July Pharmacy Newsletter

PREFERRED DRUG LIST UPDATES

Integrated (Title 19/21 SMI) and ACC, DD, ALTCS and DCS CHP

Additions:

- *Lacosamide Soln 10mg/mL (Prior Authorization)*
- *Sorafenib 200mg Tab (Prior Authorization)*
- *Omeprazole 20mg ODT (OTC)*

Removals:

- *Lidocaine/Sorb Lotion 3%*
- *Nexavar 200mg Tab*
- *Oxycodone/APAP Soln 5/325mg*
- *Vimpat Soln 10mg/mL*

Other Updates

- None

Behavioral Health (Title 19/21 Non-SMI & Non-Title 19/21)

Additions:

- None

Removals:

- None

Other Updates

- None

** Drugs that are not on the formulary may be available via PA (prior authorization) **

- For the complete preferred drug lists, please refer to the Mercy Care websites below
  - RBHA: https://www.mercycareaz.org/providers/rbha-forproviders/pharmacy
    - Behavioral Health Preferred Drug List: For members who qualify under Non-Title 19/21 determined to have a serious mental illness (SMI) or Non-Title 19/21 children/adolescents with a serious emotional disturbance (SED), Mercy Care RBHA fills only behavioral health medications.
    - Integrated Preferred Drug List: For Title 19/21 SMI members, Mercy Care RBHA fills physical health and behavioral health medications.
    - Crisis Medication List: For adults or children who are Non-Title 19/21 and Non-SMI who present in crisis at any of the facility-based psychiatric urgent care centers, detox facilities and/or access point in Maricopa County. The medications on this list will help stabilize an individual in crisis and bridge them to a follow-up outpatient appointment.
  - ACC, DD, ALTCS and DCS CHP: https://www.mercycareaz.org/providers/completecare-forproviders/pharmacy

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

Centers for Disease Control and Prevention's (CDC) Guideline for Prescribing Opioids for Chronic Pain is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Providers 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.

Before starting opioid therapy for chronic pain, providers 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. Providers should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

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

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

When opioids are started, providers should prescribe the lowest effective dose. Providers 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.

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, providers 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**.

Providers should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Providers 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, providers should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Before starting and periodically during continuation of opioid therapy, providers should evaluate risk factors for opioid-related harms. Providers 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.

Providers should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program i.e.: AZ PMP AWARE, to determine whether the patient is receiving opioid dosages or dangerous combinations that put patients at high risk for overdose. Providers should review AZ PMP AWARE data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

When prescribing opioids for chronic pain, providers 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.

Providers should avoid prescribing opioid pain medication and benzodiazepines concurrently.

Providers 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.

Some interesting metrics to keep in mind when deciding use of opioids

Rate of opioid prescription in members with opioid use disorder is currently at 5%.

Rate of concomitant opioid treatment in members treated with benzodiazepines is currently at 14.3%.

Review use of opioid prescription in members with prior overdose.

RBHA members receiving opioids in the first quarter was 84 and second quarter was 88 members.

A quick note on prescribing SUBOXONE for maintenance treatment of opioid dependence

The maintenance dose of SUBOXONE sublingual film is generally in the range of 4 mg/1 mg buprenorphine/naloxone to 24 mg/6 mg buprenorphine/naloxone per day, depending on the individual patient and clinical response. The recommended target dosage of SUBOXONE sublingual film during maintenance is 16 mg/4 mg buprenorphine/naloxone/day as a single daily dose. **Dosages higher than 24 mg/6 mg daily have not been demonstrated to provide a clinical advantage.**

Reminder for quicker determinations of a Prior Authorization use the ePA link for Our Providers: Please click here to initiate an electronic prior authorization (ePA) request

Please take a minute for a quick survey response: Provider Survey for Quarter(s) 1 and 2_ 2022

References:

1. https://www.cdc.gov/opioids/providers/prescribing/guideline.html
2. https://www.cdc.gov/media/releases/2022/s0210-prescribing-opioids.html
3. https://www.suboxone.com/pdfs/prescribing-information.pdf

This newsletter is brought to you by the Mercy Care Pharmacy Team. For questions, please email Fanny A Musto (MustoF@mercycareaz.org), Denise Volkov (VolkovD@mercycareaz.org) or Trennette Gilbert (gilbert@mercycareaz.org)