WISAM Newsletter: March 23, 2017 Teleconference

Moderator: Aleksandra Zgierska (WISAM President; Madison)

Present: Dr. Aleksandra Zgierska (President); Dr. Matthew Felgus (President-Elect); Dr. David Galbis-Reig (Secretary); Dr. Nameeta Dookeran (Chair, Educational Committee); Dr. Subhadeep Barman (Member, Educational Committee), Dr. Mary Anne Kowol, Dr. Joseph Blustein, Dr. Blaise Vitale, Dr. Robert Sedlacek, Dr. John Ewing, MaryAnne Steiner, PharmD; Brad Bachman (ASAM's Manager of State Government Relations); Eric Osterman (BadgerBay)

Main topics addressed at tonight's teleconference

1. ASAM's State Government Relations Resource

Brad Bachman, ASAM's Manager of State Government Relations, discussed the assistance that ASAM can provide to WISAM and Wisconsin clinicians on the state level so that WISAM / clinicians can be effective in promoting change to benefit clinical community and our patients. He can also assist chapters with legislative matters and regulatory issues that are relevant to Wisconsin. This may include advice on building coalitions to advance common goals or addressing burdensome prior authorization or other issues that make clinician's work more difficult and harder for patients to access medications / other treatments.

ASAM's website has an advocacy site (http://www.asam.org/advocacy) that provides updates on advocacy related issues (http://www.asam.org/advocacy/issues), including on the state level. For example, on the Advocacy Issues site, one can check bills related to opioids that ASAM identified as concerning (there is an interactive map in the middle of the page that allows to see each state's concerning bills, if there are any); of note, no concerning opioid-related bills have been identified in Wisconsin.

If we are aware of any concerning bills related to the field of addiction care, or would like to get Brad's input / assistance, we can contact Brad at bbachman@asam.org or 301-547-4107.

The teleconference attendees brought to Brad's attention one existing bill which criminalizes the disease of addiction and deters women from treatment; the Wisconsin Act 292 of the Children's Code allows clinicians and other clinical staff to report to child protecting services / law enforcement if a woman is using drugs during pregnancy. Both ASAM and WISAM, along with other medical societies, support the repeal of this law. Representative Chris Taylor (D-Madison) is involved in the effort to create a coalition that would help repeal this law. This is particularly timely, as there is currently a lawsuit against the State of Wisconsin brought by a formerly-

pregnant woman who was incarcerated after seeking help for and disclosing drug use during pregnancy (http://www.slate.com/blogs/xx_factor/2014/12/16/tamara_loertscher_wisconsin_mother_is_thrown_in_jail_for_refusing_drug_treatment.html; http://archive.jsonline.com/news/wisconsin/pregnant-woman-challenging-wisconsin-protective-custody-law-b99411705z1-287395241.html).

2. Wisconsin-led lawsuit against the makers of buprenorphine

Wisconsin Attorney General Brad Schimmel is leading a 36-state lawsuit against the Suboxone producers (http://www.wpr.org/wisconsin-leading-antitrust-lawsuit-against-indivior-and-monosol-rx-makers-suboxone). Schimel and other attorneys general allege that drug makers Indivior and MonoSol Rx conspired to raise false safety concerns (eg, higher rate of pediatric deaths with tablets) about the tablet form of Suboxone so that they could recommend change from a tablet to a film form. Those changes extended the period when generic competitors were barred from entering the market for the film form, thus impacting pricing and access to this medication for patients.

Clinicians on the call discussed their experiences with different preparations of buprenorphine. The film form allows for the tracking of an individual medication: individual number on the film package can be tracked and traced down to an individual person / prescriber, if the pharmacy keeps track of the LOT numbers of dispensed Suboxone. Some clinicians use the LOT number on the films as one of the measures to identify a potential diversion / sharing of the films (if the numbers are not consecutive or with different LOTs – which may indicate different "batches" of medication, which, in turn, may suggest diversion).

None of the clinicians on the call have started using Probuphine. Some clinicians have been trained to place it (eg, Dr. Ewing) but have not implemented it due to the cost (the provider needs to buy the product up front, whioch is ~ $5,000 expense); in addition, the current indications make Probuphine suitable for a very selected group of patients only. Although the insert states, it is for patients who have been stabilized on up-to 8 mg/day of buprenorphine, it is unclear if it is appropriate to offer it to those who are stable on a very low daily dose of buprenorphine.

Clinicians have been much more excited about the potential of long-acting, injectable buprenorphine, which may become available in 1-2 years; clinical trials assessing these medications are still ongoing. This option would resemble more our current therapy with long-acting, injectable naltrexone.

3. ePDMP

The clinicians discussed their experience with the new ePDMP. The area of concerns, endorsed by all on the call, related to the way how daily doses of buprenorphine are converted to morphine-equivalent doses (MEDs). Because of the currently used conversion ratio, essentially all patients treated with buprenorphine for addiction are "calculated" to be on the MED doses that usually exceed the CDC recommended daily doses for pain care; therefore, majority of patients treated with buprenorphine for addiction are "flagged" in the ePDMP as exceeding 50

and 90 mg/day of MED, flagging them as "high-dose" opioid patients. First, this is inconsistent with clinical practice, in which buprenorphine is placed in a different category than full-agonist opioids and considered safer that other opioids (eg, it has a ceiling effect = effects are NOT dose dependent in the same way as for full-agonist opioids). Second, this "flagging" of buprenorphine-treated patients as those on a high daily opioid dose is concerning to clinicians who worry that this could lead to scrutiny / disciplinary actions.

