HIGHMARK Delaware
HEALTH OPTIONS

November 2019

PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

THIS ISSUE

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Important Phone Numbers

PROVIDER UPDATE

QUARTERLY OUTREACHES VIA ATLAS

Highmark Health Options is conducting quarterly outreaches to verify your provider data. Our Vendor, Atlas Systems, Inc. will perform the quarterly outreach on our behalf. Your cooperation in this process is extremely important to ensuring that your claims and other data are reflected correctly. You do not have to wait for the outreach call. You can and should check your own information on a consistent basis to make sure it reflects what it should.

GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

This newsletter summarizes the 12 recommendations contained in the CDC *Prescribing Guideline*. The recommendations are organized into three areas: (1) determining when to initiate or continue opioids for chronic pain; (2) Opioid selection, dosage, duration, follow-up, and discontinuation; and (3) assessing risk and addressing harms of opioid use. Providers are encouraged to read the full CDC *Prescribing Guideline* for additional information on improving patient outcomes, such as reduced pain and improved function. Within the CDC *Prescribing Guideline* there are recommendations that are tailored to specific populations (e.g., pregnant women, older adults) and additional guidance on opioid therapy and tapering.

Determining When to Initiate or Continue Opioids for Chronic Pain

1. Opioids are not first-line therapy.

Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

2. Establish goals for pain and function.

Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3. Discuss risks and benefits.

Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

Clinical reminders:

- Establish and measure goals for improved pain and function
- Discuss benefits, risks and availability of non-opioid therapies with patient
- Discuss pain intensity, functional impairment and quality of life

Opioid Guidelines cont.

Opioid Selection, Dosage, Duration, Follow-up and Discontinuation

1. Use immediate-release opioids when starting.
When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

2. Use the lowest effective dose.
When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME) per day, and should avoid increasing dosage to ≥ 90 MME per day or carefully justify a decision to titrate dosage to ≥ 90 MME per day.

3. Prescribe short durations for acute pain.
Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

4. Evaluate benefits and harms frequently.
Clinicians should evaluate benefits and harms with patients within one to four weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every three months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.

Clinical reminders:
- Use immediate-release opioids when starting
- Start low and go slow
- When opioids are for acute pain, prescribe no more than needed
- Do not prescribe ER/LA opioids for acute pain
- Follow-up and re-evaluate risk of harm; reduce dose or taper if needed

Opioid Guidelines cont.

Assessing Risk and Addressing Harms of Opioid Use

1. Use strategies to mitigate risk.

Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME per day), or concurrent benzodiazepine use, are present.

2. Review prescription drug monitoring program (PDMP) data.

Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every three months.

3. Use urine drug testing.

When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

4. Avoid concurrent opioid and benzodiazepine prescribing.

Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

5. Offer treatment for opioid use disorder.

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.

Clinical reminders:

- Check PDMP for high dosages and prescriptions from other providers
- Use urine drug testing to identify prescribed substances and undisclosed use
- Avoid concurrent benzodiazepine and opioid prescribing
- Arrange treatment for OUD if needed

Opioid Guidelines cont.

Provider Training

Attention: All Providers

New Opioid Trainings for Providers: Initiating Opioid Therapy and Implementing the CDC Guideline

CDC launched two (2) new opioid trainings that support providers in the safer prescribing of opioids for chronic pain. The modules are part of a series of interactive online trainings that feature recommendations from the **CDC Guideline for Prescribing Opioids for Chronic Pain**. The seventh module, **Determining Whether to Initiate Opioids for Chronic Pain**, helps providers identify and consider important patient factors when starting or continuing opioid therapy, while the eighth module, **Implementing CDC's Opioid Prescribing Guideline into Clinical Practice**, walks providers through a quality improvement (QI) process using a set of 16 clinical measures outlined in the **Quality Improvement and Care Coordination: Implementing the CDC Guideline for Prescribing Opioids** for Chronic Pain. Both modules include clinical scenarios and tools and a resource library to enhance learning.

These and all the modules in the series offer free continuing education, available on our **Training for Providers webpage**.

