Senator Gene Yaw
Chairman
The Center for Rural Pennsylvania

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I am an addiction psychiatrist and treat patients primarily who are addicted to opioids. Today's opioid epidemic stems back to the mid 1990s. In 1995, Purdue Pharma released OxyContin, which is an extended release oxycodone tablet, which was initially billed by the pharmaceutical company to have low abuse potential. Around the same time, there was a focus developing on assessing and treating pain. A joint consensus statement from two pain societies published in 1996 stated that development of addiction is low when opioids are used for pain and withholding opioids based on concerns about respiratory depression is unwarranted. Judicious use of opioid pain medications was encouraged to alleviate suffering. As you are aware, prescribing of opioid pain medications increased. From 1991 to 2013, the number of opioids prescribed in the United States went from 76 million to 207 million per IMS Health, Vector One prescription records[1] In that same period of time, deaths from prescription opioids tripled.[2]

Today, it is estimated 1.9 million Americans abuse or are addicted to pill opioids.[3] In Allegheny County, the SAMHSA National Survey on Drug Use and Health found that the prevalence of pill opioid use from 2010-2012 was 4.05%.[4] About 75% of those using opioid pills will go on to use heroin due to cost.[5] My patients tell me that they buy pills for $1 per milligram, whereas heroin costs $10 per stamp bag. Patients usually start out using heroin intranasally, then as their tolerance grows, they need to use more and more to get the same effect, so they switch to injecting it in order to use less and get a greater effect. However, with time, they become tolerant to the effects of the injected heroin as well, and again start using more and more. Currently, there are 517,000 Americans addicted to heroin.[3] Each day, 46 Americans die from prescription opioid overdoses[6] and 22 die from heroin overdoses.[7] In 2014, there were 307 overdose deaths in Allegheny County,[8] 27 in Beaver County,[9] 34 in Butler County,[8] and 37 in Washington County.[8]

I see patients in all phases of their addiction, actively using, in detoxification, and in recovery. Sadly, I have treated several patients who have overdosed on opioids and died. More than 50% of my patients have survived or witnessed an accidental overdose at some time in their lives.

To address the opioid epidemic, addiction physicians have recognized to effectively treat this opioid and overdose epidemic, we need to take a multifaceted approach. We need to:

1. Emphasize prevention. Encourage patients to discard of all unused medications, especially narcotic medications, by returning them to participating take-back pharmacies, police departments, or utilizing drug take-back days so unused drugs are not used by unintended recipients.
2. Educate medical students, residents, physicians about addiction and proper opioid prescribing. An organization, Physicians for Responsible Opioid Prescribing (www.supportprop.org) provides continuing medical education on responsible opioid prescribing. In addition to physicians, dentists, advance practice nurses, and physician's assistants also need basic and continuing education on proper opioid prescribing. All healthcare professionals need more training in recognizing signs and symptoms of addictive disorders and effectively working with patients with addictive disorders. I am a member of The Coalition on Physician Education in Substance Use Disorders (COPE) and we are working on encouraging the integration of increased education on addiction into allopathic and osteopathic medical school curricula.
3. Use prescription drug monitoring databases to ensure we have as much data available to us as possible to make sound clinical decisions. Of note, Pennsylvania's prescription drug monitoring program (PDMP) was signed into law on October 27, 2014, and originally anticipated to take effect June 30, 2015, but did not come to fruition due to budget constraints. It is reported that the PDMP will go live in August 2016.

4. Use FDA-approved medications to treat opioid use disorder, including methadone, buprenorphine, and naltrexone. These medications are effective in reducing opioid use, preventing relapse, reducing transmission of HIV and hepatitis C from injection drug use, and reducing emergency room visits and hospitalizations.[10] These medications, however, are underutilized currently.
5. Provide overdose prevention training and co-prescribe naloxone when prescribing opioids in case of accidental overdose.

Opioid use disorder, as known as opioid addiction, is a chronic, relapsing, life-threatening, but treatable disease of the brain. Addiction is not a choice or lack of willpower. It is not a time-limited illness. Yet, the patients I see each day are given these messages by their friends, family, the media, healthcare workers, and insurance providers.

Patients with addictive disorders face barriers when trying to seek medications for treatment of opioid use disorder, including wait-lists to get into methadone maintenance programs and buprenorphine clinics, difficulty finding physicians who accept Medicaid who will prescribe stabilizing medications,[11] difficulty getting into rehabilitation programs, rigorous prior-authorization requirements[12] which set up barriers to patients being able to afford medications.

