



Medication-Assisted Treatment for Opioid Use Disorders

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About the speaker

Gary M. Henschen, M.D. is Senior Vice President, Medical Management for Magellan Healthcare, Inc. He has been employed by Magellan since 2001, and has been in his current position since 2008.

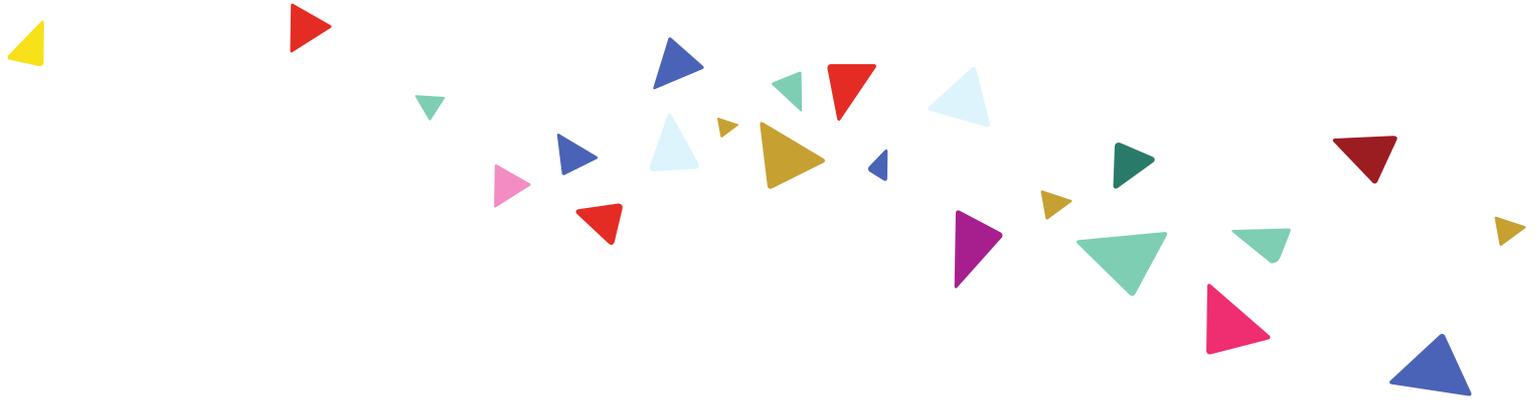
In his current role, he directs a team that develops medical necessity criteria, new technology assessments, and clinical practice guidelines for behavioral health. He provides clinical expertise in new product development and the quality improvement program of Magellan. He oversees medical management for Magellan's behavioral health programs.

Prior to joining Magellan, Dr. Henschen was Chief Medical Officer of Charter Behavioral Health Systems, LLC. He was previously in private practice for psychiatry and psychoanalysis in Greensboro, North Carolina for 15 years.

Dr. Henschen is a graduate of Davidson College. He received the M.D. degree from the University of North Carolina at Chapel Hill. He completed his internship in medicine at Letterman Army Medical Center, San Francisco, and completed military service with the U.S. Army in Germany where he was flight surgeon and commander of the 536th General Dispensary.

Dr. Henschen completed his residency and chief residency in psychiatry at Duke Medical Center, and completed psychoanalytic training at the UNC-Duke Psychoanalytic Institute. His research interests have included the assessment and prevention of suicide; psychiatric consultation-liaison with primary care physicians; the development of quality metrics; addressing the needs of individuals diagnosed with both serious mental illness and substance use disorders; and providing consultation to behavioral special investigation units.

Dr. Henschen is licensed to practice medicine in Georgia, North Carolina, Tennessee, New Jersey, Pennsylvania and Iowa.



Disclosure

Gary Henschen, M.D. has no relevant financial relationship or commercial interest that could be reasonably construed as a conflict of interest.

Magellan Health: One company, two unique platforms



Focused on Complex Populations, Delivering Differentiated Services

State Medicaid programs and integrated management for special populations, including individuals with serious mental illness and those needing long-term services and supports

Behavioral health management and employee assistance programs

Specialty healthcare management, including musculoskeletal, cardiac and advanced imaging

25.3 million
commercial
behavioral lives

25.1 million
commercial
specialty lives

5.1 million
lives in
government
programs



Offices in 26
states & D.C.



Full-Service PBM Focused on High-Growth Specialty Spend

Full-service Pharmacy Benefit Manager (PBM) that expands beyond traditional core services

Value-driven solutions: targeted clinical and powerful engagement strategies, advanced analytics, leading-edge specialty pharmacy programs

More than 40 years of Medicaid and more than 30 years of self-funded employer experience

Medicare Part D Prescription Drug Program

13.3 million
medical pharmacy
lives

1.9 million
commercial
PBM lives

26 states
& Washington, DC
in State Medicaid
PBA business



10,000
Total Employees

Learning objectives

Upon completion of this activity, participants should be able to:

✓ **Demonstrate the effective use of naltrexone** in opioid use disorders

✓ **Demonstrate the effective use of buprenorphine** in opioid use disorders

✓ **Report theories** explaining the need for psychosocial interventions in SUD treatment

✓ **Explain the role** of medication-assisted treatment in the continuum of care for substance use disorder patients

✓ **Explain barriers** to the use of medication-assisted treatment for patients with opioid use disorders

✓ **Outline interventions** prescribers should make to prevent abuse of opioid medications

Opioid abuse in the headlines



Photo-Illustration by Bartholomew Cooke for TIME

Opioid addiction and the resulting overdoses and deaths...[are] in my view, the toughest public health challenge that we face at FDA.

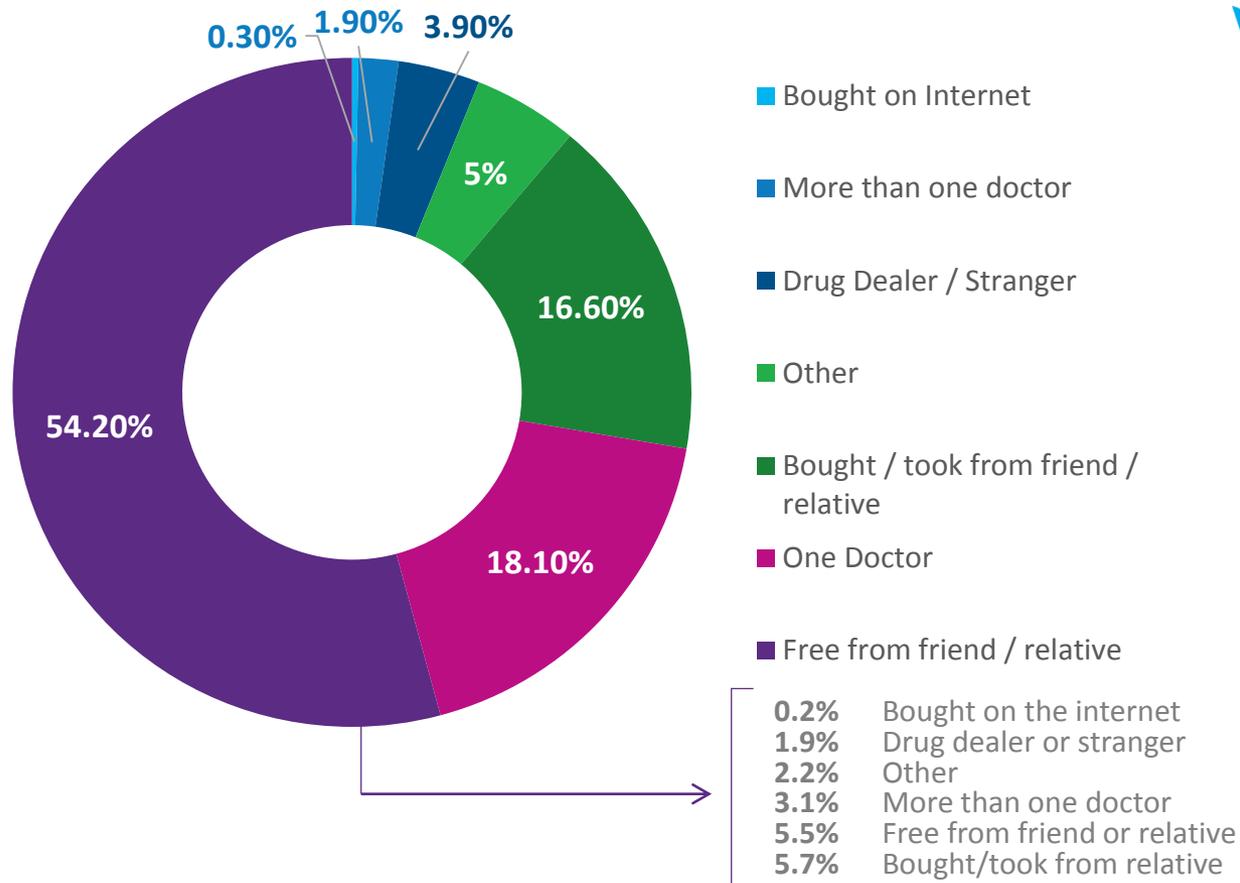
- Scott Gottlieb, MD, Commissioner of the Food and Drug Administration



