Controlling Utilization Through Formularies

December 3, 2014
About Helios

Helios, the new name for Progressive Medical and PMSI, is bringing the focus of workers’ compensation and auto-no fault pharmacy benefit management, ancillary services, and Settlement Solutions back to where it belongs – the injured party. Along with this new name comes a passion and intensity on delivering value beyond just the transactional savings for which we excel. To learn how our creative and innovative tools, expertise, and industry leadership can help your business shine, visit www.HeliosComp.com.
Today’s Webinar

► The presentation will last one hour

► All attendee phones are muted, but you can ask questions using the chat box on the right side of your screen.

► If we are unable to answer your question during the presentation, we will respond to you via email shortly following the webinar

► There is no CE available for this webinar

► The slide deck will be emailed out to all registrants of this webinar

► At the end of today’s webinar, we ask that you complete a short survey to let us know if the information shared today was helpful and what information you’d like us to cover in the future
Your Presenters

Brian Allen, VP Government Affairs

Matt Foster, PharmD
Clinical Pharmacy Manager
WORKERS’ COMPENSATION
POLICY EVOLUTION
Workers’ Compensation Medication Policy Evolution

► The public policy debate and efforts on workers’ compensation and medical costs continue to evolve

► Initial public policies focused on reducing front end costs by reducing fee schedules
  - Led to blanket cuts/reductions in pharmacy fee schedules
  - Looked at efforts to replace Average Wholesale Price (AWP) with another source or reduce dispensing fees
  - Failed to reduce key cost driver

► As medical and pharmacy data became more readily available policy drivers shifted
  - Utilization of medical services became the target
  - States began to pay attention to utilization, implementing generic mandates, and limited prior authorization requirements
  - Still focused on controlling medical price and short-term utilization fixes

► Eventual focus on data driven results – WCRI/NCCI/CWCI – Lead to a “Eureka Moment”
  - Marketplace became aware of long-term utilization as a cost driver
  - Efforts to control utilization – both as cost driver and safety factor – became more prevalent
  - Long-term costs – opioids and loss work time – also factored into present day policy efforts
Early Treatment Guideline and Formulary Efforts

The “Monopolistic” state of Washington leads the way for others

► Initiates a Preferred Drug List (PDL) for workers’ compensation claims
► Develops and implements the first formulary applicable to workers’ compensation claims

**PDL**

► State Preferred Drug List from which Dept of L&I uses a subset for WC
► Non-preferred Medications generally require prior-authorization

**Outpatient Medication Formulary**

► Formulary developed by Pharmacy and Therapeutics (P&T) Committee
► Medications are permitted or require prior authorization – Medications not prior authorized can be denied
Early Treatment Guideline and Formulary Efforts

Texas workers’ compensation reforms in 2005 take bold step forward

- Still required rule-making
- First of its kind - closed or open formulary
- Not initiated until 2011 and not fully implemented until 2013
- Oklahoma quickly follows suit  More to come?

Closed Formulary
- New claims impacted in 2011 and legacy claims in 2013
- ODG Drug Appendix A classifies medications
- “N” drugs deemed not medically necessary (front line usage)
- Usage of “N” drugs require prospective utilization review for medical necessity
- Initial indications are that 85% of “N” drugs have been changed by pharmacy outreach
The Second Wave

Delaware

PDL List
► “Preferred” and “non-preferred” medications
► Proof of non-preferred medication usage and written justification (state format) for all preferred medications

Prior written authorization
OxyContin®, Oxycodone ER, Actiq® and transmucosal Fentanyl

New York

Non-Acute Pain Treatment Guidelines
► Assist doctors in treating non-acute pain with both opioids and non-opioids
► Requires greater communication between provider and patient
► Includes treatment agreements and documentation

Oklahoma

Closed Formulary
► Implemented a Closed Formulary
► Requires prior-authorization on all medications indicated as “N” by ODG
► Requires prior-authorization for all compounds
► Implemented in 2014 – Eventual data and results will be telling
MEDICATION USE IN WORKERS’ COMPENSATION
Workers’ Compensation vs. Group Health

