



Opioid Use Disorder and Treatment

OBJECTIVE

The objective of this Clinical Practice Guideline (CPG) is to provide evidence-based practice recommendations on opioid use and treatment. The CPG discusses care management and behavioral health implications. In addition, the CPG outlines the organizations that WellCare aligns with regarding opioid use and treatment; relevant Measurements of Compliance and Measureable Health Outcomes are also included.

OVERVIEW

Opioid abuse and addiction is a serious problem in the United States. Deaths due to drug overdose have risen over the past two decades; nationally it has become the leading cause of injury death in the United States. Prescription drugs, especially opioid analgesics. This includes a class of prescription drugs such as hydrocodone, oxycodone, morphine, and methadone used to treat both acute and chronic pain. These drugs have increasingly contributed to drug overdose deaths over the last decade. From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled. Heroin-related deaths have also increased since 2010, with a 39 percent increase between 2012 and 2013. Attention has focused on prevention efforts and treatment. Mortality data show that there was a 6 percent increase in drug overdose deaths between 2012 and 2013. Approximately 37 percent (16,235) of overdose deaths involved prescription opioids. While this number is largely unchanged, the mortality rate from heroin overdose increased each year from 2010 to 2013. Heroin-related deaths due to overdose increased by 39 percent from 2012 to 2013 alone and were approximately 19 percent (8,257) of all drug overdose deaths in 2013.¹ According to the National Institute on Drug Abuse (NIDA), 2.1 million Americans live with pain reliever opioid addiction disease, while 467,000 Americans live with heroin opioid addiction disease. Overdose deaths now compare to the number of deaths due to motor vehicle crashes; estimates of the societal costs of opioid misuse is over \$55 billion per year.²

Prescription opioids – such as hydrocodone, oxycodone, morphine, and codeine, and the illegal opioid, heroin – are a class of drugs chemically similar to alkaloids found in opium poppies. They are primarily used as painkillers and have potential for misuse; repeated use increases the risk of developing an opioid use disorder. Every day, 44 people die in the U.S due to overdose of prescription painkillers. Results from the National Survey on Drug Use and Health (NSDUH) found that 50 percent of people who misused prescription painkillers got them from a friend or relative for free – 22 percent obtained them from a doctor. Tolerance increases with repeated use; this can cause someone to turn to the black market and even switch from prescription drugs to cheaper (and risky) substitutes like heroin. In addition:³

- 4.3 million Americans engaged in non-medical use of prescription painkillers in the last month
- Approximately 1.9 million Americans met criteria for prescription painkillers use disorder based on their use of prescription painkillers in the past year
- 1.4 million people used prescription painkillers non-medically for the first time in the past year
- Average age for first-time prescription painkiller use was 21
- Many young people who inject heroin report misuse of prescription opioids before starting to use heroin

Prescription opioids are available as immediate-release (IR) or extended release/long-acting (ER/LA) formulations. While improper use of any opioid can result in serious side effects, including overdose and death, risk significantly increases with ER/LA formulations. Using additional drugs such as benzodiazepines (e.g., sedatives like Xanax) and

antidepressants increase the risk of overdose death. Existing evidence shows higher overdose risk among:¹

- White and American Indian/Alaska Native people
- Men (although overdose among women is on the rise)
- People living in rural areas (clusters in the Southeast—especially in the Appalachian region)
- Adults aged 45-54 years
- People who obtain multiple controlled substance prescriptions (especially the combination of opioid analgesics and benzodiazepines) from multiple providers
- People who take high daily dosages of opioid pain relievers

Chronic nonmedical use of prescription opioids (nonmedical use of > 200 days or more in the past year) had increased by roughly 75 percent between 2002-2003 and 2009-2010. Among those age 12 or older in 2012-2013 who used prescription pain relievers non-medically, 53 percent received them from a friend or relative for free and approximately 15 percent bought or took them from a friend or relative. Research indicates that the source for nonmedical users varies significantly depending on the frequency of nonmedical use. While occasional nonmedical users (those who use the drugs non-medically \leq 30 days a year) are most likely to obtain their drugs from a friend or relative for free, the highest-use, highest-risk nonmedical users (those who reported nonmedical use 200 or more days a year) were more likely to obtain their drugs directly from a doctor's prescription than from any other source.¹

Rates of emergency department (ED) visits associated with pharmaceutical misuse or abuse increased 114 percent between 2004 and 2011. In 2011, over 1.4 million ED visits annually were due to the misuse or abuse of pharmaceuticals; 420,000 involved prescription opioids and 425,000 involved benzodiazepines. The admission rate for substance abuse treatment for prescription opioid abuse in 2009 was almost six times the rate in 1999. Prescription opioid abuse can also result in other health consequences such as neonatal abstinence syndrome, increased risk of transmission of HIV and Hepatitis C (associated with injection) and fractures in older adults (due to falls).¹

