



FIRST SCRIPT®

2014 Drug Trends Analysis

Drug Utilization & Spending Trends
in Workers' Compensation

Published June 2015



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Introduction

We are excited to introduce the 2014 Coventry First Script *Drug Trends Analysis*. This year's report continues to provide a view into the traditional network trends that align with our previous reports, and is consistent with the approach taken by competitors. However, unlike other drug trend reports and our previous reports, this is the first year that we provide a line of sight into the total pharmacy exposure within our book of business, incorporating prescriptions that have been managed as well as those that are (yet) unmanaged.

Coventry's First Script 2014 Drug Trends Analysis marks an industry first—a fully transparent examination of total prescription drug trends for workers' compensation.

First Script total pharmacy management

Pharmacy care in workers' compensation has evolved markedly over the last decade. Significant numbers of injured workers are now receiving their medications outside the retail pharmacy setting where protective measures exist to avoid the risks associated with adverse drug interactions and duplicative therapies.

These new channels, which do not operate within the same protective oversight model as a traditional retail pharmacy, pose documented risk to patient safety as well as impose incremental costs onto the workers' compensation system. The increasing use of non-traditional dispensing channels, such as compounding pharmacies and physicians who directly dispense, has created even greater risks to injured worker safety and to the cost burden on the system.

In an effort to mitigate these mounting safety and cost risks, we've expanded our management reach beyond the traditional network into non-traditional pharmacy channels, including billers for physician-dispensed medications, occupational-medicine clinics, third-party billers, external mail houses, and compounding prescription sources. By including every possible pharmaceutical transaction, we are able to focus our efforts to improve clinical outcomes and pricing opportunities. If our clients are paying for it and their injured workers are taking it, we are using it to improve their outcomes.

First Script's total pharmacy management model is designed to safeguard every injured worker in our care and to promote optimal patient and aggregate program outcomes. We are also committed to ensuring that reimbursement for medications is at the lowest defensible level to mitigate any excessive cost risk to the workers' compensation system.

No script unmanaged, no injured worker left behind

Through our total pharmacy management approach, we've developed an exceptional level of clinical oversight for the injured workers in our care. We review every prescription for clinical appropriateness regardless of where it was dispensed or billed and present a complete utilization picture for each injured worker. Our expanded prescription data set enables us to identify injured worker risks that were previously invisible when viewed through the limits of a traditional network lens.

Our clinical staff, product development, and analytic teams collaborate to design sophisticated data models to continuously refine the injured worker risk identification and adjuster decision-support tools that are detailed throughout this report. Most recently, we enhanced our Urine Drug Monitoring (UDM) capability to leverage our expanded pharmacy data set and incorporate medical risk factors such as psychiatric comorbidities, high-risk diagnoses, aberrant behaviors, and a history of substance abuse that can be leading indicators for dependency, addiction, or even diversion. Our program ensures a closed loop and continued decision-support so that all findings are appropriately actionable within future treatment planning and claim management. Please read the specifics of this enhanced program on page 56.

First Script, Every Script—aggregate pharmacy trends

Because you cannot manage what you do not measure, First Script goes beyond the traditional in-network view to provide full transparency into the total pharmacy experience.

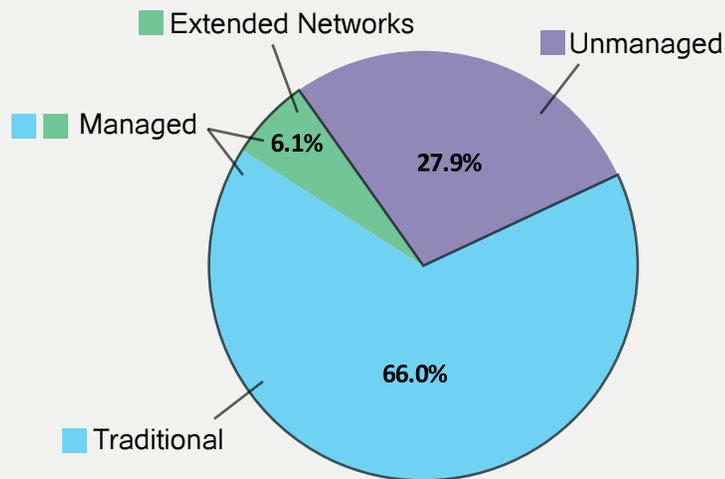
Our data set for the aggregate view consists of all National Drug Codes (NDCs) within our clients' overall claim experience, regardless of dispensing or billing channel.

For a more sophisticated analysis of trends that occur in different settings, we have grouped the data into three sections: the traditional view, the managed view, and the unmanaged view. A detailed description of each grouping is provided in the methodology.

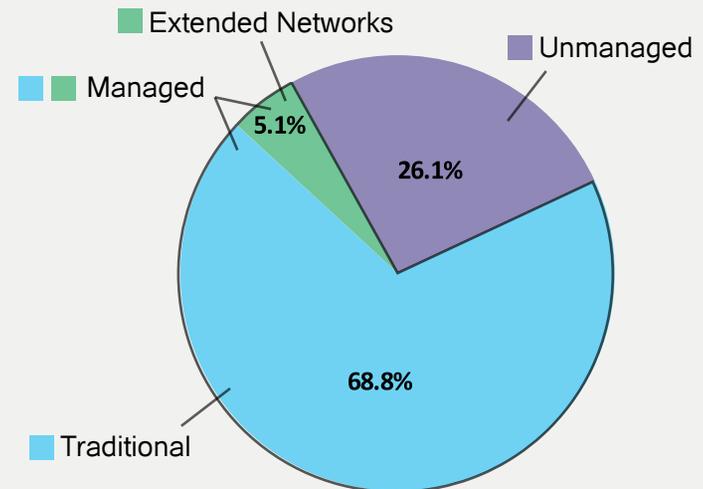
This analysis represents a significant departure from our previous reports as well as from those published within the industry, all of which focus solely on in-network retail and mail order pharmacy data.

2014 aggregate pharmacy trends

Utilization Volume by Network Type



Spend by Network Type



Managed View { **Traditional View**—First Script retail and mail order prescriptions
First Script Extended Network—Direct contracts with physician dispensers and clinics

Unmanaged View **Unmanaged Prescriptions**—Out-of-network (OON) prescription data captured through medical bill review

Readers be aware!

Buyers, and the market in general, look to the various annual PBM publications to understand trends in cost and utilization as well as to compare and contrast performance among pharmacy management suppliers. Unfortunately, owing to vastly different methodologies for analysis among suppliers, as well as different books of business that result in different claim populations, it is difficult to create an apples-to-apples comparison.

Critical differences in First Script's drug trend methodologies

1

Using all available data means accurate trend results

First Script includes all commercial workers' compensation client data in our reported trends. We do not rely on a carefully-groomed subset of clients to represent the experience. We prefer to present results that more accurately reflect our true book of business.

2

Transparent view of each year

First Script reports on each trend year separately and does not blend more than 12 months of data together. This has been done intentionally to create a more transparent view of trends occurring in each specific year.

3

Additional views for a total pharmacy experience

In this year's *Drug Trends Analysis* and going forward, we offer additional views that represent the total pharmacy experience: managed prescription trends and unmanaged prescription trends.

Our analysis is designed to better inform our clients on their total pharmacy experience and exposure. While there is some risk associated with adjusting our methodology, our obligation to represent the total pharmacy experience to our customers has become imperative given the myriad of new and problematic pharmacy channels available to injured workers today. Our clients do not have the luxury of limiting their pharmacy exposure to traditional network channels since their injured workers are filling through non-network channels.

For additional insight into this ground-breaking view, please be sure to participate in our ongoing webinars that will explain the detail behind our total pharmacy experience and trends.

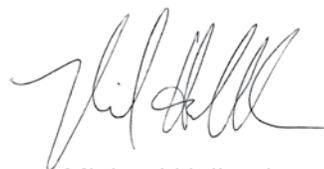
Looking ahead, we are confident we will generate even greater value to our customers through our total pharmacy approach as we bring greater numbers of the unmanaged prescription populations into our managed programs, as well as through more precise data analytics and increased regulatory participation.

We are looking forward to delivering upon our commitment for 2015.

First Script. Every Script.



Betsy Robinson
Senior Vice President,
Product Development and Marketing



Michael Halbach
Vice President,
First Script PBM

Methodology

The *2014 Drug Trends Analysis* is based on transactions billed through Coventry Workers' Comp Services' Pharmacy Management Program, First Script, as well as transactions from associated medical bill review systems, to reflect the total pharmacy exposure for our client base. As noted in our introduction, this year we are presenting three different views of pharmacy data; traditional, managed, and unmanaged.



The traditional view includes our retail and mail order prescription data, accounting for 66% of total pharmacy transactions and 68.8% of total paid amounts. This view is meant to serve as a benchmark to current industry reports as well as to provide a means for relating First Script's current trends to our historical reporting.



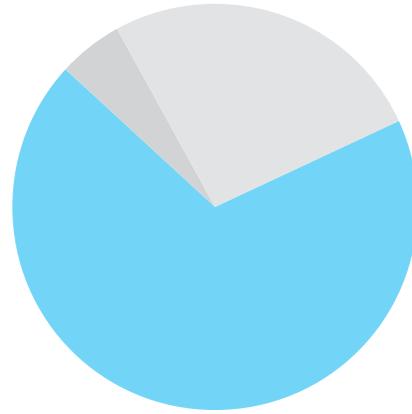
The managed view includes our retail, mail order, and our "extended network" data, accounting for 72.1% of all pharmacy transactions and 73.9% of total paid amounts. This view provides a more accurate portrayal of pharmacy trends through additional script data that is captured by our extended networks. Our extended network is comprised of direct contracts with non-traditional pharmacy billing sources such as physician dispensers and clinics. The extended network accounts for 6.1% of total transactions and 5.1% of total paid amounts. This data is not typically incorporated as part of traditional PBM drug trends reports.



The unmanaged view includes out-of-network prescription data captured through medical bill review, accounting for 27.9% of total pharmacy transactions and 26.1% of total paid amounts. This view provides insightful information about the cost and utilization trends for prescriptions dispensed or billed out-of-network. This data is not incorporated within traditional industry drug trend reports.

When viewed collectively, the managed and unmanaged views provide a comprehensive or "total" view of pharmacy data reflective of what Coventry and its clients must solve for annually.

Compound medication trends are included in this report but have been excluded from the overall trends and addressed separately in their own section due to the uniqueness of compound bill data.



Chapter 1

Traditional View

Data Includes Retail + Mail Order Prescriptions

The Traditional View Represents:
66% of Total Prescriptions in 2014
68.8% of Total Pharmacy Spend in 2014

Introduction to the Traditional View

Workers' compensation Pharmacy Benefit Managers (PBMs), including Coventry's First Script program, traditionally report on annual drug trends for their retail and mail order experience. In fact, over the years, PBMs have exclusively focused on this subset of scripts for reporting their impact on the client experience through discounts in pricing per script as well as point-of-sale edits for utilization management prior to the prescription being dispensed.

One of the key competitive differentiators PBMs promote in the market is maximized retail network size and penetration. Despite dispensing carve outs driven by third-party billers and specialty/compounding pharmacies in the retail segment, First Script has maximized its penetration to the point where it typically exceeds 95%. However, this percentage reflects penetration into the population of prescriptions that are dispensed within the retail network only, not to the total pharmacy experience.

This "traditional view" accounts for 66% of all pharmacy transactions and 68.8% of all pharmacy spend in 2014.

The intent of sharing the traditional view is to enable the reader to compare our 2014 results to those in prior years. It also provides a valid market benchmark for pharmacy experience where the most mature clinical and cost management tools are applied.

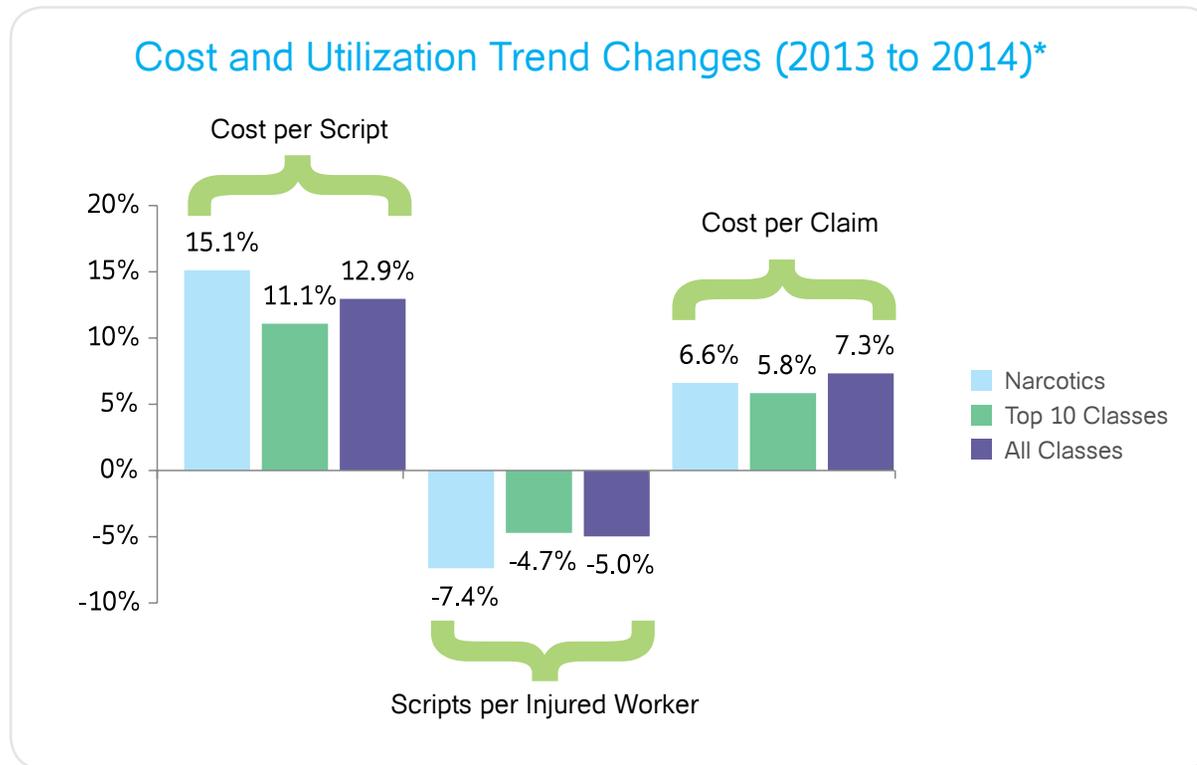


Traditional View – Key Trends

In 2014, there was an increase of 7.3% in the average prescription cost per claim. This increase was primarily due to the growth in Average Wholesale Price (AWP) for frequently prescribed medications.

Other key trends in 2014 include:

- Double-digit AWP increases for many of the top prescribed narcotic medications
- Narcotic utilization decreased 7.4%
- The Non-steroidal Anti Inflammatory Drug (NSAID) class increased 21.9% in cost per script
- 4.5% decline in the average Morphine Equivalent Dose (MED) per script
- Generic utilization increased 5.9% and is attributed in part to the generic releases of two top 10 medications



*Excludes compound drugs.

Overall average cost per script increased **12.9%**

Scripts per injured worker decreased **5%**

Overall average cost per claim increased **7.3%**

MED decreased **4.5%**

Generic utilization **82%**
an increase of 5.9% from 2013

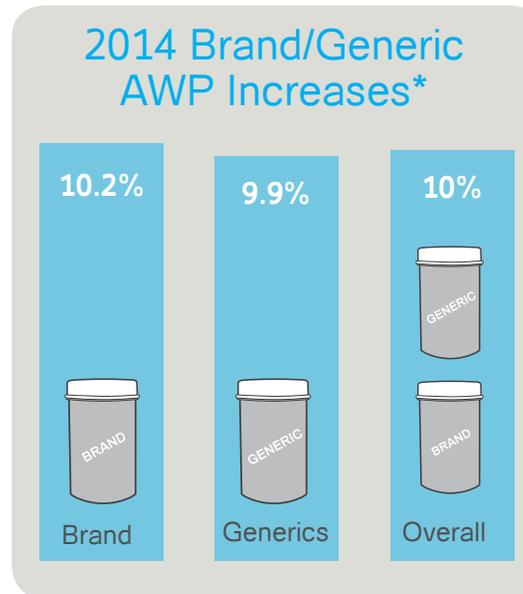
Generic efficiency **=96.4%**

Average Wholesale Price (AWP) Trends

In 2014 the significant increase in generic AWP was the primary driver of increased prescription cost per claim. The most heavily impacted drug classes include narcotics, NSAIDs, and muscle relaxants. The specific impact of these increases has been noted throughout the report.

Factors contributing to the significant increase in AWP include:

- Increasing costs to cover future patent expiration
- Increased Food and Drug Administration (FDA) oversight and changes in drug schedules
- Consolidation of drug manufacturers
- Regulatory reform
- Product shortages



How does AWP increase impact your spend?

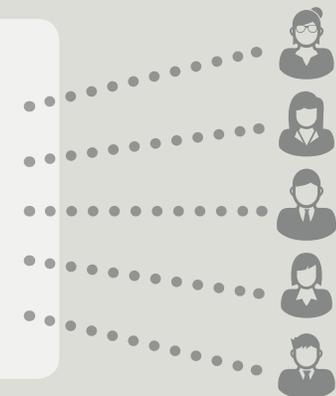
AWP is used to guide pharmacy reimbursement rates and fee schedules

Pharmacy Fee Schedules

Pharmacies

PBMs

AWP impact for each client depends on the mix of drugs prescribed and the specific utilization controls in place



*Excludes compound drugs.

New Brand Drugs

How new brand drugs are managed through First Script

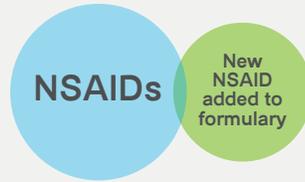
Driven by client-specific drug formularies and national guidelines



If client covers drug class



Drug is added to formulary



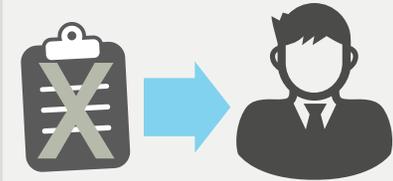
Client follows ODG



Drug coverage will follow ODG



Prior Authorization (PA) approval required for drugs not recommended by First Script



2014 NEW BRAND DRUGS

Zohydro* ER (non-abuse deterrent) Extended-release hydrocodone opioid medication; used to treat pain

EARLY 2015 NEW BRAND DRUGS

Zohydro® ER (abuse deterrent) Extended-release hydrocodone opioid medication with abuse deterrent properties; used to treat pain

Hysingla™ ER (abuse deterrent) Extended-release hydrocodone opioid medication with abuse deterrent properties; used to treat pain

Targiniq™ (abuse deterrent) Extended-release oxycodone/naloxone opioid medication with abuse deterrent properties; used to treat pain

Embeda® Extended-release morphine/naltrexone opioid medication; used to treat moderate to severe pain; went through FDA relabeling process

New Generics

How new generic drugs are managed through First Script

Required by most clients when a bio-equivalent is available for a brand-name medication



Brand-name drug is blocked at point-of-sale as soon as the generic is available, unless a PA is in place



Scenarios where the brand drug may be dispensed instead of the generic



Physicians may require the brand-name product



Pharmacists can override the generic when there are market availability issues



Injured worker requests the brand drug and adjuster overrides the PA



Notable new generics

Celebrex®

A top 10 drug in our book of business. The new generic, which was released in December of 2014, is expected to have a significant positive impact on the NSAID spend in 2015.

Abilify®

An antipsychotic medication that falls within our top 10 therapeutic classes. The generic formulation became available in April 2015 and should have a positive impact on spend within this drug class.

Nexium®

An antiulcer medication that falls within our top 10 therapeutic classes. The new generic formulation was approved in January 2015. The generic formulation is expected to become available this year and should have a positive impact on spend within the antiulcer drug class.



New Generics (cont.)

2014 NEW GENERICS		
Avinza® (morphine ER)	Used for the treatment of moderate to severe pain	Released 2-2014
Celebrex®* (celecoxib)	Top 10 drug and most notable new generic; used for acute pain	Released 12-2014
Lunesta®* (eszopiclone)	Used for the treatment of insomnia	Released 4-2014
Pennsaid®* (diclofenac)	Used for relief of osteoarthritis pain of the knee	Released 5-2014

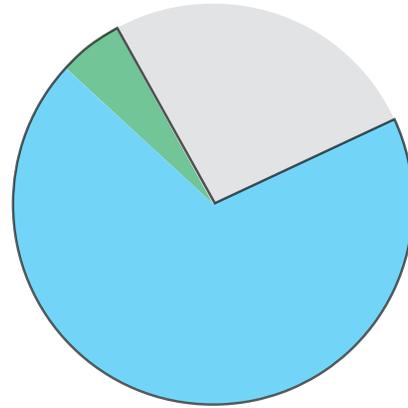
2015 NEW GENERICS		
Abilify®* (aripiprazole)	Used for schizophrenia, bipolar disorder, and adjunctive treatment in major depressive disorder	
Nexium®* (esomeprazole) (delayed release)	Used for gastric ulcer and prophylaxis for NSAID-associated gastropathy (prescription generic approved 1-2015; the over-the-counter version approved 5-2014)	
Axert® (almotriptan)	For the acute treatment of migraine attacks and headaches (typically not a high volume workers' compensation drug)	

*This will have a positive impact on spend in 2015.



