The data provided in this First Script Pharmacy Trend Report (formally named First Script Drug Trends Report) includes transactions billed through Coventry Workers’ Comp Services’ Pharmacy Management Program, First Script, from January 2012 to December 2012, while last year’s Drug Trends Report included data from December 2010 to November 2011. Therefore, some of the year-over-year figures reported herein for 2011 will not tie exactly to what was reported previously. Based on feedback received from the 2011 Drug Trends, all data presented here and in the future will be based on the calendar year. Where applicable, data comparisons are made from previous years. Supported by recent research, nationally published statistics, and other objective data sources, current workers’ compensation trends are illuminated. Clinical categorization is derived from FDBTM, formerly known as the First Databank database. Pricing data supplied is drawn from the Medi-Span® database.
Planning for the future requires understanding the past. Coventry’s *First Script Pharmacy Trend Analysis* analyzes our extensive pharmacy data set within the context of our experience year-over-year. Our analytic focus helps us to understand emerging trends and create strategies to improve future drug utilization while eliminating unnecessary spending.

The role of a Pharmacy Benefit Manager (PBM) in workers’ compensation is evolving in response to new dispensing practices and a growing recognition that all pharmacy utilization – not just that which is dispensed in a retail setting – impacts the health of a patient and can dramatically change the outcome of a claim.

First Script has evolved significantly over the past year.

Today we manage an injured worker’s pharmacy care to support health and safety, no matter where the medication was dispensed or who bills us. New dispensing and billing practices bring inflated prices for traditional medications, and because of our broad Coventry network capabilities, we are able to aggressively reduce each prescription to its lowest defensible rate for our customers.

*First Script’s total pharmacy management leverages integrated medical, pharmacy and claim data for risk detection to trigger immediate outreach by a broad team of Coventry clinicians...doctors, pharmacists, nurses...to drive outcomes beyond the reach of competitive PBMs...* 

It is only through total pharmacy management that we can promote patient safety, drive appropriate utilization and spending, and mitigate the risks associated with inappropriate drug use and dependence.

We are excited about the results our programs have demonstrated for our clients and injured workers and look forward to an eventful year.

First Script continues to be on the forefront of changes in legislation, changes in drug management programs, and new and innovative programs to control costs while more effectively supporting injured workers and their employers.

We will continue in our quest to leave no script unmanaged, and no injured worker left behind.

Brian Carpenter, R.Ph.  
VP, Product Development

Alan Madison  
VP, Operations
No Script Unmanaged.
No Injured Worker Left Behind.

Total medication spend decreased an average of **15%** \(\downarrow\) per claim in years 1-10.

Total narcotic spend decreased an average of **17%** \(\downarrow\) per claim in years 1-10.

MED has declined **11%** \(\downarrow\) in the first two years post injury and **8%** \(\downarrow\) in years 3-5.
External Influences on Spend

2012 Average Wholesale Price (AWP) Changes

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>AWP Impact*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antidepressant Medications, Non-TCA</td>
<td>1.2%</td>
</tr>
<tr>
<td>Analgesics, Narcotic, Sustained-Release</td>
<td>1.0%</td>
</tr>
<tr>
<td>Dermatological/Topical Preparations</td>
<td>0.9%</td>
</tr>
<tr>
<td>Analgesics, Narcotic, Short-Acting</td>
<td>0.8%</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>0.7%</td>
</tr>
<tr>
<td>Muscle Relaxants</td>
<td>0.6%</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>0.6%</td>
</tr>
<tr>
<td>Stimulant Agents</td>
<td>0.3%</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>0.3%</td>
</tr>
<tr>
<td>Antiulcer Medications</td>
<td>0.2%</td>
</tr>
<tr>
<td>Antianxiety Medications</td>
<td>0.1%</td>
</tr>
<tr>
<td>Sedative/Hypnotics</td>
<td>0.1%</td>
</tr>
<tr>
<td>Respiratory Medications</td>
<td>0.1%</td>
</tr>
<tr>
<td>Migraine Medications</td>
<td>0.1%</td>
</tr>
<tr>
<td>Impotence Medications</td>
<td>0.1%</td>
</tr>
<tr>
<td>Nutritional Products</td>
<td>0.1%</td>
</tr>
<tr>
<td>All Others</td>
<td>0.3%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>7.5%</strong></td>
</tr>
</tbody>
</table>

*Based on AWP increase and spend, excluding compound drugs

Quick Facts

- Clients experienced a 5.3% decrease in drug utilization due to First Script Utilization Management Programs.
- This utilization decrease offset the AWP increases realized, resulting in an overall book of business drug spend increase of 2.2%.

2 Common Drugs with Large AWP Increases

- **Cymbalta® 19.4%↑**
- **OxyContin® 5%↑**

As noted with previous years, brand medications with patents due to expire typically experience significant AWP increases. The trend continued in 2012 as noted with medications such as Cymbalta®, Opana® ER, Lidoderm®, Suboxone®, and OxyContin® (patent extension granted for OxyContin® due to FDA decision). This trend is very impactful to clients with older claims as they tend to have more branded single source medications as part of their utilization pattern. Part of the First Script book includes some very mature claims which influence the overall AWP impact.
Industry trends indicate that nearly eight out of every ten prescriptions are now written for generic drugs.³

