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2019

Clinical Review

Key Updates, Studies and Legislation

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Evaluating Combination Medications

Originally published March 13, 2019

Learn what combination medications are, how they impact workers' compensation claims and what major combination medications your program should evaluate.

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Evaluating Combination Medications

Pricing for prescription drugs is a topic of much discussion. Combination drugs are often under scrutiny as a common practice for manufacturers to create new brand medications.

While these combination drugs are effective, they may be more expensive and no more effective than their separate generic components that typically come at a significantly lower Average Wholesale Price (AWP). AWP is the average value of a drug when sold to customers such as physicians and pharmacies, and is typically used to calculate the cost of a particular drug.


However, prescribing in workers' compensation is multifaceted. It is important to understand why physicians and patients might want the combination brand and how it can impact the overall claim cost, and then identify some commonly used combination medications you may want to evaluate in your clinical program.

What are combination medications?

Combination drug therapy is the use of two or more fixed-dose medications in a single-dose formulation (e.g. tablet or capsule). It can also be the use of two separate drugs to treat a condition (e.g. two different types of medications for blood pressure).

Combination drugs differ from compound medications. Compound medications are personalized for each patient, in which a pharmacist or company uses one or more ingredients to make a different product. Most compound medications are creams, lotions or solutions, whereas combination drugs are typically tablets or capsules and are not personalized for a patient. To learn more about compounded drugs, [click here](#).

The prescribing of combination medications goes beyond mere cost; some patients may have a medical necessity for taking one pill over several. Prescribing behaviors are complex and each patient has unique needs. However, it is important to evaluate whether these medications are medically necessary for all claims and if there are alternatives that can provide the same drug therapy.



Famotidine and ibuprofen cost **under \$100 total** for a 30-day supply, while their brand name Duexis® AWP is **\$2,978.64 per month**.

Are combination medications better than their generic alternatives?

The idea of taking one medication instead of two (or perhaps several) is certainly compelling. Reducing the number of pills a patient has to take may increase likelihood that the person will take all needed medications, especially if taking multiple pills is difficult for that person. However, in terms of efficacy, combination medications typically offer no advantage over their generic ingredients. For instance, taking one Duexis® (famotidine 26.6mg and ibuprofen 800mg) brand tablet is therapeutically equivalent to taking each medication separately, one famotidine 20mg tablet and one ibuprofen 800mg tablet.

Why do combination medications create an issue in workers' compensation?

As with many concerns in the workers' compensation industry, stakeholders have to consider why costs are significantly higher than expected and if these high costs are justifiable. When a combination medication is created, the price for the drug can inflate dramatically. Considering that the efficacy of this combination drug is often no different from its generic alternatives, this price often reflects the convenience of taking just one medication instead of several. For instance, famotidine and ibuprofen together cost under \$100 for a 30-day supply while their brand name Duexis® AWP is \$2,978.64 per month.

When building out your clinical program, how can you recognize where these combination drugs might be impacting your business? The first step is to identify the most commonly used combination drugs and their generic alternatives. Let's look at which affect the workers' compensation industry most often.

Duexis® (famotidine and ibuprofen)

Duexis is a combination of ibuprofen (800 mg) and famotidine (26.6 mg), available in a tablet. Both famotidine and ibuprofen have been available in generic form for years; they are available as over-the-counter medications and are relatively inexpensive. Famotidine is taken with ibuprofen to lessen stomach upset, since famotidine is an H2 receptor blocker and reduces stomach acid.

As stated earlier, Duexis® can cost nearly \$3,000 for a one-month supply, while the same dosage of ibuprofen and famotidine together cost less than \$100. With this stark difference in pricing, why might some prescribers opt for Duexis® over its generic counterparts?

Why might some prescribers opt for an expensive combination medication over its generic ingredients?

Part of this may have to do with lack of awareness of available generics as well as consumer perception of generic drugs. Although the FDA requires that a generic drug be bioequivalent to its brand name counterpart, stigma still exists about the efficacy of generics. [A 2015 review published on the US National Library of Medicine](#), National Institution of Health found that, of the population in the studies reviewed, “laypeople were significantly more likely to view generics as less effective than branded medications compared to doctors and pharmacists.” Additionally, the study concluded, “These results suggest that there are a significant number of laypeople, doctors and pharmacists with concerns about the efficacy, safety and quality of generic medicines.”

