Workers' Comp

Why Opioid Trends Are Changing in Workers' Comp

August 8, 2023
16 MIN READ
Author profile image

Nikki Wilson, Pharm.D., MBA

Senior Director, Clinical Pharmacy Services

Tom Kerr (TK): The Enlyte Drug Trends Report has uncovered a lot important information regarding changes in pharmacy spend and utilization. To discuss highlights from part 3 of the report, we welcome back Nikki Wilson, Senior Director, Clinical Pharmacy Services and Solutions at Enlyte.

Nikki, in looking at the report, 2022 saw declining trends overall in opioid utilization and spend, along with continued reductions in morphine equivalent dose (MED). Let's talk about some of the medications behind those numbers that were driving the activity within the class.

Nikki Wilson (NW): If we look at our top five opioid medications by cost, we see a list that includes oxycodone, hydrocodone, and tapentadol products.

And those meds actually represent the majority of the opioid scripts and costs for 2022, accounting for 63.5 percent of costs and 52.1 percent of the usage associated with the therapeutic class with the opioid class.

Their activity in looking at this can actually offer further insight into the favorable trends that we saw experienced among this impactful category, and we're continuing to carve that out separately for additional analysis in that third drug trends, report and highlights that we come out with.

So, oxycodone products held the top spots for cost in 2022. In particular, OxyContin, which is a controlled?release or long?acting version of oxycodone, took the top spot for cost at 23 percent, followed closely by the combination product of oxycodone with the active ingredient that's in over?the?counter Tylenol, which is acetaminophen.

So, oxycodone plus acetaminophen marketed under names such as Percocet or Endocet, accounted for 21.4 percent of cost. So, its cost percentage was due, in part, to the volume of prescriptions represented in that category.

However, OxyContin in the book remains largely a brand?only medication. So, while the volume was comparatively low when we're looking at all the other opioids in the top five, it was only 5.5 percent of total opioid scripts. Still high enough in cost to secure that No. 1 spot by medications cost.

No. 3 by cost was the hydrocodone, acetaminophen products, and those remained the top med category by utilization within the opioid drug class, making up just over a quarter of the total opioid scripts at 28.7 percent. But then, they make up only 7.6 percent of total opioid costs, so they're No. 3. That category includes generic versions of common brands, Vicodin, Norco, Lortab. And then, the remaining two medications rounding out the top five ranked by cost are both brand?only tapentadol products, we know them in the marketplace as Nucynta and Nucynta ER or extended?release Nucynta.

And, of note, Nucynta actually first showed up in our top five fairly recently, a few years back in 2019. And one of the reasons we see it used fairly commonly in the comp space is like tramadol, tapentadol actually has a mixed mechanism of action unique among the opioids. It targets the mu?opioid receptors for mu?opioid agonism, which most of the opioids do in the class, and that's where the analgesic effects come from, but it also impacts norepinephrine reuptake and, to a lesser degree, serotonin reuptake.

And why is that important? That's important because, in our pain management space, some of the drugs that target those noradrenergic receptors and neurotransmitters that are playing a role in pain function and management can be useful in, let's say, chronic pain conditions or nerve-related pain conditions.

That's one of the reasons we might use an antidepressant, for example, that also targets those same neurotransmitters when we're looking at dealing with chronic pain. So, it's actually a unique opioid for that reason where it's got that mixed mechanism of action. It touts potentially better side effect profiles compared to some of the other opioids and might be a useful option for patients with more chronic or nerve?related pain if we're going to use an opioid at all because it's got that activity.

Just an interesting side note on why these are being used so often on the market, and I'll tell you a little more about how that breaks down here. In 2022, Nucynta and Nucynta ER held the No. 4 and No. 5 spots by cost respectively with Nucynta actually bumping tramadol out of the rank of that fifth spot from the year prior.

Those two drugs, as I mentioned, are currently only available as brand?name medications, which contributes to that larger cost share. We do expect the patent protections for those products to expire sometime mid, maybe even late 2025. So that would allow for the introduction of generics, but for now, they're brand?only.

To put this in perspective of how that impacts the price tag, tramadol is the third-highest opioid by rank, by use, while Nucynta is No. 13 by use, but it's the fourth and fifth highest in cost. So that gives some insight into how

the higher dollar amount associated with the brand Nucynta products drives it up the list in terms of opioid cost ranking.