Quick Facts

- Over the last two years, generic utilization has increased year-over-year and is now approaching 79% (see the Units chart below). Generics are cost-effective and contribute to decreased pharmacy spend.
- Generic efficiency (the actual number of scripts that were filled with generics which could have been filled with generics) grew from 90% in 2010 to 97% in 2012.
- Brand drugs with generics available are five times more costly per script than the average generic script.
- Spend for brand with generic drugs has been cut by 59% since 2010, with nearly half of that decrease over the last year alone.
- Concentrating on brand with generic drugs through physician outreach has reduced that category by nearly two-thirds.
- Brand-only drugs have increased in utilization by 1.1% and spend by 8% versus last year.
  - A majority of the increase can be attributed to the reclassification of OxyContin® as a brand-only medication as its generics were no longer available by 2012.
One of the most critical patient safety issues in 2012 was narcotic overutilization. Through the application of clinically based programs and enhanced client education through webinars and publications, First Script clients realized meaningful decreases in narcotic utilization in 2012. Narcotic spend and scripts per claim decreased 17% and 15%, respectively, versus 2011, with the greatest decrease in spend experienced in years 5-8, and utilization decrease in claims over 5 years.

**Quick Facts**

- Total narcotic spend decreased an average of 17% versus 2011 for claims up to 10 years post-injury.
- Cost per narcotic decreased 3.4% in the first two years post injury and 1.6% in years 3-10.
- Scripts per claim decreased an average of 5%.

**Narcotic Scripts per Claim 2012 vs. 2011**

- **7% ↓** Short-Acting Narcotic Scripts per Claim
- **3.2% ↓** Sustained-Release Narcotics Scripts per Claim
Morphine Equivalency

MED Explained

Morphine was the first compound to be manufactured from opium and utilized on its own to treat pain, cough, anxiety, asthma, etc. As other compounds were manufactured, morphine became known as the opioid ‘gold standard.’

MED is a conversion of various opioids to a Morphine Equivalent Dose by the use of accepted conversion tables (see table to right). As such, relative potency, duration of action, side effects, etc., of any newly discovered narcotic are compared to those of morphine. As more and more opioids became available, and more patients began utilizing opioids, it became important to have a method to compare medication potency, thereby ensuring patients can be safely migrated to other opioids.

MED for Selected Narcotics

<table>
<thead>
<tr>
<th>Narcotic</th>
<th>Approximate Equianalgesic Dose (oral &amp; transdermal)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine (reference)</td>
<td>30 mg</td>
</tr>
<tr>
<td>Codeine</td>
<td>200 mg</td>
</tr>
<tr>
<td>Fentanyl transdermal</td>
<td>12.5 mcg/hr</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30 mg</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5 mg</td>
</tr>
<tr>
<td>Methadone Chronic: 4 mg†</td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20 mg</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10 mg</td>
</tr>
</tbody>
</table>

*Adapted from VA 2003 & FDA labeling
†Equianalgesic dosing ratios between methadone and other opioids are complex, thus requiring slow, cautious conversion (Ayonrinde 2000)

Average MED at 5 Years Post-Injury

As illustrated in the chart above, the average MED per claim at five years post-injury across the First Script book of business has been steadily declining since 2010. This decline is attributed to the focus applied to narcotic use, including drug lists, outreach, early narcotic intervention and utilization management best practices. Currently, at five years post injury, the average claim utilizing opioids has an average MED of 77.

Washington Landmark Study

When discussing narcotic safety, decreases in MED may be more meaningful than changes in script volume or spend. Landmark study results published in tandem with the Washington State Opioid Guidelines in 2010 demonstrated a nine-fold increase in overdose and death for those patients receiving at least 100 MED. Since that evidence was released, the industry has begun utilizing that bar as a ‘high-dose’ opioid threshold. A goal of reducing MED below that level has been established.

Quick Facts

- Since 2010, the average Morphine Equivalent Dose (MED) for First Script injured workers has declined 11% in the first 2 years post-injury, and 8% in years 3-5.
- Although First Script continues working to further decrease opioid use, 5 years post-injury the average MED is 77, well below the 100 MED safety threshold.
Early Narcotic Intervention

Continues to Increase Patient Safety and Curtail Opioid Use

During Early Narcotic Intervention, registered pharmacists call the prescriber to discuss alternative treatments, adding/revising treatment plans, including the use of provider tools such as opioid contracts and Prescription Drug Monitoring Programs (PDMPs). The goal of the outreach is to influence future prescribing habits and decrease narcotic utilization.

When the prescriber discusses the treatment plan with the pharmacist, First Script has demonstrated opioid use reduction in 97% of the cases. In such cases, the average MED dropped from 61 pre-intervention to 5.5 post-intervention.

Claims enrolled in the Early Narcotic Intervention Program demonstrated

18% ↓ in MED the first year

and 37% ↓ in MED in year two

Differences in Average MED for Clinical Outreach Claims vs. Non-Clinical Outreach Claims

Average MED was analyzed for claims enrolled in the Early Narcotic Intervention Program and those not enrolled. In the early stages of the claim, the average MED was consistent for both groups. However, the MED differences begin occurring between four and twelve months post injury. Nevertheless, once claims surpass the 12-month mark, the average MED is significantly less for those claims in the clinical outreach program (75 MED) versus the remainder of the book of business (99 MED), demonstrating the program impact.
Quick Reference to Federal Controlled Substance Schedules

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules under federal law. Substances are placed in their respective schedule based on whether they have a currently accepted medical use or treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused. Some restrictions on prescriptions can vary by state. Restrictions listed below are based on federal law. Any state may require additional or tighter criteria.

Schedule I Controlled Substances (CI)
Substances in this schedule have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse. Some examples of Schedule I substances are: heroin, marijuana, peyote, and ecstasy. Prescriptions for these substances are illegal by federal law.

