Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders

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Executive Summary

Approximately eight percent of individuals in the United States have a substance use disorder. Each year, an estimated 85,000 deaths are attributed to the use of alcohol and 17,000 deaths to the use of illicit drugs (Mokdad, Marks, Stroup, & Gerberding, 2004). Excessive alcohol consumption is associated with multiple adverse health and social consequences, including liver cirrhosis, certain cancers, fetal alcohol spectrum disorder, unintentional injuries, and violent behaviors (Bouchery, Harwood, Sacks, Simon, & Brewer, 2011). The use of illicit drugs has been linked to a variety of adverse health events, including HIV/AIDS, hepatitis and other infectious diseases, prenatal conditions, kidney and liver damage, stroke, and a number of respiratory, cardiovascular, and neurologic disorders (Devlin & Henry, 2008; National Institute on Drug Abuse [NIDA], 2012). In 2007, the estimated economic cost of alcohol abuse and illicit drug use in the United States was $234.8 billion and $193 billion, respectively (National Drug Intelligence Center, 2010; Rehm et al., 2009).

Fortunately, various effective options exist for treating these disorders, including a number of medications that have been approved by the U.S. Food and Drug Administration. These medications include disulfiram and acamprosate for treatment of alcohol dependence; methadone, buprenorphine, and buprenorphine-naloxone for treatment of opioid dependence; and naltrexone (oral and an injectable extended-release formulation) for treatment of alcohol or opioid dependence. This report describes (1) the treatment effectiveness and cost effectiveness of these medications, (2) their current coverage under each Medicaid program, and (3) examples of innovative financing and delivery models used by states to provide the medications to consumers.

A review of Medicaid policies in 2013 revealed that all 51 Medicaid programs include disulfiram and oral naltrexone on their Preferred Drug Lists (PDLs). If a medication is not included on the PDL, the prescriber must obtain permission from the member's pharmacy benefit plan before the product can be prescribed; otherwise, the medication will not be covered. Methadone, acamprosate, and injectable extended-release naltrexone were less widely listed. One explanation for the relatively limited availability of acamprosate and extended-release naltrexone is that these medications are not yet available in generic form. In 2013, only 13 Medicaid programs included all available medications for treating alcohol and opioid use disorders in their Medicaid PDLs.

Many Medicaid programs use **benefit design requirements**, such as *prior authorization*, to contain expenditures and encourage the proper use of medications for the treatment of alcohol and opioid disorders. Research on the use of prior authorization requirements with psychiatric medications—including antipsychotics, antidepressants, smoking-cessation medications, and medications to treat bipolar disorder—has revealed that prior authorization may reduce medication expenditures. However, these requirements can have the unintended consequence of reducing use of medication and access to treatment. Potential barriers to access may be reduced as payers and providers move from a paper-based prior authorization process to an electronic, real-time, standardized process. This process may better integrate into providers' workflow, and it could reduce the time providers and patients must wait to secure authorization. Among the medications we reviewed, prior authorization was used most commonly for

buprenorphine/buprenorphine-naloxone and was employed by 48 Medicaid programs. However, buprenorphine-naloxone recently became available as a generic medication. As a result, some Medicaid programs may relax their prior authorization requirements if cheaper, generic versions of this medication become available.

Step-therapy is a benefit design that requires patients to try a first-line medication, such as a generic medication, before they can receive a second-line treatment, such as a branded medication. Among the medications we reviewed, step therapy was only used for injectable, extended-release naltrexone; this is likely because this medication is more expensive than other medications for alcohol or opioid use.

There are 11 state Medicaid programs that place a *lifetime limit* on the use of buprenorphine-naloxone. Lifetime limits are rarely used for any other type of schedule III medication prescribed to treat a chronic disease. Given that addiction is a chronic disease, lifetime limits are inconsistent with clinical evidence and best practices.

States are using a variety of **innovative approaches** to finance and deliver medications for alcohol and opioid use disorders. For example, Massachusetts is addressing the opioid addiction epidemic by expanding medication access through the use of a *nurse manager model*. This model allows physicians to treat more patients with buprenorphine. Another example is the *Maryland Buprenorphine Initiative*, which significantly reduced opioid treatment waitlists and heroin-related deaths by using a team of health care and social workers. These individuals help patients in treatment at substance abuse specialty programs obtain access to health insurance and primary care providers and referrals to outpatient providers to continue integrated substance abuse and primary care. As a final example, Vermont is developing a regional comprehensive addiction treatment infrastructure, which they describe as a "*Hub and Spoke*" system. *Hubs* are specialty substance abuse centers that provide treatment to complex patients with opioid addiction and serve as a regional coordinating and integrating arm of the system. *Spokes* are teams of providers who serve less medically complex patients.

Medicaid serves over 60 million adult and child beneficiaries annually. An estimated 9–14 percent of Medicaid beneficiaries have a substance use disorder (Adelmann, 2003). Given the important role that medications can play in treating these disorders, it is critical that Medicaid programs continue to develop clinically effective and cost-effective delivery and financing approaches to providing these medications to beneficiaries. The present report can be a resource guide for those efforts.

I. Introduction

Addiction is a chronic, relapsing brain disease that is characterized by compulsive drug or alcohol seeking and use, despite harmful consequences (National Institute on Drug Abuse [NIDA], 1999). Each year, an estimated 85,000 deaths are attributed to the use of alcohol and 17,000 deaths to the use of illicit drugs (Mokdad et al., 2004). Excessive alcohol consumption is associated with multiple adverse health and social consequences, including liver cirrhosis, certain cancers, fetal alcohol spectrum disorder, unintentional injuries, and violent behaviors (Bouchery et al., 2011). The use of illicit drugs has been linked to a variety of adverse health events, including HIV/AIDS, hepatitis and other infectious diseases, prenatal conditions, kidney and liver damage, stroke, and a number of respiratory, cardiovascular, and neurologic disorders (Devlin & Henry, 2008; NIDA, 2012). In 2007, the estimated economic cost of alcohol abuse and illicit drug use in the United States was $234.8 billion and $193 billion, respectively (National Drug Intelligence Center, 2010; Rehm et al., 2009).

Addiction, like many other chronic diseases, is a treatable condition. Treatment enables individuals to counteract addiction's powerful effects on the brain and behavior and allows them to regain control of their lives. There are a variety of evidence-based approaches to treating addiction to alcohol and opioids. Treatment can include behavioral therapy (such as cognitive-behavioral therapy or contingency management), medications, or a combination of approaches. Medications can help individuals with substance use disorders reestablish normal brain functioning, prevent relapse, and reduce cravings (NIDA, 2009). The following medications have been approved by the U.S. Food and Drug Administration (FDA) for treatment of alcohol and opioid dependence:

Alcohol dependence—

- Disulfiram
- Naltrexone (oral)
- Naltrexone extended release (injectable)
- Acamprosate

Opioid dependence—

- Naltrexone (oral)
- Naltrexone extended release (injectable)
- Buprenorphine
- Buprenorphine-naloxone
- Methadone

In 2012, an estimated 23.1 million people aged 12 years or older needed treatment for an illicit drug or alcohol use problem (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013a). SAMHSA found that, of these individuals, 4.0 million received treatment for a problem related to the use of alcohol or illicit drugs. Among those who needed treatment for alcohol or illicit drugs but not did receive it, the most frequently reported reason was that individuals felt they did not need treatment (94.6

percent). Among those who recognized a need for treatment and made an effort to get it, lack of health coverage was the most frequently reported reason for not receiving treatment (38.2 percent).

Health insurance significantly increases access to substance abuse treatment by making it more affordable. Medicaid, in particular, is a critical payment source. Medicaid is one of the largest single payers of medications for treating substance use disorders (Levit et al., 2013).

The primary purpose of this report is to present information about Medicaid coverage of medications used to treat alcohol and opioid use disorders. Medications intended for the treatment of nicotine or tobacco use are not included. The report is divided into three sections:

1. Considerations for covering medications for alcohol and opioid use disorders, including treatment effectiveness and cost effectiveness of the medications
2. Current Medicaid coverage of medications for alcohol and opioid use disorders
3. Examples of innovative coverage and financing models

In addition to describing their treatment and cost effectiveness, the first section reviews policies and regulations that affect the coverage of and access to these medications. The second section describes availability of these medications on Medicaid Preferred Drug Lists (PDLs) for all 50 states and the District of Columbia in 2013, and it explains the different benefit design elements most commonly used for each medication. The third section gives some examples of the way states are using innovative financing and delivery models to achieve positive outcomes.

II. Considerations for Covering Medications for Alcohol and Opioid Use Disorders

Preferred Drug Lists are used by Medicaid agencies to apply scientific evidence to pharmacy benefit management to ensure access to effective medications and restrict inappropriate use. The Medicaid agency's approval process for including new medications on their PDL and for reconsidering existing medications is often conducted through the state's Pharmacy and Therapeutics Committee, although separate drug utilization review committees can contribute to the process. Decisions can take up to 6 months, although priority reviews can be enacted when appropriate. The approval process includes literature and evidence review, efficacy determination, proposed protocol provisions, and safety and cost considerations (American Society of Addiction Medicine [ASAM], 2013).

This section presents topics that the Pharmacy and Therapeutics Committees may consider as they determine whether medications for alcohol or opioid dependence will be available through the Medicaid PDL. In particular, the evidence regarding the treatment efficacy of these medications, their cost effectiveness and cost offset, and the policies and regulations that may impact their coverage in Medicaid are discussed.

A. Efficacy of Medications Used to Treat Alcohol and Opioid Use Disorders

All of the medications reviewed in this section have been approved by the FDA; thus, all have met the FDA requirements for substantial evidence of safety and efficacy. During the approval process, the FDA weighs a medication's risks and benefits. All of the medications discussed below have undergone rigorous evaluation and demonstrated clear evidence of efficacy and safety when used appropriately.

Medications for Alcohol Dependence

The medications currently approved for treatment of alcohol dependence are disulfiram (also available as Antabuse®), oral naltrexone (also available as Revia® and Depade®), injectable extended-release naltrexone (only available as Vivitrol®), and acamprosate (only available as Campral®) (Table 1). Injectable extended-release naltrexone and acamprosate were developed fairly recently compared with the other aforementioned medications, and they are not yet available in generic form. In general, scientific research has found that these medications for alcohol dependence help maintain abstinence, reduce the risk of relapse, and reduce drinking severity.

Table 1. Medications Used to Treat Alcohol Dependence

Medication	Year of First FDA Approval[a]	Mechanism of Action	Is a Generic Version Available?
Disulfiram (Antabuse)	1951	Alcohol antagonist—disulfiram plus alcohol will produce flushing, throbbing in head and neck, headache, nausea, vomiting, and other highly unpleasant symptoms	Yes
Oral naltrexone (Revia, Depade)	1994	Opioid antagonist—blocks opioid receptors that are involved in alcohol and opioid cravings	Yes
Injectable extended-release naltrexone (Vivitrol)	2006	Opioid antagonist—blocks opioid receptors that are involved in alcohol and opioid cravings	No
Acamprosate calcium (Campral)	2004	Possible glutamate antagonist and gamma-aminobutyric acid (GABA) agonist (not fully known)—reduces symptoms of withdrawal and craving	No

[a] For more information on FDA approval of drugs see: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm.

Disulfiram

Disulfiram is the oldest medication used in the treatment of alcohol addiction. Disulfiram works by producing sensitivity to alcohol, which results in a highly unpleasant reaction when the patient ingests even small amounts. These symptoms include flushing, throbbing headache, nausea, vomiting, and other highly unpleasant symptoms (Table 1). In essence, the medication works by punishing subsequent alcohol use for about 24–30 hours.

Research has shown that when disulfiram is taken consistently and under supervision, the medication increases abstinence and decreases the severity of alcohol consumption (Brewer, Meyers, & Johnsen, 2000; SAMHSA, 2009a). The mechanism of action for disulfiram, which is an aversive reaction upon drinking alcohol, may lead to poor adherence. Subsequently, expert consensus recommends using disulfiram only with reliable and highly motivated individuals in monitored situations (where another person administers the medication) or in circumstances where it is necessary to deter an anticipated high-risk situation (Garbutt, 2009; Garbutt, West, Carey, Lohr, & Crews, 1999; Mann, 2004; Suh, Pettinati, Kampman, & O'Brien, 2006).

In 2009, U.S. spending on disulfiram totaled $19.3 million (SAMHSA, 2013b). More information about disulfiram is available on the FDA drug label (http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=f0ca0e1f-9641-48d5-9367-e5d1069e8680).

Naltrexone (oral and injectable)

Naltrexone is an opioid antagonist that is used to prevent the reinforcing effects of alcohol and opioids (Table 1). It may reduce craving and, as a result, reduce the consumption of these substances. The FDA also approved an injectable extended-release formulation of naltrexone (Vivitrol) in 2006. This formulation is more expensive than the oral form, but it is given once every 4 weeks rather than taken daily.

Many literature reviews and meta-analyses of randomized controlled trials have found that the use of naltrexone for alcohol dependence is effective in reducing the number of heavy drinking days (Bouza, Angeles, Munoz, & Amate, 2004; Lobmaier, Kunøe, Gossop, & Waal, 2011; Maisel, Blodgett, Wilbourne, Humphreys, & Finney, 2013; Pettinati et al., 2006; SAMHSA, 2009a; Srisurapanont & Jarusuraisin, 2010). In particular, participants in the studies showed less frequent relapses and significant reductions in heavy or excessive drinking.

