Drug Trends Analysis

Drug Utilization and Spending Trends in Workers’ Compensation
The data provided in this First Script Drug Trends Analysis includes transactions billed through Coventry Workers’ Comp Services’ Pharmacy Management Program, First Script, from January 2013 to December 2013. Average Wholesale Price (AWP) was used as the pricing basis to provide clean data comparisons for the entire book of business. This approach normalized the data and removed biases related to contracted pricing and variance in jurisdictional fee schedules. Client contracted pricing is less than AWP. The methodology was applied to previous years to ensure consistency in the data trending. Compounds were excluded from trending. Supported by recent research, nationally published statistics, and other objective data sources, current workers’ compensation trends are illuminated. Clinical categorization is derived from fdb™, formerly known as the First Databank database.6 Pricing data supplied is drawn from the Medi-Span65 database.

Coventry Workers’ Comp Services
Last year we made a commitment to our customers that First Script would “leave no script unmanaged” and that “no injured worker would be left behind.” So where did that lead?

We’ve made meaningful progress toward this goal in 2013 by expanding our reach into non-traditional pharmacy agents including billers for physician dispensed medications, occupational-medicine clinics, third-party billers, external mail houses, and compounding prescription sources to manage all pharmacy utilization and spend.

As a result of our advancements in 2013, we are able to capture not only the First Script but Every Script and deliver an unprecedented level of clinical management for our customers and their injured workers.

Today we clinically review every prescription no matter where it was dispensed or billed and are able to present a complete utilization picture at the customer and injured worker level. Our expanded prescription data set accelerates clinical insight to identify injured worker risks that were previously unknown.

With this broader view, our clinical staff and data analytic teams collaborate to develop sophisticated data models to refine our injured worker risk identification and RxProfile. This focus also enables continuous clinical product development and enhancements for our customers.

Last year we provided impact data driven by our Early Narcotic Intervention program, and we have continued to strengthen this program throughout 2013. Today First Script reaches out not only to prescribers but also to injured workers, creating educational opportunities while performing outreach to confirm an expected date for opioid cessation which is recorded into our Point-of-Sale (POS) system. We hold ourselves and the prescriber accountable for appropriate medication therapy and the safety of every injured worker in our care. We encourage injured workers to be active in treatment decision-making to promote their own recovery. As you will see, our data demonstrates that this broad-based campaign is working well.

A few trend highlights from this year’s report include:

- Claimants using narcotics across the First Script book of business have declined
- The top 10 drugs remained consistent; however, the top two most prescribed narcotics declined from 2012
- Oxycontin®, Vicodin® and Opana® ER had decreases in utilization and spend from the prior year
- The number of narcotic prescriptions remained relatively flat in newer claims (years 1-4), demonstrating the ongoing effectiveness of our early intervention programs
- The cost per narcotic script decreased year-over-year for all claim years (1-10), when normalized for inflation
- Focused attention on decreasing narcotics resulted in utilization increases across adjuvant medications to support pain management
- AWP increased 12.5% in 2013, the greatest increase in the past four years
- Generic utilization and efficiency continue to improve

Our Regulatory & Legislative Affairs team relies upon the Coventry expanded data store and our internal analytic expertise to understand customer experience and risk to craft position papers that influence regulators during the draft rule process. Our efforts have promoted positive legislative changes in several states.

Looking ahead, we are confident we will generate even greater value to our customers through our ongoing clinical and expanded network enhancements, risk analytics and regulatory activity.

Optimal outcomes and cost savings can only be achieved through an “all in” focused pharmacy management solution. We are looking forward to delivering upon our commitment for 2014.

First Script. Every Script.

Brian Carpenter, R.Ph.    Alan Madison
VP, Product Development   VP, Operations
Understanding Total Pharmacy Spend

What business wants to make decisions based on incomplete information? Yet sometimes, we’re forced to do just that. Fortunately, when it comes to what we spend on prescriptions, the answers are available. In fact, employers and payors may be able to achieve greater clarity and control around pharmacy than they realize.

Seeing the Big Picture

Historically, prescriptions have been split between those submitted through a Pharmacy Benefit Management (PBM) and out-of-network “paper” bills submitted through bill review. PBM programs have previously focused on retail network prescriptions — those from contracted network pharmacies. They apply contracted rates to those prescriptions captured only within the network — and derive network penetration percentages strictly from PBM transactions. That’s a good start, but employers and payors understand that it’s not the entire picture. To get a better handle on prescriptions (and an accurate understanding of total pharmacy spend and risk), First Script goes beyond a retail-only view and captures prescriptions filled at non-network pharmacies, through clinical and specialty/compounding pharmacies or in the doctor’s office, and those that pass through third-party billers. This requires extended network relationships with non-traditional dispensing and billing sources, as well as mail order pharmacies and compounding networks. We are leveraging extended networks through First Script to drive pharmacy expenses below fee schedule and remove these prescription bills from the bill review process — typically eliminating bill review fees.

To get a better handle on prescriptions First Script goes beyond a retail only view and captures prescriptions filled at non-network pharmacies, through specialty/compounding pharmacies or in the doctor’s office, and those that pass through third-party billers.

Integrated Information Increases Opportunities

Having an eye on all prescriptions regardless of billing source — in network, extended networks (both managed by the First Script) and prescription transactions captured in bill review — provides advantages beyond understanding total pharmacy spend. This comprehensive approach offers greater opportunities to reduce spending through utilization management (UM) and, most importantly, to improve clinical outcomes.

Of course, the earlier the interaction, the greater the ability to impact the claim, particularly when narcotics are involved. For First Script at the POS, that can mean alerts, drug utilization review edits, and application of drug formularies, including formularies specific to the injured worker and the injury. But, again, this is just the beginning. This level of impact is only possible with a consolidated drug utilization history. Integrating the prescription data from non-traditional PBM sources, like extended networks and bill review, increases the effectiveness of POS edits before the next fill is dispensed. Further, this integration also supports the most impactful drug utilization assessments and prescriber outreach on otherwise potentially “runaway” claims.

Making a Difference Where It Matters

Cost control is critical, but ideally the goal is a better outcome. Getting a handle on the whole prescription picture provides the information necessary to engage all claim stakeholders and support the timely outreach and interaction necessary to achieve that goal. This is especially true when opioids are involved. Early intervention — whether provider outreach, patient education, or interaction with a nurse case manager — can play an important role in helping the injured worker move toward recovery.
Accessing the full prescription history, regardless of where the drugs are dispensed, makes it possible for First Script to develop a complete prescription profile that gives the adjuster and case manager more valuable insight than a series of individual PBM alerts can provide.

Clearly, capturing data from the first script, including every script, not just those filled within the retail network, provides valuable answers to a great many questions. It not only helps control costs and gives a more accurate picture of pharmacy spend, but it weaves a safety net that helps ensure that no injured worker is left behind.

Armed with answers to questions about the patient’s history, drug use, comorbidities and more, the adjuster and nurse are better able to select the most effective tools and identify next steps in the plan of action.

By putting all drug-related information in one place, First Script RxProfiles paint a more accurate picture of patient risk.