And the last thing I'll mention when we're looking at all the trend changes that occurred in 2022 among the top five opioid meds is all of them experienced declines in scripts per claim and cost per claim from 2021 to 2022. Our total opioid utilization then, as a result, fell by 7.8 percent per claim, and cost dropped by 14.8 percent per claim, with those top five representing an 8.7 percent and 13.4 percent decrease in those same categories.

TK: OK, and even with decreases within the opioid class related to scripts per claim, cost per script, and cost per claim, you continue to highlight this therapeutic class. Why is this category still considered among the so-called "high-impact drug classes" when we look at your trend data?

NW: So, as most are aware, the U.S. continues to struggle with an opioid epidemic and the statistics behind the prevalence of opioid use and associated opioid use disorder can be really quite staggering. The scope of the opioid epidemic's pretty clear. It's led to the national emergency that was declared back in 2017, identifying this is a serious issue within public health with the leading cause of adult accidental death in the U.S. still being drug overdose.

And then, with the emergence of coronavirus and the COVID?19 pandemic, we really saw the pandemic's role as a stress multiplier contributing to some of the challenges already driving opioid misuse, abuse and overdose. The stressors of the pandemic, things like social isolation and loneliness coupled with diminished access to services such as substance abuse treatment. That all contributed to another jump in some of the statistics that we've been tracking for years related to adverse outcomes from opioids. I'll cite a survey that the Substance Abuse and Mental Health Services Administration (SAMHSA) puts out every year, the National Survey on Drug Use and Health. The 2021 survey that was released this last January in 2023, reported that there were 46.3 million Americans aged 12 or older who reported substance use disorder in the past year at the time of the survey when that included alcohol and other drug?related substance use disorders. That's roughly 16 percent of that population in that age range, with just under half of them, about 24 million, meeting actual DSM?5 criteria for a diagnosis related to substance use disorder and drug use as highest among adults ages 18 to 25. Of the 12?plus year olds with substance use disorder, 94 percent of them didn't receive treatment. So that's another 9.2 million people that also reported misuse of opioids in the past year.

So, it's this perfect storm that led to one pretty staggering statistic that really jumped out to me. With the emergence of COVID?19 and the association between overdose and the pandemic, we saw a surge in overdose deaths during that time. They were up nearly 30 percent in 2020, driven now by synthetic opioids such as fentanyl. Likely that isolation and stress, another jump in 2021, and then we saw record?high overdose deaths during the pandemic with 109,000 deaths in the 12?month period ending March 2022, which is a 44 percent jump from the same period the year prior. So, we're still learning about the follow?up from that. It's still very much an important category to track within our space to ensure we're stewarding that opioid class responsibly.

TK: So, what about the risks associated and inherent to the class overall?

NW: So, these drugs, just by nature of what they are, we have to watch for physical dependencies expected with this class of drugs. It's a neurobiological adaptation sometimes referred to as tolerance, where the body is adapting to receiving these drugs. The longer a patient's on them, the more likely he or she will develop a physical dependence that's hallmarked by withdrawal syndrome when the drugs are removed.

We also look for risks like misuse, non?medical abuse, opioid use disorder, which really can capture all aspects of what we just covered as far as risks associated with the class. It's often used synonymously with the term addiction, and it's really considered more of a disease these days. It's considered a primary chronic

neurobiological disease with genetics like social and environmental factors influencing its development and manifestations.

The other thing we know is this drug class is consistently the top utilized in workers' comp, and the evidence has shown that opioid use can have adverse impacts to claim outcomes overall. We have research that shows use of opioids for even more than seven days and a receipt of more than one opioid prescription. Those are associated with significantly greater disability durations.

The odds of chronic work loss are greater for those patients using opioid prescriptions, which exceeded 90 days. So, the longer patients are on it, or the presence of it at all, can point to some adverse outcomes as far as overall claim outcomes and return to work.

More difficult to measure, but no doubt also contributing, are adverse effects including opioid use disorder and withdrawal symptoms that I just went through. So, again, it's just pointing to the importance of risk management and enforcing evidence?based recommendations where possible.

As a whole, we saw some very positive things within the opioid class, some of the metrics that we're tracking — MED and use overall being down — so we're having some really good wins, and those are playing out in our data, even with the pandemic and everything else.

