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The Impact of Prior Authorization on Buprenorphine Dose, Relapse and Cost of Opioid Addiction Treatment

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The Impact of Prior Authorization on Buprenorphine Dose, Relapse and Cost of Opioid Addiction Treatment

Evidence from Massachusetts' Medicaid Program

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Buprenorphine/naloxone

- Introduced in 2003 (Suboxone®)
- First opioid for addiction treatment that can be dispensed in an outpatient setting and taken without direct observation
- Considered safer than methadone
- **Doses > 24 mg not recommended**



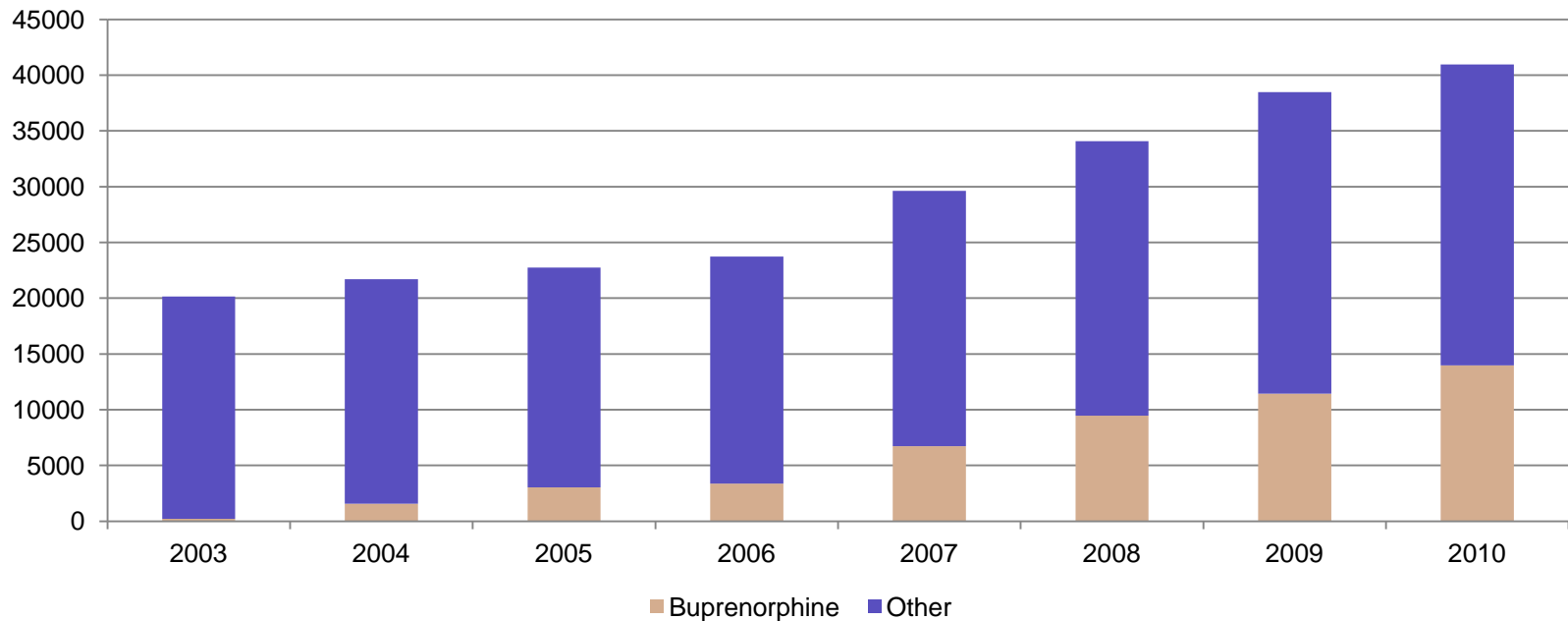
Why we are interested in Buprenorphine & Medicaid?

- Medicaid is a key payer for buprenorphine treatment
- Increasing concern about **cost** and **diversion** of buprenorphine
- Most states restrict access through prior authorization requirements



Buprenorphine treatment in MassHealth has risen steadily

MassHealth* Members with a Opioid Use Disorder Who were Treated with Buprenorphine



*Massachusetts' Medicaid program

Prior Authorization

- Prescribers must get authorization before a prescription is filled
- Seeks to reduce cost and/or improve safety
- Typically imposed by an insurer
- A favorite tool for Medicaid programs

Unanticipated Effects

- Does not always reduce costs
- May break treatment continuity
- May contribute to relapse

(Law et al, 2008; Abouzaid et al 2010; Lu et al. 2011; Morden 2008)

MassHealth* Prior Authorization for Suboxone[®]

- Implemented in January 2008
- High doses required more frequent authorization

Daily Dose	Authorization Frequency
> 32 mg	Each prescription
> 24 mg & \leq 32	Every 90 days
> 16 mg & \leq 24	Every 180 days
\leq 16 mg	None required

* The Massachusetts Medicaid Program

Research Questions

1. Did high-dose treatment decrease?
2. Did prior authorization affect medication costs and total costs?
3. Did prior authorization affect relapse rates?