This perception may be perpetuated by messaging around the combination drug. For instance, Duexis® packaging includes wording from the FDA: “Do not substitute Duexis® with the single-ingredient products of ibuprofen and famotidine.” This sentence does not explain why the two generics should not be substituted, but a look at the FDA trials conducted by the manufacturing company may provide some insight. [In the study](#) to show the efficacy of Duexis® in preventing NSAID-related ulcers, researchers compared Duexis® to ibuprofen 800mg alone. Famotidine, which is that needed stomach protectant, was not included.

Whether or not the prescribing of a combination drug is related to one of these reasons, it is important to recognize which combination medications are most often seen in workers’ compensation.

Consumer perception and a lack of understanding about combination medications may lead prescribers to opt for an expensive combination medication over its generic alternatives.



Combination Medications that Impact Workers' Compensation

Vimovo®

- AWP = \$2,978.64
- Generic alternatives esomeprazole and naproxen cost in total around \$53

Treximet®

- AWP = \$1,160.68 for 9 tablets, which equates to \$129 per tablet
- This combination drug is now available in generic form for approximately \$844.80 (9 tablets; \$94 per tablet)
- When purchased separately, sumatriptan and naproxen cost about \$236.13 in total

Reprexain®/Ibudone®/Vicoprofen

All three of these medications contain the same ingredients: hydrocodone and ibuprofen

- Reprexain® AWP = \$536.48 for 120 tablets
- Ibudone® AWP = \$157.90 for 120 tablets
- Vicoprofen® AWP = \$535.60 for 120 tablets
- Generic ingredients AWP = \$91.76 for 120 tablets

Nuedexta®

Nuedexta® has one FDA indication only. It is approved for PseudoBulbar Affect (PBA), a medical condition that causes involuntary, sudden and frequent episodes of crying and/or laughing in people living with certain neurologic conditions or brain injury. In the Workers' Compensation industry, we have seen this drug prescribed off-label.

- AWP = \$1,317.60
- Generic ingredients dextromethorphan and quinidine = \$13.89 total

Yosprala®

Yosprala® is indicated for patients who require aspirin for secondary prevention of cardiovascular and cerebrovascular events and who are at risk of developing aspirin associated gastric ulcers.

- AWP = \$197.82
- Generic ingredients aspirin and omeprazole cost \$20.31 total

How Naloxone Can Help Fight the Opioid Crisis

Originally published July 2, 2019

FDA Approved the First Generic Opioid-Antagonist
Naloxone Nasal Spray in 2019

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How Naloxone Can Help Fight the Opioid Crisis

As the U.S. looks for ways to stem the opioid crisis, one major strategy that has emerged is the use of naloxone to counteract opioid overdoses. [The FDA's recent approval of a generic version of Narcan®](#), which is the first generic formulation for naloxone nasal spray, provides another avenue to reverse the impact of the opioid crisis.

[According to the CDC](#), almost 400,000 people died from an opioid overdose between 1999 and 2017. [On average](#), more than 130 Americans die from an overdose every day, both from prescription (e.g., oxycodone, fentanyl, morphine, hydrocodone) and illicit (heroin, synthetic fentanyl) opioids. An opioid overdose leads to breathing difficulties, whereby breathing becomes shallow or even stops completely, and may lead to death if there is no immediate medical intervention. If a person administers naloxone immediately, the drug can counteract opioid overdose effects, usually within minutes.

Insights into Naloxone

In the United States, naloxone is available without a prescription in [every state except Hawaii](#). Generic injectable formulations of naloxone have been available for many years, typically used in healthcare settings. The generic Narcan® is the first generic naloxone nasal spray approved for use in the community, by individuals lacking medical training.

In April 2017, the U.S. Department of Health and Human Services announced its [5-Point Strategy](#) to combat the opioid crisis. Included in its strategy is better targeting of overdose-reversing drugs. In April 2018, Surgeon General Jerome M. Adams [issued an advisory](#) encouraging more individuals, including family, friends and those at risk of an opioid overdose, to carry naloxone at all times.

