# Table of Contents

Introduction ........................................................................................................................................................................ 1
First Script, Every Script—Aggregate Pharmacy Trends ................................................................................................. 3
Methodology ........................................................................................................................................................................ 4
Chapter 1, Traditional View ................................................................................................................................................... 5
  Key Trends ......................................................................................................................................................................... 6
  Average Wholesale Price (AWP) Trends ........................................................................................................................ 7
  New Brand Drugs .......................................................................................................................................................... 8
  New Generics ............................................................................................................................................................... 9
  Morphine Equivalent Dosing (MED) Trends ................................................................................................................ 10
Chapter 2, Managed vs. Unmanaged Views .......................................................................................................................... 11
  Introduction to the Managed and Unmanaged Views ................................................................................................ 12
  Brand and Generic Trends ........................................................................................................................................... 13
  Generic Efficiency ......................................................................................................................................................... 14
  Top Therapeutic Classes by Utilization ......................................................................................................................... 16
  Top Therapeutic Classes by Cost ................................................................................................................................ 18
  Drug Class Utilization by Claim Age ............................................................................................................................. 19
Chapter 3, Aggregate View .................................................................................................................................................. 20
  Key Trends ...................................................................................................................................................................... 21
  High-Impact Drug Classes ............................................................................................................................................. 22
Chapter 4, Opioid Trends .................................................................................................................................................... 23
  Opioid Utilization by Claim Age .................................................................................................................................... 24
  Opioid Cost by Claim Age ............................................................................................................................................. 25
  Top Opioid Trends ......................................................................................................................................................... 26
Chapter 5, Compound Medications ................................................................................................................................... 28
  Compound Trends in 2015 .............................................................................................................................................. 29
  Compound Utilization in Top States ............................................................................................................................... 31
  Compound Cost in Top States ......................................................................................................................................... 33
Chapter 6, Specialty Medications ....................................................................................................................................... 35
  Specialty Drug Trends in 2015 ......................................................................................................................................... 36
  Top Disease States for Specialty Drugs ............................................................................................................................ 37
Chapter 7, Closed Formulary Update ................................................................................................................................ 39
  State Formulary Update .................................................................................................................................................. 40
  Pre-authorization vs. Retrospective Review .................................................................................................................... 41
2015 Accomplishments ......................................................................................................................................................... 42
Looking Ahead ........................................................................................................................................................................ 43
Acronyms .............................................................................................................................................................................. 45
Contributors ......................................................................................................................................................................... 45
References ............................................................................................................................................................................ 45
Introduction

A collective effort on safety proves invaluable to patients

Patient safety is a shared responsibility. As a call to action, this idea has never resonated with greater clarity given the collective challenges we face in managing pharmacy care in workers’ compensation. The incalculable toll of the opioid epidemic and the promises and pitfalls brought by emerging drug classes and dispensing channels require new levels of coordination and data-sharing. At the same time, the dividends from well-orchestrated efforts among Pharmacy Benefit Managers (PBMs), employers, payors, prescribers, regulators, and injured workers have never been greater. The 2015 Coventry First Script® Drug Trends Analysis underscores both what is possible when once-disparate players work together and what remains to be solved.

By focusing on patient safety, regimen efficacy, and cost, PBMs emerge as keystones in a well-functioning dispensing hierarchy. To be sure, no one can supplant the relationship between injured workers and their care providers; however, alarming gaps in patient safety documented in recent years make clear that prescribers cannot be expected to service the needs of patient safety and outcomes in an information vacuum.

The greatest successes arise when there is shared ownership of patient safety and recovery. Consider the sizable drop in hydrocodone usage laid out in this report. This significant easing of a seemingly intractable trend would not have been possible with a single PBM acting unilaterally or if the task was left only to diligent prescribers. Instead, PBMs and health care professionals, among others, pushed rule-makers to tighten access to opioid medications. In late 2014, the Drug Enforcement Agency (DEA) rescheduled hydrocodone-combination products after overdose deaths involving prescription opioids quadrupled in less than a 15-year time span. In approximately the same period, drug manufacturers reported a fourfold increase in opioid drug sales.1 Since the rule change, some opioid prescriptions have disappeared in favor of safer alternatives, as evidenced in this report by an uptick in use of nonsteroidal anti-inflammatory drugs (NSAIDs) and anticonvulsants. PBMs helped usher in the shift by serving up more data highlighting the ruinous effects of errant opioid use. Together, each actor made possible the work of the other. The result is fewer patients left to deal with the ravages of addiction. Still, there is more work to be done. The Centers for Disease Control and Prevention’s (CDC) 2016 update to opioid-prescribing guidelines carves an important benchmark for prescribers and PBMs. Further shifts in prescriber practices away from excessive use of hydrocodone-combination products and other opioids would fan much-needed progress.

Early action on compounds offers lessons for specialty drugs

The successes of the past year extend beyond the drop in opioid prescribing. Use of compound medications fell in 2015 because of a range of factors. These include evaluating compounds at a drug-ingredient level, advocating for state reform measures, educating claims personnel to help them make better approval decisions, and further refining network oversight. Regulators responded to well-publicized concerns about safety and entreaties from PBMs and payors by rolling out new restrictions on compound use. Lawmakers were able to forestall a worsening of the problem because they acted as the trend began to emerge. More work is needed, but we have pushed back the initial surge and are continuing to hone our efforts.

The same playbook of collaboration used to arrest compounds should be deployed to better understand the perhaps unprecedented promise of specialty medications as well as their attendant cost challenges. Specialty drugs typically include prescriptions that are considered to be high cost and/or treat chronic or complex medical conditions. These medicines, which often require special handling, are forecast to be the largest driver of increased branded drug spending in the coming years. Specialty drugs today represent a small slice of overall spending in workers’ compensation, but the pace of growth logged again in 2015 demands attention.

The ability of some specialty medications to cure conditions, rather than merely mask them, changes the calculus of how to balance efficacy, safety, and cost. Prescribers, PBMs, regulators, payors, and, indeed, patients will be forced to grapple with whether to spend perhaps tens of thousands of dollars in a short period to reach for outcomes once deemed unattainable. Such questions take on added complexity for workers’ compensation injuries when there is a need to sort through which conditions are tied to a claim.
Improved data-sharing enables all sides to make better decisions

New frontiers like specialty medications dictate that PBMs forge new ties with prescribers so that understanding and intervention can occur sooner. This type of longer-term, collaborative thinking would represent a promising shift. Arming caregivers with relevant data enables them to make more considered decisions and thereby increase patient safety and recovery.

Data transparency at the point-of-care is critical because of well-documented challenges that must be met: disparate channels often make it difficult to corral patient data, and poor visibility into group health patient conditions and regimens means it can be difficult to obtain a complete picture of care.

