Health Plan Rx "Safe Prescribing" Guide

Health Plan	Medi-Cal Specialty Mental Health Services[1]	Medi-Cal Managed Care Plan Behavioral Health Services[2]
Care1st Health Plan **Care1st.com**	San Diego Access & Crisis Line (888) 724-7240	Care1st Health Plan (855) 321-2211
Community Health Group **Chgsd.com**		Behavioral Health Services (800) 404-3332
Health Net **HealthNet.com**		Managed Health Network (MHN) (888) 426-0030
Kaiser Permanente **KP.org**		Kaiser Permanente, Department of Psychiatry (877) 496-0450
Molina Healthcare **MolinaHealthcare.com**		Molina Healthcare (888) 665-4621

(*Medi-Cal beneficiaries can access a County Behavioral Health program directly.)

(*For emergencies call 911 or the Access & Crisis Line at (888) 724-7240)

<u>Medi-Cal Managed Care Plan Behavioral Health Services</u>

Medi-Cal Managed Care Plans cover behavioral health services for all members, unless they have a serious and persistent psychiatric illness requiring complex biopsychosocial services in order to maintain stability. Each Medi-Cal Managed Care Plan has their own network of contracted behavioral health providers.

<u>Medi-Cal Specialty Mental Health Services</u>

County Behavioral Health Services provides covered benefits for all Medi-Cal beneficiaries, including those on a Medi-Cal Managed Care Plan, with serious and persistent psychiatric illness requiring complex biopsychosocial services in order to maintain stability. These services are commonly provided by San Diego County's contracted network and inpatient psychiatric hospitals.

<u>Substance Use Treatment</u>

Medi-Cal beneficiaries can receive substance abuse services through the County Behavioral Health Services' Alcohol and Drug Program. These programs can be accessed by calling the Access & Crisis Line. Medi-Cal beneficiaries in need of acute medical detoxification are covered by their Medi-Cal Managed Care Plan. Acute medical detoxification means treatment in an acute medical facility for a serious medical condition relating to substance withdrawal. Additionally, voluntary inpatient detoxification is available and covered by the State's fee-for-service system.

<u>Consumer Center for Health Education & Advocacy</u>

The Consumer Center for Health Education & Advocacy helps beneficiaries understand how to use physical and behavioral health services. If there is a problem getting necessary care through a managed care plan, members and providers should first contact the plan's customer service department. In most cases, the health plan will resolve the issue. Occasionally, a plan member may feel his/her needs are not being met and may need a third party to help break down a barrier. The Consumer Center works closely with the health plans to figure out where the barrier is and how to resolve the problem. The Consumer Center for Health Education & Advocacy number is: (877) 734-3258.

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Prescription Drug Abuse is a leading cause of unintended death in San Diego County. The following are recommendations for health plans and providers to promote safe prescribing.

	Topic	Rationale	Recommendation
1	**Restricted Status Program for high risk patients**	28% of overdose deaths in San Diego County occurred in patients with multiple providers and pharmacies. They consumed over 50% of all prescriptions of those who died.	HEALTHPLAN PROGRAM: A safety program should be created to have high-risk patients, who utilize multiple providers and multiple pharmacies, receive coordinated care by allowing only one provider and one pharmacy for prescription benefits. Develop a coordinated care safety program to discourage utilization of multiple providers and multiple pharmacies and requires using only one provider and one pharmacy for prescription benefits.
2	**Acute Pain**	CDC recommendation states that three of fewer days are usually sufficient for most nontraumatic pain not related to major surgery.	PRIOR AUTHORIZATION: Any patient with a first time opioid prescription will be limited to no more than 30 tablets. TAR can be submitted additional medication based on continued need.
3	**New Start Precautions**	Continuing opioids without functional improvement is not evidence based. 70% of all San Diego prescription deaths involved individuals with the same prescription for 3 consecutive months or more.	NEW STARTS: Create a prior authorization process for new start chronic opioids (continued new opioids after 1-3 months) that includes medical indication, opioid risk assessment, CURES report, medication agreement, and tapering plan.
4	**High Morphine Equivalents**	High dose increases risk of overdose death and medical complications.	NEW STARTS: When patients are receiving escalating dosage of opioids and reach a new higher dose of morphine milligram equivalents per day of 90 MME , prior authorization would be required. Palliative care and hospice are exceptions.