FDA Approval of Narcan®

[In a statement released by the FDA in April 2019](#), after approval of generic Narcan® by the FDA, Douglas Throckmorton, M.D. said, "In the wake of the opioid crisis, a number of efforts are underway to make this emergency overdose reversal treatment more readily available and more accessible. In addition to this approval of the first generic naloxone nasal spray, moving forward we will prioritize our review of generic drug applications for naloxone." Throckmorton is the deputy center director for regulatory programs in the FDA's Center for Drug Evaluation and Research.

The cost of generic injectable naloxone vials is very low. However, the price of two auto-injectors (brand name Evzio®) in the U.S. has [increased from \\$575 in 2014 to \\$4,100 in 2019](#). The cost of Narcan® Nasal Spray (two-pack) is approximately \$125. The price for generic naloxone nasal spray (two-pack) is anticipated to be approximately \$40.

Future of the Opioid Crisis

The FDA has determined that further expanding availability and access to overdose-reversing drugs could help address the public health emergency. Approval of generic naloxone nasal spray is one way the FDA is working to increase access to life-saving treatments.

For the workers' compensation industry, opioids continue to pose a challenge to stakeholders and injured workers. This approval of generic Narcan® and the availability of other naloxone generics provide hope for saving lives as we continue to battle this epidemic.

Opioids in 2019: New Regulations and Studies

Originally published July 3, 2019

Many new developments arose in 2019 related to the opioid epidemic

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Opioids in 2019: Insights into New Regulations and Studies of the Epidemic

Momentum in battling the opioid crisis continues. As more states enact opioid prescribing limits, the federal government proposes new legislation, while new studies look at the impact of opioid laws and medical marijuana on lessening opioid abuse.

Let's take a look at a few recent trends.

Opioid Tapering

The Food and Drug Administration (FDA) recently announced [changes to opioid analgesic labeling](#) for tapering physically dependent patients. The requirement change aims to provide "better information for how to properly taper patients who are physically dependent on opioids."

In the press release from the FDA, the department highlights that current labeling, in conjunction with CDC guidelines for prescribing opioids, explain the "need to gradually reduce the dosage of an opioid medication over time, while monitoring carefully for signs of withdrawal."

However, the FDA acknowledges that this approach to tapering is not always used in practice. In their effort to improve the outcomes of tapering, the FDA is requiring changes to prescribing information for all outpatient opioid analgesic medications.

The FDA also issued a [Drug Safety Communication](#) for providers and patients that discusses how to safely taper off opioids, including details on withdrawal symptoms for patients, instructions for health care professionals and other resources.

Bystanders were present for more than 40% of opioid-related overdose deaths between 2016 and 2017 in the U.S., yet **"naloxone was rarely administered by a layperson."**¹

¹ <https://www.cdc.gov/mmwr/volumes/67/wr/mm6734a2.htm>



Opioid Antagonist Prescriptions

[According to the Centers of Disease Control and Prevention](#) (CDC), of the opioid-related overdose deaths in the United States between 2016 and 2017, bystanders were present for more than 40 percent. However, “naloxone was rarely administered by a layperson.”

In a push to increase the availability and use of potentially life-saving opioid antagonists, many states are considering [co-prescribing of antagonist prescriptions](#). Several states proposed bills in 2019 to require co-prescribing.

Arizona, California, Ohio, Rhode Island, Vermont, Virginia and Washington now require physicians to offer antagonist prescriptions when prescribing opioids to patients considered at high risk of overdosing. Federally, the FDA is considering whether to require co-prescribing nationally, which would create an additional 48 million antagonist doses.

Although antagonist prescriptions are becoming more common, these medications still face inflated prices like many other medications on the market. [Senate investigation found](#) that, between 2014 and 2017, the company of a branded version of an opioid antagonist had raised the price for two injectors 600 percent to \$4,100. In 2019, a generic of Narcan nasal spray was released, with pricing around \$40.

Medical Marijuana and Opioids

Medical marijuana is increasingly being viewed as a potential alternative to opioids for patients experiencing pain. During the 2019 legislative sessions, several states considered legalizing medical marijuana for the first time, expanding their medical marijuana programs or legalizing recreational marijuana. However, despite the push to legalize the drug, there remains little clinical research on the purported benefits or side effects of medical marijuana, especially in the treatment of pain.

