the issues for Mississippi Division of Medicaid (DOM) and the number of cases that would be affected by additional clinical edits. All analyses utilized prescription and medical administrative claims for fee-for-service (FFS) and the two coordinated care organizations (CCOs- UnitedHealthcare and Magnolia) for the period January 1, 2015 – December 31, 2015. The CDC guidelines exclude care for cancer patients, therefore all patient with documentation of cancer diagnoses in the medical claims for 2015 were excluded from the analyses. It is important to note that a few cancer patients may be included since cancer diagnoses may not be present in medical claims but documentation was provided during manual prior authorization.

CURRENT UTILIZATION OF NARCOTICS

Statistics for utilization of opioids during 2015 for Mississippi Medicaid are shown in Table 1. It should be noted that in the DOM Universal Preferred Drug List (UPDL) opioids are listed as short acting (SA) and long acting (LA) narcotic analgesics. These products will be referred to as opioids in this report. The nine most frequently used SA opioids are preferred products and account for 99.8% of all SA narcotic prescriptions. During this period, the UPDL only included four LA opioids as preferred drugs. These drugs accounted for about 88% of prescriptions. The DUR Board reviewed methadone use during the August 2015 meeting and recommended to the P&T Committee that methadone be changed to non-preferred status. The P&T Committee approved this recommendation and this change was made in the UPDL as of October 1, 2015.

[10] OIG Work Plan 2016, p 31. http://oig.hhs.gov/reports-and-publications/archives/workplan/2016/oig-work-plan-2016.pdf

TABLE 1: Utilization of Short Acting and Long Acting Opioids (2015 - Excludes benericiaries with cancer diagnoses)												
	TOTAL			FFS			UHC			MAG		
Drug Product	Number Rx Fills	Number Unique Benes	Number Unique Prescribers	Number Rx Fills	Number Unique Benes	Number Unique Prescribers	Number Rx Fills	Number Unique Benes	Number Unique Prescribers	Number Rx Fills	Number Unique Benes	Number Unique Prescribers
SHORT ACTING (SA)	**339,887**			**60,097**			**140,050**			**139,421**		
Hydrocodone-Acetaminophen	214,524	78,097	6,980	34,928	19,824	4,030	90,326	30,531	5,015	89,071	32,153	5,229
Acetaminophen-Codeine	38,199	30,243	3,330	11,640	10,229	1,955	13,069	10,355	2,079	13,424	10,437	2,201
Tramadol	37,580	19,129	3,672	5,668	3,693	1,751	14,616	7,458	2,493	17,277	8,603	2,621
Oxycodone w/ Acetaminophen	35,550	19,434	3,417	5,744	3,265	1,540	14,330	8,257	2,099	15,449	8,343	2,256
Oxycodone	8,218	1,715	768	1,011	353	297	5,177	949	416	2,029	502	341
Tramadol-Acetaminophen	2,432	1,655	502	440	319	172	788	590	266	1,202	759	320
Hydromorphone	1,251	476	287	239	103	96	684	242	132	328	143	118
Meperidine	963	772	215	267	231	66	372	293	118	319	250	106
Morphine Sulfate	570	202	134	86	47	49	331	94	54	153	62	52
Hydrocodone-Ibuprofen	188	133	98	33	12	14	132	104	77	23	17	17
Butalbital-Acetaminophen-Caff w/ COD	138	68	61	0	0	0	93	54	47	45	14	15
Oxycodone-Aspirin	85	79	13	9	9	2	49	48	9	27	22	6
Butalbital-Aspirin-Caff w/ Codeine	42	23	26	0	0	0	19	16	15	23	7	11
Oxymorphone	36	14	13	1	1	1	25	10	10	10	4	5
Nucynta	33	9	11	2	2	2	13	4	4	18	4	7
Butorphanol Tartrate Nasal	27	8	8	17	4	4	1	1	1	9	4	4
Codeine	13	8	9	1	1	1	4	4	4	8	3	4
Fentanyl	13	2	3	0	0	0	13	2	3	0	0	0
Acetaminophen-Caffeine-Dihydrocodeine	8	8	6	2	2	2	5	5	5	1	1	1
Opium Tincture	6	3	3	5	2	2	1	1	1	0	0	0
Pentazocine w/ Naloxone	6	3	3	0	0	0	1	1	1	5	2	2
Belladonna Alkaloids & Opium Suppos	5	5	4	4	4	4	1	1	1	0	0	0
LONG ACTING (LA)	**12,735**			**2,675**			**5,603**			**4,456**		
Morphine Sulfate CR	4,845	903	469	767	204	183	2,035	371	223	2,043	378	253
Fentanyl TD Patch	3,932	737	437	1,435	266	250	1,344	259	166	1,152	248	177
Methadone	1,344	260	135	220	69	62	603	105	66	521	110	61
Oxymorphone ER	1,100	271	92	101	33	23	710	166	73	289	83	48
Buprenorphine TD Patch	727	220	99	34	25	16	481	154	76	212	64	49
Oxycodone ER	576	115	123	81	14	23	334	83	91	161	22	32
Embeda	130	90	37	31	20	17	52	34	19	47	36	20
Nucynta ER	43	9	10	2	1	1	25	4	5	16	4	5
Tramadol SR	20	9	9	0	0	0	10	7	7	10	2	2
Hydromorphone ER	10	4	4	4	1	1	6	3	3	0	0	0
Zohydro ER	8	6	6	0	0	0	3	3	3	5	3	3

