

### Access to Medications Talking Points

- **Drug overdoses are the current leading cause of accidental death in the U.S., having surpassed traffic fatalities. Opioid addiction is driving this epidemic.**
  - There were 47,055 lethal drug overdoses in 2014, with 18,893 overdose deaths related to prescription opioid analgesics, and 10,574 overdose deaths related to heroin.<sup>1</sup>
  - Since 1999, sales of prescription pain medications have increased by 300 percent. In 2012, 259 million prescriptions were written for these drugs, which is more than enough to give every American adult their own bottle of pills.<sup>2</sup>
  - The increase in availability of prescription opioids has been accompanied by an increase in opioid misuse and addiction.<sup>3</sup>
  - Four in five new heroin users started out by misusing prescription drugs.<sup>4</sup> As a consequence, the number of heroin-related deaths in the U.S. nearly quadrupled in the past decade.<sup>5</sup>
- **Studies have shown that opioid addiction medications are clinically effective in reducing drug use and promoting recovery.**
  - Methadone maintenance treatment, when used as part of a comprehensive treatment approach, continues to accrue evidence for its effectiveness in engaging and retaining patients in treatment, reducing withdrawal and craving symptoms, reducing opioid misuse, and reducing many opioid addiction-related health and social problems, particularly risk of infectious diseases.<sup>6</sup>
  - Relative to outpatient, abstinence-oriented drug addiction treatment, office-based outpatient treatment (OBOT) with buprenorphine improves six-month treatment engagement, significantly reduces cravings, illicit opioid use and mortality and improves psychosocial outcomes.<sup>6</sup>
  - Extended-release injectable naltrexone can essentially eliminate the rewarding effects of self-administered opioids, thereby dramatically reducing opioid use and opioid-related health and social problems.<sup>6</sup>
  - Those receiving medications as part of their treatment are 75 percent less likely to die because of addiction than those not receiving medications.<sup>7</sup>
- **Using medications for opioid addiction treatment results in decreased health care costs and criminal justice expenditures.**
  - Treatment is less expensive than alternatives. The average cost for 1 full year of methadone maintenance treatment is approximately \$4,700 per patient, whereas 1 full year of imprisonment costs approximately \$18,400 per person.<sup>8</sup>
  - Every \$1 invested in addiction treatment yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs and theft alone. When savings

related to health care are included, total savings can exceed costs by a ratio of 12:1.<sup>9</sup>

- Methadone and buprenorphine treatment episodes have been associated with \$223 to \$153 lower total health care expenditures per month than other non-medication behavioral health treatment episodes, most likely because patients are less than one half as likely to relapse when treated with methadone or buprenorphine than if they receive treatment without medication.<sup>10</sup>
  - The costs of a monthly dose for oral naltrexone is approximately \$60. In comparison, typical costs for self-administered insulin for diabetes are approximately \$180 to \$240. Extended release naltrexone is more expensive at approximately \$700 a monthly dose, but a year of treatment using extended release naltrexone is \$10,000 less than a year of imprisonment.<sup>6,8</sup>
- **While these medications' effectiveness has been proven, there are significant barriers to access.**
    - Significant access barriers to methadone include waiting lists for treatment entry, limited geographic coverage, limited insurance coverage and the requirement that many patients receive methadone at Opioid Treatment Programs daily.<sup>11</sup>
    - Qualified physicians who have received a special waiver may treat patients in their office with buprenorphine. However, federal law limits a physician to treating no more than 100 patients. In a recent survey, 66% of addiction specialists reported that their patient demand for treatment exceeds the 100-patient prescribing limit.<sup>12</sup>
    - Medications for the treatment of opioid addiction are often subject to additional, onerous utilization management practices by public and private payers, including prior authorization requirements, fail first policies and requirements for psychosocial services that may either be unavailable or not covered by a patient's plan.<sup>12</sup>

---

<sup>1</sup> Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Mortality File. (2015). Number and Age-Adjusted Rates of Drug-poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 2000–2014. Atlanta, GA: Center for Disease Control and Prevention. Available at

[http://www.cdc.gov/nchs/data/health\\_policy/AADR\\_drug\\_poisoning\\_involving\\_OA\\_Heroin\\_US\\_2000-2014.pdf](http://www.cdc.gov/nchs/data/health_policy/AADR_drug_poisoning_involving_OA_Heroin_US_2000-2014.pdf).

<sup>2</sup> Centers for Disease Control and Prevention. (2014). Opioid Painkiller Prescribing, Where You Live Makes a Difference. Atlanta, GA: Centers for Disease Control and Prevention. Available at

<http://www.cdc.gov/vitalsigns/opioid-prescribing/>.

<sup>3</sup> Paulozzi MD, Jones PharmD, Mack PhD, Rudd MSPH. Vital Signs: Overdoses of Prescription Opioid Pain Relievers – United State, 1999-2008. *Division of Unintentional Injury Prevention, National Center for Injury Prevention and Control, Center for Disease Control and Prevention*. 2011:60:5.

<sup>4</sup> Jones CM. Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers - United States, 2002-2004 and 2008-2010. *Drug Alcohol Depend*. 2013 Sep 1;132(1-2):95-100. doi: 10.1016/j.drugalcdep.2013.01.007. Epub 2013 Feb 12.