Medication Utilization By Class

- The top medication classes in workers’ compensation are drastically different than those in group health
- Representative of the treatment of physical injuries versus other chronic disease treatments

<table>
<thead>
<tr>
<th>Rank</th>
<th>Workers’ Compensation</th>
<th>Group Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Narcotic Analgesics</td>
<td>Lipid-regulators</td>
</tr>
<tr>
<td>2</td>
<td>Anticonvulsants</td>
<td>Antidepressants</td>
</tr>
<tr>
<td>3</td>
<td>NSAI Ds</td>
<td>Narcotic Analgesics</td>
</tr>
<tr>
<td>4</td>
<td>Antidepressants</td>
<td>Beta-blockers (hypertension)</td>
</tr>
<tr>
<td>5</td>
<td>Dermatologics</td>
<td>ACE-inhibitors (hypertension)</td>
</tr>
<tr>
<td>6</td>
<td>Muscle Relaxants</td>
<td>Antidiabetics</td>
</tr>
<tr>
<td>7</td>
<td>Ulcer medications</td>
<td>Respiratory agents</td>
</tr>
<tr>
<td>8</td>
<td>Sedative-hypnotics</td>
<td>Ulcer medications</td>
</tr>
<tr>
<td>9</td>
<td>Respiratory agents</td>
<td>Diuretics (hypertension)</td>
</tr>
<tr>
<td>10</td>
<td>Antipsychotics</td>
<td>Anticonvulsants</td>
</tr>
</tbody>
</table>

Source: IMS Health, National Prescription Audit, Dec 2010; Progressive-PMSI Annual Drug Trends 2013
Workers’ Compensation vs. Group Health

*Utilization By Medication*

- The top medications in workers’ compensation demonstrate an even further divergence between workers’ compensation and group health.

- Half of the top medications in workers’ compensations are opioids; no opioids are in the top spend in group health.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Workers’ Compensation</th>
<th>Group Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>OxyContin (opioid)</td>
<td>Abilify (antipsychotic)</td>
</tr>
<tr>
<td>2</td>
<td>Lidoderm (dermatologic)</td>
<td>Nexium (antacid)</td>
</tr>
<tr>
<td>3</td>
<td><strong>Cymbalta (antidepressant)</strong></td>
<td>Humira (biological)</td>
</tr>
<tr>
<td>4</td>
<td>Celebrex (antiinflammatory)</td>
<td>Crestor (lipid disorder)</td>
</tr>
<tr>
<td>5</td>
<td>Lyrica (anticonvulsant)</td>
<td><strong>Cymbalta (antidepressant)</strong></td>
</tr>
<tr>
<td>6</td>
<td>Vicodin/Lortab (opioid)</td>
<td>Advair (antiasthmatic)</td>
</tr>
<tr>
<td>7</td>
<td>Percocet (opioid)</td>
<td>Enbrel (biological)</td>
</tr>
<tr>
<td>8</td>
<td>Duragesic (opioid)</td>
<td>Remicaide (biological)</td>
</tr>
<tr>
<td>9</td>
<td>Neurontin (anticonvulsant)</td>
<td>Copaxone (biological)</td>
</tr>
<tr>
<td>10</td>
<td>Opana ER (opioid)</td>
<td>Neulasta (blood modifier)</td>
</tr>
</tbody>
</table>

Source: [http://www.drugs.com/stats/top100/2013/sales](http://www.drugs.com/stats/top100/2013/sales); Progressive-PMSI Annual Drug Trends 2013
MEDICATION AVAILABILITY IN WORKERS’ COMPENSATION
Medications Availability in Workers’ Compensation

- Formularies
- Treatment Guidelines
- Therapeutics
- Financial Aspects
FDA approved indications - Based on initial submissions to FDA (Other indications may be approved before patent life runs out.)

