Mountain-Pacific Quality Health
DUR PROGRAM NEWS
WINTER 2023

Butrans® or Belbuca® for Medicaid Patients with Chronic Pain

Suboxone® is not FDA-approved for pain

In pain management literature and professional journals, buprenorphine is being recommended as a safer option for pain management than full mu opioids. It poses a lower risk of overdose death and provides pain management.

Buprenorphine injection was originally patented in 1965 as a treatment for pain in the hospital setting. When choosing buprenorphine for pain management only, it is important to be cognizant of which product you choose for your Medicaid patients. Currently on the market are two buprenorphine products that are labeled and marketed for pain management only. Butrans® Transdermal System (patch) and Belbuca® (buccal film) are both covered by Montana Medicaid for chronic pain management without subsequent opioid restriction due to their use for pain. Butrans® is the preferred product for Montana Medicaid, but Belbuca® is available with a prior authorization if Butrans® is not an option for the patient.

This is an important topic, because the Montana Medicaid Prior Authorization and Case Management program recently received questions about coverage of opioid prescriptions for chronic pain management in patients previously treated with Suboxone®, Zubsolv®, Sublocade® or buprenorphine sublingual tablets. Unless there are extenuating circumstances, patients who have been approved for these medications are restricted to non-coverage for subsequent chronic opioid treatment due to their opioid use disorder diagnosis. Coverage for outpatient emergent pain management can be prior authorized, and opioids remain a covered service in the inpatient setting. The coverage for chronic outpatient opioids, however, is suspended. Prior authorization remains an option with clinical rationale, but this is not a simple option for the provider. According to the U.S. Food and Drug Administration (FDA) labeling, these medications are ONLY indicated for opioid use disorder, and that is the only diagnosis covered by Montana Medicaid. The prior authorization paperwork required for approval of these medications lists this restriction.

Medicaid has two ways to prior authorize medications for opioid use disorder. A provider can sign up with Montana Department of Public Health and Human Services (DPHHS) and fill out an attestation of adherence to Medicaid policy[1]. After a provider is enrolled, their Suboxone® film prescriptions (currently

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Montana Healthcare Pharmacy Programs Link
(Current Montana Healthcare Programs Preferred Drug List, Provider Notices, DUR Board/ Meeting Information, Resources)
http://medicaidprovider.mt.gov/19

For current drug prior authorization criteria: https://www.mpqhf.org/corporate/montanans-with-medicaid/pharmacy/

The Drug Utilization Review (DUR) Program, administered by Mountain-Pacific through a contract with the Allied Health Services Bureau of the Montana Department of Public Health and Human Services, is the quality assurance body seeking to assure the quality of pharmaceutical care and to help provide rational, cost-effective medication therapy for Montana Healthcare Programs members.

Montana Healthcare Programs Drug Prior Authorization Unit 1-800-395-7961

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www.mpqhf.org

Butrans® or Belbuca® for Chronic Pain (cont.)

the preferred drug for Montana Medicaid) will go through without requiring additional prior approval. If a provider has not signed the attestation, they must request prior authorization[2] for each new preferred drug prescription, as well as those that are non-preferred.

If a provider wants to use a buprenorphine product for chronic pain management in a patient who does not have opioid use disorder, the best option is to use one of the products with the FDA indication for pain management, Butrans® or Belbuca®. Then, if the patient does not respond to buprenorphine as a pain management option, the provider can choose to use opioids within the Medicaid criteria without further barriers. When a provider chooses to use Suboxone®, the patient is automatically restricted from subsequent opioid prescriptions by Montana Medicaid. If this is done in error, the issue can be resolved, but it takes time and paperwork. The best option is to choose wisely!