New Drug Applications

2015 NEW DRUG APPLICATIONS (NDA) SUBMITTED TO THE FDA		
Oxaydo™ (abuse deterrent)	Used for the management of acute to chronic moderate/severe pain where the use of an opioid analgesic is appropriate	Q3 2015 (anticipated)
Hydrocodone-acetaminophen ER	Used for management of moderate to severe acute pain; oral formulation has immediate and extended-release components in a tamper-resistant form	Q2 2015 (originally anticipated)
Xtampza™ ER (abuse deterrent)	Oxycodone ER is indicated for the management of moderate to severe acute pain; oral formulation has immediate and extended-release components in a tamper-resistant form	Q4 2015 (anticipated)
Hydrocodone ER (abuse deterrent)	Acetaminophen-free formulation for around-the-clock pain that is severe enough to require narcotic therapy	Q4 2015 (anticipated)
Brexpiprazole	An add-on therapy primarily for the treatment of depression and schizophrenia	Q3 2015 (anticipated)
Plumiaz™	Diazepam nasal spray used as an antiepileptic	2015 (no precise date)
Yosprala™	Aspirin/omeprazole indicated for secondary prevention of cardiovascular events in patients with risk of gastric ulcers	2015 (no precise date)
Oxycodone/Naltrexone ER	Used to treat moderate-to-severe pain, including lower back pain	Q4 2015 (anticipated)



Chapter 2 Managed View

Data Includes Retail + Mail Order + Extended Network Prescriptions

The Managed View Represents:
72.1% of Total Prescriptions in 2014
73.9% of Total Pharmacy Spend in 2014



Introduction to the Managed View

The "managed view" in this report represents all prescriptions managed through a First Script contract. This includes our retail, mail order, and extended networks contracts. Although extended (or specialty) networks have been emerging within the workers' compensation pharmacy market for a number of years, they have become a greater focus for leading workers' compensation PBMs such as First Script. Extended networks reach beyond the traditional retail space into alternative billing and dispensing channels. These channels include third-party billers, physicians and clinics where dispensing occurs as well as independent mail order pharmacies.

By contracting with these dispensing and billing channels, we continue to expand our management reach to influence price controls and apply a larger clinical tool set to a larger percentage of our clients' pharmacy experience. It is for this reason that we have created what we term the "managed view" combining the traditional retail and mail order pharmacies with our extended network contracted entities.

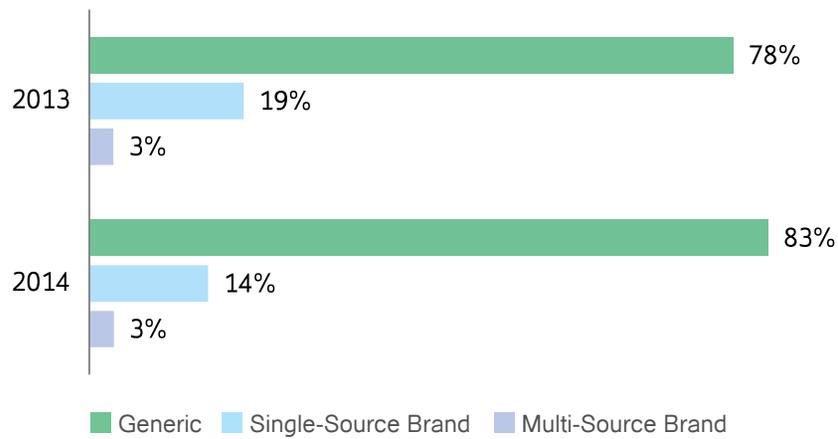
This managed view accounts for 72.1% of all pharmacy transactions and 73.9% of all pharmacy spend in 2014. By combining the traditional view with our extended network transactions, the managed view provides the reader pharmacy data that encapsulates all transactions subject to clinical and pricing controls by contract.





Brand and Generic Trends

Brand vs. Generic Utilization*

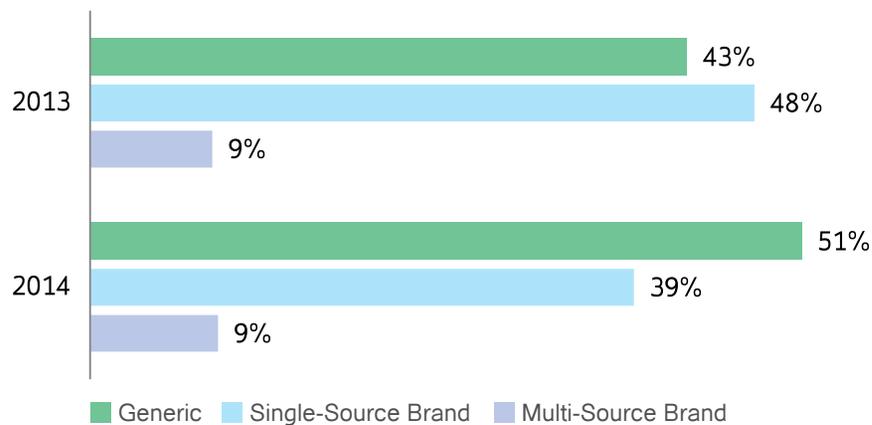


5.4%

increase in generic utilization

In 2014, we saw the most significant increase in generic utilization of the last four years. The newly released generic formulations of Cymbalta® and Lidoderm® greatly contributed to this increase. Both of these medications fall within our top 10 drugs by spend.

Brand vs. Generic Spend*



19.3%

increase in generic spend

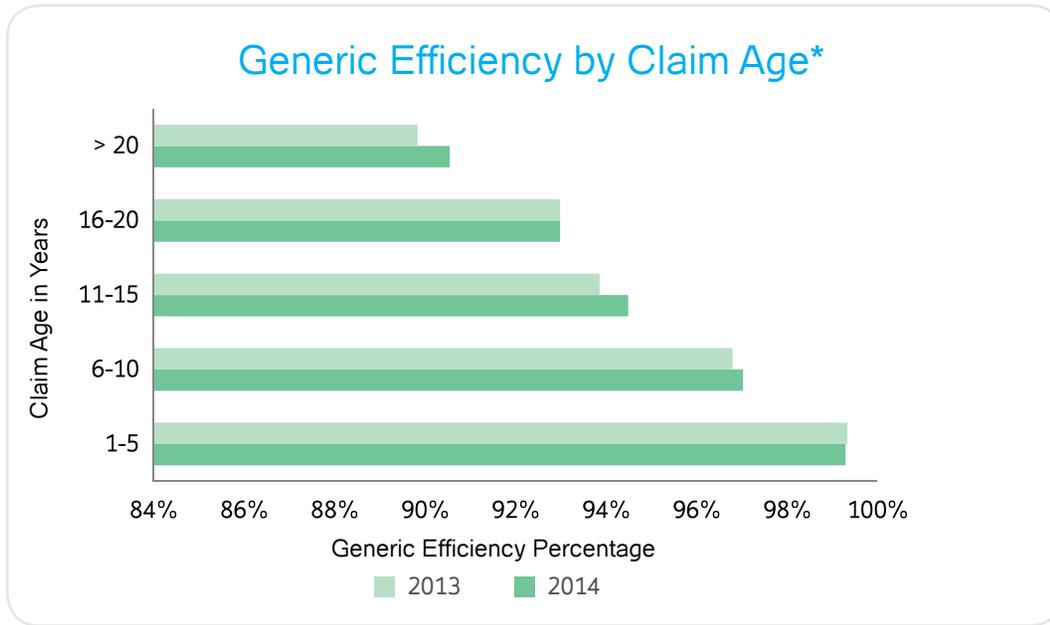
We saw a substantial shift in brand vs. generic spend from 2013 to 2014. The inflated AWP drove up costs of frequently prescribed generic medications, resulting in an increased prescription cost per claim. The impact of this year's inflated AWP has been noted throughout the report.

*Excludes compound drugs.



Brand and Generic Trends (cont.)

$$\frac{\text{Actual number of prescriptions filled as generics}}{\text{Total number that could be filled as generics}} = \text{Generic Efficiency (GE)}$$



Managed
 2014 overall
 average
 generic
 efficiency
 rate of
96.6%

Why not 100%?

GE for managed scripts was the same or better for all claim years in 2014. This means that generics were used more often when they were available. However, similar to past trends, efficiency erodes as the claim ages. This could be due to:

Physician requests the brand medication because the generic was ineffective or the claimant has a condition that would produce an adverse effect.

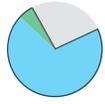


Claimant requests the brand medication, in this circumstance the adjuster's approval is required.

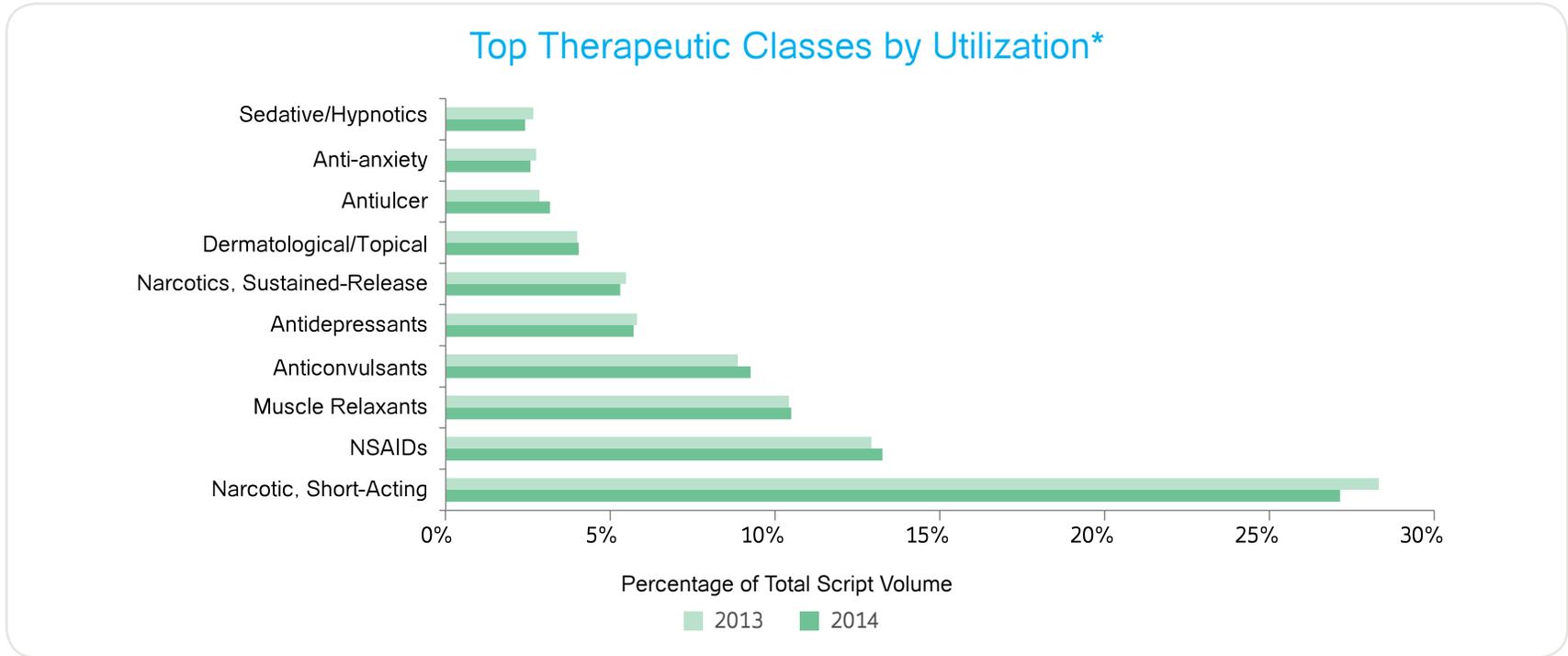


We are pleased with our year-over-year improvement in generic efficiency. However, the data demonstrates an opportunity to better manage older claims collaboratively with the adjuster and physician. Claims aged 1-10 years accounted for 86% of all claims, while claims over 10 years of age accounted for only 14% of all claims in 2014. Additionally, First Script employs generic opportunity letters encouraging physicians to use generics when available.

*Excludes compound drugs.



Top Therapeutic Classes



Total narcotic utilization decreased

The year-over-year decline in narcotic utilization has been sustained by the ongoing success of our clinical outreach and narcotic management programs.

Short-acting narcotics declined
4.1%

Sustained-release narcotics declined
3.2%

Anticonvulsant utilization increased 4.4%

This non-narcotic class of medications can be used to treat neuropathic and/or chronic pain. Increased utilization of anticonvulsants was driven by the generic medication, gabapentin. However, the brand drug Lyrica®, continues to drive spend in this drug class.

Increased utilization of NSAIDs (2.6%) and antiulcer drugs (10.7%)

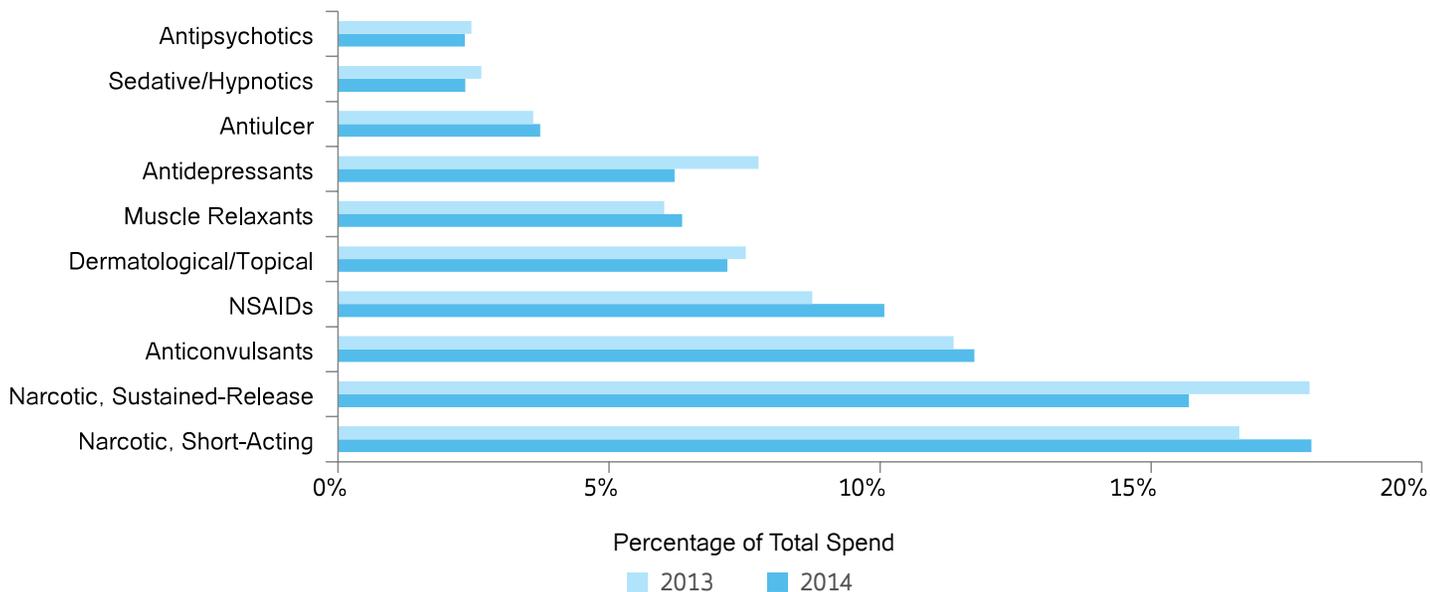
The increased utilization of antiulcer medications is related to the development of gastrointestinal adverse effects that can occur with chronic use of NSAIDs.

*Excludes compound drugs.



Top Therapeutic Classes (cont.)

Top Therapeutic Classes by Spend*



NSAID spend increased **15.2%**

Key drivers impacting the increased spend were Duexis® and Vimovo®, both brand-name combination NSAID and antiulcer medications. Duexis® incurred a 63% increase in AWP. Similarly, Vimovo® experienced a 590% increase in AWP. Meanwhile, Celebrex®, the top NSAID drug by spend, fell from 46.5% to 40.9% of all managed spend within this therapeutic class. The Celebrex® patent expired at the end of 2014 and the availability of a generic version is expected to positively impact spend within the NSAID class for in 2015.

Short-acting narcotic spend increased **8%**

Despite decreased utilization, the increased spend on short-acting narcotics was driven by rising AWP for commonly prescribed medications such as Percocet® and Roxicodone®.

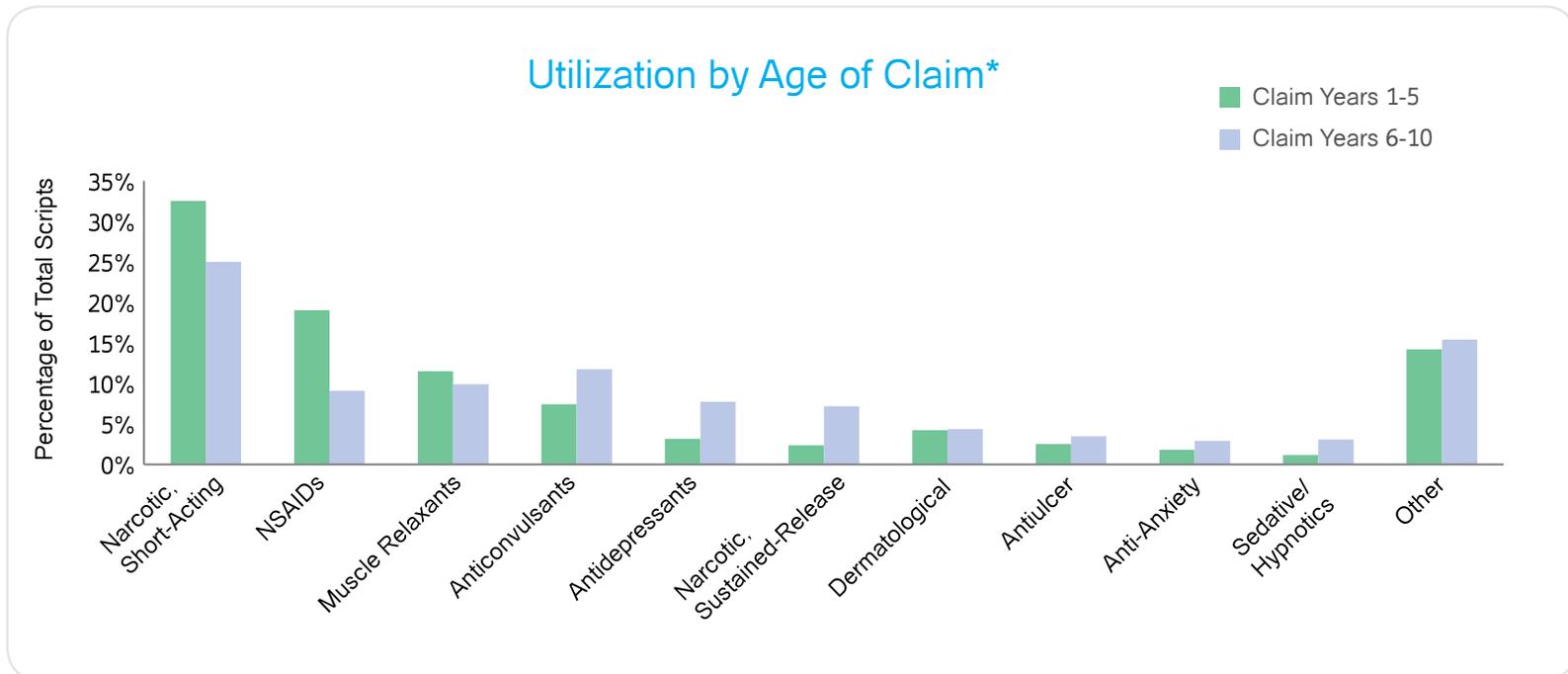
Spend on antidepressants decreased **20%**

The release of generic Cymbalta® in 2013 drove the significant reduction in spend for antidepressants.

*Excludes compound drugs.



Class Utilization by Age of Claim



Claims years 1-5 (77.8% of all claims)

Medications for claims in years one through five are typically prescribed to treat acute pain and have higher utilization of:

- Short-acting narcotics
- NSAIDs
- Muscle relaxants

Claims years 6-10 (8.2% of all claims)

Medications for claims in years six through 10 are typically prescribed to treat chronic, neuropathic, or psychogenic pain and have higher utilization of:

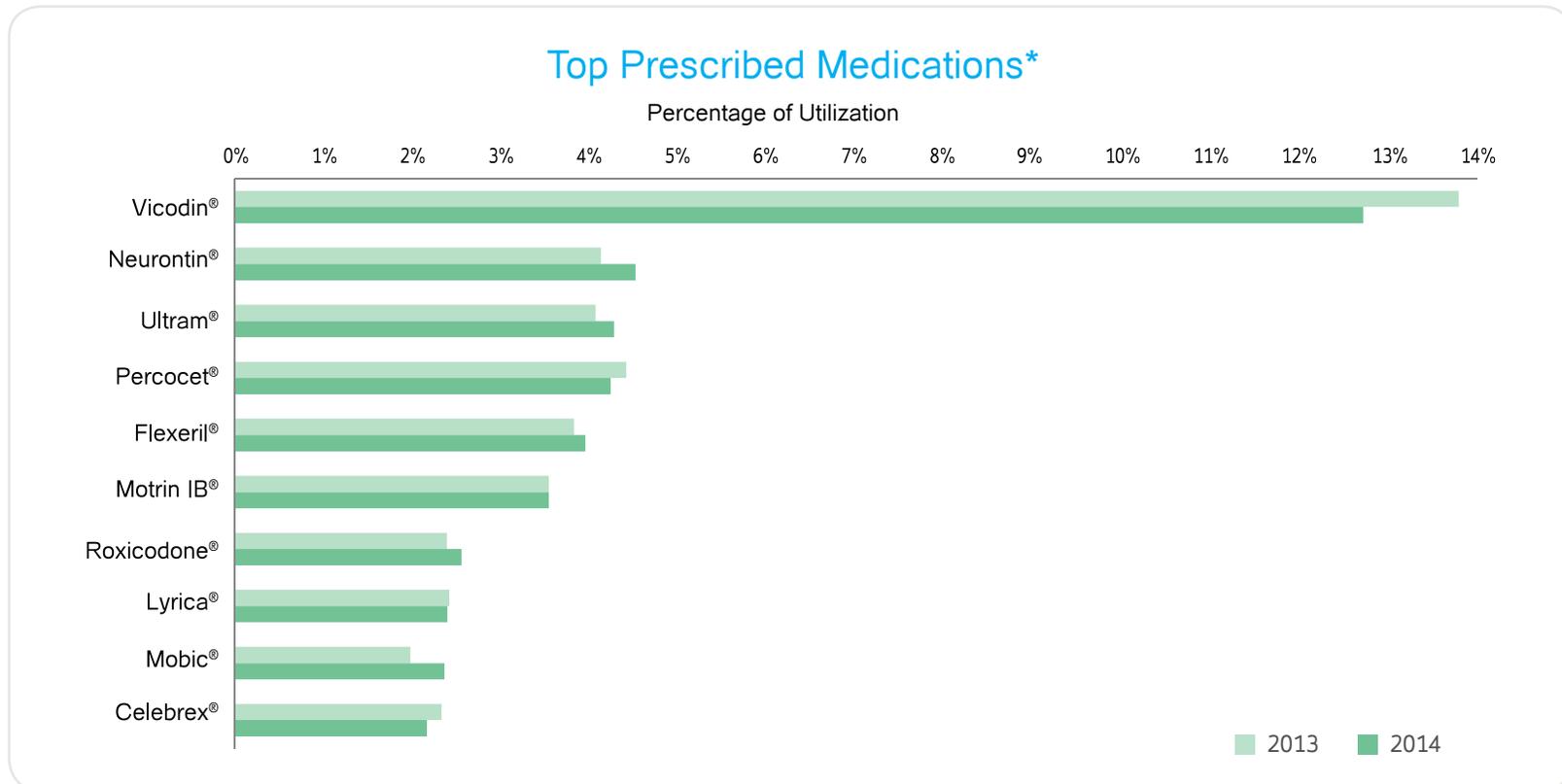
- Long-acting narcotics
- Anticonvulsants
- Antidepressants

*Excludes compound drugs.





