Worldwide, Canada is second only to the United States in per capita consumption of prescription opioids. The author—who notes that it will take a comprehensive, holistic approach to address this crisis—discusses national strategies as well as steps plan sponsors and benefit providers can take to be part of the solution.
The opioid crisis has gripped North America since the early 2000s, with no end in sight. We have all seen the headlines. But how big is this problem? How is Canada addressing it? And what roles do benefit providers and plan sponsors play in helping to combat this serious and far-reaching situation?

The Statistics Tell a Grim Story

Canada is the second-largest consumer per capita of prescription opioids in the world—second only to the United States. In 2017, there were 4,100 opioid-related deaths in Canada—about 11 deaths per 100,000 Canadians.\(^1\) By the end of 2018, that number had risen to 4,500 deaths for a rate of 12 deaths per 100,000 Canadians.\(^2\) To put these numbers in perspective, there were 1,841 automobile fatalities in Canada during 2017.\(^3\)

It is a commonly held misconception that opioid deaths are largely related to illicit drug use; in truth, the opioid crisis affects individuals from all walks of life and from all areas of Canada. While the emergence of illegally manufactured fentanyl and carfentanil has captured much media attention, one in three deaths was of an individual who was receiving prescription opioids from their physician,\(^4\) and three out of four heroin users started by taking prescription opioids.\(^5\)

Counterintuitively, the overall quantity of opioids dispensed in Canada declined by 10.1% between 2016 and 2017, as did the overall quantity of benzodiazepines and benzodiazepine-related drugs, which declined by 5.9% between 2016 and 2017.\(^6\) However, despite this decrease in the amount of prescribed opioids, the harms associated with their use—hospitalizations and deaths—are on the rise, according to the 2018 report *Pan-Canadian Trends in the Prescribing of Opioids and Benzodiazepines*. It is important to note that the report did not consider over-the-counter and illicit drug use. This is why a comprehensive and holistic approach that considers all sources of opioid use is necessary to address this problem.

How Canada Is Addressing the Crisis

The opioid crisis arose due to numerous factors, and it will take the efforts of numerous stakeholders to resolve it. In 2016, the government of Canada made a commitment to address the problem by focusing its efforts on five key areas.

- **Better informing Canadians about the risks of opioids**, for example, with new warning stickers, patient information sheets and reviews of best practices.
- **Supporting better prescribing practices** by promoting prescription-monitoring programs, examining pharmacy records, sharing information with the provincial and territorial licensing bodies, and developing an e-prescribing solution.
- **Reducing easy access to unnecessary opioids**, including clear contraindications for approved opioids, regulatory changes that will propose requiring a prescription for low-dose codeine products and mandatory risk management plans for certain opioids.
• Supporting better treatment options for patients, such as better and faster access to naloxone, expediting the review of non-opioid pain relievers and reexamining special requirements for methadone.

• Improving the evidence base by bringing together experts in the field to discuss how to improve data collection.\(^7\)

The federal government has put a greater focus on public health by replacing the National Anti-Drug Strategy, which relied heavily on enforcement, with the Canadian Drugs and Substances Strategy. In addition, there is more coordination among partner organizations, such as the provinces and territories, and enhanced collaboration with other countries, including the U.S. and Mexico, to address drug trafficking. Canada is also working closely with China to disrupt the export of illegally manufactured fentanyl.\(^8\)

Canada has also made a number of legislative and regulatory changes that address barriers to services or treatment options, enforcement gaps and legal protections for individuals who seek emergency help during an overdose. As well, enhanced compliance and enforcement measures were put into place to target illegal activities related to opioids. New funding is available to establish and support programs that provide necessary services, such as mental health and addiction services. And a number of clinical guidelines were established or updated to support appropriate opioid use and addiction treatment.\(^9\)

Lastly, in recognition that knowledge and information are key to tackling the opioid crisis, all levels of government in Canada collaborated to improve the collection of reliable and complete data about opioids. Prior to 2017, there was little information available and, where data was being collected, there was inconsistency in what was being measured and how. In 2017, the federal, provincial and territorial governments agreed on common definitions and a uniform reporting template for apparent opioid-related death surveillance.\(^10\)

