

First Script Prescription Benefit News for Workers' Compensation

February 2018



Ask The Pharmacist

To suggest a topic, send an email to:
AskThePharmacist@cvty.us.com

Can you provide a list of non-drug or non-opioid alternatives for pain?

As always, this remains a helpful topic to review and refresh periodically. The following will outline, in brief, some of the available non-pharmacologic and non-opioid pain management options.

Non-pharmacologic options for pain

While we as a society are becoming increasingly familiar with many of the risks and possible negative outcomes that can be tied to the use of opioid medications, it is important to note that no medication is without some degree of potential adverse effect. For this reason, non-pharmaceutical options can be an attractive and beneficial modality for addressing various types of pain complaints. For the purposes of this article, a general list segmented by intervention type will be provided along with minimal details. Further information related to these approaches can be found in a number of additional pain management resources, including the American Chronic Pain Association's (ACPA) "Resource Guide to Chronic Pain Management," which is updated annually (see <https://theacpa.org> for additional information). For reference, the below list will follow a similar classification as that found within the ACPA's document differentiating between so-called "active" and "passive" interventions.

Active interventions

Active interventions are those that require individual or interdisciplinary/multidisciplinary* engagement in the treatment method or care program. Examples include exercise, Pilates, and yoga as well as various techniques such as postural retraining, art and music therapy, and a number of psychological and behavioral interventions including cognitive behavioral therapy (CBT). Functional Restoration Programs and approaches would also fall under this category and may include and/or combine a variety of active, passive, and pharmaceutical interventions with a focus on treating the "whole person," not just the physical ailment, in an effort to achieve a goal-oriented outcome such as return-to-work or return-to-function. In addition to the methods described above, there are a number of available "self-management" options for injured workers that can include various applications such as online tools, printed materials, videos, pain journals or calendars, and involvement in support groups.

Passive interventions

Passive interventions are those that do not require the injured worker to actively participate and may include the use of heat and cold, therapeutic massage, taping, acupuncture, cupping, spinal manipulation therapy, and external electrical stimulation devices (e.g., Transcutaneous Electrical Nerve Stimulation [TENS], Interferential Current Stimulation [ICS]).

Non-opioid medications for pain

When pharmaceuticals are considered to be an appropriate component of the pain treatment regimen, guidelines support the use of non-opioid drugs to be tried first wherever possible with opioids reserved for those patients who are unable to achieve pain relief using first-line medications. The following is a general list, in no particular order, of non-opioid analgesic and assistive medications that may be beneficial for managing certain types of pain.

**Among several types of health care professionals such as medical doctors, physical therapists, psychologists, etc., either within the same facility or coordinated at different locations.*

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Acetaminophen, NSAIDs, salicylates

Nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen (Tylenol®), and salicylate drugs such as Aspirin represent the group of medications in the non-opioid analgesic (or pain relieving) drug category. Several of these drugs are available without a prescription (i.e., over-the-counter [OTC]), including acetaminophen, Aspirin, and the NSAIDs ibuprofen (Advil®, Motrin®) or naproxen (Aleve®). NSAIDs and Aspirin work to treat pain, inflammation, and fever. Acetaminophen does not have anti-inflammatory properties and is indicated for pain and fever. NSAIDs and Aspirin may not be appropriate for individuals with gastrointestinal concerns (e.g., ulcer, those prone to bleeding risk), and the main concern with acetaminophen is that it can be toxic to the liver, particularly if taken in high doses.

Corticosteroids

Corticosteroids such as dexamethasone or methylprednisolone (Medrol Dosepak®, Depo-Medrol®) are powerful anti-inflammatories. However, their use is often limited to a short duration of time (three weeks or less) due to side effects and lacking efficacy beyond this period. General adverse effects associated with corticosteroids can include stomach upset, headache, or dizziness. Long term use of these types of drugs has been associated with weight gain, increased risk of infections, decreased bone strength, and hormone production irregularities.

Antidepressants and anticonvulsants

Some of the drugs originally studied and FDA-approved for depression and seizure disorders have been found to be effective for the management of certain types of pain, namely, chronic and/or nerve-related pain. Antidepressants such as amitriptyline (and others within the tricyclic antidepressant [TCA] therapeutic class) or selective norepinephrine reuptake inhibitor (SNRI) antidepressants such as duloxetine (Cymbalta®) have evidence to support their use in these types of pain, and they can represent a viable alternative to chronic opioid therapy. The same is true of anticonvulsants such as gabapentin (Neurontin®).