Top Medications



Utilization

Medications with the most significant decreases were hydrocodone-acetaminophen (Vicodin®) and oxycodone-acetaminophen (Percocet®), both narcotics. The rescheduling of hydrocodone combination products from a Schedule III drug to a Schedule II drug in 2014 contributed to the decline in utilization.

Vicodin®

The #1 prescribed medication had the largest decrease in utilization over the last three years.

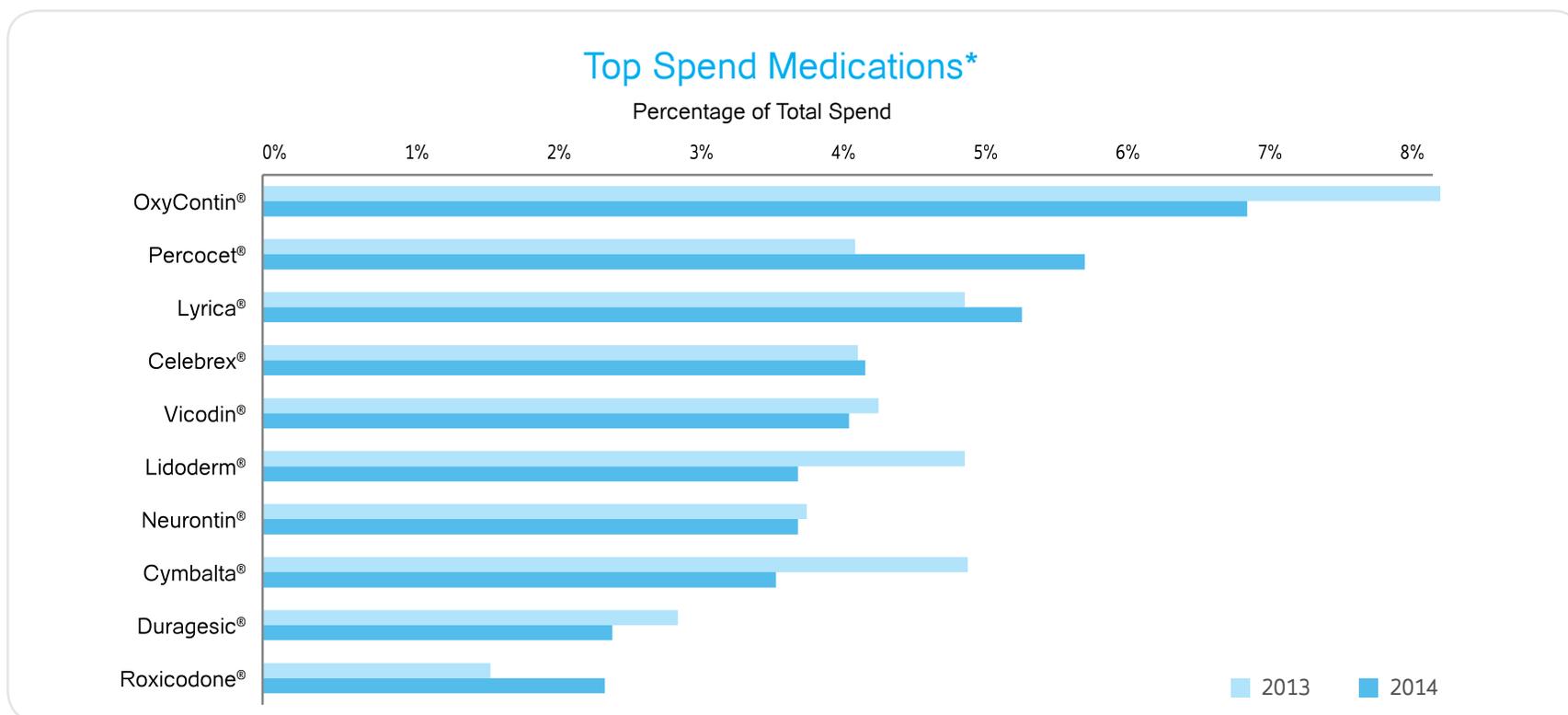


Vicodin® utilization decreased by **7.8%**

*Medications in these charts are a pool of brand and generic. Brand names are provided for reference. Excludes compound drugs.



Top Medications (cont.)



Medications with the most significant changes in spend

Cymbalta®

Decrease is due to the newly released generic formulation that became available at the end of 2013.



Cymbalta® spend decreased by **27.2%**

Percocet® & Roxicodone®

The increases in spend for oxycodone-acetaminophen (Percocet®) and oxycodone (Roxicodone®) are attributed to the generic AWP increases in 2014.

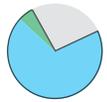


Percocet® spend increased by **38.8%**

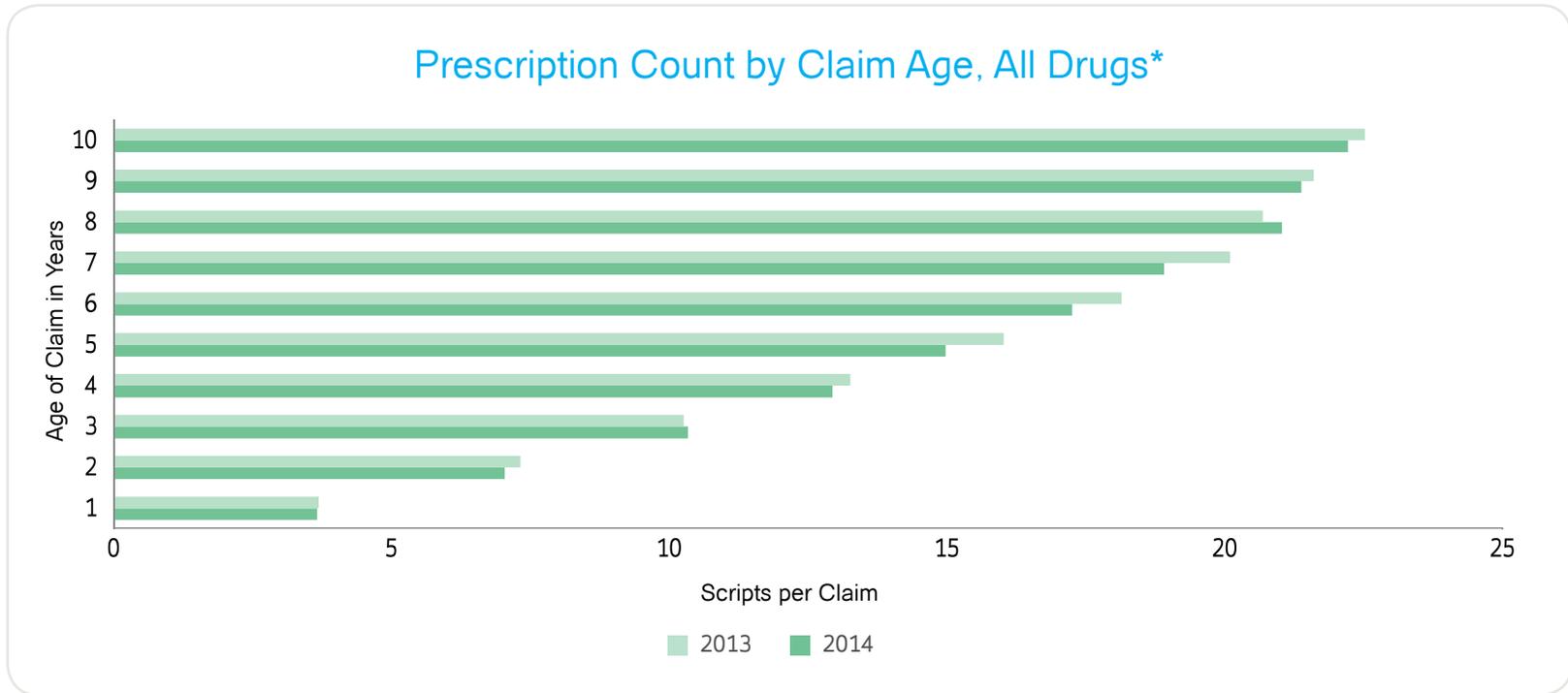


Roxicodone® spend increased by **50%**

*Medications in these charts are a pool of brand and generic. Brand names are provided for reference. Excludes compound drugs.



Prescription Trends by Claim Age



Utilization by claim age

This year's trending remained consistent with previous years. The number of prescriptions increases as the claim ages, typically driven by adjuvant therapies such as anticonvulsants and antidepressants that support pain management and lessen narcotic burden.

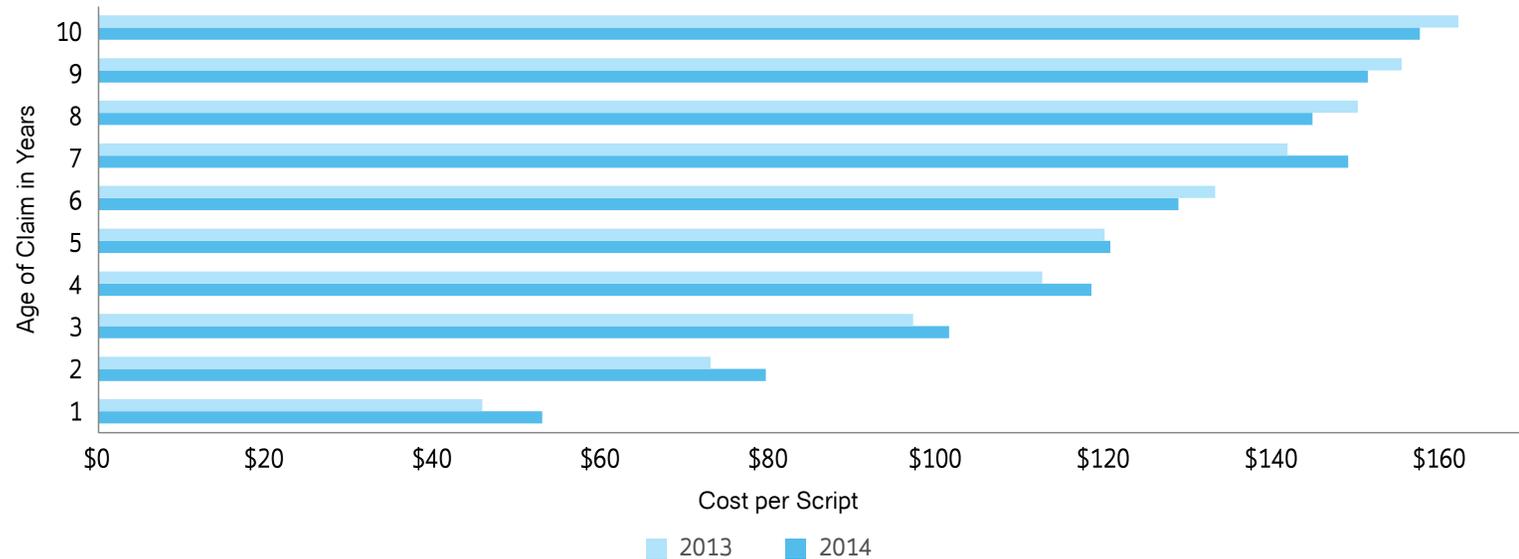
In 2014, there was a decrease in the average number of scripts per claim for 8 of the 10 claim years represented. Claims aged 1-10 years account for 86% of all claims.

*Excludes compound drugs.



Prescription Trends by Claim Age (cont.)

Prescription Cost by Claim Age, All Drugs* (inflation adjusted)



Spend by claim age

The trend has demonstrated as the claims age, the cost per script increases. This is typically due to:

- Increased strength and/or dosage of existing drugs
- More expensive single-source, brand-name medications are being used

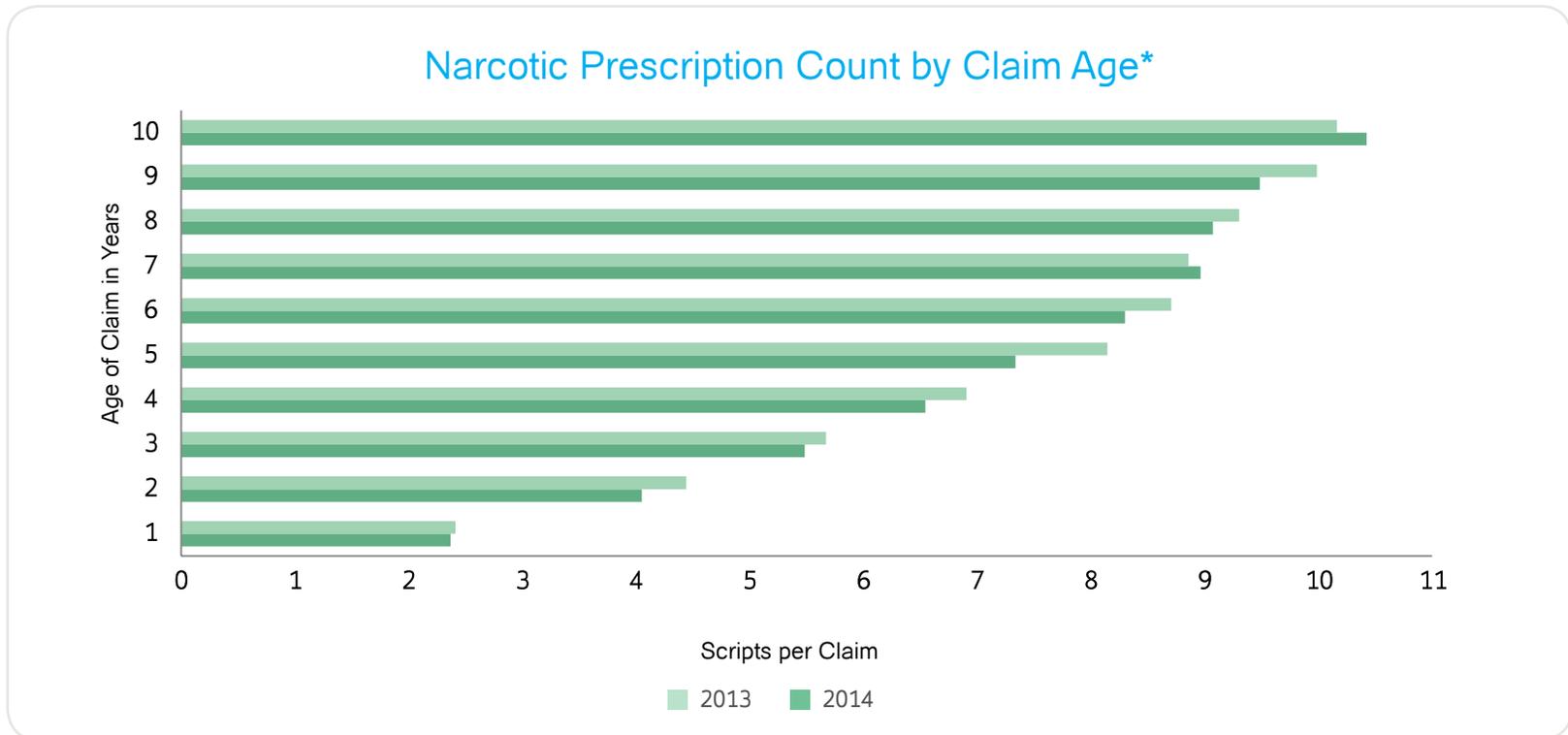
Despite the decrease in utilization, 6 out of 10 claim years experienced an increase in the average cost per script. These increases are directly related to the rise in AWP for commonly prescribed medications.

Drug selection is a key factor and is why formulary alignment remains extremely important in managing prescription costs. Expensive, non-formulary medications may not be appropriate in terms of managing pharmaceutical care while controlling costs. First Script rules block these types of medications, alerting adjusters to apply other clinical interventions.

*Excludes compound drugs.



Narcotic Trends by Claim Age



Narcotic utilization

Eight of the 10 claim years continued to see decreases in narcotic utilization in 2014. Claims between 1 and 10 years as shown above, account for the majority of all narcotic claims with managed prescriptions at 83.9%.

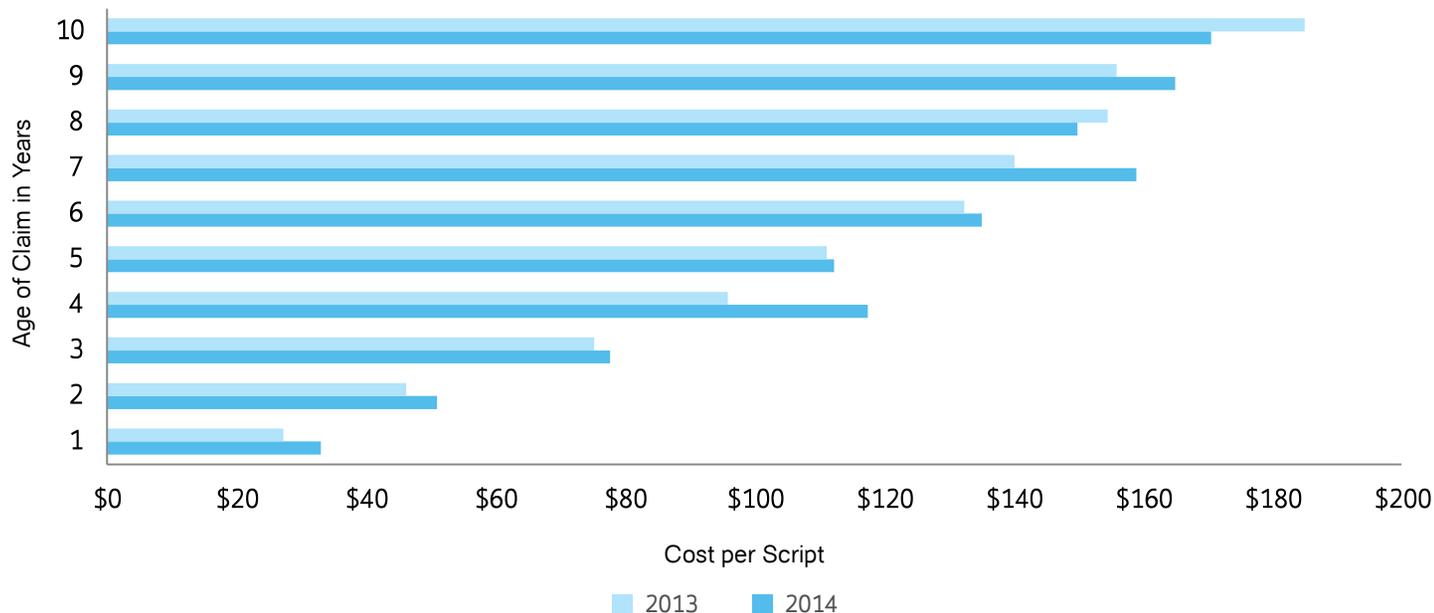
One and two year old claims continued to see decreases in the number of narcotic prescriptions per claim, reflecting the positive impact of our early intervention programs.

*Narcotic claims only. Excludes compound drugs.



Narcotic Trends by Claim Age (cont.)

Narcotic Prescription Cost by Claim Age* (inflation adjusted)



Narcotic spend

Cost per narcotic script increased in 8 of the 10 claim years. This is primarily attributed to the increases in AWP for commonly prescribed generic narcotics such as oxycodone-acetaminophen (Percocet®) and oxycodone (Roxicodone®).

