


Say “**Yes**” to Programs to Control Drug Use

by | Linda Cahn

By putting evidence-based limits on prescription drug use, plan sponsors likely are protecting both participants' health and plan resources.



Our kick-off presentation to a dozen management and union representatives to describe our pharmacy benefit management (PBM) request for proposal strategy had only just

begun when it was suddenly interrupted:

"The answer is 'no,'" a union representative stated quite firmly and aggressively.

Slow on the uptake, I wasn't sure what he meant. Silence filled the room.

"The answer is 'no,'" he reasserted, a notch louder and even more adamantly.

Still unsure of what he meant, I sputtered: "I don't know what you're trying to tell me."

"The answer is 'no,'" he repeated a third time. Again, silence filled the room.

Finally, he made clear his meaning: "Our union members will have access to every drug that's on the market, whenever they want it, in whatever quantity they want it and for any purpose they want it. Do you understand?"

I understood perfectly. I also knew I had my work cut out for me. For while this union representative undoubtedly thought he was fighting on the side of the gods by ensuring his plan participants would have unbridled drug access, his position likely endangered participants' health and imperiled future compensation increases due to wasteful drug spending.

Somehow, I needed to convince this man—like so many other union, corporate and municipal plan representatives

I'd previously worked with—that after we put an airtight PBM contract in place, we should turn our attention to taking advantage of that contract to implement evidence-based, comprehensive programs to control participants' drug use. After all, such programs are in participants' and plans' interests, not contrary to them.

The Painkiller Problem

According to the Centers for Disease Control (CDC), almost 17,000 people died from painkiller overdoses last year—about 46 people per day. For every death, about 30 others were admitted to emergency rooms.

Strikingly, enough prescription painkillers are prescribed annually to medicate every American adult for one month around the clock. The most commonly prescribed drugs are the strongest pain medications—opioids like Vicodin®, OxyContin®, Percocet® and Duragesic® and generics like hydrocodone, oxycodone, fentanyl, hydromorphone and morphine.

As the CDC's director summarized the problem: "Prescription drug overdose is epidemic in the United States. All too often . . . the treatment is becoming the problem."¹

If only my new union friend would listen to—and pay attention to—the CDC's blunt recommendations: Painkiller use should be tightly controlled and continuously monitored to ensure wise use.

What Constitutes Wise Use?

The strongest painkillers—opioids—are intended to ease severe short-term pain from, say, surgery or a broken bone or to manage chronic pain from terminal or very serious illness—

es, like cancer. But there's little evidence opioids are effective in controlling long-term pain from persistent back problems, arthritis or nerve damage.

Equally important, individuals who take opioids for more than a few weeks risk developing a drug tolerance; they require higher and higher doses for the drugs to work, breeding dependence. In turn, higher doses of opioids often cause nausea, constipation, immune system disruption, sexual problems and fuzzy-headedness that interferes with—or entirely prevents—competent daily functioning. Continued long-term opioid use also sometimes creates an even greater sensitivity to pain. Finally, from 5% to 25% of long-term opioid users become addicts.²

Despite these horrifying facts, it's estimated that 90% of people suffering long-term pain are prescribed opioids.³ That's true even though over-the-counter medicines like acetaminophen (Tylenol®), ibuprofen (Advil®) and naproxen (Aleve®) may work just as well for many types of chronic pain. And if they don't, other prescription drugs are wiser choices for chronic pain caused by nerve problems, migraines, fibromyalgia and other similar health issues. Also, non-drug approaches like exercise, massage and physical therapy often are useful in alleviating chronic pain.⁴

Thus, rather than providing plan participants access to every painkiller—in any quantity, for as long as desired—my union friend and all plans that care about their participants' health should try to limit and control prescription painkiller use. Painkillers should be used for as short a period as possible, in as low a dosage and as limited a quantity as reasonable, and only when they are therapeutically appropriate.