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5	**Methadone Restriction**	Over 30% of overdose deaths involve methadone. In a study of San Diego methadone related deaths, 100% of methadone deaths that there included in the CURES system, were prescribed by a primary care provider. Genetic testing should be considered to determine if individuals could metabolize the drug and avoid cardiac toxicity and prolonged QT syndrome. The CDC recommendation is that methadone should not be used as a first line long acting opioid agent.	PROVIDER RESTRICTION: Create a prior authorization for non-pain providers who want to prescribe methadone. The medication can be given with coordinated care with pain management. There should be no restrictions for hospice and palliative care. FORMULARY: Restrict to only methadone 5mg tablets, and limit to 90 per month. NEW STARTS: Methadone should not be prescribed as a first line long acting opioid without trial of other long acting opioids.
6	**Overdose Feedback to Providers**	In a study of 3000 patients who overdosed on prescription opioids and survived, 7% overdose again, and 70% received new prescriptions from same doctors who treated them before the overdose.	HEALTHPLAN FEEDBACK: Health plans should provide feedback to providers if their patient was in the hospital for a medication poisoning. Providers and then encouraged to develop a prevention plan that includes checking CURES, limiting additive CNS depressant medications, a tapering plan, and evaluation for potential addiction.
7	**Limit Concurrent Opioid and Benzodiazepine Prescriptions**	More than 30% of opioid deaths involve use of benzodiazepines. San Diego data showed that 50% of prescription deaths were given this combination and 20% died with this combination.	NEW STARTS: New start patients who require chronic combination of benzodiazepine and opioids use would require prior authorization. TAR should include single physician coordination of both medications, justification for combined medication, and tapering plan. EXISITING PATIENTS: Patients who are already on opioid and benzodiazepine combination will require an interdisciplinary approach to tapering.
8	**Naloxone**	One overdose death is prevented for every 164 naloxone prescriptions. The CDC recommends Naloxone prescriptions for patients on $\geq$50 morphine equivalents per day.	EDUCATION: Providers should consider naloxone to patients on > 50 morphine equivalents per day. Pharmacies may dispense naloxone without a prescription, however the medication may not be coverage by insurance from the pharmacist, therefore may require a prescription from the provider. For Medi-Cal, naloxone is covered as a carve-out and no authorization is needed. The nasal atomizer is not a medical device and cannot be billed; it could be purchased by the patient ($5) or the plan and distributed to providers to dispense with the prescription.

