



FACTS ABOUT NALOXONE: THE OPIOID OVERDOSE RESCUE DRUG

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MORE STATES ARE ADVANCING INITIATIVES TOWARD NALOXONE AND OPIOID CO-PRESCRIBING MANDATES

The U.S. opioid epidemic is in full swing and shows no signs of slowing down. **Opioid overdose deaths contributed to over 47,000 deaths in the US in 2017**, which is more than double the rate over the last decade.¹ **Many states and the US government have declared the opioid epidemic as a public health emergency.**² Action is elicited from stakeholders at all levels of the health care spectrum.

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5-POINTS

The U.S. Department of Health and Human Services (DHHS) laid out a five-point opioid strategy to fight the crisis in 2017, which includes:³



Strengthening public health surveillance



Advancing the practice of pain management



Improving access to treatment and recovery services



Targeted availability and distribution of overdose reversing drugs



Supporting cutting-edge research drugs

The strategy to increase targeted availability and distribution of overdose reversing drugs is referring to naloxone. Naloxone is an opioid antagonist that blocks the effects of opioids and reverses an overdose. This medication is an essential tool that can be used in the event of an opioid overdose and has its role in the current opioid epidemic. While it is crucial to implement strategies toward reducing inappropriate use that leads to abuse and addiction in the first place, rescuing patients from overdoses will dramatically reduce mortality associated with opioid misuse. For this reason, all 51 US jurisdictions have enacted naloxone access laws that remove varying levels of restrictions for naloxone.⁴ The next step however, appears to be the enactment of naloxone co-prescribing laws.

¹ Understanding the epidemic. CDC. December 2018. Available: <https://www.cdc.gov/drugoverdose/epidemic/index.html>. Accessed July 24, 2019.

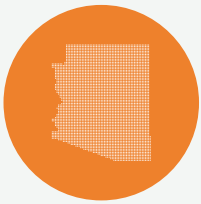
² Sullivan T. President trump declares opioid crisis a national emergency. May 2018. Available: <https://www.policymed.com/2017/08/president-trump-declares-opioid-crisis-a-national-emergency.html>. Accessed July 24, 2019.

³ The opioid epidemic in numbers. HHS. Available: <https://www.hhs.gov/opioids/>. Accessed July 24, 2019.

⁴ Naloxone overdose prevention laws. Legal Science. July 2017. Available: <http://www.pdaps.org/datasets/laws-regulating-administration-of-naloxone-1501695139>. Accessed July 24, 2019.

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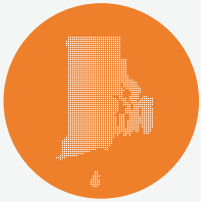
require a prescriber to write a prescription for naloxone along with opioids



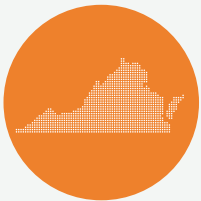
ARIZONA



NEW MEXICO



RHODE ISLAND



VIRGINIA



VERMONT



WASHINGTON

A growing number of states have passed or are leaning towards passing laws that require prescribers to co-prescribe naloxone with opioids. Currently, there are eight states with some version of this mandate. Six states including Arizona, New Mexico, Rhode Island, Virginia, Vermont and Washington require a prescriber to write a prescription for naloxone along with opioids, while California and Ohio only ask that prescribers offer to write for naloxone for at-risk patients. Although the criteria for at-risk patients differ from state-to-state, they are centered on specific daily morphine equivalence dose (MED) levels, concurrent use of benzodiazepines and underlying medication conditions that enhance opioid risk, such as obstructive sleep apnea. Patients who have a history of drug addiction or opioid use disorder are automatically considered at risk. Rhode Island currently has the strictest rule requiring that naloxone be co-prescribed for patients taking 50 mg MED or more, while Virginia draws the line more liberally at 120 mg MED. According to the CDC, the risk of overdose death doubles with patients whose MED is 50 mg/day and above.⁵ For this reason, the CDC issued recommendations for naloxone co-prescribing to all patients receiving 50 mg MED/day or more.⁶

⁵ Calculating total daily dose of opioids for safer dosage. CDC. Available: https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf. Accessed July 24, 2019.

⁶ Naloxone: the opioid reversal drug that saves lives. HHS. Available: <https://www.hhs.gov/opioids/sites/default/files/2018-12/naloxone-coprescribing-guidance.pdf>. Accessed July 24, 2019.