Schedule II Controlled Substances (CII)
Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence. Examples of Schedule II narcotics include: hydromorphone (Dilaudid®) and oxycodone (OxyContin®, Percocet®). Examples of Schedule II stimulants include: Adderall® and Ritalin®. In general, prescriptions for CII drugs must be written (not called in by phone or voicemail) or securely sent through approved electronic prescribing software. Refills are not permitted.

Schedule III Controlled Substances (CIII)
Substances in this schedule have less potential for abuse than substances in Schedules I or II and abuse may lead to moderate physical dependence or high psychological dependence. Schedule III narcotics include: combination products containing less than 15 mg of hydrocodone per dosage unit (Vicodin®), products containing less than 90 mg of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®, Butrans®). Examples of Schedule III non-narcotics include: ketamine and anabolic steroids such as Androgel®. Prescriptions for CIII-CV medications expire six months after the date written and may be refilled up to five times during that period.

Schedule IV Controlled Substances (CIV)
Substances in this schedule have a low potential for abuse relative to substances in Schedules I-III. Schedule IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), diazepam (Valium®), lorazepam (Ativan®), and temazepam (Restoril®).

Schedule V Controlled Substances (CV)
Substances in this schedule have the lowest potential for abuse relative to substances listed in all other Schedules and consist primarily of preparations containing limited quantities of certain narcotics. An example of a Schedule V substance is Phenergan with Codeine®. In some states, small quantities of cough medications may be sold through the pharmacy without a prescription, though in practice this is rarely done. Another CV medication commonly prescribed in workers’ comp is Lyrica® (pregabalin).
First Script has worked diligently to reverse the trend of increased drug utilization in older claims through evidence-based drug lists, identification of at-risk claims, prescriber outreach, and selective use of Drug Utilization Assessment/Peer-to-Peer (DUA/P2P).

**Quick Facts**

- Total medication spend for claims up to 10 years post-injury decreased an average of 15% versus 2011.
- Scripts per claim decreased an average of 16% in the same period, with those over one year decreasing 18%.
- Scripts per claim have decreased an average of 19% due to Prescriber Outreach Programs.

Even with significant outside influences on the cost per prescription, First Script was successful in decreasing the number of scripts per claim per year by 15% from 2010 and 2011. In addition to aggressive pricing, these results highlight the importance of vigilant claims management, steering prescribing to alternative generic therapies.
Enabling claims examiners and case managers to make educated decisions about drug therapy is a priority. Our clinical team often receives questions that we know others could benefit from seeing.

Our answer: Ask The Pharmacist email blasts. Currently received by nurse case managers, medical directors, claims examiners, and account managers, these email blasts allow us to educate and provide consultation to a larger audience.

Ask The Pharmacist email blasts are distributed three times a month on various topics, such as:

- Opioid Hyperalgesia
- Morphine Equivalence
- Opioid Management
- Drug Administration
- Dependence
- Controlled Substances
- Mail Order
- Addiction
- Drug Recalls
- Repackaged Drugs

Readers are encouraged to ask their most pressing questions by sending an email to askthepharmacist@cvty.com.
The Drug Utilization Assessment/Peer-to-Peer (DUA/P2P) Program is a valuable and effective program to assist in managing pharmacy overutilization, excessive or unusual prescribing habits, and optimizing claimant outcomes. Unlike the Early Narcotic Intervention Program, which addresses only new narcotic use, the DUA/P2P process can be applied anytime during the life of the claim.

### DUA

- Drug Utilization Assessments require
  - 12 months of medical history
  - 6 months of prescription history
- Cases are identified through the First Script profiling process or via referral from the adjuster or case manager.
- Documenting evidence-based recommendations to optimize the current drug regimen.
- Simplifying and minimizing medications to ensure the injured worker receives necessary therapy.
- Reviewing current drug regimen, emphasizing appropriateness, drug interactions, dosing, MED, and number of prescriptions.

### P2P

- Once a DUA is complete, best practice is to perform a Peer-to-Peer discussion with the prescriber.
- The DUA report is discussed with the goal of helping ensure that necessary changes to the drug therapy are made.
- Agreements are documented in the First Script point-of-sale system and Coventry Bill Review for adherence monitoring.
- Lack of compliance with agreements are addressed by the case manager assigned to the case.

### DUA/P2P Results

- **Recommended changes are implemented in nearly three out of every four cases**: 74%
- **Average annual savings per claim**: $7500
- **Delivering a 400% ROI to First Script clients**
**DUA/P2P Case Study**

A 34 year-old male with chronic lower back pain with radiculopathy, stenosis, and lumbago. History of discectomy and fusion of L5-S1. Currently utilizes a spinal cord stimulator. Worker also has a history of depression that is not claim related.

