ASAM The Voice of Addiction Medicine
American Society of Addiction Medicine

OPIOID ADDICTION DISEASE: STABILIZING MEDICATION ACCESS

Stabilizing medication for patients living with chronic opioid addiction disease is uniquely controlled, with insurance limitations not supported by medical knowledge[i]

- The U.S. Food and Drug Administration (FDA) has approved three stabilizing medications to treat patients living with chronic opioid addiction disease: buprenorphine, methadone, and naltrexone
- Medicaid covers some of these FDA-approved stabilizing medications, but severe restrictions create *de facto* denial of access[ii]
- 11 states impose preset "lifetime" medication limits on buprenorphine[iii]
- Private insurance plans often cover stabilizing medications, then require complicated prior authorization and/or restrict amounts of medication authorized[iv]

Stabilizing medications are cost effective

- Costs are comparable to stabilizing medications used for diabetes[v]
- Cost per year for opioid addiction disease-related infectious diseases are two to four times greater than the cost of the stabilizing medication methadone[vi]
- Two-year buprenorphine or methadone stabilizing medication costs 50% less than residential treatment programs[vii]

Private insurance challenges:

- Private insurers restrict stabilizing medications for opioid addiction disease[viii]:
  - Amount of medication authorized
  - Length of coverage time
  - Payment for medication administration
  - Location of medication administration
  - Availability of medications during treatment phases
- "Prior authorization" requirements[ix]
  - Criteria and verification processes vague
  - Approval uncertain
  - Denials common

Public insurance challenges:

- Multiple states require "fail first" outpatient treatments before paying for stabilizing medications[x]
- A shortage of Medicaid-eligible physicians or providers who can prescribe stabilizing medications[xi]
- Rigorous prior-authorization requirements for continued use of medications[xii]
- Predetermined maximum daily dosages[xiii]
- "Lifetime" limits on stabilizing medication amounts and treatment periods [xiv]

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[i] Stabilizing medications for patients living with chronic opioid addiction disease are uniquely controlled, with insurance limitations not supported by medical knowledge, according to Treatment Research Institute findings (*FDA approved medications for the treatment of opiate dependence: Literature reviews on effectiveness & cost effectiveness;* Chalk, M. et al., 2013).

[ii] Medicaid covers some FDA-approved stabilizing medications, but severe restrictions create *de facto* denial of access, according to The Avisa Group's work (*Availability without accessibility? State Medicaid coverage and authorization requirements for opioid dependence medications;* Rinaldo, S. & Rinaldo, D., 2013).

[iii] 11 states impose preset "lifetime" medication limits on buprenorphine, according to The Avisa Group (*Availability without accessibility? State Medicaid coverage and authorization requirements for opioid dependence medications;* Rinaldo, S. & Rinaldo, D., 2013).

[iv] Private insurance plans often cover stabilizing medications, then require complicated prior authorization and/or restrict amounts of medication authorized, according to research conducted by Treatment Research Institute (*Report of commercial health plan medication coverage and benefits survey;* Chalk, M. et al., 2013).

[v] Costs for stabilizing medications for opioid addiction disease are comparable to those used for diabetes, according to Treatment Research Institute findings (*FDA approved medications for the treatment of opiate dependence: Literature reviews on effectiveness & cost effectiveness;* Chalk, M. et al., 2013).

[vi] Cost per year for opioid addiction disease-related infectious diseases are two to four times greater than the cost of the stabilizing medication methadone, according to Treatment Research Institute (*FDA approved medications for the treatment of opiate dependence: Literature reviews on effectiveness & cost effectiveness;* Chalk, M. et al., 2013).

[vii] An Australian treatment outcome study shows that two-year buprenorphine or methadone maintenance costs (in Australian dollars) $5,000, compared to $11,000 for residential rehabilitation. (*Health services use and treatment costs over 12 months among heroin users: Findings from the Australian Treatment Outcome Study (ATOS);* Ross et al., 2003; Shanahan et al., 2003)

[viii] Private insurers restrict access to stabilizing medications to treat opioid addiction disease by limiting medication or formulation coverage and imposing strict prior authorization and/or step therapy requirements (*Report of commercial health plan medication coverage and benefits survey;* Chalk, M. et al., 2013).

[ix] *Report of commercial health plan medication coverage and benefits survey;* Chalk, M. et al., 2013.

[x] Multiple states require "fail first" outpatient treatments before paying for stabilizing medications, creating a high-risk environment for fragile patients. This can result in fatalities and overdoses, according to Treatment Research Institute findings (*Report of commercial health plan medication coverage and benefits survey;* Chalk, M. et al., 2013).

[xi] A shortage of Medicaid-eligible physicians or organizational providers who prescribe addiction medications has developed — one state has only one Medicaid-eligible methadone clinic. This can be especially harmful when low-income opioid addiction patients are unable to find/ access Medicaid-eligible providers in their area, according to The Avisa Group (*Availability without accessibility? State Medicaid coverage and authorization requirements for opioid dependence medications;* Rinaldo, S. & Rinaldo, D., 2013).

[xii] Rigorous prior-authorization requirements for continued use of medications, sometimes within as little as six months. Prior authorization requirements can also change substantially over time, without notice, and severely restrict or deny access to medication, according to research conducted by The Avisa Group (Availability without accessibility? State Medicaid coverage and authorization requirements for opioid dependence medications; Rinaldo, S. & Rinaldo, D., 2013).

[xiii] *Availability without accessibility? State Medicaid coverage and authorization requirements for opioid dependence medications;* Rinaldo, S. & Rinaldo, D., 2013.

[xiv] *Availability without accessibility? State Medicaid coverage and authorization requirements for opioid dependence medications;* Rinaldo, S. & Rinaldo, D., 2013.