Off-label use
- Very common in workers’ compensation, especially in treatment of nerve pain
- Case reports of success (or failure) for use outside the FDA indication
- Additional clinical studies that were not submitted to the FDA

Post-marketing surveillance (safety) - May drive restrictions to use; Black Box warnings
Black Box Warnings

► At time of FDA approval, or from post marketing surveillance, a medication may receive a “black box warning”
► May be medication-based or class-based (NSAIDs, Long-acting Opioids)

**WARNING: CARDIOVASCULAR AND GASTROINTESTINAL RISK**

*See full prescribing information for complete boxed warning*

**Cardiovascular Risk**
- Nonsteroidal anti-inflammatory drugs (NSAIDs) may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at greater risk. (5.1)
- Flector Patch is contraindicated in the peri-operative setting of coronary artery bypass graft (CABG) surgery. (4)

**Gastrointestinal Risk**
- NSAIDs, including diclofenac, cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at greater risk for serious gastrointestinal events. (5.2)

**WARNING: ADDICTION, ABUSE, AND MISUSE: LIFE-THREATENING RESPIRATORY DEPRESSION; ACCIDENTAL INGESTION; NEONATAL OPIOID WITHDRAWAL SYNDROME; and INTERACTION WITH ALCOHOL**

*See full prescribing information for complete boxed warning.*

- **OPANA ER exposes users to risks of addiction, abuse, and misuse, which can lead to overdose and death. Assess each patient’s risk before prescribing, and monitor regularly for development of these behaviors or conditions. (5.1)**
- **Serious, life-threatening, or fatal respiratory depression may occur. Monitor closely, especially upon initiation or following a dose increase. Instruct patients to swallow OPANA ER tablets whole to avoid exposure to a potentially fatal dose of oxymorphone. (5.2)**
- **Accidental ingestion of OPANA ER, especially in children, can result in fatal overdose of oxymorphone. (5.2)**
- **Prolonged use of OPANA ER during pregnancy can result in neonatal opioid withdrawal syndrome, which may be life-threatening if not recognized and treated. If opioid use is required for a prolonged period in a pregnant woman, advise the patient of the risk of neonatal opioid withdrawal syndrome and ensure that appropriate treatment will be available (5.3).**
- **Instruct patients not to consume alcohol or any product containing alcohol while taking OPANA ER because co-ingestion can result in fatal plasma oxymorphone levels. (5.4)**
Financial Aspects

► Cost of Medication
  – Direct costs (cost of prescription)
  – Indirect costs (lab tests, follow up visits, administration devices)

► Availability
  – Retail
  – Specialty pharmacy

► Preferred Drug Lists
  – Drives towards specific branded medications
  – Still emphasizes the need to use generic medications as first-line therapy
Treatment Guidelines (Association)

*Established using critical reviews of literature and other indicators to define place in therapy*

- Evidence based
- Total body of evidence
- Harms
- Clarity
- Functional improvement
- Return to work
- Less invasive
- Cost
- Informed patient
Treatment Guidelines (State)

Multiple states have applied treatment guidelines

- Official Disability Guidelines (ODG)
- American College of Occupational & Environmental Medicine (ACOEM)
- Individual

Without Radiculopathy (90% of cases)

- If necessary, based on severity and difficulty of job, while encouraging return to activity as much as possible; limited passive therapy with heat/ice (3-4 times/day), stretching/exercise (training by physical therapist OK), appropriate analgesia (i.e., acetaminophen) and/or anti-inflammatory (i.e., ibuprofen) [Benchmark cost: $44], back to work except for severe cases in 72 hours, possibly modified duty, AVOID bed rest.
- REASSURE PATIENT: Patient education is common problem, usually a self-limiting and benign disease that tends to improve spontaneously over time (See Return to work for studies on recovery time).
- No X-Rays unless significant trauma (e.g., a fall).
- If muscle spasms, then consider muscle relaxant with limited sedative side effects [Benchmark cost: $44] (Note: The purpose of muscle relaxants is to facilitate return to work, but muscle relaxants have not been shown to be more effective than NSAIDS).