We are becoming more collaborative at the point-of-care. Prescriber programs have moved far beyond the early days of dispatching letters to physicians. Increased prescriber education and better identification of errant prescribing patterns can help us move toward our shared safety and recovery goals. The shift to intervening with relevant information sooner in the life of a claim means PBMs can serve as more than watchdogs and adopt a more consultative role with prescribers, case managers, and rule-makers. Successes in patient outcomes are possible when we are accountable to one another. PBMs should continue to share data with regulators and lawmakers. We also must do our part to educate injured workers, prescribers, and employers.

Achievement, as this report makes clear, arrives in many forms. In 2015, First Script’s cost per claim edged up less than 1% because a decrease in utilization largely offset an increase in cost per prescription. This moderation is evidence that it is possible to bend the cost curve and slow a major force in overall medical inflation.

We believe a comprehensive view—showing all pharmacy utilization whether managed through a network or unmanaged—remains the most effective way to understand the full pharmacy landscape. As an industry, we need to continue to work to get relevant data to decision-makers in a usable and timely fashion so we can most ably advance patient safety and recovery. As we have seen, the risks of inaction are great, and the benefits of coordinated efforts are enormous.

Betsy Robinson
Senior Vice President
Product Development and Marketing

Michael Halbach
Vice President
First Script PBM
First Script, Every Script—Aggregate Pharmacy Trends

First Script continues to provide complete transparency into the total pharmacy experience. Given the shift in medication dispensing patterns over the last few years in workers’ comp, we began to adjust the way we report on those medications in our 2014 Drug Trends Analysis. It is no longer sufficient to solely analyze and report on medications dispensed in traditional settings. We believe it is necessary to analyze and report on medications dispensed in all settings to gain a true understanding of the total pharmacy experience. We have grouped the data into four sections: the traditional view, the managed view, the unmanaged view, and the aggregate view. A detailed description of each grouping is provided in the methodology section.

The aggregate pharmacy trends shown below combine the traditional, managed, and unmanaged views into one comprehensive picture.

*The numbers reflected in this and other charts throughout this report may not add up to 100% due to rounding.*
Methodology

The 2015 Drug Trends Analysis is based on transactions billed through Coventry’s PBM Program, First Script, as well as transactions from medical bill review to reflect the total pharmacy exposure for our client base.

As noted in the introduction, we are continuing the reporting format established for 2014 results in which we presented the data for traditional, managed, and unmanaged views. This year we are expanding upon that to include a chapter on aggregate trends.

Compound medication trends are included in this report but have been excluded from the overall trends and addressed in their own section due to the uniqueness of the medication data for these prescriptions.

The Traditional View
This view includes retail and mail-order prescription data and accounts for 66.7% of the total pharmacy transactions and 69.5% of the paid amounts. This view is meant to be a benchmark to traditional industry reports as well as First Script’s historical reporting.

The Managed View
The managed view includes retail, mail-order, and extended-network data that represents 71.7% of all prescriptions and 75.4% of the total paid amounts. This view provides a more accurate portrayal of managed pharmacy trends due to the additional prescription data that is captured through our extended network. Our extended network is comprised of direct contracts with non-traditional pharmacy billing sources such as physician dispensers and clinics. The extended network accounts for 5% of all transactions and 5.9% of all paid amounts.

The Unmanaged View
This view accounts for 28.2% of total pharmacy transactions and 24.6% of total allowed amounts for out-of-network prescription data captured through medical bill review. This view provides insightful information about the cost and utilization trends for prescriptions dispensed or billed out-of-network. This information is not included within traditional industry drug trend reports.

The Aggregate View
The aggregate view accounts for 100% of pharmacy transactions and costs, consolidating the managed and unmanaged views. The claim populations within the managed and unmanaged views are very different and play a significant role in the variation between trends. However, when all prescriptions are included it provides a more accurate depiction of the trends our clients are experiencing.
Chapter 1
Traditional View

Data Includes Retail + Mail-Order Prescriptions

The Traditional View Represents:
66.7% of Total Prescriptions in 2015
69.5% of Total Pharmacy Cost in 2015
Key trends in 2015

Overall cost per claim increased 0.8%.

Opioids
- Cost per claim for opioids fell 0.5%
- Cost per script increase was mitigated by a 7.5% decrease in utilization
- Morphine Equivalent Dosing (MED) declined 1.8%—the third consecutive annual decrease

Dermatological/topicals and muscle relaxants show increasing trend (cost per claim)
- Rose 7% and 7.7%, respectively, due to increased cost per script

Generic usage
- Generic utilization increased by 3.5% to 84.9%, primarily due to the use of generic Celebrex® in 2015
- Generic efficiency remained consistent year-over-year at 96.7%
Average Wholesale Price (AWP) Trends

First Script’s overall AWP increased 5.5% in 2015. This is roughly half of the overall AWP increase of 10% we experienced the prior year. The 2015 overall AWP increase was driven mostly by the 10.1% increase in AWP for brand drugs, while the AWP increase for generic drugs was much lower at 2.3%.

![AWP Increases Chart]

One of the key drivers behind the increase in AWP for brand drugs was short-acting opioids which showed an increase of 14.6%. The brand drug Nucynta® substantially contributed to the increase for this therapeutic class with a 55% jump in AWP. In addition, there was a 9.5% rise in AWP for anticonvulsants, driven by the 9.6% AWP increase for the brand drug Lyrica®.

![Factors contributing to the significant increase in AWP]

Factors contributing to the significant increase in AWP:

- Increasing costs to cover future patent expiration
- Increased FDA oversight and changes in drug schedules
- Consolidation of drug manufacturers
- Regulatory reform
- Product shortages

