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Pharmacy Benefit News

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Specialty Spotlight

Naloxone For Opiate Overdose

The prescribing/dispensing of Naloxone for opiate overdoses has received a great deal of attention of late. Less attention has been addressed in the literature about Health Plan/Payer issues. Several States have published guidelines, e.g., Washington State, but what of employers, and public or private Health Plans? We certainly cannot answer for Health Plans or every benefit, but we can bring the issue forward to allow for a more robust discussion.

Typical questions are, for example: Is this a covered benefit? If a pharmacist dispenses naloxone to the public, is this a covered benefit? If a Prior authorization is required, then what are the criteria?

As a result, we are devoting this issue of the Pharmacy Benefit News to Payer concerns. This is not an exhaustive review, but a few primary references that seem to address some of the payer concerns. Benefit coverage is dependent on each benefit plan so our comments are directed to general benefit issues.

Typical Payer Questions

1. What are Payers deciding re the necessity and application for use of opioid antagonists for patients per order of a pharmacist?

Comments:

- The pharmacist does not have to make a prescription. The dispensing electronic document/log is the actual proxy for a prescription. However, benefits apply to prescription medications so pharmacist dispensing in this case may require language expansion in the benefit. Pharmacist dispensing directly to the public may not be a covered benefit, nor may dispensing to a third party who is not the patient.
- Pharmacists may require a cash payment for third party dispensing of Naloxone. Part of the rationale would be the pharmacist's time estimated at somewhere between 15-30 minutes per patient.

2. When is it appropriate for these drugs to be dispensed. For example, is it "any time a narcotic is dispensed"? What to do about a 10

day supply, post-op, or number of refills?

Comments:

- There is no current standard. The usual is for chronic therapy only. However, the following risk factors have been published: [http://cpnp.org/guideline/naloxone]
- Naloxone should be considered for all patients exposed to opioids regardless of the source. The risk of a potentially fatal opioid overdose is a hazard of the drug and the drug combinations that are used. This applies to those who take opioids for pain and to those who misuse them.
- Additional overdose risk factors include the following:

  1. Concurrent use of benzodiazepines or alcohol
  2. History of opioid addiction or other substance use disorder
  3. Comorbid mental illness
  4. Receiving prescriptions from multiple pharmacies and prescribers
  5. Daily opioid doses exceeding 100 mg of morphine equivalents per day (MED). (Note: While 120 MED is common, there is some disparity with some using 60, 90, o0r even 50 MED.)
  6. Receiving a methadone prescription
  7. Recent emergency medical care for opioid poisoning/intoxication/overdose
  8. Recent release from incarceration/prison/jail
  9. Recent discharge from opioid detox or abstinence based program
  10. Comorbid renal dysfunction, hepatic disease, or respiratory diagnoses (smoking/COPD/emphysema /asthma/sleep apnea/other)

3. What if the patient is not the individual receiving the prescription?

Comment:

- Naloxone is a bystander-administered drug, and the request for naloxone may come from caregivers.

4. Is it appropriate to request documentation from the MD re why the patient is on a narcotic and anticipated length of treatment?

Comments:

- Due to the nature of Naloxone use it may be appropriate to ask if they are prescribing for the patient or for a third party recipient. Both physicians and pharmacists can prescribe/dispense to third parties, e.g., care givers, medical professionals, interested parties, family members, etc.
- In the case of third parties, i.e., this is not a prescription written for the patient who will take the medication, so is it technically covered in the benefit? This may require a specific benefit statement, or identify as a non-covered issues and the patient would have to pay cash for the medication.

5. If the MD indicates long term pain management, is it appropriate to question other (than opiate) treatment alternatives?

Comment:

- Commonly, it has been appropriate to question if the World Health Organization (WHO) step therapy (for chronic non-malignant pain) has been tried including OTC analgesics, NSAIDS (contraindicated in cardiovascular or kidney disease), topical NSAID analgesics, Cognitive behavioral therapy adjunctive treatment for chronic non-malignant pain, etc.

6. Is approval of treatment consistent with the benefit language? If a physician is prescribing for a patient, then that is usually consistent with the benefit?

Comment:

- However, the benefit allows for Prior Authorizations and that is where criteria may be used to request further information from the prescriber.

Price Comparison of Naloxone Dosage Forms

Product Name	Package Size	Package SUM	Package Desc	Unit Price WAC	Unit Price AWP
NALOXONE 0.4MG/ML INJ	1	ML	Vial	$15.59 - $18.98	$18.53 - $23.72
NALOXONE 0.4MG/ML INJ	10	ML	Vial	$11.70 - $11.87	$14.04 -$14.25
NALOXONE 0.4MG/ML INJ	1	ML	Syringe	$15.44 - $16.50	$18.53 - $19.80
NARCAN SPR	1	EA	Box	$62.50	$75.00
EVZIO INJ	0.4	ML	Package	$575.00	$690.00

References:

1. The CDC has recently published guidelines for opioid prescribing. I have attached the CDC documents to this email.

2. Washington State: stopoverdose.org/pharmacy.htm

3. The American Medical Association, the American Public Health Association and the American Pharmacists Association have all endorsed policies to expand availability of take-home naloxone:

- Promoting Prevention of Fatal Opioid Overdose, AMA Adopts New Policies, June 2012
- Preventing Overdose Through Education and Naloxone Distribution, APHA Policy Number: LB-12-02, Oct. 2012
- Pharmacists and Naloxone: a Life or Death Difference, APhA, April 2015.

Professional research articles also suggest prescribing take-home naloxone to those at risk for having an opioid overdose. For example: Diagnosing and treating opioid dependence (Hill KP, Rice LS, Connery HS, Weiss RD. Journal of Family Practice 2012;61(10):588-597).

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