Coverage of Buprenorphine Medications That Treat Opioid Use Disorder by State Medicaid Programs

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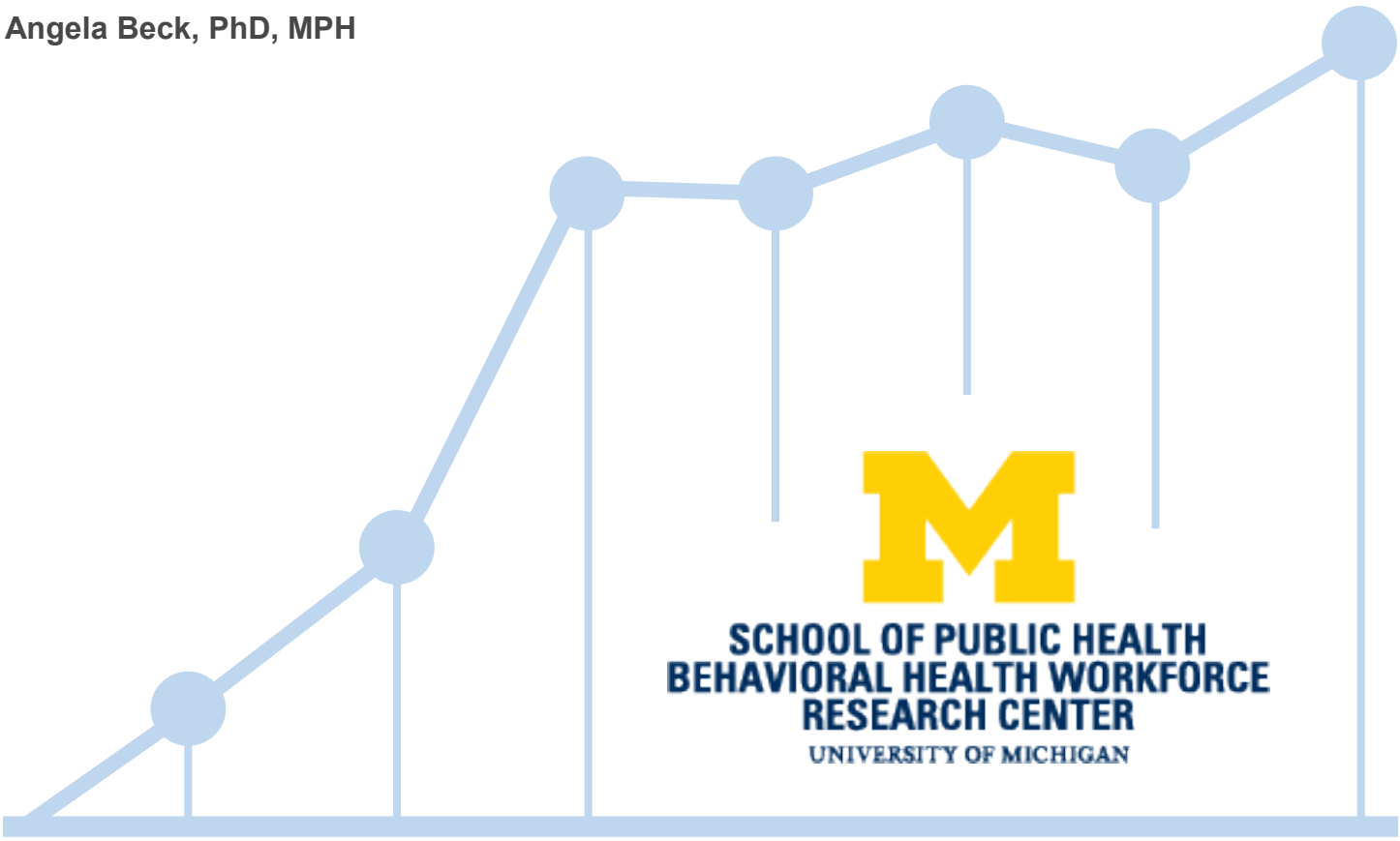

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Table of Contents

Abstract

Objectives

This project explores the application of prior authorization (PA) requirements to buprenorphine, 1 of 3 Food and Drug Administration–approved medications used in the treatment of opioid use disorder, by Medicaid programs in 2019.

