Medi-Cal Rx "Safe Prescribing" Guide

Medi-Cal Managed Care Plan Health	Medi-Cal Specialty Mental Health Services[1] Drug Medi-Cal Organized Delivery System	Medi-Cal Managed Care Plan Behavioral Health Services[2]
Aetna Better Health	San Diego Access & Crisis Line (888) 724-7240	Aetna Better Health (855) 772-9076
Blue Shield CA Promise Health Plan	San Diego Access & Crisis Line (888) 724-7240	Blue Shield CA Promise Health Plan (855) 321-2211
Community Health Group	San Diego Access & Crisis Line (888) 724-7240	Behavioral Health Services (800) 404-3332
Health Net	San Diego Access & Crisis Line (888) 724-7240	Managed Health Network (MHN) (888) 426-0030
Kaiser Permanente	San Diego Access & Crisis Line (888) 724-7240	Kaiser Permanente, Department of Psychiatry (877) 496-0450
Molina Healthcare	San Diego Access & Crisis Line (888) 724-7240	Molina Healthcare (888) 665-4621
United Healthcare	San Diego Access & Crisis Line (888) 724-7240	United Healthcare (866) 270-5785

(*Medi-Cal beneficiaries can access a County Behavioral Health program directly.)

(*For emergencies call 911 or the Access & Crisis Line at (888) 724-7240)

Medi-Cal Specialty Mental Health Services[1]

County Behavioral Health Services covers inpatient and outpatient **Medi-Cal Specialty Mental Health** services to all Medi-Cal beneficiaries including those on a Medi-Cal Managed Care Plan. Covered benefits are for clients with serious and persistent psychiatric illness requiring complex biopsychosocial services in order to maintain stability. These services are commonly provided by San Diego County's contracted network and inpatient psychiatric hospitals.

Substance Use Treatment

Medi-Cal beneficiaries can receive substance abuse services through the San Diego County Drug Medi-Cal Organized Delivery System. These programs can be accessed by calling the Access & Crisis Line. Medi-Cal beneficiaries in need of Acute Medical Detoxification are covered by their Medi-Cal Managed Care Plan. Acute Medical detoxification means treatment in an acute medical facility for a serious medical condition relating to substance withdrawal. Additionally, **Voluntary Inpatient Detox** is available and covered by the State's Fee for Service system.

Medi-Cal Managed Care Plan Behavioral Health Services[2]

Medi-Cal Managed Care Plans cover behavioral health services for members who do not qualify for **Specialty Mental Health** covered by the County. Each Medi-Cal Managed Care Plan has their own network of contracted behavioral health providers.

Consumer Center for Health Education & Advocacy

The Consumer Center for Health Education & Advocacy helps beneficiaries understand how to use physical and behavioral health services. If there is a problem getting necessary care through a managed care plan, members and providers should first contact the plan's customer service department. In most cases, the health plan will resolve the issue. Occasionally, a plan member may feel his/her needs are not being met and may need a third party to help break down a barrier. The Consumer Center works closely with the health plans to figure out where the barrier is and how to resolve the problem. The Consumer Center for Health Education & Advocacy number is: (877) 734-3258.

Prescription Drug Abuse is a leading cause of unintended death in San Diego County. The following are recommendations for health plans and providers to take to promote safe prescribing.