References:

[1]Montana Healthcare Programs Notice: Electronic Prior Authorization Process for Suboxone Films for Medication Assisted Therapy (June 20, 2019). https://www.mpqhf.org/corporate/wp-content/uploads/2023/01/Medication-Assisted-Therapy-MAT-Provider-Notice-and-Attestation-Form-508-Compliant.pdf

[2]Montana Healthcare Programs Buprenorphine-containing Products (transmucosal) for Opioid Substance Use Disorder (updated February 2021). https://www.mpqhf.org/corporate/wp-content/uploads/2023/01/Medication-Assisted-Therapy-MAT-Provider-Notice-and-Attestation-Form-508-Compliant.pdf

Tridemic: What Is This?

On the December 3, 2022, at the Centers for Disease Control and Prevention/Infectious Diseases Society of America (CDC/IDSA) clinician call, the first topic of concern was the influenza, respiratory syncytial virus (RSV) and COVID-19 tridemic. During the call, it was noted that cases of RSV and influenza have been unseasonably high this year. The number of COVID-19 cases are also beginning to rise, as they did last year during this time period.

For a perspective closer to home, *Public Health Insider* interviewed Seattle & King County Communicable Disease and Epidemiology section lead, Dr. Eric Chow, MD, MS, MPH. He responded to questions about how these respiratory viruses are affecting the area with "Yes, both locally and nationally we're seeing a rise in these respiratory viruses. This is concerning both for the health of our most vulnerable residents, such as young children, older adults and for people with underlying conditions. It's also concerning for our health care system, which for many months has been experiencing staffing shortages and limited available hospital beds for new patients."

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Tridemic (cont.)

According to the CDC and Montana DPHHS, who track infectious disease in Montana, we are facing an early and active flu season as well as more weekly confirmed cases of RSV than in either of the previous two years. The 2022-2023 influenza case count curve starts very early compared to the historical comparison, and weekly aggregate cases started to exceed the peak number of cases reported for the previous 2021-2022 influenza season. While the 2020- 2021 season is included in the comparison, no confirmed influenza cases were reported during that season (Influenza [seasonal flu] [mt.gov]). COVID-19 numbers have also begun to trend upward again. For the week ending December 9, 2022, Montana had 1,140 new cases of COVID-19 statewide. For the week ending December 16, 2022, Montana Response:COVID-19[1] shows only seven of our 56 counties having no new reported infections. Knowing what this tridemic is prompts us to consider our response. The CDC/IDSA recommends the following:

- Focusing on vaccines for influenza and COVID-19 for prevention of widespread infection of these viruses
- Accurate diagnosis using appropriate testing to determine etiology of the specific infection and guide therapy
- Prompt and guideline-based treatment of those who do become very ill
- Rapid prescribing of antivirals for influenza for those at high risk for influenza complications

Treatment for those exposed should be considered.

References:

[1]Montana Response: COVID-19 - Coronavirus - Global, National and State Information Resources
https://montana.maps.arcgis.com/apps/MapSeries/index.html?appid=7c34f3412536439491adcc2103421d4b

A Peek at Some of the Changes to the CDC Opioid Guidelines 2022 vs. 2016

In 2016, the CDC published its first Clinical Practice Guideline for Prescribing Opioids for Chronic Pain. After an in-depth discussion, the CDC softened regarding certain pain conditions. It spelled out specific dose limits and days' supply recommendations for safer prescribing. States implemented regulations on new opioid prescriptions and insurance companies limited payment for doses above the recommended safe levels.

Long-term pain patients had differing reactions to these changes. Some had a dramatic increase in function without additional pain when their doses were reduced, while others ended up migrating to illicit opioids as their prescription doses decreased.

Opioid prescribing and pain management became a medical hot potato. It is important to remember we were at the height of the "prescription opioid epidemic" in 2016. Now we have moved into just the "opioid epidemic," because prescription opioids like Oxycontin® moved out of the spotlight due to the flood of illicit fentanyl that now claims the majority of lives when it comes to opioid-related deaths. The CDC guidelines in 2016 did reduce some of the excessive prescribing of the prior decade. The 2022 guidelines appear to view opioid prescribing from a different point in time and with a different goal. The mandates have disappeared, and prescribers are encouraged to work with and educate their patients to further maximize all pain modalities, not just opioids. Prescribers are encouraged to also include their patients in decision-making.