In 2009, U.S. spending on naltrexone totaled $22.6 million (SAMHSA, 2013b). More information about oral naltrexone is available on the FDA drug label (http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=49aa3d6d-2270-4615-aafa-b440859ab870). More information about injectable naltrexone is available on the FDA drug label (http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=74696d65-6973-6275-7461-77696e646f77).

Acamprosate

The mechanism of action for acamprosate is still being understood. Acamprosate may be a possible glutamate antagonist and GABA agonist; these substances reduce the symptoms of withdrawal and craving (Table 1).

Acamprosate's efficacy has been shown in short-term and long-term studies. Research shows that acamprosate is effective in increasing the cumulative days of abstinence among individuals with alcohol dependence (Bouza et al., 2004; Maisel et al., 2013; Mann, Lehert, & Morgan, 2004; Rosner et al., 2010, SAMHSA, 2009a). Acamprosate may be more effective among individuals who are motivated for complete abstinence from alcohol and may be more effective when provided over a long period of time.

Brand vs. Generic

Brand-name drugs are patented and marketed by the manufacturer after undergoing extensive research and subsequent FDA approval. Once the patent expires, other manufacturers can produce *generic equivalents*, or *generics*, which are required by the FDA to be therapeutically equivalent to the branded version. Generic equivalents are typically priced much lower than existing brand medications.

Clinical trials in Europe and Asia (Kranzler & Gage, 2008) show more positive outcomes than two major trials in the United States: one by Mason, Goodman, Chabac, and Lehert (2006) and the COMBINE study—a study of combined pharmacotherapies and behavioral interventions (Anton et al., 2006). The discrepancies in efficacy between the U.S. trials and non-U.S. trials—the latter of which comprise the bulk of the trials—have not been fully explained. Some potential explanations may be differences in the

research designs used in the United States versus other countries or differences in the populations that were recruited for these trials.

In 2009, U.S. spending on acamprosate totaled $28.4 million (SAMHSA, 2013b). More information about acamprosate is available on the FDA drug label (http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=1c427b06-32d4-482f-bb83-71e386c1e203).

Medications for Opioid Dependence

Medications currently approved for maintenance treatment of opioid dependence include oral naltrexone (also available but less common as Revia and Depade); injectable extended-release naltrexone (only available as Vivitrol); buprenorphine, buprenorphine-naloxone (also available as Suboxone® or Zubsolv®); and methadone (also available as Dolophine®) (Table 2). Generic versions of buprenorphine and buprenorphine-naloxone were made available in 2009 and 2013, respectively. The only medication for the treatment of opioid dependence that is not available in a generic version is injectable extended-release naltrexone.

Scientific research has established that treatment of opioid addiction with medication increases patient retention in treatment and improves social functioning, and it decreases drug use, infectious disease transmission, criminal activities, and the risk of overdose and death (Connock et al., 2007, Johnson et al., 2000, Kakko et al., 2003, Zaric, Barnett, & Brandeau, 2000).

Naltrexone (Oral and Injectable)

Naltrexone was first approved by the FDA in1984 for treating opioid dependence. Naltrexone is a long-acting opioid antagonist (Table 2). The medication works by displacing any opioids on the patient's opioid receptors and tightly binding to those receptors for 24–30 hours (oral) or up to 30 days (extended release injection). This makes the opioid receptors unavailable for activation should the individual subsequently take any opioid.

Studies have found that naltrexone can be effective in decreasing relapse to illicit opioid use (SAMHSA, 2005); however, this is dependent on adherence to treatment, which is often low for oral naltrexone (Johansson, Berglund, & Lindgren, 2006; Swift, Oslin, Alexander, & Forman, 2011). Displacement of opioid agonist from mu opioid receptors in an individual who is opioid-dependent can result in precipitated opioid withdrawal. In 2010, the FDA approved the extended-release injectable formulation of naltrexone (Vivitrol).

Table 2. Medications Used to Treat Opioid Dependence

Medication	Year of First FDA Approval[a]	Category and Mechanism of Action	Is a Generic Version Available?
Naltrexone – oral	1984	Opioid antagonist—blocks opioid receptors that are involved in opioid's euphoric effect	Yes
Naltrexone extended release – injectable	2010	Opioid antagonist—blocks opioid receptors that are involved in opioid's euphoric effect	No
Buprenorphine-naloxone/ buprenorphine	2002	Partial mu-opioid agonist and kappa-opioid antagonist—compete with other opioids by suppressing withdrawal symptoms and cravings. Naloxone is added to diminish misuse. It has a negative impact when the substance is injected rather than taken sublingually as prescribed.	Yes
Methadone	1947	Full mu-opioid agonist—competes with other opioids by suppressing withdrawal symptoms and cravings	Yes

[a] For more information on FDA approval of drugs see: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm.

Buprenorphine and Buprenorphine-Naloxone

Buprenorphine is a partial mu-opioid agonist and kappa-opioid antagonist (Table 2). Buprenorphine by itself (generic form approved by the FDA in 2009) is indicated for the withdrawal phase of opioid dependence and induction into treatment, although buprenorphine-naloxone can also be used for withdrawal and induction.

Buprenorphine-naloxone is indicated for the treatment of opioid dependence; the generic form was approved by the FDA in 2013 (FDA, 2011a; FDA, 2011b). Buprenorphine sublingual tablets contain no naloxone and are preferred for use only during induction (National Library of Medicine, 2012). Naloxone is combined with buprenorphine to reduce the risk of it being misused or injected for the purpose of creating a euphoric effect. When taken sublingually, naloxone has little effect; however, when injected it can cause a withdrawal syndrome among individuals who are opioid-dependent.

Diversion Potential of Buprenorphine

Policymakers have expressed concern about the potential for abuse of buprenorphine. In making decisions about coverage, it is important to weigh the potential harm from diversion against the consequences of limiting access to effective treatment. Poison centers and emergency departments have reported that, among adults, fewer emergency visits related to buprenorphine reflect life-threatening situations and result in hospital admission than visits related to the use of heroin, methadone, or oxycodone (Bronstein et al., 2009). Buprenorphine-naloxone has also been reformulated to an individually packaged sublingual film version in efforts to reduce its potential for diversion as well as its accidental use by children (Clark & Baxter, 2013).

Spending on Buprenorphine-Naloxone

Much of the recent growth in spending on medications for substance use disorders has been a result of the growth in spending on buprenorphine-naloxone, or Suboxone. This medication was first introduced to the market in 2002 and grew to a spending of $754 million in 2009. This accounted for 85 percent of the expenditures on medications for substance use disorders in 2009. Buprenorphine by itself, or Subutex, accounted for another 7 percent of the medication expenditures in 2009 (SAMHSA, 2013b). The generic forms of buprenorphine and buprenorphine were approved by the FDA in 2009 and 2013, respectively. Spending on these medications may decrease as cheaper, generic forms become available (Grabowski & Vernon, 1992; Saha, Grabowski, Birnbaum, Greenberg, & Bizan, 2006).

A number of comprehensive reviews have concluded that there is a high level of evidence from numerous randomized clinical trials indicating that buprenorphine is a safe and effective treatment for opioid dependence (Barnett, Rodgers, & Bloch, 2001; Mattick, Kimber, Breen, & Davoli, 2008; Thomas et al., 2013). A recent study also explored the effects of tapering off of buprenorphine when treating individuals with prescription opioid dependence. The authors found that people had good outcomes while taking buprenorphine, but relapse rates were high following tapering—even after 12 weeks of treatment (Weiss et al., 2011).

In 2009, U.S. spending on buprenorphine and buprenorphine-naloxone totaled $954.9 million (SAMHSA, 2013b). More information about buprenorphine is available on the FDA drug label (http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=1bf8b35a-b769-465c-a2f8-099868dfcd2f). More information about buprenorphine-naloxone is available on the FDA drug label (http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=17b63f10-c9df-44be-80fa-6f1c305583b8).

Methadone

Maintenance treatment with methadone has been used for many decades in the United States. Pharmacologically, methadone is a long-acting (24–30 hours) opioid agonist; that is, it imitates the action of an opiate such as heroin by occupying and activating the body's opioid receptors (Table 2). Because the medication is taken orally and because it has a slow and very long period of metabolism, it does not generate the extreme euphoria of short-acting, injectable opioids (e.g., heroin or many pharmaceutical opioids) in properly prescribed doses (Rettig & Yarmolinsky, 1995).

A high level of evidence from multiple randomized controlled trials over the past four decades supports methadone maintenance treatment (MMT) as an effective method to reduce craving, use of opioids, and overdose; additionally, MMT usually improves health and social function (Mattick, Breen, Kimber, & Davoli, 2009; SAMHSA, 2005; Sees et al., 2000).

More information about methadone is available on the FDA drug label (http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=e6af84de-cbfc-4a3b-bd73-6bcf77337168).

B. Cost Offset and Cost Effectiveness of Medications for Alcohol and Opioid Use Disorders

In 2007, the estimated economic costs of alcohol abuse and illicit drug use in the United States were $234.8 billion and $193 billion, respectively (National Drug Intelligence Center, 2010; Rehm et al., 2009). Studies have shown that the benefits of substance abuse treatments far outweigh the costs (SAMHSA, 2009b). For every $100,000 spent on treatment, $487,000 of health care costs and $700,000 of crime costs can be avoided (Hartz et al., 1999; NIDA, 1999).

One study examined Medicaid spending in Ohio among adults with a substance use disorder who used a substance abuse treatment service compared with an untreated control group (Gerson et al., 2001). The authors found that the cost of medical use in the untreated group exceeded that of the treated group at every point during the 1-year study period. Another study examined the effect of substance abuse treatment on Medicaid medical care expenditures among clients on welfare in the State of Washington (Wickizer, Krupski, Stark, Mancso, and Campbell, 2006). The results showed that substance abuse treatment was associated with a reduction in medical expenses of approximately $2,500 annually.

Cost offset is defined as the economic savings from an intervention after accounting for the economic costs of that intervention. ***Cost effectiveness*** is defined as the comparison between the costs of the intervention and some positive result from the intervention that is typically quantified in an individual's quality-adjusted life years.

Controlled Substance Schedules

Substances deemed to be "controlled" under the Controlled Substances Act (CSA) are divided into five schedules. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and their likelihood of causing dependence when abused.

Schedule I substances have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

Schedule II substances include methadone and have high potential for abuse, which may lead to severe psychological or physical dependence.

Schedule III substances include buprenorphine and have less abuse potential than those in Schedules I or II. Abuse may lead to moderate or low physical dependence or high psychological dependence.

Schedule IV substances have low abuse potential relative to those listed in Schedule III.

Schedule V substances have low abuse potential relative to those listed in Schedule IV, and they have preparations containing limited quantities of certain narcotics.

Medications for treating opioid use disorders have been found to be cost offsetting and cost effective. One study estimated that, over a lifetime, methadone treatment yielded $37.72 in benefits for each $1 in cost (Zarkin, Dunlap, Hicks, & Mamo, 2005). A separate study found that every dollar invested in methadone treatment resulted in a $4.87 offset in health care costs (Hartz et al., 1999).

One study focusing on cost effectiveness estimated that providing long-term, office-based brand buprenorphine-naloxone treatment for patients with opioid dependence who are clinically stabilized costs $35,100 for every quality-adjusted life year (QALY) saved, and it has a 64 percent probability of being less than the benchmark cost-effectiveness threshold of $100,000/QALY (Schackman, Leff, Polsky, Moore, & Fiellin, 2012).

A systematic review of the literature on the costs, cost savings, and cost-effectiveness of medications for treating alcohol dependence found that pharmacotherapy treatment of alcohol dependence produced marked economic benefits (Schwappach et al., 2012). One of these studies was a large randomized controlled trial in the United States, which found that medical management in conjunction with naltrexone therapy or naltrexone and acamprosate therapy were more cost effective than all other treatments evaluated (Zarkin et al., 2008). The intervention treatment groups in this study included a behavioral intervention, medical management plus behavioral intervention, and medical management in combination with naltrexone, acamprosate, both drugs, or placebo. The authors of this study found meaningful increases in abstinence and reductions in heavy drinking for every dollar spent on treatment with naltrexone. These authors also conducted a follow-up study estimating the effect of these interventions on overall social costs, including treatment costs from health care utilization, arrests, and motor vehicle accidents. The groups that received an alcohol pharmacotherapy had significantly lower median costs relative to the placebo group; these median cost differences were $2,500 to $3,800 less than the median costs of the placebo group (Zarkin et al., 2010).

A separate study found that patients who received alcoholism medications had fewer inpatient detoxification days, alcoholism-related inpatient days, and alcoholism-related emergency department visits than similar patients with a diagnosis of alcohol dependence who did not fill any prescriptions for alcohol medications (Mark, Montejano, Kranzler, Chalk, & Gastfriend, 2010).

C. State and Federal Regulations Affecting the Prescription and Dispensing of Medications for Alcohol and Opioid Use Disorders

Medications for treatment of alcohol and opioid use disorders must be prescribed or dispensed by individuals who are licensed to perform these activities in each state; however, additional rules and regulations apply to methadone and buprenorphine because they are controlled substances under the Comprehensive Drug Abuse Prevention and Control Act. The rules and regulations impact access to these medications even when they are covered by insurance.

Methadone is a schedule II drug. Therefore, for the purpose of treating opioid addiction, it must be dispensed by an opioid treatment program (OTP) that has been certified by SAMHSA and registered as a narcotic treatment program by the U.S. Drug Enforcement Agency (DEA) (Department of Justice, 2007; SAMHSA, 2004). Physician assistants or nurse practitioners may also dispense methadone or buprenorphine to a patient under the direction of the OTP medical director who is certified by SAMHSA and registered with the DEA, as long as this activity is consistent with state law. Buprenorphine is a schedule III drug. As a result of the Drug Addiction Treatment Act of 2000, physicians outside of opioid treatment programs can prescribe it to patients if they have registered with the DEA after completing a waiver notification with SAMHSA and completing opioid treatment training (SAMHSA, n.d.). Table 3 summarizes these federal restrictions.