Other Initiatives in Canada

A team of Canadian physicians, in partnership with the Canadian Medical Association, organized the Choosing Wisely Canada campaign in 2014. Its goal is to help clinicians and patients engage in conversations about unnecessary tests and treatments and make smart and effective choices to ensure high-quality care. Opioid Wisely, an initiative of Choosing Wisely Canada, adopted a set of 15 specialty-specific recommendations for prescribing opioid medications. For example, the College of Family Physicians of Canada says that patients should not continue on opioids beyond the immediate period after surgery—typically three days or less, and rarely more than seven days. The initiative is supported by more than 30 organizations representing doctors, dentists, pharmacists, nurse practitioners, other health professionals, and patients and their families.\(^11\)

Canada Health Infoway launched an e-prescribing service, PrescribeIT™, which facilitates the secure electronic transmission of prescriptions to ensure that they cannot be altered or forged. Prescription details are autopopulated directly into the pharmacy software from a physician’s electronic medical record, preventing the fraud and misuse associated with handwritten and faxed prescriptions. Features under development include helping prescribers easily identify when a patient’s doses of opioids exceed the national guidelines or when a patient is receiving opioid prescriptions from multiple prescribers.\(^12\)

At the local and provincial level, the Patch-for-Patch (P4P) Fentanyl Return Program ensures that used fentanyl patches are returned to the pharmacy before additional patches are dispensed. An analysis in 2019 found that the implementation of a P4P program in select counties in Ontario was associated with a lower volume of fentanyl patches dispensed by pharmacies, without an increase in use of other opioids. However, the program had no measurable impact on rates of opioid-related hospital visits or deaths. The recommendation is that P4P programs be used as part of a larger opioid strategy—underscoring the need for a multifaceted approach.\(^13\)

Learn More

Education

Canadian Health and Wellness Innovations Conference
February 23-26, 2020, Savannah, Georgia
Visit www.iifebp.org/canadahealth for more information.

From the Bookstore

Mental Health and Substance Abuse Benefits:
2018 Survey Results
Visit www.iifebp.org/mentalhealth2018 for more information.
The Role of Benefit Providers: What Are the Options?

It’s become clear by now that the opioid crisis is a complicated problem requiring a collective effort. Every stakeholder, including benefit providers, will need to consider its role and its contribution to the solution, keeping in mind that opioids often play an important role in patient care—specifically for patients with acute pain, cancer-related pain and/or terminal illness. It is crucial to balance appropriate access with efforts aimed at preventing misuse. Any strategies implemented by benefit providers—including the following—must take into consideration clinical evidence and practice guidelines.

Listing Decisions

Cost alone cannot be the sole driver of listing decisions. In the U.S., it has been alleged that insurers and pharmacy benefit managers use cost rather than safety to inform listing decisions, and there are a number of accounts of patients being denied access to non-opioid alternatives and/or pushed to low-cost opioid drugs even when not supported by the guidelines. For example, a large U.S. health insurer placed a non-opioid brand-name drug that treats nerve pain on its most expensive tier, while it placed generic opioids on its list of preferred alternatives.14

Drug Utilization Reviews and Morphine Equivalent Dose (MED)

In simple terms, this is the process of identifying plan members whose drug usage exceeds an established utilization threshold and requiring additional clinical information before a claim payment is allowed. It is important that these reviews are based on relevant and clinically meaningful information, not simply dollars paid by the plan. While using dollars as a measure helps limit plan sponsors’ exposure to opioid spend, it does little to ensure safe and appropriate access to treatment. Because there is significant variability in both cost and potency of opioids, tracking dollars does not reliably identify misuse and can limit access for patients with a legitimate need.

Using MED is a better approach for ensuring safety and access. It allows the calculation of an individual’s total opioid use regardless of quantity, cost and potency of the products dispensed. In light of the current crisis, MED-based drug utilization reviews should be standardly implemented by every pharmacy benefit manager. Reviews can also extend beyond opioid utilization to look at concurrent use of other high-risk drugs such as benzodiazepines (e.g., Valium and Xanax), other sedative hypnotics (e.g., Imovane and Sublinox) or any central nervous system depressants such as gabapentinoids (e.g., Neurontin and Lyrica). When combined with opioids, these drugs increase the risk of overdose and death.15

Abuse-Deterrent Formulations

These products, OxyNeo for example, have technology that discourages tampering and makes the pills difficult to crush, chew or dissolve. That means they have lower street value and are less likely to be illicitly diverted. While abuse-deterrent formulations are costlier products than regular (non-abuse-deterrent) formulations, it is sound practice to restrict reimbursement to the abuse-deterrent formulations where available.

Long-Acting Formulations

Due to the large amount of drug in each tablet, long-acting formulations carry a greater risk of overdose than immediate-release opioid products. Long-acting formulations do not generally have a role in treatment initiation; their benefit is typically limited to providing comfort and simplicity for patients who require continuous pain management. A prior authorization process for long-acting formulations limits access to patients who have been established on treatment and require chronic management of pain.