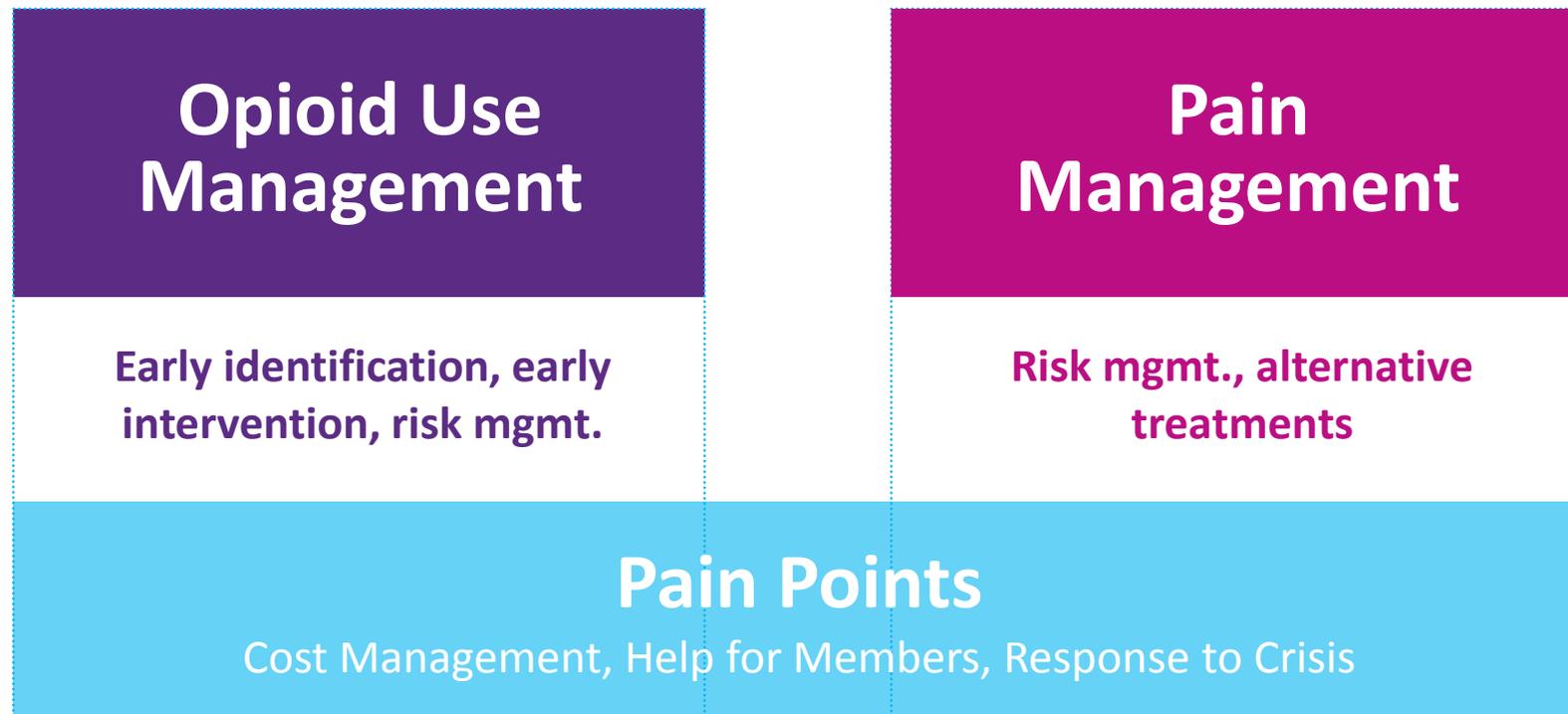
Users of opioid prescriptions

Where Prescription Drugs are Obtained

- Those with chronic pain
- Chronic pain affects more than 1 in 3 Americans
- IOM estimates 110 million chronic pain sufferers
- Those using for non-medical purposes
- Estimated 52 million Americans over 12 have used prescription drugs for non-medical purposes
- In 2010, of 9 million prescription drug abusers, 5.1 million abused painkillers

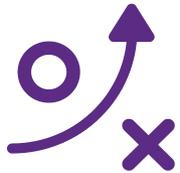


A Comprehensive Model: Solutions consumers are asking for



*How are they the same? How are they different?
What the areas of overlap and where do the concepts diverge?*

Slippery slope to addiction



Over-prescribing

- Pharmaceutical marketing
- Pain as a symptom, not a disease
- Little consideration for patient's substance use history, assessing for risk of addiction
- No consensus about who should receive how much opioid and for how long



Unknowingly risking addiction

- Opioids suppress pain
- Painkillers can create a euphoric, relaxed sensation
- Can provide a release from stress
- Significant adverse side effects, overdose deaths