Methods

- Medicaid claims January 2007 through December of 2008
- Additional data on other publically funded detoxification treatment
- Limited to those who used Suboxone®
- Three treatment groups: Low dose < 16 mg/day, Medium 16-24 mg, High >24mg

Time series

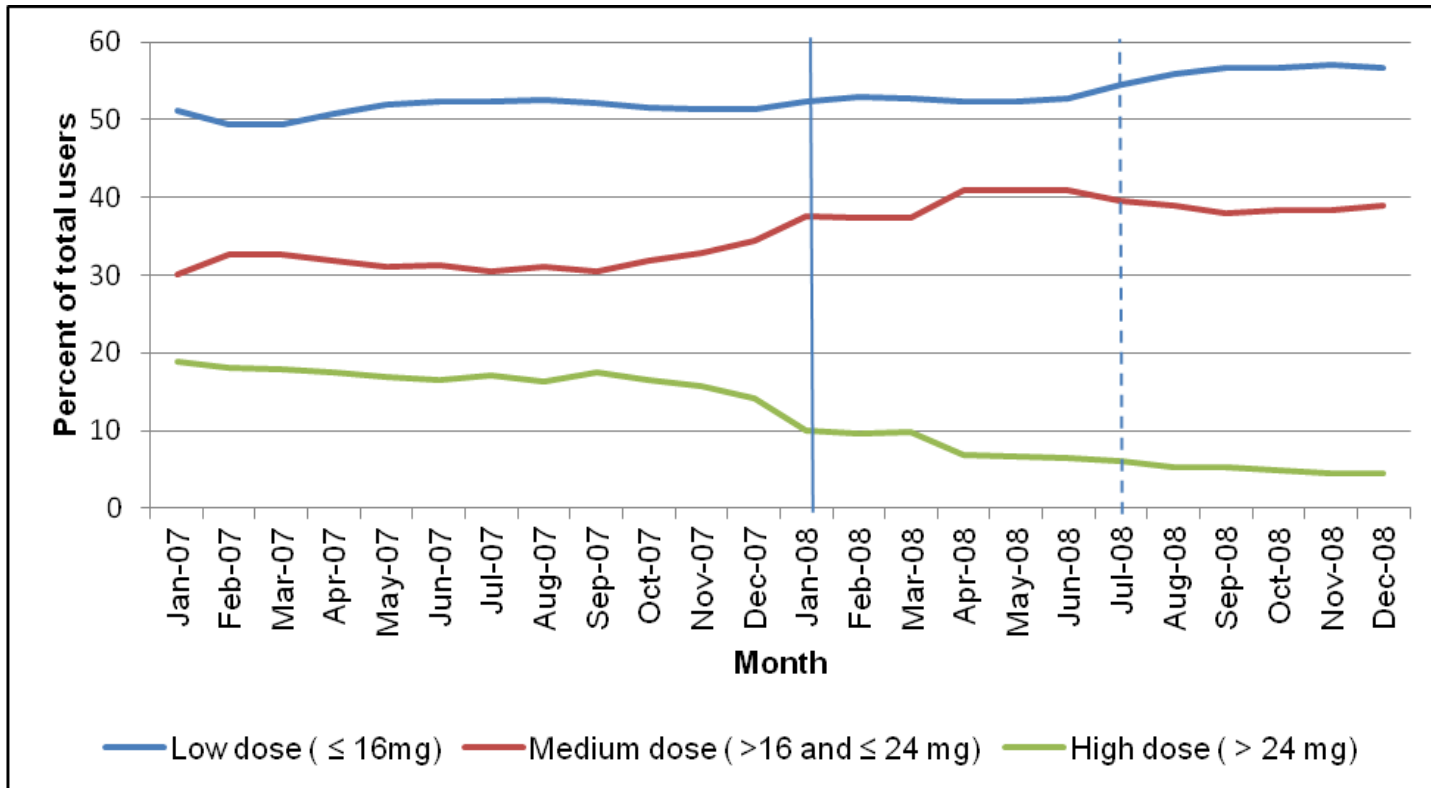
- Population level analysis
 - analyzed claims for all patients using month as the unit of observation
- Individual level multivariable analysis
 - analyzed claims for continuously enrolled patients as the unit of observation (n =2,049)
- Generalized estimating equations for both

Suboxone users in 2007

	Low n = 908	Medium n = 699	High n = 442	Total n= 2,049
Age	32.9 (9.9)	33.1 (9.4)	34.2 (9.7)	33.2 (9.7)
% Women	43.1%	37.0%	33.3%	38.9%
MH conditions	1.4 (1.5)	1.3 (1.4)	1.2 (1.2)	1.3 (1.4)
Physical conditions	0.7 (1.0)	0.6 (0.9)	0.8 (1.0)	0.7 (1.0)
Suboxone® \$/month	\$164 (\$96)	\$284 (\$128)	\$362 (\$179)	\$248 (151)
Total \$/month	\$1,372 (\$1,640)	\$1,110 (\$1,025)	\$1,102 (\$1,185)	\$1,224 (\$1,367)