[A recent study](#) measured the self-reported use of marijuana during recovery from musculoskeletal injuries, including painful disorders of muscles, tendons and nerves. This study found that the amount of opioid use was the highest among patients using marijuana during their recovery. Similar results were found for the duration of opioid prescriptions:

- Patients who did not use marijuana during their recovery used opioids for around 15 days.
- Patients who used marijuana during their recovery averaged 90 days for opioid use.

[Another study](#) looked at the rate of opioid overdoses in states with legalized marijuana, with opioid data through 2017. The researchers found that states with legal medical marijuana actually had higher rates of opioid overdose deaths, contradicting [a study from 2014](#) that found opioid-related overdose deaths decreased in states with legalized medical marijuana. At the time of the 2014 study, thirteen states had legalized medical marijuana, whereas nearly 30 states had legalized the drug by 2017. The findings from the 2017 study call into question the belief that marijuana can help stem the opioid crisis.

The results of these studies underscore the importance of more clinical research into the potential benefits and side effects of marijuana, especially as more states look to the drug to help in the opioid crisis.

States See Success: A Look at California

[A recent study from the California Workers' Compensation Institute](#) (CWCI) found that non-steroidal anti-inflammatories (NSAIDs) superseded opioids as the most common therapeutic drug group prescribed to injured workers in the state. In the first half of 2018, the state saw opioids decrease to 18 percent of the total prescriptions filled, down from 30.5 percent a decade before.

CWCI attributes much of this success to the efforts of utilization review, independent medical review, restrictions on payers, medical provider networks, pharmacy benefit managers and the Medical Treatment Utilization Schedule (MTUS) formulary.

States Push Back Against Opioid Limit Laws

Despite many states moving forward with opioid prescribing limit laws and other opioid-related regulations, a few states have looked at legislation pushing back against these limits. [New York's AB 102](#) would amend every insurance policy in the state to require the coverage of opioids, which would not require prior authorization. Additionally, the carrier would not be able to charge a different rate for any medications in the opioid class. New York has other bills running that continue on the path of limiting opioid prescribing, including a bill to limit prescribing for acute pain to a 3-day supply.

[Maine also had SP 165](#) running, which would change opioid limits from a 30-day supply to a 6-month supply if the patient is over 63 or if the patient has been prescribed medication for chronic pain continually for at least five years. This bill did not pass the state legislature.

Conclusion

States are taking several courses of action to help battle the opioid epidemic. Although most states are looking at prescribing limit laws, antagonist co-prescribing and other opioid-related regulations, some are pushing back against the limits that have already been put in place. Studies continue to emerge on the effectiveness of opioid prescribing limits, formularies and the potential for marijuana to be used as a substitute for opioids in the management of pain. The efforts of those in the workers' compensation industry as well as state and federal legislatures to curb opioid abuse and deaths, while still providing the best patient care, has been tireless. Hopefully we will continue to see more positive outcomes in the near future.

Opioids decreased to 18% of total prescriptions filled in California in the first half of 2018, down from 30.5% a decade before.¹