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9	**Buprenorphine**	Buprenorphine can be helpful in tapering and preventing relapse for individuals with opioid addiction. It cannot be started in individuals who still have opioids in their system. Physicians are required to complete an eight-hour training to qualify for a waiver to prescribe and dispense buprenorphine.	HEALTH PLAN COVERAGE: Health plans should cover buprenorphine certification for providers and give incentives for accepting referrals.
10	**Tramadol (Ultram)**	There is an increase in prescriptions of tramadol and therefore increased deaths (20 in 2015). This medication is considered addictive in morphine equivalents and CNS depressant effects. One tablet of 50mg tramadol has more morphine equivalents than one Norco 5/325.	EDUCATION: Tramadol should be included in morphine equivalent calculations.
11	**Carisoprodol (Soma)**	Carisoprodol quickly metabolizes to meprobamate, an anxiolytic known for its addictive potential. The half-life of soma is 100 minutes while the half-life of meprobamate is 6-17 hours. Carisoprodol is off the market in several European countries. It is part of the "un-holy trinity" that includes opioids and benzodiazepines. There is no evidence for long-term benefit for carisoprodol.	NON-FORMUALRY Remove carisoprodol from formulary or create strict prior authorization that requires medical justification. Limited to short-term (acute) use only, per FDA approved indication. Ongoing use requires failure of at least 3 formulary muscle relaxants: baclofen, cyclobenzaprine, methocarbamol, tizanidine (tablets only), chlorzoxazone. TAR must include accurate diagnosis as provided by PRESCRIBER and include all necessary/relevant clinical documentation to support medical justification (clinic notes, lab reports, specialist consults, imaging reports, etc).
12	**Alprazolam (Xanax)**	Deaths that include benzodiazepines are accelerating. Alprazolam is the most prescribed and most addictive of all the benzodiazepines. The medication peaks at 1-2 hours, but last for only 5 hours. Tolerance, psychological and physical dependence may occur in as little as 10 days. Alprazolam is relatively contraindicated in bipolar disease and mania because of potential exacerbation of mania. The American Psychiatric Association guidelines recommend benzodiazepines such as Xanax for short term use only.	NON-FORMULARY Coverage duration: Anxiety 3 months, Cancer - 1 year, Epiplepsy - 1 year. Alprazolam should be limited to guidelines by teh American Psychiatric Association. TAR should include documentaiton of trial and failure or inadequate treatment response to forumary loarzepam and other forumalary benzodiazepines OR diagnosis of epilespy or cancer.

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13	**Zolpidem (Ambien)**	Zolpidem is the number one drug of abuse among addicted patients who are in the medical profession according to the Betty Ford Center. In 2013, San Diego had 17 zolpidem-associated deaths, and it was prescribed to 43 patients that died from prescription overdose.	EDUCATION: Dosage adjustments may be necessary when combined with other CNS depressants because of potential additive effects.
14	**Promethazine with Codeine Syrup**	Narcotic Antitussive medications are a known drug of abuse. "Purple drank" is one of the slang terms used for the concoction that includes this medication. It has been popularized in hip hop music.	NON-FORUMULARY Coverage limits: Limit to adult age 18 and older with limit to 30 ml per day, 240 ml per fill, and 3 refills per year. The American Academy of pediatrics does not recommend the use of codeine or other antitussives in children. Non-drug treatment is preferred.
15	**Diphenhydramine (Benadryl)**	There were 26 deaths associated with diphenhydramine in San Diego in 2014. The medication has addictive CNS depressant effects when combined with opioids or benzodiazepines.	EDUCATION: Diphenhydramine use should be limited when combined with benzodiazepines and opioids due to additive CNS depressant effects.
16	**Other Pain Modalities**	Pain treatment requires a multidisciplinary approach and not just prescriptions. This may include evidence-based modalities that may include biofeedback, massage, acupuncture, and other modalities.	HEALTHPLAN INTERDISCIPLINARY COVERGE: Health plans are encouraged to provide other evidence based modalities for pain management that do not include pain prescriptions for select patients. This is an opportunity to improve pain management and reduce potential patient harms from overuse, in conjunction withy potential cost savings.
17	**Marijuana**	Marijuana is a CNS depressant. The potency of THC has gone up from 3% to up to 33% in the past 30 years. Marijuana toxicity is a frequent cause for emergency care. Marijuana is the number one drug found in fatal car accidents. The percentage of THC and ration of THC/CBD from dispensary marijuana is unknown. Studies on benefit of marijuana use 3% THC content.	EDUCATION: Dronabinol is a schedule III prescription that can be given that contains defined quantities of THC and is used for as an adjunct for nausea. Marijuana should be limited when combined with benzodiazepines and opioids due to additive CNS depressant effects.

