North Dakota Medicaid Pharmacy Program Quarterly News

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Welcome to the "North Dakota Medicaid Pharmacy Program Quarterly News," a pharmacy newsletter presented by the North Dakota Department of Human Services and published by Health Information Designs, LLC. This newsletter is published as part of a continuing effort to keep the Medicaid provider community informed of important changes in the North Dakota Medicaid Pharmacy Program.

The North Dakota Department of Human Services has contracted with Health Information Designs, LLC (HID) to review and process prior authorizations (PAs) for medications. For a current list of medications requiring a PA, as well as the necessary forms and criteria, visit www.hidesigns.com/ndmedicaid, or call HID at (866) 773-0695 to have this information faxed. An important feature on this website is the NDC Drug Lookup. This allows you to determine if a specific NDC is covered (effective date), reimbursement amount, MAC pricing, copay information, and any limitations (prior authorization or quantity limits).

This newsletter provides benzodiazepine prescribing information and the CDC recommendations for prescribing opioids for chronic pain.

The North Dakota Medicaid Pharmacy Program team appreciates your comments and suggestions regarding this newsletter. To suggest topics for inclusion, or to make comments, please contact Health Information Designs, LLC at (334) 502-3262, call toll free at 1-800-225-6998, or e-mail us at info@hidinc.com.

north dakota department of human services

Helpful Numbers

PA Help Desk	866-773-0695
To fax PAs	855-207-0250
To report adverse reactions	800-FDA-1088

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Important Benzodiazepine Prescribing Information

Summary written by Justin Smothers, 2016 PharmD Candidate, Auburn School of Pharmacy

Risks Associated with Long-term Benzodiazepine Use

The use of long-term benzodiazepine therapy is known to carry risks of dependence and withdrawal, and negative side effects such as cognitive dysfunction. Acute cognitive dysfunction such as drowsiness, increased reaction time, motor incoordination, and anterograde amnesia has been observed in patients taking benzodiazepines. In addition, a meta-analysis of studies looking at withdrawal from an average of 17 mg per day of diazepam found that long-term use led to substantial cognitive decline that did not resolve three months after discontinuation. Withdrawal symptoms are seen in roughly 30% of patients who attempt to discontinue their medication after long-term treatment. Caution should be exercised when considering patients for long-term benzodiazepine therapy, especially when used for off-label indications.

Increased Risk of Death Associated with Concurrent Use of Benzodiazepines and Suboxone®, or Opioids

The co-administration of opioids and benzodiazepines should be done with caution. The concurrent use of these agents may result in respiratory depression, hypotension, profound sedation, or coma. A number of post-marketing reports have been published regarding coma and death associated with concomitant use of Suboxone® with benzodiazepines. In many, but not all, of these cases, buprenorphine was misused by self-injection. It is advised to use caution when prescribing Suboxone® to patients on benzodiazepine therapy and to warn patients of the potential danger associated with the combination. Park et al. found that roughly 50% of the deaths from drug overdose occurred in patients who were prescribed benzodiazepines and opioids. The risk of death increased with history of benzodiazepine prescription and also with increasing benzodiazepine daily dose. If concurrent administration is clinically warranted, consider dosage reduction of one or both agents.

Benzodiazepines not First Line Treatment for PTSD

The latest VA clinical practice guidelines recommend SSRIs as first line treatment in PTSD. SSRIs are the only medications with approved indications for the treatment of PTSD by the FDA. Benzodiazepines are the only potentially addictive group of medications discussed for treatment of PTSD. There are a limited number of studies that have not shown benzodiazepines to be useful in treating the core PTSD symptoms. It is currently recommended that benzodiazepines be used in great caution in PTSD. If they are used, it is recommended that therapy be short-term use only (no more than five days) with frequent re-evaluation for side effects.

Benzodiazepines not First Line Long-Term Treatment Option for GAD

Current World Federation of Societies of Biological Psychiatry guidelines for the management of generalized anxiety disorder list SSRIs/SNRIs as the first-line long-term treatment option for patients diagnosed with GAD. While benzodiazepines are widely used due to their proven effectiveness and rapid onset of action in GAD, their role in long-term management of the disorder is less clear. Benzodiazepines are also not effective in resolving the depression often accompanying GAD. Long-term benzodiazepine therapy should be used with caution, especially in elderly patients, due to a greater risk of adverse events.

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CDC Recommendations for Prescribing Opioids for Chronic Pain

The Centers for Disease Control and Prevention (CDC) released updated recommendations for the prescribing of opioids to patients 18 years of age or older for chronic pain outside of active cancer, palliative, and end-of-life care by primary care clinicians. Chronic pain is defined as "pain conditions that typically last > 3 months or past the time of normal tissue healing." The guidelines also address the use of opioid pain medications in special populations, such as pregnant women, older adults, and those with a history of substance use disorder.

The recommendations are grouped into three areas of consideration:

Determining When to Initiate or Continue Opioids for Chronic Pain

- Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy.
- Before patients are started on opioid therapy, clinicians should establish realistic treatment goals. Clinicians should also establish a discontinuation plan if benefits of opioid therapy do not outweigh risks.
- Before starting and during opioid therapy, clinicians should discuss known risks and benefits of opioid therapy.

Opioid Selection, Dosage, Duration, Follow-up, and Discontinuation

- Immediate-release opioids should be initiated first for chronic pain.
- Clinicians should prescribe the lowest effective dosage when beginning opioid therapy. Clinicians should reassess individual benefits and risks when increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day.
- If opioids are being prescribed for acute pain, clinicians should prescribe the lowest effective dose of immediate release opioids for the shortest amount of time (typically < 7 days).
- Clinicians should assess benefits and harms with patients within 1 to 4 weeks of opioid therapy initiation. Patients on continued opioid therapy should be evaluated at least every 3 months. If continued therapy is found to increase harm, clinicians should optimize other therapies and taper opioids to lower dosages or taper and discontinue opioids.

Assessing Risk and Addressing Harms of Opioid Use

- Clinicians should consider offering naloxone when patients are at an increased risk for opioid overdose. Factors that increase the risk of overdose are: history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use.
- State Prescription Drug Monitoring Program (PDMP) database should be reviewed when initiating opioid therapy and periodically during opioid therapy.
- Urine drug testing should be performed when initiating opioid therapy and at least annually during opioid treatment.
- Clinicians should avoid prescribing benzodiazepines and opioid medications concurrently.
- Clinicians should offer medication-assisted treatment to patients with opioid use disorder. This could include treatment with buprenorphine or methadone in combination with behavioral therapies.

References:

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