Heroin

Illegal opiate drugs (such as heroin) and the misuse of legally available pain relievers (such as oxycodone and hydrocodone) can have serious negative health effects. The drug is diluted with other drugs or with sugar, starch, powdered milk, or quinine before injecting, smoking, or snorting. Physical symptoms include euphoria, drowsiness, respiratory depression, constricted pupils, nausea, and dry mouth. An overdose causes slow and shallow breathing, blue lips and fingernails, clammy skin, convulsions, coma, and can be fatal. Additional findings from NSDUH:³

- Individuals also face a higher risk of overdose and for diseases like HIV and hepatitis C due to intravenous use
- 4.8 million people have used heroin at some point in their lives
- Among people between the ages of 12 and 49, the average age of first use was 28
- 212,000 people aged 12 or older used heroin for the first time within the past 12 months
- Approximately 435,000 people were regular (past-month) users of heroin

A retrospective analysis of heroin use in the United States over the last 50 years showed that among people who initiated abuse of opioids in the 1960s, 80 percent reported they initiated with heroin. In contrast, among those who began abusing opioids in the 2000s, 75 percent of individuals indicated they initiated their abuse with prescription opioids. In terms of determining factors for this shift to heroin use, study results indicate that heroin has become more accessible and significantly cheaper, is easier to inhale/inject, and the potency is much greater than prescription opioids. States and cities have reported significant increases in heroin deaths since 2010, and recent analysis shows that the rate for deaths involving heroin has almost tripled since 2010. A CDC analysis of 28 states from 2010-2012 show heroin overdose death rates in 2012 highest among:¹

- Adults aged 25-34 years old
- White, non-Hispanic people
- Men
- People living in the Northeast and Midwest

The U.S. Department of Health and Human Services (HHS) has made addressing the opioid abuse problem a high priority. Two broad goals include decreasing opioid overdoses and overall overdose mortality as well decreasing the prevalence of opioid use disorder. Initiatives by the U.S. Department of HHS include prescribing practices to reduce opioid use disorders and overdose; expanded use and distribution of naloxone; and expansion of Medication-Assisted Treatment (MAT) to reduce opioid use disorders and overdose.¹

Clinical indications for opioid treatment in adults include chronic pain for a duration of ≥ 12 weeks (not including cancer and palliative and end-of-life care) and moderate to severe pain with failure to respond effectively to non-opioid therapies (pharmacologic and non-pharmacologic therapies). The patient must also agree to opioid maintenance therapy, have no contraindications to opioid therapy, and is a suitable candidate for long-term opioid analgesia.*⁴

* For example, benefits outweigh risks based on assessment using validated instrument (e.g., Diagnosis, Intractability, Risk, Efficacy [DIRE] tool, the Opioid Risk Tool [ORT], or Screener and Opioid Assessment for Patients with Pain - Revised [SOAPP-R]).

Alternatives to outpatient opioid maintenance therapy for chronic pain lasting longer ≥ 12 weeks may include 1 or more of the following:⁴

- Multidisciplinary pain rehabilitation
- Physical treatments (e.g., exercise therapy, weight loss)
- Cognitive behavioral therapy (e.g., relaxation technique, stress-reduction techniques)
- Non-opioid medications (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs], tricyclic antidepressants [TCAs], serotonin-norepinephrine reuptake inhibitors [SNRIs], anticonvulsants)

Hierarchy of Support

GUIDELINE HIERARCHY

CPGs are updated annually or as necessary due to updates made to guidelines or recommendations by the American Society of Addiction Medicine (ASAM), Substance Abuse and Mental Health Services Administration (SAMHSA), American Medical Association (AMA), American Congress of Obstetricians and Gynecologists (ACOG), and the Centers for Disease Control and Prevention (CDC). When there are differing opinions noted by national organizations, WellCare will default to the member's benefit structure as deemed by state contracts and Medicaid / Medicare regulations. If there is no specific language pertaining to the opioid use and treatment, WellCare will default (in order) to the following:

- National Committee for Quality Assurance (NCQA);
- United States Preventive Services Task Force (USPSTF), National Quality Strategy (NQS), Agency for Healthcare Research and Quality (AHRQ);
- Specialty associations, colleges, societies, etc. (e.g., American Academy of Family Physicians, American Congress of Obstetricians and Gynecologists, American Cancer Society, etc.).

Links to websites within the CPGs are provided for the convenience of Providers. Listings do not imply endorsement by WellCare of the information contained on these websites. NOTE: All links are current and accessible at the time of MPC approval.

WellCare aligns with ASAM, SAMHSA, AMA, ACOG, and CDC on the topic of opioid use and treatment. Highlights from their respective publications are noted below.

AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM)

The American Society of Addiction Medicine (ASAM) released the *National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use*. It assists clinicians prescribing pharmacotherapies to patients with addiction related to opioid use and addresses knowledge gaps about the benefits of treatment medications and their role in recovery, while guiding evidence-based coverage standards by payers. Recommendations are categorized in the following parts:^{5,6}

1. Assessment and Diagnosis of Opioid Use Disorder
2. Treatment Options
3. Treating Opioid Withdrawal
4. Methadone
5. Buprenorphine
6. Naltrexone
7. Psychosocial Treatment in Conjunction With Medications for the Treatment of Opioid Use Disorder
8. Special Populations: Pregnant Women
9. Special Populations: Individuals With Pain

10. Special Populations: Adolescents
11. Special Populations: Individuals With Co-Occurring Psychiatric Disorders
12. Special Populations: Individuals in the Criminal Justice System
13. Naloxone for the Treatment of Opioid Overdose

To view the guideline in its entirety, click [here](#).

*Additional Policy Statements by ASAM*⁷

Pharmacological Therapies for Opioid Use Disorders

The following are recommendations by ASAM on pharmacological therapies for opioid use disorders:

1. Treatment for any patient with an opioid use disorder should be based on a thorough evaluation of the patient by a knowledgeable and skilled physician, and designed in an individualized manner to best meet that patient's needs. Multidimensional assessment of the primary condition and co-occurring conditions should lead to initiation of and ongoing engagement in treatment.
2. Pharmacological therapy can be a part of effective professional treatment for opioid use disorder, and should be delivered by physicians appropriately trained and qualified in the treatment of opioid withdrawal and opioid addiction. Furthermore, pharmacological therapy is best accompanied by and provided in conjunction with evidence-based psychosocial treatments and recovery support interventions as described in the ASAM Patient Placement Criteria.
3. Decisions about the appropriate type, modality and duration of treatment should remain the purview of the treatment provider and the patient, working in collaboration to achieve shared treatment goals.
4. Arbitrary limitations on the duration of treatment, medication dosage or on levels of care, that are not supported by medical evidence, are not appropriate and can be specifically detrimental to the wellbeing of the patient and his/her community. Thus, such arbitrary treatment limitations should not be imposed by law, regulation, or health insurance practices.
5. Arbitrary limits on the number of patients who can be treated by a physician or the number and variety of pharmacologic and/or psychosocial therapies that may be used for treatment should not be imposed by law, regulation, or health insurance practices.
6. Prior authorization requirements, medical necessity criteria tests, patient copays or in/out-of-network provider requirements for opioid use disorder treatment should be on par with similar requirements for other chronic medical illnesses.
7. Pharmacological therapy guidelines for use by treatment providers in the care of patients with opioid use disorder should be developed by addiction physician specialists^{vii}, in partnership with the U.S. Department of Health and Human Services and other federal, state and local public-private partnerships.
8. Long-term prospective studies aimed toward defining best practices should be developed and funded.

To view the policy statement in its entirety, click [here](#).

Measures to Counteract Prescription Drug Diversion, Misuse and Addiction⁸

The following components are recommended by ASAM to be included in the public policy response to the growing problem of prescription drug addiction, diversion, misuse and overdose deaths:

Prescriber education including information specific to mandatory prescribers, specific drug classes, and quality indicators.

Patient education should be carried out by the prescribers of controlled substances. Education should include information on safe drug storage and disposal practices by patients. This will aid in prevention of unauthorized use, theft, or accidental overdose by children. Providers should provide educational materials about chronic pain and the risks vs. benefits of long-term use of medications as part of their prescribing practices.

Medical school and residency education should be provided as well with a focus on curricula topics that focus on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education.

Prescription Drug Monitoring Programs (PDMP) should be included to ensure effective monitoring as well as how states monitor PDMPs. Protection of PDMP data is also a key issue that Providers should understand.

To view the policy statement in its entirety, click [here](#).

Opioid Abuse, Dependence and Addiction in Pregnancy (Joint Statement by ASAM and ACOG)⁹

The ASAM and the American College of Obstetricians and Gynecologists (ACOG) published a joint statement on *Opioid Abuse, Dependence, and Addition in Pregnancy*. Opioid use in pregnancy is not uncommon, and the use of illicit opioids during pregnancy is associated with an increased risk of adverse outcomes. While the current standard of care for pregnant women with opioid dependence is referral for opioid-assisted therapy with methadone, emerging evidence suggests that buprenorphine also should be considered. Medically supervised tapered doses of opioids during pregnancy often result in relapse to former use. Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in preterm labor, fetal distress, or fetal demise. During the intrapartum and postpartum period, special con-siderations are needed for women who are opioid dependent to ensure appropriate pain management, to prevent postpartum relapse and a risk of overdose, and to ensure adequate contraception to prevent unintended pregnancies. Patient stabilization with opioid-assisted therapy is compatible with breastfeeding. Neonatal abstinence syndrome is an expected and treatable condition that follows prenatal exposure to opioid agonists. To view the policy statement in its entirety, click [here](#).

