A Pharmacy Perspective to Opioid and Whole Health Management

Maria Lopes, MD, MS, *Chief Medical Officer, Magellan Rx*
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About the speaker

Dr. Maria Lopes has been in the managed care industry for over 19 years. She is currently the Chief Medical Officer of Magellan Rx and was formerly Chief Medical Officer of GHI/Emblem Health, Chief Medical Director of Horizon BCBS NJ and CMO of AMC Health.

In her role at Magellan Rx, she oversees clinical program development and implementation, formulary management, patient outreach and clinical assessment, pathway development and strategic solutions across medical and pharmacy benefits, including: Oncology, RA, MS, IVIG, HAE, HIV, HepC, Neurotoxins, Gaucher’s, Hemophilia and PAH. She works closely with over 40 health plans to bring customized and innovative solutions that add quantifiable clinical and economic value.

Dr. Lopes has extensive experience in disease and case management, employee health and wellness, and quality initiatives to improve HEDIS/Medicare STAR performance. She has been responsible for medical policy development and Implementation, correct coding initiatives, fraud and abuse, physician profiling and the development of a medical home pilot project in NY. She has overseen medical and pharmacy utilization in a network and a staff model. She has worked closely with Geisinger Health Systems on innovative strategies in e-health, data analytics and HIT to improve patient engagement, care coordination and align incentives as part of Geisinger's Proven Health Navigator (advanced medical home).

Dr. Lopes is an obstetrician and gynecologist. She has a BA in biochemistry from Wesleyan University, received her medical degree from the University of Connecticut and has a master’s degree in administrative medicine from the University of Wisconsin.
Disclosure

Maria Lopes, MD, MS has no relevant financial relationship or commercial interest that could be reasonably construed as a conflict of interest.
Course syllabus

- Discuss the national scope of opioid misuse, abuse, and addiction
- Review updated 2016 CDC Guidelines for Chronic Pain Management with Opioids
- Describe current intervention strategies focused on minimizing the inappropriate use of opioids
- Examine organizational updates and trends to reduce the misuse and abuse of opioids
Learning objectives

• Recognize the epidemic of opioid addiction and abuse in the U.S.
• Understand the consequences of opioid misuse and its toll on the healthcare system
• Describe the updated CDC guidelines for management of chronic pain with opioids
• Explain interventional strategies for combating the inappropriate use of opioids
• Examine the current national landscape and the recent strategies implemented to minimize opioid abuse and misuse
National scope of opioid misuse, abuse and addiction

Section 1
Opioid misuse

According to the CDC, 20% of people who present to physicians with pain will receive an opioid.

259 million prescriptions for opioids were filled in 2012.

According to DSM-IV criteria, in 2013 there were 1.9 million people who abused or were dependent on opioids.
Opioid misuse

How different misusers of pain relievers get their drugs

<table>
<thead>
<tr>
<th>Methods and sources for obtaining pain relievers</th>
<th>Recent Initiates</th>
<th>Occasional Users</th>
<th>Frequent or Chronic Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bought from friend/relative, dealer, or internet</td>
<td>9%</td>
<td>13%</td>
<td>28%</td>
</tr>
<tr>
<td>Prescribed from 1 or more doctors</td>
<td>17%</td>
<td>17%</td>
<td>26%</td>
</tr>
<tr>
<td>Obtained from friend/relative for free or w/o asking</td>
<td>68%</td>
<td>66%</td>
<td>41%</td>
</tr>
</tbody>
</table>
Consequences of misuse

Opioid sales and related deaths are rising together

Between 2000 and 2014, there were 165,000 deaths due to opioid overdose
  • About 28,000 of these deaths were in 2014
  • Since 2000, the rate of opioid overdose has TRIPLED

Opioids make up 61% of all drug overdoses

In 2014, there were 420,000 emergency room visits directly related to opioid misuse
2011 American Academy of Pain study on cost of opioid misuse in America

- Estimated societal cost at $55.7 billion
  - $25.6 billion was lost in workplace productivity
  - $25 billion in medical costs
  - $5.1 billion in criminal justice
Medical costs

