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American Pharmacists Association
House of Delegates – National Harbor, Maryland

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NEW BUSINESS

(To be submitted and introduced by Delegates only)

Introduced by: Matt Lacroix, PharmD, MS, BCPS
(Name)

2/19/2020 **(Date)**

Rhode Island Delegation **(Organization)**

Subject: Increasing Access to and Advocacy for Medications for Opioid Use Disorder (MOUD)

Motions: To adopt the following policy statements listed below.

1. APhA supports the use of evidence-based medication as first-line treatment for opioid use disorder for patients, including healthcare professionals, such as pharmacists, in and out of the workplace, for as long as needed to treat their disease.

2. APhA encourages pharmacies to maintain an inventory of medications of public health importance, particularly medications for opioid use disorder, to ensure access for patients.

3. APhA encourages pharmacists and payers ensure patients have equitable access to and coverage for at least one medication from each class of medications used in the treatment of opioid use disorder, such as making medications available on the payor's lowest cost-sharing tier.

Background:
Opioid use disorder (OUD) is a chronic relapsing-remitting disorder characterized by both biological and psychological components exacerbated by sequences of use and return use due to physical symptoms of withdrawal. These include cravings, nausea, vomiting, body aches, anxiety, diaphoresis, and tachycardia. The most effective treatments for opioid use disorder across all treatment settings to enable recovery are medications such as methadone, buprenorphine, and naltrexone (MOUD).[1] Maintenance MOUD are significantly more effective at reducing opioid overdose and other serious events at 3 and 12 months than treatments that do not include medications, including inpatient rehabilitation, behavioral health, and detoxification.[2–5] Maintenance therapy results in significantly better treatment retention.[6,7] Most importantly, long-term use of some medications reduces mortality by at least 50%[8] and are cost-effective.[9] Treatment duration lasts as long as the person needs to take the medication in their recovery, due primarily to the significantly higher risk of overdose when medications are discontinued.[7,10] MOUD are first-line treatments of OUD according to the American Society for Addiction Medicine (ASAM)[11] the National Academies of Sciences, Engineering, and Medicine,[12] the US Department of Health and Human Services (DHHS),[13] the Canadian Medical Association[14] the Centers for Disease Control and Prevention (CDC)[15] and the World Health Organization (WHO).[16] **The American Pharmacists' Association should join these organizations in support of MOUD as first line treatment, and work with them to reduce logistical and financial barriers for this frequently marginalized and vulnerable population.**

Of the more than 2 million people living with OUD, only 1 of 5 people receive any form of treatment.[15,17] Healthcare professionals, a group at higher risk of developing OUD, particularly lack access to MOUD in employee assistance plans and in recovery networks.[18] Few, if any, other chronic disease medications are limited as much as MOUD for patients and for healthcare workers, including medication classes with more narrow therapeutic indices and greater risks of adverse effects such as antipsychotics, insulins, benzodiazepines, and opioids. In a 2019 commentary, the authors outlined the discrepancies in OUD care between what is recommended and prioritized in physician recovery programs versus what is the gold standard for our patients, namely, evidence-based medications for opioid use disorder.[18] Although current programs for physicians and likely pharmacists do show good outcomes, the data showing this is derived from small, incomplete, biased sources; programs do not transparently report the comprehensive data needed to determine true outcomes that lack self-selection bias.[19] **APhA must support equitable access to and use of first-line treatment for OUD for patients, providers, and pharmacists.**

Even when people voluntarily obtain treatment for their OUD, further barriers await them, unique to this common chronic illness. To receive methadone, one of the most studied medications in the world, a patient must travel to a clinic, if they have transportation, sometimes for hours, on a daily basis.[20] Federal

regulations require near-monthly counseling and regular, observed urine samples for toxicology testing to receive methadone. Opioid treatment programs also employ other non-patient-centered restrictions, in addition to limited operating hours only in the mornings. Although several countries, including Canada, Australia, and the United Kingdom embrace pharmacy methadone access, and methadone is permitted to be stocked in community pharmacies, current Drug Enforcement Agency (DEA) regulations prohibit methadone dispensing for OUD from pharmacies.

To obtain buprenorphine, the patients' provider must have completed training and applied to receive a waiver from the federal government to prescribe it. The waiver is currently only available to physicians, midwives, nurse practitioners, and physician assistants, although APhA joined other pharmacy organizations in a letter to the Centers for Medicare and Medicaid service (CMS) to expand the scope of the pharmacist by adding them to the list of providers able to obtain a waiver. For current providers, this 8-24 hour training is only rarely integrated into any curricula nor post-graduate training, leaving 40% of the counties in the United States without even one waivered provider[21] and little possibility of a sustainable supply. Once a waiver is obtained, providers are limited to how many patients that they can treat – limits that are not proven to reduce diversion, ostensibly the reason that limits were established. In fact, few providers have come close to their patient limit, and many providers are not treating anyone with OUD.[22]

In several areas, when patients bring buprenorphine prescriptions to be filled at their pharmacy, an improvement over the current methadone access model, the pharmacy may not stock their desired formulation, or any formulation of this essential medicine.[23] This has led patients to take serious and often life-threatening risks with the increasingly unsafe and potent supply of illegal opioids just to mitigate or avoid physical symptoms of withdrawal. When patients first appointment was delayed, a significant and large number of patients starting using opioids again.[24,25]

Pharmacists must make every effort to stock buprenorphine as they would any other medication of public health importance, especially as efforts to expand treatment access and the number of waivered providers increase.[26]