Date of injury: 2010

Intervention: 3 years post-injury

**Drug regimen before intervention**

- Fentanyl® 100 mcg patch, 1 patch every 2 days
- Hydromorphone®, 4 mg tablets, 4 daily
- Gabapentin®, 100 and 800 mg capsules/tablets, 3,000 mg daily
- Cymbalta®, 60 mg capsules, 2 capsules daily
- Clonazepam®, 0.5 mg tablets, 2 daily
- Diazepam®, 5 mg tablets, 2 daily
- Baclofen®, 20 mg tablets, 4 daily
- Lyrica®, 75 mg capsules, 3 daily
- Total MED = 304, total medications = 9

**Medication issues addressed**

- Duplicate benzodiazepine therapy (Diazepam® and Clonazepam®)
- These medications are controlled substances that increase risk for respiratory depression and overdose when utilized with opioids
- Benzodiazepines are sedatives and may increase symptoms of depression such as lack of energy, inability to enjoy daily activities, and reduced thought clarity
- Duplicate anticonvulsant therapy (Lyrica® and gabapentin, for probable nerve pain) prescribed by two different providers
- Chronic opioid use, which could also be impacting the patient’s depression
- MED at unsafe levels
- Chronic use of opioids is also associated with an increased risk of depression. Tapering opioids may improve the patient’s mental health status

**Drug regimen 5 months after intervention**

- Gabapentin®, 100 and 800 mg capsules/tablets, 3,000 mg daily
- Cymbalta®, 60 mg capsules, 2 capsules daily
- Oxycodone, 5 mg tablets, 4 daily
- Total MED = 30, total medications = 4

**Annual savings for this claim:**

$22,116

**MED reduction in 5 months:**

90%

**Overall script reduction:**

56%

with a significant decrease in medications that could contribute to the patient’s existing depression
A 66 year-old male with a slip/fall injury to the neck and lower back.

History of high blood pressure.

Date of injury: 1987

Intervention: 20 years post-injury

Drug regimen before intervention
- Venlafaxine® ER, 75 mg capsule, daily for depression
- Oxycodone, 30 mg tablet, 3 daily for pain
- Omeprazole, 20 mg capsule, daily for GERD
- Lyrica®, 150 mg capsule, 2 daily for nerve pain
- Mobic®, 15 mg tablet, daily for inflammation/pain
- OxyContin®, 60 mg tablet, 2 daily for pain
- Total MED = 315, total medications = 6

Medication issues addressed
- History of high blood pressure, which is a risk factor for heart disease, with chronic use of Mobic® (meloxicam), an NSAID which also increases risk for heart disease
  - Naproxen, another NSAID, is less likely to contribute to heart disease and is a safer option for the injured worker if long-term NSAID therapy is needed
- Significant MED more than 20 years post-injury
  - The suggestion was made to switch to a generic morphine ER/IR combination and to taper off of narcotics over the next 6-36 months
- Within 3 months, the MED had been reduced by nearly 60%
- Rotating narcotics may facilitate tapering and reduce hyperalgesia
- Omeprazole was discontinued with the switches to naproxen and/or morphine
- Lyrica® dose was lowered along with the narcotic doses
- Venlafaxine® ER was appropriate to continue for this patient

Drug regimen 3 months after intervention
- Venlafaxine® ER, 75 mg capsule daily for depression
- Lyrica®, 100 mg capsule, 2 daily for nerve pain
- Naproxen, 550 mg tablet, 2 daily for inflammation/pain
- Morphine IR, 15 mg tablet, 3 daily for pain
- Morphine ER, 30 mg tablet, 3 daily for pain
- Total MED = 135, total medications = 5
In the battle concerning sustained-release narcotics, the graphs below indicate things are moving in the right direction. While a single data point does not equate to a trend, our narcotic intervention activities demonstrate impact. Reviewing the total number of prescriptions dispensed through First Script, there have been decreases in the number of both short-acting and sustained-release narcotics.

Most of the other therapeutic classes remained consistent year-over-year with the exceptions of anticonvulsants and antiulcer medications. Anticonvulsants are used to aid in chronic pain management. With the exception of Lyrica®, anticonvulsants are not addictive, nor abused. Antulcer medications are generally used as adjunct therapies to support side effects of many of the pain management medications, especially non-steroidal anti-inflammatory drugs (NSAIDs).

### Trends in Top Therapeutic Classes

#### Top 10 Therapeutic Classes Percentage of Total Amount Billed

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Percentage of Total Amount Billed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics, Short-Acting</td>
<td>20%</td>
</tr>
<tr>
<td>Analgesics, Sustained-Release</td>
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</tr>
<tr>
<td>NSAIDs</td>
<td>10%</td>
</tr>
<tr>
<td>Anti-anxiety Medications, Non-TCA</td>
<td>5%</td>
</tr>
<tr>
<td>Dermatological/Topical Preparations</td>
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<td>Antipsychotics</td>
<td>5%</td>
</tr>
</tbody>
</table>

#### Top 10 Therapeutic Classes Percentage of Total Prescriptions

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</tr>
</thead>
<tbody>
<tr>
<td>Analgesics, Short-Acting</td>
<td>30%</td>
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<td>Antipsychotics</td>
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</tr>
<tr>
<td>Antidepressants</td>
<td>5%</td>
</tr>
<tr>
<td>Anti-anxiety Medications, TCA</td>
<td>5%</td>
</tr>
</tbody>
</table>

### Quick Facts

- Short-acting narcotics have moved to the top therapeutic class.
- Spend and scripts for antianxiety medications, sedative/hypnotics and muscle relaxants have steadily decreased.
- Ranking for NSAIDs, anticonvulsants and dermatological/topical preparations have remained steady.
- Anticonvulsants, appropriate for chronic use in some cases, have increased.

### Sustained-Release Narcotics

- Fell from the #1 class to #2, based on amount billed.
- Number of scripts have decreased slightly as well.
- Decreasing use of this class is important in that sustained-release narcotics:
  - Contain more active ingredients per dose than most short-acting narcotics, contributing to higher rates of misuse, abuse and diversion.
  - Are indicative of chronic opioid use, as around-the-clock narcotic levels are needed to manage pain.
Similar to the Top 10 Therapeutic Classes, 2012 did not experience much change for the Top Ten Drugs. OxyContin® and the other opioids in the Top Ten Drug List continued to decrease in spend and utilization year-over-year. Non-narcotic pain management alternatives such as generic Neurontin® and Cymbalta® are on the rise.