NOTE: Encounter data for Magnolia are not complete for November and December.

RECOMMENDATIONS FROM THE CDC OPIOID PRESCRIBING GUIDELINES

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

   CDC background on recommendation:

   ER/LA opioids include methadone, transdermal fentanyl, and extended-release versions of opioids such as oxycodone, oxymorphone, hydrocodone, and morphine. The clinical evidence review found a fair-quality study showing a higher risk for overdose among patients initiating treatment with ER/LA opioids than among those initiating treatment with immediate-release opioids.[11] The clinical evidence review did not find evidence that continuous, time-scheduled use of ER/LA opioids is more effective or safer than intermittent use of immediate-release opioids or that time-scheduled use of ER/LA opioids reduces risks for opioid misuse or addiction.

   Experts agreed that for patients not already receiving opioids, clinicians should not initiate opioid treatment with ER/LA opioids and should not prescribe ER/LA opioids for intermittent use. ER/LA opioids should be reserved for severe, continuous pain and should be considered only for patients who have received immediate-release opioids daily for at least 1 week.

   Mississippi Medicaid data:

   New starts in therapy are typically identified by using a "wash out" period during which a beneficiary did not fill a prescription for the targeted therapy. MS-DUR identified new starts for narcotic therapy using a 60-day and 90-day wash out period. As shown in Table 2, most of the new starts were for SA opioids. Using a 60-day period to define a new start, only 711 (0.70%) of beneficiaries had a new narcotic start that was not for a SA narcotic. This number drops to 396 (0.46%) when using a 90-day period to define a new start. Although the number of new starts for LA opioids is small, this does occur and may need to be addressed.

[11] Miller M, Barber CW, Leatherman S, et al. Prescription opioid duration of action and the risk of unintentional overdose among patients receiving opioid therapy. JAMA Intern Med 2015;175:608–15. http:// dx.doi.org/10.1001/jamainternmed.2014.8071

TABLE 2: Distribution of Non-Cancer Beneficiaries By Number of New Opioid Starts and Number of New Starts for Short Acting (SA) Opioids
(2015 - Excludes benericiaries with cancer diagnoses)