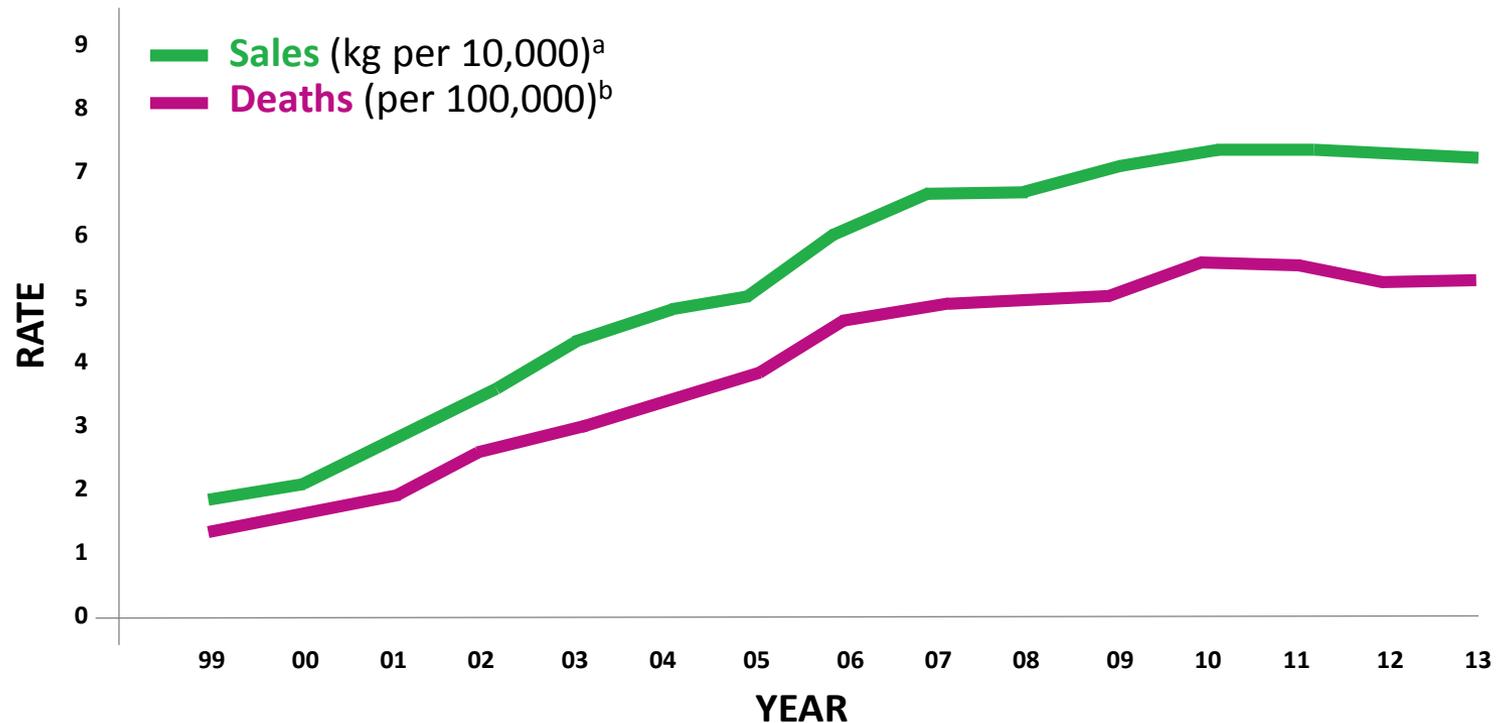


Improper use to abuse

- 2 million Americans met the criteria for an opioid use disorder
- Taking someone else's medication to self-medicate
- Taking opioids in a way other than prescribed
- Taking medication to get high

Unintentional overdose with prescription opioids

Prescription Painkiller Sales & Deaths



Deaths from prescription painkillers have **quadrupled** since 1999, killing more than **16,000** people in the U.S. in 2013.⁶ **Nearly two million** Americans, aged 12 or older, either abused or were dependent on opioids in 2013.⁷

⁶ (2015) CDC. National Vital Statistics System mortality data. <http://www.cdc.gov/nchs/deaths.htm>

⁷ (2013) SAMHSA, *Results from the 2012 National Survey on Drug Use and Health: Summary of National*

11 *Findings*, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: SAMHSA

Integrated substance use solutions

Evidence-based and cost-effective treatments



Medication-assisted treatment (MAT)

Use of medications, in combination with counseling and behavioral therapies, to provide whole-patient approach to treatment



Office-based opioid treatment (OBOT)

Breakthrough for patients who find it difficult to abstain from opioids and cannot successfully complete treatment



Ambulatory detoxification

Cost-effective and safe service for members requiring detoxification



Co-occurring disorders

Improved identification and treatment of co-occurring mental health and substance abuse disorders



Screening tools and processes

SBIRT and other screening tools that direct PCP to the appropriate treatment (referral, brief intervention, CCBT)

Medication-assisted treatment (MAT)



Important role of medications in treatment of SUD

- **Medications highly underutilized**
- **APA and NCQA performance measures**
 - Psychosocial interventions
 - Pharmacologic interventions
- **Psychosocial interventions must accompany MAT**
- **Medications mandated in VA**
- **Magellan's OBOT initiative**



Increasing recognition of the role of medications in treatment of SUD

Barriers to utilization of these medications

- Lack of education of clinicians
- Perceived ineffectiveness
- Medications will reduce motivation for psychosocial treatment
- Side effects
- Cost
- Lack of time in patient management
- Reluctance to take medications
- Formulary status in health plan
- Lack of education in SUD facility staff



Pre-test question #1

Q. Which of the following is not an FDA-approved medication for opioid dependence?

- A. Zubsolv
- B. Topiramate
- C. Naltrexone
- D. Vivitrol

Pre-test question #2

Q. Which of the following are used to treat alcohol dependence?

- A. Acamprosate
- B. Oral naltrexone
- C. Long-acting injectable naltrexone
- D. All of the above

Pre-test Question #3

Q: True or False?

Medications for the treatment of substance use disorders are highly over-utilized.

Pre-test Question #4

Q: Which of the following conditions is NOT associated with greater risk for opioid dependency according to the Magellan analysis of data from a 2.5 million member health plan?

- A. Childbirth
- B. Sleep disorders
- C. Anxiety disorders
- D. Depressive disorders

Pre-test Question #5

Q: Which of the following medical services is NOT associated with greater risk for opioid dependency according to the Magellan analysis of data from a 2.5 million member health plan?

- A. General anesthesia
- B. Flu shots
- C. Inpatient or outpatient surgery
- D. Frequent emergency room visits

Why is medication-assisted treatment for SUD's so important?

Several decades of medical research has taught us that effective opioid drug treatment requires a long-term approach with medication-assisted therapies ... counseling support and similar means to assist with psychosocial challenges.

Compared to counseling alone, participation in MAT resulted in approximately a 50% reduction in overdose fatalities.



Terry Horton, MD
Chief of the Division of Addiction Medicine
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Wilmington, Delaware

Medication-assisted treatment (MAT) introduction

Medication-assisted treatment is most successful as part of a **multi-pronged approach** to substance use treatment

Medications can address the neurobiological aspect of addiction but the psychological and social aspects should also be addressed

- Counseling and mutual help groups are also important to give the individual the best chance of success

The selection of medication should take into account individual preference, past treatment history, setting in which the individual will receive the medication and psychosocial supports

- Opioid treatment programs (OTPs) offer methadone and often buprenorphine
- Office-based opioid treatment (OBOT) is limited to buprenorphine

Medication-assisted treatment (MAT) introduction

Buprenorphine is the only FDA-approved MAT in those under age 18, and even this is only approved for those 16 and older

- » *There are no FDA-approved MAT during pregnancy. All FDA-approved medications are pregnancy category “C” — use when benefits outweigh risks. Animal studies indicate some risk or no animal or human studies available*
- » *Methadone and buprenorphine have been used in pregnancy, but risks to the fetus are not certain*

Disulfiram (Antabuse)

- ✓ FDA-approved for alcohol dependence
- ✓ Blocks alcohol dehydrogenase, which increases acetaldehyde when an individual drinks

Side effects: Alcohol-disulfiram reaction

- Nausea
- Vomiting
- Flushing
- Weakness

Dosage: 125-500 mg/day

No risk of abuse; not a controlled substance

Acamprosate (Campral)

- ✓ **FDA-approved for alcohol dependence**
- ✓ **Exact mechanism of action unknown but appears to stabilize the glutamate system**

Trials: More than 17 clinical trials

Results: Generally indicated 50% increase in abstinence rates

Acamprosate (Campral)

- ✓ **Does not metabolize through the liver; generally safer for alcoholics with liver impairment**

Side effects: Minimal (e.g., diarrhea)

Drug interactions: Few; increases naltrexone blood levels

Dosage: 666 mg three times a day

No risk of abuse; not a controlled substance

Oral naltrexone (ReVia)

- ✓ FDA-approved for both alcohol and opioid dependence
- ✓ Classified as an opioid antagonist
- ✓ Lengthens time to relapse to drinking and amount of drinking
- ✓ Diminishes the pleasurable effects of drinking and high-risk drinking
- ✓ Blocks “high” of endogenous opioids
- ✓ In alcoholics, those with high levels of craving responded better to NTX
- ✓ Better response in alcoholics with family history of alcoholism

Trials: More than 29 clinical trials

Oral naltrexone (ReVia)

- ✓ **Poor medication adherence and high dropout rate** for general opioid dependent users
- ✓ **It should be reserved for highly motivated individuals or certain populations**, such as court-mandated individuals, individuals on probation, impaired professionals
- ✓ **Must be opioid-free for 7-10 days.** Consider naltrexone challenge if not sure - 25mg po x1, repeat in 1 hour if no withdrawal symptoms

Side effects: Metabolized through the liver; may cause hepatotoxicity at doses 5x therapeutic

Drug interactions: Do not use with disulfiram (Antabuse); antagonizes opioid analgesics, opioid containing cough/cold medications and antidiarrheal agents