Table 3. Federal Prescribing Regulations for Medications Used to Treat Alcohol and Opioid Use Disorders

Medication	Federal Restrictions
Disulfiram	Can be prescribed by a licensed health care professional or practitioner
Acamprosate	Can be prescribed by a licensed health care professional or practitioner
Naltrexone	Can be prescribed by a licensed health care professional or practitioner
Buprenorphine-naloxone/ buprenorphine	Limits office-based use to physicians who complete special training, submit a waiver notification to SAMHSA, and (upon approval) are given a modified registration number by the DEA
Methadone	Can only be dispensed by a SAMHSA-certified opioid treatment program that has been registered as a narcotic treatment program by the DEA

Additional policies affect access to medications for alcohol and opioid use disorders. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires that the cost-sharing and treatment limitations (both quantitative and nonquantitative) for medications used to treat substance use disorders, if covered by a health plan, must be comparable to and no more restrictive than medications for other medical or surgical needs (Center for Consumer Information and Insurance Oversight, 2013a). This MHPAEA requirement is satisfied if health plans use a tiered formulary, where different financial requirements and treatment limits are imposed uniformly for different tiers of drugs based on factors unrelated to diagnosis, such as the cost and efficacy of the drug (Department of the Treasury, 2010). The MHPAEA regulations pertain to nonfederal government plans with more than 100 employees and group health plans of private employers with more than 50 employees (Center for Consumer Information and Insurance Oversight, 2013a). The Centers for Medicare & Medicaid Services (CMS) recently provided guidance that clarifies how the MHPAEA requirements are to be applied to the Children's Health Insurance Program, Medicaid benchmark benefit plans, and Medicaid managed care plans (CMS, 2013).

Under the Affordable Care Act, prescription drug benefits are essential health benefits that must be covered under the health insurance marketplaces (Center for Consumer Information and Insurance Oversight, 2013b). All benchmark plans must cover one drug in every United States Pharmacopeia (USP) therapeutic category and class. The medications discussed in this report are included in the USP category of *Anti-Addiction/Substance Abuse Treatment Agents*. Within this USP category, these medications fall into a number of USP classes, including *Alcohol Deterrents/Anti-Craving* and *Opioid Antagonists*. For example, benchmark plans are required to cover at least one drug in the *Alcohol Deterrents/Anti-Craving* USP class, which includes acamprosate, disulfiram, or naltrexone (U.S. Pharmacopeial Convention, 2013). The final

rules for the regulation specify, however, that health plans providing the essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs that are not covered by the health plan (Department of Health and Human Services, 2013).

III. Medicaid Coverage of Medications for Alcohol and Opioid Use Disorders

This section summarizes Medicaid coverage policies for medications used to treat alcohol and opioid use disorders in the United States and the District of Columbia. Information is presented about whether a medication is included on Medicaid Preferred Drug Lists. Requirements for prior authorization, quantity limits, treatment limits, step therapy, and concurrent behavioral therapy are also described.

Data Sources

To obtain information on coverage, we used various data sources. The most recent Medicaid pharmacy documents were retrieved from Medicaid and state government websites and examined for information related to coverage and financing. Further internet queries were conducted within Medicaid and state government sites for documents containing information on maximum allowable costs, prior authorization forms, and online drug search tools. The list of documents used for this review can be found in Appendix A, Table A-1.

A large number of the Medicaid pharmacy documents do not mention medications for treatment of alcohol dependence; therefore, this information was further supplemented by 2011 and 2012 Medicaid State Drug Utilization Data (CMS, n.d.). These data include a count of the number of medications for alcohol and opioid use disorders that are paid by Medicaid during one quarter for each year. If the Medicaid programs paid for an alcohol or opioid use disorder medication during the reported quarter of either 2011 or 2012, then the state was classified as covering the drug. Medicaid pharmacy documents also provided added insight into pharmacy benefit design. Greater details on the benefit design within each state are outlined in the footnotes to the tables in Appendix A.

A third data source was a recent report sponsored by the American Society of Addiction Medicine (ASAM, 2013). This report surveyed Medicaid directors and asked them about coverage of medications for opioid dependence. We used this report to determine state coverage of methadone for opioid dependence and prior authorization requirements for the other medications discussed in this report. Our findings on methadone coverage were based solely on the results of this survey, because it explicitly asked respondents about coverage for opioid addiction. Generally, methadone prescribing for opioid addiction is not covered in the Medicaid State Drug Utilization data. Many state documents were also unclear about whether methadone was covered for chronic pain or opioid addiction, and the ASAM study only captured coverage details regarding opioid addiction. If a state did not respond to this survey, Medicaid prescription documents were used.

The data from these three sources were reconciled, and the results are outlined by each drug and state in Appendix A. In general, we used the survey responses and Medicaid reimbursements as the first source and the pharmacy documents as a secondary source. If a survey respondent from the ASAM study said that the medication was covered, this was accepted as true even if no reimbursement for the drug was found in the two sampled quarters of the Drug Utilization files. If a respondent was uncertain of coverage or said it

was not covered and there was reimbursement for that drug in 2011 or 2012, then the drug was considered covered.

Benefit Design Elements

Common Medicaid benefit design elements and their respective definitions are listed below.

Preferred Drug List (PDL) is a list of the drugs that providers are permitted to prescribe without seeking prior authorization. If a drug is not included on the PDL, the provider must obtain approval from the state Medicaid agency before the drug can be dispensed.

Prior Authorization requires that a prescriber must obtain permission from the pharmacy benefit plan prior to prescribing a product to a member. Without permission, the product will not be covered. Some prior authorization forms require the prescribing medical provider to have referred the patient to concurrent behavioral therapy. Requirements for behavioral therapy may also be imposed by the payers through clinical edits.

Clinical (point-of-sale) edits is a generic term for a variety of reviews that are conducted, often at the benefit plan and pharmacy levels, to help ensure the therapeutically prudent use of pharmaceutical products as well as the optimization of benefit program funds.

With *drug utilization reviews*, claims processors match information on claims against a clinical database and a member's prior pharmacy history in order to assess clinical issues with prescriptions, duplication of therapy, and compatibility. These reviews can stop prescriptions from being filled until the prescriber corrects a discrepancy, or they will prompt a warning to the pharmacist before dispensing.

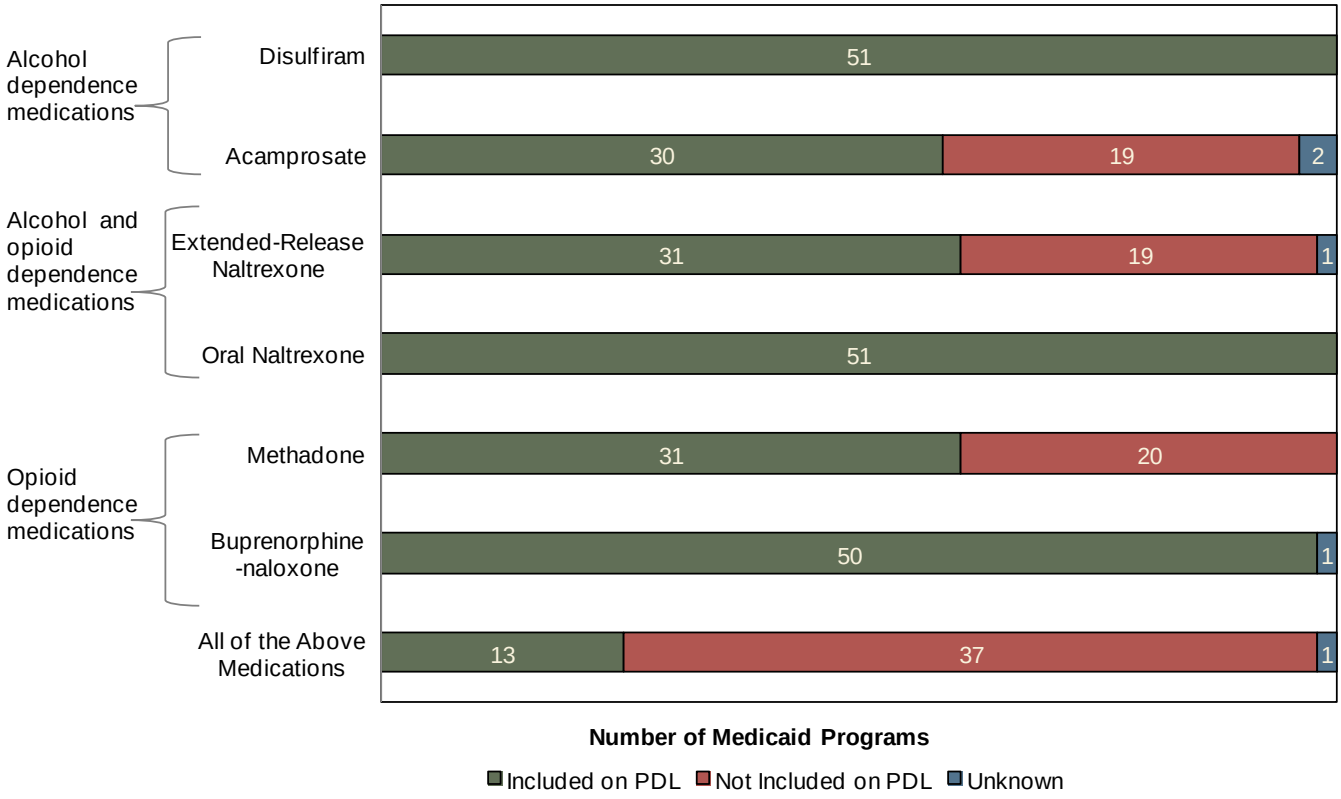
Quantity level limits define the maximum quantity of medication that is covered for one prescription or copayment. Typically, a prescription may only be for a 30-day supply or (in the case of mail-order) a 90-day supply.

Step therapy occurs when a claims processor must verify that the patient first tried a more cost-effective medication before filling a more expensive alternative. If the first-line treatment was ineffective or not tolerated by the patient, the "next step up" may be authorized.

A. Inclusion of Medications for Alcohol and Opioid Use Disorders on Medicaid Preferred Drug Lists

Figure 1 provides a summary of the number of Medicaid programs that include medications for alcohol and opioid use disorders on their respective PDLs. Overall, only 13 state Medicaid programs included all medications on their PDLs. All 51 Medicaid programs included disulfiram and oral naltrexone on their PDLs, whereas buprenorphine-naloxone was available on 50 PDLs. The three drugs with the least coverage across Medicaid programs were acamprosate, extended-release naltrexone, and methadone for the purpose of treating opioid addiction. Acamprosate and extended-release naltrexone are not yet available in generic versions, which may explain why they are less frequently included in PDLs.

Figure 1. Availability of Medications for Alcohol and Opioid Use Disorders on Medicaid Preferred Drug Lists, 2011–2013



Sources: State documents listed in Appendix A, the 2011 and 2012 Medicaid state drug utilization data, and ASAM 2013

Organizational Benefit Silos

One challenge to establishing a benefit design for medications to treat alcohol and opioid use disorders is that the medications can involve four different Medicaid operations: opioid treatment programs, pharmacy benefits, medical benefits, and pharmacy contracting. These areas often function independently in their decision systems, staffing, and approval process (ASAM, 2013).

B. Medicaid Benefit Limits on Medications for Alcohol and Opioid Use Disorders

Medicaid programs have used various techniques in their benefit designs to try to constrain costs and encourage the proper use of medications for alcohol and opioid use disorders. The most common techniques found in this study are outlined in Table 4. In general, more management techniques were used for medications to treat opioid use disorders than those to treat alcohol use disorders.

Prior authorization was frequently required in Medicaid programs for medications to treat opioid and alcohol use disorders. Among the Medicaid programs with available information on benefit design, prior authorization for buprenorphine-naloxone was required by 48 Medicaid programs. Prior authorization for injectable extended-release naltrexone and oral naltrexone was used in over one-quarter of all Medicaid programs. A few programs required prior authorization for disulfiram (5 states) and acamprosate (5 states).

A number of states also required evidence that the patient was being referred to or receiving behavioral therapy with their medications. These requirements almost exclusively applied to medications for opioid use disorders. Documentation of behavioral therapy was required by 21 programs for buprenorphine-naloxone, 15 programs for methadone, and 15 programs for injectable extended-release naltrexone.

Quantity limits are often used by Medicaid programs. Quantity limits for disulfiram, acamprosate, oral naltrexone, and injectable extended-release naltrexone were present in less than 10 percent of states. Quantity limits for buprenorphine-naloxone were used by 34 Medicaid programs.

In addition to quantity limits, some states established lifetime treatment limits specifically for buprenorphine-naloxone. Four states (District of Columbia, Illinois, Michigan, and Washington) established a 1-year limit in total length of treatment with buprenorphine-naloxone, six states (Arkansas, Maine, Mississippi, Montana, Virginia, and Wyoming) established a 2-year treatment limit, and one state (Utah) established a 3-year treatment limit. This benefit design element is one that should be carefully considered by payers, because it can impose significant challenges for individuals with opioid use disorders. Opioid addiction is a chronic disease; as a result,

Substance Abuse Relapse: Just Like Other Chronic Diseases

Substance abuse treatment, including medication therapy, enables people to counteract the powerfully disruptive effects of addiction on the brain and behavior and to regain control of their lives. However, the chronic nature of the disease means that relapse is likely. Studies have found that 1 year after discharge from treatment programs, 40 percent to 60 percent of individuals relapse in using alcohol or illicit drugs (McLellan, Lewis, O'Brien, and Kleber, 2000). This is similar to the 30 percent to 50 percent relapse rate for adults with diabetes and to the 50 percent to 70 percent relapse rate of adults being treated for hypertension or asthma (McLellan et al., 2000).

individuals remain at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences (McLellan, Lewis, O'Brien, & Kleber, 2000; NIDA, 1999).