An expanded effort to reduce narcotic utilization and increase patient safety

Our team of clinical pharmacists developed focus groups in collaboration with our clients



The groups analyze and design custom strategies targeted at the top narcotic users in our book of business



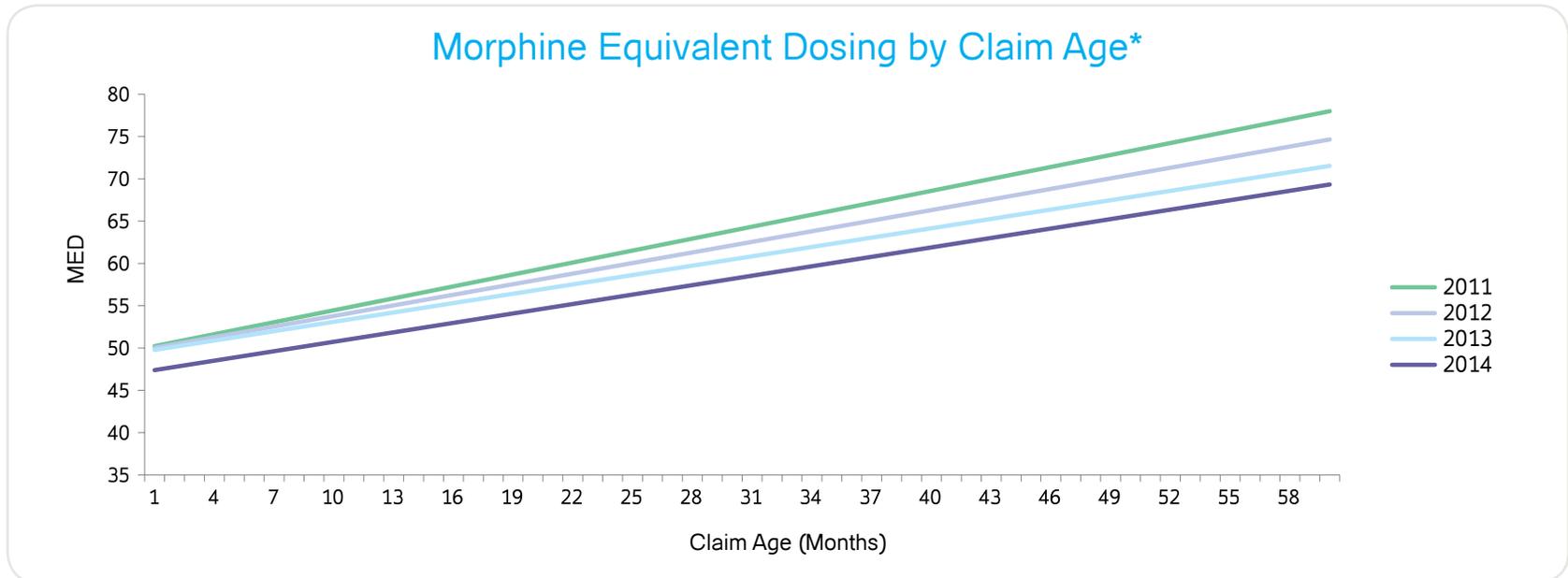
Education for adjusters has had a positive impact



*Narcotic claims only. Excludes compound drugs.



Morphine Equivalent Dose (MED)



Our clinical programs have continuously reduced MED over the last four years

This has been achieved through:

- Early intervention and outreach programs to prescribers and patients
- Physician, injured worker, and adjuster education initiatives
- Development of targeted focus groups to analyze and design strategies that reduce narcotic utilization
- Adoptions of state-based closed formularies and medical guidelines
- National emphasis on increasing physician utilization of PDMPs (Prescription Drug Monitoring Programs)

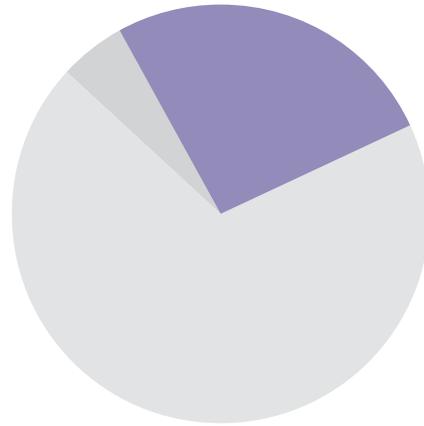


As the trending indicates, the average daily MED per script progressively increases as the claim ages



The average daily MED decreased **4.4%** from 2013

*Excludes intravenous and injection route of administration.



Chapter 3 Unmanaged View

Out-of-Network Prescriptions

The Unmanaged View Represents:
27.9% of Total Prescriptions in 2014
26.1% of Total Pharmacy Spend in 2014



Introduction to the Unmanaged View

First Script remains heavily penetrated in the traditional retail space and has market-leading extended networks. However, there are still a substantial number of pharmacy transactions that process out-of-network without the benefit of our clinical edits and cost saving tools.

Unmanaged transactions are collected through direct connections with medical bill review systems and consist of direct bills from Physicians and clinics, smaller non-network pharmacies and specialty pharmacies as well as non-contracted third-party billers.

These unmanaged scripts are utilized within all retrospective clinical utilization management. Additionally, both managed and unmanaged script data is integrated within our risk model to sharpen our focus on emerging clinical risks. This holistic view ensures intervention before adverse claim development occurs.

While the dispensing channels for out-of-network prescriptions are highly fragmented, when combined they account for 27.9% of total prescription utilization and 26.1% of total pharmacy spend for 2014. First Script continuously analyzes the unmanaged population of prescriptions to identify opportunity for increased penetration and total pharmacy management.

The intent of sharing this unmanaged view is to provide transparency and to foster an awareness about the cost and utilization trends associated with out-of-network prescriptions.

After analyzing injured workers who filled prescriptions out-of-network (unmanaged), we found they are uniquely different from those who filled exclusively within the retail, mail order, or extended networks (managed view).

Key differences in the unmanaged population vs. managed population

In 2014, injured workers with unmanaged scripts:

Had an **average claim age of 1.7 years** vs. five years for those in the managed population

Comprised of **more one-fill-only claims (65%)** vs. 36% for claims with managed fills

Different prescribing patterns

More NSAIDs (25.1%) vs. 13.3% with managed

Less short-acting narcotics (18.2%) vs. 27.1% with managed

More dermatological/topical scripts (7.6%) vs. 4% with managed

These key measures illustrate a few of the differences between the two groups and indicate that care should be taken when making comparisons and generalizations across an entire book of business.



Brand and Generic Trends

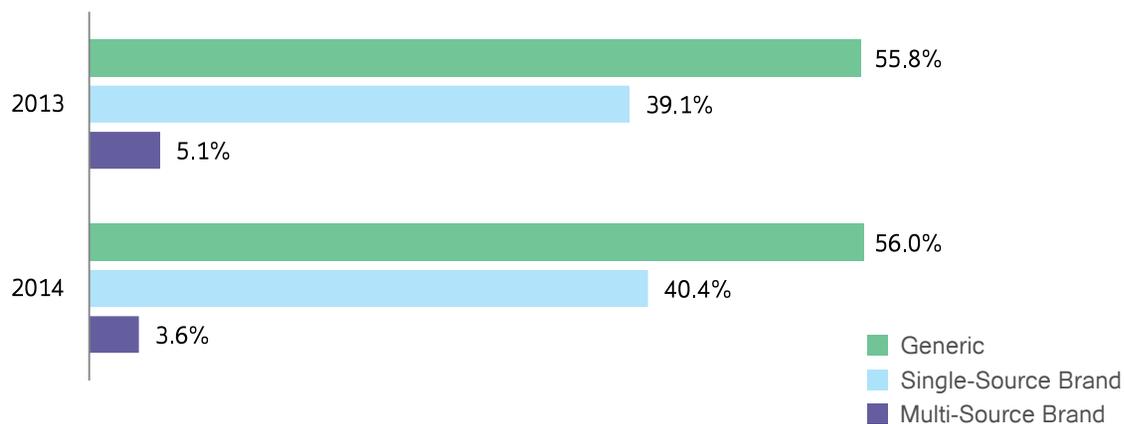
Generic vs. Brand Utilization*



2014 generic utilization for unmanaged prescriptions was **81.8%**

Unmanaged utilization
Shifts in unmanaged brand and generic utilization were mostly attributed to the 2013 releases of generics for Cymbalta® (duloxetine) and Lidoderm® (lidocaine patch).

Generic vs. Brand Spend*

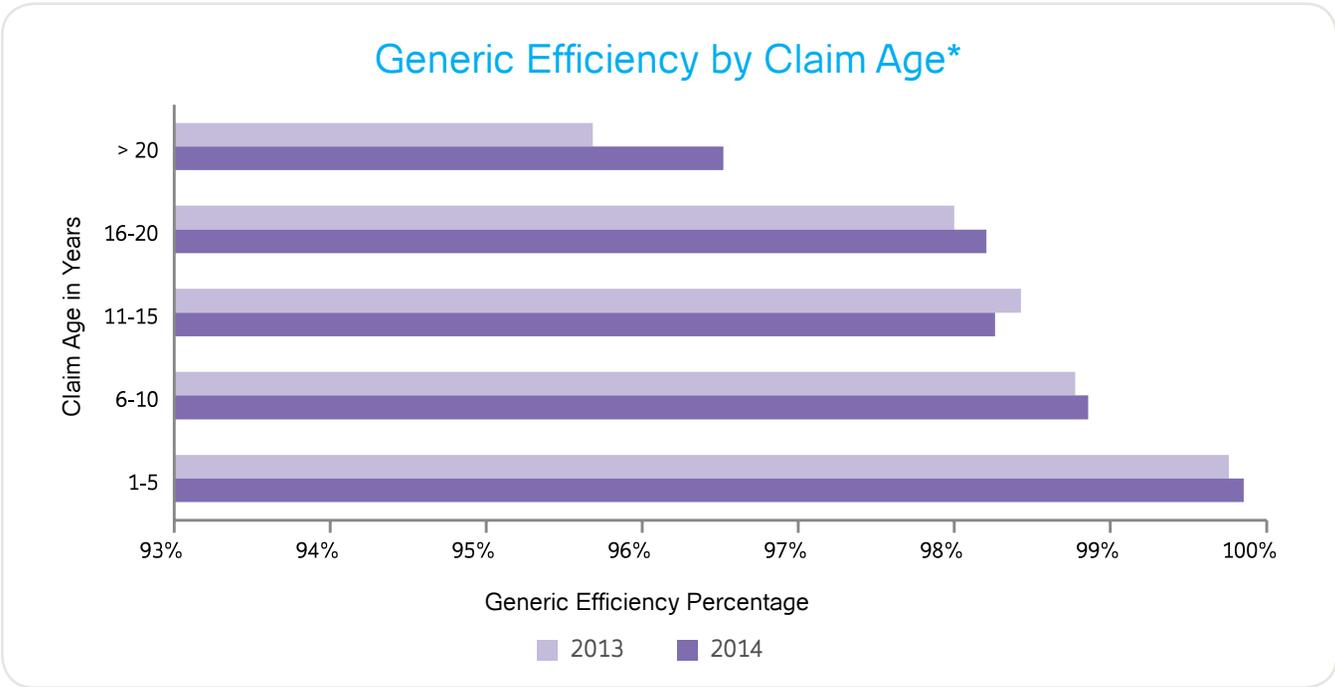


Unmanaged spend
The increase in unmanaged single-source brand spend was driven by the dermatological/topical drugs Terocin, New Terocin, Lidopro, and Menthoderm.

*Excludes compound drugs.

Brand and Generic Trends (cont.)

$$\frac{\text{Actual number of prescriptions filled as generics}}{\text{Total number that could be filled as generics}} = \text{Generic Efficiency}$$



Unmanaged
 2014 overall
 average
 generic
 efficiency
 rate of
99.6%

Generic Efficiency (GE) for unmanaged scripts

A high overall average GE rate for unmanaged scripts can be misleading due to the vast differences in claim population and drug mix. The majority of unmanaged prescriptions are first and often times the only fills, whereas the majority of managed fills are for claims between the ages of one to five years. We know that GE tends to erode as the claim ages, which explains the slight difference between the unmanaged GE rate and the managed GE rate. When comparing generic efficiency through this lens the rates are very similar.

GE for claims 1-5 years old

Managed	Unmanaged
99.3%	99.9%

*Excludes compound drugs.



Top Therapeutic Classes by Utilization

Top 10 Therapeutic Classes Ranked by Utilization* Managed

Therapeutic Class	Rank 2014	% of Total Scripts
Short-Acting Narcotics	1	27.2%
NSAIDs	2	13.3%
Muscle Relaxants	3	10.5%
Anticonvulsants	4	9.3%
Antidepressants	5	5.7%
Sustained-Release Narcotics	6	5.3%
Dermatological/Topical	7	4.0%
Antiulcer	8	3.2%
Anti-Anxiety	9	2.6%
Sedative/Hypnotics	10	2.4%
Top 10 Classes		83.4%

Top 10 Therapeutic Classes Ranked by Utilization* Unmanaged

Therapeutic Class	Rank 2014	% of Total Scripts
NSAIDs	1	25.1%
Short-Acting Narcotics	2	18.3%
Muscle Relaxants	3	12.3%
Dermatological/Topical	4	7.6%
Antiulcer	5	5.6%
Steroid	6	4.8%
Anticonvulsants	7	3.9%
Anti-infective	8	3.0%
Analgesics, Non-Narcotic	9	2.9%
Antidepressants	10	2.1%
Top 10 Therapeutic Classes		85.6%

Differences in utilization by class

The differences in therapeutic class utilization are directly related to the differences in claim populations. The population most responsible for unmanaged scripts frequently only fills one prescription. These fills are typically right after the injury occurs and are for medications used to treat acute pain. NSAIDs have long been among the first-line agents for the management of acute pain, which is consistent with what is being shown in the unmanaged table.

Most significant changes in unmanaged class utilization from 2013



*Excludes compound drugs.



Top Therapeutic Classes by Spend

Top 10 Therapeutic Classes Ranked by Spend* Managed

Therapeutic Class	Rank 2014	% of Total Scripts
Short-Acting Narcotics	1	18.0%
Sustained-Release Narcotics	2	15.7%
Anticonvulsants	3	11.7%
NSAIDs	4	10.1%
Dermatological/Topical	5	7.2%
Muscle Relaxants	6	6.4%
Antidepressants	7	6.2%
Antiulcer	8	3.7%
Sedative/Hypnotics	9	2.4%
Antipsychotics	10	2.3%
Top 10 Classes		83.6%

Top 10 Therapeutic Classes Ranked by Spend* Unmanaged

Therapeutic Class	Rank 2014	% of Total Scripts
Dermatological/Topical	1	22.1%
NSAIDs	2	13.0%
Short-Acting Narcotics	3	12.6%
Antiulcer	4	9.2%
Muscle Relaxants	5	9.2%
Anticonvulsants	6	6.4%
Sustained-Release Narcotics	7	5.7%
Antiemetics	8	2.9%
Antidepressants	9	2.9%
Anti-infective	10	2.3%
Top 10 Classes		86.3%

Dermatological/topical unmanaged spend

Topical OTC (Over-the-Counter) medications may seem like an attractive treatment option as they typically result in low or negligible systemic absorption, leading to minimal adverse effects compared to oral formulations. However, in certain types of pain there is also limited evidence for efficacy with most topical agents. In addition, multiple ingredient branded formulations tend to be expensive and lower cost alternative OTCs are often available with the same or similar active ingredients. Examples include Terocin, New Terocin, Lidopro, Methoderm, Dendracin, and Medrox. These types of topical medications are also becoming more common in workers' compensation (see chart to right). To illustrate the cost difference these multiple ingredient products represent, let's look at New Terocin lotion which contains methyl salicylate 25%, menthol 10%, and capsaicin 0.025% (AWP \$398.40 for 120ml bottle). Comparatively, these same ingredients can be found separately as capsaicin 0.025% cream and Muscle Rub Cream (methyl salicylate 15%, menthol 10%) or Bengay® Ultra Strength Cream (methyl salicylate 30%, menthol 10%, camphor 4%), for example, at about one-fifteenth the price.

Dermatological/Topical Therapeutic Drug Class

Percentage of Total Unmanaged Spend

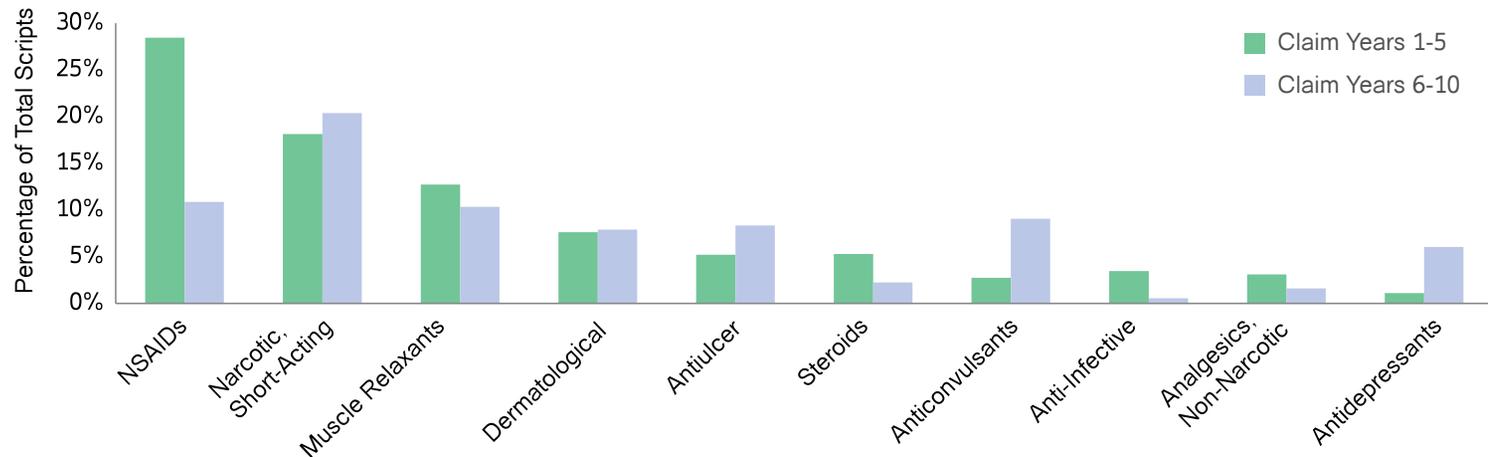


*Excludes compound drugs.



Class Utilization by Age of Claim

2014 Utilization by Age of Claim*



Claim years 1-5 (93.4% of all claims)

A majority of the unmanaged medications for claims one to five years old are typically prescribed and dispensed immediately post-injury as the first and/or only fill. Whereas the majority of medications post first fill for those with continuing needs will flow through retail or mail order and are therefore "managed."

Medications for these claims are typically prescribed to treat acute pain and had higher utilization of the following:

- NSAIDs
- Short-acting narcotics
- Muscle relaxants

Claim years 6-10 (3.6% of all claims)

Claims in years 6-10 typically have more complex conditions and therefore require more complex medication regimens. Older claims had higher utilization of the following therapeutic classes among unmanaged scripts:

- Short-acting narcotics used for breakthrough pain
- Antiulcer medications for gastrointestinal adverse effects that can develop with chronic NSAID use
- Anticonvulsants for neuropathic and/or chronic pain
- Antidepressants for psychogenic, neuropathic and/or chronic pain

*Excludes compound drugs.



Top Medications by Utilization

Top 10 Medications Ranked by Utilization* Managed

Medication	Rank 2014	% of Total Scripts
Vicodin®	1	12.7%
Neurontin®	2	4.5%
Ultram®	3	4.3%
Percocet®	4	4.2%
Flexeril®	5	3.9%
Motrin® IB	6	3.5%
Roxicodone®	7	2.6%
Lyrica®	8	2.4%
Mobic®	9	2.4%
Celebrex®	10	2.2%
Top 10 Classes		42.7%

Top 10 Medications Ranked by Utilization* Unmanaged

Medication	Rank 2014	% of Total Scripts
Vicodin®	1	8.3%
Motrin® IB	2	7.1%
Flexeril®	3	6.4%
Ultram®	4	4.4%
Midol®	5	4.4%
Mobic®	6	3.9%
Prilosec®	7	3.7%
Naprosyn®	8	2.9%
Neurontin®	9	2.5%
Nabumetone®	10	2.1%
Top 10 Classes		45.9%

Unmanaged medication increases

Unmanaged medications with considerable increases in utilization include nabumetone, Mobic®, and Naprosyn®, all of which fall into the NSAID therapeutic class. Conversely, medications with notable decreases in utilization include Vicodin® (hydrocodone-acetaminophen), Prilosec®, and Ultram®.

Vicodin®

Utilization of the #1 prescribed unmanaged medication continued to decline for the fourth year in a row.



Vicodin®
utilization
decreased by
9.7%

*Medications in these charts are a pool of brand and generic. Brand names are provided for reference. Excludes compound drugs.



Top Medications by Spend

Top 10 Medications Ranked by Spend* Managed

Medication	Rank 2014	% of Total Scripts
OxyContin®	1	6.7%
Percocet®	2	5.6%
Lyrica®	3	5.2%
Celebrex®	4	4.1%
Vicodin®	5	4.0%
Lidoderm	6	3.7%
Neurontin®	7	3.7%
Cymbalta®	8	3.5%
Duragesic®	9	2.4%
Roxicodone®	10	2.3%
Top 10 Classes		41.2%

Top 10 Medications Ranked by Spend* Unmanaged

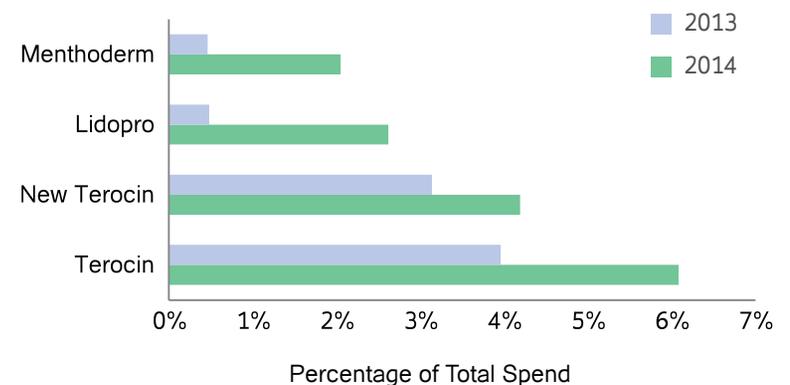
Medication	Rank 2014	% of Total Scripts
Terocin®	1	6.1%
Tramadol® HCL ER	2	5.5%
Prilosec®	3	5.4%
Mobic®	4	5.1%
Flexeril®	5	4.3%
New Terocin®	6	4.2%
Vicodin®	7	3.1%
Neurontin®	8	3.0%
Lidopro®	9	2.6%
Menthoderm®	10	2.1%
Top 10 Classes		41.3%

Four of the 10 unmanaged prescriptions ranked by spend were for branded topical medications, all of which had substantial increases in spend for 2014.

Terocin® moved from the #5 to the #1 spot in 2014 unmanaged prescription spend

Terocin contains “N” Drug ingredients per the ODG formulary (capsaicin and lidocaine) along with two other active ingredients (menthol and methyl salicylate). According to ODG, capsaicin is recommended only for those who have not responded to or are intolerant of other treatments. No commercially prepared forms of lidocaine, other than prescription-only lidocaine 5% patches (Lidoderm® and generic), are considered to be options for neuropathic pain. Menthol is not addressed in the ODG formulary.