¹ https://www.cwci.org/press_release.html?id=690

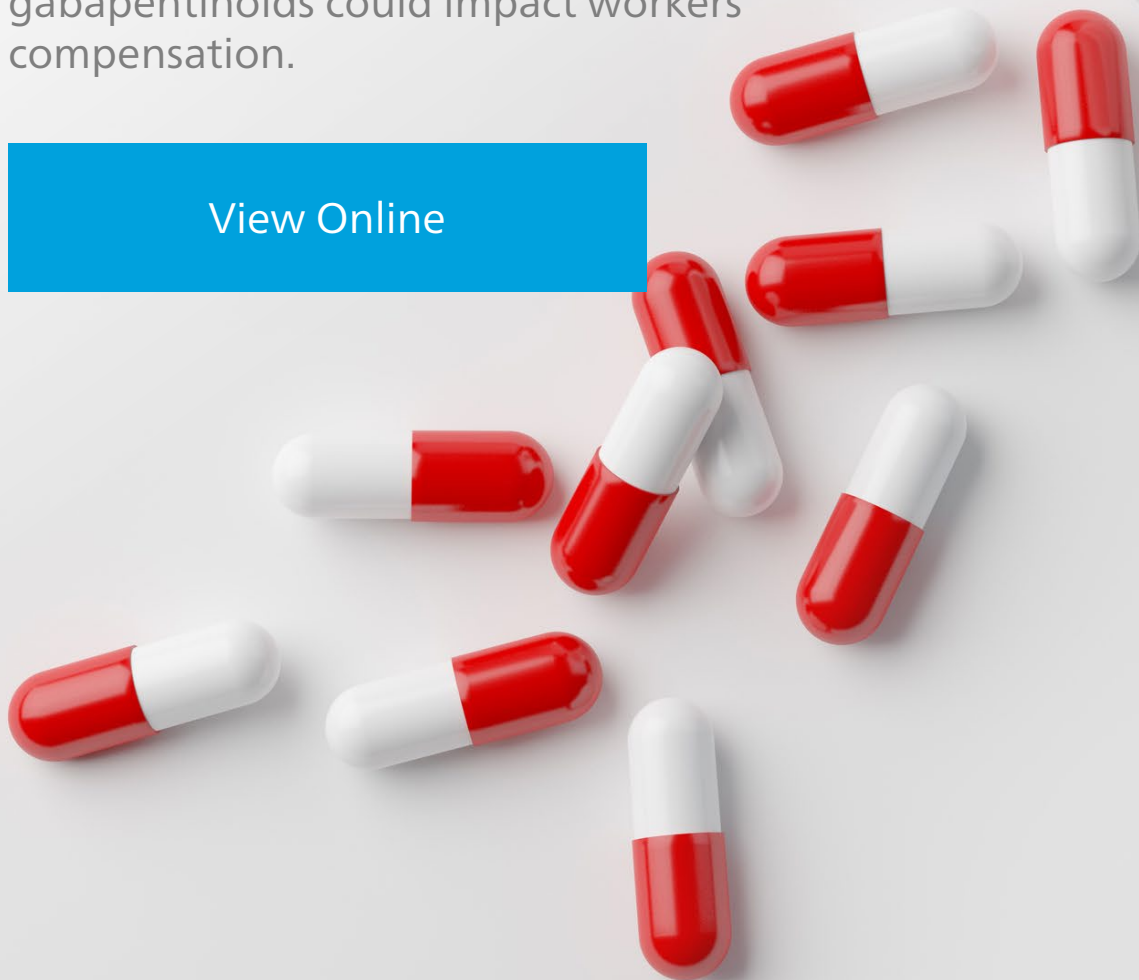


Gabapentinoids in Workers' Compensation

Originally published October 14, 2019

Learn how the rise in prescriptions of gabapentinoids could impact workers' compensation.

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Gabapentinoids in Workers' Compensation

Nearly [20 percent of U.S. adults suffer from chronic pain](#). This is especially vital in the workers' compensation world that is now asking, 'are gabapentinoids the answer to that pain?'

Current increases in prescribing of gabapentinoids and the drugs' less addictive qualities as compared to opioids may initially suggest so. However, recent research and legislative changes at the state level suggest that, in the push to find alternatives to opioids, we may not be finding the right answer in gabapentinoids.

Several questions arise as we move forward in trying to find alternative ways to manage pain. Are gabapentinoids effective at treating pain? Are they a viable alternative? Are they the answer to the opioid crisis?

Let's take a closer look at these medications and their use in workers' compensation, including considerations we should make as we help get injured workers back to health.

Background on Gabapentinoids

Gabapentinoids are a sub-class of anticonvulsant medications, which includes gabapentin (brand name Neurontin) and pregabalin (brand name Lyrica). Both have been available on the market for more than a decade, with gabapentin earning FDA approval in 1993 and pregabalin approved in 2004. This class of drugs is approved for treatment of epilepsy, postherpetic neuralgia, neuropathic pain and fibromyalgia, among other conditions. (View Lyrica's indications and usage [here](#). View Neurontin's indications and usage [here](#).)

According to NCCI, Lyrica was the [number one drug, in terms of cost](#), prescribed in the workers' compensation industry in 2016. In July 2019, the first generic version of pregabalin [became available](#), which may help reduce some of the cost associated with the brand name version.