Methods

Investigators reviewed 45 Medicaid preferred drug lists in 2019 to determine coverage of 8 buprenorphine forms, and if coverage required PA. The authors calculated the proportion of plans that covered, covered with PA, and covered without PA at least one buprenorphine product, as well as the percentage of plans that covered at least 1 buprenorphine form.

Results

An overwhelming proportion of Medicaid programs covered buprenorphine alone and buprenorphine/naloxone combination forms in the preferred drug list. However, with the exception of Suboxone™, all other buprenorphine formulations were subject to PA by more than two thirds of PDLs. Although all plans (100%) covered at least 1 buprenorphine form, almost 30% of plans did not cover at least 1 buprenorphine form without PA.

Conclusions

Although Medicaid programs largely cover buprenorphine products, many continue to apply PA requirements. In the midst of the opioid epidemic, it is challenging to justify the exclusion of buprenorphine coverage and imposition of burdensome utilization management requirements. As policymakers consider strategies to decrease opioid-related morbidity and mortality, they should consider opportunities to mandate the removal of PA. Researchers can expand upon this project by exploring how to define adequate buprenorphine access.

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Background

Buprenorphine is an effective medication for the treatment of opioid use disorder (OUD). It promotes long-term recovery and decreases the risk of mortality.[1–6] Buprenorphine treatment increases engagement in addiction treatment,[7] reduces emergency department admissions,[8,9] and is cost effective compared with brief intervention or referral treatments.[10]

Buprenorphine is 1 of 3 medications, along with methadone and naltrexone, approved for the treatment of OUD. Buprenorphine is a partial opioid agonist, meaning it does not completely bind to the μ-opioid receptor. As a partial agonist, it has a ceiling effect, meaning its euphoric effects plateau and do not heighten with increased dosing.[11–13] Buprenorphine is currently available as a daily medication or in long-acting forms. It is also available alone or in combination with naloxone.[1] Experts recommend buprenorphine–naloxone forms over other buprenorphine products because naloxone attenuates the partial agonist effect, reducing its euphoric capacity. Naloxone is contraindicated for patients who are pregnant or have co-occurring conditions. Buprenorphine prescribing is limited to qualified office-based prescribers who have a demonstrated or certified ability to treat and manage patients with opioid dependence.[14]

Federal and state governments have implemented policies to increase access to buprenorphine and other medications approved for the treatment of OUD.[11] For instance, policymakers mandated mental health and substance use disorder coverage by public and private payers,[15–18] and expanded the type of providers eligible to prescribe buprenorphine for OUD to include nurse practitioners and physician assistants.[19] However, a persistent barrier to buprenorphine access is prior authorization (PA).

The utilization management practice of PA is employed by insurers and requires healthcare providers to obtain approval from a health plan before a service is delivered to the patient in order to qualify for payment coverage. Existing literature demonstrates that PA policies reduce prescribing of the targeted prescription.[20–24] Research on PA applied to buprenorphine confirms these findings, demonstrating that PA reduces buprenorphine prescribing.[25] A 2020 study using Medicare Part D claims showed plans that removed PA for buprenorphine–naloxone products had an associated increase in the number of buprenorphine–naloxone prescriptions filled, and that PA removal was associated with a decrease in healthcare utilization and expenditures.[26] Furthermore, PA is also associated with reduced likelihood of addiction treatment programs offering buprenorphine products,[27] and providers confirm that PA creates barriers to obtaining reimbursement.[28]

Owing to PA creating barriers to medication access, some public and private programs have removed PA for medications used in the treatment of OUD.[25,29,30] However, PA requirements remain common in Medicaid and private insurance.[25,31,32] Research on Medicaid programs show that although states have increased coverage of medications used in the treatment of OUD, many continue to impose or increase coverage limitations, including PA, that create potential barriers to medication utilization.[33,34] In 2017, although >85% of marketplace plans covered at least 1 buprenorphine formulation, 60% of plans also required PA for at least 1 buprenorphine form.[35]

This study analyzes how state Medicaid programs apply PA to buprenorphine products. As Medicaid is the dominant payor for behavioral health services in the U.S., an analysis of Medicaid PA requirements for buprenorphine products is essential to understanding how states use insurance policies to impact access to medications essential to the treatment of OUD. Existing research does not speak to the prevalence of PA requirements for specific buprenorphine formulations. To help fill this gap, this paper aims to take a formulation-level approach to compare how PA requirements are applied to buprenorphine products by Medicaid programs. We first review how Medicaid programs apply PA to buprenorphine products and then assess how formulation-level requirements impact overall buprenorphine access for Medicaid beneficiaries at the plan-level.

