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**The Idaho Statesman**
Boise, Idaho
**Friday Sept. 1, 2017**
**by Audrey Dutton**


# In chronic pain? Skip tramadol — take morphine, insurers tell some patients

Dr. Richard Radnovich, who specializes in pain management, was trying to get an insurance company to cover a patient's prescriptions earlier this month.

He wanted to give the patient tramadol. The pain medication is a "Schedule IV" drug, which means it has a "low potential for abuse and low risk of dependence," according to the federal classification system set up to chart drug risks.

But the insurance company insisted the patient first try morphine. A "Schedule II," two steps above tramadol on the ranking of addictive drugs, it has a "high potential for abuse, with use potentially leading to severe psychological or physical dependence."

At least five times since late July, three different health insurance companies have told Radnovich that his patients first must try a drug federal agencies say is more prone to abuse before they will cover the treatment he wants to give them.

Radnovich is not a family doctor. His patients typically come to him as a last resort. They've had multiple back surgeries. They were in horrible car crashes. They have fibromyalgia or chronic pain that isn't relieved by physical therapy.

In at least three cases, patients with Regence BlueShield of Idaho plans were denied Radnovich's choice of a Butrans patch — a long-acting version of the opioid buprenorphine that is "Schedule III," with a "moderate to low potential for physical and psychological dependence."

Instead of the patch, Regence was willing to pay for a fentanyl patch or morphine tablets.

Radnovich was vexed by that decision.

"There is no reliable evidence that any one opioid is more effective or safer than another ..." Regence said in an emailed statement. "All opioids are prone to addiction and diversion."

All opioids are indeed dangerous when people don't use them as prescribed. Fentanyl, also a Schedule II, is particularly dangerous when used recreationally or misused accidentally.

## *Failing the steps*

In the medical world, an insurer telling the doctor that a patient must try a certain drug before another is called "step therapy."

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The companies often require patients to try cheaper drugs — and "fail" to benefit from them — before turning to expensive or brand-name ones. If the doctor and patient do not want to comply, they can ask the insurer to reconsider, or the patient can pay out of pocket for the prescription instead of getting insurance coverage.

Step therapy is a way for insurance companies to save themselves and their members money.

Earlier this month, for example, the price at a local pharmacy for a month's worth of Butrans patches was $360 to $650. Ninety morphine tablets cost about $240.

But the practice is controversial, forcing some patients to waste time and money on treatments that do not work. Other states have passed laws to ban the practice. Radnovich last year proposed that the Idaho Medical Association push for such legislation here.

Step therapy interferes with a doctor's ability to make decisions based on a patient's individual needs, said Stacey Worthy, who leads an advocacy group called Aimed Alliance in Washington, D.C. The group is funded in part by pharmaceutical companies.

"I don't think the insurer should be interfering with the relationship, and there are other checks and balances in place to make sure these rogue [opioid] prescribers are being caught, losing their licenses, going to jail," Worthy said, referring to state-run prescription databases, medical board sanctions and arrests in recent years. "The issue here isn't whether they should try out a less addictive medication first, but it's who is making the decision. ... When you have step therapy, it's the insurer who is requiring it, not the physician."

Regence is changing its policy in January to get rid of the step-therapy requirement for patients to first try low-cost morphine. Instead, Regence plans to focus on "appropriate quantities and durations for acute use" and "appropriate patient selection, dosing and monitoring for chronic opioid use," the company told the Statesman.

## *Opioid use vs. opioid abuse*

There is some rationale for the insurers' decisions.

Guidance issued last year by the Centers for Disease Control and Prevention discouraged doctors from prescribing opioids to patients with chronic pain. Primary care doctors should prescribe only the lowest possible dose, in an immediate-release form, for a short amount of time, it says. The CDC notes health care providers wrote 249 million opioid prescriptions in 2013, and many of those prescriptions were not used for medical purposes.

But not all patients are the same, Radnovich and advocacy groups said. Those who end up at Radnovich's clinic have endured years of pain. Some cannot walk without medication. Being required to take Schedule II drugs may complicate their treatment — for example, you can't get refills of those drugs.