![2015 Brand/Generic AWP Increases Chart]
## New Brand Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>FDA Indications</th>
<th>Approved</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zohydro® ER (hydrocodone ER)</td>
<td>Pain</td>
<td>1/30/15</td>
<td>2nd version; added abuse-deterrent property</td>
</tr>
<tr>
<td>Zarxio® (filgrastim-sndz)</td>
<td>Neutropenia</td>
<td>3/6/15</td>
<td>Biosimilar to Neupogen* (1st biosimilar approved in U.S.)</td>
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<tr>
<td>Rexulti® (brexipiprazole)</td>
<td>Schizophrenia &amp; depression</td>
<td>7/10/15</td>
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<tr>
<td>Daklinza™ (daclatasvir)</td>
<td>Hep C</td>
<td>7/24/15</td>
<td></td>
</tr>
<tr>
<td>Technivie™ (ombitasvir/ paritaprevir/ritonavir)</td>
<td>Hep C</td>
<td>7/24/15</td>
<td></td>
</tr>
<tr>
<td>Praluent® (alirocumab)</td>
<td>Lipid disorders</td>
<td>7/24/15</td>
<td></td>
</tr>
<tr>
<td>Repatha™ (evolocumab)</td>
<td>Lipid disorders</td>
<td>8/27/15</td>
<td></td>
</tr>
<tr>
<td>MorphaBond™ (morphine ER)</td>
<td>Pain</td>
<td>10/2/15</td>
<td>Abuse-deterrent property</td>
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<tr>
<td>Aristada™ (aripiprazole lauroxil)</td>
<td>Schizophrenia</td>
<td>10/5/15</td>
<td>New injectable formulation</td>
</tr>
<tr>
<td>Vivlodex™ (meloxicam)</td>
<td>Osteoarthritis</td>
<td>10/22/15</td>
<td>New formulation with microbeads</td>
</tr>
<tr>
<td>Belbuca™ (buprenorphine )</td>
<td>Pain</td>
<td>10/23/15</td>
<td>New formulation as buccal film</td>
</tr>
<tr>
<td>Nucala® (mepolizumab)</td>
<td>Asthma</td>
<td>11/4/15</td>
<td></td>
</tr>
<tr>
<td>Ionsys® (fentanyl)</td>
<td>Pain</td>
<td>11/12/15</td>
<td>New transdermal formulation</td>
</tr>
<tr>
<td>Narcan™ (naloxone)</td>
<td>Opioid overdose</td>
<td>11/18/15</td>
<td>New intranasal formulation</td>
</tr>
<tr>
<td>Zepatier™ (elbasvir/ grazoprevir)</td>
<td>Hep C</td>
<td>1/28/16</td>
<td></td>
</tr>
<tr>
<td>Briviact* (brivaracetam)</td>
<td>Seizures</td>
<td>2/18/16</td>
<td></td>
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<tr>
<td>Odefsey® (emtricitabine/ rilpivirine/tenofovir alafenamide)</td>
<td>HIV</td>
<td>3/1/16</td>
<td></td>
</tr>
<tr>
<td>Descovy® (emtricitabine/ tenofovir alafenamide)</td>
<td>HIV</td>
<td>4/4/16</td>
<td></td>
</tr>
<tr>
<td>Inflectra™ (infliximab-dyyb)</td>
<td>Rheumatoid arthritis</td>
<td>4/5/16</td>
<td>Biosimilar to Remicade®</td>
</tr>
<tr>
<td>Xtampza™ ER (oxycodone ER)</td>
<td>Pain</td>
<td>4/26/16</td>
<td>FDA temporarily approved; pending release due to Purdue lawsuit</td>
</tr>
<tr>
<td>Probuphine® (buprenorphine)</td>
<td>Pain</td>
<td>5/26/16</td>
<td>Subdermal implant</td>
</tr>
<tr>
<td>Remoxy™ (oxycodone ER)</td>
<td>Pain</td>
<td>9/25/16</td>
<td>Awaiting FDA final action for NDA resubmission</td>
</tr>
<tr>
<td>Arymo™ ER (morphine ER)</td>
<td>Pain</td>
<td>10/14/16</td>
<td>Abuse-deterrent property</td>
</tr>
<tr>
<td>ARX-04 (sufentanil)</td>
<td>Pain</td>
<td>TBA</td>
<td>Sublingual tablet formulation in trial phase III</td>
</tr>
<tr>
<td>Troxyca ER; (oxycodone/naltrexone)</td>
<td>Pain</td>
<td>TBA</td>
<td>Awaiting FDA final action for NDA</td>
</tr>
<tr>
<td>Vantrela ER (hydrocodone ER)</td>
<td>Pain</td>
<td>TBA</td>
<td>Abuse-deterrent property</td>
</tr>
<tr>
<td>Apadaz (benzhydrocodone/APAP)</td>
<td>Pain</td>
<td>TBA</td>
<td>FDA determined NDA not ready for approval; pending re-evaluation</td>
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<tr>
<td>Tanezumab</td>
<td>Pain</td>
<td>TBA</td>
<td>Phase III for osteoarthritis; phase II for chronic pain (tanezumab is a biologic)</td>
</tr>
</tbody>
</table>

### How does First Script manage new brand drugs?

- First Script P&T Committee reviews new drugs on the market
- Recommendation considers national guidelines, clinical evidence, & cost-effective alternatives
- Formulary includes new drug if criteria are met*
- Smart PA is required for drugs that are not recommended by First Script

*Clients may opt out of First Script’s recommendation.
New Generics

2015–2016 | New Generics

<table>
<thead>
<tr>
<th>Drug</th>
<th>FDA Indications</th>
<th>Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nexium® (esomeprazole)</td>
<td>Antiulcer</td>
<td>1/26/15</td>
</tr>
<tr>
<td>Skelaxin® (metaxalone)</td>
<td>Muscle relaxant</td>
<td>2/27/15</td>
</tr>
<tr>
<td>Viread® (tenofovir)</td>
<td>HIV</td>
<td>3/15/15</td>
</tr>
<tr>
<td>Abilify® (aripiprazole)</td>
<td>Antipsychotic</td>
<td>4/28/15</td>
</tr>
<tr>
<td>Intermezzo® (zolpidem)</td>
<td>Sedative/hypnotic</td>
<td>6/3/15</td>
</tr>
<tr>
<td>Pristiq® (desvenlafaxine)</td>
<td>Antidepressant</td>
<td>6/29/15</td>
</tr>
<tr>
<td>Prilosec® OTC® (omeprazole)</td>
<td>Antiulcer</td>
<td>7/30/15</td>
</tr>
<tr>
<td>Invega® ER (paliperidone)</td>
<td>Antipsychotic</td>
<td>8/3/15</td>
</tr>
<tr>
<td>Fortesta® (testosterone)</td>
<td>Hormone Therapy</td>
<td>8/5/15</td>
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<tr>
<td>Keppra® (levetiracetam)</td>
<td>Anticonvulsant</td>
<td>12/16/15</td>
</tr>
<tr>
<td>Zipsor® (diclofenac)</td>
<td>Pain</td>
<td>2/23/16</td>
</tr>
<tr>
<td>Viagra® (sildenafil)</td>
<td>Impotence</td>
<td>3/9/16</td>
</tr>
<tr>
<td>Voltaren® Gel 1% (diclofenac)</td>
<td>Osteoarthritis</td>
<td>3/9/16</td>
</tr>
<tr>
<td>Nuvigil® (armodafinil)</td>
<td>Stimulant</td>
<td>6/1/16</td>
</tr>
<tr>
<td>Seroquel XR® (quetiapine)</td>
<td>Antipsychotic</td>
<td>11/1/16</td>
</tr>
</tbody>
</table>

Notable new generics

**Voltaren® Gel**
A top 10 topical medication in our book of business. The generic formulation became available in 2016 and should have a positive impact on cost within this class.

**Skelaxin®**
A muscle relaxant medication that falls within our top 10 therapeutic classes. The generic formulation was approved in early 2015 and likely contributed to the 11.7% decrease in managed cost for this drug.

**Keppra®**
An anticonvulsant that falls within our top 10 therapeutic classes. The new generic, which was released in 2015, is expected to have a significant positive impact on cost in 2016.

How does First Script manage new generic drugs?