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA)

The SAMHSA guidelines reflect the obligation of opioid treatment programs (OTPs) to deliver care consistent with the patient-centered, integrated, and recovery oriented standards of addiction treatment and medical care in general. Also, the guideline discusses the role of technology's changing role in healthcare. The guidelines also adhere to Title 42 of the Code of Federal Regulations Part 8.12. The 2015 update should be the primary reference and central measure for program staff, accreditation bodies and other stakeholders on the delivery of care in OTPs that is both high quality and in compliance with federal regulations. Guidance on the following topics are also included:^{10,11,12}

- New ways to assess and counsel patients
- Treatment of pregnant patients
- Patient withdrawal from medication assisted treatment
- Management of patients with multiple problems, including chronic pain
- Telemedicine
- Electronic health records
- Prescription drug monitoring programs
- Recovery
- The role of physicians, nurses, and other program staff
- The full range of FDA-approved medications including methadone, buprenorphine and injectable naltrexone

To view the guidelines in their entirety, click [here](#).

AMERICAN MEDICAL ASSOCIATION (AMA)

The AMA Opioid Task Force represents more than 25 states; participants from various specialties were invited by the AMA Board of Trustees to help reduce the nation's burden from prescription opioids and heroin.^{13,14}

Goals of the AMA Task Force include:

- Increase physicians' registration and use of effective Prescription Drug Monitoring Programs (PDMPs)
- Enhance physicians' education on effective, evidence-based prescribing
- Reduce the stigma of chronic pain and promote comprehensive assessment and treatment
- Reduce the stigma of substance use disorder and enhance access to treatment

- Expand access to naloxone in the community and through co-prescribing
- Promote safe storage and disposal of opioids and all medications

The Task Force also works with state medical societies to address legislation and regulation ranging from developing effective prescription drug monitoring programs, continuing medical education, restrictions on treatment for opioid use disorder as well as enactment of naloxone access and Good Samaritan overdose protections.

CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC)

This CDC guideline provides recommendations for primary care clinicians who are prescribing opioids to patients 18 and older for chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. The guideline addresses:^{15,16}

- When to initiate or continue opioids for chronic pain;
- Opioid selection, dosage, duration, follow-up, and discontinuation; and
- Assessing risk and addressing harms of opioid use.

The guideline is intended to improve communication between clinicians and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder, overdose, and death. The CDC has also provided a checklist for prescribing opioids for chronic pain (<http://stacks.cdc.gov/view/cdc/38025>) as well as a website (<http://www.cdc.gov/drugoverdose/prescribingresources.html>) with additional tools to guide clinicians in implementing the recommendations. To view the guidelines in their entirety, click [here](#).

Evidence Based Practice

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ) has published the following report(s):

- **Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings**¹⁷ ([click here](#))

The purpose of the Technical Brief is to describe promising and innovative medication-assisted treatment (MAT) models of care in primary care settings (including rural or other underserved settings), describe barriers to MAT implementation, summarize the evidence available on MAT models of care in primary care settings, identify gaps in the evidence base, and guide future research. Also discusses uptake of agonist and antagonist pharmacotherapy in conjunction with psychosocial services for more effective treatment of OUDs.

- **The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain**¹⁸ ([click here](#))
Evidence on long-term opioid therapy for chronic pain is very limited but suggests an increased risk of serious harms that appears to be dose-dependent. The report also notes the need for more research to understand long-term benefits, risk of abuse and related outcomes, and effectiveness of different opioid prescribing methods and risk mitigation strategies

MEASUREMENT OF COMPLIANCE

There are no published measures of compliance from CMS or NCQA.

Care Management

The goals for Care Management are to support the member's ability to self-manage their disorder, minimize risk factors and remove barriers preventing the member from achieving goals. Care Managers should use an interdisciplinary approach to coordinate between multiple health and social services, advocate on behalf of the member, assist the member with needs (including those outside of substance abuse treatment) and connect the member to and work with the member's family, social network, community resources and self-help groups to support recovery. One of the main goals of treatment of opiate users is to help members recognize that their opiate use is a problem, and help them acquire the motivation, tools and resources to remain abstinent. Care Managers should also help determine what level of care member is most appropriate for. Member should be connected to the least restrictive level of care to cause the least interruption of their life. Many factors should be considered when determining what level of care to refer member

to including; the member's preference, co-occurring diagnoses, prior treatment response and clinical severity.