TK: Nikki, what are some approaches that can be deployed to help ensure opioid utilization is appropriate?

NW: The best practices are out there. Several national organizations have produced evidence?based recommendations of guidelines around when to prescribe opioids, when to continue or discontinue use, appropriate durations of use according to injury type, dosing limitations, when to involve a pain specialist, how to identify whether a patient is a candidate for opioid therapy, what to monitor throughout treatment with opioids, and how to manage those side effects.

There's a lot of good resources that exist today considering where we've come from and everything that we know about this class. Some guidelines are even state specific.

Juris is a big piece of our workers' comp world, and so we have a number of treatment guidelines that are driven from a juris perspective or even state?based formularies that have come out and put limitations. There's also published guidance available from various medical societies, including the American Pain Society, American Academy of Pain Medicine, American Society of Anesthesiologists. The U.S. Centers for Disease Control and Prevention have published updates to their opioid prescribing for chronic pain, and we do have some evidence? based guidelines available from workers' comp?specific national entities such as American College of Occupational and Environmental Medicine (ACOEM), as well as the Work Loss Data Institute, which is the company behind the Official Disability Guidelines (ODG).

This should offer a good sample of what's available, and many of those resources offer guidance and outline what should transpire if prescribers identify risk or if an opiate overdose occurs, as well as place in therapy and other pain treatment options.

TK: And how can these best practices be implemented?

NW: Goals for improvements to the injured employee's level of pain and function should be a big part of the discussion; frequent evaluation for harm, benefits of the opioid. What are the side effects? Are we at risk of developing opioid use disorder? What's going on with our patient?

Prescribers have a number of best practices they can follow, including prescribing the lowest effective dose, making slow increases as necessary with an MED of 50 or less recommended for all opioids prescribed as there's been a risk shown to jumping above that dose. A threshold recommended not to go above is typically held at 90 and aligns closely with CDC and ODG.

And then, things like frequent review of the state prescription drug monitoring program can help point to discrepancies in use of that opioid. That's all tracked at the state level and there are various PDMP repositories. Prescribers can access that and check before prescribing or during prescribing. Things like urine drug testing, regular evaluations for substance use disorder, consideration for an opioid antagonist or reversal agent like naloxone. Risk guidelines often point to anytime an opioid is used with MED 50 or above, consider prescribing naloxone.

Those can all help decrease incident of misuse and abuse, or death from overdose. And then looking at what are the other medications or comorbid factors the patient receiving opioids has in place. So, considering potentially increased risk from other CNS depressant medications, medications that are causing decreased respirations or central nervous system depression, or if they're an alcohol user — avoiding those and prescribing any other CNS depressants for patients using opioids that's recommended. Do they have comorbid conditions that are impacting breathing rates or might be an indicator of abuse?

Those are some of the recommendations we can look to make sure that the use is appropriate.

TK: OK. Great. And following along with that theme of risk and safety, let's talk about some of the evidence-based medication approaches we're tracking when it comes to managing opioid use disorder and minimizing risk with opioids.

NW: Yeah. So as far as medications go, we have a number of different approaches for pain management overall. One of the big things is considering alternative analgesics or other non?opioid medications as part of pain management wherever possible. If we're going to use an opioid, using the lowest effective dose for the shortest duration possible, not co?prescribing with dangerous drugs, considering naloxone we're needed.

So, there's a number of other things that can be done, including those screenings I discussed for opioid use disorder risk and identifying that diagnosis. Medication?assisted treatment (MAT) is one of the options for managing when we've got a patient who either is at risk of developing opioid use disorder and we want to try to minimize that risk, or we've identified or diagnosed opioid use disorder and we're still trying to manage pain or wean them off the opioid of abuse.

So, MAT is one of the things that we have started tracking in our drug trends just to see what's happening in that space. MAT is a method typically applied along with counseling and other support. And the FDA, along with several state and national opioid guidelines that we referenced, continue to promote MAT as an effective treatment option for OUD that can help some people sustain recovery.

Naloxone, on the other hand, is prescribed as more of an immediate safety measure. It's the opiate overdose reversal agent, or essentially a drug that reverses the immediate effects of opioid intoxication to allow time for that person to obtain emergency medical care following an overdose.