ODG Return-To-Work Pathways (B47.2 lumber sprain & 724.2 lumber):

- Modified Duty:
  - Mild (Grade I):
    - Clerical/modified work: 0 days
  - Severe (Grade II-III):
    - Clerical/modified work: 3 days

(See ODG Capabilities & Activity Modifications for Restricted Work under "Work" in Procedure Summary for Ergonomic accommodations)

- Second visit (day 3-10 — about 1 week after first visit, or sooner, because delayed treatment is not recommended):
  - Document progress (flexibility, areas of tenderness, motor strength, straight leg raise — sitting & supine)
  - If still 50% disabled (i.e., cannot return to work) then consider referral for exercise/instruction/manual therapy [Benchmark cost: $250];
Pain Management in Workers’ Compensation

Individual State Guideline Adoption

Key

- ODG Guidelines
- ODG & ACOEM Guidelines
- No/Own Guidelines

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Recent ACOEM Changes

► In most cases, Morphine Equivalency Dose (MED) should be limited to 50 mg, particularly in the acute setting; although, sub-acute and chronic pain patients may require higher doses.

► Impact is mainly on chronically injured workers.

► Targets claimants for an earlier intervention in order to address ongoing pain management before dosage continues to escalate.

**Average MED by Age of Claim**

![Bar chart showing average MED by age of claim.](chart.png)

- >1202
- 51-1202
- 0-50
Formularies

A medication’s place on a formulary evaluates these indicators

- Is it safe?
- Is it effective?
- What is the cost? Not just acquisition cost, but total cost of therapy (pharmacy and medical)
Formularies in Workers’ Compensation

Pharmacy Benefit Management Level

- Formularies to drive appropriate selection of medications for the injured worker have been established at the PBM level
- Serve to drive the appropriate initial use of medications; when medications are not typical first-line therapy or related to an injury, a “block” is created to seek additional approval, either at the adjuster, case manager, or UR level
# Typical Workers’ Compensation Formulary Offerings

<table>
<thead>
<tr>
<th>Brief Description</th>
<th>First Fill Formulary</th>
<th>Workers’ Compensation Global Formulary</th>
<th>Injury-Based Formulary</th>
<th>Client-Custom Formulary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description</strong></td>
<td>A limited set of medications mainly used in the treatment of an acute industrial injury</td>
<td>Medications that are typically prescribed for the treatment of common workers’ compensation injuries</td>
<td>Medications typically prescribed for treatment of specific injuries</td>
<td>Allows client-specific utilization patterns and clinical approaches to determine formulary design</td>
</tr>
<tr>
<td><strong>Division Based on Age of Claim</strong></td>
<td>Only valid until the claim information is received through eligibility</td>
<td>Acute and Chronic</td>
<td>Generally only valid in the acute phase of injury</td>
<td>Acute and Chronic</td>
</tr>
<tr>
<td><strong>Required Data Elements</strong></td>
<td>None (prior to eligibility information being received)</td>
<td>Standard eligibility feed</td>
<td>Diagnosis codes must be provided, either WCIO/NCCI body part and nature of injury or ICD9 codes. If ICD9 based, only compensable injuries should be provided</td>
<td>Will be determined based on formulary</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Includes medications typically related to initial treatment of workers’ compensation injuries until eligibility information is received. After that, the formulary changes to the client’s selected formulary</td>
<td>Provides medications related to a broad range of injuries typical in workers’ compensation for that particular client, while limiting medications used in chronic injuries to the chronic phase of injury</td>
<td>Provides medications specific only to the compensable injury as communicated by the client; all other medications require authorization</td>
<td>Provides medications related to a broad range of injuries typical in workers’ compensation for that particular client, while limiting medications used in chronic injuries to the chronic phase of injury</td>
</tr>
<tr>
<td><strong>Precautions</strong></td>
<td>Only valid until eligibility information is obtained</td>
<td>May provide limited access to medications not related directly to the compensable injury</td>
<td>May restrict access to appropriate medications needed to treat injuries that do not respond to initial therapy; compensable injury information must be included in eligibility feed to trigger appropriate injury-based formulary</td>
<td>May provide limited access to medications not related to the compensable injury</td>
</tr>
</tbody>
</table>
State-Based Formulary Offerings

► ODG-based formularies
  – **Texas**: all “N” drugs require prior authorization ("Y" or unaddressed medications can be addressed via UR after initial coverage)
  – **Oklahoma**: all “Y” drugs are covered (“N” or unaddressed medications can be addressed after initial coverage)
► **Washington**: Implemented a state-specific formulary (administered by the state) requiring prior-authorization for indicated medications
► **Ohio**: Implemented a state-specific formulary (administered by BWC) requiring prior-authorization for indicated medications
## State-Based Formulary Offerings