For opiate abuse there are generally two treatment options; opioid maintenance treatment and detoxification. Opiate withdrawals are very unpleasant, but not usually life threatening. Withdrawal symptoms include sweating, anxiety, muscle aches and pains, stomach pain, nausea, vomiting, diarrhea, weakness and sleep problems. Medication assisted treatment for opiate use should be used in conjunction with counseling and additional social supports. Studies have shown that medication assisted therapy reduces overdose deaths and increases social functioning and retention of treatment. Medication assisted treatment can last months, a year, several years or be life-long.¹⁷

There are three main MAT medications prescribed for treatment of Opioid Use Disorder:²²

- **Methadone** is an opioid agonist that taken orally so that it reaches the brain slowly, reducing euphoria while preventing symptoms of opioid withdrawal. Methadone is commonly provided in a clinic setting; it is not a take-home medication.
- **Buprenorphine** is a partial opioid agonist that also relieves drug cravings without producing euphoria or dangerous side effects of other opioids. Buprenorphine can be prescribed as a take-home medication. Can also be given in combination with naloxone. Is considered more convenient, safer, and less stigmatizing. The standalone form is preferred for pregnant patients and those transferring from methadone.
- **Naltrexone** – An opioid antagonist for relapse prevention that reduces cravings and reduces the euphoric effects of alcohol and opioids. This medication is available orally or in an extended-release injection given monthly. Was found to be more effective with members who are highly motivated, legally mandated to receive treatment, or taking the medication under supervision of friends or family.

MAT should be used for at least 90 days to be effective, and some studies have shown it to be more effective after at least 3 years of use. There is no recommended time limit for use.²²

Preventing overdose should be a major concern for Care Managers and providers. Members should be educated on the increased risk of overdose following a relapse after detoxification has occurred. Providers should consider a relapse prevention plan including counseling, a naloxone prescription, and MAT. Members who are inpatient for detoxification should have a discharge plan in place that includes outpatient counseling and 12-step programs or peer support services. There is an increased risk of opioid overdose for members who are also taking benzodiazepines, so members should be educated on the risks and be prescribed naloxone^X. Members should be educated on the signs of overdose and when to seek emergency services. Opioid overdose occurs gradually as the drug depresses a person's breathing and heart rate, therefore there is usually a window of 1 to 3 hours where naloxone can be given to prevent death.⁶

MEASURABLE HEALTH OUTCOMES

Targeted Case Management outcomes (**Extended Program Goals**) result from successful self-management (see Case Management Objectives).

- **Symptoms:** Member will show a reduction of opiate use as evidenced by a CAGE < 2 within 90 days
- **Symptoms:** Member's UDS will be negative within 90 days as evidenced by labs or provider report
- **Adherence:** Member will be adherent to prescribed maintenance medications >80% of the time as evidenced by pharmacy claims within 30 days
- **Engagement:** Member will have a reduction of arrests related to substance use by at least 75% within 6 months as evidenced by provider report or public arrest records
- **Engagement:** Member will be connected to a job or vocational rehab program at least 20 hours a week within 90 days as evidenced by member or provider report
- **Utilization:** Member will have a reduction of inpatient services related to substance use including detox and residential treatment by at least 50% within 6 months as evidenced by service authorizations
- **Utilization:** Member will be enrolled in an outpatient substance abuse program such as PHP/IOP and attend >75% of approved days within 60 days as evidenced by service authorizations, medical claims or provider report
- **Utilization:** Member will be enrolled in a residential substance abuse program for at least 7 days and successfully complete the program within 60 days as evidenced by provider report
- **Utilization:** Member will be connected to an outpatient or residential treatment program within 7 days of

discharge from a detoxification admission and attend >75% of appointments within 30 days as evidenced by service authorization, medical claims or provider report

CASE MANAGEMENT GOALS

Goals should target specific care gaps and/or adherence issues, and measure the member's progress towards self-management and adherence which lead to the targeted health outcomes above.

- **Symptoms:** Member will list at least 3 triggers for opioid use and at least 3 ways of avoiding triggers by 60 days
- **Adherence:** Member will be able to fill prescribed maintenance medication within 7 days of receiving prescription
- **Adherence:** Member will schedule outpatient provider appointments and agree to follow treatment protocol including adhering to drug tests and filling medications on time within 30 days
- **Engagement:** Member will discuss the dangers of continued opioid use and treatment options, including maintenance medications, with provider within 30 days
- **Engagement:** Member will be connected to a counselor and will be able to identify at least 3 coping skills or healthy behaviors within 60 days
- **Engagement:** Member will be able to identify at least 3 ways opioid use negative affected their life and identify at least 3 healthy behaviors they can practice (such as attending a support group, looking for a job, or finding a hobby) within 60 days
- **Engagement:** Member will state at least 3 things they can do to create, improve or repair a healthy relationship by 60 days
- **Engagement:** Member will be make a schedule of a daily routine including attending counseling or support groups, attending a job, vocational training or volunteer or social opportunity and completing daily errands within 60 days
- **Engagement:** Member will attend at least one 12 step meeting a week such as NA, SMART etc. within 60 days
- **Utilization:** Member will be connected with substance abuse residential, PHP/IOP or outpatient treatment within 30 days