	Number of New Starts	Number of New Starts for SA Narcotics					
		0	1	2	3	4	5
TOTAL							
First Opioid fill in 60 days (n = 96,931)	1	391	80,343	-	-	-	-
	2	39	90	14,102	-	-	-
	3	4	5	14	1845	-	-
	4	1	0	0	0	95	-
	5	0	0	0	0	0	2
First opioid fill in 90 days (n = 83,315)	1	264	75,734	-	-	-	-
	2	7	34	6,163	-	-	-
	3	0	0	0	113	-	-
FFS							
First opioid fill in 60 days (n = 18,468)	1	83	17,116	-	-	-	-
	2	3	12	1,071	-	-	-
	3	1	1	6	162	-	-
	4	0	0	0	0	13	-
	5	0	0	0	0	0	-
First opioid fill in 90 days (n = 14,251)	1	71	13,724	-	-	-	-
	2	1	6	438	-	-	-
	3	0	0	0	11	-	-
UNITEDHEALTH CARE							
First opioid fill in 60 days (n = 38,453)	1	156	31,173	-	-	-	-
	2	18	45	6,159	-	-	-
	3	2	2	6	853	-	-
	4	1	0	0	0	37	-
	5	0	0	0	0	0	1
First opioid fill in 90 days (n = 33,771)	1	103	30,755	-	-	-	-
	2	5	20	2,833	-	-	-
	3	0	0	0	55	-	-
MAGNOLIA							
First opioid fill in 60 days (n = 39,827)	1	152	31,882	-	-	-	-
	2	18	33	6,863	-	-	-
	3	1	2	2	828	-	-
	4	0	0	0	0	45	-
	5	0	0	0	0	0	1
First opioid fill in 90 days (n = 34,130)	1	90	31,099	-	-	-	-
	2	1	8	2,885	-	-	-
	3	0	0	0	47	-	-

NOTE: Encounter data for Magnolia are not complete for November - December 2015.

Shaded cells indicate beneficiaries having new starts that were not for SA opioids.

The intermittent use of LA opioids is examined in Table 3. The percentage of patients taking LA opioids that had new starts for LA opioids indicates two potential problems with respect to the CDC guidelines. First, beneficiaries filling only 1 or 2 prescriptions for LA opioids but having the LA narcotic prescription classified as a new start, indicates that SA opioids are not always being used before patients are transitioned to LA opioids. Secondly, beneficiaries with a large

number of LA narcotic fills and having new starts for LA opioids, indicates that some patients are using LA opioids intermittently.

TABLE 3: Distribution of Beneficiaries Taking Long Acting Opioids By Having New Starts for LA Opioids
(2015 - Excludes benericiaries with cancer diagnoses)

		TOTAL			FFS			UnitedHealth Care			Magnolia		
			Percent With New Start for LA Opioid			Percent With New Start for LA Opioid			Percent With New Start for LA Opioid			Percent With New Start for LA Opioid	
		Number of Benes	60-day Criteria	90-day Criteria	Number of Benes	60-day Criteria	90-day Criteria	Number of Benes	60-day Criteria	90-day Criteria	Number of Benes	60-day Criteria	90-day Criteria
Number of Long Acting Opioid Fills	1	581	22.3%	17.9%	113	38.9%	35.4%	251	22.7%	15.9%	216	18.5%	11.1%
	2	310	27.7%	19.7%	62	33.9%	25.8%	135	23.0%	17.0%	113	30.1%	19.5%
	3	187	23.0%	13.9%	31	38.7%	22.6%	91	24.2%	16.5%	65	13.9%	6.2%
	4	167	28.7%	18.0%	30	10.0%	10.0%	64	35.9%	18.8%	73	30.1%	20.6%
	5+	1,086	20.8%	7.7%	177	14.7%	6.8%	485	20.0%	7.8%	424	24.3%	8.0%

NOTE: Encounter data for Magnolia are not complete for November - December 2015.

Potential DUR recommendations for consideration by Board:

a. New narcotic prescriptions (first narcotic fill within 90 days) must be for a SA narcotic.

This edit would support the CDC recommendations that use of SA opioids for initial treatment before moving to LA opioids and that LA opioids not be used intermittently.

2. **CDC recommendation:** ***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 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.***

CDC background on recommendation:

Benefits of high-dose opioids for chronic pain are not established. The clinical evidence review found only one study[12] addressing effectiveness of dose titration for outcomes related to pain control, function, and quality of life. This randomized trial found no difference in pain or function between a more liberal opioid dose escalation strategy and maintenance of current dosage. At the same time, risks for serious harms related to opioid therapy increase at higher opioid dosage.