Near the beginning of the 2022 CDC Clinical Practice Guideline for Prescribing Opioids for Pain, the authors discuss the rationale for the update to the 2016 published guideline. "Since release of the 2016 CDC Opioid Prescribing Guideline, new evidence has emerged on the benefits and risks of prescription

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opioids for both acute and chronic pain, comparisons with nonopioid pain treatments, dosing strategies, opioid dose-dependent effects, risk mitigation strategies and opioid tapering and discontinuation."[2]

Utilizing new data from numerous studies, the updated 2022 guidelines follow the basic format of the previous guidelines, but from a slightly different perspective. Language such as "when to initiate" has been replaced by "whether or not to initiate," and "avoid prescribing" is now "use particular caution when prescribing." The recommendation suggesting caution when considering increasing doses to ≥50 morphine milligram equivalents (MME)/day and avoid or carefully justify a decision for increasing to ≥90 MME/day is not spelled out in the new guidelines. Instead, the 2022 guidelines encourage prescribers to carefully evaluate individual benefits and risks when considering dose and avoid those likely to yield diminishing returns in benefits relative to risks to the patient.

In several sections of the 2022 guidelines, the prescriber is tasked with decision-making with the patient as opposed to sole decision-making. Education of the patient about risk and benefit and how to mitigate risk is encouraged. The new guideline also goes further in recommendations about tapering opioids and referring patients for medications for opioid use disorder (MOUD). Abrupt tapering or discontinuation of opioids, unless there is an immediate danger to the patient, and detoxification without MOUD are not recommended due to increased risk to the patient.

Below is a table for side-by-side comparison of the recommendations from the 2016 and 2022 guidelines. The recommendations are grouped into several areas for consideration. The 2016 guidelines list three areas of recommendations, and the 2022 guidelines expanded to four areas. Each guideline has 12 total recommendations divided into these areas. The complete guideline includes a subsequent expanded explanation of each recommendation as well as a grade on the strength of the recommendation.

After the table is the different MME from each of the guidelines. There are several changes to specific drug-recommended equivalents in the 2022 document. Hydromorphone and methadone have different factors for calculation. Tramadol and tapentadol equivalents, which were not included in 2016, have been added to the 2022 table.

2016 Guidelines[1] **Recomendations**	**2022 Guidelines[2]** **Recomendations**
Determining when to initiate or continue opioids for chronic pain	***Determining when to initiate or continue opioids for chronic pain***
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.	1. Nonopioid therapies are at least as effective as opioids for many common types of acute pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider opioid therapy for acute pain if benefits are anticipated to outweigh risks to the patient. Before prescribing opioid therapy for acute pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy.
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.	2. Nonopioid therapies are preferred for subacute and chronic pain. Clinicians should maximize use of nonpharmacologic and nonopioid pharmacologic therapies as appropriate for the specific condition and patient and only consider initiating opioid therapy if expected benefits for pain and function are anticipated to outweigh risks to the patient. Before starting opioid therapy for subacute or chronic pain, clinicians should discuss with patients the realistic benefits and known risks of opioid therapy, should work with patients to establish treatment goals for pain and function and should consider how opioid therapy will be discontinued if benefits do not outweigh risks.

CDC Opioid Guidelines (cont.)