For more information, **visit** www.sandiegosafeprescribing.org

	Recommendation	Rational	Comments
1	**Restricted Status Program for high risk patients**	28% of deaths in San Diego county occurred in patients with multiple providers and pharmacies. They consumed over 50% of all prescriptions of those who died.	HEALTH PLAN PROGRAM: Recommend that a safety program be created to have high risk patients, who utilize multiple providers and multiple pharmacies, receive coordinated care by allowing only one provider and one pharmacy to prescribe pain management prescriptions.
2	**Acute Pain**	CDC recommendations states that three or fewer days are usually sufficient for most non-traumatic pain unrelated to major surgery.	PRIOR AUTHORIZATION: Recommend that health plans add utilization management strategies to prevent acute treatment from becoming chronic. An example would be to limit first-time opioid prescriptions to no more than 30 tablets. Treatment beyond 30 tablets may be available with prior authorization.
3	**New Start Precautions**	Continuing opioids without functional improvement is not evidence based. 70% of all San Diego prescription deaths involved individuals with the same prescription for 3 consecutive months or more.	NEW STARTS: Recommend the creation of a prior authorization process for new start chronic opioids (continued new opioids after 1-3 months) that included medial indication, opioid risk assessment, CURES report, medication agreement, and tapering.
4	**Methadone Restriction**	Over 30% of overdose deaths involve methadone.100% of methadone deaths from a prescription-involved primary care. Genetic testing should be considered to determine if individuals could metabolize the drug and avoid cardiac toxicity.	PROVIDER RESTRICTION: Recommend requiring prior authorization for non-pain providers who want to prescribe methadone The medication can be given with coordinated care with pain management. There should be no restrictions for hospice and palliative care.
5	**High Morphine Equivalents**	High dose increases risk of overdose death and medical complications.	NEW STARTS: When patients are receiving escalating dosage of opioids and reach a new higher dose of morphine milligram equivalents per day of 90 MME, recommend that prior authorization be required. Palliative care and hospice are exceptions.
6	**Overdose Feedback to Providers**	In a study of 3000 patients who overdosed on prescriptions opioids and survived, 7% overdosed again, and 70% received new prescriptions from the same doctors who treated them before the overdose.	HEALTH PLAN FEEDBACK: Recommend that health plans provide feedback to prescribers if their patient was in the hospital for a medication poisoning. Providers are then encouraged to develop a prevention plan that includes checking CURES, limiting additive CNS depressant medications, a tapering plan, and evaluation for potential addiction.
7	**Benadryl**	There were 26 Benadryl associated deaths in 2014. The medication has addictive CNS depressant effects.	EDUCATION: Diphenhydramine use should be limited when combined with benzodiazepines and opiods due to additive CNS depressant effects. Prescriber education is recommended for Benadryl use.

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8	**Soma (Carisoprodol)**	Soma quickly metabolizes to meprobamate, an anxiolytic known for its addictive potential. The half-life of soma is 100 minutes while the half-life of meprobamate is 6-17 hours. Soma is off the market in several European countries. It is part of the "holy trinity" that includes opioids and benzodiazepines. Soma has no evidence for long-term benefit.	Consider removing carisoprodol from formulary when possible or create strict prior authorization that requires medical justification. Limited to short-term (acute) use only, per the FDA approved indication. Recommend that ongoing use requires failure of other muscle relaxants covered by the plan: e.g. baclofen, cyclobenzaprine, methocarbamol, tizanidine or chlorzoxazone. Recommend that the justification include an accurate diagnosis as provided by PRESCRIBER and include all necessary/relevant clinical documentation to support medical justification (clinic notes, lab reports, specialist consults, imaging reports etc…).
9	**Naloxone Access**	One overdose death is prevented for every 164 naloxone prescriptions. The CDC recommends Naloxone prescriptions for patient on more than 50 morphine equivalents per day. Opioid and Benzodiazepine combination is an addition indication for naloxone prescription.	EDUCATION: Providers should prescribe naloxone to patient on more than 50 morphine equivalents per day and those with opioid and benzodiazepine co-prescribing. Pharmacies may dispense naloxone without a prescription, however the medication may not be covered by insurance from the pharmacist, therefore may require prior authorization. For Medi-Cal, the drug is covered as a carve-out and is covered without authorization. Pharmacies should submit the claim to the Medi-Cal Fee for Service Claims Processor. The nasal atomizer is not a medical device and cannot be billed; it could be purchased by the patient ($5) or the plan and distributed to providers to dispense with the prescription.
10	**Alprazolam (Xanax)**	Deaths that include benzodiazepines are increasing. Xanax is the most prescribed and most addictive of all the benzodiazepines. The medication peaks at 1-2 hours, but last for only 5 hours. Tolerance, psychological and physical dependence may occur in as little as 10 days. Bipolar and mania is relatively contraindicated for Xanax because of potential exacerbation of mania. The American Psychiatric Association guidelines recommend benzodiazepines such as Xanax for short term use only.	Recommended coverage duration: Anxiety - 3 months, Cancer - 1 year, Epilepsy – 1 year. Xanax should be limited to guidelines by the American Psychiatric Association.