With gabapentinoids' ability to treat neuropathic pain, some have considered the drug class an optional alternative for opioids. However, the use of gabapentinoids for off-label pain treatment is becoming increasingly common. In fact, [the FDA commissioner said](#) in a speech in 2018 that, "Some literature suggests that clinicians may be prescribing these drugs off-label to patients with various types of pain, as alternatives to opioids, outside the approved indications for gabapentinoids." [Some studies](#) have found that up to 95 percent of gabapentin is prescribed today for off-label indications.

Prescribing of gabapentinoids has also risen in recent years, by [64% from 2012 to 2016](#). Opioid prescribing, meanwhile, has [decreased since its peak in 2012](#).

The CDC, in its [opioid prescribing guidelines study](#), states, "Several guidelines agree that first- and second-line drugs for neuropathic pain include anticonvulsants (gabapentin or pregabalin)...." The guidelines do not suggest uses outside of the FDA's indicated uses, but do suggest that gabapentinoids are a good option to try to treat neuropathic pain before opioids are attempted.

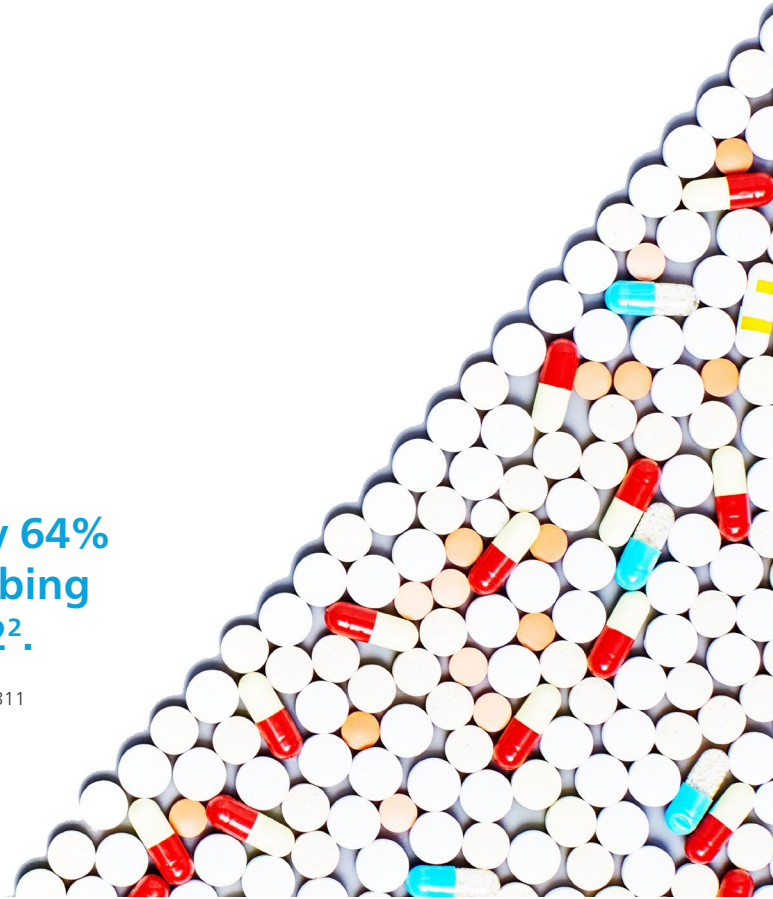
As we better understand the increase in prescribing of gabapentinoids, especially for off-label use, what should we consider for the workers' compensation industry?



↑ 64%

Prescribing of gabapentinoids **rose by 64%** from 2012 to 2016¹, while the **prescribing of opioids has decreased since 2012**².

1 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6153543/#bibr4-1178221818801311>
2 <https://www.cdc.gov/drugoverdose/maps/rxrate-maps.html>



Gabapentinoids' Use in Workers' Compensation

In workers' compensation, gabapentinoids are most often used for the treatment of neuropathic pain associated with spinal cord injury or other areas of the body where nerves may have been damaged by an injury and cause substantial pain for the injured worker.

The trend in decreased opioid prescribing and increased gabapentin and pregabalin prescribing is similar in workers' compensation. In 2018, anticonvulsants became the third most prescribed therapeutic classification of medications in the California workers' compensation space, based on a [study by CWCI](#). Nationally, Lyrica (pregabalin) and gabapentin were the #1 and #3 drugs, respectively, [by spend](#), in 2016, making up 7.2% and 3.8% of the total drug spend in the workers' compensation arena.