Lidoderm® remains the second most prescribed drug with the second largest proportion of spend. The patch is not FDA-approved to treat chronic pain conditions in workers’ comp. Evidence-based studies demonstrating the lack of efficacy in pain management can be found at www.clinicaltrials.gov. In alignment with the FDA view of Lidoderm®, First Script does not include the medication on any of our drug lists and claims examiner approval is required for Lidoderm® to be dispensed through the POS system.

Quick Facts

- OxyContin® represented less than 9% of total spend versus more than 10% in 2010.
- All opioids on the Top Ten Drug List have decreased in spend since 2011.
- Lidoderm® remains the second most prescribed drug with the second largest proportion of spend.

The goal of the Therapeutic Alternative Program (TAP) is to optimize treatment outcomes while increasing appropriate generic utilization and maximizing cost-effectiveness for specific drugs. The process is simple – the First Script Clinical Pharmacy Team performs a telephonic outreach to the provider to discuss alternative therapies, incorporating recommendations from the Coventry Pharmacy & Therapeutics (P&T) Committee. Currently, the TAP Program addresses the use of Cymbalta®, Celebrex®, Flector®, Lyrica®, and Lidoderm®. Criteria for additional medications are underway.
Clinical Wins

Celexa® (Citalopram) Six Month Follow-Up Shows Lasting Impact

Last year the recommended dosage for the popular antidepressant Celexa® was revised from 60 mg to 40 mg per day due to indications that the higher dose could lead to potentially fatal heart arrhythmia in some patients.

In an initial study, First Script identified providers who continued to prescribe higher doses three months after the revision announcement. These providers were contacted with pertinent information about the dosage change. Ninety days after the initial outreach, prescribing data was analyzed to determine if a change in prescribing patterns had occurred, and indeed, 58% of the providers receiving letters did change their therapy.

To determine the long-term effects, a second analysis was performed at 180 days post-outreach. At this point, 47% of the affected claimants continued with the same therapy they were receiving at the 90-day mark, and an additional 35% positively changed their therapy and improved their safety profile.

90-Day Results

- 58% didn’t change regimen
- 27% switched to an improved regimen
- 31% reduced/discontinued use
- 42% didn’t change regimen

180-Day Results

- 35% reduced/discontinued use
- 47% continued therapy in place at 90 days
- 18% switched to a different regimen

Celexa® Prescription Cost per Day

90 days after the outreach, the cost per day decreased by 16%.
**Lyrica® Provider Outreach Case Study**

The First Script Provider Outreach Program targeted improved patient safety and significant client savings for injured workers taking the popular anticonvulsant Lyrica®, which is typically utilized to treat chronic nerve pain.

First Script sent letters to those prescribers whose patients received prescriptions in excess of the daily recommended dose. The outreach was intended to communicate the recommended daily dose of Lyrica® and the risk associated with increased use. Ninety days after the outreach, a review of the data was performed. First Script found that in more than 35% of the cases, their safety profile had improved – 21% discontinued anticonvulsant therapy and 15% began receiving a dose below the 600 mg threshold. In addition, a 13% reduction in spend was observed.

Again, a targeted, evidence-based provider outreach can have significant, positive impact on patient safety and client spend. First Script will continue to identify new drug changes that could benefit from outreach and report such findings as they occur.6, 7

*Note: Lyrica® (pregabalin) is a CV controlled substance indicated to treat fibromyalgia, shingles and diabetic nerve pain, partial onset seizures in adults, and nerve pain associated with spinal cord injuries. Common side effects that occur with Lyrica® include: dizziness, somnolence, weight gain, peripheral edema, increased thoughts of suicide, and hypersensitivity reactions. Injured workers currently taking more than 600 mg per day are advised not to change their daily dose without speaking to their health care provider. Those injured workers requiring a dose reduction should be tapered down slowly to avoid any withdrawal effects.*

**Quick Facts**

- More than 35% of cases showed safety profile improvements.
- 21% discontinued anticonvulsant therapy.
- 15% began receiving a dose below the maximum 600 mg threshold.
- A 13% reduction in spend was observed.
Progress with Muscle Relaxants

Muscle relaxants are indicated only for acute musculoskeletal pain – exceptions being tizanidine and baclofen which both have studies supporting longer-term use. There appears to be a disconnect between clinical evidence and prescribing practices in workers’ comp. Part of this may be related to patients obtaining a euphoric effect when muscle relaxants are taken in combination with narcotics. The combination of the two medications is dangerous due to the increased central nervous system depression which could lead to fatal consequences.

First Script has been diligently working with the prescribing community to decrease the inappropriate use of muscle relaxants. Through the incorporation of state guidelines, injury-specific drug lists, adjuster alerts for chronic use, physician outreach through educational letters, and peer review conversations, the overall trend in muscle relaxant use is heading in the right direction.

Quick Facts

- Muscle relaxants constitute just under 10% of all prescriptions and are in the Top Ten Therapeutic Classes for the First Script book of business.
- Since 2010, spend and utilization have been on the decline, attributable to successful integration of clinical programs.
- Although muscle relaxants are most effective in the first four days of treatment, they are often prescribed chronically.
- Baclofen and tizanidine (Zanaflex®) are the only two muscle relaxants that have sufficient evidence to support long-term use.
- The most significant declines were observed for Soma®, a controlled substance, and Amrix®, neither of which is formulary approved by Official Disability Guidelines.
Physician Dispensed Medications
The Issue and the Solution

The Myth
When medications are dispensed in a physician’s office, patients are more compliant with the medication regimen, and therefore, recover faster.