While discussing the ePDMP, we were reminded that opioid treatment programs (OTPs) are not reporting buprenorphine or methadone they dispense (this is due to the confidentiality laws); in addition, VA pharmacies are not required to report (they can on a voluntary basis). It is worth knowing that the ePDMP-recorded "fill date" means the date when the medication was placed in the bottle, not necessarily when the patient picked it up (ie, the fill date can be earlier than the pick-up date).

Reminder: register for the ePDMP

All prescribers need to register for the new Wisconsin ePDMP at https://pdmp.wi.gov/. Beginning April 1, 2017, it will be mandatory for all prescribers to query the ePDMP prior to issuing a prescription for any controlled substance except under the following circumstances: (2015 Wisconsin Act 266):

a. The patient is receiving hospice care, as defined in s. 50.94 (1) (a).
b. The prescription order is for a number of doses that is intended to last the patient 3 days or less and is not subject to refill.
c. The monitored prescription drug is lawfully administered to the patient.
d. Due to emergency, it is not possible for the practitioner to review the patient's records under the program before the practitioner issues a prescription order for the patient.
e. The practitioner is unable to review the patient's records under the program because the digital platform for the program is not operational or due to other technological failure if the practitioner reports that failure to the board.

Meeting adjourned at 8:06 PM.

The next WISAM Teleconference will occur on Thursday, Apr 27, 2017, 7-8 PM.

Please let Cindy Burzinski, WISAM's Executive Administrator, know if you have suggestions for topics to discuss at the upcoming teleconference or if there are any errors in the current document: Cindy.Burzinski@fammed.wisc.edu

IMPORTANT REMINDERS

Please remember to **renew your ASAM / WISAM membership** or consider becoming a member (open to all clinicians). More details can be found at: http://www.asam.org/membership

Please mark your calendars for the **ASAM's 48th Annual Conference** on April 6-9, 2017 in New Orleans (http://www.asam.org/education/live-online-cme/the-asam-annual-conference).
The WISAM meeting at this conference will be held on Friday, Apr 7, 1-2 PM.

Please mark your calendars for the **WISAM 2017 Annual Conference** on September 14-16, 2017 at the Pyle Center, Madison, WI
(Thu and Fri: educational topics and workshops; Sat: buprenorphine / Probuphine® training).

RESOURCES
TO ENHANCE CLINICAL CARE RELATED TO ADDICTION MEDICINE

FREE CSAM Webinars
These live webinars are FREE for all clinicians (4th Fri of the month, 12-1 PM PST). Current series of 12 monthly webinars is designed to support the implementation of Medication Assisted Treatment (MAT) in primary care. In general, CSAM (California Society of Addiction Medicine) offers great resources, available at: http://cme.csam-asam.org/content/buprenorphine-resources#overlay-context=courses

FREE Provider's Clinical Support System (PCSS) for Medication-Assisted Treatments (PCSS-MAT: http://pcssmat.org) and Opioid Prescribing (PCSS-O: http://pcss-o.org): excellent free resource, funded by a grant from SAMHSA; it offers free webinars available "real-time" or via the archived library. One can sign up for regular news emails from them.

FREE David Mee-Lee's monthly Tips and Topics, sent via email (one needs to sign-up to it), it is an excellent resource:
dmeelee@changecompanies.net
http://www.changecompanies.net

FREE Join Together Daily News is a news service from the Partnership for Drug-Free Kids that provides daily or breaking news on the top substance abuse and addiction news that impacts our work, life and community. It also provides original reporting and/or commentary features published every Wednesday by influential thought leaders in the addiction field or staff.
http://www.drugfree.org/join-together/

PAID The Carlat Report: Addiction Medicine (however, it appears to be a paid resource, ~$109/year); a link to the copy of the recent report is attached so that you can get a flavor of what it is: http://carlataddictiontreatment.com/sites/default/files/CATR_May2016.pdf

The National Academy of Sciences (IOM) Recent Report on Cannabis

"*The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research*" was published in Jan 2017; free copy is available for a limited time at the following web site:

https://www.nap.edu/login.php?record_id=24625&page=https%3A%2F%2Fwww.nap.edu%2Fdownload%2F24625.

a. The report's tone is generally favorable toward use of cannabis as medicine despite not-so-convincing evidence on some of the recommendations.
b. The report is surprisingly sparse on discussing potential adverse effects of cannabis and cannabinoids (in general).
c. The report makes recommendations regarding the need for more research.
d. Provides should familiarize themselves with the report as patients (and other professionals) are likely to ask questions about this issue.
e. It's worth remembering that marijuana use is illegal in Wisconsin; professional societies, including the ASAM/WISAM, overall do not endorse its use (as a plant) for medicinal purposes due to lack of convincing evidence for effectiveness, while, at the same time, presence of evidence for harms, including addiction (as outlined in a recent ASAM's white paper on this topic); cannabis produces sedating effects, which can potentiate sedating effects of other substances, eg, opioids.