The contextual evidence review found that although there is not a single dosage threshold below which overdose risk is eliminated, holding dosages <50 MME/day would likely reduce risk among a large proportion of patients who would experience fatal overdose at higher prescribed dosages. Experts agreed that lower dosages of opioids reduce the risk for overdose,

[12] Naliboff BD, WuSM, Schieffer B, et al. A randomized trial of 2 prescription strategies for opioid treatment of chronic nonmalignant pain. J Pain 2011;12:288–96. http://dx.doi.org/10.1016/j. jpain.2010.09.003

but that a single dosage threshold for safe opioid use could not be identified. Experts noted that daily opioid dosages close to or greater than 100 MME/day are associated with significant risks, that dosages <50 MME/day are safer than dosages of 50–100 MME/day, and that dosages <20 MME/day are safer than dosages of 20–50 MME/day. One expert thought that a specific dosage at which the benefit/risk ratio of opioid therapy decreases could not be identified. Most experts agreed that, in general, increasing dosages to 50 or more MME/day increases overdose risk without necessarily adding benefits for pain control or function and that clinicians should carefully reassess evidence of individual benefits and risks when considering increasing opioid dosages to ≥50 MME/day. Most experts also agreed that opioid dosages should not be increased to ≥90 MME/day without careful justification based on diagnosis and on individualized assessment of benefits and risks.

Mississippi Medicaid data:

Table 4 shows the distributions of beneficiaries taking opioids based on the highest MEDD for an individual prescription filled and for the highest MEDD for all opioids being used concomitantly. A description of how MEDD is computed and examples from actual prescriptions filled in 2015 are included in the attachment. Concomitant use was assumed to occur when beneficiaries filled narcotic prescriptions with overlapping days of supply. Overall, 23% of beneficiaries taking opioids had individual prescriptions written for ≥50 MEDD and 4.6% had individual prescriptions written for ≥90 MEDD. These percentages increase slightly (27.4% and 6.2%, respectively) when potential concomitant use of opioids is considered. Based on the evidence in the CDC guidelines, these beneficiaries are at increased risk of opioid overdose and death.

TABLE 4: Distribution of Beneficiaries Taking Opioids by Maximum Morphine Equivalent Daily Dose (MEDD) for Individual Opioid Prescriptions and For All Concomitant Opioid Prescriptions
(2015 - Excludes benericiaries with cancer diagnoses)

		TOTAL (n = 120,158)		FFS (n = 26,014)		UnitedHealth Care (n = 46,135)		Magnolia (n = 48,009)	
Maximum MEDD for Individual Rx*	<50	92,573	77.0%	22,284	85.7%	34,181	74.1%	36,108	75.2%
	50 - 89	22,059	18.4%	3,097	11.9%	9,562	20.7%	9,400	19.6%
	90 - 119	3,609	3.0%	379	1.5%	1,541	3.3%	1,689	3.5%
	120 +	1,917	1.6%	254	1.0%	851	1.8%	812	1.7%
Maximum MEDD for ALL Concomitant Rxs*	<50	87,204	72.6%	21,789	83.8%	31,222	67.7%	34,193	71.2%
	50 - 89	25,515	21.2%	3,381	13.0%	11,444	24.8%	10,690	22.3%
	90 - 119	4,458	3.7%	460	1.8%	2,002	4.3%	1,996	4.2%
	120 +	2,981	2.5%	384	1.5%	1,467	3.2%	1,130	2.4%

** Distributions are significantly different among plans (p < 0.001).*
NOTE: Encounter data for Magnolia are not complete for November - December 2015.

Potential DUR recommendations for consideration by Board:

b. Individual prescriptions for opioids with an MEDD of ≥ 90 must require a manual PA with documentation that the benefits outweigh the risks and that the patient has been counseled about the risks of overdose and death.

