The study was a prospective cohort with a concurrent control comparison utilizing administrative pharmacy claims data. The Florida Blue PBM, Prime, identified members during a 3-month period (April–June 2017) who had high opioid and controlled substance utilization and filled most of their opioid claims at either Walgreens Florida pharmacy in Florida intervention group or a non-Walgreens retail pharmacy chain in Florida (control group). The list of intervention group members was sent to Walgreens pharmacy chain in July 2017 to provide the Opioid Safety Guide at the member’s next opioid prescription dispensing.

Study population:
An a priori study design was used by identifying the Walgreens intervention group, whether or not they receive an Opioid Safety Guide and pharmacist consultation were calculated. If a member did not receive a consultation, an index date was assigned based on their first claim. If a member did not have an opioid claim, an index date was assigned at random.

A control group was created using identical Florida Blue member identification numbers for members who filled most of their opioid claims at Walgreens retail pharmacy chain. Member information was not sent to the non-Walgreens retail chain pharmacy.

• Members were included in the analysis if they had a controlled substance score greater than or equal to four consecutive quarters, more than one opioid claim, and were continuously enrolled during a 300-day pre- and post-period.

• Opioid claims were identified by Generic Product Identifier (GPI) from the Pharmacy Quality Alliance (PQA’s) list of opioids.

• A post-difference-in-difference analysis was implemented to re-intervene the intervention group’s change in study outcomes from the pre-index (baseline) period to the post-index period and compared change to changes in the control group.

Outcome measures:
• Naloxone in all forms were compared in the pre-period versus the post-period.

• Opioid utilization was assessed by opioid diversion, morphine milligram equivalents (MME), and overall opioid claim count. MME was calculated using the Centers for Medicare and Medicaid services (CMS) overspill monitoring system (OMS) method.

• Note: All morphine products were excluded.

• Opioid diversion was defined by a member who did not have opioid drug supply in the last 45 days at the end of the post-period.

• Overall opioid claim count was assessed by the average number of claims per member in the pre- versus post-period.

• Average number of opioid prescriptions per member and whether a member had a long-acting opioid in their chart at any time were also noted.

• SAS 9.4 (SAS Institute Inc., Cary, NC) was used for all analyses.

• Generalized linear models were fit to measure the outcome changes in the 180 days post-index (July–December) compared to the 180 days pre-index data between the intervention and control group members, with adjustment for age, gender, Charlson Comorbidity Index score, and body mass index.

• Statistical significance for all analyses was set at p < 0.01.

Results
The intervention was associated with a 9-fold increase in odds of members receiving a naloxone claim*.

Conclusions
This study found a 9-fold increase in odds of a member receiving naloxone, consistent with the U.S. Surgeon General’s Advisory recommending naloxone access for high opioid dose users.

Results suggest the collaboration was impactful between a health insurer, pharmacy benefit manager and chain pharmacy to identify high dose high opioid users and manage with an Opioid Safety Guide at prescription pick up.

Additional work is needed to determine successful opioid dose reduction interventions.

References