Eleven states have implemented lifetime limits for how long their Medicaid programs will pay for buprenorphine,[13] 14 states have implemented buprenorphine dose limits,[14] and one state (i.e., Maine) has implemented a two-year lifetime limit for Medicaid payment for methadone. These limits have restricted patients' access to treatment and put them at risk for relapse and overdose, and there is no evidence behind these practices.[15]

Fortunately, Pennsylvania has not instituted a lifetime limit for buprenorphine treatment but Pennsylvania Medicaid does have a dose limit of 16 mg daily. Patients on buprenorphine treatment need their treating physician to submit prior authorizations documenting participation in psychosocial therapy, urine drug testing, and relapse status, every six months. Some managed care companies require patients who want to use extended release naltrexone for treatment to use the immediate release naltrexone first, as part of a step therapy requirement. The patient is required to "fail" this treatment in order to be approved for the more expensive treatment. This puts the patient at risk for relapse and overdose. In fact, I had one patient for whom the insurance company refused to authorize the extended release naltrexone and required him to take the naltrexone tablets first. The patient took the tablets for a short time and relapsed on heroin and then overdosed. Fortunately he survived the overdose, underwent detoxification again, and then started the extended release naltrexone and began a long period of recovery.

Despite The Mental Health Parity and Addiction Equity Act of 2008, there are still private insurers in the Southwest Pennsylvania region who do not pay for outpatient detoxification. These patients who have this insurance company who come to the program have to pay out-of-pocket or try to find an inpatient detoxification facility which limits their access to treatment.

In Pennsylvania, patients with opioid use disorders have to complete several hurdles in order to get lifesaving medications authorized by their insurance companies as described above. These same patients could get prescriptions for most immediate release (e.g., oxycodone) and several extended release opioids (e.g., oxymorphone ER, Fentanyl patch), without any step therapy requirements, prior authorizations, and/or requirements for additional treatment such as physical therapy.

In closing, patients with addiction need to be treated as all other patients with chronic diseases. A patient with high blood pressure is not expected to stop blood pressure medications once his/her blood pressure is stabilized or to maintain the gains made by medication through lifestyle changes (e.g., diet and exercise) if these haven't been successful treatments previously. Likewise, limits on medications to treat opioid and other addictions should not be time limited. Once patients stabilize on methadone, buprenorphine, or naltrexone, they should not be expected to stop the medications and maintain their recovery with therapy alone. Patients with opioid addiction should not need to "fail" a treatment before their insurance will pay for a more expensive medication, especially since "failure" could be a matter of life and death.

I am hopeful that you will find my comments helpful in understanding the opioid epidemic and barriers those with the disease of opioid addiction are facing in Western Pennsylvania, and also in the greater United States.

Respectfully submitted,

Julie Kmiec, DO
Addiction Psychiatrist

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[1] IMS Health, Vector One: National, Years 1991-1996, Data Extracted 201. IMS Health, National Prescription Audit, Years 1997-2013, Data Extracted 2014.
[2] Mack, K.A. Drug-induced deaths - United States, 1999-2010. MMWR Surveill Summ. 2013 Nov 22;62 Suppl 3:161-3. CDC
[3] In 2013, the *National Survey on Drug Use and Health (NSDUH)* estimated that 1.9 million Americans live with opioid pain reliever addiction and 517,000 are addicted to heroin. http://www.samhsa.gov/data/sites/default/files/NSDUH-SR200-RecoveryMonth-2014/NSDUH-SR200-RecoveryMonth-2014.htm
[4] http://www.samhsa.gov/data/sites/default/files/substate2k12-StateTabs/NSDUHsubstateStateTabsPA2012.htm
[5] Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. JAMAPsychiatry. 2014 Jul 1;71(7):821-6. doi: 10.1001/jamapsychiatry.2014.366. PubMed PMID: 24871348.
[6] According to the Centers for Disease Control and Prevention (CDC), 46 Americans die every day from opioid prescription drug overdoses; that translates to almost two deaths an hour and 17,000 annually. CDC Vital Signs, July 2014 (http://www.cdc.gov/vitalsigns/opioid-prescribing/)
[7] According to the Centers for Disease Control and Prevention (CDC), more than 8,000 Americans die annually from heroin overdoses. http://www.cdc.gov/nchs/data/databriefs/db190.htm
[8] DEA Intelligence Report: Analysis of drug related overdose deaths in Pennsylvania, 2014 http://www.dea.gov/divisions/phi/2015/phi111715_attach.pdf
[9] http://www.timesonline.com/lifestyles/healthandwellness/drug-overdoses-in-state-beaver-county-we-re-seeing-only/article_b20be3a6-fa5e-11e4-9eeb-03981efb8cae.html
[10] http://www.asam.org/docs/default-source/2015-conference-epk/asam-impact_cce-4-02-14.pdf?sfvrsn=4#search="proven clinical and cost effectiveness opioid use"
[11] 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).
[12] 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).
[13] 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).
[14] http://www.asam.org/docs/default-source/2015-conference-epk/asam-impact_barriers4-02-14.pdf?sfvrsn=4#search="medications for the treatment of opioid use disord"
[15] 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).