Reese Family Practice, P.C.
Randy Reese, M.D.

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November 29th, 2018

Oregon Health Plan (OHP) aka Trillium Product and Therapeutic Committee:

I have been in private practice in the primary care setting for over 30 years. I have been board certified in Emergency and Geriatric Medicine in addition to Family Practice. I have also worked at the largest Psychiatric Hospital in the United States. This is to say that in my years of serving the community it has been of dire importance to offer depth and breadth of experience to my patient care.

In 2017 I saw it as my duty to help my patients who are suffering from opiate addiction. I have seen this disease cripple families and destroy lives and I see drug addiction, especially, opiate addiction, as a public health crisis and as a Family Physician it is my responsibility to offer options for my patients to heal this disease. I have been able to see lives transform with inductions onto Buprenorphine, but for some of my patient's this treatment is not enough. As you may know that any successful addiction treatment is coupled with supportive behavioral therapy, but not only are we in a crisis for opiate addiction, we are in a crisis for mental health workers that accept Medicaid insurance to support this population. This is just one piece of the puzzle that has interfered with the ability to successfully treat these patient's that suffer from moderate to severe opiate addiction. The concern that I hope to stress upon you today is that Medication Assisted Treatment (MAT) for some of my patient's with moderate to severe opioid use disorder with Buprenorphine tablets or films is just not enough. In my experience the patients that have moderate to severe opioid use on oral Buprenorphine have the ability to stop and start treatment at their will to allow them to resume use of their drug of choice, be it heroin or prescribed opiates despite MAT. In these patients it is futile to utilize oral treatment as this is not treating the disease but allowing the patient to continue to allow their disease to be in control. In these patient's it is my only recommendation to utilize injectable Buprenorphine in the form of Sublocade. By using an injection the patient's with moderate to severe opioid use disorder are given their life back. They are no longer "tied" to a pill or film to curb their cravings to relapse. They no longer have the ups and downs of oral dosing with inconsistent Buprenorphine concentrations in their blood which eliminates the break-through cravings in-between dosing. Lastly, they no longer have a daily reminder of taking something to treat their addiction and I have seen my patient's with opioid use disorder feel liberated from their disease when they are transitioned to Sublocade.

As a prescriber, I am limited to treat my patients based on formularies and if a medication is not included in the formulary and the process to even just have the insurance company consider making an exception is tedious and time consuming. I plead Oregon Health Plan (OHP) aka Trillium to consider adding Sublocade as a step-wise treatment in their formulary for patients with moderate to severe opioid use disorder and improve access to this life changing an lifesaving medication.

Thank you for your consideration on this matter in helping our community.

From: Katie Nicosia
Sent: Wednesday, November 28, 2018 8:19:08 PM
To: Pharmacy Drug Information
Subject: OUD/Sublocade 11/29/18 meeting

To Whom It May Concern (and it should concern all of us),

Let me start off by thanking you for giving me this opportunity to discuss my experience and voice my concerns regarding Opioid Use Disorder treatment and PA issues.

I am a Family Nurse Practitioner who owns The Reclaim Clinic. I am the sole provider/prescriber. My practice is in a rural portion of Yamhill County in Newberg and I currently have roughly 45-50 patients (although this is increasing rapidly), all of whom have Opioid Use Disorder. Over 90% of my patients have Medicaid insurance.

For the last several months, I have been lucky enough to initiate Sublocade (XR injectable buprenorphine) on four patients. These patients have had tremendous success (holding down jobs for the first time, getting promotions, going to college, and ..... one even started having shoes on himself and his daughter during appointments with me for the first time in a year)! All of them had severe Opioid Use Disorder and had been 'failing' suboxone or rather suboxone had been failing them despite their commitment to recovery.

For each of those patients, I had to spend countless hours trying to get insurance companies (one has commercial; one has commercial and OHP; two have solely OHP) to approve a Prior Authorization. I even had to appeal initial denials. Now, let me point out that these are the patients that I have eventually gotten approvals for Sublocade. I am now starting to get denials to my appeals for other OHP patients that I know would benefit from Sublocade. The last patient I appealed and OHP continued to deny has now relapsed and his family does not know where he is. This is a person (not a number) who wanted help, who came to me for help, who I have been working with for a year, who now could be dead because insurance companies (namely OHP) have placed more importance on their box-checking than my clinical experience, my professional recommendations, and their customer's life.

Of course, I assume, these non-sensical PA denials come down to finances. Sublocade obviously costs more per month than generic Suboxone sublingual tablets. However, if Suboxone is not working and the patient continues to relapse, the treatment needs to be re-evaluated. What are the next options for these patients? The patient could continue to be prescribed suboxone and we could all magically think that somehow the patient with severe OUD and no social support will suddenly stay clean despite history showing us that suboxone is not actually treating this patient. In this case, the patient would continue to relapse and has a high chance of an overdose that is either fatal or lands them for weeks in an ICU with anoxic brain injuries ($$$$). Or, the patient could go into an inpatient facility. This is terribly expensive and does not come with a guarantee the patient will remain clean (we all know the relapse rates for OUD even with inpatient treatment). Again, $$$$. Or, the patient could be transported daily to a methadone clinic.