Generics are required when a bioequivalent is available for a brand-name medication

The brand-name drug is blocked at point-of-sale as soon as the generic is available, unless a prior authorization is in place

When might a brand drug be dispensed instead of the generic?

Physician requires the brand-name product

Pharmacist overrides the generic when there are market-availability issues

Injured worker requests the brand drug and adjuster overrides the prior authorization
Morphine Equivalent Dosing (MED) Trends

Percentage of Opioid Scripts with 100+ MED*

We have seen a steady decline in the overall utilization of opioids over the last four years. In addition, we have noticed a corresponding decline in the percentage of opioid scripts with MED over 100.

Key contributors to the year-over-year decline in MED

**EARLY INTERVENTION** and outreach programs to prescribers and patients

**EDUCATION** initiatives for physicians, injured workers, and adjusters

**FOCUS GROUPS** to analyze and design strategies that reduce opioid utilization

**ADOPTION** of state-based closed formularies and medical guidelines

**PDMPs** are being utilized more frequently due to national emphasis surrounding prescription drug monitoring

---

*Injections and intravenous scripts have been excluded.*
Chapter 2
Managed vs. Unmanaged Views

Managed Data Includes Retail + Mail-Order + Extended-Network Prescriptions

The Managed View Represents:
71.7% of Total Prescriptions in 2015
75.4% of Total Pharmacy Cost in 2015

Unmanaged Data Includes Out-of-Network Prescriptions

The Unmanaged View Represents:
28.2% of Total Prescriptions in 2015
24.6% of Total Pharmacy Cost in 2015
Our analysis found that injured workers who filled managed prescriptions generally had different characteristics than those who filled unmanaged prescriptions. As an introduction to the next section, we have highlighted some key differences between the two populations that comprise the managed and unmanaged views.

**Managed vs. Unmanaged Top Injuries/Diagnoses 2015***

<table>
<thead>
<tr>
<th>Injury Type</th>
<th>Managed</th>
<th>Unmanaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back disorders, other &amp; unspecified</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>Joint disorders, other &amp; unspecified</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Back sprains/strains, other &amp; unspecified</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Intervertebral disc disorders</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Sprains/strains of shoulder &amp; upper arm</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>Open wound, finger</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Although ranked in different order, back disorders, joint disorders, and back sprains/strains were the top three for both groups. Intervertebral disc disorders ranked #4 for the managed prescriptions but much lower at 15th for unmanaged prescriptions.

*Top 5 Injury diagnoses for managed and unmanaged. Based on claims for select clients with medical services in bill review.

Managed claims treat more serious injuries

Unmanaged prescriptions appear to be prescribed for less serious diagnoses, such as open wound (finger), ranked #5 compared to #16 for managed.

Cervical region disorders, ranking 6th highest for the managed population, were much lower at #16 for the unmanaged group.
The release of celecoxib (generic Celebrex®), in May 2014, greatly contributed to the increase in generic utilization and decrease in brand-drug dollars spent for both the managed and unmanaged populations, as usage of brand Celebrex® fell significantly. In addition, usage of the anticonvulsant gabapentin (generic Neurontin®) rose 13% for the managed population.
Generic Efficiency

Managed Generic Efficiency by Claim Age

Unmanaged Generic Efficiency by Claim Age

Overall generic efficiency remains high for all claim years in 2015. We observed notable differences in claim years 1–5 in managed versus unmanaged. Greater generic efficiency in the managed space for younger claims may be due to several factors. However, the fills coming through for this population are typically first-line, generic agents guided in part by formulary rules applied at the point-of-sale. The unmanaged fills for younger claims include more outliers with data showing some higher-priced brand medications that are generally marketed to or dispensed by physicians directly.
Top Therapeutic Classes by Utilization

Managed Top Therapeutic Classes by Utilization

The top 10 most utilized therapeutic classes accounted for 84.8% of managed drug cost.

Opioid use is trending downward, potentially contributing to increases in other drug classes such as anticonvulsants, commonly used to treat chronic pain.

Other factors influencing the decline in opioids:
- Rescheduling of HCPs*
- Revised medical treatment guidelines
- Greater awareness of opioid misuse

Cardiovascular/anthypertensives are typically prescribed to treat patients with high blood pressure. Several therapeutic classes commonly seen in workers’ compensation claims can worsen high blood pressure and increase the risk of heart disease or stroke. Medications of particular concern include those from the anti-inflammatory or antidepressant classes.

*HCPs (hydrocodone-combination products), one of the top-prescribed medications, were re-classified from Schedule III to the more restrictive Schedule II Controlled Substance status by the DEA in October 2014.
The growing use of non-opioid medications to treat pain, such as NSAIDs and non-opioid analgesics, is favorable from a clinical perspective and is a trend we expect to continue.

The top 10 most utilized therapeutic classes accounted for 88% of unmanaged drug cost.

- **Non-opioid analgesics 22.3%**
- **Opioid utilization decreased 17.7%**
- **NSAID utilization increased 12.9%**

The overall decline in usage of topicals can be attributed to:

- Increased awareness around the lack of clinical evidence for these drugs
- First Script’s efforts to bring more OON scripts under management after the appropriate utilization criteria have been met
Managed Top Therapeutic Classes by Percentage of Total Cost

- Opioids declined 2.3%
- The top 10 classes by cost accounted for 84.8% of all managed drug cost

Dermatological/topical utilization remained flat while cost rose 12.7%
Terocin, a multi-ingredient topical, represents the main driver for this increase
Similar products have inflated prices compared with alternative over-the-counter products with similar active ingredients

Unmanaged Top Therapeutic Classes by Percentage of Total Cost

- The top 10 classes accounted for 89.1% of all unmanaged drug cost

Dollars spent on NSAIDs increased 28.1%
Decreases in opioid utilization led to a 13.3% decline in dollars spent on opioids
Drug Class Utilization by Claim Age

Managed Utilization by Claim Age—Top Classes

Percentage of Total Scripts

Unmanaged Utilization by Claim Age—Top Classes

Percentage of Total Scripts

Managed population

Claims younger than one year utilized more
- Short-acting opioids
- NSAIDs
- Muscle relaxants

Claims older than two years utilized more
- Anticonvulsants
- Sustained-release opioids
- Antidepressants

Unmanaged population

Claims younger than one year utilized more
- NSAIDs
- Anti-infectives
- Muscle relaxants

Claims older than two years utilized more
- Dermatological/Topicals
- Antulcers
- Anticonvulsants

Claim Years 0–1

Claim Years 2 and older
Chapter 3
Aggregate View

Data Includes Managed + Unmanaged Prescriptions

The Aggregate View Represents:
100% of Total Prescriptions in 2015
100% of Total Pharmacy Cost in 2015
Aggregate Key Trends

For the first time since reporting drug trends from a managed and unmanaged perspective, we are reporting on aggregate key trends. The charts in this section incorporate all pharmacy transactions that have been broken out in prior chapters. Comparisons between the traditional and aggregate views are outlined herein.