Dosage: 50 mg/day

No risk of abuse; not a controlled substance

Long-acting injectable naltrexone (Vivitrol)

- ✓ **FDA-approved in 2006 for alcohol dependence** in individuals who are not actively using alcohol at the time of initiation
- ✓ **FDA-approved in 2010 for opioid dependence** for the prevention of relapse to opioid misuse following opioid detoxification
- ✓ **Competitive antagonist at opioid receptor sites within the brain**
- ✓ **Efficacy noted in maintaining abstinence, reducing cravings for opioids**

Side effects: Same cautions and side effects as oral naltrexone, except injection-site reactions

- Cold-like symptoms, fatigue, abdominal cramping, diarrhea
- Injection-site reactions such as bruising, swelling, tenderness, pain—generally due to poor injection technique and giving subcutaneous instead of IM injection

Long-acting injectable naltrexone (Vivitrol)

- ✓ **Individual should be opioid-free for 7-10** days prior to giving injection to avoid opioid withdrawal
- ✓ **No risk of abuse**; not a controlled substance
- ✓ **Metabolized in the liver**; no renal clearance
- ✓ **May cause liver enzyme elevation and hepatitis**; baseline liver enzymes are recommended; can continue naltrexone with mild liver enzyme elevation

Post-marketing reports: Suicidality, depression, anxiety and mood symptoms. Whether these were directly related to naltrexone unclear

Dosage: 380 mg IM in gluteus every four weeks; given once monthly as an intramuscular injection

Methadone

- ✓ **FDA-approved for opioid dependence; can only be used in a registered clinic**
- ✓ **Controlled schedule II substance**
- ✓ **Full opioid agonist at mu receptor**

Cautions: May cause respiratory depression, QT prolongation and cardiac arrhythmias

Drug interactions: Contraindicated with partial/mixed opioid agonists (e.g., buprenorphine), opioid antagonists (e.g., naltrexone) and tramadol (Ultram)

Dosage: Initially 10 mg/day (first dosage no greater than 30 mg by regulation, and no more than 40 mg on the first day); titrated up to 80-120 mg

Better treatment retention with daily maintenance dosage of 60 mg or more

Buprenorphine (Subutex) and Buprenorphine/naloxone (Suboxone, Zubsolv)

- ✓ **FDA-approved**; only a licensed and registered “qualifying physician” with additional training may prescribe
- ✓ **Can be used for office-based treatment**
- ✓ **Partial opioid agonist at mu receptor**; opioid antagonist at kappa receptor
- ✓ **Suboxone or Zubsolv is the medication that is used clinically for maintenance treatment** since it has naloxone added to it to prevent abuse. Naloxone precipitates opioid withdrawal if an opioid-dependent individual dissolves and injects Suboxone tablet
- ✓ **Metabolized in the liver**; generally only mild elevations in liver enzymes

Buprenorphine and buprenorphine/naloxone

- ✓ **Better treatment retention with dosage of 16 mg or more**
- ✓ **New generic formulation in tablet form but cost is still high**
- ✓ **Some abuse potential**
- ✓ **Controlled schedule III substance**

Side effects: Mainly nausea and constipation

Cautions: Respiratory depression when combined with other CNS depressants

Dosage: 4-24 mg/day sublingual (Suboxone) film. **Induction:** 8mg on day 1; 16mg on day 2; Target dose = 16mg daily (range 4-24mg daily); Give first dose at least 4 hrs after last use of opioids

- Zubsolv 2.8-17.1 mg/day; sublingual tablet; 5.7 mg of Zubsolv=8 mg of Suboxone

Probuphine (buprenorphine implant)

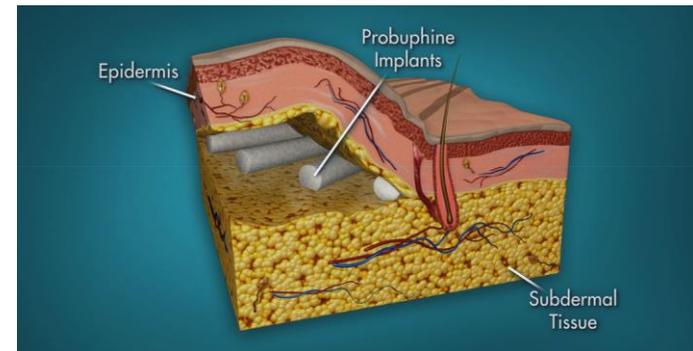
- ✓ **Recently approved by FDA**
- ✓ **First implantable buprenorphine for maintenance treatment of opioid dependence** (as part of a program including counseling and psychosocial support)
- ✓ **Four one-inch rods** are placed under the skin on the inside of the upper arm

Advantages:

- Convenience—no need to remember to take medication
- Less risk of overdose and diversion
- Efficacy equal to sublingual buprenorphine

Disadvantages:

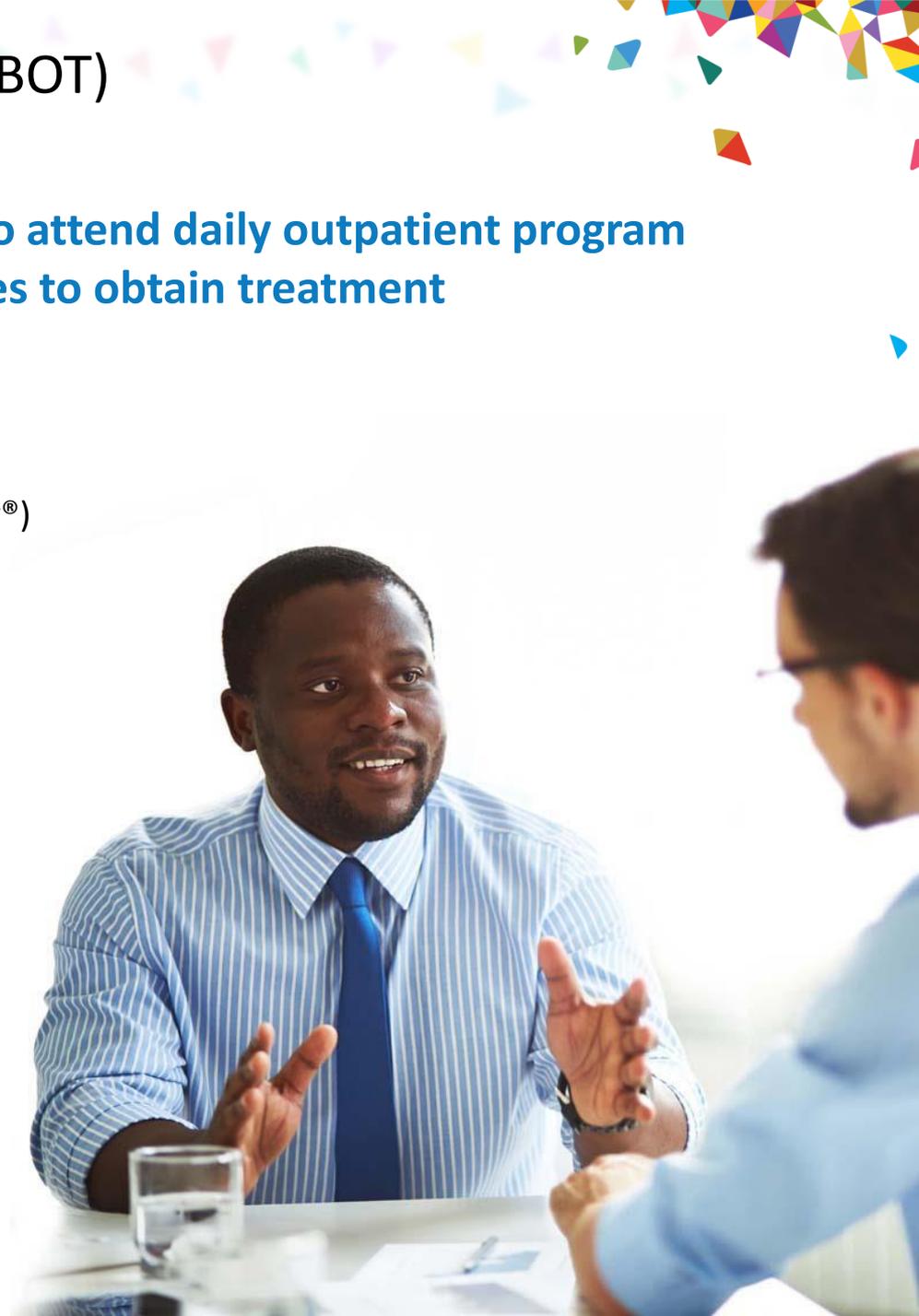
- Need for surgical procedure
- Only those health care providers that have received the live Probuphine REMS (Risk Evaluation and Mitigation Strategy) training can insert and remove the implants
- Implant-site adverse effects such as pain, itching and redness