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Generic Equivalent</th>
<th>Status</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baclofen</td>
<td>Lioresal®</td>
<td>Yes</td>
<td>Y</td>
<td>$21.93</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>N/A</td>
<td>Yes</td>
<td>N</td>
<td>$12.00</td>
</tr>
<tr>
<td>Carisoprodol</td>
<td>Soma®</td>
<td>Yes</td>
<td>N</td>
<td>$8.67</td>
</tr>
<tr>
<td>Chlorzoxazone</td>
<td>Parafon Forte®, Paraflex®, Relax™ DS, Remular S™</td>
<td>Yes</td>
<td>Y</td>
<td>$17.82</td>
</tr>
<tr>
<td>Chlorzoxazone</td>
<td>Lorzone®</td>
<td>No</td>
<td>N</td>
<td>$571.54</td>
</tr>
<tr>
<td>Cyclobenzaprine</td>
<td>Flexeril®, Fexmid™</td>
<td>Yes</td>
<td>Y</td>
<td>$3.25</td>
</tr>
<tr>
<td>Cyclobenzaprine ER</td>
<td>Amrix®</td>
<td>No</td>
<td>N</td>
<td>$680.00</td>
</tr>
<tr>
<td>Dantrolene</td>
<td>Dantrium®</td>
<td>Yes</td>
<td>N</td>
<td>$106.93</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Valium</td>
<td>Yes</td>
<td>N</td>
<td>$2.98</td>
</tr>
<tr>
<td>Meprobamate</td>
<td>Miltown</td>
<td>Yes</td>
<td>N</td>
<td>$214.72</td>
</tr>
<tr>
<td>Metaxalone</td>
<td>Skelaxin®</td>
<td>Yes</td>
<td>Y</td>
<td>$205.05</td>
</tr>
<tr>
<td>Methocarbamol</td>
<td>Robaxin®, Relaxin™</td>
<td>Yes</td>
<td>Y</td>
<td>$9.94</td>
</tr>
</tbody>
</table>
Workers’ Compensation Medication Utilization Controls

Data - Reflects most current published jurisdictional medical treatment guidelines (prescription drug usage specifically) for workers' compensation

Current as of Sept 2014
Combining Treatment Guidelines and Formularies

What to do when an injured worker meets or exceeds clinical guidelines

**Passive/Informational**

Notify prescriber or client that therapy exceeds current recommended guidelines

**Active/Interventional**

- Intervention at prescriber level to address therapeutic issue, and drive appropriate changes to therapy
- Require a prior authorization for certain medications of medication classes
- Provide Utilization Review as the claim continues to age and medications continue for longer periods of time
## Pain Management in Workers’ Compensation

### Examples of State-Specific Strategies

<table>
<thead>
<tr>
<th></th>
<th>Washington</th>
<th>Texas</th>
<th>California</th>
<th>New York</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direction of Care/ Patient Choice</strong></td>
<td>Employee, from the network</td>
<td>Employee, from the network. If no choice within 14 days, the network will assign a doctor</td>
<td>Employer controls choice for first 30 days following injury unless EE has requested treatment by personal physician prior to injury</td>
<td>Employee, from the network and can change providers as often as desired</td>
</tr>
<tr>
<td><strong>Formulary Adoption</strong></td>
<td>Subject to PA</td>
<td>Closed Formulary</td>
<td>PBM-managed, subject to PA</td>
<td>PBM-managed, subject to PA</td>
</tr>
<tr>
<td></td>
<td>Washington’s Labor and Industry Department maintains. Subject to PA</td>
<td></td>
<td>Closed formulary being considered</td>
<td></td>
</tr>
<tr>
<td><strong>Guideline Adoption</strong></td>
<td>Own State Guidelines</td>
<td>ODG Guideline</td>
<td>ACOEM/ODG/MTUS</td>
<td>Own State Guidelines</td>
</tr>
<tr>
<td><strong>Performance/Outcomes</strong></td>
<td>Positive outcomes:</td>
<td>Positive outcomes:</td>
<td>Positive outcomes:</td>
<td>Negative outcomes:</td>
</tr>
<tr>
<td></td>
<td>• 27% decrease in average MED/day</td>
<td>Texas reforms credited with 49% reduction in cost</td>
<td>Insurers have realized a 70% aggregate reduction in costs since 2003</td>
<td>WC costs increased by 4.5% Benefit payments increased by 11.5%</td>
</tr>
</tbody>
</table>
Positive Results: Texas Closed Formulary