Topical analgesics

There are many topical medications available for pain relief, running the gamut from OTC products such as Bengay® or Icy Hot® (camphor menthol, methyl salicylate) to prescriptions containing NSAIDs and corticosteroids or other types of anesthetics such as lidocaine. The delivery of topical medications is typically in the form of creams, gels, lotions, ointments, or patches with a minimal amount of the drug reaching the blood stream compared to oral (by mouth) or injectable counterparts, thus the incidence of systemic (whole body) adverse effects is lower. These types of pain medications may be appropriate for certain individuals who are unable to take a drug by mouth due to risk of side effects or an inability to swallow, for example, or they may be helpful as additive options for local (specific area) relief to an external pain site (e.g., elbow joint pain, burns, etc.). The important thing to keep in mind is that some topical medications can be very expensive, and these often have a lower cost alternative with similar topical ingredients available or, in some cases, first-line oral options.

Others

Other types of medications may be useful for targeted interventions or to manage some of the more common complaints of those suffering from pain. For example, medications that can assist with sleep hygiene or managing insomnia such as zolpidem (Ambien®) or melatonin, musculoskeletal relaxants such as baclofen, or migraine treatments may be helpful depending on the specific type of pain experienced by the injured worker.

Cannabinoids

The topic of medical marijuana is included here with caution as cannabis is still considered federally illegal and an illicit substance; however, several states have enacted legislation allowing for medicinal use of marijuana typically with accompanying restrictions to the types of ailments for which it can be used as well as specific cannabinoids that may be covered. This subject is being discussed with increasing frequency in the world of medicine. While studies related to medical efficacy are growing, we still do not have a standard method for comparing products and ensuring drug safety and consistency for important treatment components such as dosing and potency as medical cannabis products do not go through the same rigorous process and controls as drugs approved by the FDA. For the time being, most recommendations promote the use of all evidence-based, FDA-approved pharmaceuticals prior to turning to medical cannabis wherever possible.

For further insight into non-opioid alternative pain medications or for questions related to a specific injured worker's care, please consider reaching out to our team of clinical pharmacists at askthepharmacist@cvty.com.

First Script Provides Clinical Recommendations to Assist in Decision Making

First Script Smart Prior Authorizations (Smart PAs) simplify adjuster decision making for injured workers.

Recommendations backed by clinical research and experience

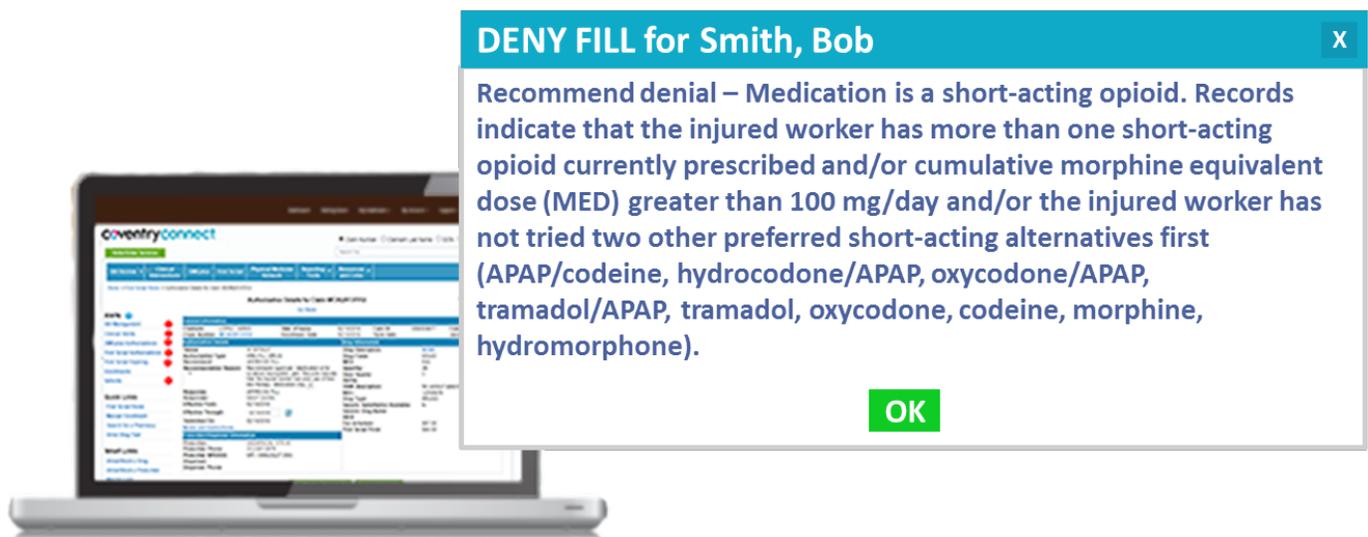
First Script clinical pharmacists have decades of collective experience, and have designed PA recommendations based on real world experience. Each message provides a clinically-based recommendation, including references such as the Official Disability Guidelines (ODG), to ensure the most pertinent information is available to the adjuster at the decision point.