2016 Guidelines[1] Recomendations	2022 Guidelines[2] Recomendations
Determining when to initiate or continue opioids for chronic pain	***Determining when to initiate or continue opioids for chronic pain***
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.	
Opioid selection, dosage, duration, follow-up and discontinuation	***Selecting opioids and determining opioid dosages***
4. When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.	3. When starting opioid therapy for acute, subacute or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and 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.	4. When opioids are initiated for opioid-naïve patients with acute, subacute or chronic pain, clinicians should prescribe the lowest effective dosage. If opioids are continued for subacute or chronic pain, clinicians should use caution when prescribing opioids at any dosage, should carefully evaluate individual benefits and risks when considering increasing dosage and should avoid increasing dosage above levels likely to yield diminishing returns in benefits relative to risks to patients.
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	5. For patients already receiving opioid therapy, clinicians should carefully weigh benefits and risks and exercise care when changing opioid dosage. If benefits outweigh risks of continued opioid therapy, clinicians should work closely with patients to optimize nonopioid therapies while continuing opioid therapy. If benefits do not outweigh risks of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual circumstances of the patient, appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue such as warning signs of impending overdose (e.g., confusion, sedation, or slurred speech), opioid therapy should not be discontinued abruptly, and clinicians should not rapidly reduce opioid dosages from higher dosages.
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.	

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CDC Opioid Guidelines (cont.)

2016 Guidelines[1] Recomendations	2022 Guidelines[2] Recomendations
	Deciding duration of initial opioid prescription and conducting follow-up
	6. When opioids are needed for acute pain, clinicians should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids.
	7. Clinicians should evaluate benefits and risks with patients within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain or of dosage escalation. Clinicians should regularly reevaluate benefits and risks of continued opioid therapy with patients.
Assessing risk and addressing harms of opioid use	***Assessing risk and addressing potential harms of opioid use***
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.	8. Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk for opioid-related harms and discuss risk with patients. Clinicians should work with patients to incorporate into the management plan strategies to mitigate risk, including offering naloxone.
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.	9. When prescribing initial opioid therapy for acute, subacute or chronic pain, and periodically during opioid therapy for chronic pain, 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 combinations that put the patient at high risk for overdose.
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.	10. When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.
11. Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.	11. Clinicians should use particular caution when prescribing opioid pain medication and benzodiazepines concurrently and consider whether benefits outweigh risks of concurrent prescribing of opioids and other central nervous system depressants.
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.	12. Clinicians should offer or arrange treatment with evidence-based medications to treat patients with opioid use disorder. Detoxification on its own, without medications for opioid use disorder, is not recommended for opioid use disorder because of increased risks for resuming drug use, overdose and overdose death.

References:

[1]http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?s_cid=rr6501e1_w.htm
[2]https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1

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MME Dose Chart CDC Guidelines 2022

Morphine milligram equivalent doses for commonly prescribed opioids for pain management

Codeine	0.15
Fentanyl transdermal mcg/hr	2.4
Hydrocodone	1.0
Hydromorphone	5.0
Methadone	4.7
Morphine	1.0
Oxycodone	1.5
Oxymorphone	3.0
Tapentadol[Ŧ]	0.4
Tramadol[§]	0.2

Sources: Adapted from Von Korff M, Saunders K, Ray GT, et al. Clin J Pain 2008;24:521–7 and Nielsen S, Degenhardt L, Hoban B, Gisev N. Pharmacoepidemiol Drug Saf 2016;25:733–7. https://www.cdc.gov/mmwr/volumes/71/rr/pdfs/rr7103a1-H.pdf

[Ŧ]Tapentadol is a μ-receptor agonist and norepinephrine reuptake inhibitor. MMEs are based on degree of μ-receptor agonist activity; however, it is unknown whether tapentadol is associated with overdose in the same dose-dependent manner as observed with medications that are solely μ-receptor agonists.

[§]Tramadol is a μ-receptor agonist and norepinephrine and serotonin reuptake inhibitor. MMEs are based on degree of μ-receptor agonist activity; however, it is unknown whether tramadol is associated with overdose in the same dose dependent manner as observed with medications that are solely μ-receptor agonists.

MME Dose Chart CDC Guidelines 2016

Calculating morphine milligram equivalents (MME)

OPIOID	CONVERSION FACTOR
Codeine	0.15
Fentanyl transdermal (mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
>61-80mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

Calculating Total Daily Dose of Opioids For Safer Dosages, 2016, p.2, Calculating Total Daily Dose of Opioids For Safer Dosage. https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf