Maryland-DC Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 578 Maryland Medical Assistance Program - Prior Authorization for Drug Products to Treat an Opioid Use Disorder – Prohibition House Health & Government Operations Feb 16, 2022
SUPPORT

Testimony by Joseph A. Adams, MD, FASAM, Chair, Public Policy Committee

Prior authorization, by design, erects barriers to medication treatment for opioid use disorder (OUD). Because medications are the primary treatment for OUD, this directly hinders our efforts at addressing the opioid overdose crisis. We should be facilitating treatment, not hindering it.
Medications are the principle OUD treatment, namely: methadone, buprenorphine (transmucosal or injectable), or injectable naltrexone (Vivitrol). (Psychosocial counseling should be a part of treatment).
OUD is unique in that medication treatment for OUD is the essential treatment for the great majority with moderate to severe OUD.

In fact, the term “Medication Assisted Treatment” (MAT) is now out of favor, and is being replaced in the literature by either the term ‘Medication Treatment” (MT) or “Medications for OUD” (MOUD). This is because “Medication Assisted Treatment” implies that medication is something other than treatment. But, **in fact, medication is the treatment** (ideally combined with psychosocial treatment).

Medications for OUD are the most mis-understood treatments in the world.
Many patients, families, and some policymakers are under the impression that patients should try to avoid using medications, or should come off them as soon as possible, and that these medications are “addicting.” The gold standard treatments, methadone and buprenorphine, are opioids and cause ‘physical dependence,’ which is not at all the same as “addiction.”

Because of this “medication stigma,” policy makers, including in Maryland, have not understood what’s important in reversing the overdose epidemic, which increased 30% since last year.
The response seems to be focused on distributing Narcan, which is fine, and important,

but **the only way to significantly impact the opioid overdose epidemic is through increased access to treatment**, and [[for the great majority with established OUD]] that means **medication treatment**.

Other approaches include increased access to peer and recovery services, syringe service programs, overdose prevention clinics, all of which keep people alive, and healthier, and get more people into treatment over time. And also prevention in terms of reducing opioid prescribing for pain, but these are beyond the scope of this hearing).
[And also, Prevention in terms of reducing over-prescribing, especially post-operatively.]

The experience in France illustrates the profound importance of medication treatment. In 1995, when France removed essentially all barriers to buprenorphine prescribing, 20% of all French physicians began treating OUD with medication. **The number of people treated with buprenorphine rose ten fold. Overdose deaths declined by 80%.** (Auriacombe et al).

(cont’d . . .)

Having a variety of medication options is critical. Patients are often reluctant to start medication treatment, and having a variety of choices and options can do wonders in getting them to start treatment.

There is a tremendous effort to get more providers to participate in prescribing medication for OUD; relatively few are willing at this time. And prior auth requirements, by design, just erect an additional barrier. This requires prescribers to suddenly drop what they're doing and start making phone calls so they can prescribe a medicine. **This creates a significant barrier to treatment.**

Scores of studies, published over decades, have confirmed,– ad nauseum –that the great majority of patients with OUD, [[Need MEDICATION treatment to maintain recovery]]
certainly those with moderate to severe OUD, have a very low chance of recovery without mediations for OUD. **Over 80% will relapse within about a year after gradually tapering off of medications within the first 6 – 12 months.** Psychosocial treatment – by itself – is ineffective for OUD. I've included some of these studies, including one review of the literature entitled "Leaving methadone treatment: **Lessons Learned, Lessons Forgotten, Lessons Ignored**". That was published over 20 years ago. (Margura S. et al).

REFERENCES

Auriacombe M et al. French Field Experience with Buprenorphine, The American Journal on Addictions, 13:S17–S28, 2004

Magura S, ET AL. Leaving methadone treatment: lessons learned, lessons forgotten, lessons ignored. Review Mt Sinai J Med. 2001 Jan;68(1):62-74. http://bit.ly/leavingMTHD

OUD agonists lowers risk of OD death by 80% compared to psychosocial treatment.

Krawczyk N et al. Opioid agonist treatment and fatal overdose risk in a state-wide US population receiving opioid use disorder services. Addiction. 2020 Sep; 115(9): 1683–1694.
Free: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7426244/

Among over 40,000 patients with opioid use disorder treated with various modalities, only treatment with buprenorphine or methadone was associated with reduced risk of overdose and serious opioid-related acute care.

Wakeman SE et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Netw Open. 2020;3(2)
free: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760032

"Behavioral interventions alone have extremely poor outcomes, with more than 80% of patients returning to drug use. Similarly poor results are seen with medication assisted tapering . . . "Longer periods of tapering (1–6 months) with methadone or buprenorphine are also ineffective in promoting abstinence beyond the initial stabilization period."

Bart G, Maintenance medication for opioid addiction: the Foundation of Recovery
J Addict Dis. 2012; 31(3):207. Free: www.ncbi.nlm.nih.gov/pmc/articles/PMC3411273/

"Patients who discontinue OUD medication generally return to illicit opioid use.". . Arbitrary time limits are inadvisable."

SAMHSA, Treatment Improvement Protocol 63   Updated 2020
Substance Abuse and Mental Health Services Administration.

Of over 4,000 patients who started a methadone taper, 13% had a “successful taper” defined as remaining alive, reaching a dose ≤5mg per day, not re-entering treatment, and not having an opioid-related hospitalization within 18 months. These poor outcomes are consistent with the findings of prior analyses.” (additional references cited).

Nosyk B, et al. Defining dosing pattern characteristics of successful tapers following methadone maintenance treatment: results from a population-based retrospective cohort study. Addiction. 2012;107(9):1621   free: www.ncbi.nlm.nih.gov/pmc/articles/PMC3376663/

"All studies of tapering and discontinuation demonstrate very high rates of relapse.”

pg. 40, ‘Medications for opioid use disorder save lives.’ National Academies of Sciences, Engineering, and Medicine. 2019. Washington, DC. The National Academies Press
Full document: free: www.nap.edu/download/25310

“There is consensus in the scientific literature that the opioid agonist medications methadone and buprenorphine are the most effective treatments for opioid use disorder. Despite increasing opioid overdose deaths in the United States, these medications remain substantially underutilized. For no other medical conditions for which an effective treatment exists is that treatment used so infrequently.” . . . A key strategy to address the epidemic is to expand access to the opioid agonist medications for addiction treatment (MAT) methadone and buprenorphine

Allen B, et al. Underutilization of medications to treat opioid use disorder: what role does stigma play? Subst Abuse. 2019;40(4):459–65.

When communities expand access to opioid agonist treatment, overdose mortality decreases substantially

Larochelle MR et al. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality Ann Intern Med, 169 (2018), pp. 137-146

Sordo L et al. G. Barrio, M.J. Bravo, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies BMJ, 357 (2017), p. j1550

Patients treated with methadone or buprenorphine have an 80% lower risk of dying from overdose compared to patients in treatment without medications.

Alcoholism & Drug Abuse Weekly, 28 February 2020
https://onlinelibrary.wiley.com/doi/10.1002/adaw.32642

Winograd RP, et al. The case for a medication first approach to the treatment of opioid use disorder. Am J Drug Alcohol Abuse. 2019;45(4):333-340.