How Painkiller Use Can Be Controlled

Plan representatives who want to protect participants from unwise painkiller use while ensuring the best possible patient outcomes can:

- Start by asking their PBM to implement *quantity limit programs*. By way of example only, the PBM likely has available a quantity limit program that limits OxyContin to twice daily use, preventing the common but unwise practice of taking OxyContin three times daily.
- Tell the PBM the plan wants to add *step-therapy programs* that will require participants to try less dangerous (and less costly) drugs before using more dangerous (and more expensive) medications.
- Also, tell the PBM the plan wants to implement *prior authorization programs* that allow opioid access only for treating short-term pain problems or long-term serious illnesses like cancer and that preclude access for other long-term chronic pain issues like backaches, migraines and fibromyalgia.

Moreover, when implementing step-therapy and prior authorization programs, plan sponsors should verify that the PBM is preventing certain off-label painkiller use, a common and dangerous prescribing practice. For example, when the Food and Drug Administration (FDA) approved the rapid-onset narcotic Subsys® (which is sprayed under the tongue), the FDA warned that Subsys should be prescribed only by oncologists and pain specialists and taken only by cancer patients who are already using round-the-clock pain-

killers but are still in need of additional medication to control breakthrough pain. However, according to a company that analyzes drug use, only about 1% of Subsys prescriptions are actually written by oncologists and about half are written by pain specialists. But almost half of all Subsys prescriptions are written by general practitioners, neurologists, dentists and even podiatrists, who clearly are prescribing Subsys for indications other than breakthrough cancer pain.⁵

Health plan sponsors should also consider excluding from coverage the new-to-market painkiller Zohydro® ER, an extended-release, long-acting form of hydrocodone. For unlike cell phones and many other consumer items, the “latest” is often not the “greatest” when it comes to drugs, as can be seen from Zohydro ER.

When the FDA approved Zohydro ER in October 2013, it did so contrary to the recommendation of its own expert advisory panel, which voted 11-2 against approval. Given that the drug is a high-dose formulation with no drug abuse deterrents built into the tablet (which are now present with OxyContin), the FDA's approval caused an immediate uproar that has only grown over time.

In March 2014, Rep. Stephen Lynch (D-Mass.) and Sen. Joe Manchin III (D-W.Va.) introduced legislation that would withdraw FDA's Zohydro approval. In September 2014, antiaddiction groups called for FDA Commissioner Margaret Hamburg to resign over Zohydro's approval. The attorneys general of 28 states have asked the FDA to reconsider its decision. And more than half of all states have taken some action to try to restrict the drug's use.

Plan representatives who are reluctant to require a PBM to implement drug restrictions because they think doctors should be free to prescribe without interference should keep the following in mind: Doctors not only have to keep abreast of new drug warnings, they must also track warnings for older drugs that have long been on the market.

Does it make sense for any plan to spend any money—let alone large amounts of money—for a controversial and widely challenged drug like Zohydro ER when other, less expensive and safer drugs are available for use?

Other Quantity Limit Programs

Numerous other drug categories besides painkillers cry out for rational quantity limit programs.

For example, almost all specialty drugs should carry quantity limits of no more than 30 days. Patients often take only limited quantities of these drugs before giving them up, so a 30-day “cap” makes sense for most specialty drugs. Some—like high-cost oncology drugs—should have even tighter quantity limit restrictions, since patients often stop taking these drugs after a few days because of their side effects.