94.9% of medical costs are due to excess care and medication
- Medicaid patients contribute to 1/3 of the costs
- Privately and uninsured patients each contribute slightly less than 1/3 of the costs
- Medicare patients contribute around 4.6%

Substance abuse treatment accounted for 4.5% of total costs

Prevention and research combined for 0.6%
Updated CDC 2016 guidelines for chronic pain management with opioids

Section 2
Revised CDC guidelines

In March 2016, the CDC released the revised guidelines for opioid prescriptions to combat abuse and misuse

The intention of these guidelines is to ensure that patients and/or prescribers work together to consider:

• Safer treatment options
• Better potential outcomes
• Decreasing the number of overdoses and adverse events
Recommendations: When to initiate treatment

Non-pharmacological and non-opioid treatment

• Before use of opioid, prescribers should consider non-pharmacological and/or non-opioid options first
• Opioids should only be used when benefits are anticipated
Recommendations: When to initiate treatment

Treatment goals

• Goals should be discussed with all patients before starting opioids
  – Goals include improvement of pain and/or function and when opioids should be discontinued

• Only continue treatment if meaningful outcomes are established
Recommendations: When to initiate treatment

Risks and benefits

• Should be discussed with patients before AND during treatment
• Goal should always be functional improvement even when pain is present
• Patient should be made aware that there is no good evidence of pain or functional improvement in the long-term
• Always discuss overdose, misuse and abuse risks
• Discuss risks of people using someone else’s medication
Recommendations:

Opioid selection, dosage, duration, follow-up, and discontinuation

Immediate-release opioids

- When starting opioid therapy, always begin with immediate-release opioids
- Evidence shows immediate-release formulations have a lower risk of overdose when initiating therapy
- No evidence exists that extended-release opioids are more effective or safe
Recommendations: Opioid selection, dosage, duration, follow-up, and discontinuation

Lowest effective dose

• When starting opioids, clinicians should ALWAYS prescribe the lowest effective dose
• Re-assess the evidence of individual benefit when considering increasing the dose to >50 MME per day
• Avoid increasing dose to >90 MME per day without a careful, justified decision
Recommendations:
Opioid selection, dosage, duration, follow-up, and discontinuation

Acute pain

• The lowest effective dose of immediate-release opioids should be used
• Quantity should not exceed the expected duration of pain severe enough to require opioids
  – More than 7 days will rarely be needed
  – Be aware of state laws pertaining to prescribing of acute pain prescriptions
Recommendations:
Opioid selection, dosage, duration, follow-up, and discontinuation

Evaluation of chronic pain

• Conduct a risk versus benefit assessment within one to four weeks of starting therapy or conducting a dose escalation
  – Should be conducted no later than every THREE months
  – If benefits do not outweigh risk, clinicians should work with the patient to taper the dose or discontinue therapy
Recommendations:
Assessing risk and addressing harm of use

Risk factor assessment

• Before AND during opioid therapy, risk factors for harm should be assessed
• Clinicians should incorporate strategies to mitigate risk
• Offer naloxone when factors are present that increase risk of overdose
Recommendations:
Assessing risk and addressing harm of use

Risk factor assessment (cont.)

• Strategies to mitigate risk:
  – Working with patients to maintain lowest possible dose
  – Careful titration, when appropriate
  – Increased monitoring
  – Appropriate lab tests for at-risk populations
    o Patients with sleep-disordered breathing
    o Pregnant women
    o Patients with renal or hepatic impairment
    o Geriatric patients
    o Patients with mental health conditions
    o Patients with substance abuse disorders and/or prior overdose
Recommendations:
Assessing risk and addressing harm of use

Review history of controlled substances

• Review a patient’s controlled substance history through PDMP to see if the patient is receiving a dangerous dose of opioids or combinations of other controlled substances that would put them at risk
• The PDMP should be reviewed when starting therapy and at least every 3 months thereafter unless otherwise noted by state regulations
Recommendations:
Assessing risk and addressing harm of use