Methods

As of October 2019, there were 8 buprenorphine products available (Table 1). The list includes brand name and generic versions of buprenorphine and buprenorphine/naloxone combination forms, as well as long-acting and daily methods of administration.

Table 1. Available buprenorphine products approved for the treatment of opioid use disorder (October 2019)

Proprietary Name	Buprenorphine or Buprenorphine / Naloxone	Long-acting / Daily	Dosage Form	Approval Date
Probuphine™	Buprenorphine	Long-acting	Implant	2016
Sublocade™	Buprenorphine	Long-acting	Solution	2017
Bunavail™	Buprenorphine / naloxone	Daily	Film	2014
Suboxone™	Buprenorphine / naloxone	Daily	Film	2010
Zubsolv™	Buprenorphine / naloxone	Daily	Tablet	2013
N/A – generic	Buprenorphine / naloxone	Daily	Tablet	2013
N/A – generic	Buprenorphine / naloxone	Daily	Film	2018
N/A – generic	Buprenorphine	Daily	Tablet	2009

Note: Subutex is excluded because it was discontinued at the time of analysis.

In October 2019, a researcher reviewed 45 online accessible Medicaid preferred drug lists (PDLs) for buprenorphine coverage requirements. The research team did not review Medicaid PDLs for 5 states (California, Connecticut, Hawaii, Kansas, and New Mexico) because the formulary was associated with a broken link. A researcher determined if the PDL covered a buprenorphine form, and if coverage required PA. For each buprenorphine product, researchers calculated the proportion of PDLs that covered, covered with PA, and covered without PA, as well as the percentage of plans that covered at least 1 buprenorphine formulation.

Results

Table 2 displays state Medicaid coverage of buprenorphine products in 2019. An overwhelming proportion of Medicaid programs included brand name buprenorphine/naloxone forms in their PDL; 100% of formularies reviewed covered Suboxone™ and Zubsolv™, and 98% of PDLs covered Bunavail™. Although the percentage of PDLs that included tablet buprenorphine/naloxone on the Medicaid formulary was >90%, the proportion including film buprenorphine/naloxone was <65%. Long-acting buprenorphine forms were less likely to be covered by state Medicaid programs with just over half of PDLs covering Probuphine™ (53%) and more than three quarters covering Sublocade™ (75%).

With the exception of Suboxone™, all other buprenorphine formulations were subject to PA by more than two thirds of PDLs. PDLs applied PA frequently to Probuphine™ (92%) and Sublocade™ (82%), both of which are long-acting forms of buprenorphine. Suboxone™ was subject to PA by only 36% of PDLs as compared with Bunavail™ (86%), Zubsolv™ (80%), buprenorphine/naloxone film (79%), and buprenorphine/naloxone tablet (71%).

Although all plans covered at least 1 buprenorphine form, PDLs varied on whether they applied PA to covered products. More than 25% of plans did not cover any buprenorphine product without PA. When

examining buprenorphine/naloxone forms, 66.6% of PDLs covered at least 1 product without PA. Only 7 PDLs covered at least 1 long-acting buprenorphine form without PA, meaning that almost 80% of PDLs imposed a