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11	**Buprenorphine Access**	Buprenorphine can be helpful for individuals with opioid addiction in tapering and preventing relapse. It cannot be started in individuals who still have opioids in their system. Physicians are required to complete an eight-hour training to qualify for a waiver to prescribe and dispense buprenorphine.	HEALTH PLAN COVERAGE: Recommend that health plans cover buprenorphine certification for providers and give incentives for accepting referrals. For Medi-Cal, buprenorphine is covered as a carve-out and no authorization is needed. The pharmacy should submit the claim to the Medi-Cal Fee for Service Claims Processor.
12	**Other Pain Modalities**	Pain treatment requires a multidisciplinary approach and not just prescriptions. This may include modalities such as bio-feedback, massage, acupuncture, and other modalities.	Health plans are encouraged to provide other modalities for pain management that do not include prescriptions for select patients. This is an opportunity to improve pain management and reduce potential patient harms from overuse, in conjunction with potential cost savings.
13	**Limit Concurrent Opioid and Benzodiazepine**	More than 30% of opioid deaths involve use of benzodiazepines. San Diego data showed that 50% of prescription deaths were given this combination.	NEW STARTS: Recommend implementing a prior authorization requirement for new start patients who require a chronic combination of benzodiazepine and opioids. Approval of the request should be based on a single physician prescriber to coordinate both medications, justification for combined medications, and a tapering plan. EXISTING PATIENTS: Patients who are already on opioid and benzodiazepine combination is best handled through an interdisciplinary approach for tapering.
14	**Tramadol (Ultram)**	There is an increase in prescriptions of Tramadol and therefore increased deaths (20 in 2015). One tablet of 50mg Tramadol has more morphine equivalents than one Norco 5/325.	Education is necessary for providers about Tramadol. This medication is considered addictive in morphine equivalents and CNS depressant effects.
15	**Zolpidem (Ambien)**	In 2013, San Diego had 43 patients that died from prescription overdose. A sleep aid is generally not recommended for longer than 2 weeks because of lack of prolonged efficacy.	Consider prior authorization for new start individuals who require daily long-term prescriptions.
16	**Marijuana**	Marijuana is a CNS depressant. The potency of THC has gone up from 3% to up to 33% in the past 30 years. Marijuana is the number one drug found in fatal car accidents.	There is no evidence-based literature that promotes marijuana for pain management. Dronabinol is a schedule III prescription that can be given that contains defined quantities of THC and is used for as an adjunct for nausea. Some clinics and providers have patient chose between marijuana use and opioids for pain managements. All should understand that addictive effects of multiple CNS depressive agents. Appropriate patient education needs to be developed regarding potential interactions between prescribed medications and marijuana.

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17	**Clinical Consultation**	Primary care physicians often face a difficult task in weaning and managing patients who are on multiple or high dose prescriptions. These patients are often at highest risk and also at highest intensity of management requirements.	CONSULTATION MECHANISM UCSF Clinical Consultation Center. ✓ UCSF provided clinical consultation for physicians who have questions on HIV prophylaxis medications, Hepatitis C treatment, as well as opioid treatment. The San Diego Prescription Drug Abuse Task Force can provide a forum to discuss difficult cases. Health Plans should develop a system for consultation to address difficult patient cases in a systematic and consistent mechanism.