This was one CareOregon PharmD's choice for one of my patients whom I tried to get Sublocade covered for. Let's think about that. Transportation paid for by OHP daily to a methadone clinic (Tigard or Salem are the closet ones for my patients) is disgustingly expensive and reinforces the "professional patient" stigma which keeps daily dosed patients from getting jobs and becoming contributing members to society. Wait for it....$$$$. Also, methadone is one of the most common prescription drugs involved in opioid overdose deaths. Or, the patient could receive a once-monthly injection of XR buprenorphine. They will receive a steady dose of buprenorphine that will decrease cravings and allow them to move on with their lives and strengthen their recovery.

Since opening my practice two years ago, my relapse rate is 30% with a success rate of 70% based on continued clean time. My goal is to improve that to 80% success rate and getting my high risk patients on Sublocade would be one excellent way to save more of my patients' lives.

Thanks again for taking the time to read this and please do not hesitate to contact me!

Katie Nicosia FNP
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From: Dr. Martin Klos MD MBA
Sent: Wednesday, November 28, 2018 10:06:21 AM
To: Pharmacy Drug Information
Subject: Addiction med treatment

I am a little reluctant to send this email as I found out in the past that the P&T committee is relatively useless in dealing with our CCOs. However as a board certified addictionologist I am a strong advocate of any and all treatments for addiction, including the new medicine Sublocade. It and others like it (still in the pipeline) will allow longer term treatments for addiction and may help to decrease our relapse rates. My reluctance about addressing the P&Y committee is because I have seen the sad response of the CCOs to your previous recommendation of stopping prior authorizations for addiction medicine treatment. Our local CCOs where I work (Lane, Douglas and Clatsop county) all put onerous or impossible requirements on the PA system so that my patients have in several cases relapsed and are using Heroin instead of receiving this life saving therapy. It is disappointing to say the least.

Martin M. Klos MD MBA

From: Diman R Lamichhane
Sent: Wednesday, January 16, 2019 8:42:24 AM
To: Pharmacy Drug Information
Subject: Written Testimony

To Oregon Medicaid,

I am writing this letter as a request to add Xeljanz in the preferred drug list. It is effective, safe and liked by the patient as it is oral.

Diman Lamichhane MD
Rheumatologist
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January 10, 2019

ATTN: Oregon Pharmacy & Therapeutics Committee

We are writing this letter in anticipation of the upcoming review of Biologics for Autoimmune Conditions on January 24, 2019.

We are asking that the P&T Committee consider adding Xeljanz to the preferred drug list for Oregon Medicaid patients.

Xeljanz has been effective at relieving the signs and symptoms for many of our Rheumatoid Arthritis and Psoriatic Arthritis patients, with a meaningful improvement in quality of life. When we are determining the best treatment options for these patients, there are circumstances in which a non-biologic, oral agent, with the flexibility to be used with or without Methotrexate, is deal. Currently, the preferred medication on the Oregon Medicaid formulary are both TNF biologics. It would be of great value to our patients if a medication with an alternative mechanism of action, specifically Xeljanz (JAK inhibitor), be available first line as well. Please consider removing the current step edit that is in place, allowing us to prescribe Xeljanz earlier for the appropriate patients.

We would appreciate this letter being read during your upcoming review. Thank you for your consideration.

Sincerely,

Neha Rich-Garg, M.D.

11/29/2018

To Whom it Concerns

My name is Maria Fife. I am a family nurse practitioner working in primary care in Stayton, Oregon. I am also buprenorphine waivered and served as an RN in a chemical dependency treatment center for four years prior to becoming a nurse practitioner. I have seen buprenorphine save countless lives.

I wanted to address the coverage of medications related to opioid substance use disorder. Currently, Willamette Valley Community Health is covering generic buprenorphine/naloxone tablets (with an occasional exception of buprenorphine monotherapy) only. Perhaps it's variability in the manufacturing of the medication or perhaps it's part of addiction, but often the tablets are not sufficient. I have patients that are requesting doses beyond ASAM guidelines, that are still struggling with cravings at 24 mg which keeps them at a high risk for relapse. With relapse there is often overdose and death.

It's my recommendation that the Oregon Health Plan start considering other buprenorphine treatments. I am very interested in providing my patients the monthly injectable buprenorphine or the implantable buprenorphine. I think this is a safer alternative for some patients as the longer steady-state of the medications can decrease cravings. It also requires less maintenance and eliminates the risk of abusing the medications, all very good things for these high-risk patients. While the medications are expensive, they are more cost-effective than hospitalizations related to over-dose and allows patients to resume normal activities to include working.

I want to thank you for your attention to this matter. I am sorry that I was not able to make it to the meeting in person, I did not have enough notice to arrange for it. I felt it was important enough of a topic to at least provide input.

Thank you,

Maria Fife, FNP-C

Canyon Family Health

Stayton, OR