⁷ Ashburn M, Bates M, Boateng S, Chitwood SD, Cleaver MA, Clemens P, Donze R, et al. Safe prescribing for worker's compensation. July 2018. Available: <https://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Documents/PA%20Guidelines%20-%20Safe%20Prescribing%20for%20Workers%20Compensation.pdf>. Accessed July 24, 2019.

⁸ Senate bill S7801-Requires the commissioner of health to develop guidelines for the prescription of opioid antagonists. Available: <https://www.nysenate.gov/legislation/bills/2017/s7801>. Accessed July 24, 2019.

⁹ Brennan Z. FDA advisory committee votes for co-prescribing naloxone with opioids. RAPS. December 2018. Available: <https://www.raps.org/news-and-articles/news-articles/2018/12/fda-advisory-committee-votes-for-co-prescribing-na>. Accessed July 24, 2019.

¹⁰ Brennan Z. FDA advisory committee votes for co-prescribing naloxone with opioids. RAPS. December 2018. Available: <https://www.raps.org/news-and-articles/news-articles/2018/12/fda-advisory-committee-votes-for-co-prescribing-na>. Accessed July 24, 2019.

¹¹ Whelan A. New laws require physicians to prescribe naloxone with opioids. EMSWORLD. February 2019. Available: <https://www.emsworld.com/news/1222288/new-laws-require-physicians-prescribe-naloxone-opioids>. Accessed July 24, 2019.

In Pennsylvania, there are no laws requiring physicians to co-prescribe naloxone, but the state health department updated its physician guidelines to recommend doctors prescribe naloxone to those receiving opioids higher than 50 mg MED.⁷ Similarly, New York is working toward enacting a bill requiring the development of guidelines for prescribers to co-prescribe naloxone.⁸

At the federal level, there has been an increasing traction and conflict on logistical, economical and risk mitigation aspects of prescribing naloxone concurrently with opioid prescriptions. Particularly after the FDA advisory committee voted in December 2018 on a recommendation to change opioid product labels to require prescribers to co-prescribe naloxone to patients who are at a high of risk of overdose.⁹ The American Medical Association (AMA) also spoke in support of naloxone co-prescribing mandates following the Surgeon General's directive last year.

Parties that voted against the committee's recommendation feel that changes to a product label might be a passive solution and might not address the underlying crisis, while driving up drug costs on a state and federal level.¹⁰ Forcing all opioid receiving patients to fill their naloxone prescription also places a stigma, even on patients who are at low risk of overdose. Moreover, the concern with co-prescribing naloxone to an individual who lives alone is that a person cannot self-administer naloxone and so the purpose of having the drug on hand is ineffective. Incidentally, people who do use opioid drugs as prescribed, but are still at increased risk for overdose, often do so in their sleep via respiratory failure.¹¹ Parties in favor of labeling changes for opioids perceive it as an opportunity for prescribers to discuss risks and responsible use of opioids, remove stigma in using naloxone and educate patients on overdose prevention and response. Another possible benefit of increased access to naloxone is the decrease of certain healthcare costs via reduction of ER visits, hospital stays and complications from having had an opioid overdose.



A recent study conducted using Medicaid data showed naloxone access laws drove up outpatient naloxone prescriptions to 74 percent of average number of naloxone prescriptions per state-quarter.¹² States that have naloxone access laws were instrumental in increasing naloxone dispensed from retail pharmacies by an average of 79 percent compared to those states that did not have such laws.¹³ FDA estimates co-prescribing naloxone to all patients on opioids could increase annual healthcare costs by \$63.9 billion to \$580.8 billion after adding 1 million existing doses and over 48 million additional naloxone doses nationally. These estimates are contested by the makers of Narcan®.¹⁴ The number of prescriptions filled nationwide for naloxone has increased 264 percent from January 2017 through August 2018 (data from IQVIA's Total Patient Tracker) to also support the argument that costs will significantly increase for prescribing naloxone in patients using opioids.¹⁵

As opioids contribute to the majority of drug expenditure among injured workers for managing non-cancer chronic pain, it is crucial to abide by the new naloxone laws and regulations across all states. At this time, not all states mandate co-prescribing naloxone with an opioid. Considering the efforts being taken by DHHS, CDC and FDA, and their encouragement to utilize naloxone more effectively, more states might adopt similar laws and regulations in the near future. While this could mean a spike in costs for creating access for naloxone, it also brings up a new conversation to be addressed between opioid prescribing providers and their patients. Although there are benefits to prescribing opioids to patients suffering from acute to chronic pain, there also exists the risk of dependence, abuse and overdose despite intent. Additionally, patients have the right to be made aware of the risks that come with taking opioids and should have access to the proper knowledge and tools to deal with adverse events, such as overdose. In addition, patients have the right to make their own decisions about their health and should be given the autonomy to decide if taking this medication would truly benefit them.