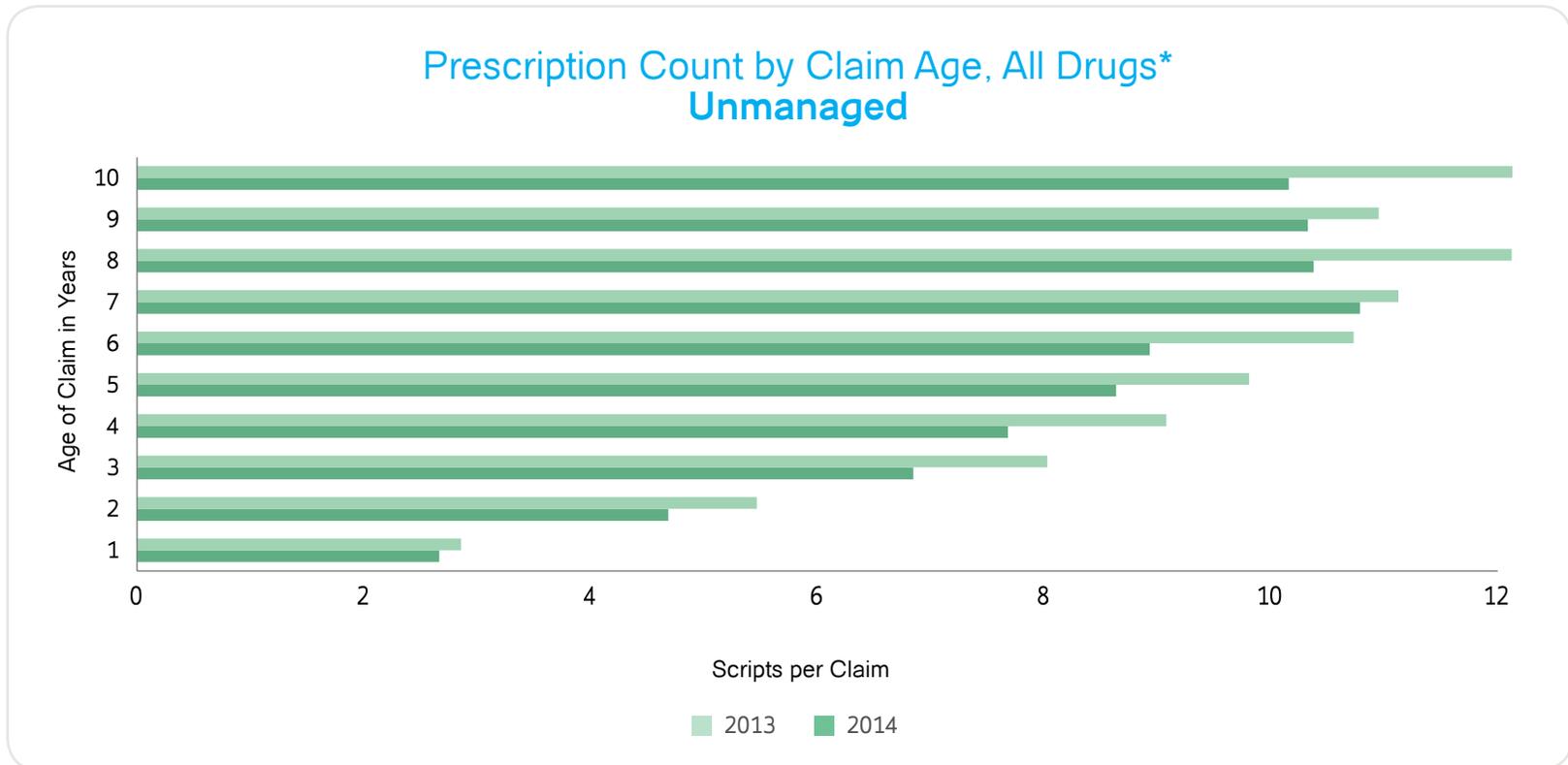
Topical Medications by Spend Unmanaged



*Medications in these charts are a pool of brand and generic. Brand names are provided for reference. Excludes compound drugs.



Prescription Trends by Claim Age



Utilization by claim age

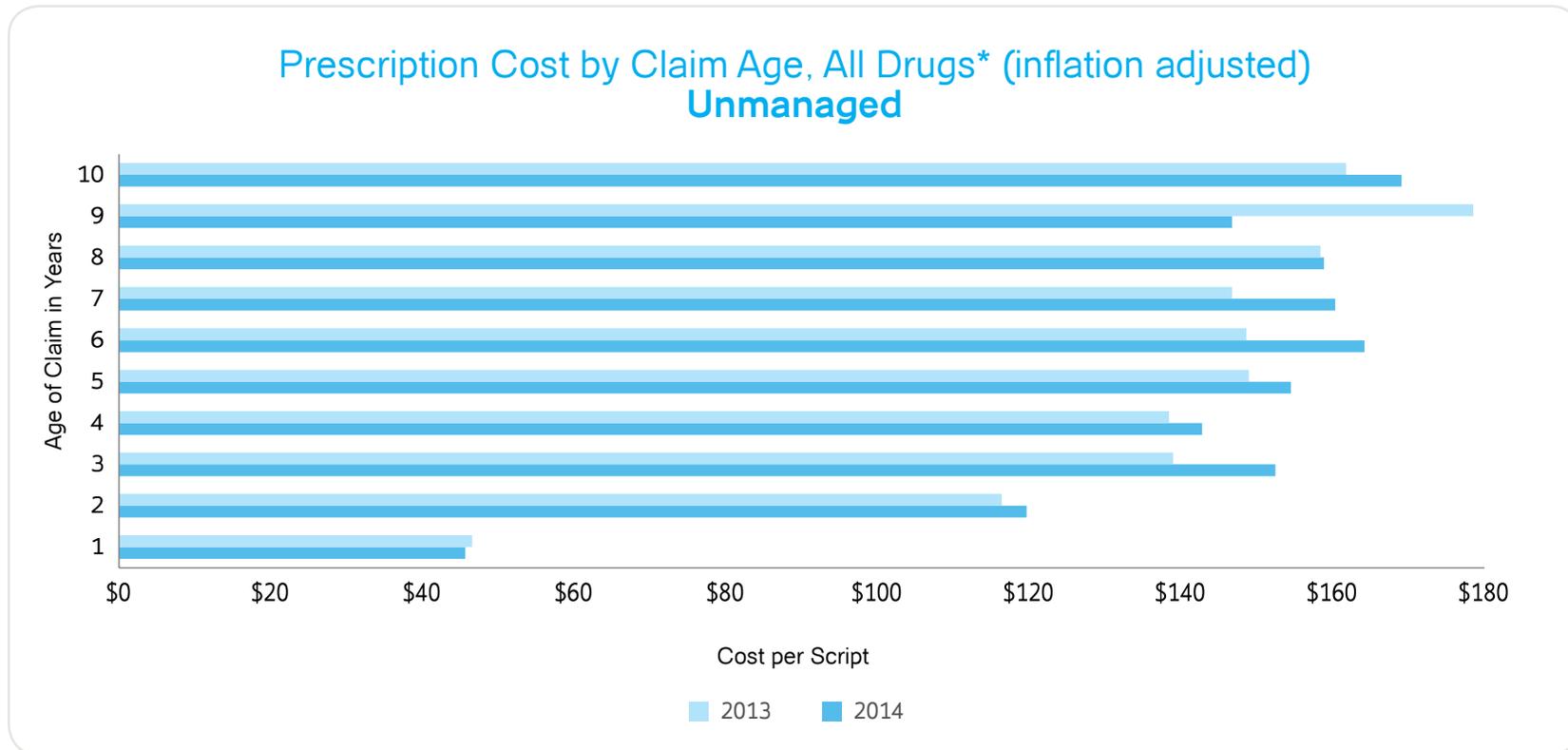
In 2014, all claim years experienced a decrease in the number of unmanaged scripts per claim. However, the number of prescriptions typically increase as a claim ages due to the complexity of older or chronic injuries that require more comprehensive pharmacological treatment.

Considering that the average claim age for the managed population is older than the unmanaged population, we would expect to see a higher number of managed scripts per claim than unmanaged.

*Excludes compound drugs.



Prescription Trends by Claim Age (cont.)



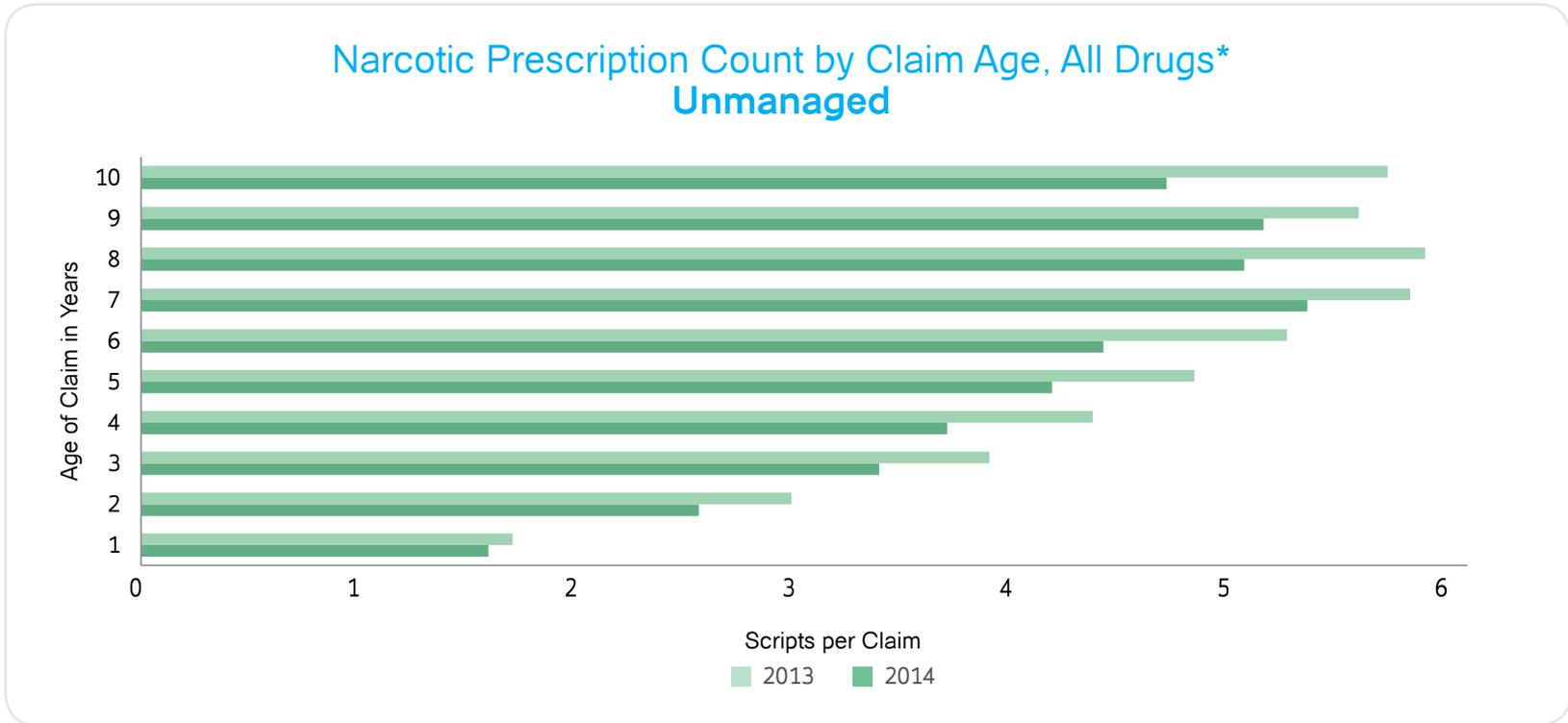
Spend by claim age

Claims ranging from 1-10 years old with unmanaged scripts accounted for 97% of all claims. Within this range of claim years, 8 of the 10 experienced an increase in the average cost per unmanaged script in 2014. These cost increases were primarily due to the AWP increases for NSAIDs, the top prescribed therapeutic class for unmanaged scripts. In addition, the growing cost of topical medications also contributed to the increase for 2014.

*Excludes compound drugs.



Narcotic Trends by Claim Age



Narcotic utilization

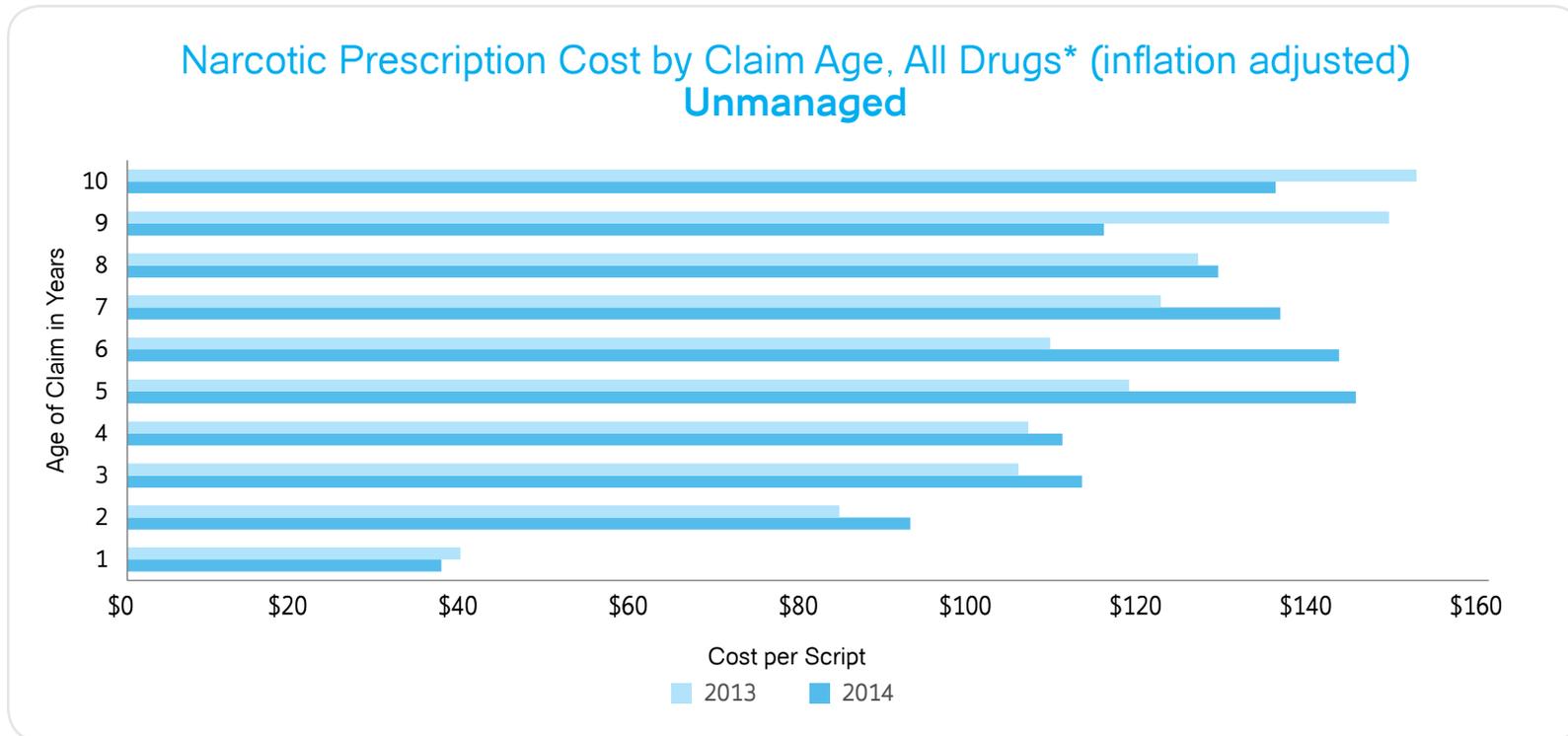
In 2014, unmanaged narcotic utilization decreased among all claim years. With the heightened awareness to reduce or eliminate opioids, other medications have come into play to manage pain. We have seen increases in the utilization of both NSAIDs and topical medications as narcotic utilization has continued to decline.

Claims 1-10 years old accounted for 96.1% of claims with unmanaged narcotic scripts

*Narcotic claims only. Excludes compound drugs.



Narcotic Trends by Claim Age (cont.)



Narcotic spend

Despite the decrease in narcotic utilization, cost per narcotic script increased in most claim years. The growing cost was primarily due to the increased generic AWP for commonly prescribed short-acting narcotics.

*Narcotic claims only. Excludes compound drugs.

Chapter 4

Compound Medications, Managed and Unmanaged



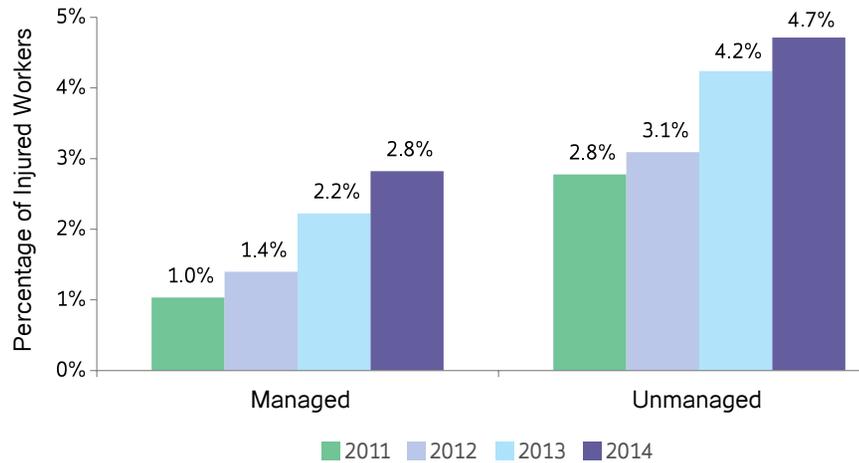
The rising use of compound medications in workers' compensation has created greater risks to injured worker safety and has become a cost burden on the system. In addition, the data continues to demonstrate growth in the number of compounds prescribed outside of the PBM network at substantially higher rates than those dispensed within the PBM network. This section provides trend information specific to compounds, which were excluded from the other sections of this report due to the unique nature of these transactions.



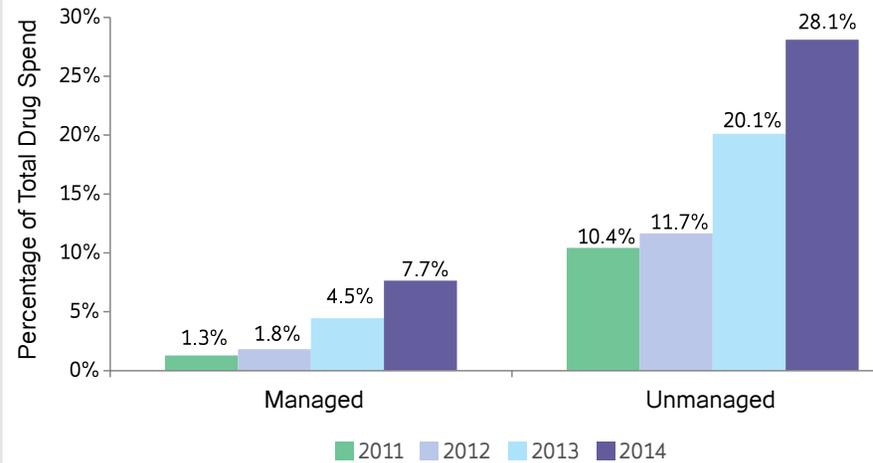
Compound Growth in 2014

In 2014, the cost and utilization of compound drugs continued to grow in both the managed and unmanaged sectors.

Injured Workers Filling at Least One Compound Prescription



Compound Spend



Injured workers who filled at least one compound prescription in 2014

Managed
2.8%

Unmanaged
4.7%

Managed spend

Compounds accounted for **7.7%** of all managed drug spend, up from 4.5% in 2013

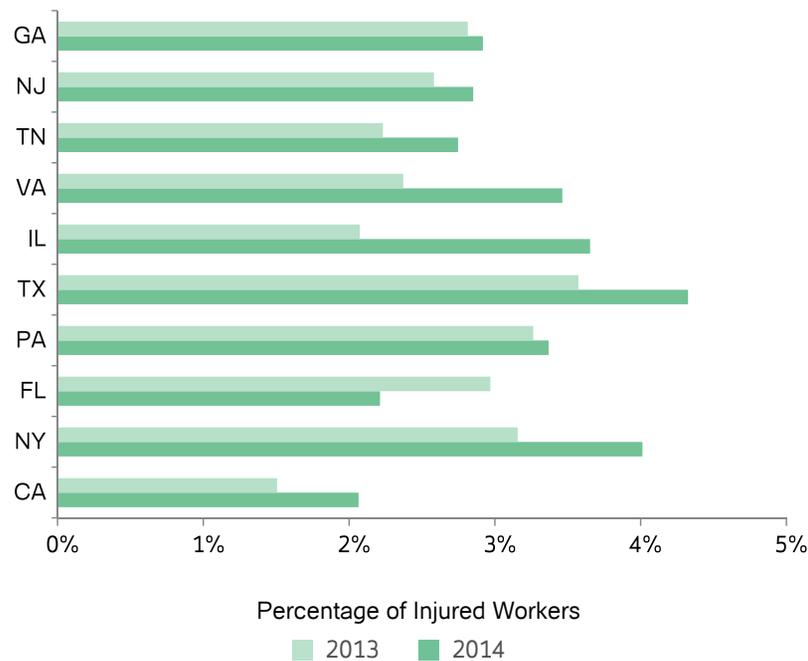
Unmanaged spend

Compounds accounted for **28.1%** of all unmanaged drug spend, up from 20.1% in 2013

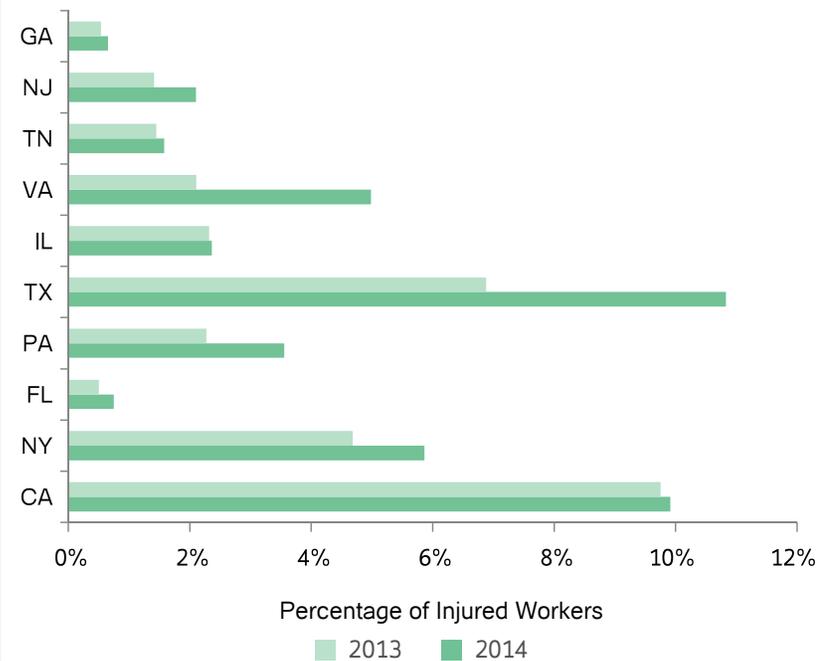
Compounds in Top States

Despite direction from medical guidelines, compound utilization as a primary line of therapy continued to grow. In addition, new formulations were being used to target gaps in medical guidelines and formularies.