Supply Limits for Both New Starts and Ongoing Prescriptions

Evidence suggests that a three- to seven-day supply is generally sufficient to manage postoperative acute pain, and data shows that a significant number of Canadians have unused opioids following surgery. Unused medications represent wasted dollars, and they often become a source for nonmedical and experimental opioid use. For example, in a Centre for Addiction and Mental Health survey of Ontario students in grades seven through 12 (which has been conducted every two years since 1977), the findings show that home is the most common source of nonmedical opioid use, as reported by 72% of students.16

Digital Tools

The use of research-supported digital tools can aid better and safer pain management for individuals with chronic pain. With connections to
physicians and care teams, these tools enable management and monitoring of pain in real time, which in turn allows for more timely interventions to take place.

**Care Pathways**

Commonly used in hospital and health care settings, care pathways ensure patients have access to evidence-based, high-quality and cost-effective treatment. This approach is best suited to managing conditions where there are clear interventions with good evidence of effectiveness. Care pathways principles can be leveraged when designing a benefit plan to integrate access to care across benefit lines. For example, a care pathway for the management of low-back pain provides adequate access to nondrug treatments, such as physiotherapy and chiropractic care, and provides access to opioid drugs only after the use of other non-opioid alternatives.\(^{17,18}\)

**Pharmacist-Led Deprescribing**

This strategy may soon be possible in Canada, pending legislation. If approved, a proposed amendment to the Controlled Drugs and Substances Act would recognize pharmacists as practitioners authorized to adapt narcotic prescriptions. This would expand access to opioid deprescribing efforts and better tailoring of doses.

**Treating Dependence and Addiction**

In addition to pain management, it is important to recognize the other side of the coin: that patients treated with opioids are at risk for dependence and addiction—another chronic and difficult-to-manage condition. Many of the pain management principles outlined for benefits plan design can also be applied to addiction management.

Guidelines to manage opioid use disorder, or addiction, strongly recommend treatment with opioid agonists, i.e., methadone and the combination of buprenorphine/naloxone (e.g., Suboxone). While their efficacy is comparable, buprenorphine/naloxone has a better safety profile, has a lower risk of overdose and poses a lower public health risk if diverted. In addition, it offers greater treatment flexibility because patients can more quickly transition from observed dosing to take-home prescriptions, meaning the overall cost of buprenorphine/naloxone is comparable, if not slightly less, than methadone. Methadone itself is very inexpensive, but daily observed dosing results in significant spend for the plan due to the dispensing fees incurred.\(^{19}\)

What about other treatment alternatives, such as detox and rehabilitation facilities? The guidelines are clear that detox alone is not recommended because the high rates of relapse result in an elevated risk of death. If detox is to be used, it needs to be quickly followed by long-term treatment. Guidelines also suggest that counselling and rehab should be made available but not be required because evidence of additional benefits is mixed. Lastly, the guidelines support a stepped and integrated care approach where treatment intensity is adjusted as necessary to recognize that patients may need to move between treatments over time.\(^{20}\)

**Plan Design Is the Key**

If the opioid crisis is to fade into history, it is critical for benefit providers to play their part. They must ensure plan design is informed by continual appraisal of available and emerging evidence and that plans provide plan members...
Endnotes

2. Ibid.
9. Ibid.
10. Ibid.
20. Ibid.

BIO

Leila Mandlsohn, Pharm.D., is a senior pharmacy strategy consultant in the pharmacy strategy team at Green Shield Canada (GSC) in Toronto, Ontario. In this role, she is responsible for all facets of drug claims, including drug evaluations, formulary design and maintenance, pharmacy provider and stakeholder relations, and drug pricing and policy. Mandlsohn brings a valuable mix of pharmacy and managed care experience from key roles in Canada and the United States, including community pharmacy experience at various independent and chain pharmacies such as Walgreens, hospital pharmacy practice at Toronto General Hospital, and pharmacy benefit management with Medco in the U.S. (now Express Scripts). A graduate of the Massachusetts College of Pharmacy and Health Sciences (B.Sc.Pharm.), she also completed a Doctor of Pharmacy (Pharm.D.) degree at the University of Kansas. Mandlsohn is a licensed pharmacist in Ontario and Massachusetts, and she is a member of the Ontario Pharmacists Association, Canadian Pharmacists Association and the Academy of Managed Care Pharmacy.