Does this increase in prescribing mean that gabapentinoids are a good alternative for treating pain? Not necessarily.

Risks of Gabapentinoids

As the rate of gabapentinoid prescribing increases, it is important to consider the risks associated with the drugs. Several studies have found that gabapentinoid abuse is rising, especially in conjunction with opioid abuse.

[In a 2017 review of 59 studies](#), researchers from the University of Texas et al. found that “gabapentinoids possess potential for abuse, particularly in individuals with a history of opioid abuse, and reports of such abuse are increasingly being documented.” In fact, [a 2017 study](#) from Midwestern University found that “gabapentin use patterns are similar to those of other abusable medications.”

The use of gabapentinoids in conjunction with opioids is of particular concern, since the overuse of gabapentin along with opioids has been shown to [increase the risk of respiratory depression by four times](#). [A study from Canada](#) found that “moderate-dose and high-dose gabapentin use was associated with a nearly 60% increase in the odds of opioid-related death relative to no concomitant gabapentin use.”

Regulations on Gabapentinoids: A New Trend?

As more becomes known about gabapentinoids, their side effects and their potential for abuse, the federal government and a few states have taken action to control the spread of gabapentinoid abuse.

Gabapentin and pregabalin are both non-exempt on the [California MTUS drug formulary](#), and require prior authorization for specific body parts. Gabapentin’s use is limited to a 4 days’ supply. ODG, on the other hand, categorizes gabapentin and pregabalin as ‘Y’ drugs, which means they are a part of the [ODG formulary](#).

In 2005, the DEA reclassified [pregabalin](#) (Lyrica) as a Schedule V controlled substance. As such, the drug is considered to:

- Have a low potential for abuse relative to drugs in Schedule IV.
- Have a currently accepted medical use.
- Abuse of the drug may lead to limited physical dependence or psychological dependence relative to the drugs in Schedule IV.

For reference, most opioids, including oxycodone and hydrocodone, are listed as [Schedule II drugs](#). [Gabapentin has not been scheduled as a controlled substance by the federal government](#). Five states, however, list gabapentin as a controlled substance, including [Kentucky](#), [Michigan](#), [Tennessee](#), [Virginia](#) and [West Virginia](#).

Interestingly, in July 2019, [North Dakota](#) published and implemented dose limits for pregabalin (Lyrica) for all existing and new prescriptions. The new limits took effect August 15, 2019. The limits for Lyrica are three capsules per day for the 25, 50, 75, and 100 mg strengths, two capsules per day for the 150, 200, 225, and 300 mg strengths, and one capsule per day for the 82.5, 165, and 330mg controlled release strengths per day.

The dosage limits in North Dakota translate to a maximum daily dose of 600 mg (two capsules of the 300mg strength). [Six hundred milligrams per day](#) is also the maximum dose recommended by Pfizer for Lyrica.

Whether this becomes a trend as more states begin to examine the potential downsides to gabapentinoids remains to be seen. As we continue to fight the opioid crisis, we must be vigilant in studying alternatives and their role in pain management and helping injured workers return to health.

Nationally, Lyrica (pregabalin) and gabapentin were the **#1 and #3 drugs, respectively, by spend**, in 2016¹.

1 https://www.ncci.com/Articles/Documents/Insights_ResearchBrief_WC_Prescription_Drugs-2018.pdf

Pondering Pot: Recent Updates and Research that Underline the Need for More Insights

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Pondering Pot: Recent Updates and Research that Underline the Need for More Insights

The U.S. Surgeon General's [recent advisory](#) on marijuana use during adolescence and pregnancy highlights a critical perspective in the push to legalize marijuana: we still do not yet know enough about the drug.

As the opioid crisis continues and states look for ways to reduce prescribing of and addiction to opioids, marijuana has repeatedly surfaced as a [potential alternative](#) in pain management. While some smaller-scale findings suggest that medical marijuana could be an effective way to manage pain, there still is not sufficient long-term clinical research to confirm that it is a viable solution.

One part of the Surgeon General's advisory states, "While CBD is not intoxicating and does not lead to addiction, its long-term effects are largely unknown, and most CBD products are untested and of uncertain purity." This is important to highlight as the workers' compensation industry continues to consider whether medical marijuana is a viable option for pain management.