Office-based opioid treatment (OBOT)

Ideal for patients who find it difficult to attend daily outpatient program and are not able to travel long distances to obtain treatment

- Occurs in provider's office
- Prescriptions can be filled at local pharmacy
 - Buprenorphine (Suboxone[®], Subutex[®], Zubsolv[®])
 - Naltrexone (Vivitrol[®], ReVia[®], Depade[®])
have better overdosing safety profile than methadone
- Suboxone must begin post-detox
- Induction can take several days
- Extended induction with Suboxone can take 2-12 weeks on outpatient basis
- Patient must be engaged in psychosocial treatments as well
- Barrier is lack of sufficient buprenorphine prescribers



Off-label medications

» Topiramate (Topamax)

Four trials have shown to decrease alcohol use (percent drinking days, days abstinent, number of drinks/day). It is hypothesized to increase GABA activity and reduce glutamate activity. No head-to-head trials comparing it with naltrexone or acamprosate. Dosage: 50-150 mg/day

» Gabapentin (Neurontin)

A couple of RCTs have demonstrated efficacy in reducing drinking and improving sleep in individuals with alcohol dependence. Insomnia is common among those with alcohol dependence and the hypothesis is that gabapentin improves drinking outcomes by improving sleep. Dosage: 900-1800 mg/day

» Baclofen (Lioresal)

Two of three trials demonstrated greater abstinence rates. Generally well-tolerated with few side effects. Dosage: 10 mg tid

» SSRIs

No benefit seen without co-morbid mental disorder. May reduce alcohol intake when depression and alcoholism co-exist)

The Case of Max

- **43-year-old** pipe fitter, developed severe disc disease
- **Multiple surgeries**, pain continues, started on prescription opiates
- **Escalated dosage** to control pain, started methadone as an attempt to detox from opiates
- **Had sedation**, confusion with methadone
- **Unsuccessful in detox** attempts, Suboxone suggested
- **Began induction** with Suboxone, began 2mg per day
- **Had mild withdrawal symptoms**, saw M.D. daily
- **Increased** to 16mg per day
- **Entered university-based** pain management program
- **Tapered Suboxone** over 6-month period



MAT in youth

» There are limited studies for MAT in adolescents.

Again, buprenorphine is the only approved medication for under age 18, and this only for 16 years and older.

» Randomized trial of detox v. 12 weeks of buprenorphine

(Woody et al, 2008). While both groups had high rates of positive urines:

- There were lower rates of positive urines up to week 8 in the buprenorphine group
- At week 12 positive urines were 51% in detox group v. 43% in buprenorphine group
- Retention in treatment in the buprenorphine group was significantly higher (70% v. 20.5%)

- » **Another trial (Marsh et al, 2005) for buprenorphine v. clonidine for detox demonstrated:**
 - Significantly improved retention (72% v. 39%)
 - Opioid-negative urines (64% v. 32%)
 - 61% of those in the buprenorphine detox group initiated trial with naltrexone compared to only 5% in the clonidine group
-

- » **A small non-controlled case series of 16 youth (avg. age 18.5) placed on extended release naltrexone (Vivitrol) showed:**
 - 10 of 16 (63%) were retained in treatment for at least 4 months
 - Nine of 16 (56%) had decreased opioid use

Vivitrol utilization among Bucks County (PA) Medicaid members

In 2015, Magellan did a comparative study of individuals receiving Vivitrol (naltrexone extended-release injection) in outpatient drug and alcohol providers in Bucks County

- ✓ 82 unduplicated members were prescribed Vivitrol from Jan to Sept 2015
- ✓ Compared four age groups: 18-27; 28-44; 45-64; 65+



Vivitrol utilization in age groups

Highest utilization: 28-44 age group at 48%

Second Highest: 18-27 age group at 43%

- Only 9% of those receiving Vivitrol were in 45-64 age range
- 0% were 65 and over

Age Group	Q1	Q2	Q3	Cumulative %
18-27	11	20	18	43%
28-44	16	23	16	48%
45-64	3	3	5	9%
65+	0	0	0	0%

Improvement opportunities

Outcome:

Most of the individuals who did not receive adjunctive psychosocial interventions besides the Vivitrol injection were those who received their prescription from a stand-alone prescriber

Low utilization of certified recovery specialists (CRS) and mobile engagement specialists (MES)

Only about half of the individuals who received their first injection did not come for a second or more injections



Opportunity:

Greater outreach to standalone providers of Vivitrol about other available substance abuse services

Create greater awareness about CRS and MES to support individuals in their recovery

Identify barriers to continuation of Vivitrol after the first injection

Magellan MAT initiative

✓ Expand network of MAT prescribers by actively promoting and campaigning to healthcare providers

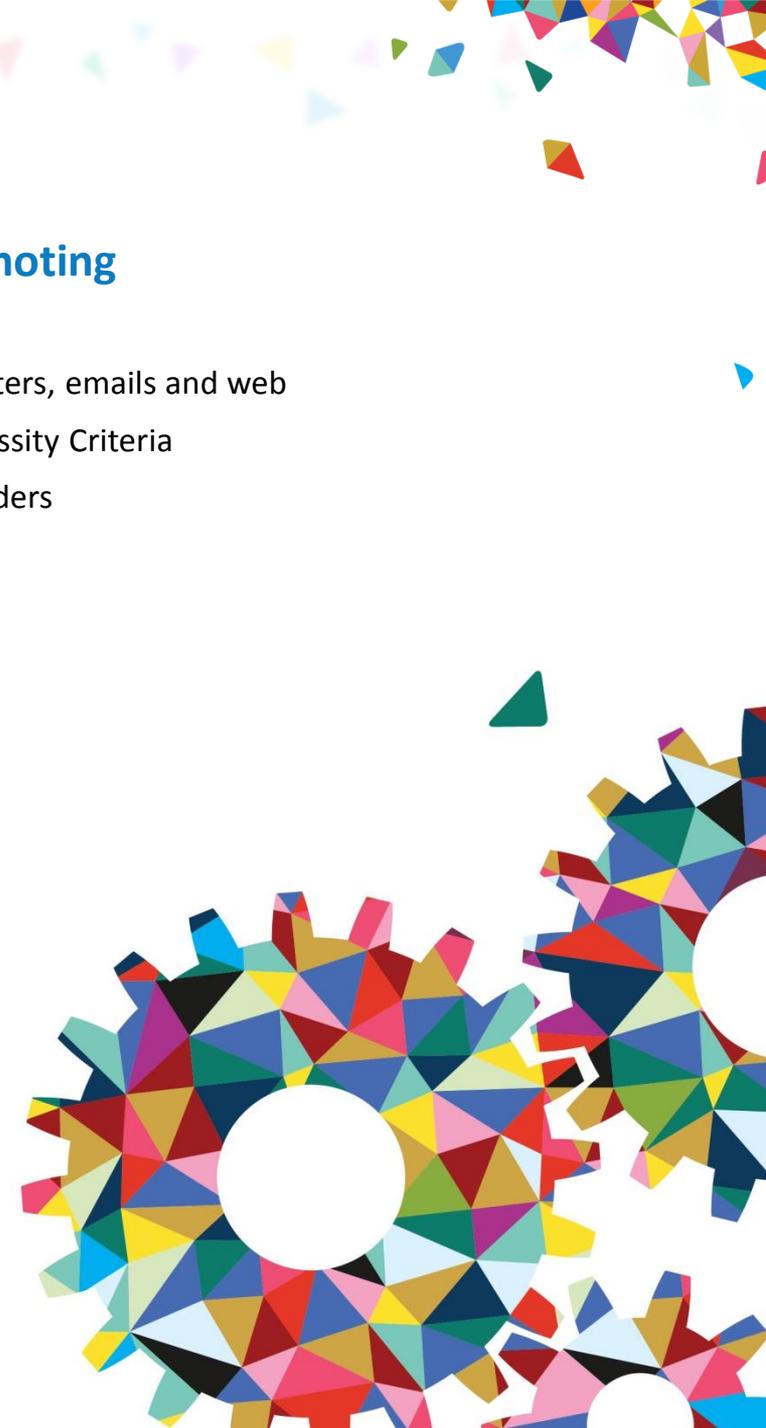
- Provider and member communications through webinars, newsletters, emails and web
- Include MAT expectations in provider handbook and Medical Necessity Criteria
- Share research and other educational material postings with providers