CASE MANAGEMENT OBJECTIVES

- Refer member to residential substance abuse programs including ATA voucher programs, PHP/IOP or outpatient programs addressing substance abuse
- Connect member to a vocational rehab program, GED course, job training, or employment assistance program
- Refer member to sober living homes or other resources available for safe and affordable housing
- Assist member in forming new peer relationships with sober supports by referring to self-help/12-step/support groups and/or other social/recreational activities
- Assess for safety concerns, including domestic violence; refer to appropriate agencies for assistance if needed
- Work with Parole/Probation Officer if indicated to connect to appropriate outpatient substance abuse programs
- Refer member to community resources for financial support and transportation and assist member in applying for food stamps or other government benefits as indicated
- Use motivational interviewing techniques to assist member in recognizing the extent of their substance abuse problem and acquiring the motivation to stay sober
- Refer to Cobalt if indicated
- Educate member on addiction and recovery and remind member of past and future consequences of continued substance abuse
- Assess barriers for treatment and work on reducing them
- Educate on coping skills such as diet, exercise and recreational activities
- Ensure that Prior Authorization is completed for maintenance medications; educate member on process
- Connect member to outpatient provider authorized to prescribe maintenance medications
- Ensure maintenance medications are locked up on a safe place away from children
- Ensure member has LFTs (liver function tests) performed if taking maintenance medications
- Educate member on signs of opiate and methadone overdoses (troubled or shallow breathing, extreme tiredness or sleepiness, blurred vision, inability to think, talk or walk normally, feeling faint, dizzy or confused)
- Educate on the importance of avoiding alcohol, sedatives, or tranquilizers in conjunction with opioids or maintenance medications

- Educate on the importance of safe sex practices and avoiding needle sharing
- Ensure member has adequate management of chronic pain by educating on non-opioid analgesics and non-pharmacologic pain treatments such as: cold and heat, TENS, massage, stretching, strength training, orthotics, positioning aids, relaxation techniques, biofeedback, guided imagery, CBT, and other forms of therapy
- Ensure member is getting proper treatment for medical conditions
- Research if member is eligible to be added on to a Prescription Drug Monitoring Program or Pharmacy or Provider Lock-in Program (for Medicaid members only)

MEDICAL BEHAVIORAL INTEGRATION

Many people become addicted to opioids after being prescribed them in order to treat pain and other health problems. Members with chronic pain should be connected to a pain management specialist that can prescribe non-opioid medications and non-pharmacological approaches to managing chronic pain. There are potentially life-threatening infections related to opioid abuse related to IV drug use and needle sharing behaviors including endocarditis, soft-tissue infections, necrotizing fasciitis and wound botulism. TB, Hepatitis, HIV and STDs are more prevalent among members receiving medication assisted treatment. Members receiving methadone assisted treatment also have higher levels of chronic pain and may experience pain more severely than members not on methadone. Methadone may also be used in chronic pain treatment. It should also be noted that medical conditions in members who have been abusing opioid medications often have been neglected or poorly managed. Use of opioids can lead to neonatal abstinence syndrome in infants born to mothers using opioids during pregnancy.¹⁹ A Naltrexone kit can be prescribed for use in case of an overdose to reverse respiratory depression. Signs of an opioid overdose should be discussed with members support system and include: clammy skin, limp body, blue fingernails or lips, vomiting, slow heartbeat, slow breathing, unable to be woken up. Warning signs that may lead up to overdose include drowsiness, mental confusion or slurred speech, shallow breathing, pinpoint pupils, low blood pressure, slow heartbeat and difficulty waking.²⁰

MEMBER EDUCATIONAL RESOURCES

There are currently no Krames educational materials available for this topic.

PHARMACOLOGY

Methadone and buprenorphine are the two main medications that can be used both to assist in detoxification and as maintenance treatment in opioid abuse treatment. Other medications, such as clonidine, are used to help with detoxification. Naltrexone is a long acting opioid antagonist which blocks the pharmacological effects of opioids and may also be used. Methadone and buprenorphine trick the brain into thinking it is getting the opioid without getting them high and is also reduces cravings and prevents withdrawals, allowing the member to focus on lifestyle changes and recovery. Naltrexone blocks the effects of an opiate if it is used and prevents the feeling of getting high. Methadone is usually dispensed daily at a treatment center, but buprenorphine and naltrexone may be prescribed for use at home. Vivitrol is an extended-release injection that can be provided by a physician once a month.²¹

THE FUTURE OF THE OPIOID EPIDEMIC

The U.S. Department of HHS outlined key successes in combating opioid abuse and addiction including PDMPs, development of guidelines, the use of naloxone, and MAT. Each are briefly outlined below:¹

Prescription Drug Monitoring Programs (PDMPs) are state-run electronic databases of prescriptions for controlled substances and are among the most promising clinical tools to curb prescription opioid abuse. PDMPs can provide a prescriber or pharmacist with important information regarding a patient's prescription history, allowing prescribers to identify patients who are potentially abusing medications.