References

Prevention, C. f. (2018). CDC.gov. Retrieved from

https://www.cdc.gov/drugoverdose/pdf/prescribing/CDC-DUIP-QualityImprovementAndCareCoordination-508.pdf

PRE-EXPOSURE PROPHYLAXIS (PrEP) CHECKLIST

Worldwide, about 2 million people become infected with human immunodeficiency virus (HIV) each year, with about 40,000 of these diagnoses occurring in the U.S. Despite these numbers, less than 20% of people who could benefit from prophylaxis are taking medication to reduce their risk of HIV infection. The United States Preventative Services Task Force (USPSTF) recently recommended offering pre-exposure prophylaxis (PrEP) to high-risk patients, to reduce the development of new cases of HIV. Oral once-daily emtricitabine 200 mg/tenofovir disoproxil fumarate 300 mg (e.g., *Truvada*,) and emtricitabine 200 mg/tenofovir alafenamide 25 mg (*Descovy*) are available options for PrEP. Use this checklist to identify high-risk patients and safely prescribe and monitor PrEP therapy.

Identify and Screen Potential Candidates

- Look for patients at high risk of HIV infection. These may include:
  - Persons who have unprotected sex with multiple partners, especially men who have sex with men.
  - Persons with a sexual partner that is HIV positive.
  - Recent intravenous (IV) drug users, especially if sharing needles (within the last six months).
  - Persons with recent sexually transmitted diseases (STDs) such as chlamydia, syphilis, and gonorrhea (e.g., within the last three to six months).
  - Persons involved in commercial sex work.
- Look for signs and symptoms of acute HIV infection. Document a **negative HIV test**.
  - If suspicion is high for an acute HIV infection, repeat the HIV test in about a month to **confirm a negative result** before prescribing PrEP. *Truvada* use in HIV-positive patients is linked to developing resistance to emtricitabine. It is not yet known if there is a link to developing resistance to emtricitabine with *Descovy* use in HIV-positive patients.
- Determine pregnancy status and discuss risks and benefits. Data do not show an increase in birth defects or adverse pregnancy outcomes for pregnant women using *Truvada* for treatment of HIV. There are not human data available to evaluate the safety of *Descovy* in pregnant women.
  - However, no controlled trials have evaluated safety and efficacy of PrEP in pregnant women.
  - Detectable blood levels of *Truvada* are seen in breastfed infants. Women should not breastfeed if taking *Truvada* or *Descovy* for HIV prevention or treatment.
- Screen for STDs and hepatitis.

PrEP Checklist cont.

Recommend PrEP

- Recommend **once-daily PrEP regimens** for most patients. Once-daily PrEP options for adults and adolescents ≥35 kg (U.S. only) include:
    - FDA- and Health Canada-approved: oral *Truvada* (200 mg/300 mg) taken once daily.
    - FDA-approved (select patient groups, see below): oral *Descovy* (200 mg/25 mg) taken once daily.
- Consider these factors to select the most appropriate once-daily option.
    - **High-risk behaviors**: *Descovy* PrEP is approved for men or transgender women who have sex with men. Some are concerned about limited data in black patients and transgender women. More data are needed before *Descovy* can be recommended in other high-risk patient groups.
    - **Renal function**: creatinine clearance (CrCl) must be ≥60 mL/min to use *Truvada* for PrEP. *Descovy* can be used in patients with CrCl as low as 30 mL/min.
    - **Drug-drug interactions**:
        - There is potential for increased kidney injury and other side effects (due to increased tenofovir disoproxil fumarate levels) when *Truvada* is used with certain hepatitic C meds (e.g., ledipasvir [*Harvoni*], velpatasvir-containing formulations [*Epclusa*, *Vosevi*]).
        - Several products can decrease tenofovir alafenamide levels and possibly reduce PrEP effectiveness with *Descovy*. Examples of meds not recommended for concomitant use include carbamazepine, phenobarbital, phenytoin, St. John's wort, and rifampin.
        - There is an increased risk of side effects with *Truvada* (including kidney injury), *Descovy*, or interacting drug, when *Descovy* or *Truvada* are used with drugs that are eliminated by active tubular secretion (e.g., acyclovir, aminoglycosides, high-dose or multiple NSAIDs).
    - **Cost**: Insurance copays will vary. Without insurance, one month of once-daily PrEP costs:
      Truvada (U.S.): about $1,760 (U.S.; anticipate generic availability in September 2020)
      Descovy: about $1,760 (U.S.)
- **On-demand** *Truvada* may be considered for men who have sex with men. (There are no data available evaluating on-demand *Descovy*.) On-demand *Truvada* (200 mg/300 mg) is complicated: Two tablets taken two to 24 hours prior to sexual exposure, followed by one tablet taken daily until 48 hours after last sexual activity.