Drug testing

• Clinicians should use drug testing before starting therapy
• Consider testing at least annually to assess prescription drug use AS WELL AS other controlled and illicit drug use
**Recommendations:**
*Assessing risk and addressing harm of use*

**Avoid dangerous combinations**
- Clinicians should avoid prescribing opioids and benzodiazepines concurrently whenever possible

**Offer treatment for opioid use disorders**
- Clinicians should offer or arrange evidence-based treatment options for patients with opioid use disorders
Current intervention strategies

Section 3
Prescription drug monitoring programs

Can be effective in identifying and reducing cases of opioid misuse/abuse

Currently, 49 states, the District of Columbia, and Guam have legislation authorizing the creation and operation of a PDMP

- Only 36 states currently record prescriber data
- 47% drop in number of high utilizers after implementing laws requiring prescribers to consult PDMPs for new patients (Tennessee)
**Prescription drug monitoring programs**

Drugs monitored by PDMPs per state:

<table>
<thead>
<tr>
<th>Schedules Controlled</th>
<th>States</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schedules II-IV</td>
<td>AZ, CA, FL, IA, KS, ME, NV, NH, OR, RI, SC, VT, VA, WV, WY</td>
<td>15</td>
</tr>
<tr>
<td>Schedules II-V</td>
<td>AL, AK, AR, CO, DE, DC, GA, GU, HI, ID, IL, IN, KY, LA, MD, MA, MI, MN, MS, MT, NE, NJ, NM, NY, NC, ND, OH, OK, PA, SD, TN, TX, UT, WA, WI</td>
<td>36</td>
</tr>
</tbody>
</table>
Prescription drug monitoring programs

Agency that administers the PDMP in each state:

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boards of Pharmacy</td>
<td>20</td>
</tr>
<tr>
<td>Consumer Protection</td>
<td>1</td>
</tr>
<tr>
<td>Departments of Health</td>
<td>13</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>7</td>
</tr>
<tr>
<td>Professional Licensing</td>
<td>6</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>51</strong></td>
</tr>
</tbody>
</table>
**Data collection interval:** The most amount of time a reporting professional is allowed to wait to report the opioid through PDMP

<table>
<thead>
<tr>
<th>Amount of time</th>
<th>States</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real Time</td>
<td>OK</td>
<td>1</td>
</tr>
<tr>
<td>Real time up to 24 hours</td>
<td>CT, NY, UT</td>
<td>3</td>
</tr>
<tr>
<td>Daily</td>
<td>AL, AZ, CO, DC, DE, IN, IL, KS, KY, LA, MA, ME, MI, MN, MS, ND, NM, NV, OH, SC, TN, WV, WY</td>
<td>23</td>
</tr>
<tr>
<td>Within 3 day</td>
<td>MD, NC, OR, PA, RI</td>
<td>5</td>
</tr>
<tr>
<td>Within 7 days</td>
<td>AR, CA, FL, GA, HI, IA, ID, MT, NH, NJ, SD, TX, VA, VT, WA, WI</td>
<td>16</td>
</tr>
<tr>
<td>Monthly</td>
<td>AK</td>
<td>1</td>
</tr>
<tr>
<td>No requirement</td>
<td>NE</td>
<td>1</td>
</tr>
</tbody>
</table>
Medicare Part D Overutilization Monitoring System (OMS)

In 2013, CMS adopted a policy for PDP sponsors to implement enhanced drug utilization reviews

- A 26% decrease (7500 fewer beneficiaries) identified as potential opioid overutilizers

Adopted an opioid overutilization policy that encompasses a medication safety approach by which sponsors are expected to reduce beneficiary overutilization of opioids and maintain access to needed medications

Part D sponsors are provided quarterly reports on high-risk beneficiaries

- Now required to provide CMS with the outcome of their review in each case
Medicare Part D Overutilization Monitoring System (OMS)

Developed a comprehensive morphine equivalent dose (MED) approach to assist Part D sponsors in identifying high-risk beneficiaries

- Beneficiaries who are dispensed opioids that are >120mg of cumulative MED for at least 90 consecutive days
- Opioid prescriptions associated with >3 prescribers and/or >3 pharmacies