Injectable extended-release naltrexone was the only medication for which Medicaid programs used step therapy (six states). This may be due to the fact that injectable, extended-release naltrexone is a relatively expensive medication.

Table 4. Medicaid Benefit Design Elements for Medications Used to Treat Alcohol and Opioid Dependence Among the States and the District of Columbia, 2011–2013

Medication	Available Information on Benefit Design	Design Type and Number of Medicaid Programs											
		Medication Available on Medicaid Preferred Drug List		Prior Authorization Required		Behavioral Therapy Required		Quantity Limits[a]		Lifetime Treatment Limits[b]		Step Therapy Used	
	N	n	% of N	n	% of N	n	% of N	n	% of N	n	% of N	n	% of N
Disulfiram	41	40	98	5	10	0	0	3	7	0	0	0	0
Acamprosate	31	31	100	5	16	1	3	2	6	0	0	0	0
Naltrexone - oral	42	42	100	12	29	1	2	3	7	0	0	0	0
Naltrexone - injectable	28	25	89	12	46	15	64	3	11	0	0	6	25
Methadone	51	31	61	13	25	15	29	10	20	0	0	0	0
Buprenorphine-naloxone	50	50	100	48	96	21	42	34	68	11	22	0	0

[a] *Quantity level limits* define the maximum quantity of medication that is covered for one prescription or copayment. Typically, a prescription may only be for a 30-day supply or, in the case of mail-order, for a 90-day supply. They do not include lifetime treatment limits.

[b] *Lifetime limits* are limits on the total length of time that that an individual can receive medications while enrolled in Medicaid.

Sources: State documents listed in Appendix A, the 2011 and 2012 Medicaid state drug utilization data, and ASAM 2013

IV. Innovative Coverage and Financing Models

This section expands upon how Medicaid programs are covering and financing medications for alcohol or opioid use disorders. It also highlights innovative state models for achieving treatment-effective and cost-effective results. Finally, this section describes initiatives in three states and a number of other cross-cutting best practices.

A. Maryland: A Comprehensive Approach to Increasing Access to Individualized Addiction Treatment with Buprenorphine and Counseling

The State of Maryland Buprenorphine Initiative is based on work that was conducted by the City of Baltimore. Heroin addiction was a major public health issue in Baltimore City. It contributed to high rates of HIV infection, crime, unemployment, and other health-related comorbidities. Data from police records and the criminal justice system confirmed a strong relationship between crime and substance use, particularly heroin. Data from the Department of Juvenile Services also highlighted that the drug market was a major factor contributing to the rise in youth violence and crime. Despite the large toll that heroin was taking on Baltimore city, the availability of substance abuse treatment remained inadequate.

Starting in 1998, the city, state leaders, and local foundations renewed efforts to expand access to drug abuse treatment to reduce the impact of heroin and other drug addiction. Although these efforts increased treatment capacity for methadone, the demand for treatment continued to significantly outweigh supply. Waiting lists at methadone clinics stretched from weeks to months (Olsen, 2011; Oros, 2008).

The Baltimore Buprenorphine Initiative was implemented in 2006 with the goal of expanding access for residents addicted to heroin and other opioids to individualized addiction treatment with buprenorphine and counseling.

Summary of Maryland Buprenorphine Treatment Model

Key Features

- Collaborative initiative to increase access to office-based opioid treatment with buprenorphine through linkage to federally qualified health centers (FQHCs)
- Use of treatment advocates and case managers to facilitate buprenorphine utilization

Financing

- Medicaid reimbursement for buprenorphine and outpatient substance abuse treatment, including comprehensive medication-assisted services

Organization

- Case managers assist patients in transitioning from a specialty substance abuse program to maintenance with a primary care physician.
- Established physician training is needed to prescribe buprenorphine.

Management

- Bureau of Substance Abuse Services created guidelines, protocols, and an information resource website.
- Baltimore City Health Department sponsored physicians to complete training to receive waivers.

Monitoring

- Conducted through select client outcome measures, such as University of Rhode Island Change Assessment (URICA) and Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

Buprenorphine was approved by the FDA in 2000. The passage of the Drug Addiction Treatment Act of 2000 offered opportunities for increased treatment access by allowing qualified physicians to provide buprenorphine in settings other than those providing traditional opioid treatment programs (e.g., methadone clinics). Settings were expanded to other locations, such as physician offices.

Although Maryland added buprenorphine to its Medicaid PDL in 2003, use of the medication was still low in 2005, and treatment need still was not being met. This was, in part, because few physicians in Baltimore had obtained the waiver needed to prescribe buprenorphine. Additionally, lack of insurance coverage was a significant barrier. The Baltimore Program Initiative aimed to address these barriers.

The program has three main steps (Baltimore City Health Department, Baltimore HealthCare Access, Inc., and Baltimore Substance Abuse Services, Inc, June 2008):

Step 1. Patient Starts Buprenorphine in a Substance Abuse Treatment Program. When a patient first seeks treatment, he or she enters a specialty substance abuse treatment program. During this treatment, the patient is inducted on buprenorphine under direct observation while also receiving intensive or standard outpatient counseling as clinically indicated.

Step 2. Patient Transitions to the Medical System. While the patient is receiving treatment in a substance abuse treatment program, a social worker from Baltimore Healthcare Access, Inc. assists the patient with locating appropriate health insurance and other social services. Most patients are eligible for Maryland's Medicaid program, which offers coverage for outpatient substance abuse treatment as well as buprenorphine. As the patient stabilizes over 2 to 4 months, the social worker helps the patient find a primary care provider in the medical system. Patients are considered ready to transfer to a primary care provider when they are stable on a consistent dose of buprenorphine, have negative drug tests, and have health insurance that will cover the cost of their treatment in the medical system.

Step 3. Patient Continues to Receive Buprenorphine from His or Her Physician. After transfer, the patient sees his or her physician for medical care and continued buprenorphine treatment. The patient can also receive at least another 3 months of counseling at his or her original treatment site and can continue to receive another 3 months of case management services from the social worker.

Rigorous studies of the Baltimore Buprenorphine Initiative found that:

- After the program was introduced in 2006, the number of heroin overdose deaths in Baltimore decreased from 184 to 118 in 2009. The total number of patients in buprenorphine treatment in Baltimore also increased from 1,795 to 7,479 during this period (Schwartz et al., 2013).
- Long waiting lists for opioid treatment were eliminated (ATForum, 2011).

In 2009, the Baltimore initiative was expanded across the state. The key steps in planning and development of the statewide expansion included:

- Assessment of need among Maryland counties
- Assessments of system capacity
- Identification of provider partners in the counties
- County and provider training, including free web-based training for physicians to receive waivers necessary to prescribe and treat individuals with buprenorphine
- A state-automated record-tracking system, which allowed Maryland to track access to buprenorphine and its impact on prevalence of opioid dependence in the expansion counties.

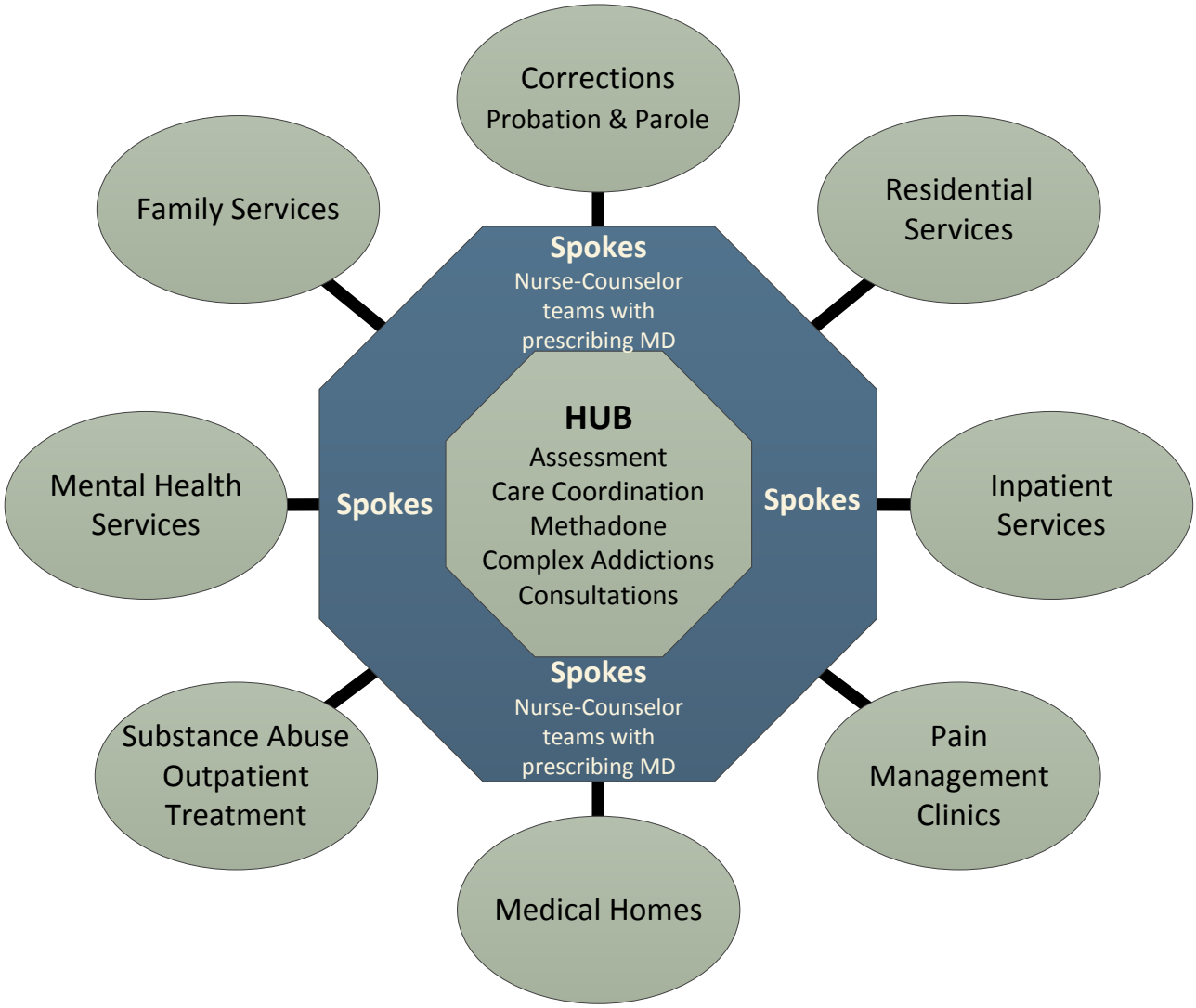
B. Vermont: Establishing a More Robust and Connected Substance Abuse Treatment System

Vermont recognized that access to opioid treatment was inadequate and that opioid treatment providers were working in relative isolation from in each other and with limited interface with primary care and mental health providers. In response, Vermont began to develop a regional comprehensive addiction treatment infrastructure. The program is described as a "*Hub and Spoke*" system.

Each center, or *Hub*, serves a geographic area and provides comprehensive addictions and co-occurring mental health treatment services to Vermont residents with opioid dependence. In addition, these specialized centers assure the provision of integrated health care, recovery supports, and rehabilitative services in coordination with medication treatment and counseling to assure a "whole-person" approach to treatment of substance use disorders.

Less clinically complex patients who require substance abuse medications but are not best suited for methadone receive treatment within what Vermont calls the *Spoke* system. A *Spoke* is composed of a designated provider (the prescribing physician) and a team of collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, and provide counseling, contingency management, and case management services (i.e., a Community Health Team) (Department of Vermont Health Access, 2012; Vermont Agency of Human Services, 2012). A spoke may consist of entities such as primary care medical homes, federally qualified health centers, independent physicians (and psychiatrists), or specialty clinic-based outpatient substance abuse treatment providers (see Figure 2).

Figure 2. Vermont Hub and Spoke System



Note: Adapted from Vermont Agency of Human Services (2012)

C. Massachusetts: Nurse Care Management Model for Buprenorphine

Massachusetts Medicaid (MassHealth) covers a relatively robust array of substance abuse treatment services, including methadone treatment, acute inpatient treatment services, outpatient counseling, case consultation, special services for pregnant women, and treatment by nurse practitioners, physician assistants, and registered nurses. MassHealth's medication benefits include coverage for all medications indicated for the treatment of substance use disorders.

Although Massachusetts covered treatment with Medicaid, treatment programs were experiencing waiting lists of more than 300 people as the opioid epidemic was continuing to grow throughout the state (LaBelle, 2010). A physician survey found that one consistently cited barrier to outpatient buprenorphine treatment expansion was a lack of adequate clinical support to meet the patient need.

Massachusetts began a "nurse management" program to address this problem. Under the program, the nurse does the majority of the up-front assessment, education management, referral to addiction treatment (as needed), adherence monitoring, paperwork to get the patient into care, and communication with prescribing physicians, addiction counselors, and pharmacists. This allows the physicians, who have obtained waivers to prescribe buprenorphine, to manage a larger group of patients.