A recent CWCI study reported that
Claims Involving Physician Dispensing Had:

17%↑ higher medical costs
13%↑ higher indemnity costs
9%↑ more lost days
than similar claims not involving physician dispensing.

The Truth
Physician dispensed medications skip a safety check for interactions with other drugs the patient may be taking. Limited opportunities exist for identification of inappropriate dispensing at the pharmacy Point-of-Sale (POS).

Our Solution for Physician Dispensed Drugs
• Physician dispensed prescriptions are integrated into the POS system.
• Enables a full history view for utilization management.
• Included in the First Script risk assessments.

this integration results in a savings of 80% from billed charges,
and 35-45% off of fee schedule

The First Script clinical solution ensures that all physician dispensed medications are integrated into the POS system allowing for a full view of medications an injured worker is taking. The POS system will capture any drug interactions on all future fills, protecting injured workers from further safety risks. The transactions are also added to the patient’s total drug utilization composite to identify other risk factors. Simultaneously, the integration of Coventry’s Bill Review with the First Script POS system, allows us to apply fee schedule rules to ensure the lowest possible jurisdictionally appropriate costs to our clients. The result? A reduction in repackaged medication spend of 80% off of billed rates and 35-45% below fee schedule is delivered, as well as visibility to all scripts, which enhances safety.
Pharmacy Headlines in 2012

Opioid Policy: Varying Approaches Across the Country

Among patients who are prescribed opioids, 20% are prescribed at high doses of 100 MED or more; these MED levels account for 80% of prescription opioid overdoses. In fact, three out of four medication overdoses are due to opioids. Narcotic overutilization continues to be a significant issue in workers’ compensation. While theories to manage the issue differ, they all have the same goal—to promote patient safety, improve outcomes, and reduce misuse, abuse, and diversion.

- The opioid epidemic remains relevant in workers’ comp—roughly one in three scripts are written for opioids
- States are passing new legislation aimed at reducing opioid abuse via Medical Treatment Guidelines (MTGs) and Prescription Drug Monitoring Programs (PDMPs)
- The Food and Drug Administration (FDA) is defining ‘abuse-resistant opioid’ and has drafted guidance on how to obtain that designation
- Continued use of opioids should now demonstrate both decreases in pain level AND improvements in functional capacity
- First Script has developed powerful, targeted tools to complement national and state objectives to reduce opioid prescribing

State Highlights

New York State has initiated a program called the I-STOP (Internet System for Tracking Over-Prescribing) Act. In September 2012, this legislation was passed to create a real-time prescription drug monitoring program, requiring electronic prescribing of controlled substances by 2014, to change hydrocodone products to Schedule II status and tramadol to a Schedule IV status, to expand prescriber education, and to provide for safer drug disposal. As of February 23, 2013, hydrocodone-containing products are no longer available for refill, and tramadol prescriptions are now limited to a six-month expiry and a maximum of five refills. Towards the end of 2013, there will be increasing numbers of electronic prescriptions (e-scribing) for controlled substances as New York offices obtain and institute the needed software to transmit them. The benefit to e-scribing controlled substances is fraud reduction: by channeling these medications through encrypted software, abusers can no longer copy or forge paper prescriptions.

The Washington guidelines were revised in 2012, approved in January 2013, and will become effective in July. One of the most critical additions was to define ‘Clinically Meaningful Improvement in Function,’ or CMIF, as a 30% functional improvement and to add the criterion as a requirement to continue opioid therapy. This definition was supported by clinical evidence, and as such, has been integrated into the Official Disability Guidelines (ODG), which are utilized as a primary injury-related resource for about 30 states.

In January 2013, cities in Maryland, Massachusetts, North Carolina, and Wisconsin were awarded grants through the 2013 Safeguard My Meds Prescription Drug Abuse Recognition Program at the United States Conference of Mayors (USCM). The cities were chosen due to local initiatives that demonstrated the greatest potential to reduce the abuse and misuse of prescription drugs, particularly among young people.

National Highlights

In late 2012, the FDA proposed draft guidance on abuse-resistant opioids. The guidance includes methods to study reductions in abuse and may enable such drugs to be called ‘safer’ than non-abuse resistant drugs.

In July 2012, a petition signed by 37 members of Physicians for Responsible Opioid Prescribing (PROP) was sent to the FDA asking that they ‘require opioid label changes that would strike the word “moderate” from chronic non-cancer pain (CNCP) opioid treatment indications and limit the drug’s use solely to severe pain—and then only for a maximum of 90 days at no more than the equivalent of 100 mg of morphine daily.’

Compounded Medications

2012 regulations required the disclosure of all compound ingredients for the first time ever. Prior to these changes, only the most expensive ingredient was billed. 2013 will offer a first look at year-over-year data regarding how the mandate has affected compound utilization. We will be better able to see which ingredients are driving utilization which will assist in determining how best to manage the category moving forward.
Meningitis Tragedy Spotlights Compounded Medications

In early October 2012, meningitis cases began making the news. By the end of 2012, hundreds of patients had been affected, with 58 losing their lives. Due to poor sterility controls, the now infamous Massachusetts compounding pharmacy, the New England Compounding Center (NECC), released fungus-contaminated steroid injections onto the market.