Share of N-Drug Cost in the Total Cost by Claim Type by Service Month

Source: Texas Department of Insurance, Workers’ Compensation Research and Evaluation Group, 2014.
Potential Impact for Other States

Opportunity to Reduce Non-formulary Drug Use in Other States by About 7-14%

Prescribers still underutilize recommended monitoring parameters when prescribing opioids in chronic pain

<table>
<thead>
<tr>
<th></th>
<th>25-State Median</th>
<th>Range for State between 20th and 80th Percentile for Each Measure</th>
<th>Range for all 25 States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimum</td>
<td>Maximum</td>
<td>Minimum</td>
</tr>
<tr>
<td>% of cases that had urine drug testing</td>
<td>16%</td>
<td>11% - 28%</td>
<td>3%</td>
</tr>
<tr>
<td>2008/2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010/2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of cases that had psychological evaluations</td>
<td>6%</td>
<td>4% - 10%</td>
<td>2%</td>
</tr>
<tr>
<td>2008/2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010/2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of cases that had psychological treatments/reports</td>
<td>5%</td>
<td>4% - 9%</td>
<td>2%</td>
</tr>
<tr>
<td>2008/2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010/2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of cases that had active physical medicine</td>
<td>87%</td>
<td>84% - 89%</td>
<td>80%</td>
</tr>
<tr>
<td>2008/2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010/2012</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Many States Looking to the Future

States Looking at Treatment Guidelines

- **Arizona** – Moving slowly with pain treatment guidelines
- **Arkansas** – Rule change underway to adopt ODG; hearing January 29, 2015
- **California** – Opioid Treatment Guidelines
- **Michigan** – Released proposed rule on compounded medications and opioid utilization; impose limits on prescribing opioids unless physician meets strict criteria
- **New York** – Continuing to refine their treatment guidelines
- **Tennessee** – Medical Advisory Committee studying options
Many States Looking to the Future

States Looking at Closed or Limited Formularies

- **Arkansas** – Closed Formulary Rule based on ODG “N” drug list currently being developed; public comment period open until hearing on January 29, 2015
- **California** – California Workers’ Compensation Institute (CWCI) study showed savings of up to $450 million a year
- **Louisiana** – Legislation introduced but not passed earlier this year; likely rulemaking in 2015
- **Oklahoma** – Working to finalize and adopt permanent rules solidifying their closed formulary
- **Tennessee** – Medical Advisory Committee to discuss closed formulary at Dec 10th meeting
Summary

- Formularies can have a positive impact on cost and utilization
  - PBMs have had success in using formularies to manage medication utilization
    - Helios saw a 9.6% reduction in MEDs in 2013
  - State-imposed formularies can add “teeth” to the process
    - More general in nature, focused on specific medications
  - PBM Medication Strategies can be more injury specific
    - Right medications for the particular injury
  - State-imposed formularies should be designed in a way that enhances what PBMs are already doing

- Treatment guidelines are gaining in popularity due to their potential positive impact
  - Texas and Oklahoma efforts indicated as reducing drug and compounded medication utilization
  - Official Disability Guidelines (ODG)
  - American College of Orthopedic and Environmental Medicine (ACOEM)
  - State specific – Medicaid P&T or Workers’ Compensation specific committee
Thank You!

Questions?

➤ You will receive an email with information on how to download and/or view this presentation online along with the other presentations in this series.

- Physician Dispensing and Compounded Medications — a Legislative and Regulatory Update
- Bending the Curve of Opioid Misuse and Abuse
➤ Please take our short survey