In a pilot study conducted to evaluate a model that included a full-time nurse program director, nurse care managers, a program coordinator, and a generalist physician (Alford et al., 2011), the nurse program director provided oversight of the nurse care managers and program coordinator and interfaced with the physicians who conducted physical examinations and prescribed buprenorphine. The program coordinator conducted all intake procedures. Patients interacted with the nurse care managers on a daily basis, either in the office or by telephone, as per federal regulations related to administering and monitoring the use of buprenorphine. All of the nurse care managers completed a one-day buprenorphine training program. Results of the initial pilot effort suggest that the model allowed waivered physicians to spend their time more efficiently with each person receiving treatment, thereby increasing patient access to buprenorphine in an office-based setting (Alford et al., 2011). This pilot evaluation paved the way for statewide expansion of the program.

Based on the success of the pilot effort, the Massachusetts Department of Public Health developed guidelines so that community health centers (CHCs) might implement the same model of care (Massachusetts Department of Public Health, 2013). Sites were held accountable through visits by state representatives to ensure that proper protocols were in place and were being followed in accordance with the written guidelines.

A critical element in obtaining financing for buprenorphine treatment in Massachusetts was a cost study conducted by the Massachusetts Department of Public Health (MADPH). The study took place after full implementation of the office-based opioid treatment with buprenorphine (OBOT-B) nurse care manager initiative, in which approximately 16 CHCs participated. MADPH funding was available initially for 3 years and was renewable for up to 7 years in total. MADPH block grant funding covered nonbillable services, including the salary of a full-time registered nurse, staff training, and technical support on the implementation of the new protocols for each qualifying program. The Massachusetts Bureau of Substance Abuse Services worked with Massachusetts Medicaid on guidelines for billing related to medications for substance use disorders under the this new model of care provision (LaBelle, 2010). In the course of the first 5 years of funding, a cost study was implemented to determine how many patients in OBOT-B the nurse care managers needed to cover their salaries. The findings of the cost study indicated that a CHC could fully fund the salary of a nurse care manager with a caseload of 100 patients, which was achievable in most of the CHC participating programs. Massachusetts was able to expand OBOT-B to additional health centers and to move toward self-sustained financing for the program. This approach may lead to additional savings for MassHealth as they become a more active purchaser of office-based opioid treatment with buprenorphine.

D. Cross-Cutting Best Practices

In this section, we discuss two aspects of benefit design that may help to increase access to substance abuse medications: eliminating lifetime limits and creating electronic, real-time, standard, prior authorization protocols.

Although the majority of Medicaid programs examined in the present study did not impose lifetime limits on the use of medications for alcohol and opioid use disorders, 11 states had lifetime limits on buprenorphine. We found no examples where formularies placed lifetime limits on the use of other schedule III medications, which include hydrocodone, phenylephrine, testosterone, codeine, and butalbital. Substance abuse is a chronic, relapsing disease similar to diabetes or asthma. A lifetime limit for opioid treatment is inconsistent with evidence and best practices. For example, a randomized multisite study found that the rate of unsuccessful outcomes if buprenorphine-naloxone was stopped after a 12-week treatment course exceeded 90 percent (Weiss et al., 2011).

Prior authorization is a common benefit design element, particularly for buprenorphine-naloxone. The prior authorization and subsequent reauthorizations of buprenorphine-naloxone may require various types of documentation. Some states require more extensive documentation than others. These requirements may include documentation of the patient's opioid addiction, drug screening tests, supplemental behavioral therapy, tapering plans, or a specific plan for following up with the patient (e.g., frequency of office visits) (see Appendix A, Additional Specifications to Table A-8 for some of the prior authorization requirements).

Although these requirements aim to ensure the proper use of buprenorphine-naloxone, they often delay access to treatment and add significant provider burden. The end result is often that the patient does not receive any medication (ASAM, 2013).

Effects of Prior Authorization on Medication Use and Costs

Research is limited regarding the impact of prior authorization (PA) on medications for alcohol and opioid use disorders. However, a number of studies have examined the effect of PA on medications to treat other chronic conditions.

Research on the effect of PA on antipsychotics to treat schizophrenia or bipolar disorder shows that PA policies lead to higher rates of treatment discontinuation and hospitalization and may present barriers to access (Abouzaid et al., 2010; Brown, Barrett, Caffery, Hourihan, & Ireys, 2013; Lu et al., 2011; Zhang, Adams, Ross-Degnan, Zhang, & Soumerai, 2009). Formulary restrictions on atypical psychotics have also been associated with higher total medical expenditures and higher social costs among Medicaid patients with schizophrenia and bipolar disorder; these higher costs may offset any savings in pharmacy costs (Seabury et al., 2014).

Vogt and colleagues (2011) found that PA requirements on second-generation antipsychotics resulted in reduced use of the atypical antipsychotics as well as a spillover effect of reduced use of all antipsychotics.

Payers are moving toward a system of real-time, standardized prior authorization at the point of care that may reduce interruptions to patient flow or access to medications. One example is the electronic prior authorization system now being used by CVS Caremark (http://www2.caremark.com/epa). Standard

operating rules concerning prior authorization for all medications, including buprenorphine, should improve access to medications used to treat alcohol and opioid use disorders.

V. Conclusion

As Medicaid programs continue to assess the needs of individuals with alcohol and opioid use disorders in their states, this report can be a resource guide for developing beneficial medication coverage and financing policies. In addition to the information provided in the narrative, the appendices can be used to compare individual state policies.

A large body of research emphasizes that disulfiram, acamprosate, naltrexone (oral and injectable), buprenorphine, buprenorphine-naloxone, and methadone are effective medications for addressing the chronic needs of individuals with alcohol and opioid use disorders. Numerous randomized controlled trials and studies using other research designs show that they are effective in improving many aspects of the quality of life of individuals receiving the treatment. Studies have also shown that these medications are cost effective and typically can pay for themselves.

Currently, only 13 state Medicaid programs include all of the available medications used to treat alcohol and opioid disorders on their Preferred Drug Lists. Some medications are included on the PDLs of every state; others, such as acamprosate, injectable extended-release naltrexone, and methadone, are less frequently covered. Therefore, there are opportunities for state Medicaid programs to expand their inclusion of these medications.

Many Medicaid programs use benefit design requirements, such as prior authorization, to contain expenditures and encourage the proper use of medications for the treatment of alcohol and opioid disorders. These requirements may reduce a patient's access to treatment and result in poorer health and economic treatment outcomes. Research on the use of prior authorization with psychiatric medications—including antipsychotics, antidepressants, and medications to treat bipolar disorder—has revealed that prior authorization can reduce medication expenditures. However, prior authorization can also have the unintended consequence of reducing use of the medication and access to treatment. Potential barriers to access may be reduced as systems move from paper-based prior authorization to an electronic, standardized process.

Most benefit design restrictions currently employed by states are for medications to treat opioid use disorders. For example, prior authorization is required for the use of buprenorphine-naloxone in 48 of the 51 Medicaid programs. A number of states also have exclusive lifetime limits on the use of buprenorphine-naloxone, even though the scientific literature shows that an opioid use disorder is a chronic disease. Lifetime limits are rarely used for any other type of schedule III medication prescribed to treat a chronic disease, and such limits on addiction medications appear to be inconsistent with clinical evidence and best practices.

This report presents innovative coverage and financing approaches that are being used to ensure cost-effective and treatment-effective outcomes in some states. Massachusetts provides an example of how treatment to address the opioid addiction epidemic can be expanded by using a nurse manager model, which frees physicians to treat more patients with buprenorphine. The Maryland Buprenorphine Initiative

significantly reduced opioid treatment waitlists and heroin opioid deaths by using a team of health care workers. The team includes a social worker that helps patients in short-term treatment at a substance abuse specialty facility access health insurance and a primary care provider. The social worker also facilitates treatment referral to outpatient providers for continuation of integrated care. Finally, Vermont has established health homes and bundled payments to facilitate more coordinated and comprehensive treatment of opioid use disorders. All of these states are using Medicaid to finance substance abuse services and medications. As Medicaid programs consider these and other innovative coverage and financing approaches, they can effectively reduce costs and improve the quality of life for individuals with opioid and alcohol use disorders.

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Appendix A. Coverage of Medications for Alcohol and Opioid Use Disorders by State

Table A-1. State Medicaid Documents Used to Identify Medication Coverage for Alcohol and Opioid Use Disorders

State	Effective Date	Document Name	Link
Alabama	4/1/2014	Alabama PDL	Link
Alabama		epocrates online - Alabama Medicaid	Link
Alaska	7/9/2012	Alaska PDL	Link
Alaska	1/2013	Suboxone/Subutex PA form	Link
Arizona	1/4/2011	Fee-For-Service Program Drug List (ADL)	Link
Arizona	2/24/2004	Fee-For-Service Provider Manual	Link
Arkansas	4/29/2014	Arkansas PDL	Link
Arkansas	1/18/2013	Prescription Drug Prior Authorization (PA) Form	Link
California	2/1/2012	Contract drug list	Link
California		epocrates online - Medi-Cal Contract Drug List	Link
Colorado	4/1/2014	Colorado PDL	Link
Colorado		Prior authorization form	Link
Colorado		epocrates online - Colorado Access Medicaid	Link
Connecticut	1/2/2014	Connecticut PDL	Link
Connecticut	4/1/2014	Connecticut MAC list	Link
Delaware	2/4/2014	Delaware PDL	Link
D.C.	3/18/2014	District of Columbia PDL	Link
D.C.		epocrates online - District of Columbia Medicaid	Link
D.C.	7/25/2008	District of Columbia Medicaid	Link
D.C.	10/1/2010	Suboxone PA form	Link
Florida	5/14/2014	Florida PDL	Link
Florida		Suboxone/Subutex PA form	Link
Georgia	4/29/2014	Georgia PDL	Link
Georgia	12/22/2010	Methadone PA Summary	Link

State	Effective Date	Document Name	Link
Hawaii	4/1/2012	Hawaii PDL	Link
Idaho	1/7/2014	Idaho PDL	Link
Idaho	5/6/2014	Average Actual Acquisition Cost (AAAC) for Brand Drugs	Link
Illinois	4/1/2014	Illinois PDL	Link
Illinois		Illinois Drug Prior Approval Program	Link
Illinois		Suboxone/Buprenorphine PA form	Link
Indiana	5/1/2014	Indiana PDL	Link
Indiana	3/1/2014	Indiana state MAC list	Link
Indiana	5//2014	Suboxone/Subutex Initiation Prior Authorization Form	Link
Iowa	6/1/2014	Iowa PDL	Link
Iowa		epocrates online - Iowa Medicaid PDL	Link
Kansas	5/1/2014	Kansas PDL	Link
Kansas	1/1/2013	Suboxone/Subutex PA form	Link
Kansas	4/13/2013	Kansas Medicaid MAC	Link
Kentucky	5/14/2014	Kentucky PDL	Link
Kentucky	11/9/2012	Quantity Limits	Link
Kentucky		epocrates online - Kentucky Medicaid	Link
Louisiana	7/1/2012	Louisiana PDL	Link
Louisiana	2/14/2013	Suboxone/Subutex PA form	Link
Maine	4/1/2014	Maine PDL	Link
Maryland	1/1/2014	Maryland PDL	Link
Maryland	11/1/2012	Quantity Limits	Link
Maryland		epocrates online - MD Medicaid (fee for service)	Link
Massachusetts	4/28/2014	Masshealth drug list	Link
Michigan	2/5/2013	MAC pricing	Link
Minnesota	5/2014	Minnesota PDL	Link
Minnesota	4/17/2014	Drugs requiring PA	Link
Minnesota	5/12/2014	Minnesota Medicaid MAC	Link
Mississippi	4/1/2014	Mississippi PDL	Link

State	Effective Date	Document Name	Link
Missouri	5/5/2014	Pharmacy page	Link
Missouri		epocrates online - Missouri HealthNet	Link
Montana	4/25/2014	Pharmacy manual	Link
Montana		Suboxone/Subutex PA form	Link
Nebraska	2/18/2014	Nebraska PDL	Link
Nebraska	5/2014	MAC pricing	Link
Nebraska		Nebraska Drug Lookup	Link
Nevada	3/25/2013	Nevada PDL	Link
Nevada	3/5/2011	PA form	Link
Nevada	4/16/2014	Nevada MAC list	Link
New Hampshire	8/30/2012	New Hampshire PDL	Link
New Hampshire		New Hampshire Medicaid	Link
New Jersey	10/1/2013	New Jersey PDL	Link
New Jersey		epocrates online - Amerigroup Community Care NJ	Link
New Mexico	5/1/2014	MAC list	Link
New Mexico		epocrates online - Amerigroup Community Care NM	Link
New York	5/1/2014	New York PDL	Link
New York		eMEDNY drug lookup	Link
New York		epocrates online - Amerigroup NY	Link
North Carolina	5/17/2014	North Carolina PDL	Link
North Carolina		Suboxone PA Form	Link
North Carolina	4/15/2013	North Caroline State MAC	Link
North Dakota	5/12/2014	Prior Authorization Lookup	Link
North Dakota		Quantity limits	Link
North Dakota		Suboxone/Subutex PA form	Link
Ohio		Ohio Medicaid Drug list	Link
Ohio		epocrates online - CareSource, Ohio MediCaid	Link
Oklahoma		epocrates online – SoonerCare PDL	Link
Oregon	5/1//2014	Oregon PDL	Link

State	Effective Date	Document Name	Link
Oregon		epocrates online - Oregon Medicaid (open-card)	Link
Pennsylvania	1/22/2014	Pennsylvania PDL	Link
Pennsylvania	3/2014	State MAC	Link
Rhode Island	9/25/2013	Rhode Island PDL	Link
Rhode Island	5/1/2014	RI state MAC List	Link
South Carolina	4/1/2013	South Carolina PDL	Link
South Carolina		South Carolina Medicaid Drug Lookup	Link
South Dakota	1/4/2013	Medications requiring PA	Link
Tennessee	5/12/2014	Tennessee PDL	Link
Texas	1/23/2013	Texas PDL	Link
Texas		epocrates online - Texas Medicaid	Link
Utah		Utah PDL	Link
Utah		Utah MAC	Link
Utah	11/15/2013	Suboxone PA form	Link
Vermont	1/1/2013	Vermont PDL	Link
Virginia		Virginia PDL	Link
Virginia		epocrates online - Virginia Medicaid PDL	Link
Washington	3/27/2014	Washington PDL	Link
Washington		epocrates online - Washington Medicaid FFS	Link
West Virginia	4/1/2014	West Virginia PDL	Link
West Virginia	4/5/2013	State MAC	Link
West Virginia	2/20/2013	Suboxone/Subutex PA form	Link
Wisconsin	3/1/2013	Wisconsin PDL	Link
Wisconsin	3/1/2013	State MAC and Diagnosis Restrictions	Link
Wyoming		Wyoming PDL	Link
Wyoming		epocrates online - Wyoming Medicaid	Link

Note: Links were current at the time this report was written. The Delaware and South Dakota sites were not operational at the time of abstraction.