As of April 2019, in an effort to accommodate the new changes in the prescribing of opioids, the FDA approved a generic naloxone spray as a cost-effective alternative to the current \$4,000 Evzio naloxone injectable. Furthermore, naloxone manufacturers are working toward switching it to an OTC product very soon. Currently, Narcan nasal spray for opioid overdose reversal is becoming a widely available and easier-to-administer option that can be found at all major pharmacy chains without a prescription, at a cost of around \$150. Having this resource for patients does allow providers to feel less obligated to co-prescribe naloxone for patients who are not at high risk for an overdose and ultimately allows the patient to decide whether or not they want to have this medication.

Patient care should be individualized, and patients should be able to decide whether they want to fill their medications without feeling pressured or obligated. Federal regulations mandating the co-prescribing of naloxone to all patients receiving opioids contradicts the very principle of patient autonomy. Through clinical programs at myMatrixx, MED and other risk factors are measured and monitored to help payers determine if a patient fits the clinical criteria that would legally mandate a naloxone prescription in the states that have enacted co-prescribing laws or guidelines. However, some prescribers may go beyond the mandates and require patients under their care to obtain naloxone even if the patient does not fit the established legislative criteria. In these instances, we have witnessed the consternation of some payers as they are challenged with the decision to authorize or deny naloxone prescriptions. In most cases, we recommend that payers accommodate naloxone prescriptions mainly because the denial of such prescriptions leaves

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the “what-if” scenario on the table. What if the patient suffers an unintended overdose following the denial of a naloxone prescription? It is important to understand that naloxone is dispensed as a stand-by prescription, should have a shelf life of at least one year, and thusly only re-prescribed when the unused naloxone has expired. Therefore, the cost of naloxone should only be incurred once annually. Our clinical intervention programs guide prescribers to Narcan and available generics to minimize the cost while accommodating prescribers’ need to be judicious toward patient safety.

The use of naloxone has become a crucial cornerstone in patient safety and advocacy by lowering the risk of overdose of injured workers who have been prescribed opioids for their pain management and are at an increased risk of overdose. Ultimately, prescribers have expertise and the scope of practice to determine whether the addition of naloxone to their treatment regimen is appropriate and necessary. The question of having the federal legislature force all prescribers to co-prescribe naloxone raises concerns about patient/prescriber decision making, removing the individualization in patient care and the potential of costing millions of dollars to implement. Unless, naloxone co-prescribing laws are enacted at the federal level, state mandates are likely to spread. As such, myMatrixx will continue to monitor the legislative landscape around this issue and provide updates and guidance to our clients to ensure that payer coverage determinations are compliant with provided clinical value.

¹² Gertner AK, Domino ME, Davis CS. Do naloxone access laws increase outpatient naloxone prescriptions? Evidence from Medicaid. *Drug Alcohol Depend.* September 2018; 190:37-41.

¹³ Xu J, Davis CS, Cruz M, Lurie P. State naloxone access laws are associated with an increase in the number of naloxone prescriptions dispensed in retail pharmacies. *Drug and Alcohol Dependence.* August 2018; 189:37-41.

¹⁴ Joseph S, Mishra M. FDA panel backs prescribing overdose reversal drug with opioids. *Reuters.* December 18, 2018. Available: <https://www.reuters.com/article/us-usa-opioids-naloxone/fda-panel-backs-prescribing-opioid-overdose-reversal-drug-along-with-painkillers-idUSKBN1OH2CA>. Accessed July 24, 2019.

¹⁵ HHS awards over \$ 1 billion to combat the opioid crisis. *HHS.* September 2018. Available: <https://www.hhs.gov/about/news/2018/09/19/hhs-awards-over-1-billion-combat-opioid-crisis.html>. Accessed July 24, 2019.





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