Guidelines that are followed and universally implemented allow integration into electronic health records or clinical decision support platforms to reduce inappropriate prescribing of drugs commonly involved in overdose deaths. Evidence shows a correlation between opioid prescribing rates and overdose death rates in the U.S. From 1999 to 2010, prescribing quadrupled in parallel to increasing opioid overdose death rates. Prescribing guidelines must encourage the use of opioids when benefits outweigh risks and that promote safe use when opioids are needed.

Naloxone is an effective drug to reverse overdose from both prescription opioids and heroin. As an opioid antagonist, naloxone binds to opioid receptors and can reverse the effects of other opioids. Naloxone can quickly restore normal

respiration to a person whose breathing has slowed or stopped as a result of heroin or prescription opioid overdose. Education efforts and the development of naloxone distribution programs have provided instructions on its use to opioid users, their friends and loved ones, and other potential bystanders. The Morbidity and Mortality Weekly Report reported that as of 2010, programs that distribute naloxone to nonmedical personnel had reported more than 10,000 overdose reversals nationwide since 1996. Given the effectiveness of naloxone in overdose reversal, the Food and Drug Administration (FDA) has encouraged innovations in more user-friendly naloxone delivery systems such as auto-injectors, made particularly for lay use outside of health care settings. FDA approved such an auto-injector in 2014.

Medication-assisted Treatment (MAT) is the use of medications (e.g., buprenorphine, methadone, extended-release injectable naltrexone), with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders, including opioid use disorders. MAT is a safe and effective strategy for decreasing the frequency and quantity of opioid use and reducing the risk of overdose and death. Studies show that the most effective treatments for opioid use disorders are those that include a set of comprehensive medical, social, psychological and rehabilitation services that address all the needs of the individual. The most prevalent forms of MAT (buprenorphine and methadone) are similar in terms of effectiveness. While evidence supports MAT, it is highly underutilized – estimates show that only 1 million of the 2.5 million Americans who might benefit from receiving it are using MAT.

Related WellCare Guidelines

In addition to the information contained in this document, please reference the following CPGs: *Behavioral Health Conditions and Substance Use in High Risk Pregnancy (HS-1040)*; *Pain Management (HS-1064)*; and *Substance Use Disorders (HS-1031)*. Information related to prevention can be found in the following age-specific Preventive Health CPGs: *Adolescent (HS-1051)*; *Adult (HS-1018)*; and *Older Adult (HS: 1063)*.

NOTE: Clinical Policies can be accessed by going to www.wellcare.com – select the Provider tab, then “Tools” and “Clinical Guidelines”.

References

- Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths -- Washington, DC: U.S. Department of Health and Human Services. Office of the Assistant Secretary for Planning and Evaluation (ASPE), 2015 / 12 p. Includes sources (*Document*) MH16D13178 <https://aspe.hhs.gov/sites/default/files/2016/02/OpioidInitiative.pdf>. Accessed June 7, 2017.
- ASAM Releases National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine Web site. <https://www.asam.org/magazine/read/article/2015/06/02/asam-releases-national-practice-guideline-for-the-use-of-medications-in-the-treatment-of-addiction-involving-opioid-use>. Published June 2, 2015. Accessed June 7, 2017.
- Opioids. Substance Abuse and Mental Health Services Administration (SAMHSA) Web site. <https://www.samhsa.gov/atod/opioids>. Published February 23, 2016. Accessed June 7, 2017.
- Outpatient Opioid Maintenance Therapy. MCG Health Behavioral Health Care 21st Edition. Published February 2017. Accessed June 7, 2017. Subscription only.
- ASAM Releases National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine Web site. <https://www.asam.org/magazine/read/article/2015/06/02/asam-releases-national-practice-guideline-for-the-use-of-medications-in-the-treatment-of-addiction-involving-opioid-use>. Published June 2, 2015. Accessed June 7, 2017.
- National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use. American Society of Addiction Medicine Web site. <https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf>. Published June 2015. Accessed June 7, 2017.
- Pharmacological Therapies for Opioid Use Disorders. American Society of Addiction Medicine Web site. <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2013/04/25/pharmacological-therapies-for-opioid-use-disorders>. Published April 2013. Accessed June 7, 2017.
- Measures to Counteract Prescription Drug Diversion, Misuse and Addiction. American Society of Addiction Medicine Web site. <https://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2012/01/26/measures-to-counteract-prescription-drug-diversion-misuse-and-addiction>. Published January 2012. Accessed June 7, 2017.
- Opioid Abuse, Dependence and Addiction in Pregnancy: A Joint Opinion of the American College of Obstetricians and Gynecologists' Committee on Health Care for Underserved Women and the American Society of Addiction Medicine. American Society of Addiction Medicine Web site. [Joint Statement on Opioid Abuse, Dependence and Addiction in Pregnancy](http://www.asam.org/advocacy/find-a-policy-statement/view-policy-statement/public-policy-statements/2012/01/26/measures-to-counteract-prescription-drug-diversion-misuse-and-addiction). Published May 2012. Accessed June 7, 2017.
- SAMHSA releases revised Federal Guidelines for Opioid Treatment Programs. Substance Abuse and Mental Health Services Administration (SAMHSA) Web site. <https://www.samhsa.gov/newsroom/press-announcements/201503270300>. Published March 27, 2015. Accessed June 7, 2017.
- Federal Guidelines for Opioid Treatment Programs. Substance Abuse and Mental Health Services Administration (SAMHSA) Web site. <http://store.samhsa.gov/shin/content/PEP15-FEDGUIDEOTP/PEP15-FEDGUIDEOTP.pdf>. Published January 2015. Accessed June 7, 2017.
- 42 CFR 8.12 - Federal opioid treatment standards. Cornell Law School Legal Information Institute Web site. <https://www.law.cornell.edu/cfr/text/42/8.12>. Published June 18, 2015. Accessed June 7, 2017.
- AMA Opioid Task Force. American Medical Association Web site. <https://www.ama-assn.org/delivering-care/ama-opioid-task-force>. Accessed June 7, 2017.
- Reducing Opioid Abuse and Misuse. American Medical Association Web site. <https://www.ama-assn.org/delivering-care/reducing-opioid-abuse-and-misuse>. Accessed June 7, 2017.
- CDC Guideline for Prescribing Opioids for Chronic Pain. Centers for Disease Control and Prevention Web site. <https://www.cdc.gov/drugoverdose/prescribing/guideline.html>. Published March 2017. Accessed June 7, 2017.
- Guideline Information for Providers. Centers for Disease Control and Prevention Web site. <https://www.cdc.gov/drugoverdose/prescribing/providers.html>. Published February 2017. Accessed June 7, 2017.
- Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings. Agency for Healthcare Research and Quality Web site. <https://www.effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productid=2350>. Published December 6, 2016. Accessed June 7, 2017.
- The Effectiveness and Risks of Long-Term Opioid Treatment of Chronic Pain. Content last reviewed October 2014. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/findings/evidence-based-reports/opioidsto.html>. Accessed June 7, 2017.
- Center for Substance Abuse Treatment. Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005. (Treatment Improvement Protocol (TIP) Series, No. 43). Chapter 10. Associated Medical Problems in Patients Who Are Opioid Addicted.