Compounded medications serve a purpose when unique formulations are needed to meet specific patient needs for ingestion/injection or when commercial products are unavailable due to drug shortages. However, not every compounded medication created is necessary. This is especially true for many of the topical compounds used in to treat workers’ comp injuries. While a topical compounded medication can offer combinations, formulations, or strengths not commercially available, requirements to show evidence of effectiveness in these individualized medications do not exist. This is especially relevant in workers’ compensation where any number of topically applied combinations of medication can be found. Compounded medications are increasing in popularity despite a general lack of data supporting their effectiveness.

These risks have certainly been a focus since the meningitis outbreak, and with each subsequent compound recall. In fact, there have been 11 recalls of compounded medications in the first quarter of 2013 as a direct result of increased inspections.\(^{14}\)

**Compound Management at First Script**

- Verification of each ingredient and corresponding cost
- Required prior authorizations for all compounds
- Recommended utilization review for medical necessity
- Identification and routing of non-network compound bills ensuring they are handled consistently with in-network prescriptions
- Educational webinars offered to adjusters addressing concerns, pitfalls and ingredients not supported by clinical studies

The goal of our compound management programs is to improve patient outcomes while decreasing claim costs. We look forward to presenting the impact of these programs with a full year of data in our 2013 *Pharmacy Trend Analysis.*

**Official Disability Guidelines (ODG), an evidence-based disability resource, states the following regarding the use of compounds:**

- Compounded medications are only recommended after first and second line FDA-approved medications have failed.
- Topical pain medications are primarily recommended for nerve pain when trials of antidepressants and anticonvulsants have failed.
- The use of topical compounded agents offers no advantage over systemic use and is currently not supported by the ODG.
- Gabapentin (for nerve pain), ketamine (a pain reliever), baclofen (muscle relaxant), cyclobenzaprine (muscle relaxant), and tetracaine powder (numbing agent) are not currently FDA approved for topical application.
- Topical medications are associated with an extremely high incidence of dermatitis or skin rashes.
- Absorption of the drugs through the skin depends on the base in which they are delivered.
- Topical treatments may result in blood concentrations and effects on the body that are highly variable when compared to commercial forms, and caution should be used for patients at-risk, including those with kidney problems.
- Topical pain medications are largely experimental in use with few properly designed clinical trials to demonstrate effectiveness or safety.
- The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required.
Texas Formulary Changes

Heading into the 21st century, the Texas State Workers’ Compensation program, also known as the Texas Department of Insurance, Division of Workers’ Compensation (TDI-DWC), found itself facing a system full of double-digit cost increases while, at the same time, injuries were decreasing. In response to the trend, House Bill 7 (HB7) was introduced during the 79th session of the Texas Legislature. Among the changes required by HB7 was the adoption of a closed drug formulary. Prior to the approval of the closed formulary, the state of Texas paid for all FDA-approved medications, regardless of the indication for use. With the collaborative input received, the closed formulary was implemented to bring more drug prescribing consistency in both certified network and non-network claims.

The Texas Formulary is based upon ODG recommendations. If a drug is prescribed that is outside of the ODG recommendations, then a preauthorization (PA) is required to justify medical necessity for the excluded drug. A PA is required for any drugs designated as ‘N’ under the ODG, meaning those drugs considered experimental, investigational or not recognized for use in treating a particular injury or condition.

The implementation of the Texas Formulary was set to be completed in two main phases, as described in the chart below, with three main milestones. The third and final milestone (green) is September 1, 2013, which brings the closed formulary back to a single track line, showing the closed formulary to be applicable for all claims, regardless of dates of injury (DOI).

After September 1, 2013, every claim must utilize the closed formulary, or the prescriber must provide documentation as to the medical necessity of the excluded drug. This documentation is then forwarded to the appropriate claims examiner for approval or denial. If desired, the claims examiner may forward the request to utilization review (UR) to further confirm medical necessity. If UR is able to determine that the ‘N’ drug in question is NOT medically necessary, then the claims examiner can deny the request from the prescriber. If UR confirms medical necessity, then the request must be approved. Integrated clients (those utilizing the First Script PBM, UR, and bill review) will have the added benefit of a streamlined process that will reduce the need for manual intervention, eliminating the burden for claims examiners.

Currently, a letter is available to clients explaining UR options, and will fulfill the official notice requirements for the Texas law. This letter invites prescribers to a conversation with a Coventry Texas UR doctor. Once the date of September 1, 2013 arrives, we expect a significant increase in requests for UR. The earlier these conversations occur, the better for everyone involved.

A white paper discussing the influence of the Texas Formulary on prescribing patterns was released by First Script in 2012. That white paper indicated significant decreases (64%) in prescriptions for ‘N’ drugs. A follow-up to that document is planned later this year to determine the impact of the formulary on UR, outcomes, and continued prescribing trends.

Texas Closed Formulary Timeline

**Medical Interlocutory Order
Expected First-Time Generics in 2013
Litigation changes patent expiration dates with regularity. However, at this time, the following medications may be available generically by the end of 2013:

<table>
<thead>
<tr>
<th>Workers’ Comp Drugs with 2013 Patent Expiry</th>
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<tbody>
<tr>
<td>Cymbalta®</td>
</tr>
<tr>
<td>Lidoderm®</td>
</tr>
<tr>
<td>Maxalt®*</td>
</tr>
<tr>
<td>OxyContin®</td>
</tr>
<tr>
<td>Valcyte®</td>
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*Late 2012 expiry

Rx Drugs with Acetaminophen Reformulated
The recommended dosage of acetaminophen has been in hot debate in recent years. In 2009, the FDA Advisory Panel suggested that the maximum dosage of acetaminophen (APAP) be reduced to 3,200 mg per day and that the maximum single dose not exceed 675 mg. The FDA did not follow these recommendations; however, a new mandate was made in January 2011. The FDA then declared that no more than 325 mg of acetaminophen per tablet will be permitted in any combination prescription products, such as Vicodin® and Percocet®, by 2014. This means the coming year may bring the possibilities of old formulations no longer being available, confusion for injured workers or prescribers as the changes occur, changes in AWP for available medications and/or the prescription of alternative medications. First Script will follow this as it unfolds, and provide recommendations on potential injured worker education.