As noted, different claim populations play a significant role in the different trends that occur within the managed and unmanaged views. However, when all scripts are consolidated into the aggregate view, it provides a more accurate picture of the pharmacy activity experienced by our clients and their injured workers.
An analysis of the aggregate trends calls attention to some of the key therapeutic classes that have the highest impact on overall utilization and cost. We have broken out the top classes that have, or are expected to have, significant impact on workers’ compensation claims. The following chapters will dive into more detail about cost and utilization trends for each of these classes.
Chapter 4
Opioid Trends

In the last few years there has been a slow yet continuous shift away from opioid medications to alternative non-opioid therapies. However, in our analysis we found that managed opioid prescriptions are typically being replaced with anticonvulsants, while unmanaged opioid prescriptions are typically being replaced with NSAIDs. This inspired us to dig deeper to better understand the differences in opioid utilization and cost across claim ages in both the managed and unmanaged populations.

Opioids Represent:
27% of Total Aggregate Prescriptions
26% of Total Aggregate Cost
Opioid Utilization by Claim Age

Managed Opioid Prescription Utilization by Claim Age*

Unmanaged Opioid Prescription Utilization by Claim Age*

Claims involving the use of opioids in the managed population tend to be older than those in the unmanaged population. In the managed population more than 43% of the claims are 3+ years old compared to only 17.4% for the unmanaged population in 2015.

Usage of opioids (per claim) has consistently declined in both populations, for all claim ages. The only exceptions being year 8 in the managed population and year 10 in the unmanaged population.

The unmanaged prescription population yields lower opioid usage per claim, which makes sense given the number of single, unrepeated fills in this category.

*Opioid claims only.
Opioid prescriptions increase in cost as the claims age, reaching upwards of $220 per prescription dispensed for older claims (8+ years) in 2015.

Subsys®, a form of fentanyl primarily used to manage breakthrough pain for cancer patients, is being prescribed for workers’ comp injuries. At a cost that ranges from $3,500–$40,000 per 30-day supply, depending upon the strength and dosage, it can easily drive up the cost per script as it has done for claims in year 5 (increase of 43.7%).

Using data analytics, we are able to identify these types of claims early on and guide them back to the appropriate path of recovery.

Increases in cost per prescription for claim ages 6–10 have been driven by a shift in drug mix (Subsys® year 6) and an increase in AWP for some high-volume opioids (e.g., Nucynta®, etc.).

* Opioid claims only.
Top Opioid Trends, Managed

Opioids in 2015 ranked #1 in both total utilization and cost for work-related injuries accounting for 31.4% of all managed utilization and 32.9% of all managed cost.

Managed
Top 5 Opioid Medications Ranked by Utilization*

<table>
<thead>
<tr>
<th>Medication*</th>
<th>% of Total Opioid Scripts</th>
<th>% of Total Opioid Cost</th>
<th>Utilization Trend</th>
<th>Cost Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vicodin®</td>
<td>34.1%</td>
<td>11.1%</td>
<td>-15.8%</td>
<td>-8.7%</td>
</tr>
<tr>
<td>Percocet®</td>
<td>14.9%</td>
<td>17.7%</td>
<td>10.9%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Ultram®</td>
<td>13.6%</td>
<td>3.8%</td>
<td>-0.5%</td>
<td>-7.6%</td>
</tr>
<tr>
<td>Roxicodone®</td>
<td>9.1%</td>
<td>6.9%</td>
<td>12.4%</td>
<td>-2.9%</td>
</tr>
<tr>
<td>OxyContin®</td>
<td>6.0%</td>
<td>19.8%</td>
<td>3.4%</td>
<td>-3.3%</td>
</tr>
<tr>
<td>All Opioids</td>
<td></td>
<td></td>
<td>-3.2%</td>
<td>-2.3%</td>
</tr>
</tbody>
</table>

Injured workers using opioids fell from 60.4% to 57.4%, a 4.7% decrease.

The rescheduling of hydrocodone-combination products (HCPs) in October 2014 curtailed the usage of short-acting opioids. Vicodin® (hydrocodone-acetaminophen) accounted for 10.7% of all managed prescriptions in 2015, down from 12.7% in 2014. Overall managed utilization for Vicodin® is down 15.8%. However, other short-acting opioids, such as Percocet® and Roxicodone®, have seen increasing usage in 2015 at 10.9% and 12.4%, respectively. While the causes for these increases are not exactly clear, the increase in Percocet® use was likely due to the increased supply after the reformulated dosage was released.

*Medications in these charts are a pool of brand and generic. Brand names are provided for reference.
Top Opioid Trends, Unmanaged

Unmanaged
Top 5 Opioid Medications Ranked by Utilization*

<table>
<thead>
<tr>
<th>Medication*</th>
<th>% of Total Opioid Scripts</th>
<th>% of Total Opioid Cost</th>
<th>Utilization Trend</th>
<th>Cost Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vicodin®</td>
<td>34.0%</td>
<td>12.9%</td>
<td>-33.3%</td>
<td>-35.1%</td>
</tr>
<tr>
<td>Ultram®</td>
<td>24.0%</td>
<td>10.1%</td>
<td>-11.6%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Percocet®</td>
<td>9.8%</td>
<td>13.4%</td>
<td>24.1%</td>
<td>13.2%</td>
</tr>
<tr>
<td>Cocet Plus®</td>
<td>7.3%</td>
<td>1.3%</td>
<td>112.7%</td>
<td>157.7%</td>
</tr>
<tr>
<td>Tramadol HCL ER</td>
<td>7.1%</td>
<td>27.7%</td>
<td>-26.9%</td>
<td>-20.2%</td>
</tr>
<tr>
<td>All Opioids</td>
<td></td>
<td></td>
<td>-17.7%</td>
<td>-13.3%</td>
</tr>
</tbody>
</table>

Injured workers using opioids fell from 32.2% to 24.7%, a 23.5% decrease

Opioids in 2015 ranked #2 in unmanaged utilization and #3 in unmanaged cost for work-related injuries accounting for 16.4% of all unmanaged utilization and 15.8% of all unmanaged cost

The top 5 most utilized opioid medications accounted for 82.2% of unmanaged opioid utilization and 65.5% of unmanaged opioid cost

Rescheduling of HCPs affected the out-of-network usage of short-acting opioids. Vicodin® accounted for 5.6% of all unmanaged prescriptions in 2015, down from 8.3% in 2014. Overall unmanaged utilization for Vicodin® is down 33.3%; however, other short-acting opioids, such as Percocet® (acetaminophen-oxycodone) and Cocet Plus® (acetaminophen-codeine), have seen increasing usage in 2015 at 24.1% and 112.7%, respectively.