The PA process also considers the injured worker's prescription history. For example, they indicate whether the injured worker tried first-line therapies, or whether the prescription is justifiable for use with other medications prescribed. By providing actionable recommendations First Script takes the uncertainty out of authorization decision making.

Managing authorizations in Coventry Connect

Claims examiners are alerted when a prescription requires review through the Coventry Connect web portal. These PAs include recommendations to approve or deny the prescription based on clinical best practices that help claims examiners make the best possible decisions for their injured workers. PA decisions differing from the pharmacist recommendation require a decision reason be selected, helping us better understand the reasoning to continually improve the process. First Script can also configure the system to automate approval/denial decisions to reduce the number of PAs claims examiners receive and save them time.

Our Smart PA recommendations are presented in Coventry Connect through the First Script module. Detailed Recommendation Reasons can be reviewed from the "Authorization Details" section:



Our PAs continue to get smarter

First Script is constantly working to offer the most comprehensive and clinically sound recommendations possible. November brought new changes to the PA program including enhanced Morphine Equivalent Dosing (MED) logic and the ability to program messaging around more complex clinical rules.

We will bring you more PA update information as it occurs. In the meantime, if you would like more information about the PA program, please contact your Account Manager or Account Pharmacist.

Drug of the Month

Symproic® (naldemedine)

Symproic (naldemedine) is an opioid antagonist approved for the treatment of opioid-induced constipation (OIC) in adult patients who have chronic non-cancer pain and are currently taking opioids. The drug is the latest OIC prescription medication approved by the FDA, joining the ranks of Amitiza® (lubiprostone), Movantik® (naloxegol), and Relistor® (methylnaltrexone). Symproic is a Schedule II controlled substance, meaning it carries the highest level of restrictions set by the Drug Enforcement Administration (DEA) for prescribed substances with an approved medical use. Of note, there is evidence to suggest that Symproic may not be as effective in patients who have been using opioids for less than four weeks.

Symproic is available as a 0.2 mg tablet and is intended to be taken by mouth once daily with or without food. The drug should be discontinued when the patient is no longer receiving opioid pain medication. Although Symproic is an opioid antagonist, it may be initiated without first considering an adjustment to the patient's analgesic opioid dose. Naldemedine, the active ingredient of Symproic, is actually derived from the opioid antagonist drug naltrexone and essentially works by stopping opioids from attaching to receptors in the gut. The molecular structure of the naltrexone derivative was altered to make naldemedine less likely to cross the blood-brain barrier, meaning Symproic has little risk of reaching the brain and precipitating opioid withdrawal compared to traditional opioid antagonists. However, there is still a risk of additive effects or resulting opioid withdrawal if Symproic is used along with other opioid antagonists, such as products containing naloxone or naltrexone, thus combined use is not recommended. The most common side effects reported with Symproic are abdominal pain, diarrhea, and nausea.

The Official Disability Guidelines do not consider specifically-targeted OIC medications like Symproic to be first-line treatment for opioid-induced constipation. Instead, the ODG recommend changes to diet (such as increasing fiber and fluid intake) and trials of OTC laxatives such as polyethylene glycol, lactulose, bisacodyl, senna, or docusate prior to considering Symproic. Questions related to place in therapy for this product or any medications requested for your injured worker may be directed to our team of clinical pharmacists at askthepharmacist@cvty.com.

References:
www.accessdata.fda.gov/scripts/cder/drugsatfda/
www.odg-twc.com

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