Compound Utilization in Top States Managed



Compound Utilization in Top States Unmanaged



States with the highest increases in utilization of compounds in 2014:

Illinois (managed)

A significant increase in utilization was primarily attributed to a small group of providers. Illinois does not have fee schedule rules on compounds and doesn't allow for the direction of pharmacy care.

Texas (unmanaged)

Significant increase in the number of compounds formulated without the inclusion of N-Drug ingredients and are thereby circumventing the closed formulary.

Pennsylvania (unmanaged)

Experienced ample increases in both utilization and spend for compounds due to lack of fee schedule rules.

Virginia (unmanaged)

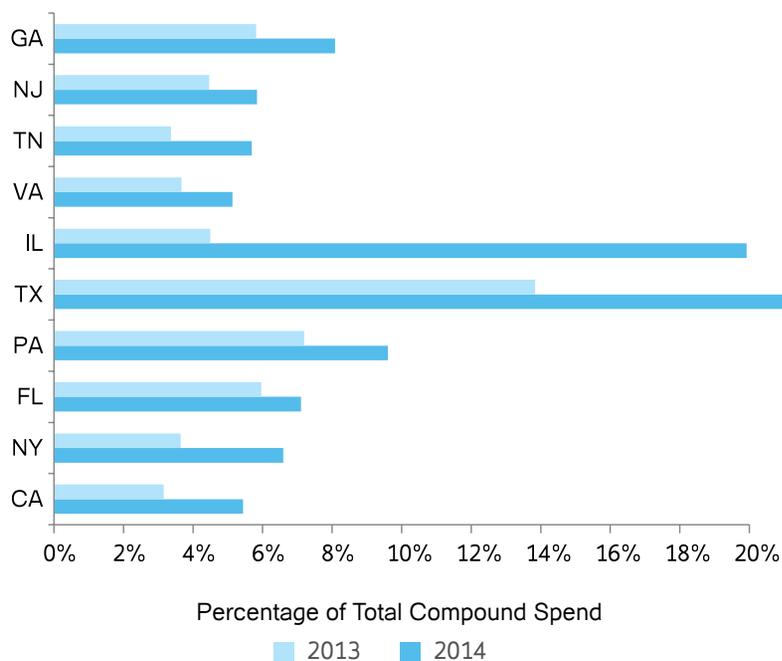
No pharmacy fee schedule or provision allowing payer to direct pharmacy care.

Compounds in Top States (cont.)

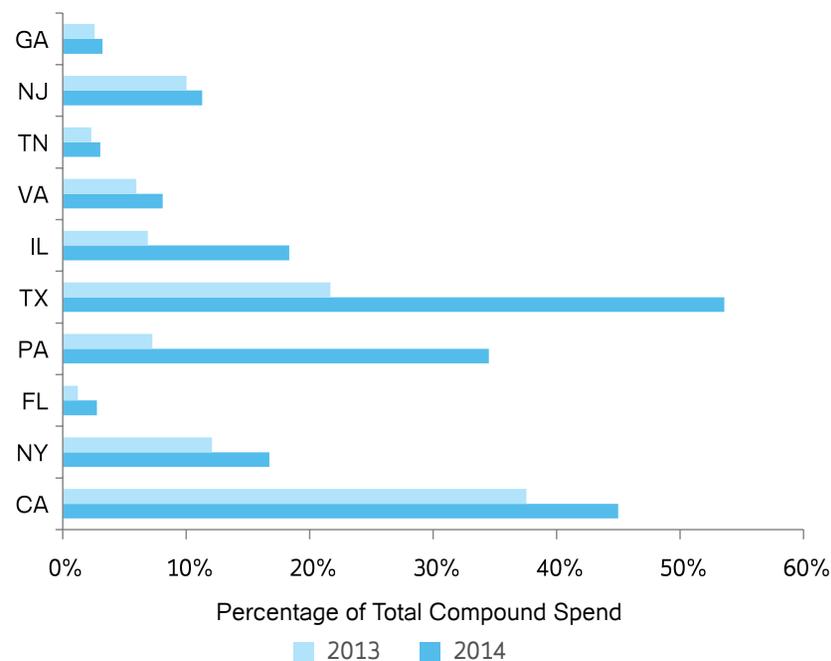
The precipitous increases in spend for 2014 were mostly a result of the following factors:

- Continued gaps in state-driven fee schedules and medical guidelines, allowing for compounds to be filled without documented medical necessity
- Continued gaps in state-driven pharmacy billing rules, allowing for compounds to be billed without sufficient information on specific ingredients contained within the medication
- Emergence of new medical billing/prescriber/pharmacy relationships focused on creating new revenue streams for all parties

Compound Spend in Top States Managed



Compound Spend in Top States Unmanaged



States with the highest increases in 2014 compound spend:

Illinois (managed)

- Primarily attributed to a small group of providers
- No fee schedule rules on compounds
- Does not allow for the direction of pharmacy care

Pennsylvania (unmanaged)

- Lack of fee schedule rules

Texas (managed & managed)

- Increases in utilization drove spend



Compound Drugs—Regulatory Reform

New York's revised treatment guidelines prohibit compounds for non-acute pain



Oklahoma's closed formulary requires ALL compounds be preauthorized



Arizona understood the need for greater billing reform in proposing the mandatory use of the NCPDP* Universal Form allowing for necessary data collection



In 2015, Arizona and Idaho are proposing measures to improve safety and processing standards



Problem

Compound medications dispensed out-of-network continue to rise

3 types of reform

1

Cost

Control reimbursement amounts



Michigan

2

Utilization

Address limitations or appropriateness



Oklahoma & New York

3

Billing

Dictate how drugs are to be billed

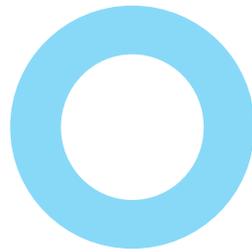


California & Arizona

*National Council for Prescription Drug Programs

Chapter 5

Closed Formulary Trends



As a response to the rapidly changing landscape, states are taking more aggressive approaches to solving the continued growth of workers' compensation pharmacy spend and utilization. Two primary vehicles being used to solve this problem are medication formularies and enhanced medical treatment guidelines. We have analyzed the states with early adoption of these vehicles to measure the impact they had on cost and utilization.

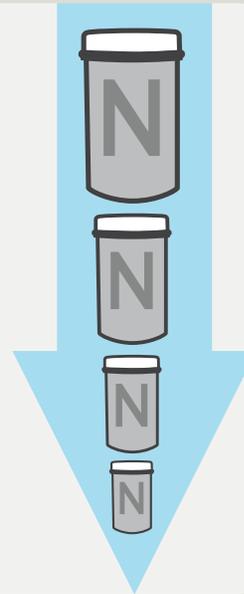
Understanding the Intent of a Closed Formulary

Expected outcomes from utilization of a closed formulary

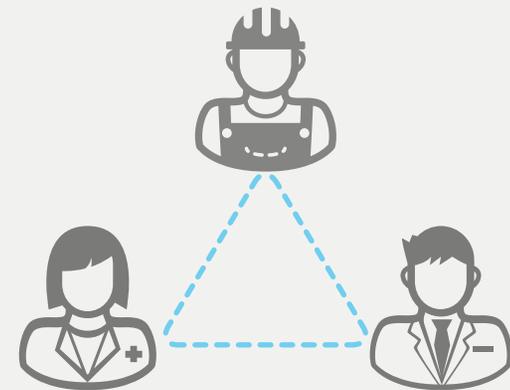
Reduction in the number of non-compensable medications being prescribed by providers and filled through workers' comp benefit plans



Reduction in the utilization of specific classes of medications, particularly narcotics



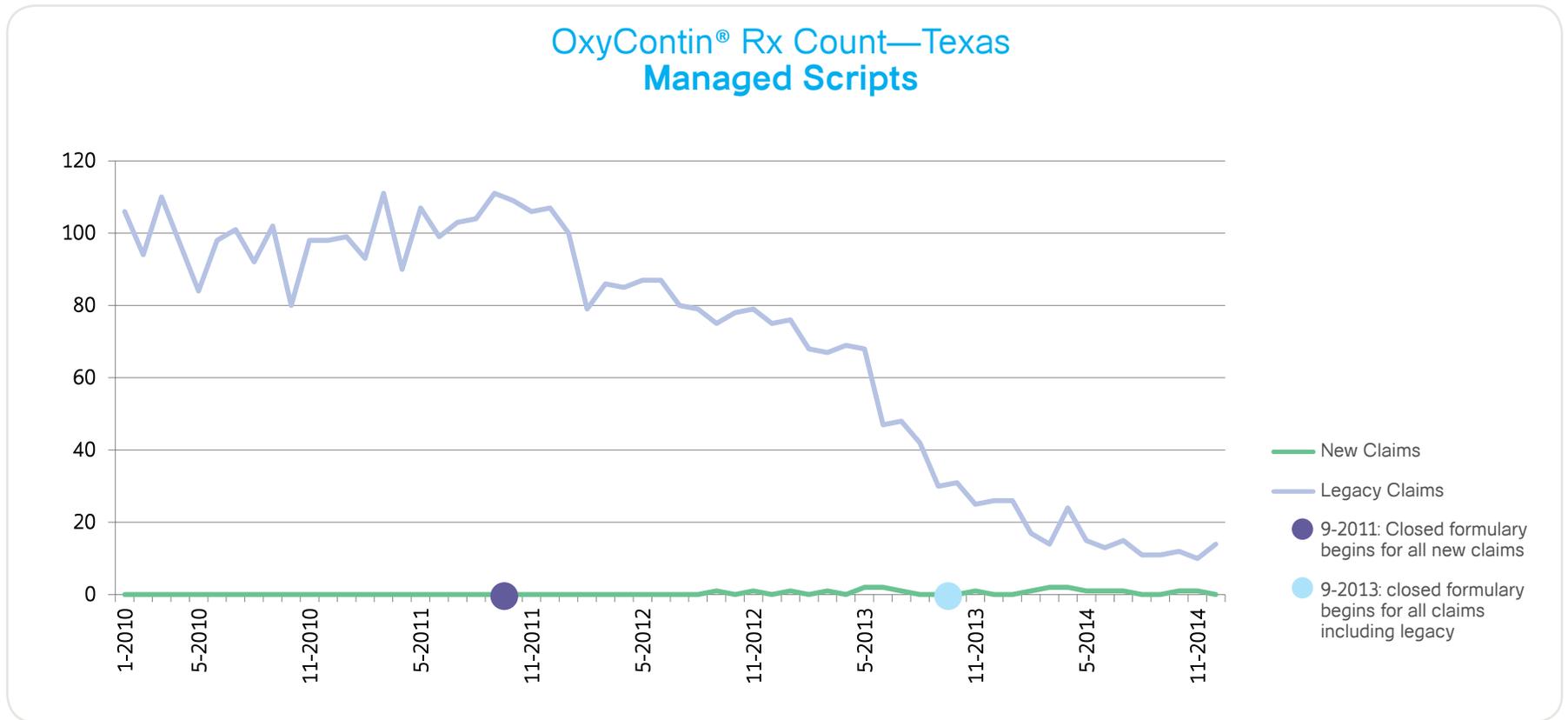
A simplified relationship between prescribers, pharmacy providers and injured workers



Recent state-by-state studies by NCCI have helped illustrate the financial benefits that select states could realize by adopting a Texas-like closed formulary. However, there are considerations that should be accounted for when a state considers a closed formulary, such as guidelines, utilization management, and legacy claims.



OxyContin® Utilization in Texas



As expected, OxyContin®, which now requires preauthorization before being dispensed in Texas, has seen a steady decline in utilization in the past four years.

Between the effective date of 9-2013 and 12-2014, OxyContin® utilization decreased among legacy claims.

**Utilization
decreased
53%**

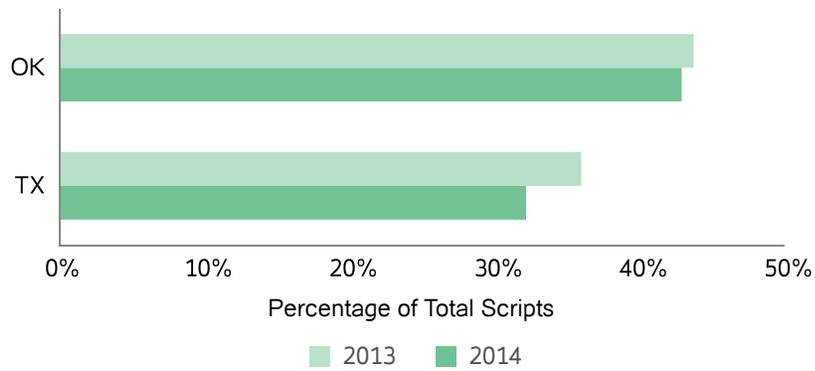




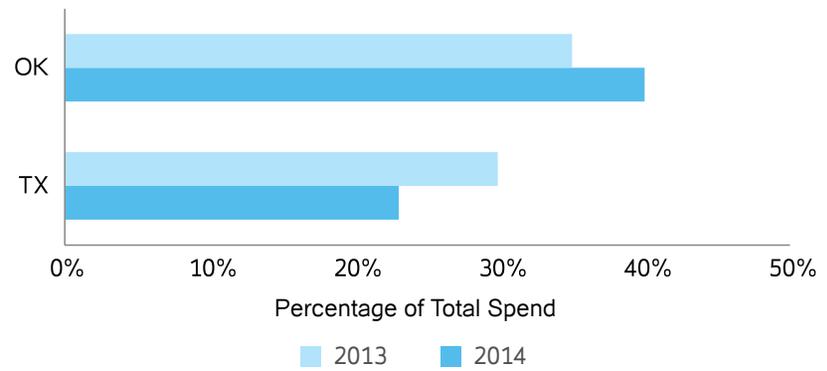
Impact of Closed Formularies on Narcotics

Texas and Oklahoma—Managed View

Narcotic Utilization by Closed Formulary Managed



Narcotic Spend by Closed Formulary Managed



Both Texas and Oklahoma have seen a reduction in narcotic utilization. Oklahoma's reduction in narcotic use is still developing, given the mid-2014 formulary effective date.



Texas
Narcotic
utilization
decreased
10.6%



Oklahoma
Narcotic
utilization
decreased
1.9%

In 2014, Oklahoma did not report a decrease in narcotic spend, most likely as a result of the mid-2014 formulary effective date and 2014 AWP increases.



Texas
Narcotic
spend
decreased
22.8%



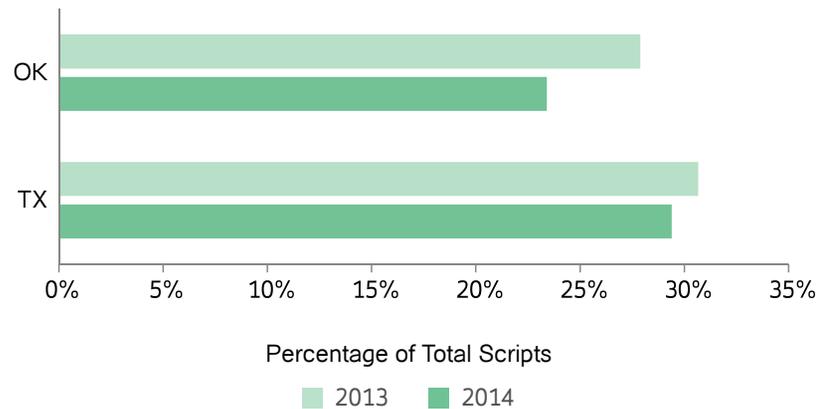
Oklahoma
Narcotic
spend
increased
14.3%



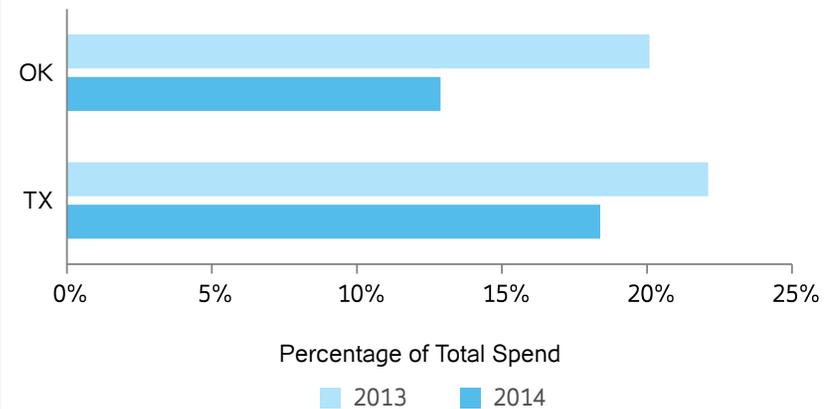
Impact of Closed Formularies on Narcotics

Texas and Oklahoma—Unmanaged View

Narcotic Utilization by Closed Formulary Unmanaged



Narcotic Spend by Closed Formulary Unmanaged

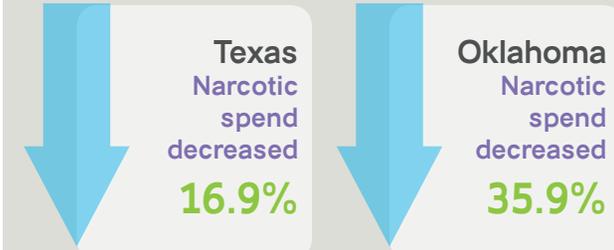


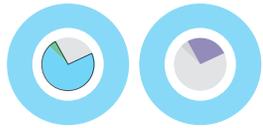
The greatest benefit from adopting a closed formulary is the positive impact it has on unmanaged prescriptions.

2014 narcotic utilization for unmanaged prescriptions:



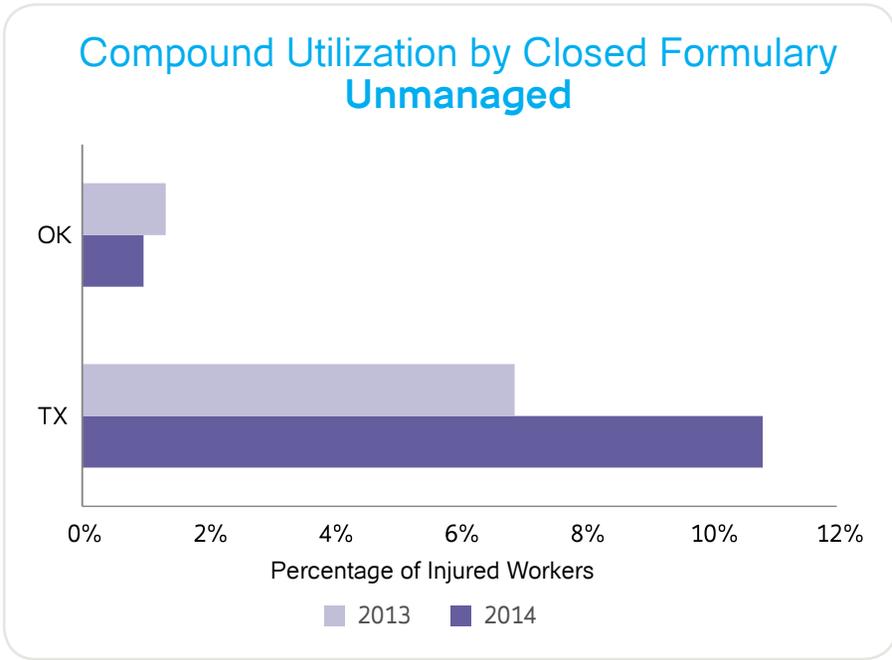
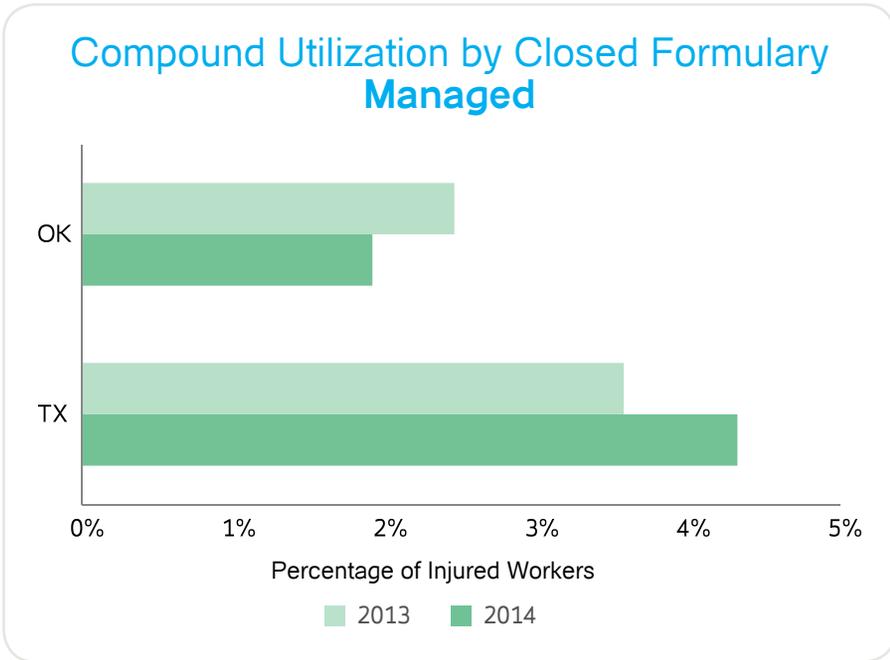
2014 narcotic spend for unmanaged prescriptions:





Impact of Closed Formularies on Compounds

Texas and Oklahoma—Managed and Unmanaged View



Oklahoma, unlike Texas, included a requirement for a PA on all compounds in its closed formulary, resulting in an immediate and significant reduction in compound utilization.