100% of prescriptions from all dispensing or billing sources

Integrated Pharmacy Database

Pricing Outcomes
Pricing through our Network, Extended Network, & Extended Pricing

Clinical Outcomes
Clinical management and decision support for TOTAL claim management
New Drugs, New Generics and What’s New in 2014

How New Drugs Are Handled

- Driven by client-specific drug formularies and national guidelines
- If a client follows best practices in alignment with ODG, handling will comply with the guidelines
- If a client covers a class of drug, new drugs in that class will be added to their formulary
- If First Script does not recommend a particular drug being included on the formulary (e.g., long-acting hydrocodone), it will be placed on the exception list requiring prior authorization before filling

Generics

- Required by most clients when a bio-equivalent is available for a brand-name medication
- Brand-name drug is blocked at POS as soon as the generic is available, unless prior authorization is in place
- Physicians may require the brand-name product
- Pharmacists can override when there are issues with market availability of the generic

New Drug Approvals Expected During 2014

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Therapeutic Class</th>
<th>Anticipated Approval Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posidur™ bupivacaine</td>
<td>Anesthetic</td>
<td>Declined by FDA Feb. 12, 2014³</td>
<td></td>
</tr>
<tr>
<td>Xartemis™ oxycodone/acetaminophen</td>
<td>Narcotic Sustained-Release</td>
<td>FDA Approved March 14, 2014⁴</td>
<td></td>
</tr>
<tr>
<td>MoxDuo® morphine/oxycodone</td>
<td>Narcotic Sustained-Release</td>
<td>Declined April 22, 2014⁵</td>
<td></td>
</tr>
<tr>
<td>Targiniq ER oxycodone/naloxone ER</td>
<td>Narcotic Sustained-Release</td>
<td>Accepted for NDA in Nov. 26, 2013 (No estimated date for approval)</td>
<td></td>
</tr>
<tr>
<td>Bunavail® BEMA buprenorphine/ naloxone</td>
<td>Narcotic Sustained-Release</td>
<td>Anticipated FDA Approval Date June 7, 2014 (Available Q3 2014 if approved)⁶</td>
<td></td>
</tr>
<tr>
<td>Zorvolex® diclofenac</td>
<td>NSAID</td>
<td>Approved Oct. 18, 2013⁷</td>
<td></td>
</tr>
</tbody>
</table>

*Product availability in the market may lag significantly and dates may change. *(†) Schedule CII pain medications to be watched closely.

New Generics 2014*

<table>
<thead>
<tr>
<th>Brand Name</th>
<th>Generic Name</th>
<th>Therapeutic Class</th>
<th>Patent Expiration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lidoderm® lidocaine patch</td>
<td>Topical Preparations</td>
<td>Late 2013</td>
<td></td>
</tr>
<tr>
<td>Cymbalta® duloxetine</td>
<td>Anti-depressant</td>
<td>Late 2013</td>
<td></td>
</tr>
<tr>
<td>Celebrex® celecoxib</td>
<td>NSAID</td>
<td>December 2014</td>
<td></td>
</tr>
<tr>
<td>Flector® diclofenac epolamine</td>
<td>Topical Preparations</td>
<td>April 2014</td>
<td></td>
</tr>
<tr>
<td>Exalgo*** hydromorphone ER</td>
<td>Narcotic Sustained-Release</td>
<td>May 2014</td>
<td></td>
</tr>
<tr>
<td>Naprelan® naproxen sodium ER</td>
<td>NSAID</td>
<td>June 2014</td>
<td></td>
</tr>
</tbody>
</table>

* Generics may be launched at later dates. **All strengths except 32 mg
Average Wholesale Price

AWP increases typically affect brand-name drugs; generics stay relatively flat

AWP increased 12.5% in 2013
- 7.5 points higher than 2012
- Greatest increase in the past 4 years

Factors that influence AWP
- Research and development costs associated with new drugs (billions of dollars)
- Increasing costs to cover future patent expiration
- New government requirements that impact supply and demand

Factors that may influence generic costs
- AWP generic pricing (new to market generics) is not significantly less than the brand-name products, i.e., the new lidocaine patch is only 10% lower than the brand-name counterpart
- New FDA proposed label changes, changing prescribing language for new safety changes, are expected to result in higher cost generics due to the legal expenses

How Does the AWP Increase Impact Your Spend?
True: AWP increased 12.5% in 2013
False: Every client’s drug spend should have increased 12.5%
Why? The mix of drugs prescribed and the First Script utilization controls will impact total spend

This year the data identifies that generic oxycodone — acetaminophen jumped in price in the range of 100% to 200% (strength dependent) just in the 4th quarter

Trend Changes From 2012 to 2013

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Change in Cost per Script</th>
<th>Change in Utilization per Claimant</th>
<th>Total Change in Cost per Claimant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narcotics (Total)</td>
<td>5.3%</td>
<td>-9.1%</td>
<td>-3.3%</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>5.5%</td>
<td>-1.9%</td>
<td>3.7%</td>
</tr>
<tr>
<td>Muscle Relaxants</td>
<td>5.6%</td>
<td>-4.7%</td>
<td>1.1%</td>
</tr>
<tr>
<td>NSAIDs</td>
<td>9.1%</td>
<td>2.2%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Dermatological/Topical Preparations</td>
<td>-3.1%</td>
<td>7.7%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Antidepressant Medications, Non-TCA</td>
<td>11.1%</td>
<td>-10.0%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Sedative/Hypnotics</td>
<td>7.4%</td>
<td>-13.6%</td>
<td>-5.2%</td>
</tr>
<tr>
<td>Antiulcer Medications</td>
<td>4.7%</td>
<td>-0.8%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>9.8%</td>
<td>-14.5%</td>
<td>-3.3%</td>
</tr>
<tr>
<td>Anti-anxiety Medications</td>
<td>5.5%</td>
<td>-15.4%</td>
<td>-9.0%</td>
</tr>
</tbody>
</table>
Brand vs. Generic Utilization

What’s What?
Multi-Source Brand (MSB) — Brand drug where generic is available
Single-Source Brand Products (SSB) — Brand drug where generic is NOT available

Generic utilization continues to climb ~4% since 2010
MSB and SSB drugs continued their decline since 2010

First Script requires generic utilization as part of all clients’ basic plan design where generic bioequivalence has been proven to provide injured workers with safe, quality alternatives to MSB products and provide our clients with lower cost solutions.
Generic Efficiency (GE)

**Generic Efficiency by Claim Age**

**Knowing your GE can help you understand if you are getting the full benefit of available generic drugs.**

**Generic efficiency erodes when:**
- Providers Dispense As Written*
- Claims examiners override generic recommendations

**Do you know what your GE is?**

<table>
<thead>
<tr>
<th>Generic Utilization</th>
<th>Generic Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of generics to total prescriptions</td>
<td>% of generic drugs prescribed when generic was available</td>
</tr>
</tbody>
</table>

**Optimal Scenario**

Total Prescriptions.................. 100  
Generics Available.................. 75  
Generics Prescribed............... 75  
Generic Utilization.................. 75%  
*Generic Efficiency .................. 100%

*This scenario is optimal because in every instance where a generic was available it was prescribed.

**Less Than Optimal Scenario**

Total Prescriptions.................. 100  
Generics Available.................. 100  
Generics Prescribed............... 50  
Generic Utilization.................. 50%  
*Generic Efficiency .................. 50%

*This scenario is less than optimal because in half of the circumstances a brand-name drug was used when a generic could have been.