✓ Intervene early in the treatment process and work closely with both providers and patients

✓ Initiate procedures to improve care coordination activities in support of transition of care

- Capture use of MAT medications in all systems
- Create internal benchmarks for use of MAT and medication guideline for staff
- Train clinical and medical staff for peer to peer discussions to increase use of MAT
- Develop outcome measures (increase in use of MAT medications and re-admission data)

✓ National quality improvement study for NCQA



MAT interventions

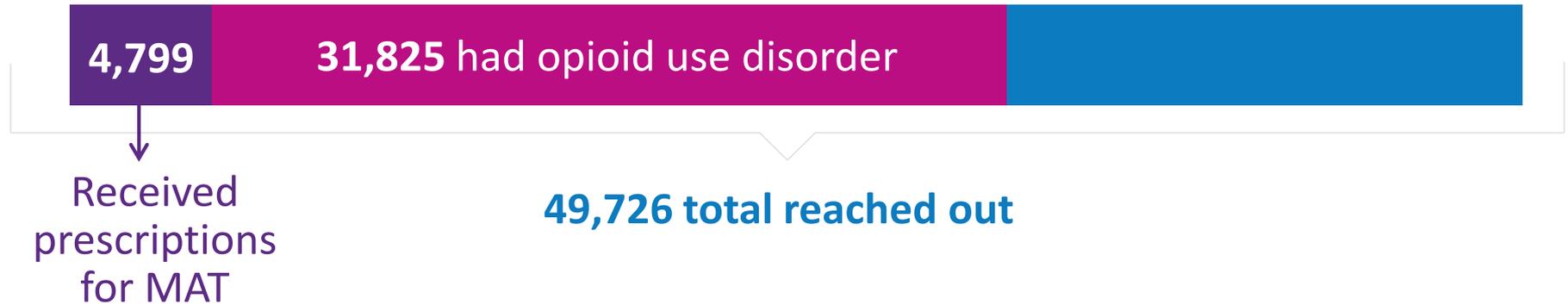
Care manager responses to the program and assessments are evaluated to determine the members' engagement categories. When an assessment is administered, a positive response for question #1 Prompts a response to questions #1 and #4. A positive response to question #2 prompts a response to Question #3.

The assessment questions and associated engagement categories are listed below.

- | | | |
|---|---|--------------|
| 1. Care manager discusses medication assisted treatment (MAT)? |  | Promotion |
| <hr/> | | |
| 2. Has the member been prescribed MAT medication? |  | Prescription |
| <hr/> | | |
| 3. Does the member have a scheduled appointment with a MAT prescriber? |  | Appointment |
| <hr/> | | |
| 4. Has the member been referred for continuing counseling / peer support treatment? |  | Support |

Use of MAT still needs improvement

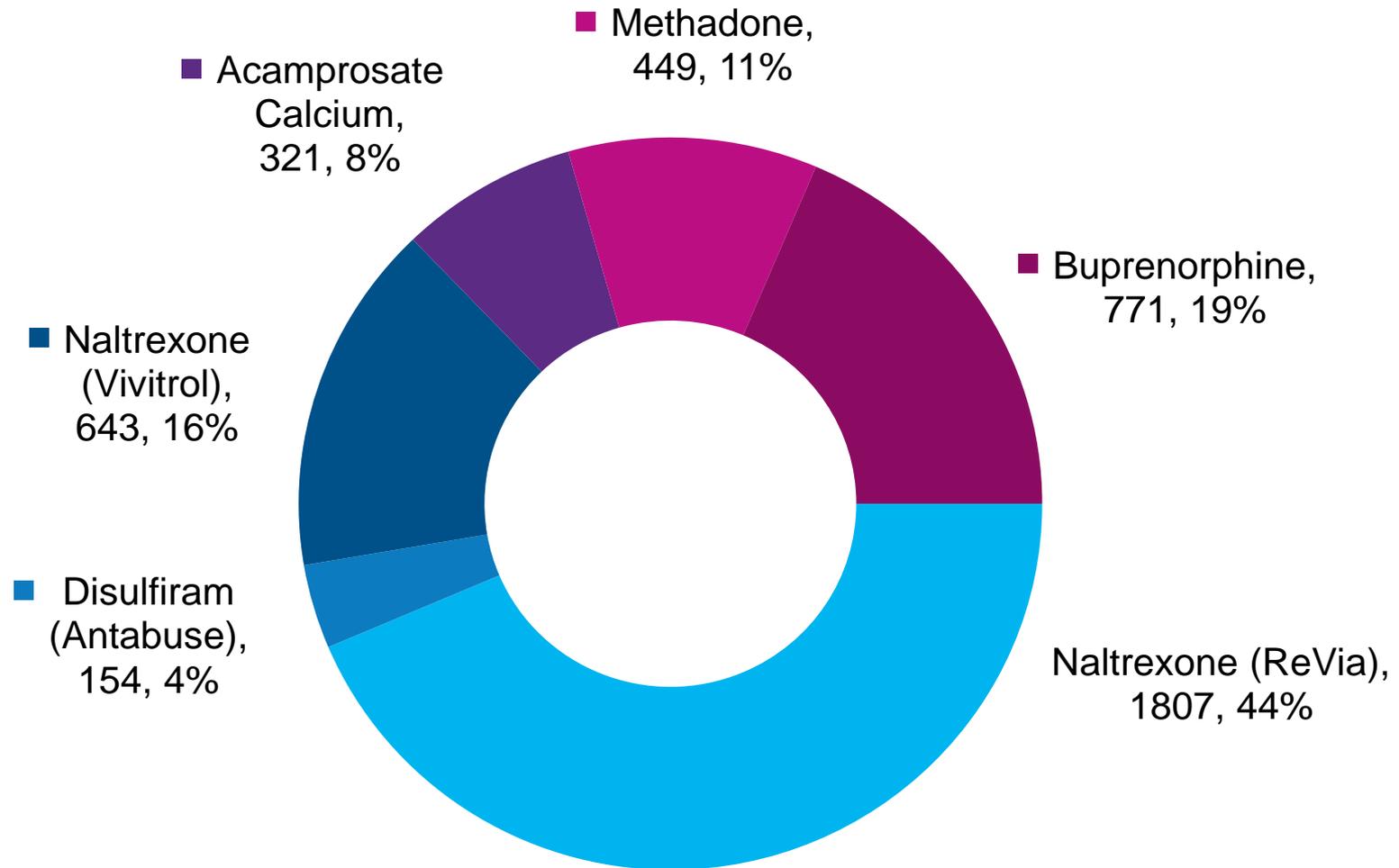
During calendar year 2016, our care managers reached out to 49,726 members and their care providers nationally to encourage the use of MAT.