Formulary differences

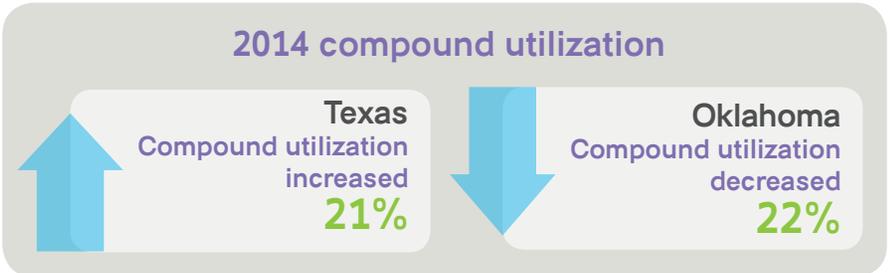
Texas does not require a PA for compound drugs

Oklahoma started requiring PAs for compounds (new claims) on Feb. 1, 2014

Number of injured workers with unmanaged compound prescriptions in 2014

Texas Increased 57.4%

Oklahoma Decreased 26.6%





Chapter 6

Hot Topics

Data Analytics

Digging Into Data to Uncover Clinical Risks

Risk analytics are a prerequisite for effectively managing pharmaceutical utilization among injured workers. But analysis is only as strong as the data upon which it is built. In addition to continuous refinement of our predictive risk models, Coventry continues to invest in a wide range of improved data capture from both network and non-network transactions.

We use this information to sharpen our focus when we uncover evidence of emerging clinical risks. We use this to leverage the findings across the full Coventry product suite. Among other benefits, our analysis allows us to alert adjusters and case managers at the appropriate time to intervene and take action.

Not too soon...or too late

Experience has taught us that appropriate early intervention can lower claim costs and improve outcomes. Our risk analytics drive toward alerting at the exact moment an intervention is needed, not a moment too soon, nor a moment too late. This level of precision can prevent payors from spending on clinical services prematurely, as well as create savings by ensuring intervention before adverse claim development occurs.

Some of the tools and programs that benefit from our comprehensive data and precise analytics include:

Rx Profile

First Script's pharmacy risk scoring tool, Rx Profile is the result of an algorithm that weights multiple claim, medication, medical, and provider data.

Smart PA

A recommendation by First Script to approve or deny a prescription that is sent with the PA, along with the clinical rationale. Medication and prescriber data is used to determine the appropriate recommendation.

DUA/P2P

Identification of claimants who warrant a retrospective drug utilization assessment (DUA) and/or peer-to-peer (P2P) review. Based on claim, medication, medical, and provider data.

Urine Drug Monitoring

Identification of appropriate candidates for medication compliance testing. Achieved through our risk stratification algorithm that includes claim, provider, medical, and medication data.

When less is more

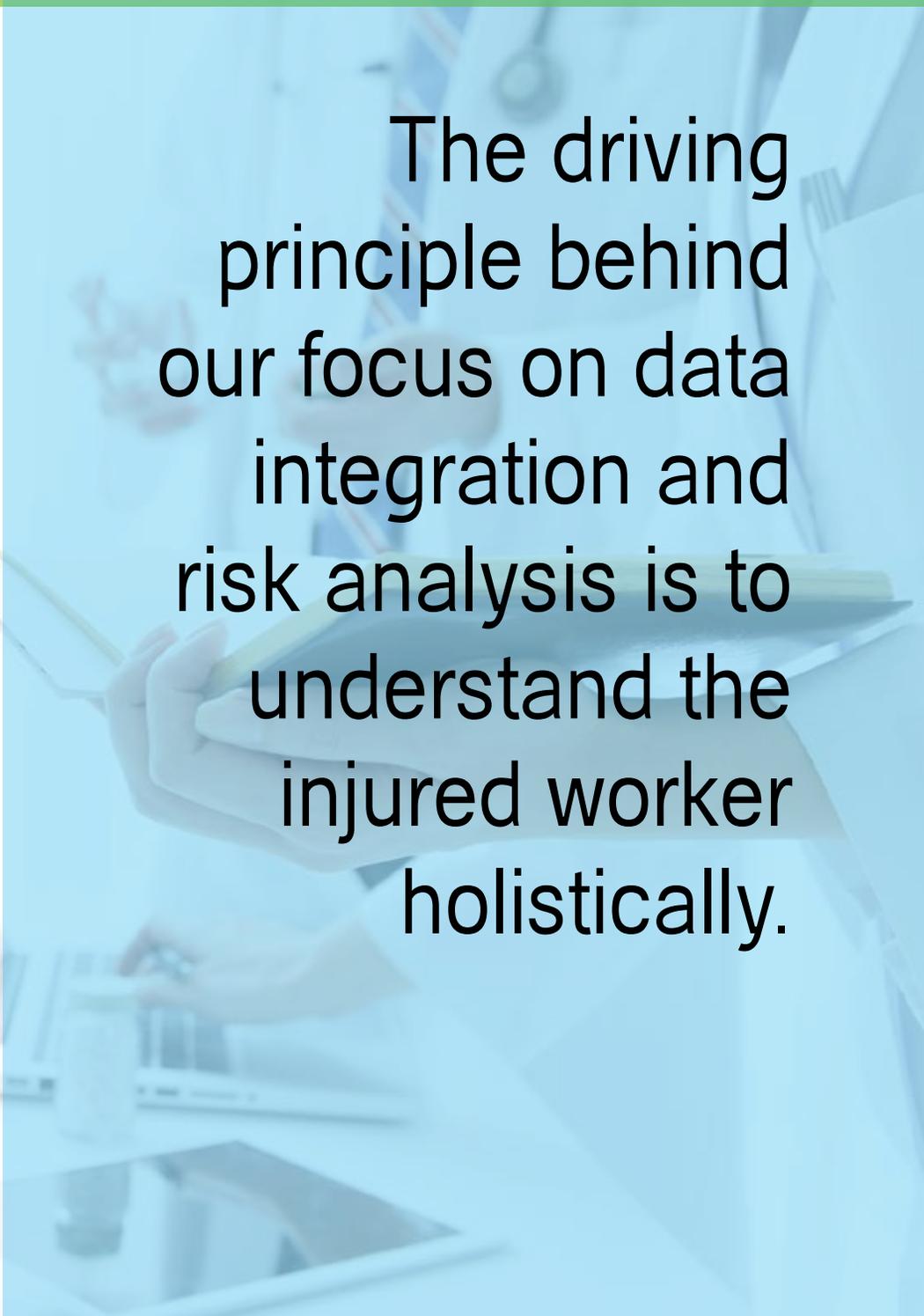
The precise output from our algorithms replaces the need for adjusters and case managers to review a myriad of individual pharmacy triggers. Instead, they receive fewer notifications and the ones they do receive prepare them to make the most effective decisions.

Adding new data to the algorithms can highlight when disparate factors might collide and upend gains in an injured worker's recovery. Wide-ranging analytics call attention to risk factors and give adjusters and case managers better insight when determining how to proceed.

The driving principle behind our focus on data integration and risk analysis is to understand the injured worker holistically. To do so, it is important to see beyond the medications related to the workplace injury. Our comprehensive data set allows for a more thorough screening for the possibility of harmful drug interactions, misuse, addiction, diversion, waste, and compromised efficacy. Managing all of this information can prove daunting, even for a single injured worker. However, Coventry organizes and presents integrated data for decision-support so adjusters and case managers can focus on helping the injured worker on the path to recovery versus wasting time trying to piece the story together.

Our digging is never done

Our robust analytics offer adjusters and prescribers alike a critical line of site into what is occurring with the injured worker. This information spans across all areas of care to ensure patient safety and promote recovery. Coventry is committed to focusing our analytic lens across our integrated clinical delivery system. Going forward, in addition to incorporating genetic testing data, we will also integrate external statistical sources including census and consumer data.



The driving principle behind our focus on data integration and risk analysis is to understand the injured worker holistically.

Urine Drug Monitoring

Increasing Patient Safety, One Cup at a Time...

It's no secret that workers' compensation patients are frequently being prescribed narcotics and other medications that can create risk for dependence and misuse. Urine Drug Monitoring (UDM) is a clinical decision-support tool that can help reduce these risks, ensure compliance with the prescribed drug regimen, and promote patient safety.

However, incorporating UDM into the narcotic management of injured workers has not been an easy task for payors. Many of the medical treatment guidelines commonly referenced in workers' compensation do not provide enough detail or have conflicting recommendations concerning the frequency or type of testing. The unintended consequence of these guides has been over-utilization and spending on tests that do not deliver value. Additionally, some physicians and adjusters are not utilizing UDM at all. Some treating doctors are not incorporating the findings from the tests into their ongoing treatment plan. Many adjusters don't understand how to incorporate testing results within their ongoing claim strategy.

This year we analyzed the various points of failure in the process of UDM for our clients. Based upon our analysis, we developed a comprehensive program that is designed to mitigate the points of failure and render UDM a highly effective means for safer narcotic therapy management.

Key areas needing strategic solutions:

Identification of appropriate candidates for testing

Test panel selection

Testing frequency

Taking action on test results

Identification

The first step is appropriately identifying which injured workers should be tested. Most UDM programs today identify candidates based on medication risk factors, such as high morphine equivalency dose, prescription "cocktails" or certain high-risk individual drugs. This is a good start, but Coventry decided to take on a more comprehensive approach that provides a much more accurate risk assessment. Our program incorporates a range of medication and medical risk factors, including a history of drug abuse or addiction, comorbid psychiatric disorders, or high-risk diagnoses. The inclusion of medical risk factors can point to patients with an increased risk of opioid misuse or abuse that would have otherwise been overlooked with medication-only risk factors.

Test panel selection

Once a candidate has been identified, it is tempting to test for everything that could be problematic. This process of over testing, however, can unnecessarily increase costs. We designed our program with test panels that are specific to each patient, with the goal of increasing efficiencies while decreasing costs.

We test the patient for currently prescribed medications to ensure that he or she is adhering to the prescribed medication regimen. If results indicate that the patient is not taking the prescribed drug, it creates an opportunity for our clinical pharmacists to have a discussion with the provider to determine why. Maybe the medications were lost or stolen. Maybe the patient could not tolerate the side effects and stopped taking them, or maybe the patient is a rapid metabolizer. Whatever the reason, the UDM results open the door to a conversation.

Our program also tests for non-prescribed medications and illicit drugs to help safeguard the patient from risk of overdose or drug interaction, to eliminate duplicate therapy, and to identify signs of opioid abuse or other behaviors that could negatively impact recovery. Again, the tendency here in the industry has typically been to over test, sometimes for as many as three dozen or more different drugs. In reality, for most injured workers it is probably only necessary to test for the 10 or 12 most commonly abused prescription or illicit drugs or drug classes, which includes their associated metabolites.

It is important to pay close attention to laboratories quoting excessively large testing panels as this is usually a marketing tactic. Some laboratories simply break out all of the various metabolites contained within the 10 to 12 most commonly abused drugs and drug classes, to create the illusion of an expanded test panel. Then each of the metabolites is charged separately when billed to the payor, driving up the cost of the test without delivering incremental insight or value to patient care.

Confirmation tests, also known as quantitative tests, are only utilized when a positive result for a specific drug is identified in the qualitative screen; otherwise, they are an unnecessary expense. However, there are a handful of medications, such as tramadol or gabapentin, that can only be tested using the more complex quantitative method, and will therefore bypass the preliminary screen and go directly to quantification.

Testing frequency

As with the test panels, the frequency of testing is not universal and is based on the patient's risk level. With a comprehensive picture of the individual, as described above, it's possible to stratify risk into low, moderate, or high, with a better degree of accuracy. Typically, for low-risk patients, we recommend retesting annually if narcotic therapy continues. Moderate-risk patients are tested approximately every six months. High-risk patients are tested three to four times a year and at any visit with possible aberrant behavior such as lost scripts or drug seeking behavior.

Taking action on test results

In order to make sure the appropriate parties are aware of when to take action, we deliver the information to everyone who has a role in the execution of the plan. In most cases, the prescriber, adjuster, and case manager all receive meaningful decision-support information about the injured worker's test results. This comprehensive report is user-friendly and easy to digest for all parties. The report also includes proposed future testing frequency, depending on the patient's risk level, and any clinical recommendations for adjuster action.

Hopefully the results are consistent with expectations. However, when results are inconsistent, an outreach from our clinical pharmacist to the provider is conducted to review the patient's test results. This discussion with the provider includes a review of the patient's medication profile, inclusive of all prescriptions regardless of dispensing source, and identified risk factors, along with current medical guidelines and recommendations for future monitoring. If test results show illicit drugs, the outreach will confirm whether or not the provider has a pain agreement in place with the patient. The objective of this discussion is to determine a plan of action. The plan may include further patient education and monitoring, implementation of a pain agreement if one is not already in place, stopping the pain medication, or discharging the patient from the practice. If the provider agrees to put a plan in place with the injured worker, we will make the appropriate edits to the point-of-sale system to close the loop in the narcotic therapy management plan.

In workers' compensation UDM is more than just a simple tool. When used within a full strategic monitoring structure, it can be a cost effective way to manage narcotic utilization and increase patient safety.

At First Script we're ensuring patient safety, one cup at a time...

Improving the Adjuster Experience

First Script Combines Technology and Clinical Expertise to Deliver Actionable Information

First Script online tools in Coventry Connect® make adjuster and case manager job duties easier, and support better decision making for all aspects of pharmacy utilization. Coventry Connect's features were directly influenced by our customers' input, and provide an online First Script experience that improves efficiency and effectiveness.

Comprehensive View



Decisions are made in context
real-time



Online Chat



Hello, how can I help you?

PA Support



Drug Class
Days' Supply
MED
UR History
Prior PAs
Other Factors



PA Decision

Proactive Approvals and Denials



Access to Priority Tasks



Clinical Alerts



Identify

Clinical Intervention



Quick Enrollment Options



Customers play a key role in enhancement process

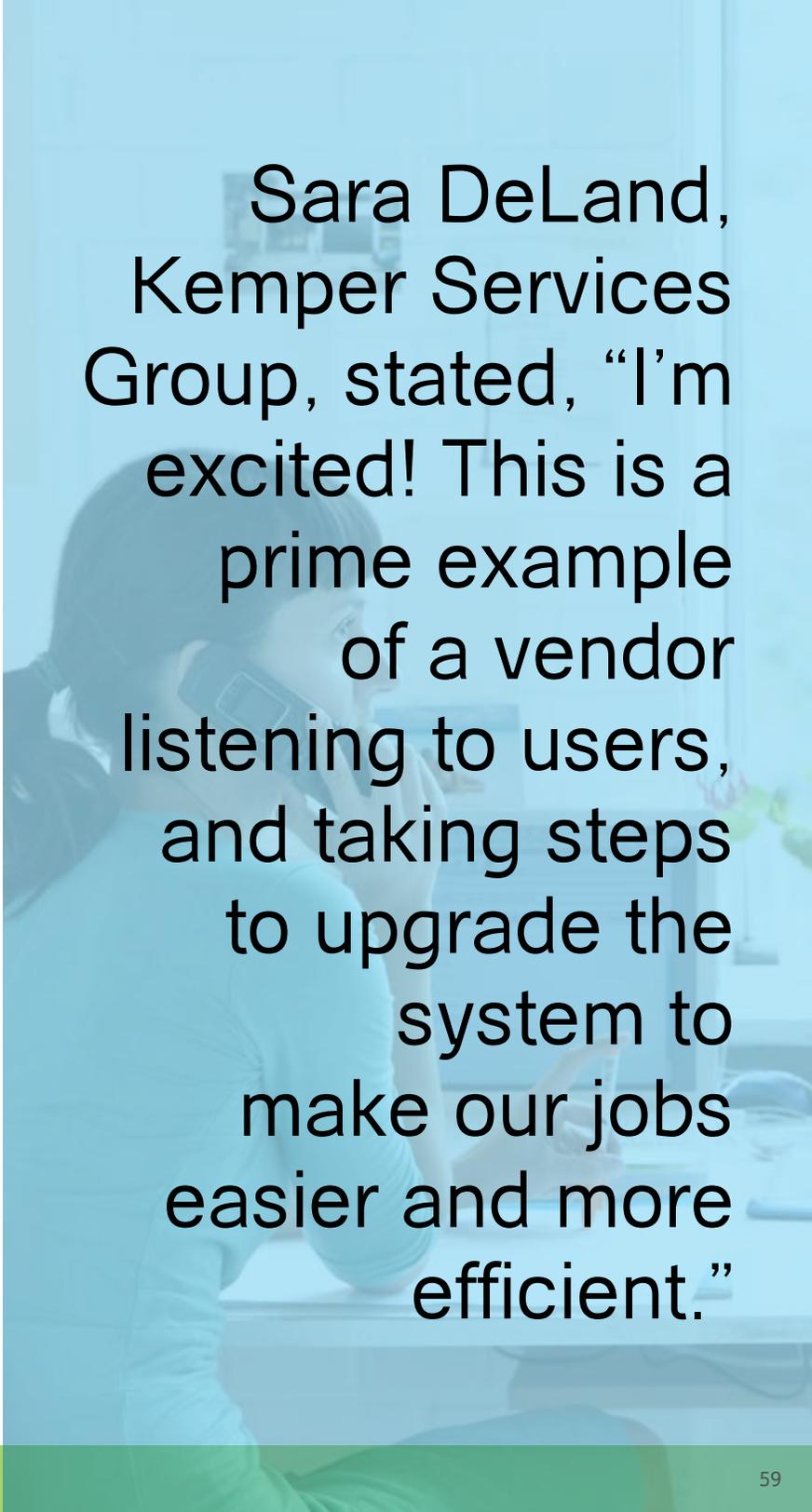
As a standard practice, we engage with Coventry Connect users through focus groups and other channels to identify opportunities to continually enhance their online First Script experience. Direct engagement with our users helps us ensure that the online tools we deliver will solve the right problems while providing a satisfying digital experience. In response to a recent demonstration of enhancements to the First Script tools in Coventry Connect, Sara DeLand, Kemper Services Group, stated, "I'm excited! This is a prime example of a vendor listening to users, and taking steps to upgrade the system to make our jobs easier and more efficient."

First Script's services, technology, and clinical expertise are combined to turn volumes of data into easily consumable, actionable information delivered right to the desktops of those who need it, when they need it. Coventry Connect helps adjusters and case managers make more effective decisions resulting in improved outcomes and reduced pharmacy spend.

Drug authorization requests include critical information such as:

- Drug class
- Days' supply
- MED
- Previous authorization activity
- Drug utilization history
- Other important factors that should be considered before drugs are approved

Through our Smart PA program, First Script's recommendation and rationale are also included

A woman with dark hair, wearing a light-colored top, is shown in profile, talking on a mobile phone. She is in an office environment with a computer monitor and other office equipment visible in the background. The image is overlaid with a semi-transparent blue filter.

Sara DeLand, Kemper Services Group, stated, "I'm excited! This is a prime example of a vendor listening to users, and taking steps to upgrade the system to make our jobs easier and more efficient."

Claims with a comorbid diagnosis nearly tripled between 2000-2009¹

Case managers are a great resource to educate and coach the injured worker to improve his or her health and promote recovery.

Comorbidities

Managing Work-Related Injuries Requires a Broader Lens

On paper, some work-related injuries sound so simple: a sprained ankle or muscle strain in the lower back, for example. In some cases, however, more is going on than meets the eye. Comorbidities (i.e., additional medical diseases or disorders) can complicate a workers' compensation claim, with a negative impact on outcomes.

According to the Centers for Disease Control, nearly half of all adults have at least one chronic condition such as arthritis, high blood pressure, obesity, cardiovascular disease or diabetes. In the general population, rates of hypertension, obesity and diabetes are increasing. No wonder the amount of workers' compensation claims with a comorbid diagnosis is also increasing. An October 2012 NCCI (National Council on Compensation Insurance) Research Brief reported that between 2000 and 2009, that share nearly tripled, from 2.4% to 6.6%.¹ In fact, the actual share may be higher, because most comorbid conditions are diagnosed outside the workers' compensation system.

NCCI noted that workers' compensation claims with a comorbid diagnosis generally received more medical services and had medical costs that were about twice as high as otherwise comparable claims. It's also interesting to note that although most workers' compensation claims are medical only, most of those with a comorbid diagnosis were more likely to be split about evenly between lost time and medical only. When obesity was the comorbid condition, 81% of claims were lost time.¹

Implications for management

When managing work-related injuries with one or more comorbid conditions, it's important to consider the impact on medical treatment as well as recovery and return-to-work. Medications can be particularly challenging. Drug interactions are one concern. Muscle relaxants and narcotic pain medications must be prescribed with caution for individuals who are already taking sleep aids, certain antihistamines, anti-convulsants for depression, or pain medication for arthritis. It's important to recognize that workers with chronic conditions may see multiple providers, each of whom is prescribing a different set of medications. A complete drug history is essential to providing the best outcomes.