Tramadol HCL ER
Of note, the drug products included under the “Tramadol HCL ER” designation were largely dominated by tramadol HCl ER 150 mg capsules, a relatively new, high-priced formulation of the drug with no equivalent. This particular strength is often directly dispensed by physicians, and the labeler (STA3, LLC) indicates the start of marketing for tramadol HCl ER 150 mg was July 1, 2015. The remaining drugs under this category were represented by, to a lesser extent, brand-name ConZip® ER capsules and generic equivalents. ConZip® was originally approved with 100, 200, and 300 mg strengths, and is similar to tramadol HCl ER 150 mg in that each capsule contains both immediate-release and extended-release tramadol.

*Medications in these charts are a pool of brand and generic. Brand names are provided for reference.
Chapter 5
Compound Medications

Compounds Represent:
1% of Total Aggregate Prescriptions
12% of Total Aggregate Cost
Compound Trends in 2015

Prior to 2015, the proliferation of compound medications prescribed for injured workers eclipsed the growth of nearly every class of medication with the exception of opioids. Most troubling, compound utilization and spending were surging without any meaningful or reliable evidence of medical efficacy to justify the growth. Increased use of compound medications was so prevalent in the unmanaged space that the workers’ compensation industry conducted studies and pushed for hearings and regulations aimed at limiting compound use to instances in which the injured worker was likely to derive more medical benefit than from the use of a commercially available medication.

The seemingly unchecked growth appeared poised to continue. For that reason, we are pleased to report the reversal of both compound spending and utilization in the managed and unmanaged spaces for 2015. There was no single catalyst or “silver bullet” for this welcome change. Instead, many factors helped restrict the use of compound medications to instances in which injured workers would likely realize medical improvement.

Factors that helped restrict the use of compounds

- Evaluating compounds for clinical necessity at the drug-ingredient level
- Network oversight, scrutinizing compound providers and, in some instances, removing providers from the network
- Advocating for continued state-reform measures requiring demonstration of a compound’s medical necessity prior to dispensing
- Education efforts, empowering claim evaluators to better make critical decisions around the approval of compound medications

Despite these recent small successes, we are at a critical juncture that requires continued scrutiny of compound utilization and cost. In three of the largest markets—Illinois, Pennsylvania, and Texas—we continue to have unreasonable growth in the unmanaged space. This rise is only reversible through continued understanding of what occurs in unmanaged pharmacy utilization and persistent advocacy by all responsible parties to drive reform efforts. The health of injured workers must come before profitability for prescribers and dispensers.
Compound Trends in 2015

Injured Workers Filling at Least One Compound Prescription

- Managed compound use fell 32.5%
- Unmanaged compound use fell 13.6%

Compound Cost

- Managed compound cost fell 29.3%
- Unmanaged compound cost rose 13.4%

Cost per compound
- Managed fell 1.6%
- Unmanaged rose 18.2%
Compound Utilization in Top States, Managed

The percentage of injured workers utilizing compounds fell across all of the top 10 jurisdictions in the managed space, with Illinois experiencing the greatest decrease at 57.7%.

California accounted for 19.2% of injured workers using compounds and experienced a decreasing trend of 7.5%.

These states accounted for nearly 17% of all injured workers using compounds.

These states had a combined decrease of 54.1%.

All other states, combined, experienced a year-over-year decrease of 25.8%. 

Top 10 states represent 60.2% of all injured workers using compounds.
Overall, the unmanaged population experienced a decrease in compound utilization in 2015. However, 6 of the top 10 jurisdictions in the unmanaged population experienced increases, with New York jumping 154.5%.

California accounted for nearly 50% of all injured workers using compounds in 2015; excluding California, the use of compounds nationally increased 16.7% (2.5% to 2.9%).
New York and Illinois had the greatest decreases in compound cost for the managed population, driven mostly by the decline in utilization.

California is the only top 10 state for the managed population that had an increase in compound cost (30.6%).

9 of the top 10 states experienced a decrease in compound cost for the managed population.
8 of the top 10 states had increases in compound cost:

- California (9.3%)
- Virginia (26%)

2 states experienced decreases in compound cost:

- California (9.3%)
- Virginia (26%)
Chapter 6
Specialty Medications

Specialty Drugs Represent:
1% of Total Aggregate Prescriptions
4% of Total Aggregate Cost

The workers’ comp industry is becoming increasingly aware of the growing challenges associated with specialty drugs. As you may recall, specialty drugs include those considered to be high cost and/or treat chronic or complex conditions. Between greater availability of new treatments and high price tags, the costs associated with these medications are expected to grow tremendously in upcoming years. These drugs also have the potential to make a real difference in the lives of injured workers and their families. However, managing the increasing cost burden while ensuring appropriate access to those who need specialty medications for work-related injuries can prove to be extremely difficult without the right tools. In this next section, our analysis dives into current trends occurring with specialty drugs in our book of business.
Specialty Drug Usage, although less than 1% of all medications utilized, has risen 18.3% for the managed population. However, a shift in the mix of specialty drugs utilized has mitigated the increasing utilization, resulting in a 1.1% decrease in total cost for these drugs.

Specialty drug usage for the unmanaged population increased 12.9%, which led to a 26.5% increase in specialty cost.

**Top 3 Managed Specialty Drugs by Total Cost**

- **Harvoni®**
  - 13.9% of specialty cost
  - 0.5% of specialty usage

- **Xarelto®**
  - 7.9% of specialty cost
  - 27.2% of specialty usage

- **Gattex®**
  - 7.5% of specialty cost
  - 0.1% of specialty usage

**Top 3 Unmanaged Specialty Drugs by Total Cost**

- **Synvisc® & Synvisc-One®**
  - 18.7% of specialty cost
  - 10.5% of specialty usage

- **Botox®**
  - 14.4% of specialty cost
  - 4.2% of specialty usage

- **Orthovisc®**
  - 7.3% of specialty cost
  - 10.9% of specialty usage
Specialty Drug Trends, Top Disease States, Managed

Top Disease States in the Managed Group

- Blood-Clotting Treatment & Prevention
- Hepatitis
- HIV/AIDS
- Osteoarthritis
- Rheumatoid Arthritis

Managed
Top Disease States for Specialty Medications Ranked by Cost

<table>
<thead>
<tr>
<th>Disease State</th>
<th>2015 % of Total Specialty Utilization</th>
<th>2015 % of Specialty Cost</th>
<th>Trend 2014–2015 % of Speciality Utilization</th>
<th>Trend 2014–2015 % of Specialty Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood-Clotting Treatment and Prevention</td>
<td>46.9%</td>
<td>18.7%</td>
<td>30.9%</td>
<td>24.4%</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>1.1%</td>
<td>16.9%</td>
<td>-43.6%</td>
<td>-48.8%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>19.5%</td>
<td>15.9%</td>
<td>19.9%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>8.2%</td>
<td>8.2%</td>
<td>9.4%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>1.5%</td>
<td>5.5%</td>
<td>-6.0%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Top Disease States</td>
<td>77.3%</td>
<td>65.3%</td>
<td>22.3%</td>
<td>-12.4%</td>
</tr>
<tr>
<td>All Disease States</td>
<td></td>
<td></td>
<td>18.3%</td>
<td>-1.1%</td>
</tr>
</tbody>
</table>

Specialty Medications
The top 5 disease states accounted for 77.3% of utilization of all specialty medications and 65.3% of cost for all specialty medications in the managed population.