**First Script’s total book had a GE of 96.3%, meaning that First Script was prevented from enforcing the generic mandate in 3.7% of the scripts.**

**The good news:** Generic Efficiency is improving in every claim age category meaning generics are being used more often when available. However, efficiency erodes as claims age, which could be due to:
- Physicians searching for any tool to manage chronic pain including using brand-only products when generics are available
- Less aggressive handling as claims age
- Injured workers become more aware of ways to obtain the brand-name products they desire

While First Script is pleased with year-over-year increases in generic efficiency for all claim age brackets, the data demonstrates an opportunity to better manage older claims collaboratively with the claims examiner and physician. Additionally, First Script employs generic opportunity letters encouraging physicians to use generics when available.
Fraud, Waste, & Abuse (FWA) Quiz

When attempting to combat fraud, waste, and abuse, First Script approaches it from different angles. Let’s test your knowledge of the techniques we use and what they mean. Match the term on the left with the description on the right. Answers below.

1. Integrated Rx  
   A. Approved list of drugs used at point-of-sale to ensure prescriptions are appropriate for the condition and the injured worker

2. RxProfile  
   B. Educating physicians on narcotic prescribing best practices and educating injured workers on the risks associated with narcotic use

3. Drug list/formulary management  
   C. Diagnosis and claim specific; Limited Day Supply; MED level per script; client customization available

4. Early Narcotic Intervention  
   D. Integration of pharmacy network, extended network bills and out-of-network transactions to apply clinical edits to the total drug experience as opposed to just managing in-network opioid activity

5. First Script POS Drug List  
   E. A risk profiling tool used for claims (targeting narcotic use) that may require a higher level of clinical intervention; helpful to guide discussions between prescribers and Coventry nurses or pharmacists

6. Limited Mail Order Fulfillment  
   F. Preventing large narcotic quantities from being dispensed through home delivery

High volume First Script network compounding pharmacies are being re-credentialed under more stringent requirements in 2014, including background checks and site audits to ensure legitimate dispensing practices.

First Script does not recommend and blocks narcotic and other controlled substances fulfillment through mail service within our program. Large quantities of narcotics in the hands of patients may lead to inadvertent drug overdose, diversion and misuse which create risks to the patient and the community.

Most Common Fraud Types
- Injured worker fraud: ID theft, forged prescriptions, duplicative or inappropriate therapy, drug seeking behavior (addiction), drug sharing, and selling.
- Pharmacy fraud: false billing, collusion with pill mills.
- Physician fraud: performing medically unnecessary services, falsifying a patient’s diagnosis to justify tests or surgeries, misrepresenting non-covered treatments as medically necessary covered treatments.

Early Identifiers of FWA
- Excessive or inappropriate use of narcotics
- Early refills of controlled substances
- Use of multiple pharmacies or physicians
- Dispensing medication at physician’s office
- Excessive DAWs from a physician

Most Frequently Abused Drugs
Pain medications — opioids mixed with benzodiazepines and muscle relaxers, deliver a euphoric high — similar to heroin.

The FDA recently approved long-acting opioid Zohydro™ ER (hydrocodone bitartrate), which is a hydrocodone extended-release capsule, Schedule II drug. The decision to approve this controversial pain medication pits the industry's desire to treat chronic pain against the current opioid epidemic being faced across the country. To address the many concerns around opioid abuse and misuse, the industry as a whole will need to come together to develop and utilize guidelines that promote oversight in addition to the appropriate utilization of opioids.

About Zohydro™ ER

The oral formulation is indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment for which alternative treatments are inadequate. Zohydro™ ER should be reserved for use with patients where alternative treatment options such as non-opioid analgesics or immediate-release opioids are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain. Additionally, if extended-release narcotics are warranted, then tamper-resistant medications should be used first for public safety reasons.

Zohydro™ ER will be implemented as part of REMS. The product carries black box warnings on addiction, abuse, and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and interaction with alcohol.10

Are Injured Workers Getting the Pain Medications They Need?

With increased scrutiny of pharmacy distribution of opioids and their attempt to prevent drug abuse, as well as the DEA's more aggressive stance of oversight, patient care can be impacted. Employers are concerned that their injured workers may not be receiving the care needed due to the limiting of medications across the spectrum of health care providers. In response to these types of concerns, The National Association of Boards of Pharmacy® (NABP®), along with a coalition of health care industry stakeholders, has issued a consensus statement regarding the collaborative steps that will be taken to help ensure the delivery of responsible and effective patient care as it relates to the prescribing and dispensing of controlled substances.11 The coalition consists of 13 participating organizations which represent physicians, pharmacists, pharmacies (including the First Script pharmacy chains), regulatory boards, wholesalers, manufacturers, and government agencies.
An ongoing Reuters/Ipsos survey noted that one in ten Americans have admitted to using medication prescribed for someone else. After marijuana, prescription drugs are the most commonly abused drug category in the U.S. Many Americans say it is not very difficult to get someone else’s prescription drugs.

Keep your eye out for the next Ask the Pharmacist update on Drug Take-Back Day. Encourage your injured workers to dispose of unused or expired medications at a local collection site to reduce the availability of prescription drugs. You can follow the take back updates at www.deadiversion.usdoj.gov/drug_disposal/takeback/.

Trends in Top Therapeutic Classes

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics, Narcotic</td>
<td>30%</td>
<td>29%</td>
<td>28%</td>
<td>27%</td>
</tr>
<tr>
<td>Non-Narcotic Antagonists</td>
<td>15%</td>
<td>16%</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>10%</td>
<td>11%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Analgesics, Non-Narcotic</td>
<td>5%</td>
<td>6%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Decongestants, Topical NPA</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Antihistamines, Sedative</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Anxiolytics, Antidepressive</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td>Sedative/hypnotics</td>
<td>5%</td>
<td>4%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Long- & short-acting narcotic utilization and spend continues to trend down. This could explain the increase in NSAIDs anticonvulsants and topicals.

Prescription trends indicate non-narcotic therapies for pain management are generally on the upswing.

Nearly 2 out of 3 people were able to get drugs not prescribed to them from family members, 25% got them from friends, and 13% said the medication was prescribed to them for a different reason.
After a heart attack, patients are often given four or more medicines and directed to take them for life. A new study shows those medicines only work to prevent another heart attack if the patient takes them all consistently and correctly.

Work comp medications are similar when considering adherence and compliance to physician directions. Consider an injured worker who is attempting to manage pain with an antidepressant such as Cymbalta®. If the injured worker does not take the medication as directed by the prescriber, the end result could be escalation of narcotic medications to manage pain. Sporadic filling of these medications raises a red flag for lack of compliance with the injured worker’s treatment plan. Tools such as RxProfile and DUA/P2Ps will aid claims examiners with identification and compliance management. If claims examiners have questions concerning patient compliance, First Script pharmacists can answer those questions by contacting askthepharmacist@cvty.com.

Drugs Only Work When Taken As Prescribed

*Based on AWP
Top 10 Billed Drugs*

- The top ten medications remain relatively consistent year-over-year.
- The patent for Lyrica® was extended until 2018, and had been expected to expire in 2013.
- Celebrex® was to be generically available in the spring of 2014. The release date is now expected to be in December 2014.
- OxyContin®, which did not rank in the Top 10, is now less than 2% of total utilization.

- Spend declined for OxyContin®, Vicodin®, Duragesic®, and Opana® ER
- Late 2013 generic availability for Lidoderm® and Cymbalta® meant minimal impact this year but should impact 2014’s Top 10 results.