Some drugs used for pain management may aggravate existing conditions. NSAIDs can stress the kidneys, and acetaminophen can be hard on the liver, so pain management can be challenging in individuals with poor liver or kidney function. Dosages often must be reduced. Because NSAIDs can cause fluid retention, they are relatively contraindicated for individuals with congestive heart failure or hypertension. Doctors will often prescribe narcotic pain medications as an alternative; however, opioids come with their own

risks. Opioids may cause sedation and increase the risk of a fall for a worker who already has balance or agility challenges. Opioids are also concerning for individuals who have a history of substance abuse.

Individuals with cardiovascular disease may take blood thinners such as aspirin or warfarin (Coumadin®) to reduce the risk of heart attack or stroke. In the event that an injury requires surgery, the doctor must weigh the risk of stopping the medication against the risk of bleeding during surgery.

Resources for recovery and return-to-work

Claims with comorbidities may take some extra effort to keep on track. It is important to know:

- What medical conditions does the injured worker have that could impact recovery and return-to-work?
- What treatment, if any, is the injured worker receiving for the comorbid condition?
- What medications is the injured worker already taking?
- What wellness programs can the injured worker access to address his or her chronic conditions?

Case managers are a great resource for managing these more complex claims. They can educate the injured worker about how the other conditions could impact his or her recovery and about the importance of documenting all medications to avoid the risk of contraindications or drug interactions. In addition, case managers can use health-coaching tools as an inexpensive way to help the injured worker to improve his or her health and prevent prolonged treatment and recovery. Health coaching tools provide a means to educate the employee about injury, illnesses, treatment options, and medications. They also encourage the injured worker to talk with the doctor about treatment options and make informed decisions in partnership with the provider.

With the increasing incidence of chronic conditions in the general population (reflected in the workforce) and the aging workforce, it makes sense to approach work-related injuries with a holistic view that addresses all factors that stand in the way of achieving the best possible outcomes.

Workers' compensation claims with a comorbid diagnosis generally received more medical services and had medical costs that were about twice as high as otherwise comparable claims.¹

The pivotal prescriber-dispensing state, Maryland, has decided to forgo any physician-dispensing reform measures for 2015 and 2016.⁸

Physician Dispensed Medications

Pharmacy Benefit Managers, employers, and their payors were collectively optimistic that there would be regulatory relief from the significant patient safety and cost risks associated with the practice of physician dispensing in workers' compensation when in 2013 prescriber-limiting rules were adopted in Florida.

There was additional hope that lasting reform was on the rise in early 2014 when a Johns Hopkins University study² definitively showed some of the negative cost and utilization consequences that can be attributed to prescriber dispensing. That study echoed similar findings by the California Workers' Compensation Institute in 2013.³ Both studies certainly helped bolster significant reform measures in Pennsylvania⁴ and Indiana⁵ in 2014 where hard caps were placed on the days' supply when a drug is dispensed by a prescriber.

But are physician dispensing reforms sustainable?

Unfortunately, in 2015 we have learned about the purposeful selection of specific national drug codes (NDCs) by repackaging entities aimed at artificially inflating costs.⁶ This prompted the Workers Compensation Research Institute to pose the question, "Are Physician Dispensing Reforms Sustainable?"⁷

Additionally, the Joint Committee on Worker's Compensation Benefits & Insurance made a public statement in the pivotal prescriber-dispensing battleground state, Maryland, that the subcommittee would not seek physician dispensing reform measures for 2015...or 2016.⁸

While each state takes a slightly different stance on how to manage the risks associated with physician dispensing, the basic tenants of reform measures today include:

Average Wholesale Price standardization through the use of only "original manufacturer's pricing"

Strengthening/imposing of prescriber preauthorization requirements before dispensing medications

Limitations on days' supply/quantity dispensed

Outright prohibition on prescriber dispensing, except in emergent circumstances

Coventry is actively engaged at a state regulatory level to advocate for physician dispensing reforms, seeking to bring about dispensing limits and cost-controls. We believe that the safest and most cost effective route to effective pharmaceutical care occurs when medications are dispensed within a retail pharmacy setting where formulary and point-of-sale edits ensure clinically appropriate utilization as well as the use of generics and less costly, therapeutically equivalent medications.

However, we have built an Extended Network of occupational health clinics, dispensing prescribers and their billing entities as an interim management tactic pending more meaningful reforms. Prescriptions processed through our Extended Networks are reviewed for clinical appropriateness and repriced to Coventry contracted rates.

Our Extended Network connects us with various stakeholders within the prescriber-dispensing sector. In so doing, we are enabling a more flexible workers' compensation platform for the current environment that allows for injured workers to receive medications within the most diverse network possible while minimizing their risk for inappropriate care. We are developing strategies to ensure that medications received through all channels are dispensed with controls for patient safety, clinical efficacy, and cost containment that are absent in an unmanaged physician dispensing scenario today.

Applying clinical protocols to all prescriptions regardless of where they are dispensed allows us to combat the known prescriber-dispensing issues on both utilization and cost containment until regulatory reforms effectively obviate this practice. Starting in 2015, we will incorporate more strategic interventions such as step-therapy, control drug-to-drug interaction, and monitor for refills made too soon.

Coventry remains a direct and proactive advocate at the state level for reform on the global appropriateness of prescriber dispensing. However, although reform is the ultimate solution, as a leading workers' compensation PBM, we believe it is our responsibility to place the most effective interim controls into place now to ensure patient safety, clinical efficacy and cost management within an environment where physician dispensing practices continue.



States that do not allow prescriber dispensing

- Louisiana
- Massachusetts
- Minnesota
- Montana
- New York
- Texas
- Utah

States with current reform measures

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Kansas
- Kentucky
- Maine
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Montana
- Nevada
- New Mexico
- New York
- North Carolina
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- Tennessee
- Washington
- West Virginia
- Wisconsin

One state, Arizona, has already taken an active position against the inclusion of medical marijuana as a part of treatment for a workers' compensation injury.⁹

Medical Marijuana Regulatory Update

Medical marijuana represented one of the most provocative themes debated in workers' compensation during 2014. While 23 states and the District of Columbia support the use of medical marijuana for the treatment of a small number of specific medical conditions, states have largely arrived at the conclusion that medical marijuana is not appropriate for traditional workers' compensation injuries. Additionally, in the limited instances where it might be considered appropriate, there is general agreement that injured workers can't be "high" in the workplace.

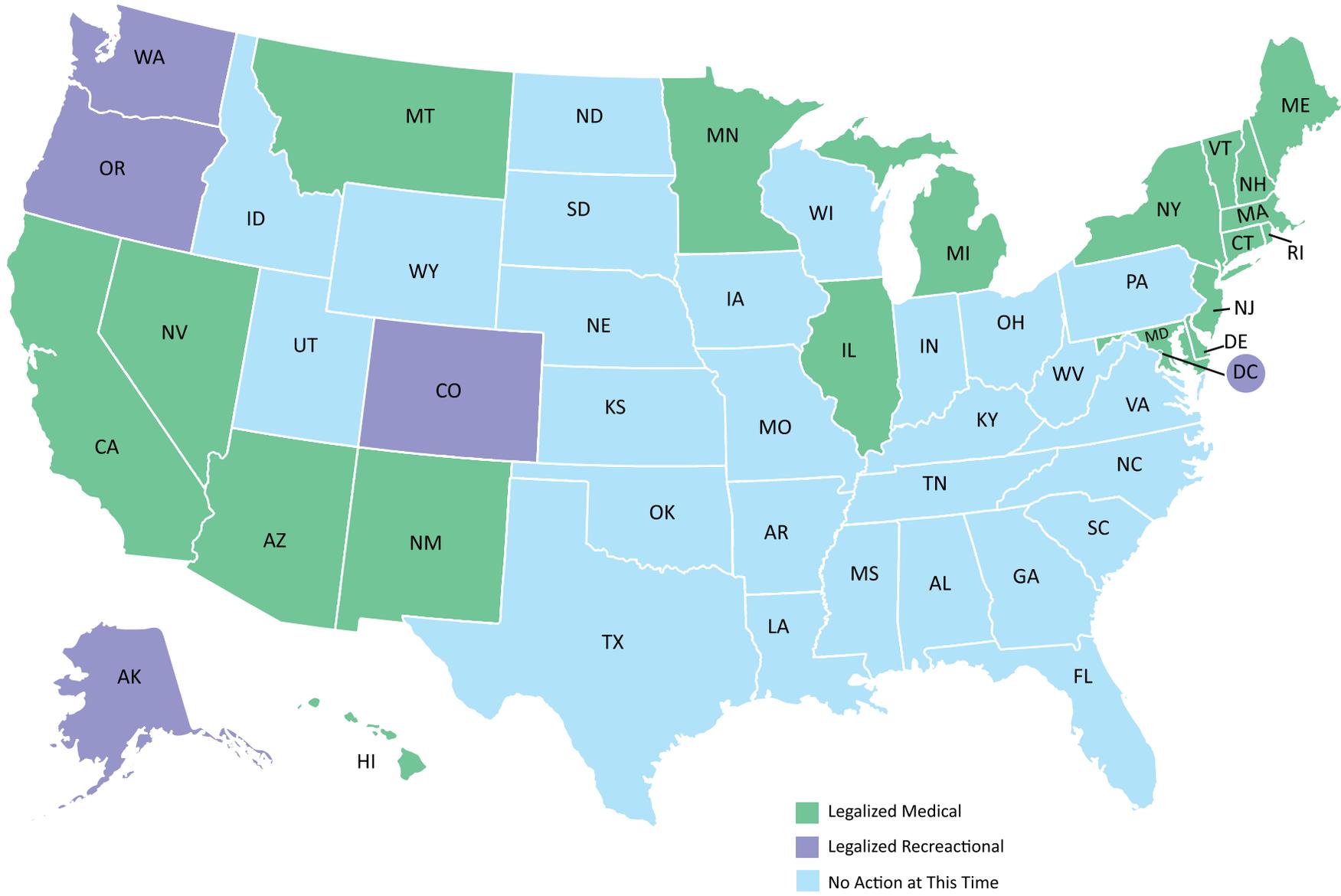
One state, Arizona, has already taken an active position against the inclusion of medical marijuana as a part of treatment for a workers' compensation injury. House Bill 2346, effective July 3, 2015, specifically exempts carriers and employers from paying for medical marijuana for workers' compensation injuries.¹⁹ Within states that generally allow the use of medical marijuana, some, like New Mexico, have to sort out the application of medical marijuana in workers' compensation through the courts. In *Miguel Maez v. Riley Industrial and Chartis* (2014), the state's Court of Appeals held that medical marijuana was part of "reasonable and necessary medical care" in relation to a specific injured worker's care.¹⁰

Looking forward, while not specific to any one medical marijuana reform measure, we do expect to see a growing need for pharmacy management solutions that can incorporate drug testing for both prescription and illicit substances. Whether mandated by law or optional as a "best practice," for those receiving an opioid or narcotic, drug testing has become an integral part of managing workers' compensation claims.

In fact, as states like Colorado, Washington, and most recently the District of Columbia, continue to legislate the allowance of marijuana for recreational purposes, drug testing will become a more critical tool in managing those claims in which medical marijuana has been prescribed and in identifying those claims where injured workers may be recreational marijuana users.

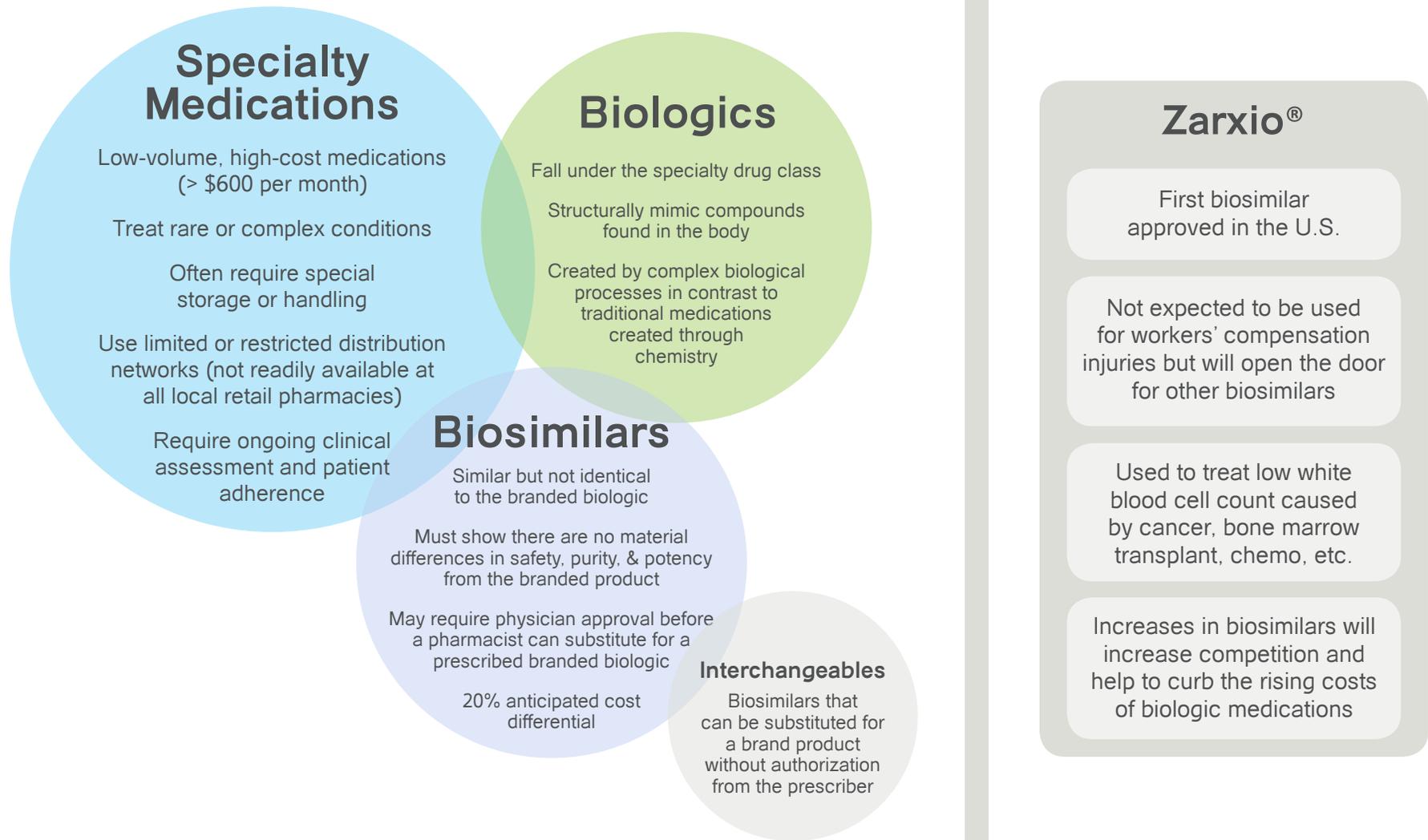
For more information on Coventry's Drug Testing Solution contact your Account Manager.

States With Legalized Medical and Recreational Marijuana¹¹



Specialty Medications

What Are They and How Do They Relate to Workers' Compensation?





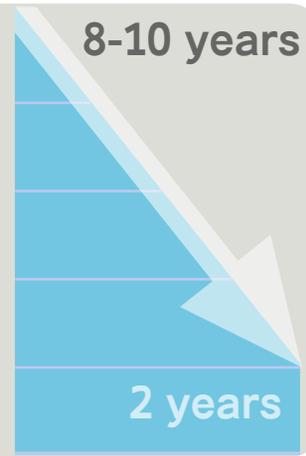
Exponential specialty drug growth expected by 2020

Fastest growing segment of the U.S. pharmaceutical market

50%

Of specialty & biologics are dispensed in doctor offices, clinics, & hospitals

The FDA's new Breakthrough Therapy Designations could reduce approval process from 8-10 years to 2 years



Solvadi®

An example of a high cost (\$84k-\$168k) biologic

Hepatitis C treatment with the potential to save a life and avoid a liver transplant

First Script will continue to monitor and report on the growth of specialty and biologic medications within workers' compensation as more information becomes available.

Managing specialty drugs

Ensure the most appropriate treatment is utilized



- Recognize that denial of the specialty medication might not be an option
- Can be achieved through UR, IME, or a DUA/P2P, depending on jurisdiction

Ensure adherence to the prescribed drug therapy regimen, especially when outcomes are improved with timely administration



- Employ case management for claimants that require specialty or biologic medications with specific treatment time durations

Monitor the treatment duration for each specific drug/patient



- Place edits at the point-of-sale to trigger a prior authorization at the anticipated treatment completion date

Reduce costs by shifting from physician/hospital dispensing to a specialty pharmacy (where appropriate)



- Approximately 50% of specialty & biologic drugs are dispensed and administered in a non-pharmacy setting
- These medications are a significant revenue source for physicians and hospitals

Physician & claimant outreach programs



- Education on the importance of medication adherence
- Guiding the injured worker to the nearest specialty pharmacy



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PHARMACY

Chapter 7

Accomplishments & Future Initiatives

This complete view offers greater opportunities to manage appropriate pharmacy utilization and, most importantly, to improve patient and program outcomes.

2014 Accomplishments

Led the industry for total prescription capture, reporting and analysis

In 2014, we broadened our analytic lens to view each client's total pharmacy experience, evolving past the industry's retail-centric definition of "network penetration." Our focus was to deliver our clients the most comprehensive and valid analyses of their aggregate pharmacy spend and utilization—regardless of the billing or dispensing sources.

The aggregation of this data also facilitated the development of a more precise risk model that is embedded within all of our clinical programs, resulting in more timely and accurate points of intervention. This comprehensive approach offers greater opportunities to manage appropriate pharmacy utilization and, most importantly, to improve patient and program outcomes.

Enhanced our comprehensive urine drug monitoring program

In 2014 we also analyzed the various points of failure which exist in urine drug monitoring programs. We used this knowledge to enhance our comprehensive program designed to mitigate those points of failure and render urine drug monitoring a highly effective means for safer narcotic therapy management. These enhancements are being piloted in 2015.

Key strategic solutions were designed to address:

Identification of appropriate candidates for testing

Test panel selection

Testing frequency

Taking action on test results

Enhanced technology and improved user experience

This year we heavily invested in a fresh user interface and new features within Coventry Connect, our user portal. Through Coventry Connect, technology and clinical expertise are combined to turn volumes of data into easily consumable and actionable information that is delivered at precisely the right moment to the desktops of those who need it. Our solutions help adjusters and case managers make more effective decisions that improve outcomes and reduce pharmacy spend.

Continued to decrease narcotic utilization

Our continued focus on proactive narcotic management resulted in a 5.9% decrease in overall managed narcotic utilization, and a 4.4% decrease in the average MED for managed prescriptions, across our book of business.

We accomplished this through:

- Early intervention and outreach programs
- Physician, injured worker, and adjuster education initiatives
- Elevating our clinical involvement with clients through targeted focus groups to analyze and design strategies that reduce narcotic utilization
- Incorporating aggregate prescription data within our risk identification tools, enabling us to assess patient risk with a higher degree of accuracy and prompt appropriate and well-timed actions
- Nurse case managers who intervene with patients and their prescribers directly within the local community to negotiate future care planning, including narcotic treatment agreements



4.4%
decrease
in MED



5.9%
decrease
in narcotic
utilization



2015 Looking Ahead

Positively influencing provider prescribing behavior

As the largest full-service, managed care organization in the industry, we have a responsibility to leverage our integration capabilities to deliver market-leading positive impact for injured workers and our clients. Our Integrated Network Provider Program will positively influence providers within the Coventry PPO (Preferred Provider Organization) network to prescribe within evidence-based standards of care. Through integration of pharmacy, networks, and case management we have designed a unique solution to improve prescribing patterns in a way that has not been available within the workers' compensation space to date.

Continued focus on compounds

There is a significant amount of complexity with juris-based regulations impacting the cost and utilization of compound medications. To better understand these complexities we have teamed up with our regulatory experts to assist in the design and execution of a comprehensive compound management solution.

Integrated total pharmacy management and reporting

We will continue to develop and enhance the integration of all prescriptions into a single aggregate view for our clients. Additional upgrades to our pharmacy platform will enable greater clinical and financial controls on all prescription transactions, resulting in even greater management over comprehensive pharmacy spend and utilization.

Targeted specialty and biologic medications management

Based on the pharmaceutical industry's focus on developing these new drugs, our expectation is that we will see increasing use of these treatments in workers' compensation in the upcoming years. In collaboration with our multidisciplinary clinical teams, we have been proactive in designing tools that will help our clients manage these unfamiliar, expensive, and complex medications.

Smart PA to drive improved prospective decisions

The most opportune moment for an adjuster to affect appropriate pharmacy utilization occurs through prior authorization decisions before a medication is dispensed. Our Smart PA program provides decision support for adjusters by sending clinical recommendations and rationale for PA requests. This additional clinical context supports defensible and consistent decision making. In 2015, we are making additional enhancements to this program such as expanding our clinical recommendations to cover more medications and therapeutic alternatives.

Continuous improvement in Coventry Connect user digital experience

As a standard practice, customers are engaged through focus groups and other channels to identify opportunities to further enhance their online user experience. Direct customer engagement helps us ensure that the online tools we deliver will solve the right problems while providing a satisfying digital experience.

Acronyms

AWP: Average Wholesale Price
DUA: Drug Utilization Assessment
ER: Extended Release
FDA: Food and Drug Administration
GE: Generic Efficiency
MED: Morphine Equivalent Dose
NCCI: National Council on Compensation Insurance
NCPDP: National Council for Prescription Drug Programs
NDA: New Drug Application
NDC: National Drug Code
NSAID: Non-steroidal Anti Inflammatory Drug
OON: Out-of-Network
ODG: Official Disability Guidelines
OTC: Over-the-Counter
P2P: Peer-to-Peer
PA: Prior Authorization or Preauthorization
PBM: Pharmacy Benefit Manager(ment)
PDL: Preferred Drug List
PDMP: Prescription Drug Monitoring Program
PPO: Preferred Provider Organization
UR: Utilization Review
UDM: Urine Drug Monitoring

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3. www.cwci.org/research.html (2/25/13, "Differences in Outcomes for Injured Workers Receiving Physician-Dispensed Repackaged Drugs in the California WC System")
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