Medications for Addiction Treatment (MAT) Legislation Components - review					
States with bills on Utilization Review (not all inclusive) - CO | HB21-1275 (2021). MN | SF0061 (not passed). IL HB01. KY | SB51, Chap. 201 (2021).					
15 states passed legislation addressing prior authorization barriers to MAT as of 2019* - Visual aid - state prior auth laws					
Bill Features	**Description**	**Medical need**	**How the barrier works**	**Notes**	**Reason to include in Oregon bill**
Formulation coverage	Medications come in various forms--oral, injectable, sublingual, etc.	Injectable beneficial--decide monthly; no diversion; higher blood levels	Injectables not available. OHP - hazardous delay. Patient returns to drug use.		Efficacy, higher blood levels can protect the patient. Efficiency of healthcare workforce time and resources (excessive clerical burdens).
Dose	OHP often denies bup. SL >24 mg/day	Some patients need >24 mg or injectable	Send two Rx's. Pharmacies confused. Patient cannot afford to pay for extra medication. Craving, worse function, return to drug use.	Insurance companies often cite FDA labeling as the reason to limit the dose. Various medications are sometimes used at lower or higher doses based on clinician judgment. Probably they limit the dose more due to stigma and excessive concerns about buprenorphine diversion (rather than cost).	Efficacy, avoid need for methadone or injectable buprenorphine
Prior authorization ban	Insurance requires review before medication approval	immediate Rx needed	Delays or denies Rx access		Safety, efficacy, efficiency
Utilization review ban	Insurance cannot terminate coverage at a later time.	SUD is a chronic condition. Medical providers are qualified to determine length of care, medication, and formulation.	Insurance may decide that after "x" months patients have to switch from injectable to sublingual buprenorphine for OUD, or that injectable naltrexone is no longer needed for Alcohol Use Disorder.	More comprehensive than banning only prior authorizations.	Comprehensive patient protection against losing medical care that is working for them.
Distribution routes	Two routes for injectable medication - buy and bill; specialty pharmacy delivery.	Buy and bill allows medical providers to buy a supply of injectable medication and have it available during an appointment when a patient decides they want to use it.	Buy and bill requires clinics to buy the medication without a guarantee that insurance will pay them back after they use it. Specialty pharmacies do not create a financial liability for medical providers since insurance companies pay for the medication prior to delivery, BUT the delays in care are not acceptable.	Patients often decide that they want injectable medication but then give up on it and do not return even after it is approved and shipped to our clinics.	Patient safety. Ensure immediate access to medication. Avoid wasting money on medication when patients do not return. (Specialty pharmacy delivered medications can ONLY be given to the patient for whom they were prescribed. So we must destroy them if the patient does not return).

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Opioid Use Disorder	Only 3 medications are FDA approved- naltrexone, buprenorphine and methadone. Methadone is not available in regular medical settings. Naltrexone is not effective for people with moderate/severe OUD (and cannot be given to people actively using fentanyl).	Immediate coverage of all forms of buprenorphine.	-	-	Buprenorphine is the only medication available to all medical providers and we need to determine the dose and route.
Alcohol Use Disorder	Only 3 medications are FDA approved- naltrexone, acamprosate, and Antabuse. Oral naltrexone is not effective.	Injectable naltrexone.	Delays or denies Rx access	Oral naltrexone is only given to make sure that patients do not have a side effect or allergy. After an oral test of tolerance, we can give the injection, which will last a month.	Efficacy, efficiency.
Nicotine Use Disorder	Various forms of treatments exist, including nicotine replacement, buproprion, and varenicline.	Patients succeed much more often at quitting when they use 2 forms of nicotine replacement and sometimes also an oral medication.	Across county lines, OHP formularies confuse medical providers. So they send an Rx that is not covered and patients often simply continue smoking or vaping rather than calling to ask for a different Rx.	A statewide OHP formulary would end this obstacle.	"Cigarette smoking is responsible for more than 480,000 deaths per year in the United States, including more than 41,000 deaths resulting from secondhand smoke exposure. This is about one in five deaths annually, or 1,300 deaths every day." CDC 2022
Lifetime limit ban	Insurance sometimes imposes restrictions on the duration of treatment.	[See utilization review ban above]			
ASAM Criteria cannot restrict	Insurance will sometimes require medical providers to do this lengthy assessment before they will cover medications. Or they create policies that make it appear that such assessments must be done or providers will suffer negative consequences.	Immediate Rx when a medical provider deems it beneficial.	Denials in coverage. Apprehension among medical providers who then do not offer SUD treatment at all because they lack the workforce that would perform the ASAM assessment.	Eg. A homeless patient sees a PCP who does not have a counselor available that day. The PCP decides not to give buprenorphine because no ASAM assessment can be done. Reference- ASAM Criteria	ASAM Criteria should help match patients to appropriate care levels, NOT reduce medication access. Consider a statement such as "outpatient medication treatment will be at the sole discretion of the medical provider and coverage will not be delayed or restricted contingent upon assessments (for example ASAM Criteria)."

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Bill Features	**Description**	**Medical need**	**How the barrier works**	**Notes**	**Reason to include in Oregon bill**
Pharmacist ordering, billing for SUD Rx	Pharmacists may be an under-used Addiction medicine workforce resource.	Some patients may be able to easily access pharmacies but not medical clinics.	Pharmacists may not prescribe MAT. (check state regulations).	Colorado passed a bill to allow pharmacists to treat patients with MAT.	Would not include this yet because ASAM has no policy in 2023 for the pharmacist role. They anticipate they will have this ready in 2024. | Pharmacists may have ideas about how to include this since it is beyond ASAM's scope. | Consider contacting pharmacist Emily Skogrand. She is an expert in SUD medication and pharmacy systems - skogrand@ohsu.edu
Enforceable	Create a mechanism and possibly a fine for insurance plans that mistakenly require a prior authorization.	Clinically important delays in care occur when patients cannot access their medication because of a lack of insurance staff training.	The insurance company staff member tells the pharmacy that there is a prior auth required even though there is not. The patient buys more drugs due to delay and withdrawal, thus risking overdose or long-term continued use.		HB 2257 (2019) sought to protect patients for a month from the p.a. requirement. However, for years, OHP continue saying that a p.a. was required. There was no reporting, incentive, or enforcement mechanism in place (or this was not widely known among medical providers).
*Barbara Andraka-Christou, Olivia Golan, Rachel Totaram, Maggie Ohama, Brendan Saloner, Adam J. Gordon & Bradley D. Stein (2023) Prior authorization restrictions on medications for opioid use disorder: trends in state laws from 2005 to 2019, Annals of Medicine, 55:1, 514-520, DOI: 10.1080/07853890.2023.2171107.					