Abbreviations: D.C., District of Columbia; FFS, fee-for-service; MAC, maximum allowable costs, PA, prior authorization; PDL, prescription drug list

Table A-2. Availability of Medications for Alcohol and Opioid Use Disorders on Medicaid Preferred Drug Lists, by State, 2011–2013

State	Disulfiram	Acamprosate	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine / Buprenorphine-naloxone	Methadone
Alabama*	Yes	Yes	Yes	Yes	Yes	Yes
Alaska	Yes	--	--	Yes	Yes	No
Arizona*	Yes	Yes	Yes	Yes	Yes	Yes
Arkansas	Yes	Yes	Yes	No	Yes	No
California*	Yes	Yes	Yes	Yes	Yes	Yes
Colorado	Yes	--	Yes	Yes	Yes	No
Connecticut	Yes	--	--	No	Yes	Yes
DC	Yes	--	Yes	No	Yes	Yes
Delaware	Yes	Yes	Yes	No	Yes	Yes
Florida*	Yes	Yes	Yes	Yes	Yes	Yes
Georgia	Yes	Yes	--	Yes	Yes	Yes
Hawaii	Yes	Yes	Yes	No	Yes	Yes
Idaho	Yes	Yes	Yes	Yes	Yes	No
Illinois	Yes	Yes	Yes	Yes	Yes	No
Indiana	Yes	--	Yes	No	Yes	No
Iowa	Yes	Yes	Yes	Yes	Yes	No
Kansas	Yes	--	Yes	No	Yes	No
Kentucky	Yes	Yes	Yes	Yes	Yes	No
Louisiana	Yes	Yes	Yes	Yes	Yes	No
Maine*	Yes	Yes	Yes	Yes	Yes	Yes
Maryland*	Yes	Yes	Yes	Yes	Yes	Yes
Massachusetts	Yes	No	Yes	Yes	Yes	Yes
Michigan*	Yes	Yes	Yes	Yes	Yes	Yes
Minnesota	Yes	No	Yes	Yes	Yes	Yes
Mississippi	Yes	No	Yes	No	Yes	No
Missouri	Yes	No	Yes	Yes	Yes	Yes

State	Disulfiram	Acamprosate	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine / Buprenorphine-naloxone	Methadone
Montana	Yes	No	Yes	No	Yes	No
Nebraska	Yes	Yes	Yes	No	Yes	No
Nevada	Yes	Yes	Yes	No	Yes	Yes
New Hampshire*	Yes	Yes	Yes	Yes	Yes	Yes
New Jersey	Yes	Yes	Yes	No	Yes	Yes
New Mexico	Yes	No	Yes	No	Yes	Yes
New York	Yes	No	Yes	No	Yes	Yes
North Carolina	Yes	Yes	Yes	No	Yes	Yes
North Dakota	Yes	No	Yes	Yes	Yes	No
Ohio*	Yes	Yes	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes	Yes	Yes	No
Oregon	Yes	Yes	Yes	No	Yes	Yes
Pennsylvania*	Yes	Yes	Yes	Yes	Yes	Yes
Rhode Island	Yes	Yes	Yes	No	Yes	Yes
South Carolina	Yes	Yes	Yes	No	Yes	No
South Dakota	Yes	Yes	Yes	--	Yes	No
Tennessee	Yes	No	Yes	Yes	Yes	No
Texas	Yes	Yes	Yes	No	Yes	Yes
Utah	Yes	No	Yes	Yes	Yes	Yes
Vermont*	Yes	Yes	Yes	Yes	Yes	Yes
Virginia	Yes	No	Yes	Yes	Yes	Yes
Washington*	Yes	Yes	Yes	Yes	Yes	Yes
West Virginia	Yes	Yes	Yes	Yes	Yes	No
Wisconsin*	Yes	Yes	Yes	Yes	Yes	Yes
Wyoming	Yes	No	Yes	Yes	Yes	No
Totals for All States						
Available	***51***	***30***	***51***	***31***	***51***	***31***
Not Available	***0***	***19***	***0***	***19***	***0***	***20***

	Disulfiram	Acamprosate	Oral Naltrexone	Extended-Release Naltrexone	Buprenorphine / Buprenorphine-naloxone	Methadone
Unknown	***0***	***2***	***0***	***1***	***0***	***0***

* Indicates that this state covers all medications for treating alcohol and opioid use disorders. Dashes indicate that the item was not mentioned.

Sources: American Society of Addiction Medicine (ASAM) 2013, state documents listed in Table A-1, and the 2011 and 2012 Medicaid state drug utilization data (see http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Programs-Data-and-Resources.html)

Table A-3. Availability of Disulfiram on Medicaid Preferred Drug Lists, by State, 2011–2013

State	Is this drug available on the Medicaid Preferred Drug List?	Is the brand drug (Antabuse®) covered?	Is prior authorization required?	Is documented counseling required?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Alabama	Yes	Yes	--	--	Yes	--	--
Alaska	Yes	--	--	--	--	--	--
Arizona	Yes	Yes	No	--	No	--	--
Arkansas	Yes	Yes	No	--	No	--	--
California	Yes	Yes	No	--	No	--	--
Colorado	Yes	Yes	No	--	No	--	--
Connecticut	Yes	--	--	--	--	--	--
DC	Yes	Yes	--	--	--	--	--
Delaware	No	--	--	--	--	--	--
Florida	Yes	--	No	--	--	--	--
Georgia	Yes	Yes	Yes	--	Yes	--	--
Hawaii	Yes	--	No	--	No	--	--
Idaho	Yes	--	--	--	--	--	--
Illinois	Yes	Yes	Yes	--	--	--	--
Indiana	Yes	Yes	--	--	--	--	--
Iowa	Yes	Yes	No	--	Yes	--	--
Kansas	Yes	--	--	--	--	--	--
Kentucky	Yes	Yes	No	--	No	--	--
Louisiana	Yes	--	--	--	--	--	--
Maine	Yes	Yes	No	--	No	--	--
Maryland	Yes	No	Yes	--	--	--	--
Massachusetts	Yes	Yes	No	--	No	--	--
Michigan	Yes	Yes	No	--	No	--	--
Minnesota	Yes	--	--	--	--	--	--
Mississippi	Yes	--	--	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Is the brand drug (Antabuse®) covered?	Is prior authorization required?	Is documented counseling required?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Missouri	Yes	--	--	--	--	--	--
Montana	Yes	--	No	--	No	--	--
Nebraska	Yes	Yes	No	--	No	--	--
Nevada	Yes	--	--	--	--	--	--
New Hampshire	Yes	Yes	No	--	No	--	--
New Jersey	Yes	Yes	--	--	--	--	--
New Mexico	Yes	Yes	--	--	--	--	--
New York	Yes	Yes	No	--	No	--	--
North Carolina	Yes	--	--	--	--	--	--
North Dakota	Yes	--	--	--	--	--	--
Ohio	Yes	Yes	No	--	No	--	--
Oklahoma	Yes	--	--	--	--	--	--
Oregon	Yes	--	--	--	--	--	--
Pennsylvania	Yes	--	--	--	--	--	--
Rhode Island	Yes	--	--	--	--	--	--
South Carolina	Yes	Yes	No	--	No	--	--
South Dakota	Yes	--	--	--	--	--	--
Tennessee	Yes	--	--	--	--	--	--
Texas	Yes	Yes	--	--	--	--	--
Utah	Yes	--	--	--	--	--	--
Vermont	Yes	Yes	Yes	--	No	--	--
Virginia	Yes	Yes	--	--	--	--	--
Washington	Yes	--	--	--	--	--	--
West Virginia	Yes	--	--	--	--	--	--
Wisconsin	Yes	Yes	--	--	--	--	--
Wyoming	Yes	Yes	Yes	--	--	--	--

	Is this drug available on the Medicaid Preferred Drug List?	Is the brand drug (Antabuse®) covered?	Is prior authorization required?	Is documented counseling required?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Totals for All States							
Yes	***51***	***26***	***5***	***0***	***3***	***0***	***0***
No	***0***	***2***	***18***	***0***	***17***	***0***	***0***
Unknown	***0***	***23***	***28***	***51***	***31***	***51***	***51***

Dashes indicate that the item was not mentioned.

Sources: ASAM 2013, state documents listed in Table A-1, and the 2011 and 2012 Medicaid state drug utilization data

Additional Specifications

Alabama: For treating alcohol dependence, the dosage is 125–500 mg orally every morning. To start, patients should receive 500 mg orally every morning for 1–2 weeks. Patients must be abstinent from alcohol for more than 12 hours.

Georgia: Disulfiram 250 mg is preferred with quantity limits. Disulfiram 500 mg requires prior authorization and has quantity limits.

Illinois: Generics do not require prior authorization.

Iowa: For treating alcohol dependence, the dosage is 125–500 mg orally every morning. To start, patients should receive 500 mg orally every morning for 1–2 weeks. Patients must be abstinent from alcohol for more than 12 hours.

Maryland: Generic is preferred; to obtain the brand product the prescriber must submit a Department of Health and Mental Hygiene Medwatch form and receive approval.

Ohio: Antabuse is not in the formulary.

Table A-4. Availability of Acamprosate on Medicaid Preferred Drug Lists, by State, 2011–2013

State	Is this drug available on the Medicaid Preferred Drug List?	Is the brand drug (Campral®) covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Alabama	Yes	--	--	--	--	--	--
Alaska	Yes	--	--	--	--	--	--
Arizona	Yes	Yes	Yes	--	Yes	--	--
Arkansas	No	--	--	--	--	--	--
California	Yes	Yes	Yes	--	--	--	--
Colorado	No	--	--	--	--	--	--
Connecticut	No	--	--	--	--	--	--
DC	No	--	--	--	--	--	--
Delaware	No	No	No	--	No	--	--
Florida	Yes	No	No	--	--	--	--
Georgia	Yes	No	No	--	No	--	--
Hawaii	Yes	No	No	--	Yes	--	--
Idaho	Yes	--	--	--	--	--	--
Illinois	No	--	--	--	--	--	--
Indiana	No	--	--	--	--	--	--
Iowa	Yes	No	No	--	No	--	--
Kansas	No	--	--	--	--	--	--
Kentucky	Yes	No	No	--	No	--	--
Louisiana	Yes	--	--	--	--	--	--
Maine	Yes	Yes	Yes	Yes	No	--	--
Maryland	Yes	--	--	--	--	--	--
Massachusetts	Yes	No	No	--	No	--	--
Michigan	Yes	Yes	Yes	--	--	--	--
Minnesota	Yes	--	--	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Is the brand drug (Campral®) covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Mississippi	No	--	--	--	--	--	--
Missouri	Yes	--	--	--	--	--	--
Montana	Yes	No	No	--	No	--	--
Nebraska	Yes	No	No	--	No	--	--
Nevada	No	--	--	--	--	--	--
New Hampshire	Yes	No	No	--	No	--	--
New Jersey	Yes	--	--	--	--	--	--
New Mexico	Yes	--	--	--	--	--	--
New York	Yes	--	--	--	--	--	--
North Carolina	No	--	--	--	--	--	--
North Dakota	--	--	--	--	--	--	--
Ohio	Yes	No	No	--	--	--	--
Oklahoma	Yes	--	--	--	--	--	--
Oregon	No	--	--	--	--	--	--
Pennsylvania	No	--	--	--	--	--	--
Rhode Island	No	--	--	--	--	--	--
South Carolina	Yes	No	No	--	No	--	--
South Dakota	--	--	--	--	--	--	--
Tennessee	Yes	--	--	--	--	--	--
Texas	No	--	--	--	--	--	--
Utah	Yes	--	--	--	--	--	--
Vermont	Yes	No	No	--	No	--	--
Virginia	Yes	--	--	--	--	--	--
Washington	Yes	Yes	Yes	--	--	--	--
West Virginia	No	--	--	--	--	--	--
Wisconsin	No	--	--	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Is the brand drug (Campral®) covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Wyoming	Yes	--	--	--	--	--	--
Totals for all States							
Yes	***30***	***4***	***5***	***1***	***2***	***0***	***0***
No	***19***	***16***	***12***	***0***	***9***	***0***	***0***
Unknown	***2***	***31***	***35***	***50***	***40***	***50***	***51***

Dashes indicate that the item was not mentioned.