This approach was based on practices conducted in Washington State
Medicare Part D Overutilization Monitoring System (OMS)

In 2014, CMS enhanced MARx to collect information from sponsors about beneficiary-level opioid POS edits

• Alerts sponsor when a beneficiary is identified by a prior sponsor as over-utilizing opioids enrolled in the sponsor’s plan

As of June 29, 2015, sponsors submitted 1,699 beneficiary-level opioid POS edits to MARx
Medicare Part D Overutilization Monitoring System (OMS)

Number of first-time overutilizers

- For Q4 (2013), OMS identified 13,393 new beneficiary opioid outliers
- For Q4 (2014), OMS only identified 7,038 new beneficiary opioid outliers (47% reduction)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Part D Enrollees</th>
<th>Total Part D Enrollees Utilizing Opioids</th>
<th>% Part D Enrollees Utilizing Opioids</th>
<th>Total Beneficiaries with at least 90 Consecutive Days &gt;120mg MED Daily AND &gt;3 Prescribers &amp; &gt;3 Pharmacies for Opioid Claims</th>
<th>Difference Year-to-Year</th>
<th>Share of Opioid Utilizers Flagged as Outliers</th>
<th>Difference in Share Year-to-Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>31,483,841</td>
<td>10,049,914</td>
<td>31.9%</td>
<td>29,404</td>
<td></td>
<td>0.293%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>37,842,632</td>
<td>11,794,908</td>
<td>31.2%</td>
<td>25,347</td>
<td>-4,057</td>
<td>0.215%</td>
<td>-0.08%</td>
</tr>
<tr>
<td>2014</td>
<td>39,982,962</td>
<td>12,308,735</td>
<td>30.8%</td>
<td>21,838</td>
<td>-3,509</td>
<td>0.177%</td>
<td>-0.04%</td>
</tr>
</tbody>
</table>
Fraud, waste and abuse (FWA)

• A unique retrospective drug use review offering an efficient and accurate process for identifying misuse and overuse
  – Focuses on members who are flagged
  – Members who are flagged have a high probability for increased use and cost in the next 12 months

• Uses the John Hopkins ACG predictive risk scores to help identify members at highest risk
John Hopkins ACG System

• An innovative and accurate way to identify individual high-risk patients and estimate resource use for an entire population based on clinically relevant classifications

• Identifies patients at high risk for using large amounts of healthcare resources in the futures and estimates potential expenses

• Captures the unexpected high-pharmacy users to address, as well as important groups of patients who offer opportunities for care management
Equian

Prescription narcotics management

• Medications at risk for fraud, waste and misuse are reviewed on a daily basis
  – Conflicts identified are overutilization of medications, therapeutic duplications, and prescription fills from multiple providers

• Pharmacists review patient profiles, prescription claim history and available intervention history

• Information is communicated directly to the providers in the form of prescriber letters or member medication profiles

• Restriction on authorized providers, restriction on retail pharmacies and prior authorization requirements for medications may occur
Magellan Rx Opioid Management Program
Key program elements

Identification of target population
- Multiple opioid prescribers
- Multiple opioid pharmacies
- Consecutive days above dosing thresholds (MED > 120 mg)

Prescriber-centric approach
- Overview of program and criteria
- Member-specific detail and case discussion
- Determine medical necessity/appropriateness of regimen
- Determine action(s) required and additional resources needed

Detailed review process by PharmD
- Case management review
- Written recommendation to plan sponsor/response to CMS

Plan sponsor implementation of necessary protocols/claim edits and notification process

Reporting of suspected fraudulent activity

Data-sharing between sponsors
# Targeting and identification

Number of opioid members with ≥ 90 consecutive days > 120 mg MED, by # of prescribers and pharmacies