Available from: <https://www.ncbi.nlm.nih.gov/books/NBK64167/>. Accessed June 27, 2017.

20. Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 13-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. https://store.samhsa.gov/shin/content/SMA13-4742/Overdose_Toolkit_2014_Jan.pdf. Accessed June 29, 2017.
21. Stotts, Angela L., Carrie L. Dodrill, and Thomas R. Kosten. "Opioid Dependence Treatment: Options In Pharmacotherapy." *Expert opinion on pharmacotherapy* 10.11 (2009): 1727-1740. *PMC*. Web. 27 June 2017.
22. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

Disclaimer

Clinical Practice Guidelines (CPGs) made available by WellCare are informational in nature and are not a substitute for the professional medical judgment of treating physicians or other health care practitioners. CPGs are based on information available at the time and may not be updated with the most current information available at subsequent times. Individuals should consult with their physician(s) regarding the appropriateness of care or treatment options to meet their specific needs or medical condition. Disclosure of a CPG is not a guarantee of coverage and is not intended to be used for Utilization Management Decisions or for claims. Members of WellCare Health Plans should consult their individual coverage documents for information regarding covered benefits. WellCare does not offer medical advice or provide medical care, and therefore cannot guarantee any results or outcomes. WellCare does not warrant or guarantee, and shall not be liable for any deficiencies in the information contained herein or for any inaccuracies or recommendations made by independent third parties from whom any of the information contained herein was obtained. Links are current at time of approval by the Medical Policy Committee (MPC) and are subject to change. Lines of business are also subject to change without notice and are noted on www.wellcare.com. Guidelines are also available on the site by selecting the Provider tab, then "Tools" and "Clinical Guidelines".

*Easy Choice Health Plan ~ Harmony Health Plan of Illinois ~ Missouri Care ~ Ohana Health Plan, a plan offered by WellCare Health Insurance of Arizona
OneCare (Care1st Health Plan Arizona, Inc.) ~ Staywell of Florida ~ WellCare Prescription Insurance ~ WellCare Texan Plus (Medicare – Dallas and Houston markets)
WellCare (Arizona, Arkansas, Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Mississippi, Nebraska, New Jersey, New York, South Carolina, Tennessee, Texas)*

Medical Policy Committee Approval History

Date	History and Revisions by the Medical Policy Committee
4/5/2018	<ul style="list-style-type: none"> • Approved by MPC. Included additional information re: Medication Assisted Therapy (MAT).
7/24/2017	<ul style="list-style-type: none"> • Approved by MPC. Enhanced Care Management and Measures of Compliance sections. Revised with CM, DM, QI, UM, BH and the Chief Medical Directors.