Proton pump inhibitors (PPIs) like Nexium®, Prilosec®, Prevacid® and generic equivalents—taken by many people because they are eating too many French fries and not enough spinach—should have quantity limits of 30 per month. Refills and renewals should be carefully scrutinized over time to limit use to appropriate time frames. Studies show that up to 70% of PPI users might not need such strong medication.⁶ And the recommended use of almost all PPIs for uncomplicated heartburn is four to eight weeks. Unfortunately, recent studies show that patients are increasingly taking PPIs for years.⁷

Although many doctors and patients consider PPIs to be relatively harmless, clinical studies reflect PPIs can have significant and even lethal side effects. If taken too long, they can also cause dependence. And when individuals try to stop taking PPIs, they sometimes experience stomach problems even worse than they originally had, a phenomenon known as the *rebound effect*.⁸

Given the many problems related to PPIs, in 2011 the consumer rights advocacy group and think tank Public Citizen petitioned the FDA to add a black box warning to all PPIs that

would identify the rebound risk as well as fracture, infection and magnesium deficiency risks.⁹ But the FDA has not acted and may not do so for years. Meanwhile, massive promotional campaigns continue to encourage doctors to prescribe—and patients to use—PPIs. Therefore, it may make sense for plans to limit quantities of PPIs to protect participants and to allow PPI use only for approved indications, especially since over-the-counter PPIs are now available at low cost.

As a final, sexier example of a therapeutic drug category crying out for a quantity limit program, take a look at erectile dysfunction (ED) drugs. We recently sorted the claims data of a new client to segregate ED drugs, eliminated all Cialis® Daily prescriptions and discovered that its existing PBM had been allowing users to take an average of 14.4 ED pills per month. That meant that the average user theoretically was having sex every other day.

According to the Kinsey Institute, almost no men—even by their own telling, whether single, partnered or married—are having sex every other day.¹⁰ Accordingly, the plan was likely paying for pills that were never being used. Or men were taking pills—or giving them to their male friends—for “recreational use.” Whatever was occurring, the plan was paying for a lot more ED pills than could possibly make sense.

As a result, out of a total annual drug spend of approximately \$22 million, the plan was spending almost \$460,000 for a single therapeutic category of drugs—ED drugs. By imposing a reasonable quantity limit program of six pills per month (for all ED prescriptions other than Cialis Daily), the plan could save almost \$250,000 annually.

Why Plans Need to Take Charge

Regardless of the therapeutic category or drug involved, plans can't necessarily depend on their PBMs to generate—and continuously update—effective quantity limit programs. PBMs often have little reason to limit the number of drugs dispensed,

which typically would also decrease the amount of money PBMs make.

Nor do many PBMs consider it their duty to encourage reluctant plan representatives to limit the number of drugs dispensed to participants—especially since PBMs often meet resistance when they try to do so.

Preventing Inappropriate Antipsychotic Use Through Other Savings Programs

For the same reasons, many PBMs also fail to encourage health plans to implement effective prior authorization and step-therapy programs. But it's also wise for plans to implement these programs, as demonstrated by a brief look at antipsychotic drugs.

The FDA approved antipsychotics like Abilify®, Risperdal®, Zyprexa®, Geodon® and Seroquel® to treat serious psychotic diseases. For example, the agency approved Abilify to treat schizophrenia, bipolar disorder and autistic irritability and as an adjunct therapy for major depressive disorder.

For many years, diagnoses of such diseases were relatively rare, so antipsychotics were rarely prescribed. However, in recent years, there's been an explosion of antipsychotic use.

As of 2013, Abilify was the top grossing drug in America, with \$6.5 billion in annual sales. That same year, about 3.5 million Americans were prescribed antipsychotics. Over the past decade, toddlers engaging in normal behaviors like temper tantrums increasingly have been diagnosed with bipolar disorder and prescribed antipsychotics. On the other end of the age continuum, about a fifth of all elderly patients in nursing homes are being given antipsychotics to try to control agitation, aggression,

hallucinations and other Alzheimer's and dementia symptoms, even though the FDA added a black box warning about the risks of such prescribing almost a decade ago.

The causes of increased antipsychotic use are many, but chief among them are manufacturers' unlawful off-label marketing and inaccurate promotional activities. According to author Don Light in *The Risks of Prescription Drugs*, "three out of every five antipsychotic drugs are prescribed for an unapproved use. Yet three-fourths of the time the off-label uses have little or no scientific support."