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18	**Clinical Consultation**	Primary care physicians often face a difficult task in weaning and managing patients who are on multiple or high dose prescriptions. These patients are often at highest risk and also at highest intensity of management requirements.	CONSULTATION MECHANISM • UCSF Clinical Consultation Center UCSF provided clinical consultation for physicians who have questions on HIV prophylaxis medications, Hepatitis C treatment, as well as opioid treatment. http://nccc.ucsf.edu/clinical-resources/substance-use-resources/ • The San Diego Prescription Drug Abuse Medical Task Force can provide a forum to discuss difficult cases. • Health plan should develop system for consultation to address difficult patient cases in a systematic and consistent mechanism.

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Recommendations for Health Plans

1. Promote regular utilization of CURES Reports

2. Promote utilization of drug screens to monitor compliance.

3. Use of medication agreement (aka compact) between prescriber and member, and document into the CURES 2.0 system

4. Create system for prescribing safety that includes: Education, Restricted status program for high-risk utilizers, formulary restrictions, prior authorization, provider restrictions, and treatment modalities that includes modalities besides prescriptions, see table.

5. Health Plans to join the One San Diego Safe Prescribing Mission.

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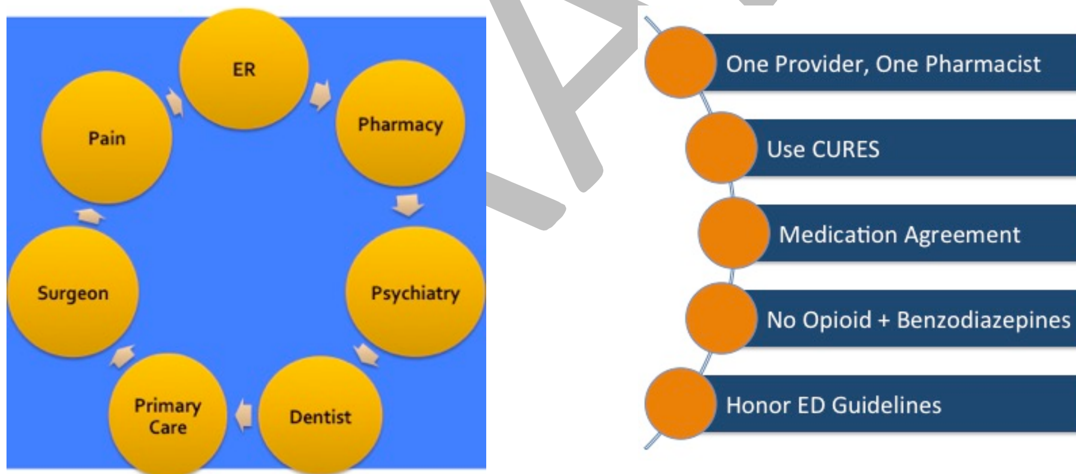
One San Diego Safe Prescribing Mission

The One San Diego Safe Prescribing Mission states a common 5 step approach is used for safe prescribing by all medical specialties: Primary Care, Emergency Medicine, Psychiatry, Pain, Surgery, Dentistry, Pharmacy, and Health Plans.



Voluntary Inpatient Detoxification

- Voluntary inpatient detoxification (VID) is a Medi-Cal benefit covered by the Department of Health Care Services Medi-Cal Program
- VID must be provided in a general acute care hospital
- Treatment must be approved by submitting a Treatment Authorization Request (TAR) to the Local Field Office (888) 724-7302

Community Health Group | Care1st Health Plan | Kaiser Permanente | OptumHealth | Molina Healthcare

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http://www.cdc.gov/vitalsigns/methadoneoverdoses/

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http://www.asam.org/docs/default-source/advocacy/mat-with-buprenorphine-summarizing-the-evidence.pdf?sfvrsn=0

11. San Diego Safe Prescribing Web Site - medical resources
http://www.SanDiegoSafePrescribing.org

12. San Diego Rx Abuse Task Force Web Site - community resources
http://sandiegorxabusetaskforce.org/

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