Helping to Solve the Epidemic of Prescription Drug Abuse

Nearly 2 million Americans abused prescription painkillers or were dependent on them in 2014

Prescription drug abuse in the United States is an epidemic. The problem is so prevalent that the Centers for Disease Control and Prevention (CDC) recently issued prescribing guidelines for opioid analgesics, saying the addictive risks from the drugs can outweigh their benefits.

The implications of the epidemic are staggering. Nearly 23,000 Americans die each year from overdoses, and many more people become addicted. Every year, more than 1.4 million people are treated in emergency departments, and an estimated 493,000 people aged 12 or older make their first use of these medications for nonmedical reasons.

Beyond Opioid Painkillers
With opioid analgesic abuse filling the headlines, state and federal officials – and presidential candidates on the campaign trail – are pressing for action to end misuse and treat addiction. But while opioid analgesics are the largest class of abused medications, they’re only a part of the story. The second and third most commonly abused prescription drug classes are:

- Central nervous system (CNS) depressants (e.g., benzodiazepines such as Valium and Xanax), prescribed to treat anxiety and sleep disorders. Nearly one-third of deaths caused by a prescription drug overdose in 2013 were tied to these medications, typically when used in combination with alcohol or opioid analgesics.
- Stimulants, most often prescribed to treat attention deficit hyperactivity disorder (e.g., Adderall and Ritalin)

Beyond the terrible human toll of addiction, prescription drug abuse places an enormous economic burden on our nation. The annual price tag of opioid analgesic abuse for health care, workplace and criminal justice system costs tops $55 billion.

Daily Dose: Every day, as a result of prescription drug abuse:

- **62** people die
- **3,836** people are treated in the ER
- **1,350** people 12 or older make their first nonmedical use
How We Got Here and Where We Need To Go

Before the 1990s, opioid analgesics – because of the risk of addiction – were typically prescribed only for the short-term treatment of moderate-to-severe pain caused by injury, surgery or end-of-life-stage disease. The publication of “The Tragedy of Needless Pain” led to a rethinking of how opioids could be used to treat chronic, non-malignant pain (e.g., lower back pain and osteoarthritis) and a shift in clinical practice and guidelines.

Painkiller prescriptions skyrocketed in the decades that followed, increasing four-fold from 1999 to 2014 even as Americans reported no corresponding increase in pain. Deaths from overuse and abuse of these drugs also quadrupled after 1999, with more than 14,000 people losing their lives in 2014. That same year, health care providers wrote approximately 249 million prescriptions for opioid analgesics – or enough for every adult American to have a bottle.

Implementing strategies to address overprescribing and prevent nonmedical use is essential. In March 2016, the CDC released voluntary guidelines to encourage primary care providers to help their patients manage chronic pain, when possible, with non-opioid painkillers or physical therapy. When opioid analgesics are needed, the CDC recommends prescribers use the lowest effective dose and monitor patients for signs of misuse.

People who abuse opioid analgesics have $15,000 higher annual health care costs

In 2013, 249 million prescriptions for opioid analgesics were written – enough for every adult American to have a bottle.

Balancing Appropriate Access and Risk of Abuse

While opioid analgesics, CNS depressants and stimulants serve legitimate medical purposes, these highly potent medications present a high risk for adverse health events. The overwhelming majority of prescribers and pharmacists recognize this risk and embrace their professional and legal obligations. At the same time, we as health care industry leaders and plan sponsors must lead the charge for additional safeguards through ongoing engagement with prescribers and members and the use of technology – at both the point of sale and through retrospective analysis – to help ensure the right person receives the right drug, at the right time.

Medication safety is a constant challenge. Plan members and physicians may be unaware of potential issues such as drug-to-
The PBM is well-situated to help identify abuse and work directly with prescribers to stop it and to help connect members with treatment resources. Unlike the prescriber and pharmacist who see only a portion of the patient’s prescription profile, PBMs have a complete view of their adjudicated prescription claims.

**Utilization management is designed to promote good health outcomes and cost-effective care.** Prior authorization restrictions such as diagnosis, contraindications evaluation and step therapy guidelines are based on clinical criteria. With quantity limits, criteria such as maximum daily dose per labeling, initial dosing frequency recommendations or dose in opioid-tolerant patients are used.

**State and federal systems provide essential information.** Forty-nine states have implemented prescription drug monitoring programs (PDMP) to equip providers and pharmacists with real-time access to information on what drugs – and in what combinations and in what doses – a patient is taking. PDMPs also track where and when these prescriptions were filled, helping to detect doctor and pharmacy shopping. A prescriber can leverage this insight to determine what therapeutic action to take and, as necessary, work with the patient to stop nonmedical or inappropriate clinical use.

**Electronic prescribing works.** Because this strategy has proven to be effective at reducing drug diversion and fraud, policymakers should consider making the practice mandatory. To support prescribers, we offer significant resources to simplify electronic prescription submissions. It is an indirect but effective way for pharmacy benefit managers (PBM) to have a positive impact on the issue.

**The role of the pharmacy is expanding.** Beyond dispensing prescribed medications, pharmacies can advise patients on how to safely return their unused drugs – avoiding an addiction entry point for friends and family members who might otherwise misuse them.

Pharmacies also are increasingly able to provide the antidote naloxone, which can be dispensed via a standing order (i.e., like a flu shot) as an injectable or nasal spray. When correctly administered and administered in time, naloxone blocks the effects of opioids and can prevent death from overdose.

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**The Role of the PBM**

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While individual paths to addiction or dependence vary, they often include doctor shopping to find a prescriber to write the prescription and pharmacy shopping to find a pharmacist to dispense it. Core safety and monitoring programs allow us to help spot this behavior through monthly and quarterly retrospective claims reviews – at retail and mail – and identify opportunities for direct prescriber and member interventions.

Case reviews are initiated by system-generated risk-scoring but confirmed through manual review by a clinical pharmacist. We also collaborate with law enforcement, at the state and federal levels, to help reduce abuse and misuse of prescription drugs.

**Member behavior targeted includes:**

- High number of controlled-substance claims
- Multiple prescribers of controlled substances
- Prescriptions filled at multiple pharmacies
- Excessive utilization
- Geographic distribution of prescribers and pharmacies
- High total-claim cost
- Number of concurrent prescribers
- Number of concurrent pharmacies

**Drug classes targeted include:**

- Narcotic/narcotic-combination drugs
- Benzodiazepine anti-anxiety and sedative/hypnotic agents
- Non-benzodiazepine sedatives/hypnotics
- Muscle relaxants (e.g., Flexeril and Soma)
- CNS stimulants
While participating in our safety and monitoring program is optional, it is offered for no additional cost as a core PBM service. Clients who participated in our core safety and monitoring programs saved more than $100 million in 2015. This figure includes $74.3 million in unnecessary pharmacy spend and $26.1 million in medical costs that were avoided.

A majority of our clients – representing 58.3 million plan members – have enrolled. That’s an increase of 22 percent from 2015.

Our enhanced audit services program includes a custom analysis of claims on the pharmacy network and specialized reporting on audit discrepancies.

Fraud and waste, like abuse, remain a persistent challenge to the health care system – creating unnecessary expense and diverting limited resources. All of us at CVS Health are committed to supporting our clients and their plan members in addressing this challenge.

Jonathan C. Roberts
President, CVS Caremark

Other Topic Resources
Controlled Substance Strategies at CVS Health, February 2016, CVS Caremark Medical Affairs
Joining the Fight Against Prescription Drug Abuse, CVS Health