Sources: ASAM 2013, state documents listed in Table A-1, and the 2011 and 2012 Medicaid state drug utilization data

Additional Specifications

Alabama: For treating alcohol dependence, the standard dosage is 666 mg orally three times per day for abstinence maintenance. Treatment should be initiated after withdrawal phase and should continue even if there is a relapse.

Arizona: Quantity limit of 180 pills in 30 days.

Hawaii: Quantity limit of 186 pills in 31 days.

Illinois: Generic does not require prior authorization.

Maine: This treatment should only be used in conjunction with formal structured outpatient detoxification programs.

Table A-5. Availability of Naltrexone on Medicaid Preferred Drug Lists, by State, 2011–2013

State	Is this drug available on the Medicaid Preferred Drug List?	Are the brand drugs (Depade® or Revia®) covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Alabama	Yes	Yes	No	--	--	--	--
Alaska	Yes	--	--	--	--	--	--
Arizona	Yes	Yes	No	--	Yes	--	--
Arkansas	Yes	Yes	No	--	--	--	--
California	Yes	Yes	Yes	--	--	--	--
Colorado	Yes	No	Yes	--	Yes	--	--
Connecticut	Yes	--	--	--	--	--	--
DC	Yes	--	--	--	--	--	--
Delaware	Yes	Yes	Yes	--	--	--	--
Florida	Yes	--	No	--	--	--	--
Georgia	Yes	--	--	--	--	--	--
Hawaii	Yes	--	No	--	No	--	--
Idaho	Yes	--	--	--	--	--	--
Illinois	Yes	Yes	Yes	--	--	--	--
Indiana	Yes	Yes	--	--	--	--	--
Iowa	Yes	Yes	Yes	--	--	--	--
Kansas	Yes	--	--	--	--	--	--
Kentucky	Yes	No	Yes	--	No	--	--
Louisiana	Yes	--	--	--	--	--	--
Maine	Yes	Yes	Yes	Yes	--	--	--
Maryland	Yes	No	--	--	--	--	--
Massachusetts	Yes	No	Yes	--	--	--	--
Michigan	Yes	Yes	No	--	No	--	--
Minnesota	Yes	--	--	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Are the brand drugs (Depade® or Revia®) covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Mississippi	Yes	--	--	--	--	--	--
Missouri	Yes	No	Yes	--	--	--	--
Montana	Yes	--	No	--	No	--	--
Nebraska	Yes	Yes	No	--	No	--	--
Nevada	Yes	--	--	--	--	--	--
New Hampshire	Yes	Yes	No	--	No	--	--
New Jersey	Yes	Yes	--	--	--	--	--
New Mexico	Yes	Yes	--	--	--	--	--
New York	Yes	Yes	--	--	--	--	--
North Carolina	Yes	--	--	--	--	--	--
North Dakota	Yes	--	--	--	--	--	--
Ohio	Yes	Yes	No	--	--	--	--
Oklahoma	Yes	--	--	--	--	--	--
Oregon	Yes	Yes	--	--	--	--	--
Pennsylvania	Yes	--	--	--	--	--	--
Rhode Island	Yes	--	--	--	--	--	--
South Carolina	Yes	Yes	No	--	No	--	--
South Dakota	Yes	--	--	--	--		
Tennessee	Yes	Yes	Yes	--	--	--	--
Texas	Yes	Yes	No	--	No	--	--
Utah	Yes	--	--	--	--	--	--
Vermont	Yes	Yes	Yes	--	Yes	--	--
Virginia	Yes	Yes	--	--	--	--	--
Washington	Yes	Yes	Yes	--	--	--	--
West Virginia	Yes	--	--	--	--	--	--
Wisconsin	Yes	Yes	--	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Are the brand drugs (Depade® or Revia®) covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Wyoming	Yes	Yes	--	--	--	--	--
Totals for All States							
Yes	***51***	***25***	***12***	***1***	***3***	***0***	***0***
No	***0***	***5***	***12***	***0***	***8***	***0***	***0***
Unknown	***0***	***21***	***27***	***51***	***40***	***51***	***51***

Dashes indicate that the item was not mentioned.

Sources: ASAM 2013, state documents listed in Table A-1, and the 2011 and 2012 Medicaid state drug utilization data

Additional Specifications

Alabama: For treating opioid addiction, the dosage is 50 mg orally every day. To start treatment, patients should receive 25 mg orally one time and then repeat in 1 hour if there are no withdrawal symptoms. Alternative dosages for treatment are 100 mg orally every other day and 150 mg orally every 3 days. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected. For treating alcohol dependence, the standard dosage is 50 mg orally every day. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected.

Arizona: Quantity limit is 60 pills in 30 days.

Colorado: For treating opioid addiction, the dosage is 50 mg orally every day. To start treatment, patients should receive 25 mg orally one time and then repeat in 1 hour if there are no withdrawal symptoms. Alternative dosages for treatment are 100 mg orally every other day and 150 mg orally every 3 days. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected. For treating alcohol dependence, the standard dosage is 50 mg orally every day. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected.

Illinois: No prior authorization is required for generic naltrexone.

Ohio: For treating opioid addiction, the dosage is 50 mg orally every day. To start treatment, patients should receive 25 mg orally one time and then repeat in 1 hour if there are no withdrawal symptoms. Alternative dosages for treatment are 100 mg orally every other day and 150 mg orally every 3 days. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected. For treating alcohol dependence, the standard dosage is 50 mg orally every day. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected.

Tennessee: Will be approved for recipients who meet the following criteria: Diagnosed with self-injurious behavior due to developmental delay OR diagnosed with opioid dependency, plus documentation that patient is opioid free (negative urine drug screen or naltrexone challenge test within the last 10 days). Note: Physician must have reviewed the Controlled Substance Database within the past 30 days to ensure that concomitant narcotic use is not occurring.

Table A-6. Availability of Extended-Release Naltrexone on Medicaid Preferred Drug Lists, by State, 2011–2013

State	Is this drug available on the Medicaid Preferred Drug List?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Alabama	Yes	No	No	--	--	--
Alaska	Yes	No	No	No	--	--
Arizona	Yes	--	Yes	--	--	Yes
Arkansas	No	--	--	--	--	--
California	Yes	Yes	Yes	--	--	--
Colorado	Yes	Yes	Yes	--	--	--
Connecticut	No	--	--	--	--	--
Delaware	No	--	--	--	--	--
DC	No	--	--	--	--	--
Florida	Yes	--	--	--	--	--
Georgia	Yes	Yes	No	Yes	--	--
Hawaii	No	--	--	--	--	--
Idaho	Yes	--	No	--	--	--
Illinois	Yes	Yes	Yes	--	--	--
Indiana	No	--	--	--	--	--
Iowa	Yes	Yes	No	--	--	--
Kansas	No	--	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Kentucky	Yes	Yes	Yes	No	--	--
Louisiana	Yes	Yes	--	--	--	--
Maine	Yes	Yes	Yes	--	--	--
Maryland	Yes	--	Yes	--	--	Yes
Massachusetts	Yes	Yes	No	--	--	Yes
Michigan	Yes	--	No	--	--	--
Minnesota	Yes	--	No	--	--	--
Mississippi	No	--	--	--	--	--
Missouri	Yes	Yes	Yes	--	--	Yes
Montana	No	--	No	--	--	--
Nebraska	No	--	Yes	--	--	--
Nevada	No	--	No	--	--	--
New Hampshire	Yes	No	No	No	--	--
New Jersey	No	--	--	--	--	--
New Mexico	No	--	--	--	--	--
New York	No	--	--	--	--	--
North Carolina	No	--	No	--	--	--
North Dakota	Yes	--	No	--	--	--
Ohio	Yes	No	No	--	--	--
Oklahoma	Yes	--	No	--	--	--
Oregon	No	--	Yes	--	--	Yes
Pennsylvania	Yes	No	No	Yes	--	--
Rhode Island	No	--	--	--	--	--
South Carolina	No	--	Yes	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee	Yes	--	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Texas	No	--	--	--	--	--
Utah	Yes	--	Yes	--	--	--
Vermont	Yes	Yes	No	Yes	--	Yes
Virginia	Yes	--	Yes	--	--	--
Washington	Yes	Yes	Yes	--	--	--
West Virginia	Yes	--	Yes	--	--	--
Wisconsin	Yes	--	No	--	--	--
Wyoming	Yes	--	No	--	--	--
Totals for All States						
Yes	***31***	***12***	***15***	***3***	***0***	***6***
No	***19***	***5***	***19***	***3***	***0***	***0***
Unknown	***1***	***34***	***17***	***45***	***51***	***45***

Dashes indicate that the item was not mentioned.

Sources: ASAM 2013, state documents listed in Table A-1, and the 2011 and 2012 Medicaid state drug utilization data

Additional Specifications

California: For treating alcohol dependence, the dosage is 380 mg intramuscular every 4 weeks. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected. For treating opioid dependence, the dosage is 380 mg intramuscular every 4 weeks following opioid detoxification.

Massachusetts: Step-therapy is required.

Missouri: Step-therapy is required.

Vermont: Quantity limit is 1 vial every 30 days.

Washington: For treating alcohol dependence, the dosage is 380 mg intramuscular every 4 weeks. Patients must be opioid free for 7–10 days. Consider the naloxone challenge test if risk of withdrawal is suspected. For treating opioid dependence, the dosage is 380 mg intramuscular every 4 weeks following opioid detoxification.

Table A-7. Availability of Methadone and Dolophine® on Medicaid Preferred Drug Lists, by State, 2011–2013

State	Is this drug available on the Medicaid Preferred Drug List?
Alabama	Yes
Alaska	No
Arizona	Yes
Arkansas	No
California	Yes
Colorado	No
Connecticut	Yes
Delaware	Yes
DC	Yes
Florida	Yes
Georgia	Yes
Hawaii	Yes
Idaho	No
Illinois	No
Indiana	No
Iowa	No
Kansas	No
Kentucky	No
Louisiana	No
Maine	Yes
Maryland	Yes
Massachusetts	Yes
Michigan	Yes
Minnesota	Yes
Mississippi	No
Missouri	Yes

State	Is this drug available on the Medicaid Preferred Drug List?
Montana	No
Nebraska	No
Nevada	Yes
New Hampshire	Yes
New Jersey	Yes
New Mexico	Yes
New York	Yes
North Carolina	Yes
North Dakota	No
Ohio	Yes
Oklahoma	No
Oregon	Yes
Pennsylvania	Yes
Rhode Island	Yes
South Carolina	No
South Dakota	No
Tennessee	No
Texas	Yes
Utah	Yes
Vermont	Yes
Virginia	Yes
Washington	Yes
West Virginia	No
Wisconsin	Yes
Wyoming	No
Total for All States	
Yes	***31***
No	***20***

	Is this drug available on the Medicaid Preferred Drug List?
Unknown	***0***

Dashes indicate that the item was not mentioned.

Source: ASAM 2013

Additional Specifications

The ASAM survey questionnaire asked respondents if their state Medicaid program offered coverage for methadone or Dolophine for the treatment of opioid dependence. We interpreted this to indicate whether the state included methadone on the Medicaid Preferred Drug List.

Table A-8. Availability of Buprenorphine-Naloxone on Medicaid Preferred Drug Lists, by State, 2011–2013

State	Is this drug available on the Medicaid Preferred Drug List?	Are tablets and film covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Alabama	Yes	Yes	Yes	No	--	--	--
Alaska	Yes	Yes	Yes	Yes	Yes	--	--
Arizona	Yes	--	Yes	--	--	--	--
Arkansas	Yes	--	Yes	Yes	--	Yes	--
California	Yes	--	Yes	Yes	--	--	--
Colorado	Yes	Yes	Yes	--	Yes	--	--
Connecticut	Yes	Yes	Yes	No	--	--	--
DC	Yes	--	Yes	Yes	Yes	Yes	--
Delaware	Yes	--	Yes	--	--	--	--
Florida	Yes	--	Yes	Yes	--	--	--
Georgia	Yes	Yes	Yes	No	Yes	--	--
Hawaii	Yes	No	Yes	--	--	--	--
Idaho	Yes	Yes	Yes	No	Yes	--	--
Illinois	Yes	Yes	Yes	Yes	Yes	Yes	--
Indiana	Yes	Yes	Yes	Yes	--	--	--
Iowa	Yes	Yes	Yes	Yes	Yes	--	--
Kansas	Yes	--	--	Yes	--	--	--
Kentucky	Yes	Yes	Yes	Yes	Yes	--	--
Louisiana	Yes	Yes	No	No	Yes	--	--
Maine	Yes	Yes	Yes	Yes	--	Yes	--
Maryland	Yes	Yes	--	--	Yes	--	--
Massachusetts	Yes	Yes	Yes	No	Yes	--	--
Michigan	Yes	Yes	Yes	--	Yes	Yes	--
Minnesota	Yes	Yes	Yes	No	Yes	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Are tablets and film covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Mississippi	Yes	Yes	Yes	No	Yes	Yes	--
Missouri	Yes	No	Yes	Yes	--	--	--
Montana	Yes	Yes	Yes	Yes	Yes	Yes	--
Nebraska	Yes	Yes	Yes	No	--	--	--
Nevada	Yes	Yes	Yes	Yes	Yes	--	--
New Hampshire	Yes	Yes	Yes	--	Yes	--	--
New Jersey	Yes	--	--	--	Yes	--	--
New Mexico	Yes	Yes	Yes	Yes	Yes	--	--
New York	Yes	Yes	Yes	No	Yes	--	--
North Carolina	Yes	Yes	Yes	No	Yes	--	--
North Dakota	Yes	--	Yes	No	Yes	--	--
Ohio	Yes	Yes	Yes	Yes	Yes	--	--
Oklahoma	Yes	--	Yes	No	Yes	--	--
Oregon	Yes	--	Yes	--	Yes	--	--
Pennsylvania	Yes	Yes	Yes	Yes	Yes	--	--
Rhode Island	--	--	--	--	--	--	--
South Carolina	Yes	No	Yes	--	Yes	--	--
South Dakota	Yes	No	Yes	--	--	--	--
Tennessee	Yes	Yes	Yes	Yes	Yes	--	--
Texas	Yes	Yes	No	--	--	--	--
Utah	Yes	--	Yes	Yes	Yes	Yes	--
Vermont	Yes	Yes	Yes	--	Yes	--	--
Virginia	Yes	Yes	Yes	--	Yes	Yes	--
Washington	Yes	--	Yes	--	Yes	Yes	--
West Virginia	Yes	Yes	Yes	Yes	Yes	--	--
Wisconsin	Yes	Yes	Yes	--	--	--	--

State	Is this drug available on the Medicaid Preferred Drug List?	Are tablets and film covered?	Is prior authorization required?	Is documented counseling required with the medication?	Are there quantity limits or maximum daily dosages?	Are there lifetime limits?	Is step-therapy used?
Wyoming	Yes	Yes	Yes	Yes	Yes	Yes	--
Total for all States							
Yes	***50***	***33***	***48***	***21***	***34***	***11***	***0***
No	***0***	***4***	***0***	***13***	***0***	***0***	***0***
Unknown	***1***	***14***	***3***	***17***	***16***	***40***	***51***

Dashes indicate that the item was not mentioned.