In 2015, utilization for blood-clotting treatment rose 30.9%. Increased usage of Xarelto® (27.8%) and Eliquis® (265.3%) drove the increase in utilization and cost for this category.

In 2015, the utilization of expensive hepatitis medications, costing roughly $18,000 per script, fell nearly 44% and helped to offset increasing costs in other categories.
### Top Disease States in the Unmanaged Group

#### Specialty Drug Trends, Top Disease States, Unmanaged

### Unmanaged

#### Top Disease States for Specialty Medications Ranked by Cost

<table>
<thead>
<tr>
<th>Disease State</th>
<th>2015 % of Total Specialty Utiliz.</th>
<th>2015 % of Specialty Cost</th>
<th>Trend 2014–2015</th>
<th>2015 Total Utilization</th>
<th>2015 Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Osteoarthritis</td>
<td>44.8%</td>
<td>39.3%</td>
<td></td>
<td>4.7%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Neuromuscular Condition</td>
<td>4.5%</td>
<td>15.1%</td>
<td></td>
<td>12.4%</td>
<td>24.7%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>6.4%</td>
<td>12.9%</td>
<td></td>
<td>32.8%</td>
<td>61.5%</td>
</tr>
<tr>
<td>Pain Management</td>
<td>1.2%</td>
<td>7.2%</td>
<td></td>
<td>203.7%</td>
<td>124.5%</td>
</tr>
<tr>
<td>Immune Deficiencies, Immunizations</td>
<td>4.4%</td>
<td>6.7%</td>
<td></td>
<td>38.4%</td>
<td>-20%</td>
</tr>
<tr>
<td><strong>Top Disease States</strong></td>
<td>61.3%</td>
<td>81.3%</td>
<td>11.1%</td>
<td>24.2%</td>
<td></td>
</tr>
<tr>
<td><strong>All Disease States</strong></td>
<td></td>
<td></td>
<td>12.9%</td>
<td>26.5%</td>
<td></td>
</tr>
</tbody>
</table>

### Specialty Medications

The top 5 disease states accounted for **61.3%** of utilization of all specialty medications and **81.3%** of cost for all specialty medications in the unmanaged population.

### Osteoarthritis (OA)

OA is the top disease state for the unmanaged population, and is treated through the use of injections that help lubricate and cushion the knee joint. Utilization has increased **4.7%** yielding a **16.6%** increase in cost.

Utilization of Prialt®, an injectable analgesic used to treat severe chronic pain, has increased by **203.7%** and helped to drive up cost both in the pain management category as well as overall.
Chapter 7
Closed Formulary Update
As the workers’ compensation ecosphere has become increasingly aware of the need to control more than just the cost of prescription medications, lawmakers continue to explore the potential for creating regulation that incorporates utilization management. The primary forms of regulation continue to be state-mandated (closed) formularies, preferred drug lists, and treatment guidelines.

Workers’ compensation experienced more attempts at state-specific formulary adoption or preferred drug lists with only California and Tennessee successfully adopting a formulary in 2015.

Michigan, Louisiana, and New York have contemplated reform that incorporates some type of drug-utilization management ranging from a mandatory formulary to blanket adoption of national treatment guidelines that would fill in the gaps of existing state treatment guidelines concerning medications.

*The North Carolina Compensation Commission is studying the impact of what a closed formulary may have, with an eye towards adopting a formulary in 2017.*
Pre-authorization vs. Retrospective Review

As utilization management regulations progress, states continue to wrestle with whether 1) medications should be pre-authorized, 2) payors should be entitled to seek retrospective utilization review of medications post-dispensing, or both.

Texas

As the first state-mandated formulary outside of a closed workers’ compensation system, Texas has been deservedly praised for the overall benefit of reduced opioid and other problematic drug classes used in its workers’ compensation system. However, had the state opted to require prior authorization for all compounds, as opposed to evaluation on a specific ingredient basis, the outcome could have been substantially better. Since 2011, the same year the Texas formulary was adopted, Texas has seen year-over-year escalation in compound utilization and cost in the unmanaged space. Unfettered growth in utilization resulted in a number of high-profile prescriber and compounding pharmacy investigations that led to the shuttering of some of the state’s more prolific compounders.

Tennessee

Coming into effect in August 2016, the Tennessee mandatory formulary will feature what many prescribers and payors believe to be a balanced approach to evaluating what drugs should be pre-authorized. Leaning on Texas’ concept of allowing an “open” formulary during the initial days following the date of injury, Tennessee has layered the ability for payors to retrospectively review any prescribed medication outside of that initial fill period. Again, beginning with the injured worker’s health in mind, this reinforces the concept of getting necessary medication to an injured worker from the outset of an injury and working to modify drug utilization over time as medical conditions become more stable. Interestingly, Tennessee has put forth a blanket prior authorization requirement for compounded medications, regardless of the first fill period, recognizing that compounds may have clinical value for certain medical conditions but that their use is more appropriate as a targeted or secondary line of medication therapy.

California

With a draft of the 2017 mandatory formulary expected soon, the clock is certainly ticking when it comes to California’s formulary. Under the watchful eyes of the Division of Workers’ Compensation, the Rand Group has spent months researching, engaging stakeholders, and crafting what could be a unique formulary. Certainly questions abound given the unique challenge of adding this mandatory formulary somewhere between the existing Medical Treatment Utilization Schedule and the California workers’ compensation system’s robust utilization review rules. What is certain is that the California formulary, like those before it, will have to contemplate whether to err on the side of requiring more drugs be pre-authorized or whether utilization review should continue to carry the banner for enforcing medical necessity retrospectively.
2015 Accomplishments

Continued opioid utilization decreases
The Coventry First Script book of business experienced a 7.5% decrease in overall opioid utilization and a 1.8% decrease in the average MED per script. The rescheduling of hydrocodone-combination products in late 2014 contributed to the decline in opioid utilization, though it was not the only factor. Our opioid-management programs have continued to produce year-over-year declines in opioid utilization throughout the last five years. Some of the key tools that help drive the success of our overall opioid-management strategy include:

- Early intervention and outreach programs to prescribers and patients
- Physician, injured worker, and adjuster education initiatives
- Increasing client-centered focus groups to analyze and design clinical strategies that reduce opioid utilization
- Incorporation of aggregate data that includes all PBM, mail-order, extended-network, and medical bill data within our risk-identification tools
- DUA/P2P (Drug Utilization Assessment/Peer-to-Peer)
- UDM (Urine Drug Monitoring) Program
- Integrated communication with our nurse case managers to negotiate future care planning, including Opioid Treatment Agreements with patients and prescribers

Mobile technology
We launched Coventry Connect® Mobile, which is designed to provide customers with access to our industry-leading care- and cost-management solutions while on the go. Adjusters and case managers can now access First Script, DMEplus®, case management, Independent Medical Exam (IME) services, and Coventry’s extensive national network of providers and pharmacies on their mobile phones and tablets. Coventry Connect Mobile assists clients in managing their claims quickly and conveniently. This portal works with our integrated suite of solutions to allow adjusters and case managers to make informed decisions that lead to better outcomes.