As a result, in the past decade federal and state prosecutors filed lawsuits against virtually every antipsychotic manufacturer. Among their many allegations: The manufacturers disseminated inaccurate information about their drugs to doctors. They hid or misrepresented clinical trial evidence. And they failed to disclose serious side effects.

Notably, even after prosecutors executed compliance agreements with some manufacturers in which the manufacturers agreed to cease their unlawful practices, prosecutors ended up filing new lawsuits alleging the manufacturers were continuing to engage in the same practices.

A South Carolina judge summed up the problem after reviewing mounds of evidence showing one antipsychotic manufacturer's "concerted effort to conceal . . . and to manipulate" information. The manufacturer had shown a "callous disregard for a patient's rights to have all information available, and in the hands of their physician, before deciding to use or continue to use" a drug.¹¹

In short, doctors may well be prescribing antipsychotics based on inaccurate and incomplete information.

That central fact is particularly troubling given antipsychotics' serious risks and side effects.

Studies show the long-term use of antipsychotics results in a reduction in life expectancy measured in decades, not just years.¹² Also, there are many serious and relatively common antipsychotic side effects, including large weight gains, diabetes, stroke and cardiac arrest.

Although rare, antipsychotics can also cause a horrific side effect called *tardive dyskinesia*. *Tardive* means delayed, and *dyskinesia* means involuntary muscle movements; together, this medical terminology means delayed involuntary muscle movements. That benign translation does nothing to warn people of what may be lying in wait should they develop tardive dyskinesia: They may experience bizarre but continuous lip movements (such as smacking, pursing or puckering). They may be unable to control their tongues, which may wag inside and outside their mouths continuously. They may repeatedly blink or have continuously rolling eyes or twitching eyebrows. Or they may repeatedly rock their bodies, or repeatedly raise and lower their arms, or suffer from repeated involuntary spastic back activity.

A lawyer I know who took the deposition of a plaintiff suffering from tardive dyskinesia told me as soon as he saw the woman, he knew he needed to settle the case immediately. He could not possibly allow the case to go before a jury, or his manufacturer client might be exposed to a very high damages verdict. A search for the phrase *tardive dyskinesia* on YouTube will turn up many videos of people suffering from the problem. Bear in

mind that after tardive dyskinesia begins, it may never end, even if the individual stops taking antipsychotics.

For all of the above reasons, it makes sense for every plan administrator to implement prior authorization programs to allow antipsychotics to be prescribed only for approved uses.

Note that it is also wise for plans to implement antipsychotic step-therapy programs for those individuals whose use is approved. Generics are available for Zyprexa (olanzapine), Seroquel (quetiapine), Risperdal (risperidone) and Geodon (ziprasidone). Those generics may cost a plan as little as one-tenth the cost of brand-drug antipsychotics, which can cost as much as \$1,000 (or more) per 30-day prescription. Expensive, long-acting injectable antipsychotics should also be limited to those few individuals who cannot self-administer those drugs.

Savings Programs Make Sense for Many Drug Categories

Antipsychotics aren't the only therapeutic category where prior authorization and step-therapy programs can protect a plan's bank account as well as participants' health.

The hepatitis C drugs Sovaldi®, Olysio® and now Harvoni® make clear that controls are imperative if plans are to survive financially. With more than three million Americans suffering from this disease, and drug costs of about \$80,000 to \$180,000 per regimen per person, plans have no choice but to create effective prior authorization programs. Only patients who are symptomatic or suffering from advanced liver disease should currently be given treatments. Delaying treatment for all others who are asymptomatic may provide the time necessary for drug costs to decrease.

Drugs designed to control diabetes provide another example of a therapeutic category where extensive programs should be implemented. To control diabetes, four quite inexpensive generic drugs (metformin and the sulfonylureas glyburide, glimepiride and glipizide) have long been on the market, and their efficacy, safety and risks are now largely known. In contrast, recently approved brand drugs like Januvia®, Janumet®, Onglyza® and Farxiga® have no such long-term, proven track record. Therefore, they carry greater risks and, in many clinical studies, have already been found to be less effective and potentially dangerous. Plus, they are all more expensive. Somewhat older brand drugs such as Avandia®, Avandamet®, Avandaryl® and Actos® have risks that are now well-known, leading many experts to warn that their use is also likely unwise.