These are two really important tools in the toolkit to try to minimize adverse effects, but we report on them both in a similar section, and I wanted to make that distinction. So, let's focus again on MAT. Specifically, we've been monitoring within our book the trends associated with the meds used for MAT. And there's three drug ingredients currently approved by the FDA for the treatment of opioid dependence or OUD. And the types of pharmacotherapy for OUD include agonist replacement treatment with methadone, which is also an opioid or the

partial agonist, buprenorphine, another opioid, but it works a little differently.

The third option is antagonist treatment, also known as abstinence therapy, and that's actually using the opioid reversal agent naltrexone that could include any of these options along with the use of additional supporting agents such as those on board to help with managing withdrawal symptoms as a means of entry into treatment.

TK: So how are these drugs employed?

NW: So, let's look at methadone and buprenorphine, which we report on primarily as both opioids themselves, but then, as such, they carry some of those same precautions and considerations as other drugs within the class. However, when they're used properly as part of an overall treatment program for OUD or even for pain management, that risk is expected to be minimized.

And as we've discussed, addiction is now thought of as a chronic disease, very appropriately the more we learn about it. And use of methadone or buprenorphine has been likened to use of a maintenance medication to manage other disease states like diabetes or heart disease. So, it's something the patient might expect to be on long term … maybe not … it's all very patient dependent.

So, the idea is they can allow the person to avoid any withdrawal symptoms and cravings that would normally occur from discontinuation of an opioid of abuse while focusing more fully on recovery and healthy living. The dosages we see used for this type of treatment have been shown to reduce opioid cravings and withdrawal and, again, intended to help restore balance to brain circuits affected by opioid use disorder which would allow the patient's brain to heal while working toward recovery.

The idea is the person will be more empowered to begin making lifestyle changes that can lead to an addiction?free future. And we are seeing that start to show up more and more in our book, which isn't a surprise given that opioids are so prevalent in this space.

Another thing to note, both national guidelines such as those from the CDC and the workers' comp specific ODG guidelines recommend use of medication?assisted therapy using methadone or buprenorphine, where appropriate. In particular, CDC has a statement in their guidelines that indicates clinicians should offer or arrange evidence?based treatment, usually medication?assisted treatment with buprenorphine or methadone in combination with behavioral therapies for patients with opioid use disorder. ODG recommends either drug for the treatment of opioid dependence in certain patients and by select prescribers. The World Health Organization also lists support of buprenorphine and methadone for OUD.

It's just one of those options for minimizing overdose risk and adverse outcome risk through treatment of opioid use disorder. Another approach, which can be used in conjunction with MAT is considering or co?prescribing a naloxone product. Some of the guidance indicates when to give naloxone. The CDC recommends offering it to both patients and household members living with patients at risk for overdose. There's a number of different criteria. ODG outlines when to consider naloxone with opioids as well. So, we have naloxone solution for injection and Narcan nasal spray, which are indicated as first?line for treatment of opioid overdose.

Ezio is a more costly brand injectable considered a second?line agent. Usually given only if the patient's unable to use either of the other formulations, if there's a barrier to education or they have a physical limitation like they can't use a nasal spray or something like that.

Third line would be a naloxone syringe used off?label with a nasal applicator if the use is customary in the clinician's practice or community. And that's something we used to see all the time before these other agents were available. The pharmacist could put that together at a low cost, but we do have FDA?approved products out

there.

So, we’re continuing to track use in our data of those evidence?based medication approaches, and we have that information on how specifically MAT drugs and naloxone have been trending in, the current opioid drug trends report. We did see some slight increases in the utilization of costs associated with MAT drugs commonly prescribed to treat OUD. They’re relatively low. Overall, we do break that down and even have a stat on if those claims that have an MED level above 50 where guidelines suggest naloxone would be indicated.

The percent that were in that category, and also those receiving prescription jumped, again, from the year before which is trending in the right direction according to the evidence?based recommendations out there when it comes to managing OUD and minimizing risk with opioids.

TK: Thanks, Nikki. In the next Enlye Drug Trends Report podcast, we’ll dive into what’s behind the rising costs associated with topicals. Until then, thanks for listening.



©2022 Enlyte Group, LLC.

mitchell | genex | coventry