“Smart PA” drives improved prospective decisions
Smart PA is a unique feature that provides clinical-decision support for adjusters at the most opportune moment to affect appropriate medication utilization. When a prior authorization (PA) for a medication is presented to an adjuster, it is accompanied by a clinical recommendation and supporting rationale indicating whether a medication is appropriate. This feature can incorporate medical, claim, physician, and other non-pharmacy data into the logic and recommendations that we share with adjusters. The additional clinical context supports defensible and consistent decision-making.

RxRN
The Coventry RxRN Program extends the reach of the PBM by combining it with the knowledge, oversight, and one-on-one delivery care model used in case management. Specially trained telephonic case managers focus on claims that are at risk due to emerging and complex pharmacy utilization. The primary objectives of the RxRN are:

- Patient safety
- Patient education
- Ensuring pharmacy utilization is medically appropriate and supports a timely medical recovery
- Achievement of medical stability and return-to-work

Comprehensive Urine Drug Monitoring Program
In 2015, the knowledge gained from our UDM pilot was used to make our program more effective and reduce unnecessary costs. One extremely successful component of the program has been the consistency in identifying the most appropriate candidates for screening through our risk-stratification algorithm. We plan to leverage this tool throughout the year to assist in the safe and effective management of opioid medications.
Looking Ahead

Positively influencing provider prescribing behavior

As the largest full-service managed care organization in the industry, we have a responsibility to leverage our integration capabilities to deliver market-leading positive impact for injured workers and our clients. Our Integrated Network Prescriber Program is poised to positively influence prescribers within the Coventry Preferred Provider Organization (PPO) network and align their prescribing behavior with evidence-based standards of care. Through integration of pharmacy, networks, and case management, we have designed a unique solution to improve prescribing patterns in a way that has not been available within the workers’ comp space to date.

Targeted specialty drug management

Specialty drugs are prescribed to treat conditions either directly or indirectly related to workplace injuries or illnesses. In 2015, there were hundreds of new specialty drugs in the pipeline; this category is considered to be the fastest-growing segment of the U.S. pharmaceutical market. One of the key challenges with specialty drugs is identifying them in the data. We are overcoming this challenge by establishing a custom specialty drug index that will enable the identification and reporting of specialty drugs. Our multidisciplinary clinical teams have been working together to design the most effective solutions for managing and educating injured workers who are being prescribed specialty medications. These new clinical tools will help our clients manage unfamiliar, expensive, and complex medications in the near future.

Opioid overdose prevention

Opioid overdoses are deadly and costly. In fact, drug overdoses have surpassed automobile accidents to become the leading cause of accidental death in the U.S. (44 deaths per day from prescription opioid overdose).2 A 2010 study found 92,200 opioid overdose-related hospital visits with an estimated $1.4 billion in associated treatment costs.3 Opioids represent the most utilized drug class in workers’ comp and our clients expect their PBM to effectively manage opioid overdose risk. Our program is a multidisciplinary solution that incorporates evidence-based recommendations (including recently released CDC opioid prescribing guidelines) to identify injured workers who may be candidates for naloxone (an opioid overdose rescue agent) consideration and/or referral to addiction/dependence treatment.

Direction of care

Medications continue to be dispensed to injured workers through a variety of providers, some of whom (physicians, independent pharmacies, compounding pharmacies) prescribe outside of a traditional PBM network. The result is a less clinically stable, and frequently more costly, ecosystem for the injured worker’s medical care. Coventry’s integrated product offerings will continue to allow for unique steering and recapturing of out-of-network prescriptions, reducing the opportunity for prescriptions to be unevaluated or unaccounted for without impeding an injured worker’s access to appropriate medications.

Clinical formulary management and optimization

Overall pharmaceutical cost continues to rise and remains an area of focus. Several of the medications driving escalating drug costs are considered to be of comparable effectiveness to alternative agents in the same therapeutic class. Clinical studies supporting superior efficacy of one agent versus another are often lacking. Effective clinical formulary management is aimed at targeting high AWP drugs and incorporating evidence-based guidelines to steer providers toward recommended alternatives, thus reducing overall cost per prescription. Our Pharmacy & Therapeutics Committee continually reviews drugs in our formulary as well as potential additions with our clients in order to achieve optimal management of drug utilization and expense.
Acronyms

AWP: Average Wholesale Price
CDC: Centers for Disease Control and Prevention
DEA: Drug Enforcement Agency
DUA: Drug Utilization Assessment
ER: Extended-Release
FDA: Food and Drug Administration
GE: Generic Efficiency
HCPs: Hydrocodone-Combination Products
IME: Independent Medical Evaluations
MED: Morphine Equivalent Dosing
NCCI: National Council on Compensation Insurance
NCPDP: National Council for Prescription Drug Programs
NDA: New Drug Application
NDC: National Drug Code
NSAID: Nonsteroidal Anti-Inflammatory Drug
OA: Osteoarthritis
ODG: Official Disability Guidelines
OON: Out-of-Network
OTC: Over-the-Counter
P2P: Peer-to-Peer
P&T Committee: Pharmacy & Therapeutics Committee
PA: Prior Authorization
PBM: Pharmacy Benefit Manager(ment)
PDL: Preferred Drug List
PDMP: Prescription Drug Monitoring Program
PPO: Preferred Provider Organization
UDM: Urine Drug Monitoring
UR: Utilization Review

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References

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2. CDC. **Accidents or Unintentional Injuries** http://www.cdc.gov/nchs/fastats/accidental-injury.htm
Coventry is the leading provider of cost and care management solutions for workers' comp, disability, and auto insurance carriers, third-party administrators, and self-insured employers. We design best-in-class products and services to help our partners return injured workers to work, to play, and to life as quickly and as cost effectively as possible. We accomplish this by developing and maintaining consultative partnerships with our clients and stakeholders, built on a foundation of trust that supports the claims management process.

**First Script**

First Script is the Pharmacy Benefit and Drug Utilization Management Program offered as part of the Coventry suite of products. First Script offers an end-to-end program designed specifically for workers’ compensation. We realize that getting 100% of the prescriptions into the network isn’t the end game; it is what you do with those scripts that matters. Early triage of each injured worker ensures that injured workers know how and where to get a prescription filled, and permits us to intervene aggressively on potentially problematic opioid utilization at the earliest point possible. Through integration with our bill review and case management programs, we are positioned to capture all prescription activity for utilization and total pharmacy risk management, ensuring that we manage not only the First Script, but Every Script.