<sup>5</sup> Hedegaard MD MSPH, Chen MS PhD, Warner PhD. Drug-Poisoning Deaths Involving Heroin: United States, 2000-2013. *National Center for Health Statistics Data Brief*. 2015:190:1-8.

<sup>6</sup> American Society of Addiction Medicine, Treatment Research Institute. (2013). FDA Approved Medications for the Treatment of Opiate Dependence: Literature Reviews on Effectiveness and Cost-Effectiveness. Chevy Chase, MD: American Society of Addiction Medicine. Available at [http://www.asam.org/docs/default-source/advocacy/aaam\\_implications-for-opioid-addiction-treatment\\_final](http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final).

<sup>7</sup> Legal Action Center. (2015). Confronting an Epidemic: The Case for Eliminating Barriers to Medication Assisted Treatment of Heroin and Opioid Addiction. Washington, D.C: Legal Action Center. Available at <http://lac.org/wp-content/uploads/2014/07/LAC-The-Case-for-Eliminating-Barriers-to-Medication-Assisted-Treatment.pdf>.

<sup>8</sup> Treatment Research Institute, American Society of Addiction Medicine. (2013). FDA Approved Medications for the Treatment of Opiate Dependence: Literature Reviews on Effectiveness and Cost-Effectiveness. Philadelphia, PA: Treatment Research Institute. Available at [http://www.asam.org/docs/default-source/advocacy/aaam\\_implications-for-opioid-addiction-treatment\\_final](http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final).

<sup>9</sup> National Institute on Drug Abuse, National Institute of Health. (2007). Cost Effectiveness of Drug Treatment. Rockville, MD: National Institute on Drug Abuse. Available at <http://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment>.

<sup>10</sup> Clark PhD, Baxter MD, Aweh MS, O'Connell MS, Fisher PhD, Barton PhD. Risk Factors for Relapse and Higher Costs Among Medicaid Members with Opioid Dependence or Abuse: Opioid Agonists, Comorbidities, and Treatment History. *Journal of Substance Abuse Treatment*. 2015;57:75-80.

<sup>11</sup> Jones PharmD MPH, Campopiano MD, Baldwin PhD MPH, McCance-Katz MD PhD. National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment. *American Journal of Public Health*. 2015;105:6:e1.

<sup>12</sup> American Society of Addiction Medicine. (2014). Medications for the Treatment of Opioid Use Disorder: Public/Private Policies. Chevy Chase, MD: American Society of Addiction Medicine. Available at [http://www.asam.org/docs/default-source/advocacy/asam-impact\\_barriers4-02-14.pdf?sfvrsn=0](http://www.asam.org/docs/default-source/advocacy/asam-impact_barriers4-02-14.pdf?sfvrsn=0).

### Appendix: Buprenorphine Diversion

- In 2014, buprenorphine was estimated to be the fourth most common controlled substance and third most common narcotic analgesic among those secured in law enforcement operations and analyzed by Federal, State or local forensic laboratories.<sup>1</sup>
  - The number of buprenorphine drug reports in 2014 represented about a third of oxycodone drug reports and less than half of hydrocodone drug reports.
  - Buprenorphine drug reports represented only 1.01% of all drug reports.

NATIONAL ESTIMATES FOR THE MOST FREQUENTLY IDENTIFIED CONTROLLED SUBSTANCES: Estimated number and percentage of total drug reports submitted to laboratories from January 1, 2014, through December 31, 2014, and analyzed by March 31, 2015.

Drug	Number	Percent (Of All Identified Drugs)
Oxycodone	43,000	2.85%
Alprazolam	40,747	2.70%
Hydrocodone	33,132	2.19%
Buprenorphine	15,209	1.01%
Clonazepam	11,797	0.78%

- Buprenorphine is often diverted for therapeutic uses by opioid-dependent persons.
  - Buprenorphine/naloxone diversion has been limited and illicit buprenorphine/naloxone—which is frequently acquired from individuals with prescriptions—is commonly used in a therapeutic, non-medically supervised manner.<sup>2</sup>
- Inability to access to treatment is a predictor of increased use of diverted buprenorphine.
  - The finding that the most robust risk factor for buprenorphine use was failing to access legitimate buprenorphine treatment implies that **increasing, not limiting, buprenorphine treatment access may be an effective response to buprenorphine diversion among persons not in treatment.**<sup>3</sup>

<sup>1</sup> U.S. Drug Enforcement Administration, Office of Diversion Control. (2015). National Forensic Laboratory Information System: Year 2014 Annual Report. Springfield, VA: U.S. Drug Enforcement Administration. Available at: <http://www.deadiversion.usdoj.gov/nflis/NFLIS2014AR.pdf>

<sup>2</sup> Yokell MA, Zaller ND, Green TC, Rich JD. Buprenorphine and Buprenorphine/Naloxone Diversion, Misuse, and Illicit Use: An International Review. *Current drug abuse reviews*. 2011;4(1):28-41.

<sup>3</sup> Lofwall MR and Havens JR. Inability to access buprenorphine treatment as a risk factor for using diverted buprenorphine. *Drug Alcohol Depend*. 2012;126:379-383.