Patients who do obtain buprenorphine and find a pharmacy that stocks their formulation, then often face financial barriers and other delays related to prior authorizations and co-pay limits. **All payors should follow the example of public third-party payors and eliminate financial and prior authorization barriers to MOUD access, saving lives, reducing ED and inpatient admissions, and costs in the process.**

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Current APhA Policy & Bylaws:

2011 **Potential Conflicts of Interest in Pharmacy Practice**

1. APhA reaffirms that as health care professionals, pharmacists are expected to act in the best interest of patients when making clinical recommendations.
2. APhA supports pharmacists using evidence-based practices to guide decisions that lead to the delivery of optimal patient care.
3. APhA supports pharmacist development, adoption, and use of policies and procedures to manage potential conflicts of interest in practice.
4. APhA should develop core principles that guide pharmacists in developing and using policies and procedures for identifying and managing potential conflicts of interest.

(JAPhA NS51(4) 482;July/August 2011)(Reviewed 2016)

2019 **Patient-Centered Care of People Who Inject Non-Medically Sanctioned Psychotropic or Psychotropic Substances**

1. APhA encourages state legislatures and boards of pharmacy to revise laws and regulations to support the patient-centered care of people who inject non-medically sanctioned psychotropic or psychoactive substances.
2. To reduce the consequences of stigma associated with injection drug use, APhA supports the expansion of interprofessional harm reduction education in the curriculum of schools and colleges of pharmacy, postgraduate training, and continuing professional development programs.
3. APhA encourages pharmacists to initiate, sustain, and integrate evidence-based harm reduction principles and programs into their practice to optimize the health of people who inject non-medically sanctioned psychotropic or psychoactive substances.
4. APhA supports pharmacists' roles to provide and promote consistent, unrestricted, and immediate access to evidence-based, mortality- and morbidity-reducing interventions to enhance the health of people who inject nonmedically sanctioned psychotropic or psychoactive substances and their communities, including: sterile syringes, needles, and other safe injection equipment, syringe disposal, fentanyl test strips, immunizations, condoms, wound care supplies, pre- and post-exposure prophylaxis medications for human immunodeficiency virus (HIV), point-of-care testing for HIV and hepatitis C virus (HCV), opioid overdose reversal medications, and medications for opioid use disorder.
5. APhA urges pharmacists to refer people who inject non-medically sanctioned psychotropic or psychoactive substances to specialists in mental health, infectious diseases, and addiction treatment; to housing, vocational, harm reduction, and recovery support services; and to overdose prevention sites and syringe service programs.

(JAPhA 59(4):e17July/August 2019)

2016 **Medication-Assisted Treatment**

APhA supports expanding access to Medication Assisted Treatment (MAT), including but not limited to pharmacist-administered injection services for treatment and maintenance of substance use disorders that are based on a valid prescription.

(JAPhA 56(4); 370 July/August 2016)

2011 **The Role and Contributions of the Pharmacist in Public Health**

In concert with the American Public Health Association's (APHA) 2006 policy statement, "The Role of the Pharmacist in Public Health," APhA encourages collaboration with APHA and other public health organizations to increase pharmacists' participation in initiatives designed to meet global, national, regional, state, local, and community health goals.
(JAPhA NS51(4) 482;July/August 2011)(Reviewed 2012)(Reviewed 2016)

1983 **Stocking a Complete Inventory of Pharmaceutical Product**

APhA supports the rights and responsibilities of individual pharmacists to determine their inventory and dispensing practices based on patient need, practice economics, practice security, and professional judgment.
(Am Pharm NS23(6):52 June 1983) (Reviewed 2004) (Reviewed 2010) (Reviewed 2015)

2005, 1977 **Government-Financed Reimbursement**

1. APhA supports only those government-operated or -financed, third-party prescription programs which ensures that participating pharmacists receive individualized, equitable compensation for professional services and reimbursement for products provided under the program.
2. APhA regards equitable compensation under any government-operated or -financed, third party prescription programs as requiring payments equivalent to a participating pharmacist's prevailing charges to the self-paying public for comparable services and products, plus additional, documented, direct and indirect costs which are generated by participation in the program.
3. APhA supports those government-operated or -financed, third-party prescription programs which base compensation for professional services on professional fees and reimbursement for products provided on actual cost, with the provision of a specific exception to this policy in those instances when equity in professional compensation cannot otherwise be attained.
(JAPhA NS17:452 July 1977) (JAPhA NS45(5):558 September/October 2005) (Reviewed 2009)(Reviewed 2011)(Reviewed 2012)(Reviewed 2017)

2005, 1981 **Third-party Reimbursement Legislation**

APhA supports enactment of legislation requiring that third-party program reimbursement to pharmacists be at least equal to the pharmacists prevailing charges to the self-paying public for comparable services and products, plus additional documented direct and indirect costs, which are generated by participating in the program.
(Am Pharm NS21(5):40 May 1981) (Reviewed 2005) (Reviewed 2009)(Reviewed 2014)(Reviewed 2019)

****Phone numbers will only be used by the New Business Review Committee in case there are questions for the delegate who submitted the New Business Item Content.**

New Business Items are due to the Speaker of the House by **February 19, 2020** (30 days prior to the start of the first House session). Consideration of urgent items can be presented with a suspension of the House Rules at the session where New Business will be acted upon. Please submit New Business Items to the Speaker of the House via email at hod@aphanet.org.