Of these, 31,825 had an opioid use disorder, or opioid use disorder combined with other drugs or alcohol, or were also diagnosed with a mental health condition.

But only 4,799 or 15.2% percent received prescriptions for MAT medications at discharge.

Discharge MAT Medication Totals & Distribution – 2016



Hospital Use of Medication-Assisted Treatment for Substance Use Disorders in Pennsylvania

Rank	Discharges	Info Available	Info Rate	MAT Prescriptions	Prescription Rate	Appt Rate
1	3,098	2,685	86.67%	262	9.76%	59.16%
2	1,858	1,298	69.86%	88	6.78%	80.68%
3	1,381	1,270	91.96%	163	12.83%	63.19%
4	1,182	1,114	94.25%	27	2.42%	81.48%
5	1,101	1,054	95.73%	99	9.39%	73.74%
6	1,094	508	46.44%	107	21.06%	54.21%
7	719	325	45.20%	184	56.62%	83.15%
8	613	280	45.68%	35	12.50%	65.71%
9	539	188	34.88%	51	27.13%	76.47%
10	537	348	64.80%	56	16.09%	85.71%



Key characteristics, predictors and behaviors associated with short-term and persistent prescription opioid use

A three-year study of a commercial health plan population



Identifying members at risk

Risk Stratification Algorithm is based on:

- ✓ Number of prescriptions filled in the last 90 days
- ✓ Morphine equivalent dose
- ✓ Front-end platform-based risk assessment

High Risk

3 or more fills in 90-day period with more than a 120 MED

10,229
(1%)

Moderate-High Risk

3 or more fills in a 90-day period with an MED of less than 120

75,064
(3%)

Moderate Risk

2 fills in a 90-day period with an MED of less than 120

82,443
(3%)

Low Risk

1 fill in a 90-day period

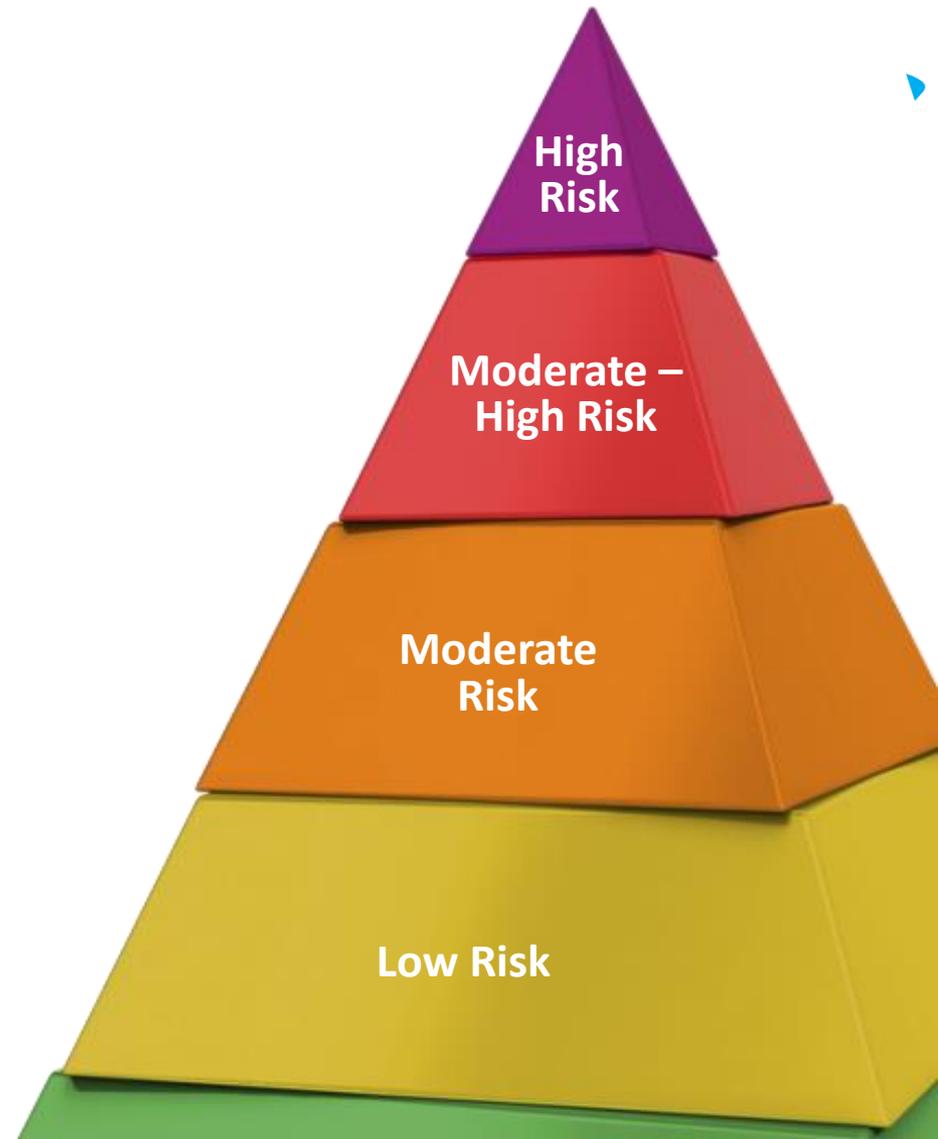
357,056
(14%)

Non Users

1,989,138
(79%)

Total Members

2,515,000



Findings: Key characteristics

Predictors: diagnoses

High risk compared to non-users	Odds ratio (p<.001)
Spondylosis and other back problems	5.3
Substance related and addictive disorders	4.6
Sleep-wake disorders	2.2
Depressive disorders	1.7
Headache	2.1
Anxiety disorders	1.5

Predictors: utilization

High risk compared to non-users	Odds ratio (p<.001)
Substance abuse services	4.5
Anesthesia	4.2
ER	3.2
Mental health services	2.3
Surgery	2.0
OP surgery	1.3

Member approach: Individualized care



Navigate through clinical content on the platform



Complete cognitive behavioral therapy, an evidence-based treatment approach for substance use, depression, anxiety, insomnia and OCD



Access educational articles and take quizzes for increased health literacy on medication safety



Attend a one-on-one coaching session

Member approach: Computerized cognitive behavioral therapy

Insomnia, anxiety,
depression, OCD &
addiction are present in

>25% of
population

& make up appx.

90% of mental health
complaints¹

Individuals struggling
with anxiety saw a

63% reduction²

in fear and panic



1. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry* 2005;62:617–627. 2. Marks, I. M., Kenwright, M., McDonough, M., Whittaker, M., & Mataix-Cols, D. (2004). Saving clinicians' time by delegating routine aspects of therapy to a computer: a randomized controlled trial in phobia/panic disorder. *Psychological Medicine*, 34, 1, 9-17. <http://www.ncbi.nlm.nih.gov/pubmed/14971623>