Specialty Medications
What’s so special?
• 15 years ago, there were 30 specialty drugs – today there are more than 200
• By 2020, specialty drugs are expected to occupy 8 of 10 spots on the Top 10 Drugs List
• Hundreds of specialty drugs are in phase II or III trials, 7% of these (42 medications) are geared for pain/inflammation
• 2012 saw an 18.4% increase in specialty spend while spending for traditional medications decreased

Are Specialty Medications Important to Injury Claims?

Specialty Drugs in Workers’ Comp
• Most likely to appear in claims involving soft tissue injuries
• Seen for conditions such as blood clot prevention and arthritis treatment
• Cost for specialty arthritis and hematological medications is generally 20 times higher than traditional therapy
• Many biologic specialty medications are injectables, and therefore, require administration by a provider, resulting in excessive costs

Coventry Specialty Drug Study
• Claims involving torn cartilage, ligaments and tendons accounted for 15% of the specialty medication spend
• Strains accounted for 7%
• Herniations and ruptures accounted for 5%

As we head towards a future of specialty medications, utilization and spend management will be key to program success. Integrated bill review uniquely positions First Script to capture these excessive costs and work with clients, providers, claimants to resolve any issues and redirect specialty scripts through our pharmacy network.

Overall Drug Spend, Workers’ Comp
Specialty drugs account for 2% of workers’ comp spend.

Drug Spend for Claims Which Include a Specialty Drug
For those claims utilizing specialty drugs, 37% of total pharmacy spend is attributed to the specialty drug.
Summary

First Script book of business trends in 2012 have been positive both in controlling costs for our customers and promoting the health and safety of their injured workers:

Generic Efficiency
Continual efforts to encourage generic drug utilization resulted in generic efficiency increases from 90-97%↑

Opioid Management
For claims in years 1-10 specific focus on the opioid epidemic demonstrated
- Total narcotic spend 17%↓
- Narcotic scripts per claim 15%↓
- Sustained-release narcotics moved down from 1st in therapeutic class to 2nd

MED Education and Impact
MED education efforts resulted in steady decreases in MED levels from 82 in 2010 down to 77 in 2012 and decreases of 11% in years 1-2 and 8% in years 3-5 post injury

Early Narcotic Intervention
Our Early Narcotic Intervention Program demonstrated an 18% decrease in MED in year 1 and 37% decrease in year 2

Physician Outreach
Physician Outreach Programs continue to show lasting effects with
- 47% continuing the therapy changes made immediately post-outreach
- As high as 58% of cases resulting in reduced, discontinued, or improved drug regimen

Physician Dispensing Solution
Our Physician Dispensing Solution delivered integration benefits:
- 80% savings from billed charges
- 35-45% off fee schedule
- A complete medication safety profile for all in-network prescriptions at POS

What’s in store for 2013
- Expanding our footprint with clients interested in:
  - 360° view of their pharmacy spend through the integration of bill review and in-network PBM prescriptions.
  - Early claim triage and intervention delivering both reduced filed claims and increased network utilization, pharmacy and physician.
  - Enhanced reporting capability to demonstrate total pharmacy experience versus in-network experience.
  - Expanding compound drug utilization review to the physician dispensing environment, ensuring that compound prescriptions are handled consistently regardless of dispensing source.
  - Delivering an enhanced adjuster experience through our Coventry Connect® portal.
  - Automated alerts advising adjusters when a case could benefit from a drug utilization assessment.
  - All prescriptions processed through Coventry Bill Review and failing POS system edits will be routed to the adjuster for approval/denial.
  - Continued client collaboration ensuring product development initiatives deliver highest value.

Together – First Script is committed to ensuring No Script Unmanaged. No Injured Worker Left Behind.
References

1. www.firstdatabank.com

2. www.medispan.com. Beginning September 2011, FDB discontinued publishing AWP information on which cost data is based. As a result, all pricing data supplied is drawn from the Medi-Span® database.


Coventry Workers’ Comp Services, a division of Aetna, is the leading provider of cost and care management solutions for property and casualty insurance carriers, (workers’ compensation and auto insurers), third-party administrators and self-insured employers. We design best-in-class products and services to help our partners restore the health and productivity of injured workers and insureds as quickly and as cost effectively as possible. We accomplish this by developing and maintaining consultative, trusting partnerships with our clients and stakeholders, built on a foundation of innovative and customized solutions that support the claims management process.

First Script is the Pharmacy Benefit and Drug Utilization Management program offered as part of the Coventry suite of products. First Script offers an end-to-end program designed specifically for workers’ compensation. We realize that getting 100% of the scripts into the network isn’t the end game, it is what you do with those scripts that matters. Early triage of each injured worker ensures that injured workers know how and where to get a prescription filled, and permits us to intervene aggressively on potentially problematic narcotic utilization at the earliest point possible. Through the integration with our bill review and case management programs, we are positioned to capture all prescription activity for utilization and total pharmacy risk management, ensuring that no script is left unmanaged, and no injured worker is left behind.