Healthy San Diego

Behavioral Health Subcommittee Recommendations

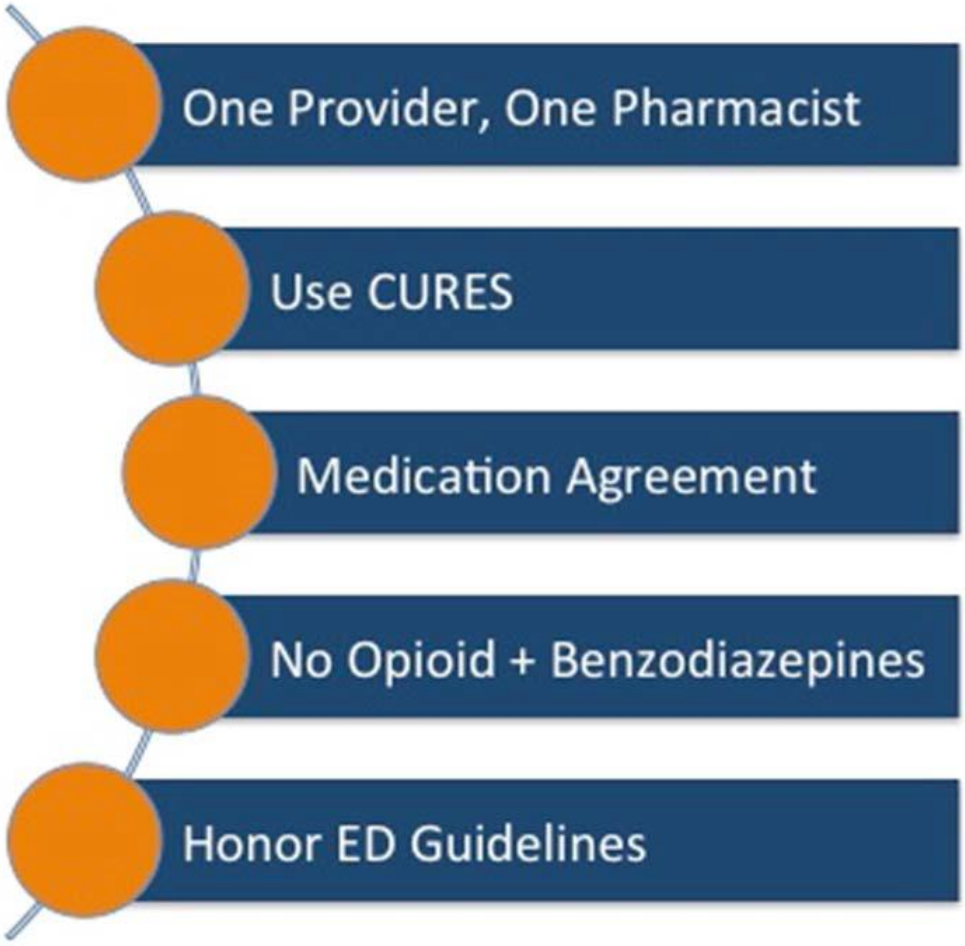
- Quantity and fill limits
- Formulary management
- Provider Restrictions
- Concurrent use edits
- Use of treatment plans to include assessment of pain; treatment modalities considered, tried and failed; treatment goals; medication necessary to manage pain
- Use of pain contract between prescriber and member
- Restrict members to one prescriber
- Restrict members to one pharmacy
- Random drug screens
- Regular review of utilization management reports based on members, prescribers and pharmacies
- CURES Report

Treatment Options

- Primary Care Provider
- Pain Management Specialist
- Health Plan Behavioral Health Services Department
- San Diego County Drug Medi-Cal Organized Delivery System
- San Diego County Access & Crisis Line

One San Diego Safe Prescribing Mission

The One San Diego Vision for Safe Prescribing, promotes a unified approach to prescribing, whether you are an emergency physician, primary care, pain specialist, surgeon, dentist, psychiatrist, pharmacist, or health plan.



REFERENCES

- 2014 consensus guideline from The American Pain Society and the American Academy of Pain Medicine recommended 200mg morphine equivalents be considered high-dose and recommended for dose decrease with signs of poor function or pain control. Many plans and clinics are using 120mg. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4043401/

- Morphine Equivalents a day. Many free opioid conversion calculators available.
- http://www.pharmacytimes.com/contributor/jeffrey-fudin/2014/09/the-perfect-storm-opioid-risks-and- the-holy-trinity

- http://www.asam.org/docs/default-source/advocacy/mat-with-buprenorphine-summarizing-the-evidence.pdf?sfvrsn=0
- http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20N/PDF%20NaloxoneOpioidSafety Patients.pdf
- 2013 San Diego Medical Examiner, CURES data study