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Given that generic metformin and the sulfonylureas will cost in the single, or at most, double digits per 30-day prescription (assuming a PBM contract contains adequate controls), why wouldn't a plan require participants to try those drugs first, before trying brand drugs that have not withstood the test of time but could cost the plan hundreds of dollars per prescription?

Similarly, a step-therapy program makes sense for cholesterol-reducing drugs. Remember the extended period from 1996 to 2011 when Lipitor® was the world's best-selling drug, with more than \$125 billion in total sales during that period? When Lipitor lost its patent and generic Lipitor became available, joining several other available generics (like generic Zocor® and Mevacor®), experts predicted that generic statins would represent as much as 90% of total sales.

But drilling down into the claims data of health plans, we often find that brand drug Crestor® now claims a large portion of cholesterol-reducing drug dollars. For example, of approximately \$22 million in total drug costs, one plan we recently examined had incurred approximately \$670,000 in total for cholesterol-reducing drugs, with more than half that amount (about \$370,000) solely for Crestor.

If the plan required its PBM to implement a step-therapy program (requiring plan participants to try generic Lipitor before using Crestor), total Crestor costs would likely be reduced by about \$250,000.

Prior authorization and step-therapy programs also make sense for drugs designed to treat rheumatoid arthritis. A recent expert study appearing in the *New England Journal of Medicine* concluded that a regimen of three inexpensive generic drugs was equally effective—with different but no less difficult side effects—as a regimen of a generic plus the far more costly injected biologic Enbrel®.¹³

In addition, according to a recent article in *Health Affairs* magazine, “three-quarters of insurers’ utilization management programs for rheumatoid arthritis require prior failure on nonbiologic treatments before coverage will be available for expensive specialty drugs [like Enbrel, Humira® and Remicade®]. More than half of the programs then require prior failure on the insurers’ ‘preferred’ biopharmaceutical, for which the plan has negotiated a price discount, before approval is granted for a nondiscounted product.”¹⁴

Plan sponsors may want to require their PBM to take steps to decrease the use of Enbrel, Humira and Remicade, each of which is likely to result in total costs per person of \$30,000 to \$60,000 annually.

A Special Warning About Prior Authorization Programs

Unfortunately, some PBMs appear to view prior authorization as money-making programs, not as opportunities to ensure wise drug use. Rather than establishing tight medical criteria and then carefully scrutinizing each prior authorization request, those PBMs simply rubber-stamp almost all requests for higher cost drugs. Alternatively, some

PBMs agree to perform prior authorizations for free or for a reduced cost in order to win RFPs and attract new clients. But then the PBMs spend as little time as possible on their prior authorization programs, again rubber-stamping almost all requests for high-cost drugs.

Accordingly, every plan should not only determine which prior authorization and step-therapy programs their PBM is running on the plan’s behalf—and carefully implement comprehensive programs—but every plan should also scrutinize its PBM’s prior authorization approval/disapproval rates.

A plan should begin its review by requesting claims data that reflects a PBM’s approval rates across all drugs in the PBM’s prior authorization program. If a PBM is approving 80% to 90% of all requests to use high-cost drugs, it’s not doing its job. In fact, it’s exposing plan participants to unwise prescribing, and it’s squandering the health plan’s opportunity to dramatically decrease its costs.