Although the advisory is specific to pregnant women and adolescents, the fact that we need to understand more about the drug applies widely. States continue to legalize or expand the legalization of marijuana, while clinical research lags behind. In 2019, [more than 700 bills](#) were considered across the United States related to cannabis. Yet, only a few studies have emerged recently to show the benefits or drawbacks of marijuana and its legalization.

Let's take a look at a few recent studies.

Recent Research

Some studies have found that cannabis can be an effective treatment for chronic pain.

Notably, [a review from JAMA](#) of 79 trials on the effectiveness of marijuana found that there was moderate evidence to suggest that cannabis is effective at treating chronic pain. [Another study](#) found that cannflavins, components of the cannabis plant, are thirty times more effective at treating pain than aspirin. Although there is not enough abundance of cannflavins in a single weight of cannabis to provide therapeutic benefits, researchers have found a way to metabolically engineer the cannflavins. This is an interesting step in research of the plant and its possible therapeutic benefits. Again, more research needs to be done to assess the true opportunity of these chemicals as alternative analgesics.

However, research has been conflicted on whether or not marijuana use reduces opioid use and rates of opioid overdose.

[One study](#), published in The Journal of Bone & Joint Surgery, looked at self-reported use of marijuana during patients' recovery from musculoskeletal injuries. The findings in this study contradict the belief that the availability of marijuana will reduce opioid use. In fact, the study found that patients who used marijuana during their recovery actually had higher rates of opioid use. Additionally, opioid prescription duration was longer for those who used marijuana during their recovery than for those who did not use marijuana (90 days versus 15 days, respectively).

[A study from Pain Medicine](#) looking at concurrent opioid and marijuana use from patients with chronic pain found that patients who used opioids and marijuana at the same time were at a higher risk for opioid misuse.

Several studies have also looked at the rate of opioid overdoses in states that legalized marijuana. An initial [study from JAMA Internal Medicine](#), published in 2014, found that, in states with legalized medical marijuana, opioid overdose deaths were 25 percent lower than in states that had not legalized marijuana. However, [a similar study](#) that was released in 2018 in the Proceedings of the National Academy of Sciences and included data through 2017 found the opposite: opioid overdose death rates were actually higher in states that had legalized medical marijuana. In this period, legalization increased moderately: twenty-three states (plus Washington DC) had legalized medical marijuana by 2014 versus 30 by 2017.

[Data from Colorado](#), which has had legal medical marijuana since 2001, shows that opioid overdose deaths have steadily increased in the state, even after legalization of recreational marijuana in 2012.

[Yet another study](#), published in the JAMA Internal Medicine journal, found that the rate of opioid prescriptions in states with legal marijuana dropped, suggesting a decline in opioid use and abuse in those states. In analyzing Medicaid prescription data (2011-2016), the researchers found that, in states with medical marijuana laws, opioid prescribing was 5.88% lower. States with legal recreational marijuana saw a 6.38% decrease in the prescribing of opioids. The authors of the research note, however, that they “do not know whether patients actually avoided or reduced opioid use because of increased access to cannabis.”

More Research is Needed

It is important to note that, although many of these studies show a correlation between marijuana legalization and opioid use or abuse, they do not prove causation. Other factors may be at play in the increase or decrease in opioid overdoses in certain states. The lack of controlled clinical trials to clarify the true benefits and side effects of medical marijuana makes it difficult to determine if the drug is actually valuable or detrimental to patients and society.

The findings across these studies underline the need for more research. Recent changes at the federal level suggest we may soon get just that: the [DEA announced](#) at the end of August that it would start processing pending applications to grow marijuana for scientific research. As of now, scientists can only obtain marijuana for research from the University of Mississippi.

Regardless of opinion on the drug, marijuana continues to be a hot topic in workers' compensation and across the country. As more becomes known about its effects and applications, we are sure to see more action taken at the state and federal level.

More than **700 bills** related to marijuana were proposed in state legislatures in 2019.



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About Mitchell ScriptAdvisor®



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Mitchell ScriptAdvisor™ is the PBM solution that leverages technology and industry expertise to connect the ENTIRE claim. Mitchell's pharmacy benefit management solution was built exclusively for auto and workers' compensation payers. It delivers a holistic view to drive data-driven decisions that deliver better outcomes for you and your claimant.

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