3. **CDC recommendation**: ***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.***

CDC background on recommendation:

Based on the contextual evidence review and expert opinion, certain risk factors are likely to increase susceptibility to opioid-associated harms and warrant incorporation of additional strategies into the management plan to mitigate risk. Clinicians should assess these risk factors periodically, with frequency varying by risk factor and patient characteristics. For example, factors that vary more frequently over time, such as alcohol use, require more frequent follow up. In addition, clinicians should consider offering naloxone, re-evaluating patients more frequently, and referring to pain and/or behavioral health specialists when factors that increase risk for harm, such as history of overdose, history of substance use disorder, higher dosages of opioids (≥50 MME/day), and concurrent use of benzodiazepines with opioids, are present.

Naloxone is an opioid antagonist that can reverse severe respiratory depression; its administration by lay persons, such as friends and family of persons who experience opioid overdose, can save lives. Naloxone precipitates acute withdrawal among patients physically dependent on opioids. Serious adverse effects, such as pulmonary edema, cardiovascular instability, and seizures, have been reported but are rare at doses consistent with labeled use for opioid overdose.[13] The contextual evidence review did not find any studies on effectiveness of prescribing naloxone for overdose prevention among patients prescribed opioids for chronic pain. However, there is evidence for effectiveness of naloxone provision in preventing opioid-related overdose death at the community level through community-based distribution (e.g., through overdose education and naloxone distribution programs in community service agencies) to persons at risk for overdose (mostly due to illicit opiate use), and it is plausible that effectiveness would be observed when naloxone is provided in the clinical setting as well. Experts agreed that it is preferable not to initiate opioid treatment when factors that increase risk for opioid-related harms are present. Opinions diverged about the likelihood of naloxone being useful to patients and the circumstances under which it

[13] Enteen L, Bauer J, McLean R, et al. Overdose prevention and naloxone prescription for opioid users in San Francisco. J Urban Health 2010;87:931–41. http://dx.doi.org/10.1007/s11524-010-9495-8

should be offered. However, most experts agreed that clinicians should consider offering naloxone when prescribing opioids to patients at increased risk for overdose, including patients with a history of overdose, patients with a history of substance use disorder, patients taking benzodiazepines with opioids, patients at risk for returning to a high dose to which they are no longer tolerant (e.g., patients recently released from prison), and patients taking higher dosages of opioids (≥50 MME/day). Practices should provide education on overdose prevention and naloxone use to patients receiving naloxone prescriptions and to members of their households.

Potential DUR recommendations for consideration by Board:

c. DOM requests feedback from the DUR Board on how and when naloxone should be made available to beneficiaries.

4. **CDC recommendation:** ***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.***

CDC background on recommendation:

Experts agreed that when opioids are needed for acute pain, clinicians should prescribe opioids at the lowest effective dose and for no longer than the expected duration of pain severe enough to require opioids to minimize unintentional initiation of long-term opioid use. The lowest effective dose can be determined using product labeling as a starting point with calibration as needed based on the severity of pain and on other clinical factors such as renal or hepatic insufficiency.

Several guidelines on opioid prescribing for acute pain from emergency departments[14, 15, 16] and other settings[17, 18] have recommended prescribing ≤3 days of opioids in most cases, whereas others have recommended ≤7 days (197) or <14 days.[19] Because physical

[14] Chu J, Farmer B, Ginsburg B, Hernandez S, Kenny J, Majlesi N. New York City emergency department discharge opioid prescribing guidelines. New York, NY: New York City Department of Health and Mental Hygiene; 2013. http://www.nyc.gov/html/doh/html/hcp/drug- opioid-guidelines.shtml

[15] Cheng D, Majlesi N. Clinical practice statement: emergency department opioid prescribing guidelines for the treatment of non- cancer related pain. Milwaukee, WI: American Academy of Emergency Medicine; 2013.

[16] American College of Emergency Physicians. Maryland emergency department and acute care facility guidelines for prescribing opioids. Baltimore, MD: Maryland Chapter, American College of Emergency Physicians; 2014. http://www.mdacep.org/MD%20ACEP%20 Pamphlet%20FINAL_April%202014.pdf

[17] Paone D, Dowell D, Heller D. Preventing misuse of prescription opioid drugs. City Health Information 2011;30:23–30.