*Medications in these charts are a pool of brand and generic. Brand names are provided for reference.
Moving Patients Away From Physical Opioid Addiction Using Other Medications

Through First Script’s ongoing clinical review and intervention on claim files, more physicians are working with us to get their patients away from long-term opioid use. Opioid addiction is more than a physical response to narcotic use. There are complex behavioral and psychological components that all need to be addressed as part of the treatment plan. There are a few different ways this can be accomplished:

**Cold Turkey Approach**
- Used in less than 25% of cases; Not very successful

**Drug Tapering**
- Decreasing dosing 5-10% every few weeks until management without the meds is feasible

**Medication Assisted Therapies**
- Using another drug to help reduce and eventually eliminate the use of opioids

The most common medication-assisted strategies include methadone, naltrexone, and combination of buprenorphine and naltrexone.

**Methadone**
- Oldest detox medication — difficult on patients and not used as first choice
- When used in a vetted detox program, methadone reduces cravings and helps to manage the physical and psychological aspects of dependence
- Can be used to manage pain; however, drug-drug interactions limit its use

**Naltrexone**
- Opioid blocker
- Its use in combination with other drugs can be problematic for most
- Can’t be used until narcotic-free for 14 days
- Most can’t tolerate this “cold turkey” approach due to physiological and psychological dependencies

**Buprenorphine/Naltrexone**
- Buprenorphine provides a feeling of normalcy without the euphoric “high” feeling
- For those in pain, it does produce analgesic effects
- Minimizes the effect of other narcotics if used
- The naltrexone prevents abuse of buprenorphine

The goal of these strategies is to address narcotic withdrawal symptoms to the point of stopping these medications. Not every physician has the ability to use these strategies as federal rules surrounding these detoxification programs require registration and certification.

Medication-assisted drug detoxification is a difficult path and may take years. With the assistance of Coventry’s pain management solution, clinicians coordinate the detox process and also support the injured worker’s psycosocial recovery. Our proprietary approach leverages Cognitive Behavioral Therapy and a personalized care pathway that actively engage injured workers in managing their own recovery.
**Coventry Workers' Comp Services**

**Controlled Substances — Who Makes the Call?**

The Drug Enforcement Agency (DEA), part of the Department of Justice, currently has responsibility for laws associated with the Controlled Substance Act (CSA).\(^\text{18}\) They are responsible for the tracking, management, and security of controlled medications throughout the distribution channel — manufacturer to end-buyer. The DEA has the ability to add, delete, or reschedule medications as patient safety information becomes available. An example is Soma\(^\text{®}\) (carisoprodol). The medication was not a controlled substance in most states until January 2012 even though it had been on the market a number of years.\(^\text{19}\)

**Feds or States: Who Has the Power?**

The distribution and use of controlled substances varies by federal and state laws. For instance, the federal schedule for hydrocodone is C-III while New York deemed the product highly abusive and moved it to C-II. States may tighten, not loosen Federal rules concerning the scheduling of medication. However, state specific legalization of marijuana has not conformed to this law.

There are cases of states actually taking a stronger stance of narcotic management. New York rescheduling the drug encourages increased interaction; this requires increased interaction with the prescribing physician as well as the pharmacy for each prescription. The result is tighter clinical oversight to ensure the patient is using the dangerous drug in a safe manner and that the patient is not diverting (selling or sharing) or abusing the medication. The FDA proposal to reschedule hydrocodone follows similar logic.

Let’s step back a moment and review the criteria as to how the DEA determines if a medication should be scheduled/controlled:

- **Its history and current pattern of abuse**
- **What, if any, risk there is to public health**
- **The scope, duration, and significance of abuse**
- **Its psychic or physiological dependence liability**
- **The drug’s actual or relative potential for abuse**
- **Scientific evidence of its pharmacologic effect, if known**
- **The state of current scientific knowledge regarding the drug or other substance**
- **Whether the substance is an immediate precursor of a substance already controlled**

NY rescheduled hydrocodone from Schedule III to Schedule II under the premise that the drug posed a significant public risk.
Note in the Schedule of Controlled Substances chart above, that marijuana is a C-I drug, meaning the medication can only be used in laboratory or investigational situations. Many states are permitting recreational or medicinal use of marijuana. However, the FDA has not approved an acceptable medical use and therefore, the DEA must leave the drug as a C-I. The DEA has the right to enforce the CSA rules around the distribution of marijuana regardless of the individual state’s stance.

### Schedule of Controlled Substances

<table>
<thead>
<tr>
<th>Classification Criteria</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>C-I</strong> Substances have no currently accepted medical use in the U.S., a lack of accepted safety for use under medical supervision, and a high potential for abuse.</td>
<td>Heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, MDMA (“Ecstasy”)</td>
</tr>
<tr>
<td><strong>C-II</strong> Substances have a high potential for abuse which may lead to severe psychological or physical dependence.</td>
<td>Hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), fentanyl (Duragesic®), morphine, opium, codeine, amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), methylphenidate (Ritalin®)</td>
</tr>
<tr>
<td><strong>C-III</strong> Potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.</td>
<td>Combination products containing less than 15 mg of hydrocodone per dosage unit (Vicodin®), products containing not more than 90 mg of codeine per dosage unit (Tylenol with Codeine®), buprenorphine (Suboxone®), benzphetamine (Didrex®), phendimetrazine, ketamine, anabolic steroids such as Depo®-Testosterone</td>
</tr>
<tr>
<td><strong>C-IV</strong> Low potential for abuse relative to substances in Schedule III.</td>
<td>Alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®)</td>
</tr>
<tr>
<td><strong>C-V</strong> Low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.</td>
<td>Cough preparations containing not more than 200 mg of codeine per 100 ml or per 100 g (Robitussin AC®, Phenergan with Codeine®), ezogabine</td>
</tr>
</tbody>
</table>
Trends in Narcotic Utilization

**Narcotic Prescription Count by Age of Injury**

- # of narcotic prescriptions have declined in year 1 and remained flat in years 2-4, demonstrating the effectiveness of early intervention.

**Narcotic Prescription Cost by Age of Injury (Inflation-Adjusted)**

- The AWP cost per narcotic prescription has declined in all years, even in the oldest claims.

- Average AWP cost per narcotic prescription has decreased since 2012.
First Script’s Early Intervention Program Yields Positive Results in Years 1-4

It is common for narcotic utilization and cost trending to differ for younger versus older claims. First Script drug trending data are similar to the industry, demonstrating more narcotic medications at higher costs as claims age.

As mentioned previously, the use of narcotics for the entire First Script book is down (often times being replaced by adjuvant pain medications). While the number of claimants using narcotics is down, utilization in those who do use them is flat in the first four years and slightly higher in older claims.

<table>
<thead>
<tr>
<th>Claim Age Years 1-4</th>
<th>Claim Age Years 5-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average cost per prescription has decreased since 2012</td>
<td>Average cost per script lower than last year — AWP increases were adjusted for inflation</td>
</tr>
<tr>
<td>Number of narcotic prescriptions have declined in year one and remained flat in years 2-4</td>
<td>Number of scripts is slightly higher than last year in this age bracket</td>
</tr>
<tr>
<td>Cost of prescriptions in years 1 and 2 is slightly lower than last year</td>
<td>Older claims continue to experience higher costs</td>
</tr>
<tr>
<td>Early intervention is having a significant impact on the cost and number of narcotics prescriptions</td>
<td>Increases in utilization demonstrate the need for drug utilization reviews on these older claims</td>
</tr>
</tbody>
</table>

**All Claims**

Claimants using narcotics across the First Script book of business have declined

Utilization of both short- and long-acting narcotics actually decreased as previously shown in the therapeutic class review

In comparing year-over-year morphine equivalence, First Script has experienced a 10.2% decrease over four years of trending

**Morphine Equivalent Dosing (MED)**

MED decreased 4% in 2013

MED has decreased for First Script a total of 10.2% in the past four years
## Pain Management Recommendations

Much discussion in the industry surrounds inappropriate opiate utilization—and rightly so. Accidental opiate death rates exceed traffic fatalities annually. The collateral costs of managing these cases for detoxification and supportive care such as drug testing and psychological impacts are staggering.

While people should be active participants for their own care and recovery, physicians have been challenged with meeting patient pain management needs. There are several pain management guidelines such as the World Health Organization pain management ladder that are available to aid clinicians in ensuring that pain management is safely handled for their patients.

In October 2013, the American Society of Anesthesiologists (ASA) published their “Choosing Wisely” list as it relates to anesthesiology. Recently the ASA has put forth a list (paraphrased below) of recommendations related to pain management. The recommendations have also been endorsed by the American Pain Society.

<table>
<thead>
<tr>
<th>Pain Management Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioids are not the first line of therapy for non-cancer pain</strong></td>
</tr>
</tbody>
</table>
| Attempt non-pharmacological therapies instead:  
- Behavioral and physical therapies.  
Use non-opiates such as non-steroidals (e.g., naproxen, ibuprofen) or anticonvulsants (e.g., gabapentin) if medication therapy is needed. |
| **Avoid chronic opioid therapies** |
| Discuss dependence and tolerance risks with the patient.  
Establish a signed patient-physician agreement to include random drug screens, and non-compliance consequences.  
Be aware of effects of concurrent use of other medications such as benzodiazepines.  
Proactively manage side effects. |
| **Avoid imaging for acute low back pain** |
| Most cases of low back pain doesn’t require imaging.  
Tests may reveal incidental findings that divert attention and increase incidence of unhelpful surgery. |
| **Avoid IV sedation with diagnostic procedures as a default practice — use local application** |
| May interfere with assessing acute pain relief of the procedure and the potential for false-positive responses.  
ASA standards exist when moderate or deep sedation is anticipated or provided. |
| **Avoid irreversible interventions for non-cancer pain** |
| Nerve block or peripheral radio frequency ablation may carry a significant long-term risk of weakness, numbness, or increased pain. |

The list of these recommendations is important because it provides “caution of using procedures” that are commonly practiced today. The cautionary approach, if followed, will aid in the mitigation of the opioid epidemic that is plaguing this country. First Script and Coventry adhere to these recommendations in our PBM and clinical programs.
Using Data to Drive Drug Safety

Any number of risk factors can contribute to a work-related injury occurring. Similarly, any number of factors can increase the risk associated with a given workers’ compensation claim. First Script digs into data to uncover evidence of emerging clinical risk and takes appropriate actions to promote patient safety and avoid unnecessary spending.

More Data or Better Data? Well, It’s Both.

Claims examiners face heavy caseloads and are already inundated with information. On the pharmacy side, with a much higher volume of transactions, the sheer number of individual prescription alerts makes it easy to miss the one that contains critical information — and difficult to put it in the proper context. After all, most claims examiners haven’t been equipped to understand the complexities of pharmacology or things like MED, yet they are often expected to manage each claim and the risks associated with multiple medications, especially opioids. First Script’s RxProfile makes their job more manageable by providing an at-a-glance view of relevant data — such as injured worker demographics, drug activity and provider prescribing patterns — and rating the claim’s risk. This stratified intelligence helps the claims examiner make timelier, more effective decisions around engaging clinical or other resources.

The Past Predicts the Future

The risk profile is based on several attributes and gives more weight to those that have been shown to increase risk, such as narcotic use with other central nervous system depressant medications like muscle relaxants, claimant age, and specific types of injuries. Based on a huge volume of historical data, including pharmacy transactions filled in and out of the PBM network, each attribute is weighted with regard to risk and then added to the total risk score on the profile. For example: someone taking hydrocodone/APAP once at bedtime will have a lower risk score than someone taking the same medication at a higher frequency, higher dose, or in combination with other medications. Morphine equivalence is a critical consideration, because research shows that the risk of overdose increases exponentially at MEDs higher than 50 mg per day. The RxProfile algorithm also considers non-narcotic medications that may contribute to risk, as well as the prescriber history, the presence of multiple prescribers, and other factors. The end result is a color-coded score card, which is updated weekly.

Focus on the Right Action

The RxProfile replaces the need to review the myriad of individual pharmacy triggers — such as a second prescriber on the file or an early refill — and focuses on factors such as increasing MED, and combinations of other factors that point to overall claim risk. Claims examiners receive fewer notifications, but the ones they receive prepare them to make decisions. Depending on the risk level, the examiner may decide to watch the claim more closely, request utilization review or a drug utilization assessment with a peer-to-peer intervention, send the claim to case management or to an independent medical examiner. Some clients have established routine cross functional team reviews using RxProfile which include their claims examiners, medical director, and nurses. First Script pharmacists are always available to answer any drug-related questions.

By bringing claims that require a higher level of clinical management to the forefront in a timely manner, RxProfile helps claims examiners mitigate risk early in the life of a claim, preventing runaway narcotic escalation with its potentially catastrophic consequences to injured workers. Coventry’s medical director often assists clients in complex claim decisions that include challenging pharmacological issues.
Prescription utilization remained flat in year 1 and increased slightly in years 2 and 3. The focus on reducing narcotic utilization across the entire book was successful, resulting in fewer using narcotic therapy. The rise in scripts per claim can be attributed to an increase in adjuvant medications for pain management.

With the heightened awareness to reduce or eliminate narcotics, other medications come into play to manage pain. First Script saw an increase in adjuvant therapies — primarily antidepressants and anticonvulsants — which contributed to more scripts per claimant. Trending also identified earlier use of adjuvants in the life of the claim. While use of safer adjuvant medications has supported the decrease in narcotics, First Script continues to monitor and review appropriateness of these prescriptions for the injury.

With the aging workforce, comorbidities are likely influencing increases in prescription drug utilization in older claims.

The average claimant population age is increasing throughout the industry. As we age, more factors — comorbidities — influence recovery time and success. Such conditions include heart disease, arthritis, diabetes, and obesity. Non-traditional comp medications are being applied to aid in recovery. The result is more prescriptions per individual. For instance, a diabetic with a foot injury may require tighter control of their diabetes. A claims examiner may allow diabetic medications to facilitate faster healing time and prevent further injury. First Script flags all prescriptions for unrelated conditions for claims examiner decision making. Examiners who allow a more holistic approach to promoting injured worker recovery may increase their near-term pharmacy spend in an effort to drive a quicker positive outcome.
Prescription Cost by Claim Age, All Drugs (Inflation-Adjusted)

All years were adjusted to minimize the influence of drug inflation to understand true trending of a cost per prescription. Our trending has demonstrated that as the claim ages, the cost per prescription increases. Contributors to the trending include: (1) more of the same drug (increased strength and/or dose), (2) more expensive single-source brand-name medications are being used, and (3) physician or adjuster approval of multi-source brand-name medications. Drug selection is a key component and why formulary alignment is extremely important in managing the prescription costs. High cost, non-formulary products, including compounded medications, may not be appropriate in managing pharmacy care and costs. First Script rules block these types of medications, alerting claims examiners to apply other clinical interventions.

Cost per script remained flat or decreased when adjusted for inflation.

Adjuvant therapies that support pain management and lessen narcotic burden tend to have a higher cost per script, especially in older claims.
**Why Would I Order a Drug Utilization Assessment (DUA)?**

**Enhances Pharmacy Benefit Management Information**
- Broader view of all aspects of the specific claim
- Specific analysis of prescription medications in- and out-of-network
- May aid in preparing for Medicare Set-aside settlement

**Identifies Utilization Issues Such As:**
- Medical appropriateness based on national guidelines
- Over-usage/under-usage
- Unnecessary or contraindicated medications
- Duplicative therapies
- Brand/generic substitutions
- Drug interactions

**What Do They Entail?**
- Review current prescription regimen
- Review of medical records and pharmacy claim data
- Recommend claimant specific alternatives
- Based on current official guidelines, state medical treatment guidelines, and best practice medical guidelines
- Summarizes current cost and potential savings based on recommended changes

**Or a Peer-to-Peer (P2P) Review?**

**Facilitates Adoption of DUA Recommendations**
- Can result in POS edits (closed-loop)
- Changes may be immediate depending on the nature of the agreement
- Medication weaning can result in longer term results
- Peer Opinions summarize the Coventry Medical Director’s recommendations in cases where treating provider refuses to discuss
- Agreements are monitored through POS edits

**Coventry Physician to Treating Physician**

The Coventry Medical Director:
- Reviews the DUA
- Contacts the treating provider
- Gains agreement
- Documents that agreement was reached
- Places agreement into the PBM systems for monitoring

**Closed-Loop Process**
- Identify at-risk behaviors
- Conduct outreach: Recommend sending a nurse case manager to obtain a prescriber-signed medication treatment plan
- Document prescriber discussions, edit POS system to manage future dispensing decisions
- Track adherence to treatment plan
How Should I Evaluate the Effectiveness of DUA and P2P Outreach in My Program?

Programs That Tout Significant Single Case Results May Not Be Delivering “Overall” Value

It’s common in the work comp industry for PBMs to share single case-study success stories, referencing projected vs. actual savings. While this can highlight a best-case scenario, the scenario is often more sizzle than steak. The most valid method for evaluating the impact of your DUA activity is to calculate in aggregate the actual changes in prescribing patterns and actual spending impact across your program.

Program Results Answer the Following Client Considerations

1. Is our investment in this program demonstrating overall positive financial results?
2. Are my injured workers living safer, healthier lives?

First Script Trending Results — Actual, Not Projected

Within the DUA/P2P program, MED decreased 40%

DUA/P2P has demonstrated significant results on older claims; however, the impact on claims as early as 90 days should not be overlooked.

Program Results Answer the Following Client Considerations

1. Is our investment in this program demonstrating overall positive financial results?
2. Are my injured workers living safer, healthier lives?

Factors That Influence Program Results

- POS edits that stop non-approved prescriptions prior to dispensing
- Converting brand or expensive drugs to generic or lower cost therapeutically equivalent drugs
- First Script holds the patient and prescriber accountable to the treatment plan
- Identification and management of inappropriate non-PBM bills prior to payment

Average Quarterly MED

Net Cost Savings

$400K
$350K
$300K
$250K
$200K
$150K
$100K
$50K
$0

Average MED

0 20 40 60 80 100 120

DUA/P2P Client Charge Cumulative
Cumulative Savings

Throughout history, the medical use of marijuana has been the subject of numerous studies, yet few substantiate medical marijuana as a safe and effective treatment for pain management. With its legalization, a growing number of injured workers, particularly those with chronic pain, will inevitably begin investigating the use of medical marijuana as a form of treatment.

Even with the growing support of medical marijuana use and state adoption, Federal laws are still categorizing marijuana as an illegal substance. How this inconsistency will play out in workers’ compensation will depend upon specific exclusions within the new medical marijuana state laws, as well as work comp regulations that define acceptable utilization and reimbursement of medical marijuana. It remains to be seen whether these laws will clearly identify the requirements and limitations for employers, physicians, and pharmacists or force the industry to interpret them for ourselves.

Most states have language that excludes workers’ comp from the medical marijuana law. Many states cite that work comp laws only cover FDA approved drugs. Although most states have exclusion language, it is not consistent or not defined adequately in the law or within other laws, leaving it to be tested in the courts.

Too Soon to Tell...But the Implications Are Far-reaching

It is far too early to predict the full impact that legalized medical marijuana will have on workers’ compensation; however, it is certain to change the way employers and medical providers address work-related injuries and their resolution. The role of the federal and state government will come into play as more states adopt legalization of both medical and recreational marijuana use. It will also be interesting to see whether medical marijuana will be dispensed in pharmacies (illegal today as not FDA approved) or physician offices and ultimately if Medicare or Medicaid will ever consider addressing these substances since they are non-FDA approved.

As time goes on, we will continue to monitor studies designed to determine the medicinal benefits of marijuana and the impact such studies have on the FDA and individual state positions regarding dispensing and reimbursement.

Questions to Consider

- What about patient safety and disclosure to other health care providers?
- If medical marijuana is approved in workers’ comp what will reimbursement and pricing look like?
- How will return-to-work and working under the influence be addressed?
- What will happen if a worker is injured on the job while under the influence of legal medical marijuana?
- Will there ever be contracted “dispensing networks”?

As a result of marijuana not having defined approved use, First Script’s POS system does not allow processing or payment of the drug. Learn more about Coventry’s bill review recommendations and practices with regards to medical marijuana here: http://coventrywcs.com/c118273.
National Association of Specialty Pharmacy (NASP) has created a taskforce to evaluate the management of medical marijuana. 23 states and the District of Columbia have approved the use of medical marijuana. A Colorado study found that only 46% of respondents believe doctors should not recommend medical marijuana; however, 60% stated its risks outweighed its benefits. 94% of patients who receive permission to use medical marijuana have chronic pain. Marijuana is a Schedule I substance and cannot be written as a traditional prescription under federal law. Legal access to medical marijuana requires a written recommendation from a licensed doctor. Often a prescription is obtained from a medical cannabis doctor who is a fully accredited doctor that specializes in medical marijuana treatment. Dispensary staff may assist in determining the marijuana type and method of use, but are not necessarily medically trained. States vary regarding registration requirements and how much medical marijuana can be possessed, purchased, and grown. In 2011 the DEA denied a petition to reschedule marijuana stating there was no evidence to support reclassification for medical use. The DEA denied a petition to reschedule marijuana stating there was no evidence to support reclassification for medical use.
Topical treatments have been commercially available for years through a whole host of products that have FDA approval to treat pain. So why does there seem to be a sudden increase in compounded medications? There is no simple answer for this.

Sophisticated compounded creams and gels are gaining acceptance by the prescribing community. Niche players are focusing on patient outcomes and providing more “scientific studies” to support the use of these topical medications. These same players are visiting prescribers, and providing the studies while claiming that the use of the compounds will decrease the need for oral medications including NSAIDs (e.g., ibuprofen, naproxen, etc.).

**While it is too soon to determine whether compounds will decrease the need for oral medications, we do know:**

- Most compounded ingredients are listed as non-formulary by ODG and therefore, not recommended as first or even second line therapies
- Efficacy of compounded medications were not measured against placebo — limited double blind studies
- The placebo effect can contribute significantly to pain relief
- No comparison data to look at skin penetration success in humans based on formula of bases
- Ingested or injected medications block or reduce pain through the central nervous system — when the same medication is applied topically, the medication activity has not been determined
- Centrally acting medications such as gabapentin & ketamine block/mitigate pain signals coming from other parts of the body
- Human trials of centrally acting meds being used for peripheral application have not been well documented
- Many medications utilized in today’s compounds are centrally acting (they work in the brain and spinal cord) when taken by mouth
- Research shows that there may be active sites in the peripheral nervous system (nerves in the body outside of the brain and spinal cord)
- Lack of clinical case study evidence of peripheral (away from the spinal cord and brain) activity

| Cost difference between oral and powder gabapentin for a 30-day supply: |
|-----------------------------|-----------------------------|-----------------------------|
| Oral: $165/month            | Cost of compounds ranges from $100 to $2000 |
| Powder: $1,400/month & one of many ingredients | The number of adjuster-approved compounds being prescribed has increased 400% over the last year in the First Script client base |
Practical Strategies for Compound Management

Coventry pharmacy data indicates:

- Compounds represent 4-5% of client TOTAL WC spend (in- and out-of-network)
- Roughly 80% of compound prescriptions are out-of-network and therefore, “paper billed”
- Paper-billed compounds are not required to follow the NCPDP D.0 format in nearly all jurisdictions which poses challenges to identify and manage these prescriptions

First Script, Coventry’s PBM program, manages to the NCPDP D.0 format and has stringent pricing mechanisms in place for network pharmacies. That is a major reason 80% of the compound prescriptions are submitted out-of-network. Financially, compounding pharmacies do not wish to have their enormous margins eroded nor be susceptible to our auditing process.

Unfortunately, most of today’s solutions are requests for action and do not prevent the dispensing of compounds. The work comp environment supports basically any medication even remotely related to the open claim to be payable. California knows this too well through their lien process.

Practical Strategies That Garner a Better Return for Our Clients:

Change compound billing practices and require UR or letter of medical necessity to support claims examiners in denying these medications until required documentation is provided; e.g., letters of medical necessity, sighting legitimate compendia, or medical record evaluation for allergies to a specific oral medication.

- Define standards to ensure compounds are identified on “paper bills.”
- Define pricing mechanisms based on largest available quantities to individual ingredient components.

First Script is working to contract with clinically and financially responsible compounding entities for inclusion in our extended network.

Our Regulatory & Legislative Affairs team works with states to supply actionable information. As this issue continues to grow, the rule-making bodies will need a clear idea of how to balance the support of the injured worker and the payor community.
The Drug Quality Security Act — Its Impact on Workers’ Comp

While it is important that all pharmacies maintain a clean environment, sterility (the absence of contamination), is not critical where topical compounds are being created. Sterility for injectable compounds, however, is vital. The tragedy resulting from poor manufacturing (resulting in contaminated steroid injections causing many patient fatalities) at the New England Compounding Center (NECC) spurred the creation of legislation to bring compounding under federal control.

<table>
<thead>
<tr>
<th>Does</th>
<th>Does Not</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulate bulk compounding agencies</td>
<td>Regulate smaller compounding businesses</td>
</tr>
<tr>
<td>Allow custom-mix manufacturers to register with the FDA and submit to federal quality inspections</td>
<td>Require registration</td>
</tr>
<tr>
<td>Move authority to the federal level vs. state</td>
<td>Require FDA oversight</td>
</tr>
<tr>
<td>Will address “track and trace” for all prescriptions from manufacturing to patient (future)</td>
<td>Provide oversight of compounding at local pharmacies</td>
</tr>
<tr>
<td>Will add serial tracking numbers to all packaging within 4 years and electronic codes within 10 (future)</td>
<td>Prevent physician ownership or financial gain in compounding pharmacies</td>
</tr>
</tbody>
</table>

When Large Volume Compounders Register, They:

Submit reports to the FDA on what is being created
Generate reports on any issues
Are subject to inspections

High volume network compounding pharmacies will be re-credentialed under more stringent requirements including background checks and site audits to ensure legitimate dispensing practices.
The cost of workers’ compensation claims skyrocket when injured employees start using narcotics. According to the examination of one large workers’ compensation insurance carrier’s claims data, the cost of a typical work-related injury, including medical expenses and lost wages for claimants that were not receiving opioids was about $13,000. However, when an employee was prescribed a short-acting opioid like Percocet®, the cost triples to $39,000. When an employee was prescribed a long-acting opioid like OxyContin®, the average claim costs explode to $117,000, an increase of 900% over the average lost-time work comp claim without the use of any opioids.28 See figure to right.

This information highlights the importance of managing opioid utilization. Contact your First Script account manager for more information on our Narcotic Management programs.

First Script Participates in ACOEM Opioid Practice Guideline Panel

First Script pharmacists continually work to do all we can to improve injured worker outcomes. Recently we were invited to participate on a panel with physicians, pharmacists and other health care professionals to review the American College of Occupational and Environmental Medicine (ACOEM) Opioid Practice Guidelines.

Opioid Guidelines:
Present evidence-based criteria to guide providers in the treatment of occupational injuries and illnesses.
Present essential information that will address injured workers’ functional impairment and safe return-to-work.

First Script specifically participated in the review of oral fentanyl and breakthrough pain, in addition to other guideline subjects.

Panels were selected to collaborate on the following areas:
• Review guideline sections to ensure accuracy
• Review evidence tables and the strength of evidence ratings
• Revise recommendations based on discussion, and the application of clinical judgment, first principles or new evidence
• Suggest additional research topics
The updated guidelines were released at the American Occupational Health Conference (AOHC) held April 27-30, 2014 in San Antonio, Texas.
The Aging Workforce and a Prescription for Safety

An aging workforce is the new norm. The U.S. Bureau of Labor Statistics estimates that by 2020, one in four American workers will be 55 or older. According to U.S. Census predictions, by 2050, more than 19 million workers will be 65 or older and will make up approximately one fifth of the U.S. workforce.

As the workforce ages, First Script considers the age of the injured worker as a risk factor and is paying close attention to the impact medications have on older individuals in order to reduce the likelihood of injuries and to promote optimal outcomes when an injury does occur.

Where Comorbidities Are Concerned

Older workers are more apt to have comorbidities or chronic conditions, such as diabetes or heart disease, that can affect organ function. Most medications are eliminated through the liver or kidneys, so liver or kidney disease can impact drug metabolism and even limit the choice of medications. For example, NSAIDs can stress the kidneys, and acetaminophen can be hard on the liver. As a result, other medications or alternative pain management modalities are often selected for pain management in older adults with poor liver or kidney function.

The following are just a few of the pharmacy related items Coventry considers in our best practices for the aging workforce:

- Medications taken for chronic conditions and comorbidities are more likely to contribute to drug interactions
- Current medications must be considered when prescribing drugs for an injury
- Muscle relaxants and narcotic pain medications must be prescribed with caution for individuals already taking sleep aids, certain antihistamines, anticonvulsants, or pain medications for arthritis or other chronic conditions
- Older workers may be treated by multiple providers who are prescribing different sets of medications
- A complete drug history is essential to providing the best outcomes

**Drug metabolism changes with age, so drugs stay in the body longer or are present in higher-than-average concentrations**

**When drugs stay in the body longer, they are more likely to cause unwanted side effects**

**Both opioids and anticonvulsants can cause dizziness—a double danger when balance is declining**

**Falls may result in fractures & injuries may be more severe and take longer to heal**

**Older workers may be more likely to take sleeping pills, which can cause next-day drowsiness and place them at higher risk of injury**
Steering Toward Safety

Focused prescription drug management is more critical when the injured worker is older. Fortunately, tools are available to help promote drug safety in an aging population. In 1991 geriatrician Mark Beers developed a list of drugs — known as the Beers Criteria — with a high likelihood of serious side effects in patients over 65. Expanded in 2003 and updated regularly, the Beers list is well known and widely used today. It includes many medications commonly used in workers’ comp, including zolpidem (Ambien®), many NSAIDs and muscle relaxants, and long- and short-acting benzodiazepines.

- First Script identifies drug-age interactions based on the Beers list and evidence-based criteria to generate intervention alerts at the POS prior to the drug being dispensed to avert age/drug related adverse events.
- Case managers or claims examiners can utilize prescription drug profiles that can be triggered based on claimant demographics, prescriber patterns, drug utilization and drug combinations.
- A 90-day medication history provides the information necessary to support timely interventions on the front end.

One such intervention could be to initiate claim-specific drug utilization assessments, which take the injured worker’s age and comorbidities into account when reviewing appropriateness, drug interactions, dosing, MED, and number of prescriptions, in order to optimize the current drug regimen. This profiling process may identify potential cases for assessment, with the goal being to simplify and minimize medications while ensuring that the injured worker receives necessary therapy. Such a review may prompt a peer-to-peer discussion with the prescriber to encourage safer medication choices.

Shape a Strategy

Prescription drug management in older workers requires informed choices and careful monitoring in order to increase safety, to encourage optimal treatment outcomes, and to help avoid re-injury. As older workers are projected to be a significant part of the workforce for decades to come, Coventry/First Script has a strategy in place with our clinical and pharmacy resources for this specific population.

One out of five workers is over the age of 55 — expected to increase to one out of four by 2020.33

Significant drug metabolism decreases after age 60, with declines beginning at age 40.34

Falls and fractures are higher risk for those taking narcotics vs. non-narcotics.35
Effective September 1, 2013, the Texas closed formulary, based on ODG, is now in place for all claims. The formulary excludes specific drugs (“N” drugs) as not recommended. If a provider wishes to prescribe an “N” drug, medical necessity documentation must be provided. A complete list of the ODG “N” drug list can be found here: www.tdi.texas.gov/wc/dm/documents/appendixa.xls.

In anticipation of the September deadline, the Texas Department of Insurance, Division of Workers’ Compensation (TDI-DWC) worked with the payer community to evaluate the status of legacy claims receiving “N” drugs and the results are:

The status of legacy claims receiving “N” drugs (based on TDI-DWC data)\textsuperscript{36}

- 47% No longer receive “N” drugs
- 36% No agreement in place
- 17% Agreements in place

With the Texas closed formulary in place it will be interesting to see how it affects those claims that have not adopted the “N” drug requirements. As the closed formulary progresses, hopefully we will also be able to determine whether it can have a significant impact on patient safety and opioid dependence or abuse. Indications so far are positive, and we are beginning to see other states, such as Ohio and Oklahoma, follow a similar path.

Texas Cost Savings Between 2009 and 2011 (based on TDI-DWC data)\textsuperscript{37}

- “N” drug cost decreased 82% as a percentage of total drug cost
- Average cost dropped 30%
- Average cost per claim dropped 45%
- Total number of prescriptions dropped 74%
- Total number of claims dropped 67%
- The number of prescriptions per claim dropped 22% from 2.41 to 1.77
First Script Yields Improved Texas Results 2009-2013

First Script data results are similar to the reported findings. OxyContin® is a non-formulary drug in Texas requiring the pre-certification and has a large impact from a utilization and safety perspective for injured workers.

Utilization of OxyContin® dropped nearly 80% from its peak utilization in 2010.

Did utilization shift to other long-acting narcotic formulary drugs?

No

Long-acting sustained ODG products:
While Oxycontin® use declined, the First Script study revealed there was no appreciable increase in the following drugs, which are all included in the ODG formulary:

- Morphine sulfate extended-release
- Fentanyl patches
- Tramadol extended-release
A new drug formulary in Oklahoma was set to look a lot like Texas but the final adopted rules resulted in something a bit more manageable:

A number of questions still remain for Oklahoma regarding the application of the closed formulary. The exemption of legacy claimants promotes variations in levels of care for legacy and newly injured workers, and leaves a lingering concern over whether or not the Oklahoma closed formulary will have similar positive impacts as what has been seen in Texas. First Script will be prepared to implement the formularies when finalized.

It's easy to join our mailing list!

Just send your email address by text message:

Text **CVTY** to **22828** to get started.

Message and data rates may apply.
2013 Accomplishments

- Pharmacy spend decreased from 2012 results when adjusted for AWP inflation
- 4% decrease in MED since 2012 for claimants using narcotics and 10.2% over the past 4 years
- Generic utilization and efficiency increased providing greater savings and value to our clients
- RxProfile provides tangible results such as demonstrated 40% MED reduction using DUA/P2P as measured in actual aggregate claim trends
- Decreased utilization and spend for both short- and long-acting narcotics
- Ongoing Extended Network enhancements increased discounts for 50% of physician bill prescriptions while including 100% of physician bills for utilization management purposes

What’s in Store for 2014

- Continued focus on narcotic management through:
  - Early intervention
  - Physician and injured worker education
  - Collaborating with the case manager, treating physician, and injured worker to reduce claim duration and severity
- Leading the industry in our quest for total prescription capture and spend reporting, facilitating informed decisions and overall best outcomes
- Elevating our clinical involvement with each of our clients and the industry to drive towards ever increasing effectiveness of clinical intelligence and interventions
- Aggressively pursuing additional extended network relationships with physician billers, non-network compounding pharmacies and other third-party billers
- Continued analytics and product development in the area of compounds and biologics
- High volume First Script network compounding pharmacies are being re-credentialed under more stringent requirements in 2014, including background checks and site audits to ensure legitimate dispensing practices.
- Enhancing our drug testing program, ensuring that the claims examiner is educated as agreements are incorporated into the claims and clinical strategy through a closed-loop process unavailable in the workers’ compensation market today
- Enhancing the claims examiner experience with new Coventry Connect features and user interface
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.
7. https://www.govtrack.us/congress/bills/113/hr3204/text

Acronyms

ACOEM: American College of Occupational and Environmental Medicine
APAP: Acetaminophen
ASA: American Society of Anesthesiologists
AWP: Average Wholesale Price
CSA: Controlled Substance Act
DAW: Dispense as Written
DEA: Drug Enforcement Agency
DUA: Drug Utilization Assessment
FDA: Food and Drug Administration
FWA: Fraud, Waste & Abuse
GE: Generic Efficiency
MED: Morphine Equivalent Dose
MSB: Multi-Source Brand

NABP*: National Association of Boards of Pharmacy
NASP: National Association of Specialty Pharmacy
NDA: New Drug Approval
NSAID: Non-steroidal Anti Inflammatory Drug
ODG: Official Disability Guidelines
P2P: Peer-to-Peer
PBM: Pharmacy Benefit Manager(ment)
POS: Point-of-Sale
REMS: Risk, Evaluation, and Mitigation Strategies
SSB: Single-Source Brand Products
TDI-DWC: Texas Department of Insurance, Division of Workers’ Compensation
UM: Utilization Management
UR: Utilization Review
You don’t need a complicated pharmacy solution, just one that captures every prescription, intervenes early, and continues to clinically manage appropriate medication use.

Let us solve this problem for you.

Problem Solved.

Case Management | Pharmacy Networks | Durable Medical Equipment Utilization Review | Nurse Triage Independent Medical Exams | Bill Review
Coventry Workers’ Comp Services 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.