<table>
<thead>
<tr>
<th>n of prescribers</th>
<th>n of pharmacies</th>
<th>2013 Q1</th>
<th>2013 Q1-Q2</th>
<th>2013 Q1-Q3</th>
<th>2013 Q1-Q4</th>
<th>2013 Q2 – 2014 Q1</th>
<th>2013 Q3 – 2014 Q2</th>
<th>% of ≥ 90 consecutive days &gt;120 MED Members</th>
<th>% of Total Opioid Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 4</td>
<td>≥ 4</td>
<td>1</td>
<td>6</td>
<td>19</td>
<td>31</td>
<td>30</td>
<td>27</td>
<td>3.74%</td>
<td>0.07%</td>
</tr>
<tr>
<td>≥ 4</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>18</td>
<td>29</td>
<td>25</td>
<td>29</td>
<td>4.02%</td>
<td>0.08%</td>
</tr>
<tr>
<td>≥ 4</td>
<td>&lt; 3</td>
<td>6</td>
<td>51</td>
<td>93</td>
<td>129</td>
<td>129</td>
<td>141</td>
<td>19.56%</td>
<td>0.38%</td>
</tr>
<tr>
<td>3</td>
<td>≥ 3</td>
<td>0</td>
<td>10</td>
<td>13</td>
<td>23</td>
<td>29</td>
<td>24</td>
<td>3.33%</td>
<td>0.06%</td>
</tr>
<tr>
<td>3</td>
<td>&lt; 3</td>
<td>19</td>
<td>46</td>
<td>66</td>
<td>82</td>
<td>102</td>
<td>95</td>
<td>13.18%</td>
<td>0.25%</td>
</tr>
<tr>
<td>&lt; 3</td>
<td>≥ 3</td>
<td>9</td>
<td>39</td>
<td>55</td>
<td>65</td>
<td>60</td>
<td>69</td>
<td>9.57%</td>
<td>0.18%</td>
</tr>
<tr>
<td>&lt; 3</td>
<td>&lt; 3</td>
<td>104</td>
<td>265</td>
<td>293</td>
<td>291</td>
<td>290</td>
<td>336</td>
<td>46.60%</td>
<td>0.90%</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>140</td>
<td>422</td>
<td>557</td>
<td>650</td>
<td>665</td>
<td>721</td>
<td>100.00%</td>
<td>1.93%</td>
</tr>
</tbody>
</table>
Patient case study

Background

Patient SH is a 55 y.o. male who has received 4 different opioid prescriptions from 2 different prescribers in June 2013

- 6/13/13: Fentanyl 100mcg/hr patches, Methadone 5mg tablets and Oxycodone 10 mg tablets from Prescriber A
- 6/8/13: Oxycodone-Acetaminophen 5-325mg tablets from Prescriber B

Patient SH was flagged on several metrics created by CMS (evaluation period January – June 2013)*

- 4 pharmacies, 4 prescribers, average daily morphine equivalent dose of 165mg

Intervention

Prescriber A outreach:

- Magellan PharmD made multiple contact attempts to gain general knowledge about patient SH
  - The patient was currently receiving opioid medications for ICD-9 codes: 722.5 (degeneration of thoracic or lumbar intervertebral disc), 723.2 (cervicalgia), and 724.2 (lumbago)
- During the 5th attempt, the PharmD was successfully able to reach Prescriber A**
### Patient case study: Intervention and outcomes

<table>
<thead>
<tr>
<th>Prescriber Outreach</th>
<th>Action Plan</th>
<th>Care Coordination</th>
<th>Quality of Care Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Prescriber A was unaware that patient SH was going to another provider for controlled substances</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescriber A notified PharmD that this was a direct violation of the pain management agreement with patient SH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescriber A was also surprised to learn that Patient SH went to numerous pharmacies</td>
<td>• Prescriber A will speak to Patient SH about violating the agreement</td>
<td>• Prescriber A will refer patient to addiction/psychiatric specialists if appropriate</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Enhanced patient contracts:</td>
<td>• Agreed to take the lead in managing the patient and will consult PharmD for triaging additional services when needed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• One pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Random urine drug screens</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Unannounced pill counts</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• “Do Not Fill Until” dates on prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prescriber A will continue to titrate down the patient’s total opioid dose while maintaining adequate pain control</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Incorporate non-pharmacologic treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Fentanyl patches will be transitioned to methadone</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Organizational updates and trends