[18] horson D, Biewen P, Bonte B, et al. Acute pain assessment and opioid prescribing protocol. Bloomington, MN: Institute for Clinical Systems Improvement; 2014. https://www.icsi.org/_asset/dyp5wm/Opioids.pdf

[19] Washington State Agency Medical Directors' Group. AMDG 2015 interagency guideline on prescribing opioids for pain. Olympia, WA: Washington State Agency Medical Directors' Group; 2015. http:// www.agencymeddirectors.wa.gov/guidelines.asp

dependence on opioids is an expected physiologic response in patients exposed to opioids for more than a few days (contextual evidence review), limiting days of opioids prescribed also should minimize the need to taper opioids to prevent distressing or unpleasant withdrawal symptoms. Experts noted that more than a few days of exposure to opioids significantly increases hazards, that each day of unnecessary opioid use increases likelihood of physical dependence without adding benefit, and that prescriptions with fewer days' supply will minimize the number of pills available for unintentional or intentional diversion. Experts thought, based on clinical experience regarding anticipated duration of pain severe enough to require an opioid, that in most cases of acute pain not related to surgery or trauma, a ≤3 days' supply of opioids will be sufficient.

Mississippi Medicaid data:

Overall, 72% of new starts for SA narcotic prescriptions were written for 7 days or less and 88% were written for 15 days or less.

TABLE 5: Distribution of Beneficiaries Having New Start for Short Acting Opioids by Number of Days Supply With Prescription
(2015 - Beneficiaries with cancer diagnoses are excluded)

	Days Supply	TOTAL		FFS		UnitedHealth Care		Magnolia	
First opioid fill in 60 days	1 - 3	40,402	35.3%	8,693	34.8%	16,595	37.9%	15,114	33.1%
	4 - 7	41,768	36.5%	9,147	36.6%	16,756	38.3%	15,865	34.8%
	8 - 15	18,196	15.9%	4,007	16.0%	5,809	13.3%	8,380	18.4%
	16 - 31	13,997	12.2%	3,128	12.5%	4,629	10.6%	6,240	13.7%
	32 - 89	33	0.0%	0	0.0%	0	0.0%	33	0.1%
	90 +	3	0.0%	0	0.0%	0	0.0%	3	0.0%
First opioid fill in 90 days	1 - 3	32,967	37.4%	6,618	35.9%	13,910	40.0%	12,439	35.5%
	4 - 7	34,096	38.6%	6,820	37.0%	14,118	40.6%	13,158	37.5%
	8 - 15	13,608	15.4%	2,907	15.8%	4,474	12.9%	6,227	17.8%
	16 - 31	7,569	8.6%	2,094	11.4%	2,242	6.5%	3,233	9.2%
	32 - 89	20	0.0%	0	0.0%	0	0.0%	20	0.1%
	90 +	3	0.0%	0	0.0%	0	0.0%	3	0.0%

** Distributions are significantly different among plans (p < 0.001).*
NOTE: Encounter data for Magnolia are not complete for November - December 2015.

Potential DUR recommendations for consideration by Board:

d. New fills (first prescription fill in 90 days) for a SA opioid can be approved through an electronic PA for a maximum of a 15 day supply / 7 day supply / or 2 7-day supplies. Use of SA opioids for longer periods will required a manual PA.

5. **CDC recommendation:** ***Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible.***

CDC background on recommendation:

Benzodiazepines and opioids both cause central nervous system depression and can decrease respiratory drive. Concurrent use is likely to put patients at greater risk for potentially fatal overdose. The clinical evidence review did not address risks of benzodiazepine co-prescription among patients prescribed opioids. However, the contextual evidence review found evidence in epidemiologic series of concurrent benzodiazepine use in large proportions of opioid-related overdose deaths, and a case-cohort study found concurrent benzodiazepine prescription with opioid prescription to be associated with a near quadrupling of risk for overdose death compared with opioid prescription alone.[20]

Experts agreed that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible.

Mississippi Medicaid data:

The distribution of beneficiaries taking opioids by number of days concurrent with taking benzodiazepines is shown in Table 6. Overall, 5.3% of beneficiaries taking opioids were concurrently taking benzodiazepines. Although this is a small percentage, but represents 6,376 beneficiaries that might be at increased risk of overdose death.