(Standard deviation)

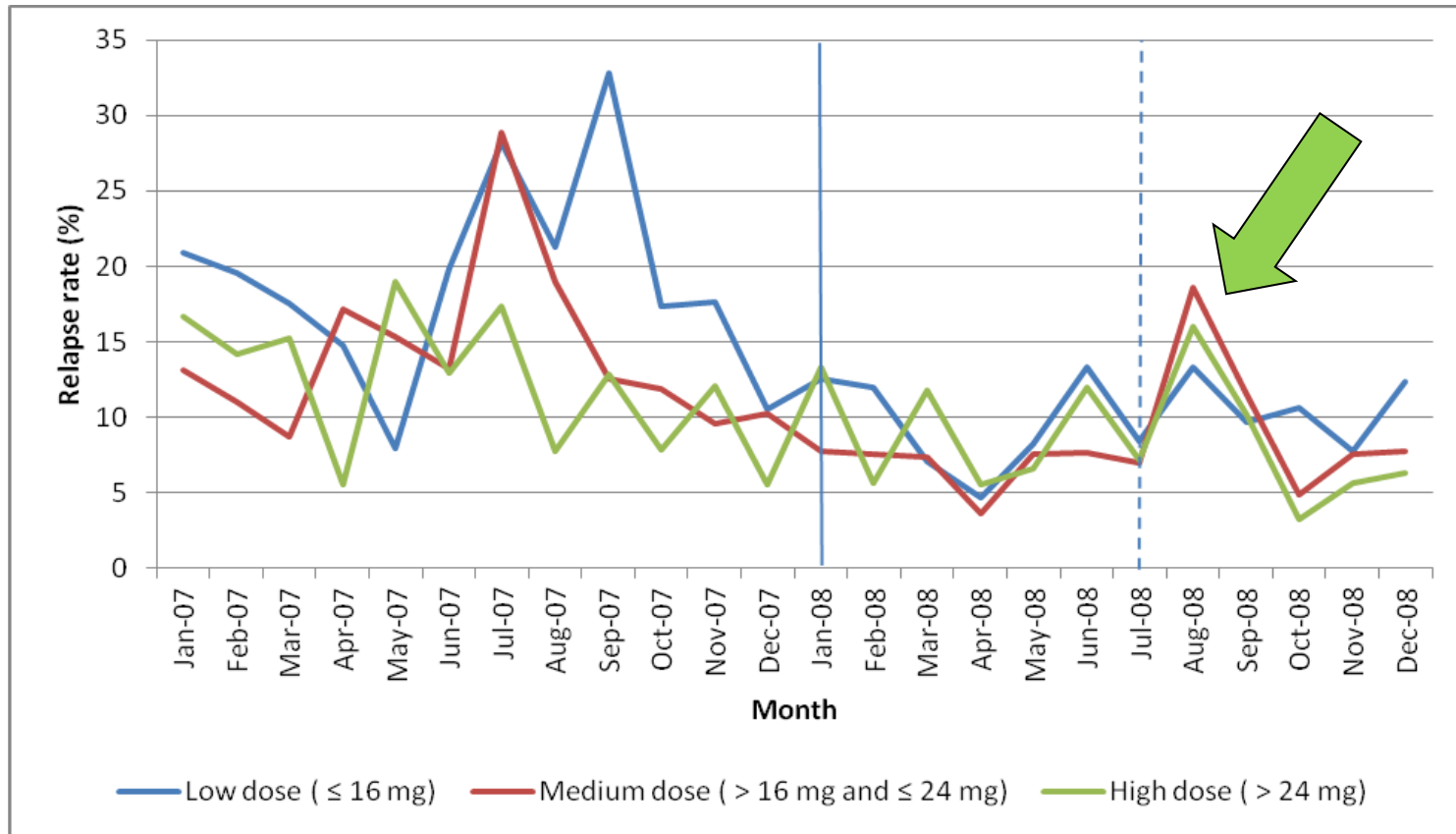
Suboxone[®] Doses Before and After Prior Authorization



Cost impact

- Suboxone[®] expenditures decreased in the high dose group
- Increased in other groups
- Net 2008 Suboxone[®] savings from \$131,347 to \$492,641
- No savings in overall healthcare costs

Temporary Increase in Relapses



Limitations

- Measures limited to administrative data
- Cannot rule out secular (time) effects

Summary

- The PA effectively lowered high doses
- Modest decrease in Suboxone[®] cost
- No impact on total cost
- Temporary increase in relapses for medium & high dose groups
- Long-term impact of dose limits needs further study

Why should we care?

- At least 6 states now place lifetime limits on buprenorphine treatment
- Limiting access to medication-assisted treatment can result in more relapses, deaths and higher costs
- Dose related PAs may be a relatively safe way to manage “over prescribing”