Sources: ASAM 2013, state documents listed in Table A-1, and the 2011 and 2012 Medicaid state drug utilization data

Additional Specifications

General dosing guidelines: Opioid dependence, maintenance treatment [4 mg/1 mg to 24 mg/6 mg sublingual every day]. Start: 12 mg/3 mg to 16 mg/4 mg sublingual every day or dose on last day of induction treatment; maximum: 24 mg/6 mg/day. Additional information: may adjust by 2 mg/0.5 mg to 4 mg/1 mg per day.

Alabama: Prior Authorization is required with appropriate diagnosis and failed trials with two preferred and prescribed generic/over-the-counter/brand name drugs, unless medical justification is documented.

Alaska: Doses > 3 units per day OR 24 mg per day will NOT be approved. Only one strength of one buprenorphine product will be authorized for use at a given time.

Arizona: Quantity Limit: 90 in 30 days.

Arkansas: Beginning April 1, 2011, Arkansas Medicaid will only authorize 24 months of buprenorphine-naloxone/Subutex therapy for each recipient. Each prior authorization will be set up for a timeframe between 3 and 6 months. Counseling documentation and drug testing are both required for renewals. If your office does not require counseling as part of your opioid dependence program, Arkansas Medicaid will not approve buprenorphine-naloxone/Subutex for those recipients.

Colorado: Buprenorphine-naloxone will be approved if the following criteria are met: The prescriber is authorized by the manufacturer to prescribe buprenorphine-naloxone. The client is not currently receiving an opioid or opioid combination product. Opioid claims will not be allowed for clients with a claim for buprenorphine-naloxone in the preceding 30 days. Buprenorphine-naloxone will not be approved for more than 24mg of buprenorphine per day.

District of Columbia: Length of Authorization is 60 days.

Florida: Prior authorization requirements include an adequate amount of psychosocial support (family or peers), a readiness for change and a personal commitment to live a drug-free lifestyle, with a willingness to comply with all elements of the treatment plan, including pharmacologic and nonpharmacologic aspects of the established protocol, with consistent regular drug screens that are negative for opiates, with a willingness to abstain from illicit drugs.

Hawaii: Only buprenorphine-naloxone film is covered.

Illinois: Medicaid will only authorize 12 months of buprenorphine-naloxone/buprenorphine therapy per patient. Approvals will be for an initial 2-month time period followed by two 3-month and one 4-month periods and a maximum of 62 dosage forms per month. Documentation of adherence to a complete treatment program will be required for renewal. Urine drug screen within the past 14 days including positive result for buprenorphine: submit results. Illinois Prescription Monitoring Program (PMP) review includes an anticipated dosing plan for induction and maintenance phases; plan for dose tapering; plan for psychosocial counseling, including the name of the psychosocial program(s) to which the patient has been referred; plan for follow up with the prescriber (e.g., frequency of office visits); description of schedule by which patient will obtain refill prescriptions (e.g., on a bi-weekly or monthly basis); informed consent regarding avoidance of combination usage with benzodiazepines, sedative/hypnotics, carisoprodol, tramadol, or alcohol; statement that the patient will only obtain buprenorphine-naloxone/buprenorphine prescriptions from the requesting prescriber and will use the same pharmacy to fill all buprenorphine-naloxone/buprenorphine prescriptions and prescriptions for other pain medications, when necessary.

Indiana: Physician has verified the risks of using buprenorphine-naloxone with alcohol or benzodiazepines, and these risks have been explained to the patient. Physician has verified that there are no untreated or unstable psychiatric conditions that would

interfere with buprenorphine-naloxone/Subutex compliance. Physician has provided documentation of the patient's referral to or active involvement in formal counseling with a licensed behavioral health provider; must also indicate the name of the behavioral health provider and where the patient is receiving counseling.

Kansas: Beneficiary needs to be actively involved in dependence treatment program.

Kentucky: Monthly urine tests for opiates because previous authorization is required. Continued participation in drug abuse counseling. The maximum FDA indicated dose of buprenorphine is 24mg/day.

Louisiana: A maximum daily dosage of up to 24 mg/day (based on buprenorphine) will be allowed for 90 consecutive days. After the 90 days has elapsed a maximum daily dosage of up to 16 mg/day (based on buprenorphine) will be allowed.

Maine: Buprenorphine-naloxone tablets are nonpreferred. There is a 32 mg induction maximum and 16 mg for maintenance therapy. There should be evidence provided of monthly monitoring including random pill counts, urine drug tests, and prescription monitoring program reports.

Massachusetts: Dosage > 90 days (> 24 and less than or equal to 32 mg/day) >180 days (> 16 mg/day and less than or equal to 24 mg/day).

Minnesota: A quantity limit of 120 per 30 days is applied to the 8 mg/2mg strength of both dosage forms and a quantity limit of 180 per 30 days is applied to the 2mg/0.5mg

Mississippi: A beneficiary will only be covered for a total of 24 months of therapy with buprenorphine-naloxone/Subutex, even when treated by different doctors. Going without medication for 60 days or more will require the beneficiary to restart treatment. A beneficiary will be allowed only one restart of treatment. Over time doses must be reduced to help the beneficiary stop being dependent on medication. Medicaid will only pay for the maximum daily dose allowed for each step in therapy. Beneficiaries cannot get a prescription for more than 5 days of an opiate while on buprenorphine-naloxone/Subutex therapy. Beneficiaries cannot get a buprenorphine-naloxone/Subutex refill if they have gotten a prescription for more than 5 days of an opiate in the last 30 days. Beneficiaries cannot have more than a total of 10 days of opiate therapy during the time on buprenorphine-naloxone/Subutex therapy. If this happens, beneficiary will no longer be eligible for buprenorphine-naloxone/Subutex coverage.

Missouri: Only the tablet is covered.

Nebraska: Other limitations apply (limitations are not mentioned).

Nevada: Recipient is in a specific substance abuse program or will receive counseling from a psychiatrist or a certified addiction specialist. Provide program/counselor name. Dosage: buprenorphine-naloxone 8 mg/2 mg sublingual tablet: 2 tablets per day; buprenorphine-naloxone 2 mg/0.5 mg sublingual tablet: 3 tablets per day

New Mexico: Physician must submit: current (up to 7 days prior to request submission date) urine drug screen results, which includes buprenorphine, and certify that the New Mexico Board of Pharmacy Prescription Monitoring Program report was pulled and does not contain opiates, tramadol, benzodiazepines, sedative-hypnotic agents, carisoprodol, or meprobamate. Any relapses by the patient, indicated by a urine drug screen positive for opiates, must be addressed by the provider. The provider must decide if the patient remains a good candidate for continued treatment. A urine drug test negative for buprenorphine also alerts the provider to possible diversion of buprenorphine, and steps such as discontinuance of buprenorphine prescriptions can be considered. If applicable, submit medical records or chart notes that include medical justification and a signed informed consent documenting the risks for combined use of buprenorphine-naloxone or buprenorphine and benzodiazepines, sedative/hypnotics carisoprodol, meprobamate, or alcohol. Indicate the psychosocial program in which the consumer is participating. Possible options include, but are not limited to, Narcotics Anonymous, Alcoholics Anonymous, therapy with a counselor, or counseling by the treating physician. A treatment plan, agreed to by the consumer and signed by the consumer, must be submitted by the requesting provider with the request.

New York: Three sublingual tablets or films per day. Maximum of 90 tablets or films dispensed as a 30-day supply.

North Carolina: Prescriber must review the Controlled Substances Reporting System Database. Maximum daily dose less than or equal to 24 mg/day. Length of therapy may be approved for up to 12 months. For requests for renewals please attach a treatment plan.

Ohio: Thirty days for initial authorization and 6 months for subsequent re-authorizations. Prior authorization includes: patient has been referred counseling for addiction treatment. Maximum dose 24mg per day (16mg is target; no patient should receive more than 32mg). Prescriber has reviewed Ohio Automated Rx Reporting System (OARRS) for opioid prescription use. Periodic drug screens are addressed in treatment plan (will be performed by prescriber or by counseling team). For re-authorizations, the dose has been reduced in the previous 6 months or the patient has been evaluated for a dose reduction and the prescriber and patient agree that a dose reduction would not be beneficial or may be harmful.

Oklahoma: Approval will be for 90 days to allow for concurrent medication monitoring. The following limitations will apply: buprenorphine-naloxone 2mg/0.5mg and 8mg/2mg tablets and film: quantity limit of 90 per 30 days.

Pennsylvania: Buprenorphine-naloxone film is preferred and tablets are nonpreferred.

South Carolina: Only buprenorphine-naloxone film is covered.

South Dakota: Only buprenorphine-naloxone film is covered.

Tennessee: Buprenorphine-naloxone will be approved for recipients who meet the criteria: physician has appropriately reviewed the Tennessee Controlled Substances Database on the date of the prior authorization request to ensure that concomitant narcotic use is not occurring. Quantity limit is as a single daily dose. Twice-daily dosing may be approved as clinically necessary. Physicians will be asked to provide an anticipated treatment plan for the patient (including anticipated dosing for induction and maintenance phases, anticipated frequency of office visits, and anticipated plan for psychosocial counseling). Quantity limits: 8/2mg: 2/day x 6 months then 1/day; 2/0.5mg: 3/day.

Texas: Film is preferred, tables are nonpreferred.

Utah: Evidence supplied of plans for on-going treatment monitoring that includes drug urine screening, or Division of Occupational & Professional Licensing reports, or random pill counts, AND Description of the psychosocial support to be received by patient, as indicated by chart notes or a brief letter of medical necessity. ·A treatment plan that includes a tapering plan or discontinuation of pharmacotherapy. No concomitant therapy with Vivitrol (naltrexone). Reauthorization period is 18-months at 24mg/day maximum dosage level if the following criteria are met: Letter of explanation detailing why an additional approval is needed. No claims data showing concomitant use of opiates may be present. Evidence of psychosocial support received by patient. Evidence that a taper plan has been attempted and, if failed, why. Detailed plans for immediate taper if initial taper failed. A negative urine screen completed within 14 days of reauthorization start date. No concomitant therapy with Vivitrol (naltrexone). Treatment will only be covered up to 36 months (18 month initial authorization and 18 month reauthorization). After 36 months, NO petitions will be approved under ANY circumstances.

Vermont: Film is preferred and no prior authorization (PA) is required, tablets are nonpreferred and PA is required.

Virginia: Maximum duration is 24 months; maximum dose is 16mg/day. Duration of service authorization is 3 months for a total of 24 months.

West Virginia: Member will be locked into one pharmacy for prescriptions for all scheduled drugs. Members will remain locked into one pharmacy until their annual review date, even if buprenorphine-naloxone/Subutex therapy is discontinued. Maximum initial dose is 24 mg per day for a maximum of a 60-day period; initial dosing is limited to once per lifetime. Maximum maintenance dose is 16 mg per day (tablet splitting for lower doses is required, when appropriate). Early refills are not permitted, including replacement of lost or stolen medication. Prior authorization is limited to a 6-month period to be dispensed in corresponding quantities for the time periods specified by the prescriber, with a maximum time period of 30 days and 60 units. Combination with benzodiazepines, hypnotics, and opioids (tramadol) will be denied. Patient must be warned about the dangers of ingesting concurrent sedating medications. Attestation from prescriber that the Board of Pharmacy Prescription Drug Monitoring Program database has been reviewed and that patient has been warned about the dangers of ingesting concurrent sedating medications.

Wisconsin: Film is preferred, tables are nonpreferred.

Wyoming: Dosage limits apply (maximum dose: 24mg/day). Client is limited to 2 years of buprenorphine-naloxone or buprenorphine use.

Appendix B: Authors and Acknowledgments

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