Thereafter, a plan should examine its PBM’s approval rates for specific drugs in the prior authorization program. The approval rates for many drugs—like Celebrex®, Makena® and Modafinil®—should be between 60% and 70%. For

other drugs—like Crestor, Vyvanse® and Victoza®—lower approval rates of between 50% and 60% are appropriate and feasible. For other drugs—like Nuvigil® and Lyrica®—approval rates should be even lower—less than 50%. Here’s why:

The FDA approved Nuvigil to treat excessive daytime sleepiness associated with obstructive sleep apnea, narcolepsy and shift-work disorder. But doctors commonly prescribe Nuvigil off label to treat attention deficit hyperactivity disorder (ADHD), chronic fatigue syndrome and depression, even though other drugs have been scientifically demonstrated through the FDA approval process to be safe and effective to treat each of those problems. And those other drugs are far less expensive. If a plan sponsor bars the off-label uses of Nuvigil, it will likely block more than half of all Nuvigil prescriptions, which typically cost about \$440 per prescription.

Similarly, Lyrica, often referred to as supercharged Neurontin (gabapentin), was approved by the FDA to treat epilepsy, diabetic neuropathic pain, postherpetic neuralgia and fibromyalgia and as an adjunctive therapy for partial onset seizures. But purported off-label promotion apparently has induced many doctors to prescribe Lyrica for many other uses, including depression and anxiety. And even though the federal government filed a lawsuit and extracted in connection with Lyrica and three other drugs the largest settlement fine in history at the time—\$2.3 billion—numerous doctors continue to prescribe high-cost Lyrica for off-label uses.

Given those facts, doesn’t it make sense for a plan to protect the health of its members and ensure that more appropriate, lower cost drugs are dis-

takeaways >>

- To help protect participants from addiction and potentially severe side effects, opioid painkillers should be allowed only when therapeutically appropriate, in the lowest reasonable dosage.
- Quantity limits often are appropriate for painkillers, proton pump inhibitors, erectile dysfunction drugs, specialty drugs and other classes of drugs.
- Step-therapy programs require patients to try less dangerous and usually less costly drugs first.
- Prior authorization programs can help prevent drugs being taken for uses for which they haven’t been approved and may not be appropriate.
- A high percentage of antipsychotic drugs are prescribed for unapproved uses.
- With new drugs continually becoming available, plans need to be sure their PBM or a third-party vendor keeps programs up to date.

pensed, especially given that Lyrica typically costs about \$245 to \$365 per prescription (depending on whether the prescription is to be used two times or three times daily)?


Require PBM to Update Programs Continuously (or Find a Third-Party Vendor That Will)

In 2012, 36 new molecular entities entered the market. Although the FDA approved all such drugs, newly approved drugs typically are tested on only a few thousand people, meaning at the time they are approved their effectiveness and safety are largely unknown.

A recent study also showed that of 522 novel drugs approved between 1996 and 2012, 11 products were withdrawn from the market entirely. Fifty drugs received boxed warnings after entering the market, and 25 received boxed warnings pre- and postmarket. The median time from approval to first postmarket boxed warning—or withdrawal—was 4.2 years. Thus, data makes clear that those who use drugs during the first few years after they enter the market are being subjected to dangers that are largely or entirely unknown.

Plan representatives who are reluctant to require a PBM to implement drug restrictions because they think doctors should be free to prescribe without interference should keep the following in mind: Doctors not only have to keep abreast of new drug warnings, they must also track warnings for older drugs that have long been on the market. A recent study showed that of 14,264 drug labels identified on the national Library of Medicine website, 35%, or 4,940, contained at least one boxed warning.

Given the large number of drugs that are continuously entering the market—and the ever-changing and abundant number of drug warnings—it's critically important that plans make sure their PBM is continuously tracking marketplace developments and updating programs. If a PBM won't or can't do so, plans should turn to a specialized third-party vendor that will.

In sum, it makes sense for plan representatives to say “yes” to quantity limit, step-therapy and prior authorization programs. Plan participants' health may depend on the strength or weakness of these programs, and plans may be able to reduce their total costs by as much as 10% to 20% by implementing more effective programs. Moreover, continuously updating programs will ensure a plan bends its cost curve significantly. 

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