Section 4
Currently, Walgreens and CVS Health have initiatives allowing patients to get naloxone without a prescription

States that have passed a Naloxone Access Law = 42
• AL, AR, CA, CO, CT, DE, FL, GA, ID, IL, IN, KY, LA, MA, MD, ME, MI, MN, MS, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI

States that have also included naloxone access provisions in their 911 Good Samaritan law = 18
• CA, CT, DE, GA, IL, KY, MA, MN, MS, NV, NJ, NM, NY, NC, PA, RI, VT, WA
Abuse-deterrent formulations and preferred formulary options

Specifically formulated to deter abuse

Targets the known or expected routes of abuse, including crushing in order to use intranasally or dissolving in order to inject the product
Opioid labeling

Extended-release and long-acting (ER/LA) opioids are not indicated for “as needed” pain relief

FDA is now requiring a new boxed warning for ER/LA and immediate release (IR) opioid formulations that are prescribed for chronic use during pregnancy
  • Use can result in neonatal opioid withdrawal syndrome (NOWS)

FDA announced requirements for class-wide safety labeling changes for IR formulations
  • Requiring a new boxed warning about the serious risks of misuse, abuse, addiction, overdose, and death
Educational opportunities

Prescriber-driven Initiatives

• Outreach/collaboration with key members of the prescribing community
• Facilitate prescribers’ education about the best uses of opioids, including the ability to identify when and with whom these products should be used

Patient-driven initiatives

• ER/LA REMS programs
  – Manufacturers are required to make available to prescribers educational materials for their patients
• FDA created medication guides for ER/LA opioids as part of the REMS program
  – Should be given to every patient to identify the best use of opioids
• Partners with DrugFree.org and other online resources
  – FDA maintains a website to educate patients on the proper disposal of medications once they are no longer needed
Prescriber education

When prescribing opioids, it is important to evaluate the member holistically

- Opioids should be avoided in combination with:
  - *Benzodiazepines and alcohol*
    - Increased risk of hospitalizations and serious outcomes
  - **Vivitrol**
    - Patients should be opioid free for a minimum of 7-10 days before starting
    - Can reduce patient tolerance to opioids after detox
      - Use of previously tolerated doses of opioids could result in potentially life-threatening side effects
  - **Attention-deficit hyperactivity disorder medications**
    - Increased risk of substance abuse disorders

- Tapering once therapy is completed or if goals not met
  - **Before discontinuing opioid treatment, patients should be slowly tapered down**
  - **Reducing weekly dosages by 10%-50% of the original opioid dosage**
    - Rate of taper should be individualized and based on patient specific factors
      - Duration of therapy, adverse events/reactions, overdoses

**Take precautions to minimize the risk of abuse and misuse**

- Patient pain contracts
  - *Limiting patients to one pharmacy*
  - *Outlining who they can and cannot receive opioids from*

- Urine toxification screening
  - *Confirm utilization of other controlled substances*
  - *Confirm use of opioids and ensure patient is not diverting medications*

<table>
<thead>
<tr>
<th>Medications</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines/ EtOH</td>
<td>• Increased risk of hospitalizations and serious outcomes</td>
</tr>
</tbody>
</table>
| Vivitrol                 | • Patients should be opioid free for a minimum of 7-10 days before starting
  • Can reduce patient tolerance to opioids after detox
  • Use of previously tolerated doses of opioids could result in potentially life-threatening side effects |
| ADHD                     | Increased risk of substance abuse disorders |

Summary

Opioid abuse, misuse, and overdose is a major epidemic that needs to be aggressively addressed on a regular basis

The updated 2016 CDC Guidelines for Chronic Pain Management with Opioids have made strides to eliminate the overutilization of opioids

Different organizations have begun initiatives to try to curb the prescribing through reward systems and penalties for over/incorrect prescribing practices

Currently, there is a large amount of public attention toward this

• While it is far from being corrected, we are making strides in the right direction
Bibliography


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