Table 2. Buprenorphine coverage by state Medicaid programs, 2019

Buprenorphine formulation	Plans that cover the drug n (%)	Plans that cover without prior authorization	Plans that cover with prior authorization
Versions of drug preferred for opioid use disorder maintenance treatment			
Long-acting implant (Probuphine™)	24 (53.3%)	2 (8.33%)	22 (91.67%)
Long-acting injection (Sublocade™)	34 (75.56%)	6 (17.65%)	28 (82.35%)
Buprenorphine/naloxone (Bunavail™)	44 (97.78%)	6 (13.64%)	38 (86.36%)
Buprenorphine/naloxone (Suboxone™)	45 (100.00%)	29 (64.44%)	16 (35.56%)
Buprenorphine/naloxone (Zubsolv™)	45 (100.00%)	9 (20.00%)	36 (80.00%)
Buprenorphine/naloxone (generic tablet)	42 (93.33%)	12 (28.57%)	30 (71.43%)
Buprenorphine/naloxone (generic film)	29 (64.44%)	6 (20.69%)	23 (79.31%)
Versions of drug recommended only for select opioid use disorder populations			
Buprenorphine (generic tablet)	45 (100.00%)	11 (24.44%)	34 (75.56%)
At least 1 buprenorphine form	45 (100.00%)	33 (73.3%)	44 (97.78%)
At least 1 long-acting form	34 (75.56%)	7 (20.59%)	28 (82.35%)
At least 1 buprenorphine/naloxone form	45 (100.00%	30 (66.67%)	41 (91.11%)

Note: The percentage of plans that cover the drug is the proportion of all reviewed preferred drug lists (45). The percentage of plans that cover the drug with and without prior authorization is the proportion of plans that cover the drug, so the denominator varies by buprenorphine formulation and equals the n calculated for the number of plans that cover the drug.

PA requirement to either Probuphine™ or Sublocade™.

Discussion

This study examined Medicaid coverage of buprenorphine products in 2019, and highlights important state-level differences in access to buprenorphine. Although Medicaid programs largely cover buprenorphine products, many continue to apply PA requirements. Even Suboxone™, the buprenorphine form least associated with PA requirements, is subject to PA in more than one third of state Medicaid programs. Though all PDLs cover at least 1 buprenorphine product, more than 25% of the reviewed Medicaid formularies impose a PA restriction to all covered buprenorphine products.

In the midst of the opioid epidemic, it is challenging to justify the exclusion of buprenorphine from Medicaid coverage, as well as the imposition of burdensome utilization management practices on essential medications used in the treatment of OUD. Indeed, these findings demonstrate that Medicaid continues to diverge from other health insurance markets that experienced a recent decline in PA requirements as a response to the opioid crisis,[26] and confirms the legacy of stringent PA requirements to buprenorphine applied by Medicaid programs.[25,31,32,34]

As policymakers consider strategies to decrease opioid-related morbidity and mortality, they should consider opportunities to mandate the removal of PA. Government policies that decrease the proportion of

plans requiring PA for buprenorphine products can lead to increases in prescribing rates and decreases in healthcare utilization and expenditures.[26] This is particularly important among state Medicaid programs. Medicaid is not only the dominant payer of behavioral health services, but Medicaid enrollees are more likely than their peers with other health coverage to experience an OUD.[36]

This study has limitations and highlights opportunities for future research. First, the authors are unable to make any statements about the implications of applying PA to buprenorphine forms in relation to treatment access. Future research should expand upon this project by examining how variation in PA requirements applied to buprenorphine products impacts prescribing, availability of buprenorphine, and healthcare utilization and expenditures. Second, this research does not shed light on why Suboxone™ is the preferred buprenorphine form. However, the findings may be another symptom of the documented anti-competitive practices of Reckitt Benckiser, Suboxone's™ parent company, which include product hops, citizen petitions, and Risk Evaluation and Mitigation Strategy abuses aimed to sustain high prices for Suboxone™ by extending brand exclusivity and impeding generic entry.[37,38] Future research should explore the hypothesis that pharmaceutical companies, in this case Reckitt Benckiser, may strategically lobby for the application of utilization management techniques to promote their products and limit prescribing of competitor forms. Finally, the data do not offer insights into how to define adequate buprenorphine access. Researchers should explore how the application of PA to different types and quantities of buprenorphine products impacts the ability of Medicaid beneficiaries to access and adjust the medication form most appropriate to their healthcare needs.

Conclusions

This study expands upon existing literature by examining the application of PA requirements to buprenorphine products by Medicaid programs. It found that although many states cover buprenorphine

forms, many limit access to buprenorphine through PA practices.

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