PrEP Checklist cont.

Monitoring

- Patients receiving PrEP should be seen **at least every 90 days** and evaluated for **adherence** and:
  - **Drug interactions** (see specific interactions in the *Recommend PrEP* section)
  - **Renal function** (at three months, then every six months)
  - **HIV or other STDs**
  - **Pregnancy status**. Perform pregnancy test for women with potential to become pregnant.
- Bone density monitoring is **not necessary for patients taking PrEP**. *Truvada* use has NOT been linked to increased fractures, despite increased osteopenia and patient complaints of bone pain. *Descovy* may be associated with improved bone mineral density biomarkers, compared to *Truvada*.
- If patients become HIV positive and are coinfected with hepatitis B, monitor liver function tests.
  - Stopping *Descovy* or *Truvada* in patients **coinfected with hepatitis B and HIV** can lead to acute hepatitis B exacerbations.

Patient Counseling

- Tell patients how long it takes for drug levels to build up for maximal protection (i.e., ~7 days [rectal tissue], ~20 days [blood and vaginal tissue]).
- Stress adherence. Missed doses are linked to reduced effectiveness.
  - Oral *Descovy* or *Truvada* significantly reduces the risk of HIV
    - For example, in men who have sex with multiple partners, daily *Truvada* prevents one case of HIV for about 60 men treated for one year.
- Tell patients about possible side effects including diarrhea, nausea, abdominal pain, flatulence, headache, and weight loss. Reassure patients that side effects often go away in days to weeks.
- Encourage acetaminophen if patients need something for pain. If possible, patients should avoid high dose or multiple NSAIDs, due to potential to reduced kidney function.
- Encourage safe sex practices, including condoms. PrEP only protects against HIV, not other STDs.
- Promote safe needle use and recommend needle exchange and/or drug treatment programs.

PrEP Checklist cont.

Help Patients Afford Prophylaxis

- Even though in the U.S. *Truvada* and *Descovy* are covered by many insurers, including Medicaid and Medicare, copays can still be high. See if patients qualify for assistance:
    - Manufacturer: https://www.gileadadvancingaccess.com.
    - CDC: https://www.cdc.gov/hiv/pdf/risk/prep/cdc-hiv-PayingforPrEP-flyer.pdf.

References

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4. Product information for *Truvada.* Gilead. Foster City, CA 94404. May 2018.
5. Product monograph for *Truvada.* Gilead Sciences. Mississauga L5N 2W3. July 2018.

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NaviNet	
NaviNet Access 24/7	Click here to enter the NaviNet Portal

Department	Contact Number	Hours
Provider Services	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m.
Member Services	1-844-325-6251	Mon. – Fri. 8 a.m. to 8 p.m.
Member Services (DSHP Plus)	1-855-401-8251	Mon. – Fri. 8 a.m. to 8 p.m.
Authorizations	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m. (24/7 secure voicemail for inpatient admissions notification)
Care Management/Long Term Services and Supports (LTSS)	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m. (after hours support accessible through the Nurse Line)
Member Eligibility Check (IVR)	1-844-325-6161	24/7
Behavioral Health	1-844-325-6251	Mon. – Fri. 8 a.m. to 5 p.m.
Opioid Management Program	855-845-6213	Mon.- Fri. 8 a.m. to 5 p.m.