TABLE 6: Distribution of Beneficiaries Taking Opioids by Number of Days Concurrent Use of Opioid and Benzodiazepine
(2015 - Beneficiaries with cancer diagnoses are excluded)

Number of Days Concurrently Taking Opioid and Benzodiazepine	TOTAL (n = 120,158)		FFS (n = 26,014)		UnitedHealth Care (n = 46,135)		Magnolia (n = 48,009)	
0	113,782	94.7%	25,130	96.6%	43,497	94.3%	45,155	94.1%
1 - 10	2,287	1.9%	382	1.5%	896	1.9%	1,009	2.1%
11 - 31	1,710	1.4%	271	1.0%	677	1.5%	762	1.6%
32 - 62	1,024	0.9%	92	0.4%	447	1.0%	485	1.0%
63 +	1,355	1.1%	139	0.5%	618	1.3%	598	1.2%

** Distributions are significantly different among plans (p < 0.001).*
NOTE: Encounter data for Magnolia are not complete for November - December 2015.

[20] Park TW, Saitz R, Ganoczy D, Ilgen MA, Bohnert AS. Benzodiazepine prescribing patterns and deaths from drug overdose among US veterans receiving opioid analgesics: case-cohort study. BMJ 2015;350:h2698. http://dx.doi.org/10.1136/bmj.h2698

Potential DUR recommendations for consideration by Board:

e. Concomitant use of opioids and benzodiazepines should require a manual PA.

f. MS-DUR should do an educational mailing to providers prescribing concurrent use of benzodiazepines and opioids.

ATTACHMENT
MORPHINE EQUIVALENT DAILY DOSE (MEDD)

Daily morphine milligram equivalents are used to assess comparative potency, but not to convert a particular opioid dosage from one product to another. The calculation to determine morphine milligram equivalents includes drug strength, quantity, days' supply and a defined conversion factor unique to each drug. The formula for computing MEDD for a prescription is:

$$\frac{\text{(Drug Strength)} \times \text{(Drug Quantity)} \times \text{(MME Conversion Factor)}}{\text{(Days Supply)}}$$

The terminology for daily morphine equivalency may vary depending on the resource used, and may be described as MEDD, morphine equivalent dose (MED), or morphine milligram equivalents (MME). By converting the dose of an opioid to a morphine equivalent dose, a clinician can determine whether a cumulative daily dose of opioids approaches an amount associated with increased risk.

EXAMPLE MEDD CALCULATIONS FROM ACTUAL PRESCRIPTIONS					
Generic Drug Name	**Drug Strength**	**Quantity**	**Conversion Ratio**	**Days Supply**	**MEDD**
Acetaminophen-Codeine 300 mg-30 mg	30	42	0.15	2	94.5
Acetaminophen-Codeine 300 mg-60 mg	60	20	0.15	3	60.0
Embeda 50-2 Mg	50	60	1	30	100.0
Fentanyl TD Patch 72HR 25 MCG/HR	25	10	7.2	19	94.7
Fentanyl TD Patch 72HR 50 MCG/HR	50	5	7.2	17	105.9
Hydrocodone-Acetaminophen 10 mg-325 mg	10	60	1	10	60.0
Hydrocodone-Acetaminophen 10 mg-325 mg	10	22	1	2	110.0
Hydromorphone HCl Tab 2 MG	2	60	4	5	96.0
Methadone HCl Tab 10 MG	10	50	3	30	50.0
Methadone HCl Tab 10 MG	10	50	3	15	100.0
Morphine Sulfate CR 15 mg	15	180	1	30	90.0
Oxycodone HCl Tab 10 MG	10	60	1.5	10	90.0
Oxycodone HCl Tab 15 MG	15	62	1.5	15	93.0

Online calculators are available to estimate MEDD. It should be noted again that these calculators are not intended for dosage conversion from one product to another, but only to assess the comparative potency of opioids. Furthermore, calculated morphine equivalency may vary between tools for certain drugs, depending on the algorithm used. One commonly used websites that offers an MEDD calculator is:

Prescription Drug Monitoring Program Training and Technical Assistance Center (PDMP TTAC)