Radnovich screens his patients before starting them on opioids and continues to monitor them while they're under his care, with methods such as urine tests, he said.

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Worthy said people who have chronic pain can be dependent on opioids, meaning they need the drugs to function and have as close to a normal life as possible. Being dependent is not the same as being addicted or abusing drugs.

The nationwide crackdown on opioids hasn't always recognized that distinction. Making it difficult for people who abuse or sell opioids to get them has also made it harder for patients who have a legitimate medical need.

The CDC "has been looking back at what they've done, and they're realizing it's affecting people who are in long-term [pain] care," said Jan Chambers, who leads the National Fibromyalgia and Chronic Pain Association.

But in January, the agency that oversees Medicare and Medicaid will require opioid prescriptions to follow the CDC's guidelines, which may leave patients in a lurch, Chambers said.

## *Doctor questions priorities*

Radnovich isn't necessarily opposed to step therapy, he said. What he questions is whether the insurers are choosing the appropriate first steps, requiring Schedule II drugs when the nation is in the middle of an opioid epidemic.

"If we want to say the priority is, 'We want to reduce the exposure to opioids in the community,' that should be a priority," he said. "We have insurance companies telling us they don't want us to prescribe more than a certain number of pills ... but yet, they'll inconsistently say, 'We want you to use morphine before you use tramadol.' "

Radnovich, whose sees up to 100 patients a week in Boise and Caldwell, said this insurance approach to opioids is a recent occurrence. He's seeing it at least two or three times a month, often with new patients. He doesn't remember it happening before last year, though he acknowledges that could be due to his and his patients' increasing reluctance to try more abuse-prone drugs.

Radnovich has received payments from drug companies that make pain medications, including more than $7,000 in 2015 for promotional speaking, training and education on products that include Butrans, according to ProPublica. He told the Statesman in 2011 that the fees, similar to those for giving expert witness testimony, cover the income he loses from being out of the office.

Radnovich said he likes using a Schedule III patch for several reasons. It distributes medication for a week. That keeps a patient from taking a pill that works for a few hours, then wears off right before the next pill is due — a cycle that creates a Pavlovian behavior with pain and pills, he said.

It's also a good option for chronic-pain patients who have a "high abuse profile," perhaps because they struggled with alcohol or drugs in the past.

One major benefit, he said, is that it doesn't produce euphoric highs.

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"I don't want to take the chance that my patient is going to like a drug too much, so I don't want them to have to be exposed to it," he said. "It's insane to me that an insurance company would force me to write morphine [prescriptions] instead of tramadol. ... In what world is that a sane response to what's going on?"

Blue Cross of Idaho's pharmacy director, Steve Olson, said the lack of one-size-fits-all treatments is why his company has "very few" approval hoops to jump through for narcotic or opioid medications. He said the company does not require patients to "step through" morphine before trying tramadol.

"We leave prescribing decisions up to providers, except for fentanyl products," Olson said. "We do require that the providers provide evidence of a cancer diagnosis for those, because fentanyl has highly addictive properties."

Regence plans to set higher bars for patients needing pain medication as part of the changes in January, said spokesman Lou Riepl. The company will require approval ahead of time for all opioids and will set limits on quantities for long-acting opioids.

That's because the company recognizes "the severity of the opioid crisis in our communities and we are committed to decreasing opioid abuse, while supporting appropriate use for people who can benefit from opioid treatment," Riepl said.

## *Controlled substances*

Schedule I: No currently accepted medical use and a high potential for abuse. Examples: heroin, marijuana, ecstasy.

Schedule II: High potential for abuse, with use potentially leading to severe psychological or physical dependence; considered dangerous. Examples: methadone, oxycodone, fentanyl and drugs with less than 15 milligrams of hydrocodone per dose.

Schedule III: Moderate to low potential for physical and psychological dependence. Examples: ketamine and drugs with less than 90 milligrams of codeine per dose, such as Tylenol with codeine.

Schedule IV: Low potential for abuse, low risk of dependence. Examples: Soma and tramadol.

Schedule V: Lower potential for abuse than Schedule IV. Examples: lyrica and cough medicine with less than 200 milligrams of codeine, such as Robitussin AC.

Source: DEA.gov

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