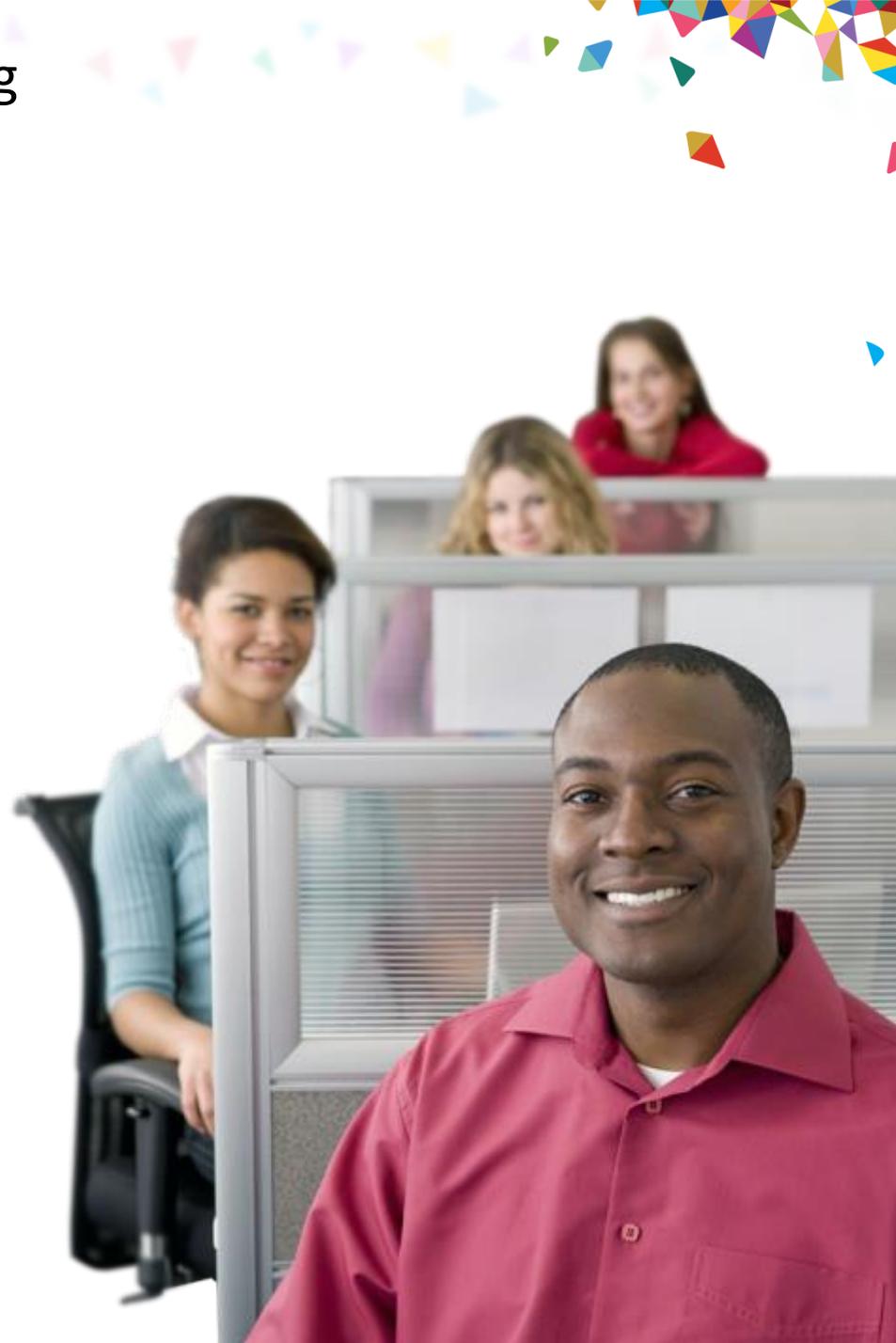
Member approach: Health coaching

Key services

- ✓ Coaching for specialty case management
- ✓ Integration of behavioral and physical health methodologies
- ✓ Strengths-based motivational interviewing approach
- ✓ Expert approach to case management vs. generalist approach
- ✓ Case managers and health coaches specially trained in prescription drug abuse and pain conditions

Key features

- ✓ Ability to service multiple time zones



Best practices for physicians and other prescribers

✓ Utilize the state PDMP program

- May authorize delegate access to staff if allowed by state
- Data contains schedules II, III and IV controlled substances
(Opioids account for half of all prescriptions)

✓ Recurring random urine drug tests- “no threshold” testing

✓ Utilize “do not fill until” dates on all opioid prescriptions

✓ Utilize pain management agreements

- Use one pharmacy for all medications
 - Notification to treating provider if / when prescribed opioids from other prescribers
-

Best practices for physicians and other prescribers

- ✓ **Underscore importance of safe storage of medications & disposal**

- ✓ **Use tamper-resistant formulations**

- ✓ **Use non-drug or non-opioid interventions for pain when feasible**

- ✓ **Patient medication diary and/or pill counts**

- ✓ **Determine if additional resources needed**
psychiatrist, pain management specialist, case management
locking patients in to one pharmacy

- ✓ **Contact dispensing pharmacies if appropriate**

Pre-test Answer #1

Q. Which of the following is not an FDA-approved medication for opioid dependence?

A. Zubsolv

B. Topiramate➔

C. Naltrexone

D. Vivitrol

- **Topiramate** (Topamax) is an anticonvulsant medication that is sometimes used off-label for treatment of alcoholism
- **Zubsolv** (buprenorphine/naloxone) is a new FDA-approved medication for opioid dependence. (5.7 mg/1.4 mg equivalent to 8 mg/2 mg of Suboxone; menthol flavor SL tablet; dissolves more quickly per manufacturer)
- **Naltrexone** is FDA approved for opioid dependence
- **Vivitrol** is a trade name for long-acting injectable naltrexone

Pre-test Answer #2

Q. Which of the following are used to treat alcohol dependence?

- A. Acamprosate
- B. Oral naltrexone
- C. Long-acting injectable naltrexone
- D. All of the above**➤

FDA-approved medications for alcohol dependence are:

- Disulfiram (Antabuse)
- Acamprosate (Campral)
- Oral naltrexone (ReVia)
- Long-acting injectable naltrexone (Vivitrol)

Pre-test Answer #3

Q: True or False?

Medications for the treatment of substance use disorders are highly over-utilized.

The answer is FALSE.

These medications are highly UNDER utilized.

Medications for the treatment of substance use disorders are highly over-utilized.

Pre-test Answer #4

Q: Which of the following conditions is NOT associated with greater risk for opioid dependency according to the Magellan analysis of data from a 2.5 million member health plan?

- A. Childbirth**
- B. Sleep disorders
- C. Anxiety disorders
- D. Depressive disorders

Pre-test Answer #5

Q: Which of the following medical services is NOT associated with greater risk for opioid dependency according to the Magellan analysis of data from a 2.5 million member health plan?

- A. General anesthesia
- B. Flu shots**
- C. Inpatient or outpatient surgery
- D. Frequent emergency room visits

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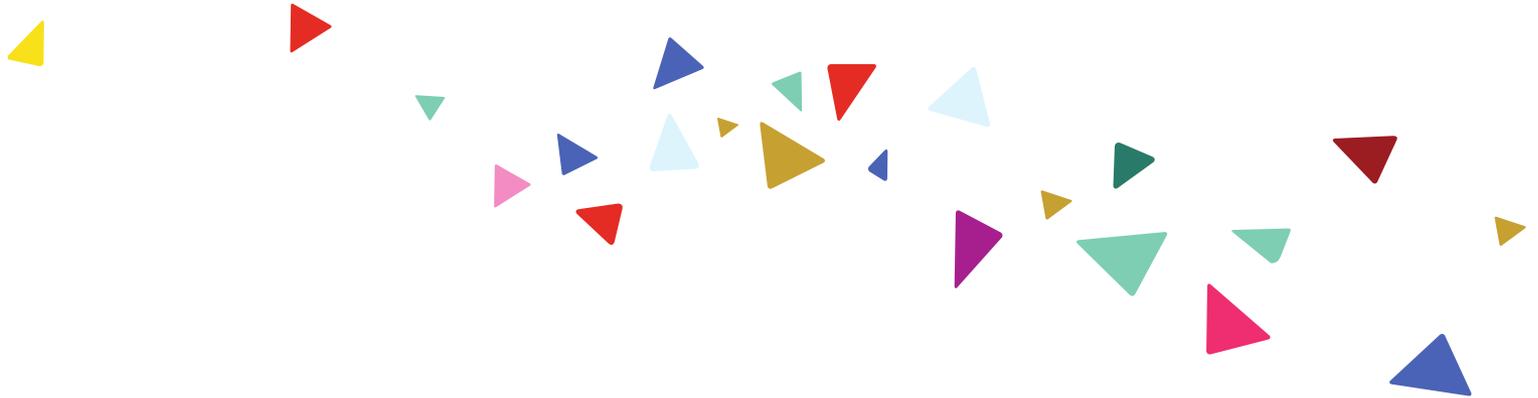
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